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# Walking Two Worlds: Healing from Trauma in the American Indian Community

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Walking Two Worlds: Healing from Trauma in the American Indian  
Community

by  
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MSW Clinical Research Paper

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### Abstract

American Indian populations are known to be affected by high rates of trauma, including the impact and perpetuating effects of historical trauma. In an effort to better understand effective ways of healing from trauma, this study explores the methods utilized by American Indian people to facilitate healing, specifically from symptoms of post-traumatic stress. Qualitative interviews were used to collect the stories and experiences of eight practitioners working with American Indian clients as they relate to the use of traditional healing practices and use of Western mental health services. Findings revealed four themes that are consistent with prior research, and yet build understanding of healing practices among American Indian people. These themes are the widespread rates of trauma, the importance of community, the spiritual realm as the context for healing, and a lack of appropriate mental health services in the American Indian community. These themes also point to the unique position of American Indian people as bridging two worlds and two routes to healing: traditional tribal beliefs and mainstream health services. Implications from this study for social work practice, policy, and research are also discussed.

*Key words:* American Indian/Alaska Native, trauma, traditional healing practices

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**Walking Two Worlds: Healing from Trauma in the American Indian Community**

Culturally relevant practice is a common theme among mental health practitioners today, especially the inclusion of client cultural practice and spirituality in the treatment process. Along with the rise of alternative medicine in mental health, there are several implications for providers working in the American Indian community. American Indian and Alaska Native (AI/AN) peoples have strong spiritual traditions that are directly rooted in culture and lifestyle, and should not be ignored in the context of mental health services. In this study, the author will seek to answer the question “How are traditional healing practices being used in the treatment of post-traumatic stress disorder (PTSD) among Native Americans?” The researcher will look specifically at PTSD as an issue affecting large numbers of Native American people because of disparities in combat exposure, family violence, and community trauma. A study of the prevalence of trauma among two American Indian populations found that lifetime trauma exposure is between 62.4% and 69.8%, a rate about 15-20% higher than that of the general U.S. population (Manson et al., 2005).

There are 565 federally recognized Indian tribes and communities in the U.S., and 2.6 million people who self-identify as Native American, although total numbers in tribal enrollment records are less due to blood-quantum requirements in some tribes. These various tribes and communities are diverse and varied in their individual beliefs and practices. The Native tribes of the Americas all come from different places, having settled in diverse geographic regions which shape their lifestyle (i.e. farmer versus hunter-gatherer), and have a unique collective experience with colonization (1862 Dakota Conflict versus the Long Walk of the Navajo). However, in the last two hundred years of

American history, federal policies and programs have been established that unite the hundreds of unique tribes under a new shared identity: American Indian. This has not been completely negative or positive, in that a united identity has been a means of more inter-tribal relationships and events such as the inter-tribal pow wow, but it has also created a means for greater misunderstanding among the majority culture of exactly what the Native American experience is, leading to stereotypes and cultural rifts. For the purposes of this study, participants will not be limited to a specific tribal affiliation nor any one specific healing practice. Traditional healers will refer to the spiritual leaders in various Native American tribes and communities who are consulted for assistance in practices such as blessing, naming, healing, and advising individuals who seek their assistance. The terms American Indian/Alaska Native, Native American, and indigenous or Native peoples will be used interchangeably throughout this paper to refer to all descendants of the original inhabitants of the Americas before European colonization.

The question of including cultural and spiritual interventions in mental health treatment is an important one for the field of social work today. Many mental health providers are finding that their clients already include some form of complementary medicine in attempting to treat their symptoms, whether they openly include these practices in their treatment plan or not (Trivieri, 2001). There is also an emphasis on culturally relevant practice, which honors the client's cultural identity and attempts to view treatment from this perspective. In some cases, this may include advocating the client's use of their tribal healing practices. Both of these trends call for a greater understanding of how Native American traditional interventions are being used by clients.

## **Literature Review**

### **Overview**

This review will cover the existing literature on the prevalence and causes of post-traumatic stress disorder (PTSD), as well as both evidence-based and alternative treatments currently being used. Special attention will be given to the incorporation of spirituality in mental health treatment, as this growing trend is especially relevant for culturally-appropriate services for American Indian and Alaska Native (AI/AN) clients. To bridge the connection between treating PTSD in the general population and among AI/AN people, the state of current mental health services for this minority group will also be explored. Finally, in consideration of all these points, the case will be made that an exploratory study on the use of traditional healing practices for AI/AN individuals with PTSD symptoms is necessary and relevant to the field of social work.

