

# American Indian and Alaska Native Mental Health Research



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# American Indian and Alaska Native Mental Health Research

## Volume 30, Issue 1, 2023

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Spero M. Manson, PhD

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# Adverse Childhood Experiences and Health-Related Quality of Life in Adulthood in American Indians and Alaska Natives

Andrei Stefanescu, PhD, MS, and Amy Hilliker, BA

*Abstract: Adverse childhood experiences (ACEs) can result in trauma that persists into adulthood. The goal of this study was to estimate the associations of ACEs with health-related quality of life (HRQOL) metrics in American Indian and Alaska Native (AI/AN) adults in the United States using data from the 2015-2019 Behavioral Risk Factor Surveillance System. Adults (n = 1,389) were asked about current health and ACEs during childhood. ACE score was defined as the total number of ACEs reported. HRQOL outcomes included fair or poor general health, poor general health, poor physical health, poor mental health, and poor physical or mental health. Weighted logistic regression was used to measure the association between ACE score and HRQOL outcomes. A unit increase in ACE score was associated with 14% greater odds of fair or poor general health (OR = 1.14, 95% CI: 1.06, 1.23) and nearly 30% greater odds of poor mental health in the last 30 days (OR = 1.29, 95% CI: 1.20, 1.40). ACEs pose a threat to quality of life in AI/AN adults. These results highlight the need for ACEs prevention in AI/AN communities. Future studies should identify factors associated with resilience to best inform prevention and treatment strategies.*

## INTRODUCTION

Adverse childhood experiences (ACEs) are events occurring from birth to age 17 that can result in long-term trauma that persists into adulthood (Centers for Disease Control and Prevention [CDC], 2021). Examples of ACEs include physical, emotional, and sexual abuse; living in a household with substance use problems; parental separation; and parental incarceration (CDC, 2021). ACEs are associated with numerous chronic illnesses and adverse health outcomes in adulthood, including cancer, heart disease, type 2 diabetes, chronic obstructive pulmonary disease, heavy drinking, depression, and poor oral health (Akinkugbe et al., 2019; Amemiya et al., 2019;

Deschênes et al., 2021; Hu et al., 2021; Merrick et al., 2019). Several studies have also identified a strong association between the number of ACEs experienced in childhood and health-related quality of life in adulthood (Chanlongbutra et al., 2018; Corso et al., 2008; Gjelsvik et al., 2014; Jelley et al., 2020; Martín-Higarza et al., 2020; Masheb et al., 2021).

American Indians and Alaska Natives (AI/ANs) are disproportionately impacted by ACEs. A recent analysis of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) found that AI/AN respondents reported the highest number of ACEs on average and had the highest rates of parental substance abuse, household violence, physical abuse, and sexual abuse of all race/ethnicity groups examined (Richards et al., 2021). These findings are consistent with other analyses of large, population-based data sets, which have found significantly higher ACE scores in AI/AN respondents compared to non-Hispanic Black, non-Hispanic White, and Hispanic respondents (Giano et al., 2021; Kenney et al., 2016). Two regional studies conducted in South Dakota also found that, compared to White residents, AI/AN residents had significantly higher ACE scores (Moon et al., 2016; Warne et al., 2017).

To date, three studies have examined associations between ACE score and health outcomes in AI/AN populations. A study looking at AI/AN adults with type 2 diabetes in five AI/AN communities in the Upper Midwest found significant negative associations between ACE score and mental and physical health (Brockie et al., 2018). Two studies of AI/AN residents of South Dakota found that higher ACE scores were associated with depression, anxiety, alcohol misuse, smoking, and post-traumatic stress disorder in adulthood (Moon et al., 2016; Warne et al., 2017). According to the literature, these associations have not been investigated in other AI/AN populations. The primary goal of this study was to estimate the associations of ACEs with health-related quality of life metrics and chronic illness in adulthood in a diverse, multi-state sample of AI/AN participants living in the United States.

## **METHODS**

### **Study Design**

The Behavioral Risk Factor Surveillance System (BRFSS) is a cross-sectional telephone survey of adults 18 and older conducted annually in all 50 U.S. states, the District of Columbia (DC), and three U.S. territories. BRFSS data collection focuses on health behavior, chronic illnesses, and prevention. Since 2009, BRFSS has included an optional ACEs module including

11 questions about childhood experiences including physical, sexual, and emotional abuse; domestic violence; living with someone with drug addiction, alcohol addiction, or mental illness; parental separation; and incarceration of a household member (CDC, 2020).

For this study, we analyzed BRFSS data that were collected between January 2015 and December 2019 from the 17 states that reported ACEs data to the CDC. Survey respondents were included if they self-identified as AI/AN and provided valid answers to the ACEs module questions. After applying these criteria, the final sample size was  $n = 1,389$ . BRFSS data were collected as part of routine public health surveillance, so this project was exempt from Institutional Review Board approval.

## **Variables**

Each ACEs question was converted to a binary variable. If a respondent answered that they experienced that ACE, the value was set to 1. Otherwise, the value was set to 0. ACE score was calculated as the sum of all individual ACE variables and ranged from 0 to 11. Because data at higher ACE scores was sparse, ACE scores between 6 and 11 were collapsed into one category. This ACE score variable (6 or more ACEs) was used as the primary predictor.

The primary health-related quality of life (HRQOL) outcomes were self-reported fair or poor general health and self-reported poor general health. For the first outcome, the fair and poor categories were combined to create an outcome measure representing less than good general health. Secondary outcomes included poor physical health (15+ days of previous 30 days experiencing physical illness or injury; yes/no), poor mental health (15+ days of previous 30 days experiencing stress, depression, or other emotional problems; yes/no), and poor physical or mental health (15+ days of previous 30 days that physical or mental health restricted the respondent from usual activities such as self-care, work, and recreation; yes/no).

Covariates included biological sex (male/female), state of residence, age (categorized into 5-year windows), and annual household income (<10K, 10-<15K, 15K-<20K, 20K-<25K, 25K-<35K, 35K-<50K, 50K-<75K, and  $\geq 75K$ ). Income and age were analyzed as continuous variables.

## **Statistical Analysis**

A summary of the study sample is presented in Table 1. Categorical variables are summarized using frequencies and weighted percentages, and continuous variables are summarized using medians and interquartile ranges. Weighted logistic regression is used to

calculate odds ratios (OR) and 95% confidence intervals (CI) for associations between continuous ACE score and HRQOL outcomes. Results are reported after adjusting for sex, state of residence, age, and income. Statistical significance was defined a priori for these analyses as  $\alpha = 0.05$ . Data management and analyses were completed using SAS 9.4.

## RESULTS

A summary of participant characteristics is presented in Table 1. After weighting, a majority of the sample was male, most respondents were in the 40-64 age range, and the respondent household income distribution was flat. Approximately 17% of the sample was composed of respondents from New Mexico, a state with a large proportion of American Indian residents. However, several states with large AI/AN populations, including Arizona, California, and Oklahoma, were not represented in the sample. Respondents reported a median of 1.8 total ACEs. Univariate summaries of the outcome variables are presented in Table 2. About a third of the sample (33.6%) reported fair or poor general health, with 11.7% reporting poor general health.

Adjusted associations between ACE score and HRQOL outcomes can be seen in Table 3. ACE score was significantly associated with all five HRQOL outcomes that we investigated. A unit increase in ACE score was associated with 14% greater odds of self-reported fair or poor general health ( $OR = 1.14$ , 95% CI: 1.06, 1.23) and 11% greater odds of self-reported poor physical health ( $OR = 1.11$ , 95% CI: 1.03, 1.20). The strongest association we identified was between ACE score and self-reported poor mental health in the last 30 days. A unit increase in ACE score was associated with nearly 30% greater odds of reporting poor mental health in the last 30 days ( $OR = 1.29$ , 95% CI: 1.20, 1.40).

**Table 1**  
**Participant characteristics ( $n = 1,389$ )**

Variable	<i>n</i>	Weighted %
<b>Sex</b>		
Male	659	55.6%
Female	730	44.3%
<b>Annual Household Income</b>		
< \$10,000	144	12.9%
\$10,000-<\$15,000	128	8.5%
\$15,000-<\$20,000	168	10.5%

*continued on next page*

**Table 1 continued**  
**Participant characteristics (n = 1,389)**

<b>Variable</b>	<b>n</b>	<b>Weighted %</b>
<b>Annual Household Income (cont.)</b>		
\$20,000-<\$25,000	151	13.6%
\$25,000-<\$35,000	138	11.5%
\$35,000-<\$50,000	139	12.8%
\$50,000-<\$75,000	127	11.3%
≥ \$75,000	192	19.0%
<b>State of Residence</b>		
Alabama	83	6.8%
Delaware	23	0.7%
Florida	125	4.7%
Indiana	50	6.6%
Iowa	26	1.9%
Michigan	71	10.9%
Mississippi	39	4.0%
Missouri	63	8.3%
New Mexico	438	17.4%
North Dakota	174	3.6%
Pennsylvania	21	7.6%
Rhode Island	35	1.3%
South Carolina	50	6.5%
Tennessee	60	6.7%
Virginia	42	6.4%
West Virginia	28	1.8%
Wisconsin	61	5.0%
<b>Age Group (years)</b>		
18-24	67	8.1%
25-29	74	7.5%
30-34	73	7.3%
35-39	88	9.6%
40-44	98	10.6%
45-49	117	10.4%
50-54	130	9.5%
55-59	151	9.4%
60-64	186	10.0%
65-69	140	5.9%
70-74	114	5.1%
75-79	59	3.1%
80+	73	3.6%
<b>ACE Score</b> (median, [Q1, Q3])	1.8	[0.1, 4.4]



**Table 2**  
**Participant outcomes (n = 1,389)**

<b>Variable</b>	<b>n</b>	<b>Weighted %</b>
<b>Fair or Poor General Health</b>		
Yes	468	33.6%
No	914	66.4%
<b>Poor General Health</b>		
Yes	173	11.7%
No	1209	88.3%
<b>Physical Health Poor 15+ of Last 30 Days</b>		
Yes	307	21.3%
No	1029	78.7%
<b>Mental Health Poor 15+ of Last 30 Days</b>		
Yes	245	20.3%
No	1106	79.7%
<b>Physical or Mental Health Poor 15+ of Last 30 Days</b>		
Yes	222	15.9%
No	1125	84.1%

**Table 3**  
**Adjusted associations between ACE score and health-related quality of life\***

<b>Outcome</b>	<b>Odds Ratio per Unit Increase in ACE Score</b>	<b>95% Confidence Interval</b>	<b>p Value</b>
<b>Fair or Poor General Health</b>	1.14	1.06, 1.23	<0.001
<b>Poor General Health</b>	1.10	1.01, 1.21	0.035
<b>Poor Physical Health</b>	1.11	1.03, 1.20	0.008
<b>Poor Mental Health</b>	1.29	1.20, 1.40	<0.001
<b>Poor Physical or Mental Health</b>	1.26	1.17, 1.37	<0.001

\*Models are adjusted for age, biological sex, income, and state of residence

## DISCUSSION

Adverse effects of ACEs historically reported in the general population are now being confirmed in the AI/AN community. In a recent publication, Elm et al. (2020) found that high ACE scores are associated with increased risk of depression and generalized anxiety disorder in American Indian adults with type 2 diabetes. In AI/AN children, Kenney et al. (2016) found that high ACE scores are associated with numerous adverse psychosocial outcomes, including

depression, anxiety, attention deficit hyperactivity disorder, low grades, and behavioral problems, possibly forming a bridge to poor mental health outcomes in adulthood. The current study confirms and builds on these results, demonstrating a negative overall association of ACEs with poor mental health in adulthood. This study is also the first to provide AI/AN-specific evidence of association between ACEs and poor physical health in adulthood in a large, multi-state data set. These results emphasize the seriousness of ACEs as a public health problem in the AI/AN population.

Preventing ACEs in AI/AN communities is critical. High ACE scores place affected individuals at risk for re-victimization later in life. In a national sample, AI/AN women with higher ACE scores were more likely to report physical intimate partner violence as adults (Pro et al., 2020). The long-term effects of ACEs can also be transgenerational, and ACE scores can have adverse effects on parenting outcomes. Childhood physical abuse was negatively associated with both parental dissatisfaction and parental role impairment in a large sample of AI/AN parents (Libby et al., 2008). Wurster et al. (2020) found that ACEs in AI/AN parents are negatively associated with their children's social-emotional functioning by way of parental emotional distress. The authors also identified a potential intervention point – high parental emotional availability diminished this relationship (Wurster et al., 2020).

Several other factors may mitigate the association between ACEs and adverse outcomes in adulthood. Bellis et al. (2017) showed that having always-available trusted adult support during childhood diminishes the harmful effects of ACEs. Strengthening tribal community bonds can also reduce harm associated with ACEs in adulthood. A recent study found that sense of belonging to the tribal community moderated the relationship between ACEs and inflammatory markers in a sample of 90 members of a Blackfeet community (John-Henderson et al., 2020). In a sample of Indigenous residents living with type 2 diabetes, social support also moderated the relationship between ACEs and physical health (Brockie et al., 2018).

This study has several key strengths. Using national BRFSS data provided a large sample size that allowed for precise estimation of measures of association. The population-based design of BRFSS provided for more accurate estimates than studies based on convenience samples or that used more restricted sampling frames. States with primarily rural and primarily urban AI/AN populations were included in the sample, providing greater diversity and representation of different built environments. The breadth of data collected through BRFSS also allowed us to adjust for major confounders that could have threatened the validity of a smaller study.

The BRFSS methodology also has certain limitations. BRFSS is a telephone-based survey, so many individuals living on rural reservation lands, where telephone access may be limited, are not covered in the survey's sampling frame. Additionally, several key states with large AI/AN populations, including Arizona, Oklahoma, Alaska, and California were not represented in the sample at all. These issues limit the generalizability of the study's findings, and follow-up investigations should aim to fill these knowledge gaps. Self-report of the variables used for this analysis is also a limitation. Imprecision in self-reported race/ethnicity may have impacted the respondents who were included in the study, and self-report of childhood ACEs introduces the threat of recall bias. While the models were adjusted for known major confounders, there is still a possibility of residual confounding from unmeasured confounders.

Despite these limitations, this study provides valuable insight into the scope of ACEs as a threat to AI/AN health and quality of life across the life course. Investigators should make efforts to conduct regional follow-up studies to assess these relationships with a more geographic focus. The relationships between ACE score and adult outcomes are likely to differ by region, as AI/AN residents of different regions of the United States experience different socioeconomic, natural, and built environments. For example, Libby et al. (2008) found that substance use fully mediated the relationship between childhood physical abuse and parental outcomes in Northern Plains tribes. However, these relationships were only partially mediated in Southwestern tribes, indicating that other factors influence these relationships in this region (Libby et al., 2008). The Indigenous population of the United States is exceptionally diverse and includes more than 550 federally recognized tribes in addition to state-recognized tribes and other Indigenous communities. There can be vast differences in culture, language, dietary patterns, and lifestyles among different tribes, especially across long distances. Another avenue for future investigation is operationalizing and assessing the impact of these cultural factors on the relationship between ACEs and health outcomes in adulthood.

Addressing ACEs as a public health problem will require a multipronged approach focusing on both prevention and mitigation. Developing strategies to reduce household destabilization in AI/AN children should be a major priority. Collaborative and family-centered approaches tailored to AI/AN communities may prevent out-of-home placement for at-risk AI/AN children, improve parent-child relationships, and prevent family separation (Lucero & Bussey, 2012). Expanding awareness of factors that mitigate the relationship between ACEs and poor outcomes in adulthood can also help inform interventions to build individual- and community-

level resilience, reduce the future health burden on AI/AN children, and improve quality of life in adults impacted by ACEs. In both children and adults, decolonized approaches to clinical counseling and integration of traditional therapeutic practices in health and wellness services may offer additional benefit to those impacted by ACEs (Gone et al., 2020; Gone, 2021). An effective example of such an approach is the Urban American Indian Traditional Spirituality Program in Detroit. This program introduced urban American Indian community members to traditional Indigenous spiritual practices aimed at improving health and well-being (Gone et al., 2020).

This study contributes to a growing body of literature on the harmful health consequences of ACEs in the AI/AN population. Given the high prevalence of ACEs in AI/ANs, it is imperative to both prevent ACEs and provide appropriate care to individuals who have been impacted by ACEs. Therapeutic and preventative strategies tailored to specific community and individual needs can reduce the health burden of ACEs on AI/AN communities and improve quality of life for AI/AN individuals. These strategies should be designed and implemented in collaboration with tribal community leaders to avoid paternalistic, oppressive, colonizing, or counterproductive interventions.

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## CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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# Primary Psychiatric Diagnoses, Commercialized Tobacco Use, and Homelessness: Comparisons Between Urban American Indian/Alaska Native and Non-American Indian/Alaska Native Adult Clinical Samples

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*Abstract: Although over 70% of American Indians and Alaska Natives (AI/ANs) reside in urban areas, our knowledge of urban AI/AN adults receiving mental health treatment is limited. This study compares primary psychiatric diagnoses, commercialized tobacco use, and homelessness between AI/AN and non-AI/AN adults receiving services in an urban public mental health agency serving primarily AI/AN people in southern California. Depressive disorders were the most common psychiatric diagnoses for both groups. However, AI/AN adult clients demonstrated significantly less anxiety disorders and significantly more homelessness. Schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, and commercialized tobacco use were higher among AI/AN adults compared to non-AI/AN adults. Results from this study offer data needed to further understand important public health issues that exist among AI/AN adults receiving mental health services in urban areas. We provide suggestions to enhance integrated and culturally appropriate treatment approaches and homelessness initiatives for this under-resourced, yet resilient population.*

## INTRODUCTION

American Indians and Alaska Natives (AI/ANs) experience numerous mental health disparities when compared to other racial/ethnic groups (Adakai et al., 2018; Danielson et al., 2018; Payne et al., 2018). For example, the largest increase in age-adjusted suicide rates from 1999 to 2017 occurred among AI/ANs (Curtin & Hedegaard, 2019). Also, traumatic experiences significantly impact AI/AN communities and are often associated with mental health and

substance use disorders (Aronson et al., 2016; Bassett et al. 2014; Beals et al., 2013; Brockie et al., 2015; Cayir et al., 2018; Ehlers et al. 2013; Emerson et al., 2017). Recent reports highlight the role of federal Indian policy and ongoing structural racism as contributors to these alarming disparities (Avalos, 2021; Churchwell et al., 2020). The scope and impact of mental illness on those experiencing these disorders is extensive, resulting in various socioeconomic and health-related hardships. Two of the most significant issues affecting those with psychiatric disorders are commercialized tobacco use (McClave et al., 2010; Smith et al., 2014) and homelessness (Fazel et al., 2008). However, our knowledge of urban AI/AN adults receiving mental health treatment, their commercialized tobacco use, and homelessness status is limited. This is important to recognize since a profound population shift has occurred over the past few decades among AI/AN people as 70% of AI/ANs now reside in urban areas (U.S. Census Bureau, 2010; Norris et al., 2010), a near doubling of that percentage since 1970 (38%; U.S. Census Bureau, n.d.).

A complex and arduous history exists as it relates to AI/ANs and their movement to urban areas, as well as for the tribal groups whose ancestral homelands were dispossessed to build urban areas, such as Los Angeles. This population has been subjected to well-documented historically based traumas, including forced and coerced relocation from Native lands, forced placement into boarding schools, and restrictions on spirituality, in an attempt to “get rid of the Indian problem” and to eradicate, fragment, and destroy the collective spirit and cultural identity of AI/ANs (United States Commission on Organization of the Executive Branch of the Government, 1949). Due, in part, to historical traumas, numerous health disparities exist among AI/ANs relative to other racial/ethnic groups (Adakai et al., 2018; Basset et al., 2014; Bullock et al., 2017; Cobb et al., 2014; Landen et al., 2014; Livingston et al., 2019; Mack et al., 2017; Nishio et al., 2017; Plescia et al., 2014; Urban Indian Health Commission, 2007; U.S. Census Bureau, 2010).

Los Angeles County, California holds the largest population of AI/ANs (229.6K) compared to any other county in the United States (U.S. Census, 2020). The movement of AI/ANs to Los Angeles is rooted in the Relocation Act of 1956 (Oklahoma State University Digital Collections, n.d.). This act encouraged AI/AN individuals and families to relocate to job training centers in various large cities across the United States, including Los Angeles. However, the promises of relocation were oftentimes not met, and the policy instead resulted in large numbers of AI/ANs experiencing homelessness and unemployment (National Archives, 2016; Nesterak, 2019). In fact, “118 Winston Street,” a location in Los Angeles’s Skid Row, became a destination for a sizeable population of AI/ANs experiencing homelessness (Thompson, 2016). The first AI/AN health and



human services agency to serve AI/ANs in Los Angeles, United American Indian Involvement, Inc. (UAI), started at this location in 1974 (UAI, n.d.a.).

The complex urban environment may pose various challenges for AI/ANs in Los Angeles County. For one, the three tribes whose ancestral homelands were taken to build Los Angeles County have been made landless and are not entitled some of the same advantages as federally recognized tribes. For these tribes, as well as the tribal people who relocated over time, the effects of urbanization have disrupted traditional AI/AN ways of life. Traditionally, AI/ANs lived in an extended family and community network. Through these connections, they were able to engage in AI/AN traditional practices that emphasize wellness and a balanced life. However, the ability for AI/ANs within urban areas to capitalize on their own culturally rooted strengths and traditions may be especially challenging in Los Angeles County. AI/ANs may be geographically and socially fragmented due to their smaller population size in comparison to other ethnic/racial groups in Los Angeles County. Also, complexities associated with AI/AN cultural identity (Brown et al., 2016; Kulis et al., 2013) and discrimination (Dickerson et al., 2019) may be reflective of less cohesive and supportive social networks within the urban setting.

Further complicating AI/AN existence in urban areas, AI/ANs may not indicate their AI/AN heritage on census or survey forms due to identifying as mixed-race and choosing not to indicate their AI/AN cultural identity, or because these survey forms do not always include the option to identify as AI/AN. Conversely, those AI/ANs who do indicate AI/AN identity in addition to other races may not be properly classified as AI/AN, which may have profound implications on resource distribution (United States Commission on Civil Rights, 2018). As a result, health reports generated by public mental and physical health departments within urban areas do not adequately represent AI/ANs, which further contributes to unmet needs within this population.

Commercialized cigarette smoking (as opposed to AI traditional uses of tobacco) is a significant public health issue affecting AI/ANs (CDC, 2019). In the United States, non-Hispanic AI/AN adults have the highest current tobacco product use (32.3%), followed by non-Hispanic multiracial adults (25.4%) and non-Hispanic Whites (21.9%; Creamer et al., 2019). In addition, urban AI/ANs demonstrate high smoking rates in the limited number of studies conducted. For example, the smoking prevalence among AIs aged  $\geq 18$  years in the Twin Cities area of Minnesota was 62%, approximately 3 times greater than the smoking prevalence among the general population of that state (Forster et al., 2007). Furthermore, the protective effects of educational attainment as it relates to cigarette smoking are less among AI/ANs compared to other racial/ethnic

groups. For example, although educational attainment in the United States helps individuals stay healthy by avoiding high-risk behaviors, this effect is smaller for AI/ANs than Whites as it relates to cigarette smoking (Assari & Bazargan, 2019).

Homelessness also highly impacts AI/ANs. AI/ANs constitute a disproportionate percentage of the 209,000 people who were counted as “homeless” in the 2010 Census (U.S. Census Bureau, 2010). According to a recent study, approximately 19% of those experiencing unsheltered homelessness in three Los Angeles neighborhoods were AI/AN (Ward et al., 2022), despite AI/ANs representing approximately 1.5% of the Los Angeles County population (U.S. Census, 2020). Over 90% of AI/AN people experiencing homelessness in Los Angeles are unsheltered (Homelessness Policy Research Institute, 2020). This is in contrast to the annual Greater Los Angeles Homeless Count which reports AI/ANs representing only 0.9% of the homeless population (LAHSA, 2022). As demonstrated by these differences, it is widely believed that is the Greater Los Angeles Homeless Count exhibits a vast undercount of AI/ANs experiencing homelessness, and this concern extends to other urban areas as well. These statistics are noteworthy since homelessness is a key determinant of poor health outcomes (Wilkinson & Marmot, 2003). In King County, Washington, the accuracy of the homeless count was challenged by AI-serving organizations. The county reformed their survey in 2018, and 2 years later the homeless count soared for AI/ANs, going from 3% of the homeless population in 2018 to 15% in 2020 (Brownstone, 2020). Nonetheless, the lack of accurate homelessness data and culturally sensitive resources for AI/ANs has been the basis for ongoing research and advocacy in urban areas. Within Los Angeles itself, in an ongoing response to a 2019 Board Motion (LACBS, 2019), the Board of Supervisors convened an internal County AI/AN Homelessness Working Group within the lead agency for homelessness services and hired a full-time consultant to help coordinate this work. Community organizing and infrastructure development continues to occur, and the first AI/AN housing development to date in Los Angeles has been established (UAI, n.d.b.).

Available data sets related to key health characteristics among urban AI/AN adults receiving mental health treatment are scarce. However, analyses of clinical mental health data within clinical settings offers an opportunity to further our knowledge of important public health issues among highly marginalized and understudied racial/ethnic groups, including urban AI/AN adults. Analyses of mental health clinical data sets may also help to enhance treatment and prevention approaches and to identify further research needs regarding this population.

The purpose of this study is to report and compare data regarding primary psychiatric diagnosis, commercialized tobacco use, and homelessness status of AI/AN adults and non-AI/AN adults receiving services at a Los Angeles County Department of Mental Health-funded agency that provides services primarily for AI/AN people. Following community-based feedback, we have chosen to specifically highlight relevant background and experiences of AI/AN people within Los Angeles County in order to help bring proper attention to the needs of this community. Due to the lack of data for AI/AN adults seeking and receiving mental health treatment, this report is urgently needed in order to address important issues within this community. All four authors of this report are AI/AN. Three are doctorate-level researchers and providers and one is currently a doctoral student. The four authors have a combined 38 years' experience working in AI/AN communities. Following feedback generated from local AI/AN community members and providers, we highlight issues that may be affecting the AI/AN community in Los Angeles County. Community members and providers believed that identifying the source of data presented and the community addressed was necessary in order to help bring attention to the needs of their community. Thus, this report is not intended to stigmatize or label the Los Angeles Native community but to acknowledge concerns and to guide in the development of appropriate policies, treatment interventions, and programs that can help enhance the health and well-being of this population.

We hypothesize that depressive disorders will be the most diagnosed psychiatric diagnoses, followed by anxiety disorders, in both groups. Also, we hypothesize that trauma and stressor-related disorders will be diagnosed more often among AI/AN adults due to their high levels of traumatic exposure. Finally, we hypothesize that commercialized cigarette smoking and homelessness will be higher among AI/ANs.

## **METHODS**

### **Setting**

This mental health clinic was created in 1987 through the Los Angeles County Department of Mental Health (LACDMH) to service the mental health needs of the AI/AN population throughout Los Angeles County. This clinic is one of the very few county-operated mental health clinics serving urban AI/ANs in the United States. Client care is primarily funded through state Medi-Cal (California's Medicaid health care program), Medicare programs, and some private insurance. The clinic's priorities are to provide AI/AN community members, families, and children

a safe place where mental wellness is fostered through delivery of comprehensive mental health services from a multidisciplinary and culturally relevant lens. This clinic serves AI/AN people from a wide variety of tribal backgrounds, cultural identities, and acculturation levels. The clinic collaborates with other local agencies serving the AI/AN community in Los Angeles County, local universities, and several social service agencies.

