Urban-Indigenous Therapeutic Landscapes:

A Case Study of an Urban American Indian Health Organization

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Abstract

We engage and extend the concept of therapeutic landscapes through a case study at an urban American Indian health organization in the Midwestern United States. This case affords insights at the unique confluence of indigeneity and urbanization, prompting us to coin the construct "urban-indigenous therapeutic landscapes" to characterize such sites. These landscapes warrant urgent attention in light of increasing urbanization and health disparities among indigenous peoples internationally. On the basis of thematic content analysis, three themes were identified from 17 open-ended interviews with American Indian community members. Specifically, respondents viewed the health organization as (a) a vital place to be among other American Indians and connected to Native culture, (b) a place where one feels at home and welcome, and (c) a place in which health services are delivered in an especially intimate and hospitable manner. Significant challenges and tensions were also communicated, in terms of unique intersections of health care and indigeneity. Results are interpreted in terms of urban Indian health organizations as urban-indigenous therapeutic landscapes.

Keywords: indigenous peoples; therapeutic landscapes; American Indians; urban Indian health organizations; health disparities

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Therapeutic landscapes are "those changing places, settings, situations, locales, and milieus that encompass the physical, psychological and social environments associated with treatment or healing" (Williams, 1999, p. 2). Since the introduction of the construct 20 years ago (Gesler, 1992), therapeutic landscapes have been conceptualized in terms of treatment and prevention of illness as well as health enhancement (Conradson, 2005; Williams, 2010b). According to Williams (2010b), the burgeoning therapeutic landscapes literature has been predominantly concerned with three domains: physical spaces associated with health (e.g., Gesler, 1996), formal sites of health care delivery (e.g., Andrews, 2004), and sites that are specific to marginalized groups and special populations (e.g., Wilson, 2003).

In this article, we engage and extend the therapeutic landscapes concept through a case study in which attention to the latter two of these three domains is undertaken for a distinctive kind of setting, namely, an urban American Indian health clinic. Such a study is innovative in at least three respects. First, as far as we are aware, it is the first article in which therapeutic landscapes for North American indigenous peoples are explicitly explored in the context of a formal health care delivery site. Second, this case has the benefit of enabling us to engage with several recent theoretical and empirical advances, including the entanglement of physical, cultural, spiritual, and relational aspects of healing places (Conradson, 2005; Wilson, 2003; Williams, 2010a), and the propensity of a place to be associated with healing for some individuals but not for others (Milligan & Bingley, 2007; Wilton & DeVerteuil, 2006). Finally, this case affords insights at the unique confluence of indigeneity and urbanization, prompting us

to coin the construct "urban-indigenous therapeutic landscapes" to characterize such sites associated with health and healing.

We begin by conceptualizing therapeutic landscapes as relevant to indigenous peoples in urban settings, and then introduce the unique role of urban-indigenous health organizations, both internationally and in the United States. Next, we describe our empirical methodology involving 17 qualitative interviews with community members associated with a single urban American Indian health organization. Subsequently, we present themes resulting from analysis of these interviews. Finally, we discuss these themes in terms of urban-indigenous therapeutic landscapes, especially in the formal health care sector.

Therapeutic Landscapes and Urban Indigenous Peoples

Growing interdisciplinary interest in therapeutic landscapes has been associated with a holistic paradigm of health as "a complex interaction of physical, mental, emotional, spiritual, environmental and societal factors" (Williams, 1999, p. 3). According to Conradson (2005), "the therapeutic landscape experience is best approached as a relational outcome, as something that emerges through a complex set of transactions between a person and their broader socio-environmental setting." Such experiences include a focus on well-being in a holistic sense (far beyond biomedical health and inclusive of psychosocial dimensions) and the wider context, or "broader web of socio-natural relations," in which individuals are embedded (p. 338). Among this broader context, interpersonal relationships, or "networks of interpersonal concern," have been shown to be especially important in the maintenance of therapeutic landscapes (Gesler, 1992, p. 738), as perhaps best exemplified in the context of "home." Being or feeling "at home" is characteristic of a strong sense of place infused with enduring and intimate interpersonal

relations; thus, home often serves as "one's ultimate place of safety" and "optimal, essential environment for healing" (Marshall, 2008, p. 263; cf. Williams, 2002).

An especially important contextual aspect of therapeutic landscapes is the role of ethnicity and culture. Therapeutic landscapes are embedded within the beliefs and value systems of different cultural groups," as well as within cultural, spiritual, and religious practices (Wilson, 2003, p. 85; cf. Williams, 2010a). Although the therapeutic landscapes literature has focused primarily on Western contexts, the unique intersection of culture, place, and health is especially salient with reference to indigenous peoples (see Basso, 1996). For example, in the context of Anishinabek First Nations communities in Ontario, Canada, Wilson (2003) described indigenous relationships with "the land" as infused with cultural beliefs (e.g., "that all things on earth are alive and contain spirits") and spiritual practices (e.g., "they communicate with the spirits of rocks and trees when dealing with problems"; p. 90). In this way, the land "represents more than just a physical or symbolic location of healing," but a "complex intersection of culture, identity, and health" (p. 91). Similar descriptions have appeared, in terms of cultural beliefs and healing practices that are intricately associated with the topography of tribal lands and sacred sites (e.g., Gone, 2008; Madge, 1998).