### **Post-traumatic Stress Disorder**

Post-traumatic stress disorder (PTSD) is an anxiety disorder that may develop in individuals who have been exposed to a traumatic event or environment. Characteristic symptoms as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) include re-experiencing the event through distressing thoughts, dreams, flashbacks or the like, avoiding stimuli, people, places, or other things associated with the trauma, and increased arousal response, with these kinds of symptoms lasting for at least one month. Depending on an individual's predisposition, the severity of the traumatic event, and protective factors, the effects of the trauma will vary. Some of the predisposing factors for reacting to trauma adversely are having had previous traumatic experiences, being faced with ongoing



stress, or lacking a strong social support system (National Institute of Mental Health [NIMH], 2011).

According to the National Institute of Mental Health, 3.5% of the adult population in the United States meets criteria for PTSD. Of this, 36.6% are classified as “severe”. However, it is important to note for the purposes of this study that Native Americans experience symptoms of traumatic stress at a much higher rate than the general population, up to a 21% lifetime prevalence (Brave Heart, Elkins, Tafoya, Bird, & Salvador, 2012; Tsosie et al., 2011). Given that thousands of people in both the Native American population and the general adult population experience potentially traumatic events every day, it is clear that many of these individuals do not develop symptoms of PTSD as diagnosed in the DSM-IV-TR. However, it is hard to say whether any one person will or will not experience post-traumatic stress because there are so many variables which affect outcomes.

One way of understanding PTSD is by its neurophysiological effects. According to Makinson and Young (2012), normal and healthy brain functioning is really a delicate balance between cognitive and emotional processes. Disorders like PTSD can occur when this balance is disrupted by some external stimulus. For example the amygdala, which is a crucial part of the limbic system, can become dysregulated by exposure to psychological trauma. This means that anxiety will be created by the body’s natural alert system when no real threat actually exists (Makinson & Young, 2012). When this response is combined with potential effects on the pre-frontal cortex, an individual may have difficulty processing the new way their brain is functioning.

To make things even more complicated, PTSD is often comorbid, meaning there are other mental health conditions alongside the PTSD diagnosis (McLean & Foa, 2011). Wisco, Marx & Keane (2012) point out that if the traumatic event was a physical attack on the individual, there may also be traumatic brain injury (TBI) involved. Or, due to the overwhelming nature of PTSD symptoms, an individual may develop substance abuse or depression. Among adults with chronic PTSD, 80% also meet criteria for chronic depression, substance abuse, or another anxiety disorder (Foa, Keane, Friedman & Cohen, 2009). Sometimes these comorbid conditions take priority in treatment, and should always be included in a comprehensive assessment and treatment plan. An integrated approach to treatment is suggested for PTSD and addiction, so that substance abuse specifically does not need to take treatment priority over PTSD (Ford & Russo, 2006; Weis, 2010). One important point about substance abuse in the Native American community is that it is often a compounding factor of trauma by leading to more violence and death within the family.

### **Causes of Post-Traumatic Stress**

There are various causes of PTSD, just as there are various definitions of what constitutes a “trauma”. Briere and Scott (2006) account for 12 different kinds of trauma including natural disasters, mass interpersonal violence, small and large scale transportation accidents, fires, rape and sexual assault, stranger physical assault, partner battery, torture, war, child abuse, and emergency worker (secondary) trauma from witnessing various traumatic events. This review will cover specific causes and compounding factors that are prevalent for the Native American community: historical and intergenerational trauma, poverty and violence, and military service.

**Historical trauma and intergenerational trauma.** Historical trauma is defined as “cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma” (Brave Heart, et al., 2011). In this case, “massive group trauma” refers to the centuries of war, violence, disease, and racism of which Native American tribes have been targets since the colonization of the Americas. Since its inception in 1995, the concept of historical trauma has been instrumental in understanding the mental health disparities that exist for American Indians and Alaska Natives, as well as indigenous peoples all over the world.

While historical trauma is not an evidenced precursor to PTSD, it creates a higher-risk environment by weakening the structure and resiliency of an entire people group. The result of historical trauma is the breakdown of cultural values due to forced separation and assimilation of American Indian families through genocide and the boarding school movement of European colonizers. Because of widespread emotional, physical, and sexual abuse in such boarding schools, it is reasonable to conclude that this movement in particular was responsible for a breakdown of family systems and cultural roles (Brave Heart et al., 2011). Furthermore, this trauma can be passed from parent to child in an intergenerational cycle of negative mental health outcomes (BigFoot & Schmidt, 2010; Vernon, 2012). The social, economic, and spiritual effects of trauma are rarely healed without having effected younger generations through channels such as social learning and co-regulation from a traumatized parent. This creates a cycle that, alongside social injustices, has made trauma an established norm in AI/AN communities (Willmon-Haque & BigFoot, 2008).