## **Participants**

AI/AN and non-AI/AN adults receiving mental health services at this clinic were included in this study. Clients of AI/AN descent are only required to self-identify as AI/AN. AI/AN descent is not a requirement to receive services. To protect the confidentiality of these tribal members, we chose to not identify their membership in specific tribal groups (Norton & Manson, 1996). We also chose not to identify this specific clinic in order to minimize stigmatization, labeling, or bring possible harm to the community. This is in recognition of past unethical research conducted among AI/AN populations (Hodge, 2012).

## **Sources of Data**

This study analyzes de-identified, cross-sectional data among urban AI/AN adults and non-AI/AN adults who were receiving mental health care services as of November 2018 at an urban public mental health clinic in Southern California. Based on clinic availability, this clinic accepts non-AI/AN clients. The non-AI/AN adults are representative of utilizers of the public mental health system. They may be referred to this clinic by other LACDMH clinics or non-LACDMH clinics.

Data was retrieved from the LACDMH Integrated Behavioral Health Information System (IBHIS) Active Clients by Program and Primary Program Report. This is a clinical report that includes primary psychiatric diagnoses, commercialized tobacco use, and homelessness status among clients receiving services at the clinic. This report was generated in November 2018. Data reflected in this report was derived from the client's baseline admission mental health assessment and updates made to their mental health record during their course of treatment as of November 2018. Since names were available in the report generated, the first author retrieved missing data, if available, by reviewing each client's chart in the IBHIS, or electronic record system.

Diagnostic criteria were updated by clinicians and clinical supervisors into the mental health record over time based on clinical presentation, life experiences, etc. using an internal

Diagnosis Form. Updates with regard to smoking and homelessness status were also updated in the clinical record made by clinicians and clinical supervisors based on clinical observations during treatment. These updates are reflected in the IBHIS Active Clients by Program and Primary Program Report.

This study was given Institutional Review Board (IRB) approval by UCLA, South General Campus IRB (SGIRB): #20-002217 and the Los Angeles County Department of Mental Health, Human Subjects Research Committee (HSRC): #355.

## **Demographics**

Gender was categorized as either male, female, or transgender. Race/ethnicity was based on self-identification as either AI/AN or non-AI/AN. Adults were categorized as being 18 years of age or older.

## **Primary Psychiatric Diagnosis**

Utilizing a semi-structured diagnostic interview, clinicians determined primary psychiatric diagnosis based on client history, assessment of symptoms, and utilizing the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder (GAD)-7 at their initial assessment. This information was then used to determine psychiatric diagnoses based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (APA, 2013) diagnostic standards. After initial diagnosis, more discussion on the psychiatric diagnosis occurs in weekly case staff meetings where clinical supervisors confirm the psychiatric diagnosis. The diagnosis form in the clinical record also reflects any changes made to their primary psychiatric diagnosis during entry into treatment and throughout their course of treatment. These diagnostic forms are also reviewed on an annual basis during quality assurance to confirm accuracy of diagnosis and any changes with client.

In addition, tri-annual assessments are conducted by clinical staff when diagnostic criteria and psychosocial events or changes are reviewed with the client. Clinicians conducting intakes are either graduate level student interns, unlicensed or licensed social workers, marriage and family therapists, or psychologists. Several staff are AI/AN or have familiarity working with AI/ANs. Other culturally relevant training and instruction working with AI/AN is provided by clinic staff and the Department of Mental Health.



## Commercialized Tobacco Use

Commercialized tobacco use was categorized as either “current smoker” (for those who were recorded as any of the following: current every day smoker, current some days smoker, heavy tobacco smoker, light tobacco smoker, or if they answered “yes” to if they currently smoke) or “current non-smoker” (for those who were recorded as any of the following: non-smoker, never smoked, smoker: inactive, former smoker, or if they answered “no” to if they currently smoke). This did not account for the use of chewing tobacco or cannabis. Unknown cases were not included in the analysis. The clinical record or baseline assessments do not inquire about the ceremonial use of tobacco.

## Homelessness Status

Homelessness status was categorized into the following categories: “yes” (answering “yes” when asked if they were homeless), “no,” (answering “no” when asked if they were homeless), “living in sober living facility,” “currently in rehabilitation facility, and “unknown.” Unknown cases were not included in the analysis. Also, “living in a sober living facility” and “currently in rehabilitation facility” were not included in the analysis since we were not able to determine their homelessness status. We obtained this information at time of intake or as housing status changed throughout the course of treatment. Clinical staff entered homelessness status into the data system allowing this information to be tracked and monitored. When clients are housed, their homelessness status is changed to reflect their current residence.

## Statistical Approach

Demographic data (age, gender, ethnicity/race) are provided in Table 1. The unit of analysis was by individual patient stratified by race (AI/AN compared to non-AI/AN). A 2x2 chi-square analysis was used to examine the association of a primary psychiatric diagnosis between AI/AN and non-AI/AN. Odds ratios (ORs) with 95% confidence interval (CIs) were reported for each group of primary clinical diagnosis with non-AI/AN considered as the reference group (Table 2). Two by two chi-square analyses and ORs were also used to assess commercialized tobacco use status and homelessness status among AI/AN and non-AI/AN (reference group; Table 3). Two-tailed tests and a significance level of 0.05 were used to determine significance. Microsoft Excel (Version 16.0.15028.20160) was used for the data analyses.

## RESULTS

### Participant Characteristics

As shown in Table 1, 259 clients receiving services at the urban public mental health clinic in Southern California were included in this study, including 165 AI/AN adults and 94 non-AI/AN adults. The average age for AI/AN adults is 44.9 years and the average age for non-AI/AN adults is 38.4 years. Both groups comprised more females than males (58% of the AI/AN group and 64% of the non-AI/AN group). Among the non-AI/AN group, the most represented racial/ethnic groups were Hispanic (44%), Caucasian (27%), and African American (13%). Additional ethnic/racial categories for AI/ANs were not available.

**Table 1**  
**Gender, race, and ethnicity/race of the sample**

<b>Characteristic</b>	<b>All adults (N = 259) n (%)</b>	<b>Non-AI/AN adults (n = 94) n (%)</b>	<b>AI/AN adults (n = 165) n (%)</b>
<b>Average age (years)</b>	41.65	38.4	44.9
<b>Gender</b>			
Female	156 (60%)	60 (64%)	96 (58%)
Male	102 (39%)	34 (36%)	68 (41%)
Transgender	1 (1%)	0 (0.0)	1 (1%)
<b>Ethnicity/Race</b>			
American Indian/Alaska Native	165 (63.5%)	0 (0.0)	165 (100%)
Hispanic	41 (16%)	41 (44%)	-
African American	12 (5%)	12 (13%)	-
Caucasian	26 (10%)	26 (28%)	-
Native Hawaiian	2 (0.5%)	2 (2%)	-
Filipino	2 (0.5%)	2 (2%)	-
Other-White	2 (0.5%)	2 (2%)	-
Unknown	2 (0.5%)	2 (2%)	-
Asian	1 (0.5%)	1 (1%)	-
Arabic	1 (0.5%)	1 (1%)	-
Indian	1 (0.5%)	1 (1%)	-
Egyptian	1 (0.5%)	1 (1%)	-
Mexican Indigenous	1 (0.5%)	1 (1%)	-
Filipino/White	1 (0.5%)	1 (1%)	-
Pakistani	1 (0.5%)	1 (1.0)	-

## Primary Psychiatric Diagnosis

As shown in Table 2, for AI/AN adults, current primary psychiatric diagnoses in descending prevalence were: (1) depressive disorders (43%), (2) schizophrenia spectrum and other psychotic disorders (17%), (3) bipolar and related disorders (13%), (4) trauma and stressor-related disorders (13%), and (5) anxiety disorders (9%). For non-AI/AN adults, current primary psychiatric diagnoses in descending order were: (1) depressive disorders (39%), (2) anxiety disorders (22%), (3) schizophrenia spectrum and other psychotic disorders (12%), (4) trauma and stressor-related disorders (11%), and (5) bipolar and related disorders (10%).

A higher proportion of AI/AN patients were diagnosed with depressive disorder, bipolar and related disorders, trauma and stressor-related disorders, or schizophrenia spectrum and other psychotic disorders compared to non-AI/AN patients. As shown in Table 4, AI/AN patients were significantly less likely to have an anxiety disorder compared to non-AI/ANs ( $p < 0.01$ ).

## Commercialized Tobacco Use and Homelessness Status

As shown in Table 3, current smoking rates were 39% for AI/AN adults and 35% for non-AI/AN adults. Thirty-four percent of AI/AN adults were experiencing homelessness compared to 20% of non-AI/AN adults. As shown in Table 5, AI/AN patients were significantly more likely to experience homelessness compared to non-AI/AN ( $p < 0.05$ ). As shown in Table 6, commercialized tobacco use status was not significantly different between AI/ANs and non-AI/ANs.

**Table 2**  
**Primary psychiatric diagnosis**

<b>Current Primary Diagnosis</b>	<b>All adults (N = 259)</b>	<b>Non-AI/AN adults (n = 94)</b>	<b>AI/AN adults (n = 165)</b>
<b>Depressive Disorders</b>	108 (42%)	37 (39%)	71 (43%)
Major Depressive Disorder	92	33	59
Persistent Depressive Disorder	10	3	7
Depressive disorder	1	0	1
Unspecified depressive disorder	4	0	4
Disruptive mood dysregulation disorder	1	1	0
<b>Bipolar and Related Disorders</b>	31 (12%)	9 (10%)	22 (13%)
Bipolar mood disorder	25	7	18
Bipolar mood disorder, type 2	6	2	4

*continued on next page*

**Table 2 continued**  
**Primary psychiatric diagnosis**

<b>Current Primary Diagnosis</b>	<b>All adults (N = 259)</b>	<b>Non-AI/AN adults (n = 94)</b>	<b>AI/AN adults (n = 165)</b>
<b>Other mood disorders</b>	6 (2%)	3 (3%)	3 (2%)
Unspecified mood (affective) disorder	5	3	2
Mood disorder NOS	1	0	1
<b>Anxiety Disorders</b>	36 (14%)	21 (22%)	15 (9%)†
Anxiety disorder	3	3	0
Generalized Anxiety Disorder	23	11	12
Anxiety disorder, unspecified	4	2	2
Anxiety disorder NOS	2	2	0
Other specified anxiety disorder	1	0	1
Panic Disorder	3	3	0
<b>Trauma-and Stressor-Related Disorders</b>	32 (12%)	10 (11%)	22 (13%)
Posttraumatic Stress Disorder	29	8	21
Trauma and stressor-related disorder	1	1	0
Adjustment disorder	2	1	1
<b>Schizophrenia Spectrum and Other Psychotic Disorders</b>	39 (15%)	11 (12%)	28 (17%)
Schizophrenia	12	4	8
Schizoaffective disorder	25	7	18
Delusional disorder	1	9	1
Unspecified psychosis not due to a substance or known physiologic condition	1	0	1
<b>Other Disorders</b>	7 (3%)	3 (3%)	4 (2%)
Phase of life problem in adult	1	0	1
Intermittent Explosive Disorder	2	2	0
Attention Deficit Hyperactivity Disorder	4	1	3

†  $p < 0.05$

**Table 3**  
**Commercialized tobacco use and homelessness status**

<b>Characteristic</b>	<b>All adults (N = 259) n (%)</b>	<b>Non-AI/AN adults (n = 94) n (%)</b>	<b>AI/AN adults (n = 165) n (%)</b>
<b>Homelessness status</b>			
No	166 (64%)	65 (69%)	101 (61%)
Yes	75 (29%)	19 (20%)	56 (34%)†
Living in sober living facility	2 (1%)	2 (2%)	0 (0%)
Currently in rehabilitation facility	2 (1%)	0 (0%)	2 (1%)
Unknown	14 (5%)	8 (9%)	6 (4%)

*continued on next page*

**Table 3 continued**  
**Commercialized tobacco use and homelessness status**

Characteristic	All adults (N = 259) n (%)	Non-AI/AN adults (n = 94) n (%)	AI/AN adults (n = 165) n (%)
<b>Currently not smoking</b>	158 (61%)	60 (64%)	98 (59%)
Non-smoker	68	21	47
"No" (to if they currently smoke)	18	8	10
Never smoked	24	22	2
Smoker: inactive	1	0	1
Former smoker	47	9	38
<b>Currently smoking</b>	97 (37%)	33 (35%)	64 (39%)
Current every day smoker	47	15	32
Current some days smoker	18	4	14
Current smoker	2	0	2
"Yes" (to if they currently smoke)	6	3	3
Heavy tobacco smoker	8	3	5
Light tobacco smoker	16	8	8
<b>Unknown smoking status</b>	4 (2%)	1 (1%)	3 (2%)

†  $p < 0.05$

**Table 4**  
**Chi-square analysis and reported odds ratios for primary psychiatric diagnosis among AI/AN & non-AI/AN**

Variable	All adults (N = 259) n (%)	Non-AI/AN adults (n = 94)			AI/AN adults (n = 165)		
		n (%)	OR	95% CI	n (%)	OR	95% CI
Depressive Disorder	108 (41.70%)	37 (39.36%)	ref	ref	71 (43.03%)	1.16	(0.69, 1.95)
Bipolar and Related Disorders	31 (11.97%)	9 (9.57%)	ref	ref	22 (13.33%)	1.45	(0.64, 3.30)
Other Mood Disorders	6 (2.32%)	3 (3.19%)	-	-	3 (1.82%)	-	-
Anxiety Disorders†	36 (13.90%)	21 (22.34%)	ref	ref	15 (9.09%)	0.35	(0.17, 0.71)
Trauma and Stressor-Related Disorders	32 (12.36%)	10 (10.64%)	ref	ref	22 (13.33%)	1.29	(0.58, 2.86)
Schizophrenia Spectrum & Other Psychotic Disorders	32 (12.36%)	11 (11.70%)	ref	ref	28 (16.97%)	1.54	(0.73, 3.26)
Other Disorders	7 (2.70%)	3 (3.19%)	-	-	4 (2.42%)	-	-

†  $p < 0.01$



**Table 5**  
**Chi-Square analysis and odds ratios for homelessness status among AI/AN & non-AI/AN\***

Variable	All adults (N = 241)	Non-AI/AN adults (n = 84)			AI/AN adults (n = 157)		
	n (%)	n (%)	OR	95% CI	n (%)	OR	95% CI
Homelessness status†			ref	ref		1.89	(1.03, 3.48)
No	166 (69%)	65 (77%)			101 (64%)		
Yes	75 (31%)	19 (23%)			56 (36%)		

\* Excludes "sober living," "rehabilitation," and "unknown" housing categories.

†  $p < 0.05$

**Table 6**  
**Chi-Square analysis and odds ratios for commercialized tobacco use among AI/AN & non-AI/AN**

Variable	All adults (N = 259)	Non-AI/AN adults (n = 94)			AI/AN adults (n = 165)		
	n (%)	n (%)	OR	95% CI	n (%)	OR	95% CI
Smoking status			ref	ref		1.19	(0.70, 2.01)
Currently not smoking	158 (61%)	60 (64%)			98 (59%)		
Currently smoking	97 (37%)	33 (35%)			64 (39%)		

## DISCUSSION

This study provides a rare opportunity to analyze and compare clinical data on AI/AN and non-AI/AN adults receiving mental health services from an urban public mental health clinic in Southern California regarding primary psychiatric diagnoses, commercialized tobacco use, and homelessness. As a result, our knowledge of understudied issues has been enhanced and may be used to improve treatment approaches for AI/AN adults receiving mental health treatment within urban areas. As expected, depressive disorders were the most common psychiatric diagnoses for both groups. Unexpectedly, anxiety disorders were much less common among AI/AN adults than non-AI/AN adults and trauma and stressor-related disorders were unexpectedly similar between groups. Also, schizophrenia spectrum and other psychotic disorders and bipolar and related disorders were more common among AI/AN adults than non-AI/AN adults. Unexpectedly, AI/AN adults and non-AI/AN adults demonstrated similar commercialized tobacco use. As hypothesized, significantly higher levels of homelessness were found among AI/AN adults.

Unexpectedly, anxiety disorders were lower than expected among the sample of AI/ANs receiving mental health services within this urban setting. Very few studies exist analyzing risk and protective factors as it relates to anxiety disorders among AI/ANs in urban areas. However, in

a systematic review of 19 studies across seven countries, modifiable risk and protective factors for anxiety disorders were identified (Zimmermann et al., 2020). Risk factors included cigarette smoking, alcohol use, cannabis use, negative appraisals of life events, avoidance, and occupational factors. Protective factors included social support, coping, and physical activity. Due to the ties that AI/AN adults may have to the community, as revealed through their knowledge of access to mental health treatment at the clinic utilized in this study, it is possible that AI/ANs in this study have social connections and support within their community that helps them with their ability to cope better with their stressors. Clearly, further studies analyzing risk and protective factors for anxiety disorders are needed to more clearly explain how urban AI/AN adults receiving mental health treatment may enhance their resilience and help them to persevere within the urban environment.

That more than one-third of AI/ANs in this study were found to be experiencing homelessness is unprecedented, and particularly at odds with local homelessness authority data where AI/AN are reported to represent only 0.9% of the homeless population (Los Angeles Homeless Services Authority, 2022). Specifically, homelessness count methodology and the definition of AI/AN used for reporting has been challenged (Los Angeles City/County Native American Indian Commission, 2019). Veracity of the study data in this case may be more reliable, given that our study site is a culturally sensitive clinic where the patient population might be self-selecting and demographics such as race may be more prone to self-confirmation. Alarming, study data exceeds the 15% rate of homelessness among AI/ANs in King County's homelessness count, a count that has been revised to be more inclusive of AI/AN people experiencing homelessness (Brownstone, 2020). Although alarming, it also points to opportunities to leverage key resources to address AI/AN homelessness, particularly in regard to housing individuals at high risk for COVID and other local initiatives, including Project Roomkey, an emergency shelter-based program. While there is no set-aside for specific populations, exploring best practices in other cities already providing culturally affirming housing may help guide culturally specific initiatives that adhere to Fair Housing laws. Key to this point is ensuring that AI/AN-serving organizations are connected to the Coordinated Entry System, in which individuals experiencing homelessness are triaged and connected to housing resources. Though there is a legacy of historical mistrust between AI/ANs and government systems (Cannon, 2020), lessons learned from our study site in providing culturally sensitive services may help in the adaptation of homeless services and other key systems in order to optimize key determinants of health among this population. Given

that disparate rates of homelessness and mental health diagnoses among AI/ANs are symptoms of colonization and structural racism, dedicated resources to address these issues are not only just but can improve health. Housing status is inextricably tied to mental health treatment outcomes (Singh et al., 2019). Intervening on both fronts may provide the foundation for further independence of individuals and improved approaches to job training, schooling, and establishing home structures for families, thereby helping to end the cycle of inter-generational trauma among this population.

This study is subject to various limitations. First, it is restricted to one urban area in Southern California and may not be representative of all urban AI/AN adults receiving mental health services in the United States. Also, we retrieved data from a secondary data source that was not designed to address specific research questions. Thus, diagnostic information may be subject to clinician interpretation creating inconsistency and inaccuracy within the clinical documentation. Also, the western construct of mental health and the DSM-5 may be considered a poor fit to meet the needs of AI/AN people, especially following experiences of intergenerational and historical trauma (Jagoo et al., 2021). Thus, there may be issues as it relates to the reliability and validity of DSM-5 for AI/AN adults whose data was used in this study. We were also not able to distinguish the use of ceremonial/traditional use of tobacco with commercialized tobacco use. Nonetheless, this study provides valuable clinical information among an understudied population in the United States.

In conclusion, results from this study reveal the utility of analyzing clinical data regarding psychiatric diagnoses, commercialized tobacco use, and homelessness among a sample of urban AI/AN and non-AI/AN adults receiving mental health services. Enhancing integrated treatment approaches aimed to address commercialized tobacco use and homelessness among urban AI/ANs receiving mental health services may help to decrease the health-related disparities experienced by this population. Additional, larger studies analyzing these issues and identifying best practices among urban AI/ANs in the United States may help to enhance our understanding of this important and resilient population.

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The authors declare that they have no conflicts of interest.

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# Prevalence of Mental Health Disorders and Treatment Utilization among Urban Lesbian, Gay, Bisexual, and Transgender American Indians and Alaska Natives

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*Abstract: We examined prevalence of mental health treatment utilization among 447 lesbian, gay, bisexual, transgender, and Two-Spirit (LGBTT-S) American Indian/Alaska Native (AI/AN) adults and the association of mental health treatment utilization with socio-demographic factors, social support, and mental health diagnoses. We derived data from the HONOR Project, a multi-site cross-sectional survey of Native LGBTT-S adults from seven U.S. metropolitan cities. Rates of lifetime mental health treatment utilization were higher for women (87%), those who were college educated (84%), and homeowners (92%). Cisgender women and transgender AI/AN adults had a higher prevalence than cisgender men of major depression, generalized anxiety, and panic disorder. Rates of subthreshold and threshold posttraumatic stress disorder were significantly higher for transgender adults. Lower positive social support and higher emotional social support were associated with greater odds of mental health treatment utilization. Mental health diagnoses and lifetime mental health treatment utilization was positively associated.*

## INTRODUCTION

In 2019, 6.9 million people in the United States self-identified as American Indian/Alaska Native (AI/AN) alone or in combination with other races (U.S. Census Bureau, 2020). Contrary to popular misrepresentations of AI/ANs as a homogenous group, they are members of distinct and diverse tribal nations and geographically dispersed, with approximately one-third living on reservations and two-thirds living in non-reservation areas (American Psychiatric Association [APA], 2017). AI/ANs are disproportionately affected by many social and behavioral factors that contribute to disparities in their health outcomes, including higher rates of mental health problems compared with non-AI/AN populations (Gone & Trimble, 2012). In 2019, over one in 10 (11.6%)

AI/AN adults reported serious psychological distress in the past year (U.S. Department of Health and Human Services, 2021). Moreover, prevalence rates for lifetime psychiatric disorders (alcohol use, drug use, mood, anxiety, and personality disorders) are higher for AI/AN men and women than non-Hispanic whites. Mental health problems are further complicated by individual experiences, historical trauma, and social and cultural factors (Rieckmann et al., 2012; Whitesell et al., 2012). The physical and mental health of AI/AN adults are negatively impacted by substance abuse, with approximately 9% of adults reporting co-occurring mental illness and substance use disorder in the past year (APA, 2017).

Research studies have indicated that the underutilization of mental health services among AI/Ans can be attributed to various factors. Brave Heart et al. (2016) examined gender differences in treatment seeking and found that compared with non-Hispanic whites, AI/AN men and women had higher odds of mental health treatment utilization. For Two-Spirit<sup>1</sup> AI/ANs who are lesbian, gay, bisexual, or transgender (LGBT-T-S), the few existing studies have indicated that compared with lesbian, gay, bisexual, or transgender (LGBT) whites and heterosexual AI/ANs, LGBT-T-S individuals are at high risk for HIV (Pearson et al., 2013) and may be at higher risk for sexual orientation victimization, including verbal, physical, and sexual assault (Balsam et al., 2004). The boarding school experience has also been shown to impact AI/AN Two-Spirit individuals with identity and mental health issues (Evans-Campbell et al., 2012). The paucity of research has resulted in a lack of tailored treatment, especially for those living in an urban setting where possible exposure to risk factors is relatively higher (Pearson et al., 2013). Other barriers related to mental health treatment utilization include mental health-related stigma, lack of access to available services, lack of culturally tailored services, socioeconomic barriers, mistrust of providers, cultural variations, and social support (Duran et al., 2005).

Social support has also been found to be associated with mental health treatment utilization. Indirect evidence indicates that people use a combination of traditional sources, social support networks, and mainstream mental health services. People with strong social relationships were more likely to seek mental health services than resolve their problems independently (Duran et al., 2005). Research suggests that the quality of interactions with social support networks (i.e., family and friends) can be associated with depressive disorders, and that social support buffers stress and trauma that precede alcohol, drug, and mental disorder outcomes (Oetzel et al., 2007).

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<sup>1</sup> The term “Two-Spirit” encompasses a fluidity of gender identity and sexuality and signifies an identity determined not solely by sexual practices but also by culturally prescribed spiritual and social roles.

Furthermore, treatment seeking for mental health disorders varies based on geographic location. Duran et al. (2005) and Oetzel et al. (2006) found that the majority of rural AI/ANs reported facing obstacles to mental health care treatment including concerns about privacy, quality of care, communication/trust with providers, and a desire for self-reliance to solve their own problems without professional treatment. Similarly, a study of AI/ANs from an urban Northern Plains clinic found that more than half of those surveyed believed that seeking treatment was unnecessary and identified lack of resources as the second most common barrier to treatment (Kropp et al., 2014).

AI/ANs are not a homogenous group; they are members of distinct and diverse tribal nations. The paths to mental health help-seeking can vary and may include traditional healing and/or mainstream treatment services (Substance Abuse and Mental Health Services Administration, 2018). AI/AN college students, reporting both high and low cultural identity, reported preferring relaxation and natural remedies to treat mental health problems (Stewart et al., 2013). Compared with their Caucasian counterparts, AI/AN college students were less likely to select therapy as a primary treatment option and were more likely to seek help from a community elder or church leader. These preferences for treatment and provider type demonstrate the need to incorporate both culture and spirituality in the treatment and recovery process for AI/AN groups dealing with mental health problems (Gilley & Co-Cké, 2005; Kropp et al., 2013; Stewart et al., 2013).

Despite the well-documented research on mental health and the development of culturally grounded interventions that consider identity, coping, quality of life, historical trauma, and traditional healing among AI/AN populations (Duran et al., 2000; Evans-Campbell et al., 2012; Walters et al., 2011), there remain gaps in the knowledge of treatment-seeking patterns for AI/ANs. Social context is integral in understanding the treatment-seeking process for AI/ANs.

Because empirical research on AI/AN LGBTTS populations is limited, we aimed to contribute to the existing literature by framing our analyses from an indigenist stress-coping framework which posits that life stressors impact health, but cultural factors may buffer or moderate the negative effects of stressors (Walters & Simoni, 2002). We examine the prevalence of mental health disorders, and the protective and risk factors that may influence mental health treatment utilization. Additionally, we consider sociodemographic factors to test the association between mental health treatment utilization behavior and some potential predictive variables, including social support, barriers to care, substance abuse, mental disorders, and various demographic variables.



## METHODS

Data derive from the Honor Project, a multi-site survey of LGBTT-S AI/ANs from seven different metropolitan cities: Seattle-Tacoma, San Francisco-Oakland, Los Angeles, Denver, Tulsa-Oklahoma City, Minneapolis-St. Paul, and New York City. Because of relocation, these sites have become microcosms of national tribal representation with all urban sites containing the top five largest tribes (i.e., Cherokee, Choctaw, Navajo, Sioux, and Chippewa) in the country, in addition to local tribal cultural groups. Thus, with the inclusion of these seven urban sites, all seven of the major tribal cultural areas are represented in the study as well. The research study procedures are detailed elsewhere (Chae & Walters, 2009; Cassels et al., 2010).