Although there is, of course, considerable diversity among indigenous peoples and associated therapeutic landscapes, one global trend is quite prominent: the rapid growth of urbanization. The year 2008 marked the first time that more than half of the world's population is living in urban areas (United Nations Human Settlements Programme, 2010). Moreover, in many large countries, the majority of indigenous peoples live in urban areas, including over 80% in New Zealand and Australia, and more than half in the United States, Canada, Brazil, Chile, and Bolivia (Trask, 2009). Migration to urban areas, which has increased dramatically in recent

decades, is due to a variety of reasons, including "displacement, eviction and separation from . . . lands, territories and resources" (Trask, 2009, p. 225), as well as "poverty, militarization, natural disasters, lack of employment opportunities, and the deterioration of traditional livelihoods" (United Nations Permanent Forum on Indigenous Issues, 2008).

Historically, urbanization has often been assumed to threaten Native identity, culture, and health (Wilson & Peters, 2005), and, indeed, urban industrialism has disrupted and dislocated indigenous communities (DeVerteuil & Wilson, 2008; Jackson, 2002). At the same time, indigenous peoples have long adapted to colonial impositions and decimations of their territories while retaining cultural identity and traditions, leading some to observe that a dichotomy between indigeneity and urbanization is historically and contemporaneously inaccurate (e.g., United Nations Human Settlements Programme, 2010; Wilson & Peters, 2005). Likewise, our term "urban-indigenous therapeutic landscapes" is intended to repudiate this false dichotomy.

Nonetheless, serious complexities surround the maintenance of indigeneity in contemporary urban settings. In addition to experiencing poverty, discrimination, health disparities, and violence shared by many other urban dwellers, urban-dwelling indigenous persons are often dispersed and relatively invisible, living away from important tribal resources and social networks (Trask, 2009). Urban American Indians, for example—unlike other major urban-dwelling ethnoracial groups in the United States—rarely reside in clustered neighborhoods and thus often lack visible community support (Lobo, 2001). Indigenous persons also often live prohibitive distances from local ecologies, sacred sites, and cultural kin associated with traditional notions of health and healing (Lobo, 2001).

For these reasons, the United Nations has recommended that governments cooperate with indigenous peoples to "establish indigenous peoples' centres in urban areas to address their

medical needs and provide legal and other forms of assistance, including helping urban indigenous peoples to deal with issues related to their cultural identity" (United Nations Permanent Forum on Indigenous Issues, 2008). Urban health organizations, among other organizations for indigenous peoples, operate in many nations. In New Zealand, for example, the Ministry of Health has contracted with "By Maori for Maori" care-provider organizations that are centered on holistic forms of health (spiritual, physical, mental, and family health) according to Maori principles, and that operate from the standpoint that "health cannot be separated from economic, cultural, education and employment factors" (Crengle, 2000, p. 50). Similar contractual arrangements have proliferated in Australia and Canada (Ellison-Loschmann & Pearce, 2006).

These organizations, as both health care facilities and sites for indigenous gathering, are obvious starting points for investigating the complexities of urban-indigenous therapeutic landscapes. Such research is urgently important in light of significant health disparities among indigenous peoples, as well as because of the difficulty of accessing desired healing modalities and/or culturally appropriate medical services (see DeVerteuil & Wilson, 2008; Lobo, 2001). However, although public health research has increasingly addressed the role of such organizations for indigenous peoples (e.g., Castor, 2006; Ellison-Loschmann & Pearce, 2006), these sites have rarely been explicitly explored in light of therapeutic landscapes. One exception, albeit not in the realm of formal health care services, is Williams and Guilmette's (2001) study of culturally-appropriate health programs for pregnant and aging women at an urban Aboriginal "Friendship Centre" in Ontario, Canada. Through these programs, otherwise isolated Aboriginal women found a healing place (in the broad sense of therapeutic landscapes) through access to culturally-specific programming, formation of intimate Aboriginal social networks, and

participation in a place that strengthened cultural identity. Our study extends inquiry of culturally-specific health programming in an ethnoracially-designated urban space, this time at a site of formal health care services.

Urban American Indians and Urban Indian Health Organizations

Urbanization of American Indians has rapidly grown in the past several decades, with at least 60 percent currently living in urban settings (Castor et al., 2006). During the early- and mid-20th century, forced migration resulted from boarding school and worker relocation programs, transplanting many American Indians into urban settings (Jackson, 2002; Lobo, 2001). As is the case globally, urban migration continues to rise, primarily due to poverty and unemployment in reservation settings. However, in spite of occupational and educational resources afforded by urban residency, health disparities are estimated to be roughly equal among reservation- and urban-dwelling American Indians (Castor et al., 2006; but see Wilson & Cardwell, 2012, indicating lower disparities for urban-dwelling, compared to reserve-dwelling, Aboriginals in Canada). Such disparities, although they may differ greatly among tribal and regional groups, include disproportionately high chronic health conditions relative to the average population, such as alcoholism (770% more deaths from), tuberculosis (750% greater), and diabetes (420% greater). American Indians are also much more likely to be injured in accidents (280% greater) and to commit suicide (170% greater), with especially high suicide rates for adolescents and young adults (380% greater for ages 15-24; 295% greater for ages 25-34; Gone, 2004; Gone & Trimble, 2012). Prevalence of mental health disorders is difficult to estimate, owing to limited epidemiological data, enormous diversity among tribal groups, and distinctive idioms of distress; however, American Indian populations have been shown to suffer at

disproportionately high rates of established psychiatric disorders, with posttraumatic stress disorder and substance dependence engendering special concern (Gone & Trimble, 2012).