Between 2005 and 2007, participants were recruited based on the following criteria: 1) age 18 years or older; 2) English-speaking; 3) self-identified as AI/AN, enrolled in a tribal nation, or having at least 25% AI/AN blood quantum; 4) self-identified as either lesbian, gay, bisexual, transgender, or Two-Spirit or engaged in same-sex sexual behavior in the past 12 months; and 5) living, working, or socializing in one of the urban study sites.

Several sampling strategies were used to minimize selection bias, including targeted, partial network sampling and respondent-driven sampling (RDS). Study coordinators at each site identified 6-8 gender- and age-diverse first wave “seeds” ( $N = 36$ ), of which 33 participated. The second wave of RDS consisted of 58 individuals identified by first wave participants, of which 50 participated. Additionally, volunteer respondents were solicited using newsletters, brochures, posters, etc., of which 368 (80.1%) participated. No significant differences were found between the RDS seeds and volunteer respondents for the cohort overall or by site on sociodemographic variables such as gender, education, employment, income, or housing.

Respondents were compensated \$65 for completing an in-person 3-to-4-hour computer-assisted self-interview at a designated study site or a private location chosen by participants. A total of 447 respondents completed the self-interview. The institutional review board at the University of Washington approved the study, and all participants provided written informed consent.

## Measures

### *Demographic Characteristics*

Assessed demographics included gender (coded as male, female, transgender), age in years, education level (coded as less than high school, high school diploma, greater than high school), and housing situation (coded as own, rent, other).

### ***Mental Health Treatment Utilization***

Lifetime mental health treatment utilization was assessed using the following four yes/no items assessing experience with psychotherapy and/or pharmacotherapy: (1) “Have you been in counseling or psychotherapy?”; (2) “Have you ever in your life been prescribed medications for depression such as Prozac, Zoloft, Elavil?”; (3) “Have you ever in your life taken any medications such as Xanax, Ativan, Valium?”; (4) “Have you ever in your life taken any medications for other mental health conditions?” We constructed a dichotomous indicator for no lifetime mental health treatment utilization (i.e., no psychotherapy or pharmacotherapy) versus any lifetime mental health treatment utilization (i.e., psychotherapy and/or pharmacotherapy).

### ***Social Support***

We used the 19-item Medical Outcomes Study-Social Support survey (MOS-SS; Sherbourne & Stewart, 1991) to assess how participants perceived the availability of four types of social support: (1) Tangible (material assistance), (2) Affective (expressing affection), (3) Positive (positive social interaction), and (4) Emotional/Informational (emotional support, guidance, or advice). The items (e.g., “Someone to confide in or talk to about yourself or your problems” or “Someone to do something enjoyable with”) are scored from 0 (*none of the time*) to 4 (*all of the time*). Items were averaged to form scores for each of the MOS-SS subscale domains, with support ranging from 0 to 4 and higher scores reflecting more social support. Previous studies have demonstrated that the MOS-SS has high internal consistency (Cronbach’s  $\alpha = .97$ ) and acceptable test–retest reliability ( $\alpha = .78$ ). The raw social support variables were scored into four summary social support variables (tangible social support, affection social support, positive social support, and emotional/informational social support) according to the scoring scheme detailed in Sherbourne and Stewart (1991). In the current study, Cronbach’s alphas were all greater than .90.

### ***Barriers to Treatment***

Participants were asked nine questions regarding whether they encountered problems in obtaining health care due to (1) distrust of providers, (2) financial barriers, or (3) accessibility. Participants were asked about problems such as “lack of respect and support from providers because I am Native” (distrust of providers), “inadequate health insurance or coverage” (financial barriers), and “lack of transportation” (accessibility). Participants were asked to respond to whether each of these barriers was 1 (*not a problem*), 2 (*a little bit of a problem*), 3 (*somewhat of*

*a problem*), or 4 (*a major problem*). Three summary variables were calculated for each of the subscales by averaging the items corresponding to each subscale.

### ***Mental Health***

The MINI-International Neuropsychiatric Interview (Sheehan et al., 1998) was used to generate diagnostic indicators based on DSM-IV criteria for major depressive disorder (10 items), generalized anxiety disorder (10 items), panic disorder (17 items), and substance use or dependence (18 items). The 17-item Post-traumatic Diagnostic Scale (PDS; Foa, 1997) was used to generate a three-category indicator of no posttraumatic stress disorder (PTSD), subthreshold PTSD, and PTSD diagnosis according to DSM-IV criteria for PTSD. We utilized the definition of subthreshold PTSD employed by Blanchard et al. (1996) which requires that an individual meet the criteria for cluster B (reexperiencing symptoms) and for either cluster C (avoidance/numbing) or cluster D (hyperarousal symptoms), as well as a duration of one month and reported impairment. This definition was chosen because of its conservative definition of subthreshold PTSD requiring at least two clusters be met, while remaining distinct from full PTSD by more than one symptom.

## **RESULTS**

### **Descriptive Statistics**

By gender, the 447 participants were 51% male, 41% female, and 8% transgender. Participants ranged in age from 18 to 67 years and the mean age was 40 years ( $SD = 10.8$ ). A descriptive summary of sociodemographic characteristics, social support, barriers to treatment, and mental health diagnoses are reported in Table 1 for those with no lifetime mental health treatment utilization (i.e., no medication and/or psychotherapy;  $n = 99$ ), those who have had any treatment in their lifetime (i.e., medication and/or psychotherapy;  $n = 348$ ), and the entire sample ( $N = 447$ ).

Descriptive statistics on current mental health diagnosis for the overall sample and separately by gender are provided in Table 2. Rates of major depression, generalized anxiety, and panic disorder were higher among female and transgender participants compared with men. Rates of both meeting or approaching (i.e., subthreshold PTSD) diagnostic criteria for PTSD were significantly higher for transgender participants.

**Table 1**  
**Socio-demographic characteristics by lifetime mental health treatment utilization among urban LGBTTT-S AI/ANs (N = 447)**

	Range	Lifetime MH Treatment			$\chi^2 / t$	df	p	% Any Treatment
		All Participants (N = 447)	None (n = 99)	Any (n = 348)				
<b>Gender</b>					17.15	2	< .001	
Male		227 (50.8%)	68 (68.7%)	159 (45.7%)				70.0%
Female		185 (41.4%)	24 (24.2%)	161 (46.4%)				87.0%
Transgender		35 (7.8%)	7 (7.1%)	28 (8.0%)				80.0%
<b>Partner</b>					0.10	1	.753	
No		208 (51.5%)	44 (50.0%)	164 (51.9%)				78.8%
Yes		196 (48.5%)	44 (50.0%)	152 (48.1%)				77.6%
<b>Education</b>					9.79	2	.007	
< HS		82 (18.3%)	21 (21.2%)	61 (17.5%)				74.4%
HS diploma		129 (28.9%)	39 (39.4%)	90 (25.9%)				69.8%
> HS		235 (52.8%)	39 (39.4%)	197 (56.6%)				83.8%
<b>Employment</b>					1.59	2	.451	
Unemployed		265 (59.3%)	57 (57.6%)	208 (59.8%)				78.4%
Part-time		84 (18.8%)	16 (16.2%)	68 (19.5%)				80.9%
Full-time		98 (21.9%)	26 (26.3%)	72 (20.7%)				73.5%
<b>Poverty</b>					0.04	1	.839	
No		163 (37.0%)	35 (36.1%)	128 (37.2%)				77.7%
Yes		278 (63.0%)	62 (63.9%)	216 (62.8%)				78.5%
<b>Housing</b>					8.00	2	.018	
Own		47 (10.5%)	4 (4.1%)	43 (12.4%)				91.5%
Rent		235 (52.7%)	49 (50.0%)	186 (53.4%)				79.1%
Other		164 (36.8%)	45 (45.9%)	119 (34.2%)				72.6%
<b>Age in years (SD)</b>	[18, 67]	39.8 (10.8)	36.5 (10.6)	40.7 (10.6)	3.51	441	< .001	
<b>Social support (SD)</b>					14.06	4	.007	
Tangible	[0, 4]	2.3 (1.2)	2.5 (1.2)	2.3 (1.2)				
Affective	[0, 4]	2.6 (1.2)	2.7 (1.2)	2.6 (1.2)				
Positive	[0, 4]	2.6 (1.2)	2.8 (1.2)	2.6 (1.1)				
Emotional	[0, 4]	2.5 (1.2)	2.7 (1.2)	2.6(1.2)				
<b>Barriers to treatment (SD)</b>					3.10	3	.377	
Distrust of providers	[1, 4]	1.5 (0.8)	1.4 (0.8)	1.6 (0.8)				
Financial barriers	[1, 4]	2.2 (1.1)	2.2 (1.2)	2.3 (1.1)				
Accessibility	[1, 4]	1.7 (0.9)	1.6 (0.8)	1.7 (1.0)				

Note. MH = Mental health, HS = high school, PTSD = Posttraumatic stress disorder

The rates for seeking treatment were higher for women (87.0%) than men (70.0%). The mean age for seeking treatment was 40.7 years ( $SD = 10.6$ ), and 36.5 ( $SD = 10.6$ ) for those who sought no treatment. For individuals with less than a high school degree, 74.4% sought treatment, 69.8% of those with a high school degree sought treatment, and 83.8% among those with post-high school education sought treatment. With respect to housing, 91.5% of those that owned their own home sought treatment, compared to 79.1% for those renting and 72.6% in other housing situations. Lower levels of perceived social support were associated with greater treatment seeking ( $p = .007$ ). There were no significant differences in treatment seeking between those with a partner versus without a partner, by employment status, by poverty level, or associated with barriers to treatment.

Adjusted associations between ACE score and HRQOL outcomes can be seen in Table 3. ACE score was significantly associated with all five HRQOL outcomes that we investigated. A unit increase in ACE score was associated with 14% greater odds of self-reported fair or poor general health ( $OR = 1.14$ , 95% CI: 1.06, 1.23) and 11% greater odds of self-reported poor physical health ( $OR = 1.11$ , 95% CI: 1.03, 1.20). The strongest association we identified was between ACE score and self-reported poor mental health in the last 30 days. A unit increase in ACE score was associated with nearly 30% greater odds of reporting poor mental health in the last 30 days ( $OR = 1.29$ , 95% CI: 1.20, 1.40).

**Table 2**  
**Prevalence of mental health disorders by gender among urban LBTT-S AI/ANs ( $N = 447$ )**

	<b>Male</b> <b>(<math>n = 227</math>)</b>	<b>Female</b> <b>(<math>n = 185</math>)</b>	<b>Transgender</b> <b>(<math>n = 35</math>)</b>	<b><i>p</i></b>
<b>Major depression</b>	28.3%	43.2%	42.9%	.005
<b>Generalized anxiety</b>	33.0%	49.7%	51.4%	.001
<b>Panic disorder</b>	13.3%	25.7%	17.1%	.006
<b>Post-traumatic stress disorder</b>				.001
Did not meet criteria	64.7%	53.3%	34.3%	
Subthreshold	19.2%	16.9%	28.6%	
Met criteria	16.1%	29.9%	37.1%	
<b>Substance Use</b>	64.8%	55.7%	75.7%	.144

## Logistic Regression Analyses

We first conducted separate analyses of each potential risk factor to understand its relationship with treatment seeking independent of other risk factors. In these models, lifetime treatment seeking was regressed on each predictor. The subscales for social support and barriers to

treatment were evaluated in a single model so they could be interpreted collectively. The results of these unadjusted analyses are included in the right-hand side of Table 1. There were statistically significant differences in rates of treatment seeking by gender, age, education, housing situation, social support, major depression diagnosis, generalized anxiety disorder diagnosis, panic disorder diagnosis, and PTSD diagnosis.

With respect to sociodemographic characteristics, female (vs. male) gender, greater age, and post-high school education was associated with greater likelihood of lifetime mental health treatment utilization. The four types of perceived social support (tangible, affective, positive, emotional/informational) were collectively associated with the likelihood of seeking mental health treatment. Collectively, barriers to treatment (distrust of providers, financial barriers, accessibility) were not associated with treatment seeking. With respect to mental health diagnosis, major depression, generalized anxiety, panic disorder, and PTSD were associated with greater lifetime mental health treatment utilization, but substance use disorder and panic disorder were not significantly associated with treatment seeking.

We next estimated multivariate models to evaluate the sociodemographic, psychosocial, and mental health variables that showed significant bivariate relationships with treatment seeking, while controlling for the effects of the other predictors. Table 3 presents the odds ratios (*ORs*), 95% confidence intervals (*CI*), and *p* values for the multivariate relationship between the risk factors and treatment seeking. The effects for gender (female vs. male), age, education, social support (positive, emotional/informational), generalized anxiety disorder diagnosis, panic disorder diagnosis, and PTSD diagnosis remained statistically significant in the multivariate model.

With respect to gender, identifying as female was associated with a 2.5-fold greater odds of lifetime mental health treatment utilization ( $OR = 2.52$ , 95%  $CI = [1.37, 4.65]$ ,  $p = .003$ ). Each additional year of age was associated with a 3% greater odds of lifetime mental health treatment utilization ( $OR = 1.03$ , 95%  $CI = [0.00, 1.06]$ ,  $p = .023$ ). Having more than a high school education was associated with a 2.6-fold greater odds of lifetime mental health treatment utilization ( $OR = 2.61$ , 95%  $CI = [1.18, 5.78]$ ,  $p = .018$ ). With respect to perceived social support, each unit increase in positive social support (on the 4-point scale) was associated with a 57% reduced odds of lifetime mental health treatment utilization ( $OR = 0.43$ , 95%  $CI = [0.21, 0.88]$ ,  $p = .022$ ) and each unit increase in emotional/information social support (on the 4-point scale) was associated with a nearly 3-fold greater odds of lifetime mental health treatment utilization ( $OR = 2.95$ , 95%  $CI = [1.45, 6.01]$ ,  $p = .003$ ). With respect to current mental health diagnosis, generalized anxiety disorder was



associated with a nearly threefold greater odds of lifetime mental health disorder ( $OR = 2.89$ , 95%  $CI = [1.50, 5.59]$ ,  $p = .002$ ), as was panic disorder ( $OR = 2.94$ , 95%  $CI = [1.11, 7.80]$ ,  $p = .030$ ). Additionally, full-threshold PTSD was associated with a 2.5-fold greater odds of lifetime mental health treatment utilization ( $OR = 2.84$ , 95%  $CI = [1.26, 6.38]$ ,  $p = .011$ ), as was subthreshold PTSD ( $OR = 2.45$ , 95%  $CI = [1.06, 5.67]$ ,  $p = .036$ ).

**Table 3**  
**Associations of demographic factors, social support, and current mental health disorders with lifetime mental health treatment utilization among urban LGBTT-S AI/ANs**

	<b>OR</b>	<b>SE</b>	<b>95% CI</b>	<b>p</b>
<b>Demographics</b>				
Gender				
Female vs. Male	<b>2.52</b>	<b>0.79</b>	<b>[1.37, 4.65]</b>	<b>.003</b>
Transgender vs. Male	1.42	0.76	[0.50, 4.06]	.509
Age in years	<b>1.03</b>	<b>0.01</b>	<b>[1.00, 1.06]</b>	<b>.023</b>
Education				
HS diploma vs. < HS	0.90	0.35	[0.42, 1.94]	.794
> HS vs. < HS	<b>2.61</b>	<b>1.06</b>	<b>[1.18, 5.78]</b>	<b>.018</b>
Housing				
Rent vs. Own	0.51	0.30	[0.16, 1.64]	.256
Other vs. Own	0.40	0.24	[0.12, 1.31]	.130
<b>Social Support</b>				
Tangible	0.82	0.21	[0.50, 1.34]	.419
Affective	0.85	0.29	[0.44, 1.64]	.627
Positive	<b>0.43</b>	<b>0.16</b>	<b>[0.21, 0.88]</b>	<b>.022</b>
Emotional	<b>2.95</b>	<b>1.07</b>	<b>[1.45, 6.01]</b>	<b>.003</b>
<b>Mental Health Disorders</b>				
Major depression	1.07	0.35	[0.57, 2.03]	.830
Generalized anxiety	<b>2.89</b>	<b>0.97</b>	<b>[1.50, 5.59]</b>	<b>.002</b>
Panic Disorder	<b>2.94</b>	<b>1.46</b>	<b>[1.11, 7.80]</b>	<b>.030</b>
Post-traumatic stress disorder				
Subthreshold vs. None	<b>2.84</b>	<b>1.17</b>	<b>[1.26, 6.38]</b>	<b>.011</b>
Met criteria vs. None	<b>2.45</b>	<b>1.05</b>	<b>[1.06, 5.67]</b>	<b>.036</b>

Note. HS = High school, PTSD = Posttraumatic stress disorder, OR = Odds ratio, SE = Standard error, CI = Confidence interval

## DISCUSSION

The present study examined lifetime rates of mental health treatment utilization in a national sample of 447 AI/AN adults that self-identified as either LGBTT-S and/or engaged in

same-sex sexual behavior and examined whether sociodemographic characteristics and current mental health diagnoses were associated with treatment utilization. Our results indicate that lifetime mental health treatment utilization was highest among women (87%), followed by transgender individuals (80%) and men (70%). However, overall rates of current mental health diagnoses were generally highest among transgender-identified participants. Thus, despite having mental health-related treatment needs comparable to or greater than cisgender<sup>2</sup> individuals, transgender individuals were less likely to have utilized treatment. Additionally, younger participants and those with less than a high school education were less likely to utilize treatment. Differences in rates of lifetime mental health treatment utilization by gender, age, and education level remained after controlling for existing mental health diagnosis.

A key objective of this study was looking beyond demographic factors related to mental health treatment utilization to the risk and protective factors that may predict treatment utilization, such as social support and perceived barriers to treatment. We found that greater positive social support was associated with less lifetime treatment utilization whereas greater emotional/information support was associated with greater lifetime utilization. These findings suggest that individuals benefiting from higher levels of positive social support (e.g., receiving practical support like transportation or financial assistance) may be less inclined to seek treatment, whereas higher levels of emotional and informational social support (e.g., receiving emotional support like encouragement) may be associated with a greater willingness to engage with treatment. Indeed, in some studies social support is an enabling factor in facilitating treatment utilization (Andersen, 1995). For AIs that sought treatment for alcohol, drug, or mental health problems, those with high levels of instrumental social support (e.g., family/friends that provide monetary assistance or use of a car) were less concerned about communicating with and trusting staff (Duran et al., 2005). Interestingly, the barriers to treatment we examined, which included distrust of providers, financial challenges, and limited accessibility, were not significantly associated with treatment utilization. The non-significant association between barriers to treatment and treatment use in our results contradict some studies that show distrust of providers had contributed to HIV clients refusing care and treatment services (Molitor et al., 2006).

There are limitations to the present study. First, because the data are cross-sectional, all findings are correlational in nature; data from prospective or experimental studies would be necessary to assess change in treatment seeking or causal effects on treatment seeking,

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<sup>2</sup> Cisgender women and cisgender men are people whose gender identity matches the sex assigned to them at birth.

respectively. Second, the smaller number of transgender participants may have limited our ability to estimate the rate of lifetime mental health utilization for this group due to larger standard errors and confidence intervals. This limitation may partially explain the lack of a statistically significant difference between transgender participants and their cisgender counterparts after controlling for other barriers to care. The evaluation of transgender participants as a single group, due to sample size limitations, represents another limitation, as male- and female-identified transgender individuals may exhibit differences in mental health utilization. Further, our definition of mental health utilization combined pharmacotherapy and psychotherapy to maximize the statistical power to evaluate a wider array of barriers to care. An important direction for future research will be to evaluate whether the barriers to mental health utilization vary by treatment type. Finally, the study population, due to the nature of Two-Spirit population identification and possible related stigma due to current social constructions of LGBT status, represented a convenience sample, which limits the generalizability of our findings to all AI/ANs and LGBTTT-S populations.

Despite these limitations, our findings support conclusions from other research studies (Qureshi et al., 2018) that underscore the treatment-related health disparities of LGBT and Two-Spirit AI/ANs and barriers to access to care (e.g., health insurance, culturally and LGBT competent providers, etc.), particularly for transgender individuals who have a higher prevalence of poorer overall health (Meyer et al., 2017). Additionally, our findings have practice implications for transgender populations. For example, individuals identifying as transgender may use a variety of unique strategies such as problem-focused, positive, active/avoidance, and religious/denial to cope with gender-related stress and mental health issues. This four-factor structure of coping strategies is based on the Brief COPE measure (Carver, 1997), and these types of strategies can significantly reduce depressive symptoms and suicidality (Freese et al., 2018), which supports the expansion of education among providers to ensure provider knowledge best supports the treatment needs and relevant coping strategies preferred by this population. In addition, HIV-positive transgender men had higher rates of poverty, unmet needs for ancillary services, and experienced suboptimal health outcomes (Lemons et al., 2018), suggesting the need to discuss financial barriers and other service needs with this population to best support access to care and improved health outcomes. Finally, including discussions of victimization may represent an important care component for LGBT and Two-Spirit populations more generally, as studies have found a significant relationship between bias-related victimization and General Anxiety Disorder (Parker et al., 2017). Exploring exposure

to violence within provider treatment modalities may increase assessment of mental health issues and referrals to appropriate treatment.

One approach to achieving the goal of health equity has been to focus on ways in which groups can reach optimal health potential (Whitehead & Dahlgren, 2006). Efforts must include meaningful LGBT and Two-Spirit participation (see, for example, Fredriksen-Goldsen et al., 2014) to improve access to care and, concomitantly, improve health outcomes. A holistic approach to advance the health of AI/ANs must be a priority for providers, program managers, policy makers, and researchers. Social policies extending equal protection and equal rights relating to health provision and access to LGBT groups must remain a priority to eliminate health inequities for these communities and reduce health disparities (Pomeranz, 2018). Moreover, existing metrics fail to adequately examine the health outcomes of Two-Spirit AI/ANs; thus, if this population is faring worse on some health indicators, we lack data to drive decision-making critical to improving the health and well-being of these individuals. At the same time, it may be that LGBT and Two-Spirit individuals may fare better with respect to some health outcomes, and additional research is needed to better understand how these types of findings might be useful in supporting health in related populations also experiencing intersectionality effects.

The indigenist stress-coping model (Walters & Simoni, 2002) provides insights into ways of promoting health among this high-need population by considering the effect of traumatic stressors on health and the cultural factors that moderate and buffer such negative stressors for LGBT and Two-Spirit AI/ANs. One possible approach may include integrating culture and context into health promotion efforts, such as in the development of health-promoting pathways (Gilley & Co-Cké, 2005). Supporting LGBT and Two-Spirit community members in participating in cultural activities, ceremonies, and other community-based activities represents one method of building social support, which in this study was related to improved access to care. Building relationships to extend the network of social, spiritual, and emotional support promotes not only social acceptance and a sense of self-worth among a historically stigmatized group, it also may serve to buffer LGBT and Two-Spirit individuals from the alienation, social isolation, and powerlessness experienced because of their intersectional status, thus reducing risky behaviors associated with heightened risk of substance abuse and supporting improved health outcomes. For example, the “Red Road” philosophy represents one Indigenous philosophy of wellness that offers opportunities to develop new and important health-promoting pathways within tribal and urban AI/AN communities. Additional federal, state, and local resources from governments and agencies are

needed to fully support and develop meaningful programs that both apply AI/AN values associated with the Red Road philosophy and tailor it for LGBT and Two-Spirit community members to best generate positive, measurable, and improved health outcomes for this community.

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### CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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# **“If you’re down, you know, get up, be proud of yourself, go forward”: Exploring Urban Southwest American Indian Individual Resilience**

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*Abstract: The diverse American Indian and Alaska Native (AI/AN) population suffers health inequities perpetuated by colonialism and post-colonialism. The urban AI/AN population is steadily increasing in part because of federal policies relocating AI/AN away from tribal lands. However, studies of AI/AN urban communities are rare, and efforts to understand and ameliorate health inequities in AI/AN communities typically emphasize deficits rather than capacities. Resilience is an important resource in this context but mainstream, rather than community-derived definitions of resilience, predominate. The present study used multi-investigator consensus analysis in a qualitative study to identify urban American Indian (AI) derived concepts and construct a definition of resilience. The study included 25 AI adults in four focus groups in three urban locales in the southwestern United States. Four resilience themes emerged: 1) AIs built strength through toughness and wisdom; 2) the value of traditional ‘lifeways’ (i.e., elements of traditional culture that help people navigate their journey through life); 3) the importance of giving and receiving help; and 4) the interconnectedness of Native lifeways, family relationships, and tribal and urban communities. Themes overlap with extant resilience conceptualizations but also provide unique insights into structure and function of urban AI resilience in the Southwest United States.*

## **INTRODUCTION**

American Indian and Alaska Native (AI/AN) peoples represent a heterogeneous population with diverse languages and cultures, unique histories, and contemporary experiences, varied geographic locations and residences (living on or off Tribal Nation territories), and lifeways (Kahn-John et al., 2021; Struthers & Peden-McAlpine, 2005; Willetto, 1996). Federal relocation

policies (i.e., a series of Relocation Acts) have fueled the growing AI/AN urban population, with up to 78% of AI/AN people currently living in urban areas (James et al., 2018; U.S. Census, 2012). Despite the large proportion of AI/ANs residing in urban areas, they have been described as an “invisible population” (D’Amico et al., 2019; Hartmann et al., 2014), largely because of their limited representation in health research (Gone & Kirmayer, 2020) with estimates that are likely to be flawed given their underrepresentation in the data (Urban Indian Health Institute, 2016).

The 1950s Urban Indian Relocation programs contributed to challenges with the current mental health and emotional well-being of urban AI/AN people due to assimilative and acculturation policies embedded therein (Gone & Trimble, 2012; Walls & Whitbeck, 2012). These histories have contributed to depression, suicide, homelessness, substance/drug abuse, and intimate partner violence among urban AI/AN people (Caetano et al., 2020; Evans-Campbell et al., 2006; Gone & Trimble, 2012; Olivet et al., 2021; Wendt et al., 2017). These disparities are partly due to the geographical separation from most Indian Health Service facilities, including access to urban tribal facilities (Forquera, 2001; Whitesell et al., 2012), and these facilities underfunded status (Hartmann et al., 2014). In addition, the well-established health inequities observed among AI/AN groups on tribal lands (Espey et al., 2014; Gone & Trimble, 2012) extends to urban AI/AN populations (Weaver, 2012). Thus, the combination of health inequity and a paucity of work with urban AI/AN people is a major impetus for our study.

Although much AI/AN health research is deficit-focused rather than asset-based (Kirmayer et al., 2009; Oré et al., 2016), greater attention to strength-based inquiry is emerging, particularly with regard to the concept of resilience (Burnette, 2018; Burnette et al., 2017; Teufel-Shone et al., 2016). Resilience refers broadly to “...good outcomes in spite of serious threats to adaptation or development” (Masten, 2001, p. 228). Although early descriptions of resilience focused on individual-level characteristics (Masten, 2001; see Kirmayer et al., 2009; Ore et al., 2016; Teufel-Shone et al., 2016 for reviews of these studies), social, cultural and spiritual domains, which are themselves embedded in families, communities, and larger social structures, are increasingly recognized as important for Indigenous mental health (Wexler et al., 2015; Gone & Kirmayer, 2020; Gone & Trimble, 2012) and well-being (Kirmayer et al., 2009; Oré et al., 2016; Stumblingbear-Riddle & Romans, 2012). Further, AI perspectives, including Indigenous frameworks, were absent in earlier investigations (Hunter et al., 2022; Kirmayer et al., 2009).

In addition to recognizing sociocultural embeddedness, it is also desirable to inform resilience inquiry by first ascertaining the definitions, conceptualizations, and/or meanings of

resilience within the populations of interest (Rudzinski et al., 2017). This approach is illustrated by the resilience conceptualization generated by a multinational study of diverse youth (Ungar 2008; Ungar & Liebenberg, 2011):

In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community, and culture to provide these health resources and experiences in culturally meaningful ways (Ungar, 2008, p. 225).

Although common elements of resilience were observed across a wide variety of cultural contexts (Ungar & Liebenberg, 2011), a key message from this work is the importance of context-specific characterization of how resilience is represented and enacted within specific cultural frameworks (Gone & Kirmayer, 2010). In line with this insight, the present study is embedded in the context of urban AIs in the Southwest United States.

This study employed qualitative methods to examine resilience among urban AI community members residing in the Southwest United States. AI people tend to distrust researchers and their studies (Dickerson et al., 2020; Smith, 2012), particularly since non-AIs (*etic* or outsiders) usually conduct these studies (Teufel-Shone et al., 2006). This work, led by AI (*emic* or insider) scholars, adhered to both formal institutional research guidelines and to informal cultural norms to better engage urban AI communities for discussion on resilience encompassing the mind, body, and spirit (Manson, 2020). Given AI peoples' lived experiences of persisting through post-colonialism and descending from survivors of colonialism, it was deemed essential to give voice to AIs' definitions of resilience (Kirmayer et al., 2009). Based upon work conducted at three sites in two states, we report on two major open-ended queries: What is resilience? and What makes you strong?

## METHODS

From February to May 2017, we conducted an exploratory phenomenological qualitative study with urban convenience samples in Albuquerque, NM; Phoenix, AZ; and Flagstaff, AZ. The sample also included homeless AIs. Three urban AI centers collaborated with the study



investigators. One focus group was held in each of these centers and a fourth focus group was held on a university campus. To follow community-based participatory research (CBPR) principles (Burhansstipanov et al., 2005), the investigators engaged AI center directors in New Mexico and Arizona. The team included the Northern Arizona University (NAU)–University of Arizona Center for American Indian Resilience (CAIR) Community and Executive Advisory Boards (CAB and EAB) who provided guidance on protocols for working with local AI people and using a CBPR approach. To enhance trustworthiness, fairness, and accuracy of qualitative data, we conducted member-checks (Schwandt et al., 2007; Thomas, 2017) of the original transcripts and to review our preliminary findings (Hartmann et al., 2014). The initial focus group discussions ranged from 135 to 195 minutes for a total of 15 hours of data collection, including member checks.

### **Participant Recruitment**

Two settings hosted recruitment: three AI urban centers and one university center. Inclusion criteria for recruitment involved: (1) self-identifying as urban AI/AN; (2) for non-university locations: adults 50 years and older; and (3) for the university location: adults 18 years and older. For non-university locations, an emphasis was placed on recruiting Native elders who are wisdom holders and not usually included in resilience studies (Fullerton et al., 2019). Recruitment flyers were posted at places frequented by the urban AI/AN populations such as urban Indian Centers and their websites (when available), health care facilities including Indian Health Service, social service organizations, and restaurants in close proximity.

### **Development of Study Items**

The investigators developed focus group protocols, open-ended questions, a demographic form, and recruitment flyers per their previous research with AI community members and review of the literature. The investigators obtained feedback on the study items from the CAIR CAB and EAB and the Chief Executive Director of an urban AI center.

Although this study posed 15 questions to focus group participants, this manuscript presents and discusses the analysis of two questions: “What is resilience?” (and its associated prompt, “What does the word ‘resilience’ mean to you?”) and “Please discuss what makes you strong.” These questions were conceptually distinct with a micro-level (or individual-level) of analysis from the remaining focus group questions, which focused on a meso-level of analysis (e.g., family). This ‘strong’ or strength-based phrasing derives from the AI perspective that all AI

cultures evidence strength (Pepic et al., 2022). The justification for reporting this focused analysis and findings is grounded in the need to address the gap in literature about AIs participants' definition of resilience and asset-based experiences.

### **Project Approvals and Notification Letters**

This study was approved by the NAU Institutional Review Board (Project Number 977165-1) and NAU's AI Tribal Liaison (Arizona Board of Regents, 2016). Respecting tribal sovereignty and nations' oversight of research with tribal citizens, the investigators sent letters of notification about potential study activities to the Navajo Nation Human Research and Review Board, the Hopi Tribe, the Inter-Tribal Council of Arizona, and the New Mexico All Pueblo Council of Governors. Although approval by these tribal entities was not a requirement (the status of data protection for urban AI/ANs is yet undetermined), we value transparency and openness and, therefore, notified these tribal authorities (Haozous et al., 2021). All urban AI center directors approved the study and provided permission to recruit at their centers and use center facilities to conduct focus groups, including networking and dissemination activities.

### **Procedures and Informed Consent**

Upon verbal agreement to participate, two duplicate informed consent forms were given to each participant. The consent form, which included permission to be audio-recorded during the focus group, the time commitment for multiple visits (Thomas, 2017), and a description of the purpose of the research, was read aloud to the participants who followed along on their copy. One informed consent form was signed, dated, and maintained in a secure location in the study office and the other was given to the participant. All individuals who appeared in the information and consent phase consented to join; no one declined or withdrew. Participants received a \$10 gift card for focus group participation and an additional \$10 gift card if they returned for the in-person member check or the dissemination meeting; receipt of up to \$30 was possible. Also, food was provided at every meeting for each focus group site (e.g., focus group discussions, in-person member check and disseminations), and some gift items (tote bags, water bottles, and notebooks) were distributed.

#### ***Focus Group Moderators***

The senior principal investigator (PI) with moderator experience conducted the first focus group while the junior PI observed and took notes. The senior and junior PIs reversed roles for the

second focus group. The remaining focus groups were led by the senior PI. Discussions were digitally recorded, and researchers took comprehensive field notes.

A slide presentation was used for introductions and to present the two open-ended focus group questions (“What is resilience?” with the associated prompt, “What does the word ‘resilience’ mean to you?”, and “Please discuss what makes you strong”). To protect participant identity, participants picked a number from a bowl; that number was used on their demographic form and for self-identification throughout the discussion. Participants would speak by first stating their identification number. Focus group questions were typically answered in English, although phrases from Native languages were sometimes provided initially and then translated by the respondent. The moderators reminded participants that private information revealed in the groups was not to be discussed outside of the focus group setting. To confirm the accuracy of the quotes and interpretation of the analysis, the investigators collected contact information for member checks on transcripts; investigators also invited participants to dissemination workshops after preliminary data evaluation (Birt et al., 2016; Hartmann et al., 2014).

### **Theoretical Approach**

Phenomenological theory, wherein the researcher seeks to understand social phenomenon from people’s viewpoint (Welman & Kruger, 1999, p. 189), framed the study as we were interested in the participants’ lived experiences (Groenewald, 2004). Significant in their lived experiences included the essential meaning contained therein (Freeman et al., 2019; Murphy et al., 2009). Investigations with AI peoples are compatible with the phenomenological approach due to use of narratives (e.g., storytelling) and culturally embedded context.

The phenomenological method is able to capture the lived experience and illuminate the words of indigenous people themselves and, thus, is able to represent, through written accounts, the lifeworld of indigenous peoples. ... The research process of phenomenology is circular, moving back and forth between the part and the whole during thematic analysis. Thematic analysis of the whole produces findings that offer an in-depth understanding of the whole of a phenomenon. Phenomenology, thus, is looked on as a harmonious, amenable, and acceptable research method to use in societies, such as those of indigenous peoples, that possess a holistic worldview (Struthers & Peden-McAlpine, 2005, p. 1267).

## Data Preparation and Analyses

### *Transcription*

The digital audio recordings from the focus groups were transcribed verbatim. Investigators performed accuracy checks of the transcripts wherein team members would initially transcribe the audio recording. In a separate session, another investigator would follow along the transcript and audio recording, making corrections as needed. At this stage, the first author then finalized the transcripts, again making corrections as required. When applicable, member check audio recordings were transcribed verbatim and incorporated into the final, community member-approved transcript. The research team returned to one location to conduct in-person member checks because phone contact was limited for some homeless participants at that site.

### *Codes*

The community member-approved transcripts from each focus group were combined into one master transcript, with responses grouped by question. These transcripts were first coded independently by three investigators. Coders generated preliminary emergent themes through recurring words, ideas, and concepts (Teufel-Shone et al., 2006). Code creation was generated inductively (i.e., data-driven based on the group discussions). An inductive approach aligned with our phenomenological approach and with AIs' own lived experiences of resilience and strength.

### *Patterns and Themes*

Once the three investigators coded all the data, the next step was to identify patterns (Teufel-Shone et al., 2006). The three sets of coded data were combined in tabular form displaying investigators' names and their coded data and were shared among the three investigators. Coders then ascertained *patterns* as evidenced by recurrent elements in the discussions identified by at least two coders. When only one investigator identified a pattern, discussion involving interrater reliability based upon team members' reasoning ensued, followed by consensus building, leading to an agreed upon set of patterns (Chief et al., 2022; Pederson et al., 2020; Teufel-Shone et al., 2006). These identified patterns were used to construct emergent *themes* and *sub-themes* arising from the participants' words (Chief et al., 2022; Sanderson et al., 2018).

## Dissemination

In accordance with CBPR research principles, the lead author returned to each setting that hosted focus group discussions to share the study results and to converse whether the results reflect

participants' meanings, perceptions, and accounts of the data (Freeman et al., 2019; Hartmann et al., 2014; Murphy et al., 2009). All attending participants endorsed the preliminary findings.

## RESULTS

### Participant Demographics

Focus group participants included 25 AI adults, ranging in age from 18 to 75 years (Table A1). Participants' educational attainment ranged from nursery school to master's degree recipients. Participants reported their household size was from 1 to 6 people. Their annual income spanned from \$2,500 to \$150,000. The majority (56%) of participants were women; however, men were well represented (40%), and one participant identified as transgender and Two Spirit. Marital status of the participants reveal that the majority were single or never married (44%), while almost a quarter were divorced (24%), and 12% were currently married (Table A2). Most participants were fully employed (52%). Over half (56%) of participants spent their childhoods on AI reservation communities. Most participants affiliated solely as Christian (52%), and others adhere only to their tribal belief systems (16%). Eighty-eight percent identified solely as AI. Seventeen different tribal affiliations were noted, with five (20%) having affiliations with more than one tribe. The wide-ranging backgrounds of the participants provides rich context for their lived experiences (Austin, 2013).

### Focus Group Discussion

Participants described their knowledge and meaning of the term 'resilience' and their descriptions of what makes them strong via their lived experiences. Analysis of these responses revealed four themes and seven sub-themes (Table A3). Discussion of themes include excerpts from focus group discussions.

#### ***Theme 1. American Indian People Built Resilient Strength via Toughness and Wisdom***

Participants shared words, phrases, metaphorical examples, and wisdom conveying their meanings and thoughts regarding the word 'resilience.'

**Sub-theme 1. Active Resistance.** Discussion on endurance, perseverance, resistance, self-survival, stubborn/stubbornness, and toughness were presented. To illustrate, a middle-aged woman's phrase about resistance included, "standing like a bump on a log." Participant's voicings

involve action-oriented choices that are future leaning and feature not giving up when faced with trials. One elder man's discussion conveys pride and perseverance. "If you're down, you know, get up, be proud of yourself, go forward. And, if you get knocked down again, you know, keep going." (See Table A3, Theme 1 for additional examples).

**Sub-theme 2. Recovery, Strength, and Wisdom.** Numerous participants report that recovery and bouncing back from hardships shows resilience. However, they point out that learning from difficult events or problems is a crucial element of resilience wherein you resolve the issue and do not repeat the problematic behaviors. A university student participant agrees with other discussants about 'bouncing back' but emphasizes the importance of learning from hardships. "I would say resilience for me is like going through tribulation, you know, so like, and able to pull through it and you know and learn something from it, so it doesn't happen again [chuckles]." (See Table A3, Theme 1 for additional examples.)

Participants actively listened to their fellow discussants and agreed with their statements but also built upon their utterances. Thus, participants endorsed that not only should one learn from problematic situations, but they also should be enriched through this process, such as enhancing strength and returning to health. An elder woman explains:

Resilience is, you're able to come back stronger from a situation that you've gone through. Or life that kinda beats you down but you come back up. And you're a better person because you have learned something from that situation. And you come away from whatever situation it is, stronger, and knowing that you are able to be healthy again.

The significance of looking towards the future and dealing with impending challenges was also stated,

Keep on going one foot in front of the other. Regardless of what happen in the back, it's already past tense. Next step, you don't know, face the battle and go at it again. Because you will face another battle. ... [Laughs] For me [chuckles] that's all, anyways, so just keep on going. Face your fears. Stand up to it. Don't back down. Bump it in [sic] head, like a resilient goat! [Scattered laughing]. (Middle-aged woman participant)



Withstanding lifeway challenges, building multi-dimensional (mind, body, and soul) strength, and acknowledging one's success were also disclosed. One middle-aged man shared that 'resilience' is unfamiliar. "To be honest with you, I gotta look that word up. I really don't know the definition of resilience [laughter]. Like I said I really don't know [laughter]. [Loudly] I'm educated but that's a new word to me."

Participants' explanations of the meaning of the term 'resilience' grew increasingly sophisticated as discussion evolved. In some cases, participants shared culturally applicable examples and personal stories to illustrate how they experienced resilience.

### ***Theme 2. Lifeways Involve Choices to Walk Toward Resilience: The Value of Traditional Native Lifeways***

In the second emergent theme, participants invoked action-oriented choices to overcome impactful lifeway challenges and return to or seek balance and harmony.

**Sub-theme 1. Resilience is Dependent on Impactful Experiences.** Participants recalled personal examples of resilience; the common denominator was how impactful these events were in their lived experiences. One elder participant shared how a colleague encouraged her to fill an Indian educator position thousands of miles from her home. A middle-aged woman participant who experienced homelessness with her young children struggled when revealing that although a harrowing event occurred at the urban community center, she also feels drawn to the warmth and support there, while simultaneously recollecting this traumatic experience that built resilience (Table A3, Theme 2). Thus, participants evidence complexities and impactful events surrounding AI resilience.

**Sub-theme 2. Storytelling Conveys Lifeway Challenges.** Participants shared stories of contending with lifeway challenges. A middle-aged woman participant recounted her heartbreaking experience of homelessness. "I mean I had everything, and I went to nothing. I was in a shelter, I had nothing, I was in the streets, we slept in a car. I almost froze to death with my kids." Further along in the focus group discussion, this participant relates later successes in leaving an abusive partner, securing employment, and attaining a stable home for her family. (Table A3, Theme 2).

**Sub-theme 3. Surviving Post Colonialism Leads to Wisdom and Resilience.** This sub-theme arose from discussion likening resilience to perseverance, overcoming obstacles and hardship from contemporary and past events that impacted AI people. Participants connected a

contemporary lifeway challenge, the North Dakota Access Pipeline, to a past historical traumatic event, "... isn't it a repeat of Wounded Knee, just saying?" [Others nodded in agreement.] In the member check, this same participant further elaborated by stating how the U.S. administration under President Trump was undermining Native sovereignty. Participants discussed colonialism via federal policies' negative impact on their lives, such as assimilation suffered in Indian boarding schools. Participants' discussion also conveyed wisdom gained through these lifeway challenges (Table A3, Theme 2).

**Sub-theme 4. Resilience Promotes Harmony and Balance.** Participants were particularly expressive and expansive on this sub-theme. Discussion featured resilience as faith, a Native worldview that embraces mental, emotional, physical, and spiritual dimensions of life, and as returning to health after adversity consistent with seeking harmony and returning to balance.

A middle-aged woman participant expressed the strengthening AI spirituality imparts. "Resilience to me is that we're spiritual people and we draw our strength and that's how we are resilient. [Chuckles] That's who we are!" Another middle-aged woman located her resilience in discovering her tribal roots (Table A3, Theme 2). These accounts resonate with the Native worldview regarding the importance of harmony and balance in all things, including their communities. Further analysis finds that spirituality and religion are their primary source of strength in their harmony and balance, followed by their extended families (Table A4).

### ***Theme 3. Help: Giving and Receiving***

The third emergent theme stressed the need for resources when undergoing resilience processes. This resource importance was also reflected by participants' emphasis on the importance of giving back once their situations improved. This included the concepts of asking for help, reciprocity, and that good citizenship makes you strong. Stability and civil conduct also foster strength, as relayed by a middle-aged male participant. "I say, be strong, go to work every day. You know, pay bills and everything. Keep on going, don't be lazy."

### ***Theme 4***

This complex theme involves three interconnected and somewhat overlapping themes: **1) Lifeways Involve Choices to Walk Towards Resilience: The Value of Native Lifeways; 2) Family Relationships and Dynamics; and 3) Communities: Tribal and Urban.** Specifically, Native lifeways and Christian spirituality infuses through dynamic family relationships and tribal and urban communities. Participants discussed that a connection with spirituality/religion and

family build strong communities. A middle-aged Two Spirit participant points to the importance of the AI urban center in shoring up their well-being and spirituality by metaphorically connecting this urban center's community life with the powerful pounding of drums (Table A3: Theme 4).

A middle-aged woman participant discussed the importance of Christianity in her life, "What made me strong was functional goal-minded, positive contributors in the community, to know there is a Creator and to have that hope and faith and positive outlook of being function-able and contributing in our community." Another elderly man participant elaborated by stating, "Okay, being a part of a thriving community and helping others with the knowledge you have based on your life, skills, and education." A middle-aged woman participant shared about the urban community as a beautiful home-like (akin to her tribal nation community) place of warmth that empowered her resilience. Accordingly, Theme 4 reflected an interconnectedness with lifeways (Native and mainstream spirituality), family relationships and dynamics, and tribal and urban community.

## DISCUSSION

In this study, urban AI participants provided their meanings, perceptions, and voiced resilience through their narratives, storytelling, and examples (Struthers & Peden-McAlpine, 2005). Discussions reveal AI viewpoints on individual resilience from participants who are currently urban dwellers, albeit the majority were raised within or near Indian Country communities. Results center on AI conceptions of resilience (Kirmayer et al., 2009) rather than researchers' preconceived definitions, thereby addressing an important oversight embedded in most studies involving AI people which often do not include the direct gathering of AI voices on the important concept of resilience (James et al., 2018; Smith, 2012).

Prior research shows that AIs generally talk about their individual resilience and strength in a storytelling format (Burnette et al., 2017; Denham, 2008, Gone, 2013; Struthers & Peden-McAlpine, 2005) that grows increasingly complex as focus group discussions progress. Their narratives and storytelling promote teaching, advice, and lessons learned, consistent with observations elsewhere (Kahn et al., 2016; Grandboise & Sanders, 2009). Aligned with an AI worldview, discussion included both positive and negative elements of participants' lived experiences but eventually sought to reach a sense of balance and harmony. Through their

discussions, participants were pleased as their storytelling about resilience indicated their actively overcoming challenges.

Studies related to AI resilience find that culture is a significant positive element (Kahn-John et al., 2021; Kahn et al., 2016; Manson, 2020; Stumblingbear-Riddle & Romans, 2012; Grandboise & Sanders, 2009). This study also finds the concept of culture prominent in the lives of the participants; however, the use of the term ‘culture’ did not strongly resonate as a descriptor of this powerful element throughout their discussions. Hence, the theme, *Lifeways Involve Choices to Walk Towards Resilience: The Value of Traditional Native Lifeways*, better encapsulates this multi-faceted, influential, and fluid concept as reflected by the lived experiences of these AI participants (Kahn-John et al., 2021; Gone, 2007).

Based on the themes and sub-themes derived from the AI participants’ voices, AI resilience is a journey created by past and present lifeway (Kahn-John et al., 2021; Willetto, 1996) challenges, during which an individual: (a) seeks to return to harmony and balance (Morehead et al., 2015), (b) is strengthened in some way (Pepic et al., 2022), and (c) attains wisdom during the journey, thereby avoiding future difficulties of the same sort. Importantly, this definition encompasses the past, present, and future which are important for AI people (Struthers & Peden-McAlpine, 2005). Participants also discussed how AI resilience is demonstrated or accomplished. From their viewpoint and through their narratives and storytelling, participants described resilience as: (a) asking for help when needed (Burrage et al., 2016) and reciprocating or giving back (Gone, 2007) when lifeway challenges have decreased; (b) drawing from their spirituality, both traditional Native lifeways and/or Christian religions (Goodkind et al., 2010); and (c) through their families (Burnette, 2018; Robbins et al., 2013) in order to build strong communities—urban and tribal (Grandboise & Sanders, 2009; Kirmayer et al., 2009).

Participants illustrate how resilience is shown through help-seeking when needed, and when their lives are better, they practice reciprocity consistent with the Native worldview of harmony and balance. This relationship aligns with other work showing that reciprocity is embedded within AI societies (Gone, 2007) and with prevalent help-seeking behavior observed among urban AI women experiencing intimate partner violence (Evans-Campbell et al., 2006).

Throughout the focus group discussions, an intersection between Native spirituality and Christianity related to tribal or nontribal lifeways became evident among some participants (cf. Goodkind et al., 2010). In other words, a specific higher power did not predominate but rather a shared valuing of the Creator and Jesus and/or God was observed (Portman & Garrett, 2006). A

case study of a multi-tribal middle-aged woman exemplified her synthesis of Navajo, Native American Church, and Christian religious belief systems (Begay & Maryboy, 2000). Perhaps participants in this study felt intrapersonal strengths from both the Creator and Christian God.

AIs' immediate and extended families are also a source of strength (Burnette, 2018; Robbins et al., 2013). Likewise, participants identify their immediate, extended, and multi-generational families as critical reserves of strength. Participants also distinguish central features of their families, such as their determination and the important teachings conveyed regarding physical, mental, and spiritual strength.

Studies have identified AI communities as an important source of resilience for AIs (Grandboise & Sanders, 2009; Kirmayer et al., 2009). In urban settings, AI people also find resilience in community. For example, in this study, participants discussed the urban community center as a welcoming place where they greeted each other with warmth and hugs. The community and university center venues were considered a home when away from their Indian Country homes. Thus, community gatherings are an essential ingredient of resilience where relationships are cultivated (Hulen et al., 2019). Place is particularly important given the greater likelihood of AIs living in cities to experience social isolation and both explicit and subtle discrimination (D'Amico et al., 2019), as well as the detrimental impact of racism on their health and well-being (Williams et al., 2019). Our study participants likewise discussed poverty, overt racism out in the streets, and social inequities suffered when living in cities.

In this study, several AI participants' statements were congruent with the resilience definition of Oré et al., which states resilience is "the ability to adapt or respond positively (i.e., to exhibit growth and transformation) to stress and adversity" (2016, p. 135). Growth and transformation following stressful circumstances is clearly evidenced by the discussants. However, 'adapting' to adverse circumstances was not revealed in participants' discussions. Ungar's (2008) definition also finds partial support (e.g., dynamic character), but substantive differences exist as well (e.g., the magnitude that learned wisdom denotes for AI focus group participants). Furthermore, just one AI participant expressed a lack of knowledge regarding the term 'resilience.'

There is partial support for prototypical definitions of individual resilience, such as "the ability to adapt or respond positively (i.e., to exhibit growth and transformation) to stress and adversity" (Oré et al., 2016, p.135) or "positive adaptation in spite of adversity" (Rudzinski et al., 2017, p.2). Specifically, urban AI participants affirm that resilience involves dealing with adversity (e.g., lifeway challenges) and positive responses (e.g., exhibit growth or transformation or return

to/seek harmony and balance) to these challenges. However, adaptation, positive or otherwise, was not revealed in the focus group discussions. Instead, participants emphasized the necessity to move away from adversity rather than adjust to it. Their focus was to proactively journey toward harmony and balance, thereby moving away from negative lifeway challenges. Participants also voiced through narratives and storytelling the importance of wisdom by learning from those challenges and not repeating them.

Partial support for elements of Ungar's (2008) resilience definition is also evidenced in our study. For example, participants discussed individual and contemporary lifeway challenges such as work and university responsibilities. Participants also revealed harsh experiences such as prejudice, discrimination, and institutional racism. Similarly, the fluid nature of Ungar's definition is likewise championed by our study participants (i.e., navigate vs. journey). We might also accept that "health-sustaining resources, including opportunities to experience feelings of well-being" (2008, p. 225) approaches what is meant by 'seeks to return to harmony and balance.' Yet, Ungar's phrasing has more passive overtones than what our participants conveyed. Participants actively sought to return to harmony and balance and are strengthened during this journey. Further, lifeway challenges are conceptually broader and more encompassing than psychological and environmental adversity. For example, participants pointed to historical and contemporary lifeway challenges such as Indian Boarding Schools, Relocation, North Dakota Access Pipeline, and Wounded Knee. Hence, when experiencing adversity, the discussants acknowledged and applied historical lifeway challenges in their examples. Participants also emphasize the central role of wisdom during their resilience journeys. It's insufficient to simply bounce back, but rather one must emerge stronger than before, learning from challenging experiences so as to avoid repeating them, thereby demonstrating wisdom. Finally, Ungar's (2008) definition explicitly includes the individual's culture, family, and community as culturally meaningful resources. Similarly, our study participants address these elements when discussing the raised question of how AI resilience is demonstrated or accomplished.

These participants resided in cities at the time of the study, although the majority were raised within the territorial borders of their tribal nations and communities. The first two authors noted that many conversed in their Native tongues during focus group breaks and after the focus groups concluded. Several participants approached the first two authors to request our tribal heritages, including our tribal nation clans as appropriate. Further, most of the participants moved to nearby cities fairly recently or were temporary urbanites while attending university. Although



these AI conceptions of resilience are drawn from urban AI voices, these participants were also robustly endowed with their tribal nation's lifeways stemming from their Indigenous worldviews (Haozous et al., 2021).

### **Limitations**

These findings may not pertain to other AI people including other urban AIs because research activity was limited to the Southwest United States. Due to resource constraints, just one student focus group was conducted on one university campus. Recruitment settings such as community centers may shape resilience trajectories and thus appear more central than they are among those who do not frequent these centers. Conversely, the integration of such places may suggest pathways for greater community integration outside of reservation boundaries.

### **Implications**

We suggest that utilizing AI urban community driven conceptualizations and definition of AI resilience may be more reliable and valid with strength-based studies, including interventions, with urban AI people (Kirmayer et al., 2009; Manson, 2020), particularly as most interventions have been designed from an *etic* (outsider) framework (Dickerson et al., 2020; Gittelsohn et al., 1999). For example, when designing interventions with urban AI people, care should be taken to encourage intervention participants to return to or to seek harmony and balance; emphasize that undergoing lifeway challenges strengthens intervention participants; and promote the wisdom participants have gained through lifeway challenges to help them avoid future difficulties.

## **CONCLUSION**

The study developed a culturally relevant definition of AI resilience built upon urban AI participants' voices as exhibited through the themes and sub-themes derived in a qualitative multi-investigator consensus analysis. AI resilience is a journey created by past and present lifeway challenges during which one: (a) seeks to return to harmony and balance, (b) is strengthened in some way by lifeway challenges, and (c) attains wisdom during the journey, thereby avoiding future difficulties. Hence, conceptions of AI resilience are multi-faceted, center on impactful events, manifest Native values, are movement-oriented, and build strength and wisdom.