With the passage of the 1976 Indian Health Care Improvement Act (Public Law 94-437), the U.S. government committed to a policy "of providing the highest possible health status" to American Indians, in connection with long-standing treaties with Native tribes (cf. Gone, 2004, p. 10). This policy acknowledged federal responsibility for funding health clinics that serve American Indians, primarily in reservation settings but also in urban areas. Today, 34 urban Indian health organizations (UIHOs) are funded by the federal Indian Health Service (IHS; Urban Indian Health Institute, 2011). Approximately 60 percent of American Indians receive health care from IHS-funded clinics, which serve as the "primary health care venue" designated for urban American Indians (Castor et al., 2006, p. 1484). These UIHOs aim to offer culturally-sensitive medical, behavioral health, and substance abuse services. In addition, they often serve as American Indian community centers, hosting cultural events, ceremonies, and traditional modes of healing (e.g., sweat lodges; Urban Indian Health Institute, 2011).

This combination of indigenous traditional practices (centered on distinctive cultural values, ceremonies, and social lives) and Western medical services appears to embody an urban-indigenous therapeutic landscape; it operates as a rare and visible urban space in which American Indian community members attempt to retain and promote traditional forms of Native social support, health, and healing. However, there are several reasons to worry that UIHOs may be limited or fragile forms of therapeutic landscapes. First, UIHOs are very limited in financial resources, collectively receiving only 1% of the IHS's already impoverished total budget (Castor et al., 2006). Thus, there may be significant limitations in providing adequate services and facilitating social support for a largely low-income community. Second, many self-identified

urban American Indians, although sharing in devastating health and economic consequences resulting from colonization, are not members of federally recognized tribes and thus may be ineligible for government-subsidized health services (Jackson, 2002; Weibel-Orlando, 1999). This, combined with community dispersal and diverse community perspectives about what it means to be "authentically" Native (Jackson, 2002), may prevent some American Indians from feeling welcome at UIHOs. Finally, as government-funded agencies, UIHOs are increasingly under pressure to provide professionalized, evidence-based interventions, yet these services may not be viewed by patients as culturally appropriate (Gone & Trimble, 2012). Thus, UIHOs may be at risk for being viewed as places that are not distinctively Native in orientation. These treatment concerns, combined with this population's massive health disparities, mark an urgent need for exploring UIHOs as urban-indigenous therapeutic landscapes.

Method

Setting

Research was conducted at a single UIHO ("Indian Health") in the Midwestern United States. Similar to other UIHOs, Indian Health provides basic medical services (e.g., family practice, pediatric services, diabetes services, HIV testing, and immunizations), behavioral health services, and substance abuse services. Individuals enrolled in federal or state recognized tribes are eligible for subsidized services, though no one is turned away. Indian Health also provides community programming (e.g., cultural events, youth substance abuse prevention, health and nutrition education, and community gardening) and traditional spiritual practices (e.g., sweat lodges, sacred fires, and occasional powwows and memorials). It is administered and staffed primarily by American Indians. Its service area population exceeds 45,000 self-identifying American Indians from among several counties, including those who endorse multiracial

identities, according to the 2000 U.S. Census (about 1.5 percent of the total population residing in the service area).

Participants

We interviewed 17 adults who self-identified as American Indian and resided in Indian Health's service area. Most (14) were recruited from 27 focus group participants in a separate community-based study at Indian Health (which explored the integration of traditional healing and mainstream services); these participants were originally recruited from staff outreach efforts (e.g., fliers, newsletters, and phone calls). The remaining three respondents were recruited through snowball sampling efforts (with no more than one referred from a single respondent), in an effort to increase the sample's heterogeneity. Prior to recruitment, approval was obtained from the researchers' Institutional Review Board and Indian Health's administration. Informed consent was obtained, and participants were given $35 as a token of appreciation. As a result of the community-based nature of recruitment, it is possible that community members with favorable views of Indian Health are overrepresented. However, considering that several (4) respondents had overall negative appraisals of Indian Health, this possible overrepresentation has not prevented a diversity of views from being included.

Respondents were diverse in terms of primary tribal background (5 Haudenosaunee, 3 Ojibwe, 3 Odawa, 3 Cherokee, 3 Other), gender (9 women, 8 men), age (6 in 50s, 4 in 30s, 4 in 60s, 2 in 40s, 1 in 20s), multiracial identity (7 American Indian only, 5 mixed White, 4 mixed Latino/a, 1 mixed Black), education (6 with Bachelor's degree or higher, 6 with some college, 4 with high school diploma or equivalent, 1 with some high school), and employment status (6 unemployed, 5 full-time, 3 part-time, 2 disabled, 1 retired). Although 12 respondents reported a significant connection with a reservation community, all had spent the vast majority of their lives

residing in urban areas. Like urban American Indians more generally, respondents varied greatly in the extent of their tribal relationships and knowledge, and also reported varying levels of involvement at Indian Health. Thirteen had attended social events, 12 had received formal health care services (11 received medical services and two received behavioral health services), and nine had attended traditional ceremonies and rituals (e.g., fire ceremonies, memorials, and sweat lodges).

Interviews

Interviews were semi-structured and open-ended, conducted by the first author, and audio-recorded; they lasted 1.5 to 2 hours and occurred at Indian Health. Brief demographic questions were followed by four sections of questions pertaining to being an American Indian residing in an urban area: (a) being at "home" (where respondents feel most at home and why) (b) narratives of healing (and where they occurred), (c) living in the city (in comparison to living at or visiting tribal areas), and (d) being at Indian Health. Entire interviews were helpful in enhancing the credibility of researcher interpretations (see Baxter & Eyles, 1997); however, because we are concerned for this article with involvement in and views of Indian Health in particular, the data set is largely confined to answers to questions from the fourth interview section devoted to "being at Indian Health." Questions for this section comprised the following: (1) How do you feel when you are here? (2) Do you feel at home? (3) What kinds of things do you do here? (4) How is it different to come *here*, as opposed to another clinic? (5) How do you feel about the physical facilities? How might they be improved? (6) How does this place help you feel connected to Native culture? Follow-up questions were asked regularly. Because respondents occasionally volunteered information concerning these questions at other times

during the interview, analyses sometimes extended into those portions; this study reflects careful review of entire transcripts, to ensure comprehensive coverage of all relevant instances.

Because the interviewer is not Native nor a community insider, cultural sensitivity and rapport were aided through prolonged engagement with Indian Health (see Baxter & Eyles, 1997), including consulting with Indian Health's advisory council, meeting most (14) respondents previously in the context of a separate study co-administered by the second author (who is Native), visiting the facilities about 10 times prior to collecting data, and volunteering at an event. In addition, on the recommendation of Indian Health's administration, the interviewer conducted three pilot interviews with Indian Health staff members. These interviews resulted in subsequent modifications in the interview protocol and thus are not included in the data reported here (but would not alter our overall analysis if included). We are unaware of any instances of respondents feeling uneasy about the interviews, and nearly all voluntarily reported afterward that they enjoyed and appreciated the experience. None of this means, of course, that the interviewer's identity or other personal characteristics did not play an important role in the process or content of the interviews, perhaps in negative ways that respondents were too polite to express or perhaps did not consciously recognize.

Data Analysis

The first author analyzed edited transcripts through conventional thematic content analysis—a constructive, iterative, and interpretive process of categorizing codes and shared themes qualitatively (Braun & Clarke, 2006; Hsieh & Shannon, 2005). Major steps of this analysis, consistent with the goals of credible and dependable results (see Baxter & Eyles, 1997), include (a) broad familiarity with the entire corpus of data, including reading and re-reading transcripts while noting initial impressions, (b) systematic generation of initial codes, including

creation of a code book with differential definitions and specific examples (available from the authors), (c) tentative identification of major themes and organization of codes into these themes, and (d) an iterative process of reviewing, restructuring, and refining codes and themes (see Braun & Clarke, 2006).

Although the time-intensive nature of this project prohibited the use of additional raters, several processes collectively served to ensure rigor of analysis. First, coding was content-based for straightforward opinions and impressions and was thus relatively transparent, thereby minimizing the need for interrater triangulation efforts. Second, intrarater consistency of coding was facilitated through the use of NVivo qualitative data analysis software (version 9), used to code textual material and interpret hierarchical relationships between identified themes. Third, we conscientiously adhered to a 15-point checklist for content analysis (see Braun & Clarke, 2006), including guidelines such as, "Themes have been checked against each other and back to the original data set," and, "All relevant extracts for . . . each theme have been collated" (p. 96). Finally, consistent with the community-based nature of this study, we distributed a presubmission manuscript to Indian Health's administration with the invitation to provide feedback, as a measure to improve credibility of results (see Baxter & Eyles, 1997).

Results

At the conclusion of data analysis, we were able to categorize each coded category into one of three general themes pertaining to views of Indian Health. Here we summarize the most prevalent and/or theoretically-relevant aspects of each theme, interspersed with exemplar interview excerpts (using pseudonyms). As we report throughout this section, themes are largely mediated by whether respondents reported an overall positive appraisal of Indian Health. Twelve participants portrayed Indian Health positively, four portrayed it negatively, and one had a mixed

appraisal. (Positive and negative appraisals were explicit and often strongly worded, and thus were obviously apparent.) In addition, each theme includes significant challenges and tensions for maintaining indigenous values and traditions in an urban health clinic.