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### CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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## APPENDIX

**Table A1**  
**Descriptive statistics – Age, household size, household income**

Indicator	Mean	Range	Standard Deviation
Age	49.46	18.5 – 74.5	16.28
Household size	2.64	1 – 6	1.85
Household annual income	\$27,039.68	\$2,500 – \$149,999.50	\$32,979.00

**Table A2**  
**Descriptive statistics – Gender, marital status, employment status, education, religious/spiritual affiliation**

	Frequency	Percentage
<b>Gender</b>		
Men	10	40
Women	14	56
Transgender and Two Spirit	1	4
<b>Marital Status</b>		
Single (never married)	11	44
Married	3	12
Cohabiting (living with partner but not legally married)	3	12
Divorced	6	24
Other (separated, widowed)	2	8
<b>Employment Status</b>		
Employed	13	52
Unemployed	4	16
Retired	3	12
Full-time student	5	20
<b>Education Attainment: Highest level of school completed</b>		
8 <sup>th</sup> grade and less	2	8
Some high school, no diploma	1	4
High school graduate, diploma or equivalent (GED)	2	8
Some college, no degree	10	40
Trade/technical/vocational training	4	16
Associate's degree	1	4
Bachelor's degree	3	12
Master's degree	2	8

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**Table A2**  
**Descriptive statistics – Gender, marital status, employment status, education, religious/spiritual affiliation**

	Frequency	Percentage
<b>Religious/Spiritual Affiliation</b>		
Tribal Belief System	4	16
Native American Church (NAC)/Peyote Road/Way	1	4
Christian	13	52
Unaffiliated	1	4
Don't know	1	4
Tribal Belief System & Catholic	2	8
Tribal Belief System & Christian	1	4
Tribal Belief System & NAC/Peyote Road/Way	1	4
Tribal Belief System & NAC/Peyote & Christian: Catholic	1	4
<b>Totals</b>	<b>25</b>	<b>100</b>

**Table A3**  
**Themes (1-4) and sub-themes: Example quotes**

Themes	Sub-themes (S) and Quotes
<b>Theme 1.</b> AI People Built Resilient Strength via Toughness and Wisdom	<p><b>S1. Active Resistance</b></p> <ul style="list-style-type: none"> <li>• "Endure toughness, yeah. Or the hardships, yeah something like that." (University man)</li> <li>• "It's how you survive, how you stand strong, even though there are challenges. There might be hard times and stuff like that. How you keep yourself strong and standing." (Middle-aged woman)</li> </ul> <p><b>S2. Recovery, Strength, and Wisdom</b></p> <ul style="list-style-type: none"> <li>• "I feel like resilience is like the ability for something to be able to take a hit, or like a large blow and see how fast it recovers." (University woman)</li> <li>• "I also think it's being able to come back with a vengeance, like stronger" [another participant chuckles]. [This elicits agreement from two other discussants]. (University woman)</li> <li>• "I think resilience is coping mentally, emotionally, physically, and spiritually." (Middle-aged woman)</li> <li>• Resilience to me means to be able to withstand whatever comes your way and being able to come back with as a stronger person body, mind, and soul. To be able to stand there and say, "I've done it. I got through this." (Middle-aged woman)</li> </ul>

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**Table A3**  
**Themes (1-4) and sub-themes: Example quotes**

Themes	Sub-themes (S) and Quotes
<b>Theme 2.</b> Lifeways Involve Choices to Walk towards Resilience: The Value of Native Lifeways	<b>S1. Resilience is Dependent on Impactful Experiences</b> <ul style="list-style-type: none"> <li>That's my resilience, okay [chuckles]. No, [softly] resilience it just. [Bit louder]... We still come back to, to where we're at because we know that this community center- this Center is available to us, but yet like we, we don't want to come back because there's certain things that you know happened and that exist and you don't wanna really like face it. (Middle-aged woman)</li> </ul>
	<b>S2. Storytelling conveys Lifeway Challenges</b> <ul style="list-style-type: none"> <li>And I'm a really hard, persevering type a guy, you know, and when I were working for the forest services, I had crews under me, and, a lot of times a lot of decisions had to be made right away. And the whole crew, man, they just look at you and you got all these eyes on ya, "What are we gonna do?" "Where are we gonna go?" You always plan ahead of time so I've learning that at a really early age just to plan ahead of time... And expect the unexpected so I'm always, I guess, a believer in expecting the worst, planning for the best and a residual plan [chuckles]. That's what keeps me strong is that mind, the stable mind, but never forgetting where--what you believe in as a Native American man. (Middle-aged man)</li> </ul>
	<b>S3. Surviving Post Colonialism Leads to Wisdom and Resilience</b> <ul style="list-style-type: none"> <li>Resilience seems to be encapsulated in what's going on with the North Dakota Access Pipeline where everyone's coming together to relive this like cultural hurt but they're growing from that experience, and kinda showing strength in numbers and strength in culture. (University woman)</li> <li>Native American land is sovereign land but you know [sic] US invaded over like 100 countries without permission like breaking US international law because like the UN's put a call on everything that doesn't relate to us and I feel like it's just like history repeating itself you know. And like they're actually going through camps and actually going into fight full on body armors or like live ammo going into these camps and they're kicking people out and arresting people like this just because Trump signed the executive order, I mean. Like more of a dictator's running this country now. (University woman)</li> <li>My mother lived on the reservation she was with seven or eight or nine, I can't remember, brothers and sisters. And she taught herself to read English by the newspaper as wallpaper. She watched her grandmother sweep the dirt floors with water to get the dust from flying around. And she couldn't wait till the bus came to relocate them to Sherman in Riverside. And she became very educated, I guess, through the boarding school and she met my father there and they got married, you know the story. And she had me, the one and only, and it was very difficult because I wanted to be Indian and she didn't want me to be Indian. And, she wouldn't teach me the language, she wouldn't teach me the culture, she wouldn't teach me. And then on top of that I end up going to an all-white school through grammar school, junior high, and high school. And I was spit at, I was kicked, I was called n***er [sic], every [sic] and I'd come home crying and my mother would say "Be tough. Say a prayer for them." I said, "Oh brother". So [laughs] years ... it was hard for me. And I always wanted to be Indian. (Elder woman)</li> </ul>

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**Table A3**  
**Themes (1-4) and sub-themes: Example quotes**

Themes	Sub-themes (S) and Quotes
<b>Theme 3.</b> Help: Giving and Receiving	<b>S1. Asking for Help, Reciprocity, and Good Citizenship Makes You Strong</b> <ul style="list-style-type: none"> <li>What makes me strong is putting down my pride. I was very prideful of having everything and going down to nothing. And asking for help from people that I wouldn't think that would give me anything. And it was given to me from people that I wouldn't expect it from, and it made me stronger to get into like the community here. Now that I got back onto my two feet, I give here in the community, I help. (Middle-aged woman)</li> <li>It was hard for me to humble myself too. Cuz [sic] I had custom homes and places and stuff, and I came down to nothing. I had to ask for help and these people here, they do help. And they joke with you, make you smile again. Give you good stuff and food everything, you know what I mean? It's a really good place to be. Not just, this woman here, there are many of them out there that can come here for services, and it's really nice. I like to see them--family. (Middle-aged woman)</li> </ul>
<b>Theme 4.</b> Lifeways Involve Choices to Walk towards Resilience: The Value of Native Lifeways: The Value of Traditional Native Lifeways' <ul style="list-style-type: none"> <li>Family Relationships and Dynamics</li> <li>Communities: Tribal and Urban</li> </ul>	<b>S1. Spirituality/Religion and Families Builds Strong Communities</b> <ul style="list-style-type: none"> <li>I still come back here because I love this place and I love the people here and just to see just to feel that just like you said the warmth and the feeling that everybody gives to, I mean just to see everybody back here is like, yeah, it's cool. [chuckles]. (Middle-aged woman)</li> <li>Everybody here we all gather up here but sometimes we visit each other once in a great while and we meet up at [urban community center], but then we come back here [referring to a different urban community center]. We come back together. <b>This is a powerful pounding drum of life here</b> [emphasis added]. (Middle-aged Two Spirit)</li> <li>I come here every time I just need, I mean just need a hug or just a smile or just to look at somebody or just to have, have like something that I have and give it here. You know because it's where I got what I needed to move on to, to live my life the way I am living it now. And I love everybody that comes here and I just love this place, it's a home away from home. And this is a community for everybody no matter where you're at, no matter what you're doing, or where you come from, this is where everybody comes to and it's a beautiful place to be. (Middle-aged woman)</li> </ul>



**Table A4**  
**Additional sub-themes**

Sub-theme	Quotes
<b>Spirituality and Religion</b>	<ul style="list-style-type: none"> <li>For me, I think my strength comes spiritually. I practice like traditional [tribal] teachings but we're also Catholic, and we also dabble in Native American Church. So, it's like you got all these spiritual stuff coming at you. But spiritually I try to focus on [tribal nation] teaching like [tribal specific lifeways]. (University woman)</li> <li>My Native American and Christian belief, that's what keeps me strong is that mind, the stable mind, but never forgetting where--what you believe in as a Native American man. I believe in spirituality as Native Americans do. I believe in my tribal beliefs. And I'm also Christian too. I believe in both of them so I don't forget either one. (Middle-aged man)</li> <li>I'm one of those people who I've seen God. I've been in and out of Heaven. I've experienced a lot of phenomena, networking with angels. So it's more than a belief it's been my existence. And I like to pass on to people in the community to be, you know we're forerunner, spiritual people. And we're--everything's, in my beliefs in what I have experienced, is we are Prayer Warriors. And so we have that within us, to know there is a Creator and to have that hope and faith and positive outlook of being functionable and contributing in our community. (Middle-aged woman)</li> </ul>
<b>Family</b>	<ul style="list-style-type: none"> <li>And especially, I get my strength from my mother. She was a very strong, determined woman. And, she would never let me say "I can't." She would say, "You do this." And I would. I never questioned her. So that's where I get my strength from. (Elder woman)</li> </ul>
<b>Extended Family</b>	<ul style="list-style-type: none"> <li>My strength, my other strength I think I gained from my family. My father, my mother, grandmother. [Short pause] And, in my old age I think I gained my strength from my children. They're my best teachers. And, I guess that's where I am today as an elder. (Elder woman)</li> <li>And not only that, my sisters stand behind me, they're really, very supportive. And my [late] dad used to be supportive, and my grandmother. So, my immediate family, they're really, really--we're there for one another, so they do make me strong. And my mom, although she's not--limited in a lot of things, but she's able to help and be there for us, so. (Middle-aged woman)</li> </ul>
<b>Family: Reservation-Based and Practicing Native Culture</b>	<ul style="list-style-type: none"> <li>What I think makes me strong, is from the beginning it's always been my family. My family's been the foundation for everything I've accomplished and everything I will accomplish, and that goes for mental, spiritually and physically because it is rigorous to be culturally active, and physically and mentally and spiritually. It requires a lot of putting your faith in the natural world as well as people, which now a days that's kind of hard. But, I believe that my family is the ground work for my strength, and then I am my own strength basically because I'm trying to take it all in, and apply it wherever I go and trying to never leave it behind no matter how far I am from home. (University woman)</li> </ul>

# **“When you hear the noise, you know it's love": Family Support in American Indian Communities**

Emily Hicks, MS, and Jessica L. Liddell PhD, MPH/MSW

*Abstract: Family relationships are an important source of emotional and instrumental support. In American Indian (AI) communities, families often provide support for women during childbirth and childrearing. The present study sought to gain insight into the influence of family during the pregnancy, childbirth, and childrearing experiences of AI women from a Gulf Coast tribe. A qualitative descriptive research design was used, and 31 interviews were conducted with women from the tribe. The average age of participants was 51.17, and the majority of women had 2 to 3 children. Data was analyzed using a content analysis approach. Themes that emerged include: Influence of Childhood on Participant's Families and Parenting Styles, Significance of Family Emotional Closeness, Significance of Family Physical Closeness, Importance of Taking Care of Family Members, Importance of Family in Childbirth, and Generational Shifts in Caregiving. Results of the study may influence health interventions for this community, and results should encourage health care providers to consider positive implications of including family and community supports in care.*

## **INTRODUCTION**

Family support is related to better physical (Hale et al., 2005; Vila, 2021) and mental health (Chung et al., 2019), and family connection and well-being is particularly central to American Indian (AI) concepts of health and well-being. In AI communities, family includes “a wide circle of relatives who are linked together in mutual dependence” (Office of Indian Education [OIE], n.d.). For example, one tribe’s traditional family structure was described as being “rooted in traditional concepts of responsibility, where each family member was responsible for the family...should an individual family member falter in his or her responsibilities, the family structure would suffer” (Killsback, 2019, p. 35). In this way, each family member is expected to contribute and share resources with others, creating collectivistic

kinship networks. Additionally, family is considered to have a spiritual component (OIE, n.d.). One tribe uses the term “mita-kuyapi-owasin,” meaning “all my relatives,” which includes not only human relationships, but also plants, animals, and natural resources (OIE, n.d., p. 3). However, these traditional kinship networks and spiritual connections with the idea of family began shifting with the onset of colonialism and forced assimilation (Killsback, 2019). Colonization shifted family structure from one where each family member participated equally and fully, to a structure of patriarchy where women and children were considered less important roles than men (Burnette, 2015; Guerrero, 2003; Liddell et al., 2021a; Smith, 2003; Spencer-Wood, 2016). Despite these harmful impacts of colonization on AI family systems, family support remains foundational for AI communities to this day.

For the tribe discussed presently, connection to family, including extended family and the community broadly, has been described as a strength (Liddell & Kington, 2021; McKinley et al., 2019). Additionally, connection with the land, resilience, problem-solving, humor, and protection of traditional practices are also strengths of this tribe (Maldonado, 2014; McKinley et al., 2019). Family and community connectedness are particularly important, as these resources have been cited as foundational for family practices, including childrearing and ability to counteract systemic barriers (Gurr, 2014; Theobald, 2019). Additionally, the continuation of cultural traditions promotes AI community health (McKinley et al., 2019).

Family provides AI communities with a source of informal support, including emotional and instrumental support (Red Horse, 1980; Weaver & White, 1997; Reinschmidt et al., 2018). For example, previous research has found that AI women experiencing depression reach out to family and community support systems first before seeking Western services (Burnette, 2016; Liddell et al., 2018). Families provide emotional support through physical and emotional connection, prayers, hearing of difficulties, and providing advice, while also providing instrumental support through aiding with childrearing and household tasks, providing transportation when needed, and assisting with traditional healing practices.

Family and community support is often provided by women, particularly during times of childbirth and childrearing (Dalla et al., 2010; Power, 2020). These support systems offer knowledge, as well as various types of instrumental and emotional supports (Hancock, 2016; Gurr, 2014; Long & Curry, 1998; Theobald, 2019). Female kin often act as birth attendants, though this practice has slowed due to assimilation and the passing of elders (Long & Curry, 1998). Historically, in some tribes, the expecting parents would move to the woman’s childhood

home in order to receive support from family members throughout the pregnancy, birth, and postpartum periods; however, this practice has also become less frequent with assimilation (Hancock, 2016).

Family and community support is often preferred over more formal sources, such as health care institutions like hospitals, due to a history of harmful and unethical services delivered to AI communities (Broome & Broome, 2007; Burnette, 2015; Burnette & Figley, 2017; Canales, 2004a; Canales 2004b; Canales et al., 2011; Garrett et al., 2015). Additionally, community support is necessary in more rural areas, where access to formal health care institutions is limited (Liddell et al., 2018; Liddell, 2020; Liddell & Lilly, 2022a; 2022b; Ehrenthal et al., 2020). Community connection is important for well-being, as isolation from one's cultural identity has been linked with poor health outcomes (King et al., 2009; Morgan et al., 2020). Historical oppression, described as "deliberate human actions and policies aimed at cultural suppression, oppression, and marginalization" (Kirmayer et al., 2011, p. 84-91), limits opportunities for cultural connection by penalizing engagement with traditional activities and use of AI languages, leading to disruptions in family and community life. Thus, efforts to repair relationships and attenuate harmful effects of historical oppression are critical (Mohatt, et al., 2011). Additionally, programs that support social participation and family and community connection can contribute to improved health (King et al., 2009; Donatuto et al., 2016).

While research suggests that family support is related to enhanced health outcomes, little is known regarding AI women's perceptions of the role that families play in childbirth and childrearing, particularly among state-recognized tribes. This study builds upon previous work done with Indigenous tribes in the Gulf Coast (Burnette, 2015; Burnette et al., 2020; Liddell et al., 2021a; Liddell et al., 2021b; McKinley et al., 2019; McKinley et al., 2020; McKinley & Miller-Scarnato, 2020) and the framework of historical oppression, resilience, and transcendence (FHORT) (Burnette & Figley, 2017) to analyze both the negative and ongoing impacts of settler colonialism on Indigenous tribes, but importantly, to also highlight the ways that Indigenous people have acted resiliently in the face of these impacts. The present study seeks to fill this gap by addressing the following research questions: What role does family play in the pregnancy, childbirth, and childrearing experiences of AI women in a Gulf Coast tribe? And how do these experiences impact AI women's well-being?

## METHODS

### Research Design

The data used presently was collected as part of a larger qualitative study exploring reproductive health care experiences of women from a state-recognized AI tribe in the Gulf Coast (Liddell, 2020; Liddell & Kington, 2021; Liddell & McKinley, 2021; Liddell & Lilly, 2022a; Liddell & Lilly, 2022b; Liddell & Doria, 2022; Liddell & McKinley, 2022; Liddell & Herzberg, 2022; Liddell & Meyer, 2022; Liddell, 2022; Carlson & Liddell, 2022; Liddell et al., 2022a; Liddell et al., 2022b; Liddell et al., 2022c; Liddell, 2023). Using culturally congruent qualitative research approaches are particularly important in research with AI communities (McKinley et al., 2019; Burnette et al., 2014), as to avoid collecting information without community context and making interpretations that may be incorrect. Using direct quotes limits opportunities for misinterpretation, which has previously contributed to historical oppression and compromised AI health and well-being (Denzin et al., 2008). Further, a community engagement approach was used, such that the project was created in alliance with a tribal community advisory board (CAB) and with tribal council approval, in addition to Tulane University Institutional Review Board approval. In depth, semi-structured interviews were conducted, and traditional content analysis was used.

### Setting and Participants

The second author conducted 31 semi-structured open-ended interviews with women from an AI Gulf Coast tribe, whose identity will remain anonymous in accordance with agreements with the tribal council and tribal CAB. Participants were at least 18 years old, identified as a woman, and as a member of the tribe. The median age of participants was 51.17, with ages ranging from 18 to 71. The majority of participants (83.4%) had at least one child, though participants with children had an average of 2-3 children. Interview questions included, “Can you tell me about your family growing up?”, “Can you tell me a little about what it’s been like to raise children?”, and “What community supports exist for raising children?” A full list of interview questions can be found in Liddell & Kington, 2021.

### **Data Collection & Analysis**

Participants were recruited through local flyers and purposeful snowball sampling, and recruitment was aided by the CAB. The semi-structured interviews used questions to follow a life course approach (Sandelowski, 2000) and were informed by the responsive interviewing model (Rubin & Rubin, 1995). Data was collected from October 2018 – February 2019, and interview length ranged from 30 - 90 minutes (mean = 66 minutes). Participants provided informed consent and were able to stop the interview at any time, or to refuse to answer any question. Participants were compensated for their time with a \$30 gift card. Interviews were recorded with the participant's permission, transcribed, and examined for accuracy.

NVivo software was used to analyze data with a traditional content analysis approach, beginning with the identification of general themes with open coding, followed by subtheme identification with direct coding (Milne & Oberle, 2005). The first author reviewed the coding of the second author to clarify the meaning and interpretation of findings and to collaboratively refine the themes of the article. The findings and coding scheme were also shared with CAB members who provided additional feedback, clarification, and contextual information on study findings. Member checking was also conducted, and participants were provided with the full set of study findings and the opportunity to give feedback or suggest changes to the study findings. Findings were also presented at tribal council meetings and approved by the tribal council. In the quotes below, anonymous identifiers are used for participants in order to demonstrate the representation of themes across interviewees.

## **RESULTS**

Family was often cited as the most important source of support for women during pregnancy and childbirth and was often instrumental in allowing women to continue to work or attend school while caring for children. Family support was often a key factor in addressing the structural gaps and needs of women. Family values and expectations were also transmitted to participants and influenced the trajectory of participants' lives. When describing why family was so important, women discussed themes related to the following: Influence of Childhood on Participant's Families and Parenting Styles; Significance of Family Emotional Closeness; Significance of Family Physical Closeness; Importance of Taking Care of Family Members; Importance of Family in Childbirth; and Generational Shifts in Caregiving.

**“You've got the Waltons there...except in a Native Tribe” and “We want[ed] to be like them”: Influence of Childhood on Participant’s Families and Parenting Styles**

Women related many stories about their childhoods, including those related to health, their families, and living on the land. Thirty women described childhood experiences that impacted who they are today (referenced 46 times). For many women, these childhood experiences impacted the type of family (size, composition, etc.) and the way they wanted to raise their own children. Generational changes were also described. Women often spoke about changes they saw between their own childhoods and the childhoods of their children. Participant 1 (age 54) described the value of being a hard worker being instilled in her during her childhood:

Mom and daddy was pretty strict on us, you know...nothing was handed to me and my sister.... Like I wanted a, I wanted a stereo. That's when everybody started getting stereos and my dad's like, you don't have that money...[and] that's not a need. That's a want...you need to learn the difference between a need and a want and so...I learned the difference between a need and want. So I started working at [name omitted] food restaurant, waitressing...and every time I go, get paid, I'd go bring my money up [put it away to save]. So I learned a long time ago, you want something, you got to work for it.

This participant described learning important values about being hard-working and self-sufficient from her parents. Participant 11 (age 36) described learning to not rely on having, and overly valuing, materialistic things because of her transient childhood:

One of the things that I take away from that [being transient] is... I always kind of pride myself on not being a materialistic kind of person.... Because I never was able to hold on to anything for long periods of time...the home life was always changing...like every six months, I lived somewhere new. So it was never really like, this is my home, these are my things, this is my bedroom. There was none of that...it was like, I come in with two bags, I leave with two bags. So as an adult...being in relationships or...with roommates or whatever... the living situation was, I was never one to be like, this is mine...even though...you think people long for that, it was like, you know, if this is an uncomfortable situation, I'll leave with the two bags that I came with...and I [have] never been one to... like



this is all mine...because everything could be replaced...I was so used to always having to replace things or never really being attached to one place.

This participant attributed her current ability to be flexible to these childhood experiences. Participant 13 (age 56) described her childhood and family as the Native version of the “Walton family”:<sup>1</sup> “Who is it, the Walton family? You’ve got the Waltons there.... Except in a Native tribe.... So that’s pretty much a...mother was at home—She always took care of the children. Papa was the provider.” This participant later expressed her desire to model the same type of family she was raised in with her own children. This quote also illustrates the desire to adapt Western mainstream ideas about what a family is, or should be, to an AI context.

All women spoke about the role of their parents in their lives, especially as it related to their own expectations about parenthood. Participant 1 (age 54) spoke admiringly of her parents and their ability to utilize what they had and provide for their family in recounting a story about her mother making underwear for the family out of sacks:

Like in a sack, like a blue bird flower...the red bird, or blackbird or something, I remember that, the sacks. Like the sacks of sugar...and the rice was in the sack, you know, it wasn’t plastic material, raw material. And Mama used to always say, yeah, I had a blue bird ass. She says, because mom they made our drawers [underwear] out of [laughter] [the sacks].... You know, my mom and on both sides, they all grew up really poor. So they utilize what they have.... So we always had...we never grew up hungry. Never.

This quote also exemplifies the importance of humor, a trait that was described as extremely important in family functioning by many women. Participant 19 (age 62) stated that she learned to be dependable and to help other people through watching their parents: “For me, I think it was my upbringing, my parents, how they kind of instilled always being there for people, always helping. So we depended on them, and they were very strong, and so we want[ed] to be like them.” Women described learning important values about humor, self-sufficiency, and taking care of others, from their parents. Participant ideas and desires about how they wanted to be as parents themselves were highly influenced by their experiences as children and by the values that were instilled by their parents.

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<sup>1</sup> A reference to a popular 1970’s show about a family in rural Virginia.

**“When you hear the noise, you know, its love”: Significance of Family Emotional Closeness**

Twenty-two women described the importance of being emotionally close with family members (referenced 60 times). Most women reported being able to rely on family members throughout their lives and how much they valued that connection. When participants experienced challenges, they reported being able to turn to family members for support. Participant 1 (age 54) described how close her family was, even among family members who were far apart in age: “I had two aunts that had 16 kids...we're a very large family. We're a very close family...We're close, close family and when something happens, we're always there for each other.” Even though she and her siblings were not of a similar age, they remained close throughout adulthood. Participant 13 (age 56) described how growing up in a close and large family could sometimes be chaotic and noisy, but how for her that was a sign of love: “It is noisy. But its love, when you hear the noise, you know, its love.”

Participant 4 (age 68) talked about as a child, family members sheltered together on boats when hurricanes would come: “When we would go on the boat when we was small they had, my uncles and cousins, they all had boats so we would all go together.” Weathering hurricanes together with extended family was mentioned by several women and not only practically helped family members by giving them a physical place with pooled resources to survive the hurricane, but also served to cement the emotional bonds between family members. These experiences demonstrate the resilience of tribal members, in addition to showing how important family closeness was for tribal members and illustrating how central extended family networks were. This contrasts with many Western conceptualizations of family which tend to focus on the nuclear family.

**“The kids didn't want to leave”: Significance of Family Physical Closeness**

Twelve women discussed valuing how physically close many of their family members were located (referenced 14 times). Many women reported living down the street from family, or in the same town. However, generational changes were also noted in this as some women also reported feeling that this was changing and were concerned that not being geographically close to family could undermine familial support, in addition to the transmission of cultural values. Participant 1 (age 54) described the importance of family members being located physically close to each other, noting that her grandmothers lived on the same street and that they would often visit them after school, helping with the gardening. She described how being physically close to family

members was a central part of her childhood, in addition to discussing the norm of family members helping out with subsistence activities, such as gardening. Participant 15 (age 52) discussed how important being physically close to family was for her children. Despite the threat of physical harm from environmental toxins in their community, this participant's adult children were resistant to leaving:

And honestly the kids did not want to leave. You know, we talked about moving because we were from my husband and I's hometown, grandparents were still there, and great grandparents and the kids didn't want to leave.... Yeah, they are there now. They're still there, they're raising their own kids.

For some participants, family proximity acted as an important way of facilitating and ensuring family closeness. Although being physically close to family had served as a protective factor for generations for many families, structural forces like climate change and pollution were acting to undermine this form of support.

### **“He takes care of me”: Importance of Taking Care of Family Members**

Twenty-nine women reported either taking care of their own family members when they had a medical or health issue or being taken care of themselves by a family member when they were sick (referenced 69 times). Many women expressed resistance to sending family members to assisted-care facilities and preferred to take care of their family members themselves. Participant 1 (age 54) described her relatives taking care of her when she was sick: “My aunts have gardens.... So that's where I get-like the other day I was sick for three weeks.... So I had both of them bringing me food...Yeah, her and Miss [name omitted], they take excellent care of me...Excellent care.”

This participant's comment also highlights the important role food has in family and community events and as a form of instrumental support for tribal members when they are in need of support. Participant 3 (age 71) described taking care of her ill husband:

He cannot speak. He cannot eat. He is bedridden. His brain was damaged on the right side. So, his left side is totally deficit.... And, [name of another tribal member] has been in that situation with a husband and her family. When you are in that situation, you think, "How much more can you take?" Then I think, "I was brought up to take it until I couldn't."

This quote also emphasizes the strength and resilience of women in this tribe and their desire to care for family members in the home, instead of in health care facilities. Taking care of family and community members was an extremely important tribal value that was mentioned across several themes and that served as a protective factor for many tribal members, who were able to remain at home or in their community instead of being placed in a medical facility. Additionally, for many women, the desire to take care of family members at home reflected concerns that their loved ones would not be well-taken care of if they weren't at home.

### **“We sat in the lobby and waited. We didn't leave the hospital”: Importance of Family in Childbirth**

Twenty women described the role of family members (other than fathers or romantic partners) during childbirth and noted that this support was extremely important (referenced 49 times). Several women described the advocate role that their family members took on, which led to them receiving better care. Participant 24 (age 43) described being with her mother-in-law when she was in labor with her first child:

My mother-in-law did...help with...my first child... 'Cause she [told me] like walk, squat whenever I feel, walk. And when I feel it [contractions], squat. Walk, squat. So she was helping me with that...I had no clue. I had no clue what I was doing, but now I do. That, so that's why she like knew when we had to leave [to go to the hospital]. She's like, yeah, okay, we have to go now. Let's go.

This participant stated that her mother-in-law gave her support in following her instincts about moving during labor, in addition to letting her know when it was time to leave for the hospital. Participant 12 (age 68) described the role of her aunt in her labor and delivery process:

I went into labor at six o'clock in the afternoon.... My mom called her sister and her sister comes over and she [mother] says, “I don't know.” Because my mom was very timid. And she says, “I don't know if she's ready to have the baby because of the way that she's doing.” And so my aunt says, “Yeah, I think she's almost ready to have that baby.” ...So we went to the hospital.

This participant describes her mother, aunt, and husband as all playing a part in her labor and going with her to the hospital. This participant went on to describe how special and important it was for her to be present at the birth of one of her grandchildren: “So my youngest one, oh yes! I was there and I cried! When I seen the baby being born, it was so beautiful!...I was in the room with my daughter-in-law when she had the baby and everything.”

Participant 15 (age 52) also described being present for the birth of her grandchildren, although she stated that her daughter didn’t necessarily want her in the room. She also stated that she helped run interference for her daughter who was concerned about her husband’s family:

I was available in the hallway.... my daughter was very private. She wanted her husband, and her best friend in the room. I told her...she said, “Mom, I don't want you to be mean to the people.” Because her husband’s family was just so many people. She said, “but you need to let them know that I'm very private.”... So I said “[daughter’s name] [is] not very comfortable with the gang of people here.” And I told her, “I will tell them, and I will be as nice as possible, but I'm gonna tell you one thing, I'll be sitting outside that door. I'm not leaving. I'm not going in the parking lot. I'm not going home. I will be outside this door and if you need me just say, ‘mom, I need you.’” Other than that, “you're in good hands, you're good. And daddy’s, he's going to be sitting in the lobby.”... We sat in the lobby and waited. We didn't leave the hospital. We stayed there until both babies were born and they were given a good sign [the doctor said they were all healthy] and said...“visiting hours are over, you need to go home.” Then the next day we came right back.

This participant expressed her commitment to being there for her daughter and supporting her daughter’s needs for privacy during labor.

Participant 5 (age 74) described her mother giving birth in a pirogue [a type of boat common historically in the area]:

My brother, right after me, he was born in a pirogue... we had to go out trapping. So we was at our camp trapping and then my mama went into labor.... she was fixing [planning] to go to my grandmother for when she was going to get in labor. So she had me and one of my brothers in the pirogue with her. Then she went into labor, and as soon as she went into labor she holler at my daddy and she told my

daddy that she was having the baby...So my daddy had to go in the bayou, pull the pirogue by the bank and get his mama to come and deliver the baby. Well the baby was already out. So, my... grandmother came and cut the umbilical cord.

This participant highlighted that family support came from a variety of sources, including her husband, mother-in-law, and other children. Women relied on their family for both emotional and instrumental support during childbirth. For example, women reported receiving practical advice from family members about what to do during labor and when they needed to go to the hospital. Women in general also described birth being a social experience, with many family members being present, indicating the value placed on childbirth in the community.

### **“It's totally different”: Generational Shifts in Caregiving**

Twelve women also stated that they saw changes in childrearing occurring in their own families and the tribal community as a whole (referenced 15 times). Participant 21 (age 68) felt that one of the main changes in childrearing was that children no longer spent as much time with parents and that it was no longer a norm to take children with adults wherever they went:

And I don't see that [taking children out with parents] these days here. I have a friend of mine; she never brings the little girl anywhere. She always leaves the little girl, leaves the little girl, leaves the little girl. And she's a schoolteacher, and I said, "They don't want to be full-time parents. They want to be full-time career people, but they don't want to be full-time parents." The guy [the friend's partner and father of child], he works at his house. He's on [a] conference [online call] with people in another state, and even in conference he brings the little girl to the mother-in-law. Just in conference, you know. I said, "Don't they know that he's got a child that he's got to take care of?" The wife is working in school, and don't they know that he's got a child? You know, but he's in conference so she's got to take care of the little girl. And it just drives me nuts.

This participant contrasts this with her own childrearing practices:

I said, "Us, we brought our kids wherever we went, you know wherever we went." But they, the girl that has the little girl, she went Black Friday shopping. And so I

called them up, her mother, I said, "Oh, I know you're babysitting. I know they didn't bring the baby shopping." And she said, "Who told you I was babysitting?" I said, "I just know. They never bring the baby." ....They can't go eat out because the baby's sleeping. They can't wake up the baby. The baby's sleeping. My babies, we bring the babies out. They fall asleep, so what, you know? The baby went to a wake, a funeral, and this guy rolled the baby in a stroller. The little girl was sleeping. Them, they wouldn't even have brought the little baby out because the little girl's sleeping. So what, you know?... Yeah, and they weren't raised that way, you know. Her mother brought her every- She had two kids, a boy and a girl, and she brought them everywhere. She never had nobody babysit her kids or nothing, but the new generation, oh, get rid of them as much as they can, you know. They have date night every Friday night....That should have been before you had the babies. Not now that you have the babies, you know?... The child should be the priority. No, it's them that's the priority, you know.... It just drives me nuts.

This participant describes feeling that parents should make their child the priority and should not depend on family members to take care of their children when they have work or social obligations or events. This participant also describes parents taking children out in public as a previous community norm, which also would have afforded children additional opportunities to learn community values and traditions. Participant 22 (age 67) also reported seeing differences in childrearing. She reported that a lack of discipline leads to children talking back more: "Today the generation is just so different. I see all these kids, how they talk to their parents and that.... But they [her children] didn't talk back." This participant went on to state that she felt her children didn't want advice about parenting from her:

First time I ever told my daughter about how to raise her son. I said, "Well, I'm not going to tell you nothing." They're going to learn. They have to raise their own, the way they want. So, my kids when they were growing up...I would fuss them...a couple of them told me, now we know why you was so rough on us. Now we know, we got kids of our own...But, you know, the new generation...It's totally different. It's way different.



This participant's quote also highlights some of the limitations of the family role, as this woman noted that her children didn't want advice from her on parenting. Participant 2 (age 55) described changes in what food infants are given: "You know, like my Mama said when y'all were little, we had no baby food. We mashed the food that we cooked and that's what y'all eat." This participant contrasted the modern-day norm of feeding babies purchased and processed baby food with feeding babies the same food the family was eating. It is unclear the difference that changes in childrearing will have on younger generations of tribal members, although women in general viewed these changes negatively. Some of these changes may indicate that family norms and values about childrearing are being transmitted less frequently, as younger women may be more likely to deviate from how they themselves were raised.

## DISCUSSION

All women mentioned the role and importance of family, especially during pregnancy and childbirth and when raising their children. The importance of and the different roles of family were mentioned more frequently than that of health care providers and facilities, despite the interview being focused on health care experiences, which typically take place outside of the home. This highlights the role that family has in mediating women's experiences of macro and mezzo health care structures and its salience for women when they reflect upon their health care and parenting experiences.

Our findings are in line with previous research highlighting the significance of AI community and family support for women (Hancock, 2016; Gurr, 2014; Theobald, 2019). Connection with family was described as an important resource, particularly when participants were ill or during childbirth. Women reported close-knit families, especially during childhood, that provided emotional and instrumental support. This support often consisted of family or friends caring for children while at work, receiving advice from trusted community members, and general support during childbirth and childrearing. AI families are often intergenerational, including extended family, with elder tribal members being well-respected (Red Horse, 1980; Weaver & White, 1997). Elders provide instrumental support (e.g., childcare), as well as serve as role models and leaders who impart cultural values and traditions to younger generations (Weaver & White, 1997). These family and community supports are particularly important for this tribe, as they are

state-recognized and do not receive the same health care resources, such as Indian Health Service (IHS) that federally recognized tribes receive.

Nearly all women emphasized the importance of being close with family members. Women reported being able to rely on family members throughout their lives and how much they valued that connection. Women discussed valuing how physically close many of their family members were located and often reported living down the street from family or in the same town. However, women also reported feeling that this was changing and were concerned that not being physically close to family could undermine familial support. Although geographically dispersed, community plays an extremely important role for many tribal members (Liddell & McKinley, 2021; McKinley et al., 2019). Participants expressed concerns about what would happen to community cohesion if disasters and climate change continued to push community members inland and away from their existing social networks. These concerns are consistent with previous research with this tribe related to the negative impact of environmental issues (Liddell & Kington, 2021; Liddell et al., 2021b).

Women reported either taking care of their own family members when they had a medical or health issue or being taken care of themselves by a family member when they were sick. Women expressed resistance to sending family members to assisted-care facilities and preferred to take care of their family members themselves. Previous research has also noted how help-seeking in AI groups is usually characterized by a combination of both formal and informal support (Beals et al., 2005; Buchwald et al., 2000; Liddell et al., 2018). These informal supports often include community or family resources, which may include emotional and instrumental support (Red Horse, 1980; Weaver & White, 1997). Notably, women also expressed concern that tribal knowledge related to healing is not being passed down to younger generations (Hicks & Liddell, in press). However, in spite of colonial impacts on Indigenous health care practices, women continue to report family and community support throughout the childbirth and childrearing process.

### **Limitations and Future Research**

The present study has several limitations of note. First, some tribal members may have been excluded due to interviews being conducted entirely in English, which is not the primary language for all tribal members. Further, results may not be translatable to other AI tribes, as all interviews were conducted within a single tribe. Finally, data was only collected at one point in

time, and future research should use a longitudinal approach, which may shed further light on generational shifts and changes across the life course.

The current study explored women's knowledge and experiences related to family support, and further studies should examine the experiences of men, Two Spirit, and non-binary tribal members. Future research is also needed to understand the influence of family and community support on mental and physical health outcomes. Generational changes related to family support was not a particular focus of this study and research explicitly focused on exploring generational changes related to family support in Indigenous communities, and particularly among tribes that are not federally recognized is needed. Research is also needed to examine the impact of living in the Gulf Coast on family and community support, as there is a dearth of literature exploring tribal members level of perceived support across geographic regions. Finally, given the differences in resources provided to federally recognized and non-federally recognized tribes, future research should examine levels of community support experienced by tribal members from both federally recognized and state-recognized tribes.

## **CONCLUSION**

The present study sought to better understand experiences related to family and community support of AI women from a state-recognized, Gulf Coast tribe. Findings from the current study highlight the importance of family emotional and instrumental support, particularly during childbirth and childrearing. Women described receiving support both from their nuclear family, as well as from extended family members. Informal support was often preferred and sought first before more formal sources. Despite the impacts of settler colonialism on traditional kinship networks, through patriarchal practices, boarding schools, and forced assimilation, women continued to support and appreciate traditional tribal kinship values and practices. These findings begin to fill knowledge gaps regarding family and community support experiences of state-recognized, Gulf Coast tribes. An important outcome of this study was the creation of the Framework of Integrated Reproductive and Sexual Health Theories (FIRSHT) conceptual framework (Liddell & McKinley, 2022) which incorporates resilience, life-course, Indigenous critical systems, and reproductive justice theories to holistically contextualize the health care experiences of Indigenous people. This framework in particular highlights the strengths and resilience of Indigenous people and acts in contrast to approaches which use a deficit approach to

understand health and wellbeing. Future researchers should be encouraged to engage in strengths-based research approaches that emphasize the strength and positive outcomes of Indigenous health and well-being to continue filling current gaps related to AI health practices. Health care providers are encouraged to consider the meaningful resources that family members and AI community members provide for AI women during pregnancy, childbirth, and childrearing. Health interventions should consider the role that family members may play and allow for extended family members to provide support and care during these times.

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The authors declare that they have no conflicts of interest.

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# Trickster Discourse and American Indian Identity in Counselor Education: A Critical Phenomenological Inquiry

Stephenie M. Wescoup, MEd, and bria g. stare, PhD

*Abstract: In this qualitative phenomenological study, authors explored an American Indian student's experiences of colonization within a master's counselor education program. Interviews were conducted with one participant that met criterion sampling. Findings outlined counselor education's assimilative capacity and Indigenous resistance to assimilation. Themes included Confronting the Threat and Being Too Indian. Authors discussed implications for counselor educators and multicultural education specifically.*

## INTRODUCTION

Literature regarding racial identity is abundant in the fields of psychology and educational research (Shin, 2015; Sue & Sue, 1990, 1991; Cross, 1995; Kim, 1981; Ruiz, 1990; Helms, 1995; Garrett & Pichette, 2000). The APA defines racial identity as one's sense of being a part of a racialized group (2023). This identity can be contextual and fluid (APA, 2023). For example, a mixed-race person may identify as Black in one setting (or point in their life) and mixed in another. Within the helping profession, previous research has focused on the *development* of racial identity and the clinical implications of it (Sue & Sue, 1990, 1991). There are disparities when it comes to who generally participates in studies regarding minoritized racialized identity development. Much of the literature includes participants identified as African American/Black, Latino/a/x or Hispanic, and Asian (Watson, 2009; Shin, 2015), but research on American Indian (AI) identity development is sparse.

AI identity is a complicated and contested topic both within and without Indian Country (Weaver, 2001), a notion that most non-Indians misunderstand or remain ignorant of (Champagne, 2010). AI racial identity is unique for AIs in that it is tied to legal membership, or *enrollment* in a tribal nation (Brayboy, 2005; Champagne, 2010). Membership is controversial

among AIs as some tribes have stricter membership laws, requiring one fourth or more *blood quantum* from one tribe, while others use lineage in considering enrollment status (TallBear, 2003). Differences in phenotype or whether one lives on or off of a reservation can also be a pressure point for lateral violence in which AIs attempt to de-tribalize or ‘out-Indian’ one another (TallBear, 2003; Weaver, 2001). The issue of blood quantum has garnered more attention in recent years for Indians and non-Indians alike and may inform competent understanding of AI identity at large (Ellinghaus, 2017; Champagne, 2010). Given that racial identity is dependent on contextual factors (APA, 2023) and linked to mental health (Sue & Sue, 1990, 1991), understanding how AI identity unfolds in settler contexts like counselor education is vital.

### **American Indian Identity**

Garrette and Pichette (2000) describe five *levels* of AI *orientation* in their model of AI identity in which use of AI language and knowledges determine orientation. *Traditional* AIs speak little English and primarily practice tribal ways of knowing and being. *Marginal* AIs are bilingual and know little to nothing about their tribal ways, but they are not fully acculturated into Settler society. *Bicultural* AIs live settler and tribal ways. *Assimilated* AIs embrace settler ways, and *pantraditional* AIs were born into settler ways but make efforts to return to tribal ways. Horse (2001) situates AI identity within a type of collective consciousness. “American Indian consciousness” is influenced by five specificities, including language, genealogy, worldview, self-concept, and enrollment status (Horse, 2001).

### **Nationalism, Cosmopolitanism, and Biculturalism**

AI people can differ in nationalism and cosmopolitanism orientations. A *nationalist* orientation stipulates tribal identity be made concrete and manifest in all aspects of daily life, valuing tribal sovereignty and autonomy. *Cosmopolitanism* holds a critical view towards sovereignty and autonomy, pointing to the inevitability of a global hybrid culture. Weaver (2013) wrote that cosmopolitanism seems to tell nationalists to “salute” *East*, insinuating that AIs should acculturate to certain settler ideas as globalization is inevitable. People can be at either extreme of the spectrum or somewhere in the middle.

Extant research regarding how Indian identity impacts academic success and persistence is mixed. Some research has linked cultural traditionalism (i.e., being strongly connected to Native culture and practicing it in all aspects of life; Garrett & Pichette, 2000) to struggles in

settler schooling (Garrett, 1999; Garcia & Ahler, 1992). Conversely, other research has linked cultural traditionalism to greater academic achievement and persistence (Huffman et al., 1986; Huffman, 2008; Whitbeck et al., 2001). Lastly, other research has found Native identity to have no impact on academic outcomes (Bryant & LaFromboise, 2005; Middlebrook et al., 2010). Fish and Syed (2018) note that linking biculturalism to persistence and success is problematic in that it puts the onus of persistence and success within the Native student versus the colonial environment. It also fails to acknowledge the difficulty Native students face when attempting to construct a sense of self and incorporating Native ontologies within an oppressive, colonial environment (Fish & Syed, 2018). Native representation in educational settings has been connected to student success (Covarrubias & Fryberg, 2015).

### **Assimilation and “Health”**

Many authors frame a bicultural identity as more adaptive/ flexible and, therefore, *healthier* (Sue & Sue, 1990, 1991; Berry, 2005). As with other Students of Color, higher education presents challenges to AI students with non-colonial identities (Pigeon, 2009; Waterman, 2019). Often these challenges are framed as an inability to adjust to higher education (Watson, 2009). Out of dissatisfaction, AI scholars within the helping profession—including first author, SW—have looked to other fields in search of alternative perspectives regarding AI identity development (e.g., AI literature, AI Studies, anthropology, etc.). Gone (2006) wrote that most models concerning AI identity within the helping profession were created by white, settler researchers. These models reflect the researchers’ intended purposes of classification for sake of essentialism and analysis. Whether such models benefit AI people is a matter of contention. When assimilative racial identity models (Shin, 2015) are utilized in clinical practice, pathologizing survivors of ongoing colonization and genocide can result. Those in resistance to colonial structures may be dubbed “unhealthy” or “underdeveloped.” Imperative here is recognizing that this logic calls for AI students to be more accommodating of colonial agendas, even in the face of ongoing settler-colonial violence taking place on college campuses, or be pathologized.

### **Identity and Higher Education**

Critical scholars identify higher education as a perpetuator of colonial agendas and violence that otherizes AI identities (Patel, 2015; Tuck & Yang, 2012; Brayboy, 2005; Stein &



de Oliveira Andreotti, 2016; Authors, in review). Within counselor education specifically, this can manifest as *surveillance* (Azarani, 2021; Brayboy, 2004), or “being closely watched in a way that controls one’s identity and actions” (Brayboy, 2004, p. 126). Native students may be forced to hide their identities for extended training periods, including during post-graduate supervision. Jackson et al. (2003) found that AI students experienced both “passive” (i.e., ignoring or singling out based upon race) and “active” (i.e., making derogatory comments about a group) racism in higher education. Most of the active racism “was typically experienced in classes or other discussions about historic or cultural issues” (p. 557), a time when faculty were present and listening. Students with minoritized (i.e., non-white) identities have reported *racial stress*. Racial stress has been correlated with an array of physical and emotional health concerns, including shorter life-expectancy (Berger & Sarnyai, 2015). Experiencing colonial violence like racism impacts AI students *physiologically*, not just academically.

However horrible, such dynamics do not make pitiable victims of AI students. Vizenor (1989) wrote at length regarding AI *survivance*. Survivance (Vizenor, 1989) combines the words “resistance” and “survival.” “Trickster discourse” (p. 187) and survivance can be seen as refusal of settler-colonial narratives that situate AIs in a position of helplessness and destitution (Vizenor, 1989). The trickster in AI storytelling is “a liberator and a healer,” helping the listener to critically think about and laugh about difficult situations (Vizenor, 1989, p. 187). Humorous and paradoxical storying are deeply embedded in Indigenous cultures of Turtle Island (i.e., North America) broadly. Such storying is also used as social commentary (Deloria, 1988; Vizenor, 1989).

### ***Native Students in Counseling and Counseling Psychology Education***

Educational researchers have found racial identity development linked to academic achievement (Watson, 2009) and most studies focus on undergraduate students. Conceptualized as a dependent variable, achievement within higher education has been measured using a variety of demarcations, including grades, motivation, retention, and persistence (Watson, 2009). Research regarding AIs students’ racial identity within graduate-level counselor education specifically is non-existent.

Racial justice and multiculturalism continue to be centered in counseling training programs in the United States, yet Natives remain invisible in educational spaces broadly (Fryberg & Eason, 2017). AI students may find themselves in counselor programs purporting an emphasis on multiculturalism yet face blatant racism and other settler-colonial violence in their

educational setting (Brayboy, 2004; Stare & Wescoup, in review). Such dynamics involve signifiers of social justice and/or claims of decolonization that mask continued colonial aspirations. In such maskings, Native students are tokenized in service of a white neoliberal agenda.

Native psychologists are severely underrepresented in the United States. AIs and Alaska Natives earned less than 1% of conferred doctorate degrees in 2019 (APA, 2019). Begay (2020) notes that a severe lack of AI psychologists practicing and engaging in research leaves the Counseling Psychology field grossly underprepared for meeting its goals of incorporating Indigenous knowledge into training programs. Furthermore, at the time of this study, we found no published research examining AI student experiences in either counselor education or counseling psychology.

## **Rationale**

The purpose of this study is to gain a deeper understanding of an AI student's experiences of colonization in master's level counselor education program. Our research question was "How are colonizing practices experienced by a master's level AI counseling student?" The goal of this study is to consider the ways one Southeastern Tribal AI graduate student seeks to retain his identity in a master's level counselor education program.

The U.S. settler-colonial project is a land occupation facilitated by the genocide of Indigenous Peoples. One of the objectives of the settler-colonial project is the erasure of AI epistemologies and prohibition of them in educational settings. This article is part of a broader qualitative research study on colonizing practices in counselor education where Stare and Wescoup (in review) explored the nature in which an AI counseling student was coerced into learning white ways of healing to participate in capitalism and the ongoing U.S. settler-colonial project. Findings included the ways in which ontological violence and erasure of Native epistemologies transcend the depth commonly conceptualized as *microaggressions* (Stare & Wescoups, in review). These findings also indicated a need to consider AI identity within the context of counselor education dynamics. Themes pertaining to AI identity were not included in the previously mentioned Stare and Wescoup (in review). This particular article contains those findings and pertains to how counselor education was survived by an AI student.

## METHODOLOGY

Researchers utilized a critical phenomenological approach to data collection and analysis (Guenther, 2013) and incorporated ethical considerations for research with Indigenous Peoples (Battiste, 2008; Smith, 2012). Critical phenomenology is an approach to understanding living embodiment and meaning-making within quasi-transcendental structures (Guenther, 2013). Where classical phenomenological approaches have been criticized for failing to accommodate the historical and social structuring of subjective experience (Guenther, 2020), the placing of individual being before intersubjectivity and social relation (Guenther, 2013), and racialization as it pertains to structural positioning and alterity (Lee, 2014), a critical phenomenology facilitates the documentation of subjective experiences within political and historical quasi-transcendental structures. Race is a socially constructed phenomenon which carries tremendous ontological weight, and its imposed structure shapes the epistemic and subjective experiences of the individual (Guenther, 2020; Lee, 2014). By including structural understandings from critical race theory, post-colonial theory, and Indigenous Ways of Knowing, our practice of critical phenomenology involved a relational understanding of lived embodiment within colonial structures of race and their imposition through educational systems. Specifically, we focus on the racialized ontological and epistemological experiences of being AI in higher education. Our study was both collaborative and critical in that we joined with co-researchers in seeking to shift our focus away from studying AIs and towards more deeply understanding the racialized colonial violence of higher education.

Indigenous scholars have emphasized the importance of Indigenous people/Peoples as research collaborators rather than subjects and the ethical necessity of joint collaboration with Indigenous peoples in research design, implementation, and outcome (Battiste, 2008; Smith, 2012). Similar to Community-Based Action Research (C-BAR), the intentionality undergirding this methodology was to benefit the co-researchers by giving them an opportunity to guide the research process, including the creation of research questions (Hacker, 2013). Authors elected critical phenomenology and accompanying research methods in close collaboration with co-researchers. Authors collaborated with co-researchers in research design with regard to selecting methodology, generating research topic and questions, interview formats, interview questions and approach to data analysis. The lived experiences documented in this critical phenomenology serve as testimony to the anger towards and absurdity of the University as a colonial structure

rather than the more common and detrimental solicitation of liberal sympathy for the plight of AIs (Tuck, 2009).

### **Data Collection & Co-Researchers**

Authors used purposive opportunity sampling to select a small sample ( $N=1$ ; Co-Researcher 2 served as triangulation source) consistent with phenomenological inquiry (Patton, 2014; Vagle, 2017). Smith (2012) writes that research with Indigenous people requires significant relationship-building and a relationship that does not end with findings. Authors and Co-Researchers were previously professionally acquainted, a positioning creating trust and collaboration in the research process and *relationality* (Smith, 2012). The idea for research collaboration arose organically from dialogues between second author and both Co-Researchers about racism in counselor education (Smith, 2012). Sampling was purposive. Authors determined small sample size on  $N=1$  based on Co-Researcher 1's 1) knowledge of tribal ways and language, 2) AI epistemology, and critical race studies. Authors were not able to find another participant that met the aforementioned criteria that Authors also had appropriate relationality with (Smith, 2012). Co-Researcher 2, Co-Researcher 1's father, assisted with triangulation. A  $N=1$  sample size was preceded by previous critical phenomenological research (Guenther, 2013) given Co-Researcher 1's depth of both traditional Native and critical race knowledge and the degree to which Native students are excluded from or do not enter counselor education. Upon obtaining IRB approval from the second author's university, second author conducted 6 in-depth interviews, 1-1.5 hours each with Co-Researcher 1 at his home, spending additional time in his neighborhood and with his family. Second author audio-recorded interviews and utilized a professional service to obtain interview transcripts. Second author led coding, member-checking, and authorship for this manuscript.

#### ***Co-Researchers***

Co-Researcher 1, Jay, was a 34-year-old master's counseling student at a southern state university. Jay is a member of a tribe from the Southeastern United States. He was in his second year of a program focusing on clinical mental health counseling. Jay resided in a large urban area with his partner and uncle. He was raised by his father in a smaller city nearby. Jay was exposed to activism and learned about AI epistemology, ceremony, and language in his upbringing.

Co-Researcher 2, Gray, was an educator employed at a southern state university and also from a Southeastern tribe. He published on topics pertaining to AI psychology, and he self-

identified as carrying a fairly centrist view of AI identity on a scale of cosmopolitan to nationalist. He indicated his son, Jay, carried a more nationalist view. Further details were omitted to protect participants' identities.