A Native Place

First, respondents with overall positive appraisals of Indian Health generally described it as a valued, uniquely Native place. Specifically, Indian Health was viewed as a place to be with other Natives, as well as a place that facilitates a cultural connection to traditional American Indian life.

Seeing and socializing with other Natives. Ten of the 12 positive respondents emphasized that a crucial aspect of Indian Health is its being a place where one can regularly see and socialize with other American Indians. Seeing other Natives was not simply a perquisite, it was one of the only places where this was expected: "If I want to come and see Native Americans, this is where I come. Because other than that, I don't know where to go. . . . anywhere in [the state], but here—is the only place" (Sarah). Even if one had Native acquaintances in the metropolitan area, Indian Health functions were described as the easiest or most frequent way of seeing them. This ease of access to other Natives was seen as especially important to those who had difficulty visiting faraway tribal or family members. Thus, Indian Health clearly served as an important if not indispensable site of interpersonal connections associated with one's Native identity.

Connection to Native culture(s). All respondents with positive or mixed appraisals of Indian Health (13) reported its importance as a place to be connected to American Indian cultural practices and worldviews. Although the backgrounds, experiences, and acculturation levels of

these respondents greatly differed, Indian Health was almost unanimously seen as a place where Native identity and culture is shared and cultivated.

> Since . . . many of the people that are here are born off the reserves and reservations, . . . it's important to have a place where you can kindle the fire of your ancestral background. . . . Your reservation is like a fire. And you're just a little splinter of that fire. . . . So when a whole bunch of people bring their flames, it's a bonfire . . . that energizes people. . . . It keeps us on that red road. (Jane)

Thus, Indian Health is not only a place to see other Natives, but it is a gathering place in which a common cultural heritage can be shared and sustained. In fact, many (8) respondents were so excited about Indian Health's potential as a Native gathering place that when asked about possible program expansions (without considering whether these were realistic), their recommendations included providing neighboring housing for venerated elders, language classes, schooling for Native children, and a swimming pool.

Many (7) respondents described feeling connected to Native culture through regularly occurring cultural practices and ceremonies. The stable presence of an important ceremonial site (a sweat lodge), combined with regular spiritual activities and rituals (e.g., sacred fires, smudging, prayers, and growing tobacco), was commonly viewed as facilitating cultural connection and traditional spirituality. For some, Indian Health was the only place in which they had regularly engaged in such activities. Two respondents even characterized specific spaces—the cultural hall and a garden where tobacco is grown—as "sacred," due to their association with regularly occurring ceremonial and spiritual activities.

In addition, several (5) respondents highlighted the importance of Native-themed artistic representations, such as murals, posters, and artifacts, in facilitating cultural connection. Several

examples of such representations were given, most notably of a large mural painted on the cultural hall's walls.

> You walk in, and a Native person sees something like that [mural]. . . . There is the elder giving the teaching. There is that corn behind him. There's the food—growing our own food. And there is the lightning, the thunder beings . . . who give us strength and guidance. There is the lodge . . . Everyone is together in a circle, facing each other. . . . Because it is like, this was done then, and we are still holding onto this now. . . . We're still growing our own foods here in the garden. We're still having our talking circles. We're still meeting as a group, as a community, as a family. We're getting our teachings of medicines, and certain aspects of culture and ways of life. (Charles)

As expressed here, artistic representations at Indian Health weave together Native identity, ecology, cosmology, and community—powerful symbols that American Indian life not only *was*, but *is*—and in this very place.

Challenges: Identity politics and multitribal concerns. Although the majority of respondents described Indian Health's facilitation of Native identity and culture in positive terms, important concerns and criticisms were also expressed. First, although respondents agreed that Indian Health is an important place to see and socialize with other American Indians, identity politics appeared to moderate the extent to which one felt that it embodied this ideal. The most strident comments in this regard came from respondents expressing negative views overall. For example, Mary said,

> There are too many faces that are always different. . . . The faces are a lot White. And a lot of them . . . try to say they are Indian, but I'm like, "Okay, whatever." And that kind of bugs me, too, when they say they are Native, and they are not. . . . I have to prove

> myself to people, like when I go out there in the world and fill out applications [requiring documentation of tribal ancestry].

From this portrayal, legitimate or authentic Native identity is contested in terms of whether it can be legally or unambiguously demonstrated (e.g., through legal tribal status), not merely affirmed; appearance and familiarity also play a role. Positive respondents expressed or implied more expansive views about Native identity, including the legitimacy of self-identity in the absence of tribal credentials. Still, several (5) respondents expressed concern about inauthentic posturing among community members, especially in terms of unnecessary self-expression. These concerns point to the delicacy of Indian Health as a therapeutic landscape intertwined with Native identity and culture.

A second challenge is the difficulty with balancing local, tribal, and multitribal concerns. Although many (8) respondents commended the Indian Health community on its ability to maintain harmony in spite of its enormous tribal diversity, several (6) addressed the importance of balancing tribal concerns. A common refrain was the importance of respecting the customs of local tribes, signifying an interesting blend of indigeneity and urbanization. Peter, from a distant tribe, explained that he ideally would participate in sweat lodges according to his tribal customs, but he is at peace with adhering to the local customs as long as his heart is in the right place. In contrast, William, from a regional tribe, expressed dissatisfaction with his perception of local influence on Indian Health's affairs: "The community here [at Indian Health] should try to be contacting . . . the local elders . . . to, you know, bring teachings . . . here to the city. . . . You are in the [tribal name] area. When in Rome, do as the Romans [do]." These varying perspectives about managing intertribal concerns highlight the difficulty if not impossibility of pleasing

everyone, alongside the perhaps paradoxical result that some from local tribes may be more dissatisfied than some from distant tribes.

A Place Like Home

For the second theme, respondents generally reported that they feel as if Indian Health, unlike urban settings generally, is a "home away from home," as well as a place they feel welcome and comfortable.

Home away from home. To varying degrees, all respondents with positive or mixed appraisals (13) expressed that Indian Health is a place where they feel at home, even characterizing this setting as a home away from home. Jane described it as "a place where people can come out of the dust storm of the city and find a haven." Charles expressed, "I don't really connect with the city . . . and that is why I am always at [Indian Health]. . . . Because I feel a connection. . . . I feel like I am with family or at home." This theme of not being fully at home in the city, and thus needing a home-like place for refreshment or connection, was quite common. Moreover, several (4) reported feeling renewed or rejuvenated through social exchanges or cultural engagement in a way that feels like going home. This experience may even entail a spiritual or psychological connection between Indian Health and one's reservation or ancestral lands: "Everything is connected in life. . . . So being here [at Indian Health], even though I'm not physically up there [at my home reservation], I'm always connected to that place" (Charles).

Feeling welcome or comfortable. In connection with respondents' reports of feeling at home, descriptors of feeling welcome and comfortable were especially common. First, most (9) respondents reported feeling especially welcome at Indian Health.

> I always know that if they [Indian Health] are still here and I need something, I can come back. . . . I've always felt welcome. I've always been able to eat or, you know, anything I needed that they had available, I was able to come and . . . be a part of it. (Sarah)

As exemplified by this excerpt, Indian Health was commonly seen as a home-like place of stability and spiritual strength, even an extension of one's family, where one can continually return, feel welcomed, and receive a meal, even after long absences. Second, although several (5) expressed reservations with Indian Health's inner-city neighborhood, most (10) described home-like comfort in its facilities and grounds. "It is just like sitting in my house. . . . I could sit here all day. And I just feel comfortable here" (Eduardo). Several even expressed hope for Indian Health to become a place where community members could simply drop in and hang out, day or night, in order to get away from the turmoil of city life.

Challenges: Alienation and fragmentation. Although Indian Health was reported to be a vitally needed urban site of connection to Native identity and culture, respondents reported two specific threats to feeling at home there: individual alienation and community fragmentation.

First, all respondents with negative or mixed appraisals (5) expressed frustration with feeling alienated or out of place at Indian Health. For three, including two longtime community members, this alienation was described in the context of a rapidly changing community.

> I have mixed feelings most of the time. I know it is an important facility, and I really want to support them and everything else like that. But I feel like I'm a stranger here sometimes. . . . If I'm not engulfed in being here on a daily basis or being involved a lot, then I am a stranger. Because there are new faces and new people, you know. (Linda)

Two others reported feeling like outsiders because of being perceived as too detached from their Native roots. According to Adam,

> When I come in here, I feel like . . . I'm not good enough. That I'm not Indian enough. And they are right. I am not. I fell through the plan. I got lost. How many people are going to come in and say, "I am a lost Indian. Can you help me find my way back?"

This problem of feeling unwelcomed due to being a "lost Indian" is relevant to views expressed by several (5) respondents about the need for much greater outreach and additional cultural education programs, considering that many urban American Indians, through no fault of their own, are significantly detached from their Native heritage (see Jackson, 2002). In sum, these expressions of alienation indicate the crucial role of longstanding interpersonal relationships in forging an urban-indigenous therapeutic landscape, and the difficulty of maintaining such in a rapidly shifting and highly diverse population.

A second threat to American Indians feeling at home at Indian Health is fragmentation and divisiveness among the organizations serving the urban Native community. Six respondents discussed contention, competition, and animosity, expressed almost entirely in the context of conflicts between Indian Health and one or more other (non-medical) Native organizations in the same metropolitan area.

> In many ways we're still very fractured. And there is a lot of healing that needs to go on. . . . We have at times a very combative and unhealthy community. Where, "You took grant money from me." . . . And, "You shouldn't have had this activity. . . . And, "I don't want those kinds of people in the organization." (Amy)

This fragmentation and contention can result in factions between community members in terms of loyalty to a single urban organization and its associated relational networks. Such division of loyalty was especially evident in terms of respondents' unprompted appraisals of Indian Health's administration. Two respondents, who were especially critical of how the present administration

did not measure up to the previous one, constructed their urban Native social networks largely in terms of one of the other Native organizations. In contrast, a few (3) participants spoke very approvingly of the current administration.

Place of Relational Care

The third and final theme is inclusive of only the 12 respondents who reported having received formal health care services at Indian Health. Positive views of Indian Health were associated with it being considered a place of exceptional relationally-grounded care, above and beyond what one might expect from the contemporary clinic. Specifically, Indian Health was seen as a place of intimate, personal care and exceptional patient hospitality.