### **Data Analysis**

Authors' critical phenomenological data analysis involved Husserlian steps of intentionality, epoche, phenomenological reduction, and transcendental subjectivity (Davis, 2020; Vagle, 2017). First author, a traditional Lakota woman (she/her/wínȟyaŋ), and second author, a white gender non-binary settler of Irish and Western European descent (pronouns: she/her/hers), reflected on their own positionalities within the U.S. settler-colonial project and perceptions of their own internalizations of colonization. First author reflected on how her Lakota identity impacted her interactions with Co-Researchers as well as how data was interpreted. She frequently paused to reflect upon how she unknowingly perpetuated settler ways of knowing such as hierarchical and linear thinking (Jun, 2019), assimilation (Brayboy, 2005), and transcendence over immanence (Deloria, 1972). Second author reflected on her white patriarchal socialization and settler positioning as well as sociohistorical underpinnings of her current collaboration with AI people in certain overlapping abolitionary interests. Authors logged and engaged with bridleing how these internalizations may affect their perceptions of data, a process that continued throughout data analysis.

Authors met weekly for 12 weeks during data analysis. First, they individually conducted multiple line-by-line readings of each interview transcript, highlighted meaning units, and wrote thick descriptions from which they developed preliminary codes (Vagle, 2017). Authors then developed preliminary themes and coding manual containing in vivo (emic) and process codes (Saldaña, 2016). In vivo codes provided labels verbatim from co-researchers' descriptions and process codes offered description of ongoing phenomena. Authors then re-coded all selected meaning units using the coding manual which they further developed and finalized in the process. Authors reached a final inter-coder agreement of 100%.

### ***Trustworthiness***

Trustworthiness is central to qualitative research validity (Vagle, 2017; Patton, 2014). Authors engaged in extensive data immersion including spending extended time with the participant and his father, repeated readings and re-readings of data sets, and verification of findings through member-checking and triangulation. First author conducted member check with

Co-Researcher 1 upon conclusion of completing the preliminary coding manual and verified accuracy of themes and selected passages. Second author triangulated with Co-Researcher 2 regarding findings and received additional contextualizing information which supplemented author's conceptualization of transcendental subjectivity and Indigenous ways of knowing. Authors consulted with other critical scholars and Indigenous researchers in electing research methodology, revisiting potentials for harm throughout the research process. Any harmful considerations that arose were discussed and resolved with Co-Researchers. In one such instance, Authors expressed concern regarding the historical mining of AI communities for resources and academic study (Patel, 2015; Trudell, 2008; Smith, 2012). Co-Researcher 1 dismissed this concern indicating his belief that this study would help first author as an AI person in counselor education, and Co-Researcher 2 expressed his belief in the potential for this study to help other AIs in counselor education as well.

## RESULTS

Authors organized findings into two themes and five subthemes. Theme One: Confronting the Threat described how Jay confronted epistemological violence in his program. It contained two subthemes (Coyote and Critical Thought) outlining the specific mechanisms through which Jay confronted this violence. Theme Two: Being Too Indian described how Jay experienced settler-colonial violence in his program when being his authentic cultural self and the consequences of those violences. It contained three subthemes, White Mask, Laying Low, and Empty Glass. All theme names and passages are directly paraphrased or verbatim participant quotes. Authors organized themes in a non-linear narrative manner reflective of the participant's lived experience. While academic writing often adheres to linear and categorical style, AI epistemologies encompass more holistic micro- and macro-perspectives. These findings may be considered through such a holistic lens, and many quotes of length are left in block format to honor Jay's storying process. Findings are specific to Jay's experiences in counselor education, but his experiences within counselor education reflect larger dynamics of settler-colonialism in civil society.

### Theme One: Confronting the Threat

In this theme, Jay described how he confronted epistemological violence in higher education. Subthemes include *Critical Thought* and *Coyote*. These describe his seeking, finding,

and grounding in cultural identity as well as his methods of cultural survival employed while in his program. As the helping field is grounded in Western, colonial epistemology—primarily positivist paradigms—Jay was expected to operate from such ways of knowing as well. In this theme, Jay described how he was able to refuse such assimilative efforts.

### ***Critical Thought***

Jay reported being raised by woke people and militants. For example, he explained how he sat in on American Indian Movement (AIM) meetings as a child. Jay also reflected on his *privilege* in having these experiences as they provided him a foundation for his tribal identity as well as understanding of colonization not shared by all modern [Southeastern tribe] people. Further, Jay described experiencing pain and suffering from internalized colonialism until he found tools to differently engage in critical thought (i.e., debate and critical race studies):

For so many years, shoot, until I was in debate, until I was 25. I was just so angry and unhappy. And I knew things were fucked up...but I didn't know why I was so sad, and I guess I didn't know what to do. Um, I never critically thought about race, and how it's- has underpinnings of everything in America that's been created...and when I did through debate, through Black people calling me out on shit and seeing...oh, I was perpetuating anti-Blackness. I was perpetuating Whiteness. Doesn't matter I have a brown body. I was still perpetuating many of these things and it was hurting me. I was perpetuating against my own being and identity, and so, critical thought got me out of that. It saved my life, from being depressed.

In deciphering his own internalized colonization and colonial positionality, Jay was able to recognize how we enacted lateral violence towards himself and others.

He also described recognizing how the English language itself was assimilative and how critical thought saved him from assimilation into The Colony, which he called “The Beast”:

Um, this language [English]. All these are kind of false things that I understand are not me... I'm one that has been swallowed by the beast. I'm inside the stomach. But I'm also fighting my way to cut my way out of that stomach...And I think that's the only way that we can truly survive within this stomach of the beast, is...questioning, and critically thinking. Critical thought, you know, that saved me, probably from suicide and...or death. Cultural death.



Jay's orientation to colonialism within counselor education was one of resistance and pessimism. He did not see any form of beneficial change coming from white, neoliberal systems like counselor education, hence his frequent cynical laughter. However, Jay did experience growth and optimism from reorientation towards his own Native identity and Ways:

But that's not to say that I haven't gained who I am more as years have went. I've attained a lot of that traditional Ways and Knowledges. I've peeled away colonial leeches more and more...and I think critical race theory has...helped me understand my positioning, my positionality in regard to white systems.

Emotional responses were a driving force in this process of reorientation, and Jay described how critical race theory (CRT) helped him to externalize feelings like anger. This helped him to see his People in a new light and to regain his "power":

And that's been invaluable, man. That has given me so much power and I've been so much less depressed because at first it was just anger, and I knew things were fucked up, but I didn't know how to articulate it, I guess. Not to people, just in my mind. I didn't know how to explain it to myself. You know, my people are drunk. My people are fat. My people die early and are considered uneducated or not smart. And you know, I think a lot of that I kind of internalized until I became versed in critical race theory.

These tools helped him to recognize his own internalized "policing" and to reclaim his identity as a Native person:

I understood that that's not who I was...I believe we each have like this BIA, Bureau of Indian Affairs, like this cop or this BIA [Bureau of Indian Affairs] agent in our heads. And sometimes we operate from that, like respectability politics, "Oh I need to pull my pants up..." That's that agent in our head. It's also surviving (Chuckles) thing, but so it's helped incredibly in that way. Understanding. I'm more comfortable. Even though the situation hasn't changed, I understand what's going on, and it...that's powerful for me.

Jay was freed from the shame that respectability politics can saddle minoritized groups with and see such social expectations as simple techniques used for access to capital. Even though Jay was still within The Beast, he was “more comfortable” in it after externalizing.

Jay repeatedly clarified his pessimism by remarking that he does not believe that the colonial system will change for the better or cease to attempt to colonize him, but that he finds power in reclaiming himself internally through epistemology and practice of his Ways.

Jay described peoples’ resistance to critical thought by saying “Critical thought is after truth. Truth. Nothing else. Truth and understanding. And people don't want that (laughs) because they have to, it's going to hurt. (Laughs) It hurts.” This played a key role for his experiences in counselor education. Ontological positionality was inseparable from classroom dynamics, and Jay was constantly tasked with interpreting violence.

I believe, that threat is not just physical, it's also cultural. As an Indigenous person, my life has been about confronting the threat or at least understanding the threat so it doesn't harm me, you know? So, I was told from a young age by my dad, by my elders, to not believe everything school was teaching me, you know, 'cause I was singing “in 1492, Columbus sailed the ocean blue,” you know? And so I had Indigenous elders telling me that was bullshit. And you know, that white folks try to teach you bullshit a lot. And so you have to be able to decipher, the settler that’s on some bullshit and also useful things that you can learn from anybody regardless of their race.

He described putting critical thought to use through a constant and emotion-laden filtering process. Jay described how his ancestors’ presence helped him to filter out The Colony’s attempts to assimilate him:

There's always that resentment, and it's a good resentment...even when I'm in class...the pessimist in me is always there. My ancestor is always right beside me, and I'm always asking myself, what would my ancestors think of this? Could they even understand this? It's pretty whack that I even can understand this...I'm filtering everything that goes through my brain. Questioning it all.

Critical thought was central to filtering, and therefore, cultural preservation. Jay described the process by saying “as a person of color, I think you're constantly having to be aware of where

the threat is, if there's a threat, uh, and how you filter the threat. Especially if you're trying to decolonize.” Jay described regularly being confronted with messages of his inferiority and attempts at cultural decimation (i.e., discourse around “savages” and technological inferiority), but filtering (i.e., critical thought) preserved him and provided relief.

### *Coyote*

Jay reported his program to be an environment with little critical discourse to foster this aforementioned alleviation, and he described often trying to inspire such discourse through his own contributions in class via his Native *trickster discourse* of “playing Coyote.”

I'll say things that's very provocative on purpose. I'm kinda playing Coyote, kinda tricking 'em. Sometimes I might even say things I don't completely agree or believe in, and I'll just say it, extreme, just to get people out of the sanitized, civilized, white bullshit way of learning that's in college all the time where one guy talks to us for three hours on a PowerPoint, and we all shut up, and we have this banking method instead. I go up in there, and, somebody says something about Native Americans, and I raise my hand and say, "Please don't call me American. I'm not American."...So there's gonna be some pushback to that. But then we can have a dialogue. Then we can have a discussion about what America is, that it was named after Amerigo Vespucci, an Italian sailor. And that was happening when my people had already been here for thousands and thousands and thousands of years with, uh, (laughs) you know, 'colleges,' and systems of being, and were living great.

Jay reported that “playing Coyote” created discomfort in classrooms and that he was often met with anger, and/or dismissed or scapegoated as a result. He described how pervasive colonialism was in his program and on a global scale and his desire to be contrarian to it:

I feel like they feel like I'm kind of a contrary...and I mean that's what resistance is. Hell yeah, I'm a contrary. I hope I am to most things here, because I think most things are messed up on this earth. And so if I'm contrary to it, maybe that puts me in some kind (chuckles) healthy space, I don't know, because this ain't healthy, what's going on. Not for me and my People.

Despite the pushback, Jay also described seeing students exhibit willingness to reflect on unquestioned settler narratives on rare occasions.

“Playing Coyote” was rooted in wisdom, resistance, and humor. Jay described the roles of Coyote in tribal traditions:

I had an elder [Comanche] recently tell me...the Coyote is at the pinnacle of knowledge and intelligence. It's at the pinnacle because he just, he understands the world and everything that's going on well, you know, from that eagle point of view. He understands everything that's happening...none of it matters. It's all ridiculous...So I can become angry and bitter, but that's kinda like whiteness controlling me. And I'm too strong for that. My people have ways of healing that people don't know about, and ways of being that people don't know about. How we kind of escape this is, you know, our laugh. Whether I'm in the stomach [of the Beast] or on the Trail of Tears or whatever, I'm going to laugh. You can't take that from me. We're the funniest People in the world. And the Coyote is someone that just causes chaos.

...The Coyote person will walk backwards, will bathe in dirt, will be a contrary to everything in certain instances. You know, we have clowns. All our tribes they have clowns. Some are called Heyoka. Some are called Yopula...They do different things, and some will be there just to fuck with you. You're not that important. I'm gonna tell you “bye” when I see you, I'm gonna tell you “hello” when I walk away. I'm gonna make you question everything. It is the person...he or she is the person that makes you crazy and think at the same time...will make you critically think. Why are you telling me hello when you see me? This is a good-bye. Huh? What the hell? Well, think about. Cuz this person...we believe those people are, usually, uh, like there's...are actual people, these clowns exist, you know, and they were chosen, we believe, by the Creator, by the Spirits.

Coyote wisdom, humor, and critical thought were central to Jay's self-understanding and survival of epistemological violence in counselor education. He told in a story:

I heard this story once...Creator when he was creating the two-legged, the human beings, it...whatever, I'm using English words and obviously these are gender

constructions and sexist blah, blah, blah, blah, whatever...was creating these people, and he was creating them out of clay, and he was putting them into this like this earth oven. And he said, "Oh, they're all white. The clay is white. I need to give them some color, so Imma bake them for a little bit." And so he put them in the oven. And as he started baking them, a coyote came around, Coyote said, "Hey, Hashtahli, Creator, you better take those out, they're gonna get burnt. You don't want them to be burnt, do you?" So the creator took them out, and they were white. They weren't no good. They weren't done. They're ugly. And so he just threw them in this place that became known as Europe. He didn't want them. And you know he was mad at Coyote, so he kicked him, kicked him, and coyote arr arr arr start running off. And that's when the Creator put them in the oven the way he wanted, the way he intended. And they came out perfect color. The color of the earth here. And he said, "These people belong here. In the greatest place in the world to protect and look over this area of earth." And you know, I've heard that and that's how people were created.

Playing Coyote also helped Jay to respond to microaggressions:

And so that, that's the Coyote, the Coyote, we survive. We laugh at you. Your great-grandma was a Cherokee Princess? We laugh. Like we have ways of laughing, of being. And to me, that's channeled through the Coyote, the ultimate intellect, the troll, the Internet troll. That's the ultimate intellect in some ways. I'm not saying there ain't dumb ones, but to the one that understands it all and is doing that, come on. That's great. Mess it all up. All this is fucked up anyways. Burn it. Burn it by... what, what, what did Joker say? He was kinda the same way, just, just mess with things. I'm not, not saying hurt people physically, I'm saying when all things are ridiculous, engage with it that way. Laugh at it.

It also allowed him to stay grounded amidst false notions of power:

Yeah. I try to, I stepped into that position sometimes. I started thinking this paper called the degree I'm going to get, it's some important, or that I'm, you know, a professor thinks I'm smart so I'm important, whatever it is. And none of it is true. It's all this ego stuff and power things happening and me thinking I'm gaining

power. And so I would much rather slip into the, the clown, the Coyote and assure myself that I'm not important, and that the stuff I'm being taught is ridiculous. And really, this whole thing is stupid. When I die, the trees are still going to be grown. You know what I mean? Everything's still going to be happening. The world will be okay without me. I wasn't even...I heard from Russell Means once that most things in the world, like bees, the Coyote, the trees, anything we talk about, if they died out, we die. The world will die. Will become damaged.

Jay was able to remember that true power lies in the connections that all living things have with each other. The credentials gained in his program were of no value in the grand scheme of things, so he did not allow his ego to be inflated by such white notions of power as educational attainment. In the end, it was all “ridiculous.”

### **Theme Two: Being Too Indian**

In this theme, Jay described how being openly Indian in his program made him a target for colonial violence. The theme also described how he survived it, namely by acting white. He explained how acting white helped him navigate Whiteness as well as the burden and/or risk of such techniques. Appeasing The Colony by acting white allowed Jay access to capital, but Jay questioned what the consequences were to him and his People in doing so. Subthemes include *White Mask*, *Laying Low*, and *Empty Glass*.

#### ***White Mask***

Jay discussed how his lived experiences informed how he navigated whiteness in his program. He described using codeswitching, dulling, or hiding his emotions and ignoring micro- and macroaggressions. Pointedly, Jay also described what he saw as the ramifications of such methods. Jay specifically described wariness around hiding his tribal identity and its potential towards internalizing Whiteness:

Throughout my life I've kind of learned how to maneuver as they do, as whiteness does. In college, in academia, college even, it's the same thing. It never really changed for me...maybe went from conservative to liberal or something. Some slight (laughs) minuscule change. But not me having to constantly put on a white mask for people. And maybe it's a mask I don't even have a choice to take off

anymore. (laughs) Maybe it's one that's just stuck now because I don't remember, I don't even remember my own face anymore. I can't take this mask off. I don't know my language well, so I speak this mask's language.

Jay reflected on the past, how he came to speak English. He reflected on the cost of him putting on the white mask. He wondered if he would have volition in taking it off. He also reflected on the minute differences between liberal and conservative politics.

Jay also used “shutting things off” as a means to protect himself from colonial violences in his program. This was an intentional act of numbing and ignoring, and there were days when he went in as his authentic Indigenous self and got hurt in doing so:

Oh yeah. It changes day to day. Some days I can, I can somehow go in there and kind of shut things off and uh, come out with not too many wounds, but the more... uh, (smacks) (pauses) cognizant I am of things going on around me... the more woke I am to those things, the more I pay attention to them, (smacks) and, operate out of my own being, indigenous, it'll hurt worse.

He elaborated on such pain by saying, “...And so, some days...I go in there, and I'm accidentally Indian. Just a little too much, and I think like a Native a little too much, and I might talk like a Native a little too much, and that's when things start hurting.” He described how being in his program continually reminded him that his People were colonized and what was lost by saying, “That's when the pain comes because that's when you realize, you know, you're not speaking your language in any way, you're not operating in your language, you're not... moving in your language, uh, in your way.”

Jay closed this theme by emotionally discussing his empathy for AIs who adapt to whiteness in order to gain access to education and survive. He also described, however, the risks in adapting to whiteness:

And so I just know that the people that it usually ends up helping, these programs, not that their heart isn't in the right place, but they've usually become whitened. And so the things that they want are the same things that, uh, white instructors have kind of encouraged their whole life. And they- and these students- and these people of color usually have received for it, scholarships, and maybe money, positionings in jobs and success. And they might still have the heart to, "But I still want to help



my people," and that's good; I'm not saying that's bad. That's a good thing to have your heart there. But I still think there- there needs to be a stripping away of everything you are after you get through (laughs) one of those systems, but there's no way it hasn't rubbed off on you. There's no way that you didn't become it a little bit in some way. And that becomes dangerous.

Jay also described the danger in Natives using white ways of knowing to help their communities. He described what he saw as the need for Natives to decolonize and retribalize themselves before entering back into their communities for the fear of lateral violence or perpetuation of colonization. Jay also pointed out how sneaky colonization can be, how it can be unconsciously internalized saying "there's no way it hasn't rubbed off on you."

### *Laying Low*

On the flip side of engaging in a white way, Jay attempted to not engage fully while in his program, to tamp down his affect. Jay described using discretion when to express himself authentically as "laying low." Jay described "com[ing] over to" whiteness to keep others in his program comfortable. He expressed consciously attempting to present himself in a less "threatening" way. He also spoke of the emotional labor involved in doing so:

So that's some of the experiences, just having to constantly come over to someone else's side. And not just language, but ways of speaking and interacting, you don't...You have to constantly be aware that you're around whiteness and you're the only brown kid in the entire class 99% of classes you take. And you don't want to seem scary or criminal or...so you're constantly aware of how you speak, how loud you're speaking so you're not taken as this angry, mean, criminal savage.

He discussed using silence in his classes as a means of just surviving them:

And, some days, I deal with them better than other days. Some days I go in there, and I...kind of pretend I'm uh, just like everyone else, or I'm just quiet and don't, I just kind of try to keep to myself and sometimes those are the best days because I can get away from that space without too many wounds after.

On the flip side, Jay also spoke to the double-bind that being silent put him in. By not speaking up in class, he ran the risk of not participating in his seminars, courses where assessments of competency can rely heavily on classroom discussions. Jay described these places where he was forced to talk for a grade as unsafe:

I think I'm usually the safest when I am allowed not to speak and just sit there and just be. But then, a lot of times professors take that as (chuckles) you're not engaging. You can get a bad grade for that sometimes.

### *Empty Glass*

Jay described the many ways in which navigating whiteness in his program took a toll on him emotionally. He also spoke to a one-way transactional relationship with his program whereby Jay sharing his identity only benefited others. In fact, sharing his identity led to an expectation of doing so, some type of unpaid labor. In explaining these experiences, he used the metaphor of "empty glass":

What ends up happening is I come into the group with my glass half full, and so does everybody else, and of course as always, race will be brought up somehow...And I usually find that the white folks in group are usually, without talking to me or looking at me, they start talking about how... they've had it hard growing up and how people of color have been racist to them and... they start kind of being defensive about, I guess feeling some kind of pressure from my body just being there, so it turns into me kind of defending that... And, it becomes that I give everything and all my water, and the white folks walk out with their glass full, and I'm empty... that's not a relationship. If you can't pour some of your water into my cup, that's not a relationship.

Jay described his requirement to speak for a grade, even when he was emotionally drained and staying silent in order to preserve himself:

Maybe some weeks I don't want to talk. You know what I mean? I won't speak at all 'cause I'm just so sick of it. It becomes hard because of course your White teacher sees you and thinks, (laughs) "Why aren't you engaging?" You know, you come into the classroom with the glass half full, and they always want you to empty it so

they have full glasses, but you always leave with that empty glass. Nothing changes for you; you step out back into oppression.

Jay went on to further describe the futility in attempting to interact with others in an authentic way. Language and/or positionality differences made Jay feel like others could not truly know or understand him. Unless others understood the settler-colonial system (i.e., the Beast) and their role in it, others could not adequately receive him. He could also not constantly remind others of the Beast:

You don't- you can't speak my language. You don't know me. I don't know me. (laughs). So, how can I give me to you? I think there's less of that going on when it's just natives around because we can again alleviate some of those colonial leeches. Some of those are gone in that circle. It still exists, but we're all in the same position. We're all in the same boat. We're all in the same place within that beast's stomach, and we can talk about it from that place. I don't have to... tell you where I'm at... (chuckles) for every hour. I don't have to explain my positioning and for instance, I think one group session somebody said (sighs) they were saying something about education and... how that's how that'll save us all, and all this stuff. And I had to again, go through the story about how my grandpa and grandma were, you know, dragged to Chilocco boarding school, and their hair was cut, and they were taught how to wave and how to clean. Not science, not math, not how to even survive really, but how to become white. And you know, I don't have to explain that to natives 'cause all our grandparents were in that boarding (scoffs) school.

Lastly, Jay demanded due compensation. By constantly being on the giving side of the one-way transactional relationship in his program, Jay wanted payment for his labor:

So, we can start at a place where I can grow, you know. So I think it can be good for white folks to have a person of color in there. Maybe that person of color...you put me in a group again with six, seven other white folks you better pay me. I better be getting paid to be the person in there that's doing all the work for the damn group and emptying my water, my glass so you can fill yours.

Regardless of Jay's pessimism, he also described how hope visited him. He described how he was unsure of being hopeful that positive changes would come from the Beast and his role in making those changes:

I don't know if it's a resistance...But maybe it's a healer that has this thing in my intellectual self I don't believe I have, called hope. And maybe I naturally have something in me that hopes that people will get better. And hopes that my people will quit being oppressed and hurt as much. And some kind of understanding will happen. Maybe there is some hope. I don't, uh, I don't, uh, really I'm not cognizant of, and it just happens. Maybe it's, I dunno, maybe that's whiteness...the disease that's reached me feeling that I need to do that, you know. Caring more than just about surviving for my individual self, but actually trying to give something to the communities I encounter, rather, whether they're against me or not. I don't know. I haven't fleshed that out enough, man. I have to think about that.

## DISCUSSION

Participating and learning about AI cultural capital empowered Jay. He drew on traditional AI teachings, teachings from his upbringing, critical race studies, and critical thought as means by which to navigate higher education and keep his identity intact. Jay called this process "confronting the threat." Traditional AI teachings were employed as Jay engaged in *trickster discourse* (Vizenor, 1989) in the classroom. By playing a contrarian role (like the Lakota *Heyoka*), Jay offered others learning opportunities to think critically about classroom conversations and content. His trickster discourse offered up space to question oft invisibilized white ways of being and knowing within educational settings. Humor was also employed, as Indigenous scholars mention use of humor as a means by which to prompt critical conversation, especially when it comes to challenging white ways of being and knowing (Deloria, 1988; Vizenor, 1989).

"Playing coyote" was a way for Jay to challenge settler thinking by shaking listeners out of the dominant white narrative. In this way, Jay's experiences provide insight into what can happen when the white and Indigenous worldviews come into contact with one another. Vizenor (1989) and Deloria (1988) have written at length about how AIs use their humor, wit, and resistance as a means of, not only survival, but their flourishing. Vizenor (1989) notes that the trickster often prompts "agonistic imagination" (p. 188), prompting those listening to focus on the

story in a new, unconventional way. Deloria (1988) describes the way in which AI people use teasing as a way to correct out-of-step behavior without causing someone public embarrassment. Humor prompts listeners to think differently without directly embarrassing them in a public space. It is vital to note that AI tribes vary in their conceptualizations of the trickster. It is inappropriate to attempt to homogenize the trickster to one typology.

### **Critical Thought and Theory**

Engaging in the classroom with a critical consciousness, Jay described how critical thought enabled him to “filter” out colonial ways of being and knowing. He also explicitly pointed to Critical Race Theory (CRT) as a tool that helped him to see how colonization manifests within himself, his counseling program, and higher education broadly. CRT came out of a response to Critical Legal Studies in the mid-1970s (Brayboy, 2005). Since then, many minoritized groups have utilized the theory to produce scholarship and praxis aimed at institutional change. Lumbee scholar Bryan Brayboy, and creator of TribalCrit, writes that “educational policies toward Indigenous peoples are intimately linked around the problematic goal of assimilation” (2005, p. 429) and that “culture, knowledge, and power take on new meaning when examined through an Indigenous lens” (p. 429).

By not swallowing white ideas whole, whiteness was not successful in swallowing Jay. He described how CRT prompted him to recognize how whiteness was internalized. Jay contrasted white ways of being and knowing taught in the classroom to those of his ancestors. Filtering out settler ontologies and epistemologies refracted assimilative schooling within his program, allowing Jay to engage in resistance and *survivance* (Vizenor, 1989). Jay linked knowledge of CRT to lifting him out of depression and empowering him as a tribal person.

Brayboy (2005)’s TribalCrit points to education as an assimilator. Jay was conscious of this and reflected on how such scholarship mirrored his own tribal teachings. He described how his family members explicitly told him not to trust common pedagogical practices and curriculum within American schooling. These practices perpetuate an imperial narrative with aims of AI erasure. A good example of this that Jay mentioned was teachings framing Christopher Columbus as a friendly explorer and deliberately omitting the genocide he inflicted upon Indigenous peoples. He also spoke to how settler scholarship explicitly framed AI peoples as “savages.” Jay described a healthy resentment that he felt towards settler schooling and a commitment to “question it all.”

Lastly, Jay alluded to the danger of AIs returning to their communities with white ways of knowing and being in tow. It is not a new idea that internalized oppression (i.e., whiteness) can lead to lateral violence. Within counselor education specifically, this may manifest as pathologization.

### **The Double Bind of Adaptation**

Regarding the sustainability of such aforementioned engagements in the classroom, it appears that Jay was regularly overwhelmed. Having an “empty glass” while attempting to complete his program likely acted as a barrier to Jay’s success and emotional and physical wellness. Berger and Saranyai (2015) wrote that experiences of racism in schooling are linked to very real negative physical outcomes. Experiences of oppression are bad for the body. Chronic overactivation of the HPA-axis has been linked to many adverse physical and psychological outcomes (Berger & Saranyai, 2015).