Intimate, personal care. Most respondents (7 of 12) described health services as personable, intimate, or particularly responsive or caring to individual needs. This level of care was most saliently communicated by way of contrast with other clinics:

> The clinic that I went to before, is just like, [monotone] "Hi, how are you? Write your name here." It is just impersonal. . . . Here . . . they will push for 25-30 minute visits. . . . To not only hear about your physical health but . . . your mental health . . . or spiritual health. . . . You feel like you're being taken care of more here, as a Native person. (Charles)

Whereas other clinics were characterized as impersonal, robotic, inhumane, rushed, and reductionist, Indian Health was consistently viewed as friendly, caring, respectful, patient, and holistic. This level of personal care was especially facilitated by providers and community members knowing each other well. Explained Peter, "I know a lot of the staff personally. I have known them a long time. And they know me. So . . . you feel . . . more free to speak your mind. . . . Some are even affectionate." Victoria expressed a similar sentiment: "[My counselor] has seen

me at different powwows and social events over the years. So she kind of knows me and my family. And that is nice." As exemplified by these excerpts, relationships with service providers transcended mere familiarity and comfort; providers were known "personally," affectionately, consistently, and outside the context of treatment.

Hospitality. A high level of intimate care appears to translate into a particularly hospitable culture at Indian Health, as discussed by a few (3 of 12) respondents. First, although one might imagine that a government-funded public clinic would be burdened by long wait times, respondents reported being delighted at the short wait times at Indian Health. "When . . . I hadn't been for years, . . . I was still . . . instantly able to be seen. I mean, that's like a godsend, actually" (Sarah). Another respondent (Eduardo) described how delighted he was to be transported for free by the staff to visit a referred specialist at a different location. Consistent with the theme of home-like comfort, these respondents portrayed an image of being among those who care for you as a family member or close friend would.

Tension: Person-centered care vs. the bureaucratic clinic. Although most respondents clearly viewed Indian Health as intimate and relational, especially in contrast with most other public clinics, many (6 of 12) expressed concern, at least implicitly, with a tension between providing person-centered care and the increasing demands of largely impersonal, bureaucratic matters (e.g., cost containment, credentialization, and professional ethics) that are characteristic of the modern clinic.

This tension is especially evident by way of comparison between two respondents' differing interpretations regarding organizational changes reportedly affected by the current administration. Mary was critical of what she perceived to be a growing "corporate" climate at the clinic.

> The previous staff and administration, they were very connected spiritually. I know they didn't do everything how [it is] supposed to be done in the book, like they are doing now. . . . I know there are things that they have to change, but from other Native people that I talk to, it did not change for the better. It feels more corporate. It feels more White. It does not feel Native. It does not feel spiritual at all anymore. . . . It just seems very uptight . . . . There's just something different in the air.

This criticism of a by-the-book and "uptight" approach to health care appears to be a reflection on the increasing burden of paperwork and legal accountability in clinics—a reflection, perhaps, of what is seen as a bureaucratic rather than a relational, spiritual, and culturally-appropriate approach to care.

In contrast, Linda extolled recent administrative changes, such as increased "professionalism."

> The changes that they made throughout the year have been great . . . They are projecting a more professional persona in the medical offices. . . . We are just not this group of Indians, you know, struggling through. There are professionals here. We are professional Native people helping other people.

Linda explained that she had avoided Indian Health for years because of concerns about patient confidentiality, but was "a little bit more comfortable" and had begun receiving services again at the time of the interview. Moreover, most respondents (8 of 12) had no problem characterizing their care as particularly intimate or hospitable in spite of this professionalism.

Discussion

In summary, respondents described Indian Health as (a) a vital place to be with other American Indians and feel connected with Native culture, (b) a home-like place where one feels

welcome and comfortable, and (c) a place where health care is especially relational and hospitable. But significant challenges and tensions were also communicated, in terms of (a) balancing competing narratives about Native identity, alongside tribal concerns, (b) servicing a rapidly changing, diverse community, with associated ills of alienation and fragmentation, and (c) providing professionalized health services amidst concerns about imitating or becoming a "whitewashed" corporate entity.

In light of these results, several important interpretations can be made regarding Indian Health as an urban-indigenous therapeutic landscape. First, consistent with scholarship on therapeutic landscapes, appraisals of Indian Health were associated with an entanglement of physical, cultural, spiritual, and relational factors pertaining to place (see Conradson, 2005). Notably, physical dimensions of the natural or built environment were typically reported as important only when these intersected with other factors. For example, Charles's description of a mural was significant insofar as it connected a physical space (the cultural hall) with shared cultural meanings surrounding traditional American Indian life. Other respondents' designations of "sacred" spaces likewise involved the association of physical spaces (the garden and the cultural hall) with spiritual and cultural practices (growing tobacco and ceremonies). Perhaps most important in this regard is the extent to which respondents, without being specifically asked by the interviewer, constructed Indian Health in terms of "networks of interpersonal concern" (Gesler, 1992, p. 738). Indian Health was viewed positively to the degree that respondents knew and felt welcome by others, had good feelings towards the administration, and were satisfied with the way community members carried on traditional ways. In contrast, it was viewed negatively to the degree that respondents felt like strangers and/or were suspicious of how the administration and other community members embodied traditional Native ideals. As bluntly

portrayed by one respondent (Mary), such negative appraisals of the place as a whole ("there's just something different in the air") can sweepingly include indictments on the grounds of culture ("it feels more White"), spirituality ("it does not feel spiritual at all anymore"), and relational processes ("it just seems very uptight"). These differing appraisals highlight how positive and negative appraisals relevant to therapeutic landscapes can be made of the same place and in light of the same intersecting factors.