Jay attempted to protect himself from such stressors by employing a variety of techniques, but these techniques came with consequences of their own. Putting on a “white mask” aided in Jay avoiding being targeted by colonial violence and allowed him to blend in, but he felt like he was losing his tribal identity in the process. Actively ignoring the violence (micro- and macroaggressions) allowed him to experience less emotional distress, but he was not able to sustain such efforts consistently. Lastly, silence allowed him to replenish his emotional reserves while still attending his classes, but he was penalized for doing so. Jay consistently found himself in a double-bind.

### **Multicultural Counseling**

Multicultural educational practices have been criticized by AIs (Castagno, 2013; Haynes Writer, 2008). Indigenous perspectives are often excluded from conversations regarding multiculturalism and social justice. Haynes Writer (2008) shared a conversation regarding this phenomenon that occurred at a Native American and Indigenous Studies Conference in 2008:

The negativity towards multicultural education and multiculturalism at the conference was accompanied by comments regarding the inclusion of Indigenous Peoples in educational contexts or content—if inclusion is not being done by us or from our frame of reference, leave Indigenous Peoples out of the discourse and

curriculum content; otherwise, colonization and oppression are perpetuated. That is, the information regarding Indigenous people must come from what we have to say about ourselves, through our stories and perspectives. As a Native person, I concur with this sentiment (p. 2).

In multicultural counselor education courses, emphasis is often placed on understanding cultural differences and power dynamics pluralistically in order to assess cultural competency. While concepts such as white privilege and oppression are often addressed, colonial positionalities which honor Native Land and Waters, recognize settler colonial structures, and designate non-AI non-Black people as settlers are sparse. Explicit reference to post-colonial and AI epistemological concepts fall outside of the bounds of current competencies and call them into question (Ratts et al., 2015; American Counseling Association, 2014). Of particular import to Jay was the unethical practice of making humans central to the web of life. Furthermore, the uniqueness of the AI positionality and of liminality (Brayboy, 2005) was lost in pluralism. Jay questioned the intentionality behind such courses and the role that they play in alleviating white guilt.

Racial identity development models were problematic here as well (Shin, 2015). Some models within multicultural counseling education cite bicultural identities as the epitome of mental health without recognizing it as problematic (Fish & Syed, 2018). Fish and Syed (2018) ask “Does the college environment permit Native American students to maintain their cultural beliefs and traditions?” (p. 393). The authors also note the significance of Natives’ relationship with education as a means to oppress and erase. The writing of this paper comes on the heels of the discovery of a mass grave of 215 children being discovered at the Canadian residential school in Kamloops, BC (Canadian Broadcasting Corporation, 2021). How counselor education is specifically linked to modern efforts to assimilate Natives and commit cultural genocide is not a conversation happening outside of Indian Country.

### **Implications for Counselor Educators**

Jay’s experiences in counselor education illustrates how counselor education can embody assimilative practices seen in education broadly. Curriculums that invisibilize Indigenous Ways of Knowing and being and center Western, colonial ways of knowing and being require Native students to “come over to whiteness” and wear a “white mask” in order to succeed in their programs. As Jay mentioned, there may also be a danger in Native students bringing these colonial



ways back into their communities. As Jay alluded to in his mentioning of boarding schools, Natives have a history of being oppressed by education. Choctaw scholar Jodi Byrd writes that centering access to education in reaches towards social justice can neglect structural oppression alive and well within education itself (2011). For Jay, settler-colonialism and whiteness were structural oppressors that met him upon entering his program, after gaining “access” to education.

It is imperative for counselor educators to recognize that Jay’s stories reflect a healthy resistance to the attempted erasure of his identity as an AI person and the erasure of the First Peoples of Turtle Island broadly. Counselor educators need to also unlearn seeing their minoritized students through a “damage-centered narrative” (Tuck, 2009, p. 415) in which settler-colonial ways of being and knowing (i.e., settler schooling) are students’ emancipators.

### **Limitations and Areas for Future Research**

Researchers were limited in this research by multiple factors. Communicating in the English language versus Jay’s tribal language may have skewed the meaning that Jay attempted to convey. Further, critical phenomenology is a western framework. Utilization of an Indigenous research methodology may be a better fit in the future. Audio transcription misses other pertinent forms of data like body language and hand gestures. This study also leaves out many details regarding interactions taking place before and after the interviews themselves were conducted. Those data add nuance and meaning to the interviews. Future researchers may consider the experiences of counseling students enrolled in tribal colleges and historically Black or Hispanic institutions in order to understand how AI identity is impacted in educational settings that are not historically white. This may also demonstrate the importance of activism and praxis to AI identity and critical thought as described by Jay. The N=1 method may also be a limitation. Having a larger sample size may have supplemented Jay’s experiences or provided alternative perspectives. While generalizability is not the goal of constructivist, qualitative approaches (Creswell & Poth, 2018), including more participants that met the above-mentioned criteria for the study may have added depth and variation to our findings.

### **CONCLUSION**

We close by emphasizing how important it is to not to view AIs as victims (Vizenor, 1989). Survivance must be recognized including the way humor for AIs may be indispensable when being

confronted with the absurdity embodied by the university and counselor education. While the larger dynamics may not be changed, counseling professors, instructors, and supervisors can seek to listen, learn, and understand to reduce direct harm to AI students.

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# Effects of a Decolonizing Training on Mental Health Professionals' Indigenous Knowledge and Beliefs and Ethnocultural Empathy

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*Abstract: Indigenous communities suffer from the highest rates of mental health disparities of any ethnic group in the United States, as well as experience significant amounts of historical and contemporary trauma including violence, racism, and childhood abuse. Unfortunately, the mental health workforce is unprepared to effectively work with this population due to the influence of stereotypes, bias, and lack of training. A 90-minute training for mental health agency employees using decolonizing methods was delivered to improve knowledge of and empathy for Indigenous patient populations (N = 166). Results indicated that the training increased participants' Indigenous knowledge and beliefs across demographic variables and may increase aspects of empathy including awareness. This training was feasible for a wide variety of mental health employees and resulted in increased learning about Indigenous people, which is a critical starting point for mental health professionals working with this population. Suggestions are offered to train mental health providers to deliver culturally responsive care to Indigenous clients and families and for decolonizing mental health professions.*

## INTRODUCTION

Mental health disparities are persistent amongst Indigenous people. In fact, Indigenous communities experience mental health concerns and substance use at higher rates than any other group in the United States (Indian Health Service, 2018). Compared to other groups, Indigenous adults experience more serious psychological distress, feelings of sadness, feelings of nervousness, and suicidal ideation (Office of Minority Health, 2018).

Contributing factors to Indigenous mental health disparities include socioeconomic status, experiences of poverty, and experiences of stress and trauma (Kenney & Singh, 2016; West et al., 2012). Indigenous people are more likely than any other group to be a victim of violence, killed by a police officer (Males, 2014), trafficked (Deer, 2010), or raped (Amnesty International, 2006;

Tjaden & Thoennes, 2000). Despite these significant mental health risks, disparities, and needs, mental health professionals are largely unaware of Indigenous peoples' mental health needs and the current and historical landscape that has created these disparities (Wendt & Gone, 2012). In fact, Indigenous clients often experience treatment that is disrespectful of their cultural and health beliefs (Findling et al., 2019; Glasnapp et al., 2009; Walls et al., 2015). Therefore, additional training is needed for mental health professionals to improve the services and outcomes for Indigenous clients and their families.

## Training

The first three authors (Indigenous women) developed a 90-minute workshop for community mental health professionals to 1) increase participants' knowledge of Indigenous people and culture and 2) increase their empathy and empathetic responses to their Indigenous clients, with the intent of increasing the positive results of service delivery for this population (See Table 1). The workshop was grounded in multicultural counseling competencies (Lewis & Ho, 1975; Sue, 2001; Sue et al., 1992), cultural humility (Rincón, 2009; Tervalon & Murray-García, 1998), and a decolonizing framework (McDowell & Hernández, 2010). Decolonization is critical in work with Indigenous populations because it is implicitly patient-centered. One must un-learn biased beliefs about Indigenous populations that are grounded in settler-colonial values to reduce ethnocentrism. This is critical to examine at the personal level for the provider, but also to properly assess and treat the harmful effects of colonization on the health and well-being of Indigenous populations today. Not only does decolonization work to unseat colonial paradigms and practices, but it also privileges and sees Indigenous knowledge, ways of being, and beliefs as valuable and critical to bring to the mental health treatment of Indigenous patients. Therefore, this training covered 1) *knowledge* of this population to reduce stereotypes, 2) *awareness* of self to uncover unconscious bias, and 3) therapeutic *skills* to effectively work with this population. The training has been described in detail elsewhere so that clinicians, supervisors, and educators can replicate it (Lewis et al., 2018).

## Purpose

The purpose of this study was to test the effectiveness of the previously described training. The following two hypotheses were tested:

- 1) *The training will increase participants' knowledge of Indigenous people and culture.*
- 2) *The training will increase empathy and empathetic responses to Indigenous clients.*

**Table 1**  
**Training content**

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1.	Introduction
2.	Identifying ancestral homelands and current Indigenous residents
3.	Limitations of cultural competency
4.	Cultural humility
5.	Activity 1: Personal assumptions
6.	History of colonization
7.	Historical loss, trauma, and oppression
8.	Health disparities
9.	Activity 2: Personal response to data presented
10.	Decolonization
11.	Clinical techniques and activities
12.	Activity 3: Application of skills to case
13.	Becoming an ally

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## METHODS

### Participants and Recruitment

A total of 166 employees of a mental health agency in the upper Midwest US participated in this study. The mental health agency is one of the largest agencies in this area and has approximately 200 employees that were all invited to attend this training. This agency provides services to adults and children including crisis services, therapy services, case management, and outpatient services.

Most study participants identified as female, heterosexual, and White. Demographic characteristics of the sample can be found in Table 2. Participants ranged in age from 23 to 76 with a mean of 42.26 years ( $SD = 12.82$ ). Reported annual household income for the whole sample ranged from \$12,000 to \$425,000; however, a histogram revealed that the next highest income was \$170,000. Once the outlier of \$425,000 was removed, the mean income was \$53,071 ( $SD = \$28,398$ ). Participants held various positions in the agency, with about half reporting a clinical position (49.4%), 19.3% reporting an administrative/clerical position, and the rest distributed among human resources, information technology, maintenance, and “other” positions.

**Table 2**  
*Demographic characteristics of sample*

	<i>n</i>	%
<b>Gender</b>		
Male	28	16.9
Female	125	75.3
<b>Sexual Orientation</b>		
Heterosexual	150	90.4
Non-heterosexual	7	4.2
<b>Race/Ethnicity</b>		
White	133	80.1
Mixed	10	6
Other	3	1.8
Indigenous	2	1.2
Asian or Asian American	2	1.2
<b>Religious Involvement</b>		
Low	32	19.3
Moderately Low	25	15.1
Moderate	41	24.7
Moderately High	36	21.7
High	22	13.3
<b>Education (highest level)</b>		
High School	7	4.2
Some college	45	27.1
Bachelor's	51	30.7
Master's	48	28.9
<b>Income</b>		
\$10,000-\$19,999	1	.6
\$20,000-\$29,999	14	8.4
\$30,000-\$39,999	35	21.1
\$40,000-\$49,999	9	5.4
\$50,000-\$59,999	16	9.6
\$60,000-\$69,999	11	6.6
\$70,000-\$79,999	4	2.4
\$80,000-\$89,999	7	4.2
\$90,000-\$99,999	7	4.2
\$100,000 +	10	6.0

## Measures

### *Indigenous Knowledge and Beliefs Scale*

To measure the content learning of participants, the authors created the Indigenous Knowledge and Beliefs Scale. To our knowledge, no other measure existed to measure the knowledge of individuals regarding Indigenous people in the Upper Midwest region. Therefore, the first author adapted the format of a lesson plan assessment developed by anti-racism educators at the University of Calgary (Chagnon-Greyeyes et al., 2015) and tailored the content to focus on the Indigenous people local to the participating mental health agency. The scale consists of 15 true-or-false items such as, “*I know what the Boarding School Era is*” or “*Indigenous people experience economic and political discrimination in education, healthcare, and social services.*” Responses were given 0 for false answers and 1 for correct answers. Possible scores ranged from 0 to 15, with a higher score indicating higher knowledge of both local and broad Indigenous knowledge and more culturally appropriate beliefs.

### *Ethnocultural Empathy*

The Scale of Ethnocultural Empathy (SEE; Wang et al., 2003) is comprised of 31 items and four subscales: Empathetic Feeling and Expression, Empathetic Perspective Taking, Acceptance of Cultural Differences, and Empathetic Awareness. The purpose of this measure is to determine the extent to which an individual values other people’s welfare with an emphasis on awareness of individuals from traditionally oppressed and marginalized groups. Items were scored on a 6-point Likert scale ranging from *strongly disagree* to *strongly agree*. Sample items include: “I seek opportunities to speak with individuals of other racial or ethnic backgrounds about their experiences” and “I feel irritated when people of different racial or ethnic backgrounds speak their language around me.” This measure has demonstrated good test-retest reliability (two-week *r* estimates ranged from .64 to .86), as well as high internal consistency (Cronbach’s alphas ranging from .73 to .91).

## Procedure

The first author delivered the training to all employees of a community mental health agency. Before the training began, attendees were asked to complete an informed consent. After informed consent was completed, participants completed a paper-and-pencil pre-test, received the 90-minute training, and then completed the posttest. Surveys were pre-numbered and given to participants in packet form so results could be matched by participant. Surveys were collected

directly after the post-test was completed. No incentives were offered. This project was reviewed and approved through the University of Minnesota Institutional Review Board.

## Data Analysis

Means and standard deviations of all study variables for pre- and post-test were carried out using SPSS version 20. Paired samples *t*-tests of pre- and post-test scores for study variables were completed. One-way analysis of variance (ANOVA) tests were used to examine the impact of several demographic and baseline variables including gender, race/ethnicity, religion, education status, and income, and on Indigenous knowledge and beliefs and ethnocultural empathy. Post-test analyses were calculated using Tukey HSD to determine between-group differences.

## RESULTS

### Descriptive Analysis

The means and standard deviations of all study variables for the pre- and post-test results are presented in Table 3.

**Table 3**  
**Paired sample *t*-tests of pre-test and post-test scores**

	Pre-test	Post-test	Paired Samples <i>t</i> -test			Effect Size
	<i>m (sd)</i>		<i>t</i>	<i>N</i>	<i>p</i>	<i>Eta</i> <sup>2</sup>
<b>Indigenous Knowledge &amp; Beliefs</b>	6.46 (2.5)	8.7 (2.09)	10.73	140	.000***	.451
<b>Ethnocultural Empathy</b>	4.53 (.6)	4.57 (.6)	1.361	136	.176	.001
Feeling and Expression	4.62 (.69)	4.6 (.82)	-.572	135	.568	.002
Perspective Taking	3.82 (.77)	3.82 (.79)	.004	135	.997	.000
Acceptance of Differences	5.19 (.73)	5.25 (.74)	1.51	136	.133	.017
Awareness	4.57 (.98)	4.7 (.98)	2.37	132	.019*	.041

Note: \*\*\**p* < .001, \*\**p* < .010, \**p* < .05

### Indigenous Knowledge and Beliefs

A paired samples *t*-test was conducted to compare pre- and post-test scores on the Indigenous Knowledge and Beliefs Scale. There was a significant increase from pre-test (*M* =

6.46,  $SD = 2.5$ ) to post-test ( $M = 8.7$ ,  $SD = 2.09$ );  $t(140) = 10.73$ ,  $p = .000$  (two-tailed). The mean increase in scores was 2.23 with a 95% confidence interval ranging from 1.82 to 2.64. The eta squared statistic was .45, indicating a very large effect size. Given the significant association and strong effect, we decided to explore the relationship between participant demographics and Indigenous knowledge and beliefs scores.

Several ANOVAs were calculated to explore the effect of age, gender, ethnicity, education, income, job category, and religious involvement on Indigenous knowledge and beliefs pre and post scores (See Table 4). Gender ( $F(1, 150) = 7.88$ ,  $p = .006$ ), ethnicity ( $F(4, 146) = 5.04$ ,  $p = .001$ ), education ( $F(4, 152) = 4.87$ ,  $p = .001$ ), and job category ( $F(6, 142) = 5.58$ ,  $p = .000$ ) had groups that significantly differed on Indigenous knowledge and beliefs pre-test scores. However, there were no significant between-group differences at post-test. Post-hoc tests were completed using Tukey HSD analysis. Female participants ( $M = 8.52$ ,  $SD = 1.91$ ) had significantly different pre-test scores ( $p = .03$ ) than male participants ( $M = 5.23$ ,  $SD = 2.65$ ). For ethnicity, White ( $M = 6.09$ ,  $SD = 2.38$ ) and Indigenous ( $M = 12.5$ ,  $SD = .71$ ) participants had significantly different pre-test scores ( $p = .002$ ). Those with a master's degree ( $M = 7.42$ ,  $SD = 2.20$ ) had significantly different pre-test scores than those with a high school or GED education ( $M = 4.57$ ,  $SD = 3.10$ ;  $p = .03$ ) and those with some college ( $M = 5.59$ ,  $SD = 2.56$ ;  $p = .0003$ ). For job category, there was only one person in the Information Technology category which prohibited post-hoc analysis. To complete a post-hoc analysis, this participant was moved to the "Other" category. We then discovered that those who work in administrative/clerical positions ( $M = 4.66$ ,  $SD = 2.56$ ) significantly differed from those who worked in clinical positions outside of the office ( $M = 7.32$ ,  $SD = 2.38$ ;  $p = .000$ ), as well as clinical positions inside the office ( $M = 6.87$ ,  $SD = 1.80$ ;  $p = .006$ ).

### **Ethnocultural Empathy**

A paired samples  $t$ -test was conducted to compare pre- and post-test scores on the Ethnocultural Empathy Scale. There was no significant difference between pre- ( $M = 4.53$ ,  $SD = .6$ ) and post-test ( $M = 4.57$ ,  $SD = .6$ ) scores on the entire scale;  $t(136) = 1.361$ ,  $p = .176$ . However, a paired samples  $t$ -test of the four subscales revealed a significant increase on the Empathetic Awareness subscale from pre- ( $M = 4.57$ ,  $SD = .98$ ) to post-test ( $M = 4.70$ ,  $SD = .98$ );  $t(132) = 2.37$ ,  $p = .019$ , with a moderate effect size of .041. There were no significant differences on the other three subscales: Empathetic Feeling and Expression, Empathetic Perspective Taking, and Acceptance of Cultural Differences.



Next, several ANOVAs were calculated to explore the effect of age, gender, ethnicity, education, income, job category, and religious involvement on ethnocultural empathy pre and post scores (See Table 4). Job category had significant between-group differences on ethnocultural empathy ( $F(6, 143) = 2.62, p = .019$ ). Tukey HSD analysis revealed no significant differences between the groups. However, the difference between those that worked as office-based clinicians ( $M = 4.6, SD = .40$ ) versus those working in maintenance ( $M = 3.67, SD = .19$ ) came closest to reaching significance ( $p = .077$ ). Ethnicity groups were also significantly different at pre-test ( $F(4, 147) = 2.39, p = .043$ ). Although no group differences reached significance, the difference between Asian ( $M = 5.6, SD = .36$ ) and White ( $M = 4.46, SD = .60$ ) respondents came closest ( $p = .068$ ). Post-test results demonstrated that educational attainment alone had significantly different ethnocultural empathy scores between groups ( $F(4, 131) = 2.47, p = .047$ ). Significant paired differences occurred between graduate school/master's degree ( $M = 4.77, SD = .52$ ) and 1-3 years of college ( $M = 4.37, SD = .58, p = .025$ ).

**Table 4**  
ANOVA and post-hoc analyses of pre-test and post-test scores by demographic groups

	Pre-test				Post-test			
	<i>df</i>	<i>F</i>	$\eta^2$	<i>p</i>	<i>df</i>	<i>F</i>	$\eta^2$	<i>p</i>
<b>Indigenous Knowledge and Beliefs</b>								
Age	4, 150	0.43	.01	.786	4, 133	0.62	.02	.650
Gender	1, 150	7.88	.05	.006	1, 133	0.42	.00	.517
Ethnicity	4, 146	5.04	.14	.001	4, 129	0.64	.02	.635
Education	4, 152	4.87	.13	.001	4, 136	0.51	.01	.732
Income	5, 108	0.22	.01	.956	5, 98	0.84	.04	.524
Job Category	6, 142	5.58	.24	.000	6, 127	1.31	.06	.257
Religion	4, 151	0.55	.01	.703	4, 134	2.30	.07	.063
<b>Ethnocultural Empathy</b>								
Age	4, 151	0.42	.01	.792	4, 128	1.21	.04	.311
Gender	1, 151	0.33	.00	.566	1, 128	0.06	.00	.804
Ethnicity	4, 147	2.39	.07	.053	4, 124	1.13	.04	.345
Education	4, 153	1.86	.05	.120	4, 131	2.47	.08	.047
Income	5, 108	0.71	.03	.614	5, 97	0.30	.02	.912
Job Category	6, 143	2.62	.11	.019	6, 122	0.77	.04	.589
Religion	4, 152	1.61	.04	.174	4, 130	1.16	.04	.332

## DISCUSSION

Indigenous people confront historical and current policies of assimilation and racism daily that significantly and negatively impact their mental health and well-being. For instance, historical trauma is related to increased mental health challenges such as anxiety (Brave Heart, 2003), depression (Whitbeck et al., 2004; Whitbeck et al., 2009), substance abuse (Myhra, 2011; Walls & Whitbeck, 2012), and suicidality (Brave Heart, 2003). While this population suffers disproportionately from mental health concerns, mental health professionals are rarely trained to work with Indigenous clients. Therefore, a training for mental health professionals was created in hopes of having a positive impact on patient outcomes for Indigenous people. The training covered 1) *knowledge* of this population to reduce stereotypes, 2) *awareness* of self to uncover unconscious bias, and 3) therapeutic *skills* to effectively work with this population.

### Indigenous Knowledge and Beliefs

Participants rated themselves significantly higher on their knowledge of Indigenous people and their belief systems after the training. Interestingly, this training appeared to flatten any differences participants showed in their pre-test knowledge of Indigenous people. In other words, before the training, participants' Indigenous knowledge and beliefs score varied based on their educational attainment, gender, ethnicity, and job categories. After the training, differences in these demographic variables were no longer significant. This suggests that the training is effective in teaching diverse groups of participants who have had varying levels of exposure to Indigenous knowledge and beliefs before the training.

The pre-test scores of Indigenous knowledge and beliefs demonstrate how complicated people's competency can be based on a variety of demographic variables. Those in clerical, maintenance, and information technology positions scored the lowest on Indigenous knowledge and beliefs before the training. These positions are critical, yet routinely not considered as part of the therapeutic team and, therefore, may not receive the same training. But if an Indigenous client is not treated respectfully at the front desk, for example, they may not feel comfortable returning to the clinic. This study reinforces the importance of training for all mental health agency employees.

Also of interest were the differences in Indigenous knowledge and beliefs by educational attainment. As income and education increase, so does Indigenous knowledge and beliefs, but

there is an unexpected drop at the doctoral level and at the \$59,000 income level. It is hard to know what may be causing this effect, but it is possible that an increase in educational attainment exposes individuals to increased knowledge about Indigenous people only to a certain point. There could be a barrier or mediator that occurs at higher educational attainment and income. It is possible that privilege may be an important factor to consider in future research as a barrier to continued improvement in cultural learning and growth.

### **Ethnocultural Empathy**

There was no significant difference between pre- and post-test scores of overall ethnocultural empathy; however, there was a significant difference on one of the subscales, Empathetic Awareness. There are several possible reasons for this outcome. First, in the training, there was only one section on self-reflection with one exercise. It is possible that this section needs to be further developed and lengthened. Second, the construct of empathy is multifaceted, and data regarding how to increase empathy towards different groups is inconclusive (Teding van Berkhout & Malouff, 2016), making it more difficult to influence than knowledge and beliefs. If this is the case, training over time, in multiple contexts, and by several supervisors may be needed for increased empathy instead of didactic or classroom learning alone. Third, there is evidence that empathy is culturally learned and is reflective of the environment and culture in which you are situated, making any change very difficult if one is not in an empathetic living environment (Font et al., 2016). Further, empathy may be created in “real life” experiences and not in classroom settings. Seeing how the ‘other’ lives, struggles, and succeeds may be the most effective way of increasing empathy for those that are culturally different.

Empathy involves being able to hold another’s viewpoint and feel or demonstrate caring feelings for that person or situation. Empathy is a critical skill for a therapist, yet White therapists are less empathetic towards racial minorities than they are towards members of their own racial group (Tettegah, 2016). While little research exists on effective strategies to improve cultural empathy, researchers shared that “the role of empathy training [is]...a powerful common factor” (Levitt et al., 2022, p. 267). More research is needed on how to effectively teach this skill and perspective, but it is possible that exploring interventions that go beyond didactic, class-based learning about minority health and empathy, such as live supervision (DePue & Lambie, 2014), service learning experiences (Lee et al., 2016; Pieters, 2015), or adding humanities education

(Meyer & Kamaka, 2019) and experiences, may be the keys to improving ethnocultural empathy for therapists.

### **Limitations and Next Steps**

While the Indigenous Knowledge and Beliefs Scale is not a validated scale, it was created to address a particular geographic location and group of people, making it more valid for that region than a general Indigenous scale. Further, it does not test objective knowledge of the topic, but self-report beliefs about knowledge instead. Future studies may test this measure using open-ended response formats. Finally, it is unknown if didactic training alone results in better care of Indigenous patients in the clinic, long-term, and with or without culturally responsive supervision. It is important to see how didactic training impacts client outcomes in addition to comparing the effects of didactic training, experiential training (e.g., role-play, community engagement, supervised therapy), and combined trainings to determine the most effective training method for positive client outcomes.

Further, it is important to test this training in a variety of settings including across different health and academic professions. This training formed the foundation for a longer training that was created for medical students (Lewis & Prunuske, 2017) that also demonstrated comparable improvements in knowledge and beliefs of the learner. Specifically, there was a significant increase in Indigenous health knowledge, cultural intelligence, and ethnocultural empathy in medical students after the completion of the training (Lewis, 2020).

## **CONCLUSION**

Results demonstrate that this training and evaluation is feasible with mental health professionals, as well as mental health agency employees who do not provide clinical services. Further, we have received additional anecdotal evidence that this training is well received in both conference and classroom settings, with behavioral health professionals, as well as medical students. This training also increased participant Indigenous knowledge and beliefs, as well as ethnocultural empathetic awareness, which holds important implications for the training of mental health professionals, particularly in areas where there are large Indigenous populations.

Mental health professionals treating Indigenous people must receive culturally informed and decolonizing training, as well as effective and ongoing culturally responsive supervision on

these topics. The benefit of this training is that it is brief, replicable, adaptable to a geographic region, and appropriate for a wide range of professions. Future research on training to prepare professionals to work effectively with Indigenous clients should further explore the ability to improve awareness (e.g., ethnocultural empathy, cultural humility) and skills (e.g., use of language, integration of Indigenous ways of healing), as well as client experiences and outcomes measured over time.

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### CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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