Second, consistent with the framing of therapeutic landscapes in terms of well-being in a holistic sense (Conradson, 2005), substantive discussions of "health" were regularly cast in well-rounded fashion. Importantly, Indian Health was celebrated *primarily* for the broader roles it played in fostering networks of interpersonal relationships relevant to Native culture, feeling at home, and reception of valued care. This holistic sense of health enhanced satisfaction of health services, as most respondents reported having received excellent care. Importantly, the quality of this care was rarely discussed in terms of practitioner expertise or medical equipment, but rather almost entirely in terms of intimate care and hospitality. One model for framing this finding is the Native/Aboriginal concept of the medicine wheel, in which physical, mental, emotional, and spiritual aspects of health are holistically incorporated (see Wilson, 2003). Thus, community members may place a higher premium than the general U.S. population on not only receiving quality physical care, but on "being taken care of" as a whole person—and "as a Native person" (Charles). The difficulty, however, is that insofar as Indian Health continues to assume the formalities of the modern professional health clinic, one possible cost may be an increasing concern with processes that are not perceived as expressive of holistic care.

Third, in terms of the "broader web of socio-natural relations" embedded in therapeutic landscapes (Conradson, 2005, p. 338), Indian Health must be understood in light of the socio-

political context of Euro-American colonization. This context allows for a public health clinic, of all places, to be viewed as a crucial urban space that can be called "home." For some, Indian Health reminds them of life on their home reservation or among Native kin; they may even feel almost as if they were "back home." But Indian Health also served as a crucial home-like place for respondents with limited or even no connections to reservation life and Native kin. We suggest that, in light of colonization and its radical unsettling of indigenous peoples (DeVerteuil & Wilson, 2008), Indian Health functions as a powerful therapeutic landscape because of the extent to which many urban American Indians are alienated by modern urban life. Whereas respondents' Native identity has been misunderstood, derided, or invisible to others in the city, Indian Health is a place—perhaps the only place—where one, ideally, *belongs* and is understood, accepted, recognized, and rejuvenated as a Native person. Importantly, this sense of belonging involves interpersonal networks of intimacy, familiarity, and shared identity, which in an urban setting likely requires the community's embrace or at least tolerance of a pan- or multi-tribal identity and culture (Fixico, 2000; Lobo, 2001). In many ways, this pragmatic tolerance appears to have been successful. However, this configuration of relationships, as with all such constructions, can be used to exclude or alienate (Weibel-Orlando, 1999, pp. 4, 43). Just as many residences are safe and comfortable only to the extent that entry is restricted, it may be that UIHOs are therapeutic landscapes for some American Indians in ways that necessarily exclude or marginalize others—illustrating another way for a place to be therapeutic for some but not all individuals (Milligan & Bingley, 2007; Wilton & DeVerteuil, 2006).

Although our primary task has been to credibly elucidate a single institutional case, several concluding recommendations can perhaps be made about the maintenance of urban-indigenous therapeutic landscapes from an international context (although we do so hesitantly

and provisionally, in light of the great diversity of indigenous peoples and urban health care settings). First, this case provides at least three general criteria from which urban-indigenous therapeutic landscapes might be evaluated or compared: fostering indigenous identity and culture, engendering home-like safety and comfort, and embodying holistic and relational care. These criteria allow for broader place-based considerations of such spaces, on top of more specific concerns such as culturally-appropriate services (see DeVerteuil & Wilson, 2008). Second, for urban locales where many indigenous peoples live but indigenous-specific clinics are rare, this case may be helpful in conceptualizing how urban health settings might be more hospitable to indigenous clients. For example, urban clinics might partner with local indigenous communities in using clinics for social events and indigenous-specific health concerns. Such concerns are especially important in light of low treatment utilization rates among indigenous persons generally (Trask, 2009). Third, this case illustrates the complexities of urban-indigenous therapeutic landscapes in terms of the diversity of service populations. Depending on the diversity of the urban-indigenous population, it may be difficult to provide outreach to culturally alienated indigenous persons without also alienating some of those who care primarily about socializing with other culturally knowledgeable and historically connected indigenous persons (see Jackson, 2002). Finally, this case provides evidence of the false dichotomy between urbanicity and indigeneity, including the viability of urban-indigenous therapeutic landscapes. Indeed, what may be the most important and optimistic aspect of this case study is a testament to the creativity, resourcefulness, and tenacity of community members in cultivating an indigenous refuge amidst the storm of urban life.

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