**Poverty and violence.** According to BigFoot and Schmidt (2010), 26% of the American Indian and Alaska Native population is living in poverty – twice the rate of the general population (13%) and almost triple the rate of White Americans only (10%). The U.S. Census and the National Survey of America’s Families both showed higher poverty rates among AI/AN families than any other ethnic group (Willmon-Haque & BigFoot, 2008).

Poverty alone is not a direct cause of trauma; rather it is a compounding factor, because it correlates with higher rates of violence in American Indian families, both of which can be directly traumatizing, especially for children (BigFoot & Schmidt, 2010; Willmon-Haque & BigFoot, 2008). In a study by Duran et al. (2009), women who had experienced either mild or severe domestic violence (79.5% of their sample) had more than five times the probability of developing PTSD than those who had not. In Minnesota, 37% of American Indian respondents to a state survey reported that they had experienced domestic violence in their lifetime. This was the highest percentage of all ethnic groups by fifteen percentage points (Buskovick & Peterson, 2009), and is still most likely underreported. According to Willmon-Haque and BigFoot (2008), domestic violence experienced by mothers affects not only the individual, but also impacts children in her care as young as one year old and leads to greater traumatic stress responses in older youth. In a study of hospitalized survivors of traumatic injury, American Indian patients (13% of the sample) had higher levels of both past traumas and risk factors for PTSD (Stephens et al., 2011).

**Military service.** American Indian men and women are widely known to serve in the military in higher rates than any other ethnic population, and have served in various

aspects of all branches of the armed forces since before the founding of the U.S. until today (Holiday, Bell, Klein & Wells, 2006). In the largest study of AI/AN Vietnam veterans, the American Indian Vietnam Veterans Project (AIVVP), not only were American Indians more likely to be exposed to war zone stress, but also to qualify for a diagnosis of PTSD (Beals et al., 2002). This survey also concluded that there are large disparities in the treatment of PTSD for American Indian Vietnam veterans.

The disparity among AI/AN veterans in developing PTSD can also be attributed to predisposing factors that result from historical trauma. Symptoms of the higher rates of violence, poverty, and family disorganization can include emotional dysregulation, aggressive behavior, and resistance to authority, all symptoms likely to be diagnosed as conduct disorder. A study by Dillard, Jacobsen, Ramsey, and Manson (2007) found an association between childhood conduct disorder and higher mean PTSD symptoms in American Indian Vietnam veterans. According to Gone & Trimble (2012), “a history of conduct disorder might indicate a compromised ability to cope with traumatic stress as a result of cognitive deficits and limited emotional regulation” (p. 140). Therefore, conduct disorder resulting from various stressors early in life may be a compounding factor for later diagnosis of PTSD post-military service. Further research is needed to determine whether this is the case for more recent AI/AN veterans, such as those returning from Iraq and Afghanistan.

### **Treatment of Post-Traumatic Stress Disorder**

**Evidence-based treatments.** There are various evidence-based treatments available for PTSD, both pharmacological and psychological. The two psychological interventions that are evidence-based include cognitive behavioral therapy (various types)

and eye-movement desensitization and reprocessing (EMDR) (Foa, Keane, Friedman & Cohen, 2009; Makinson & Young, 2012; Wisco, Marx, & Keane, 2012). Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) are also consistently gaining support, but all of these interventions are under-researched among certain veteran populations such as those returning from Iraq and Afghanistan (Wisco, Marx & Keane, 2012). It is also important to note that while PTSD is largely recognized as a universal condition, most of the research and writing around it comes from Western, industrialized countries, and these interventions need to be further researched in non-Western cultures, as well as adapted to be culturally relevant in other parts of the world (Foa, Keane, Friedman, & Cohen, 2009). AI/AN individuals in particular are extremely under-represented in efficacy studies for treatment of major disorders (Gone & Trimble, 2012). Research that does focus on the AI/AN population has mostly included single-episode and individual trauma, which fails to account for effects of repeated or complex trauma, and the family and historical contexts.

*Trauma-focused cognitive behavioral therapy.* Trauma-focused cognitive behavioral therapy (TF-CBT) is one type of CBT that is especially effective in treating PTSD. It was originally developed to treat child sexual abuse, but has been expanded to various other types of trauma as well (National Child Traumatic Stress Network, 2004). According to Makinson & Young (2012), this technique “uses the cognitive behavioral interventions of cognitive restructuring and exposure to help a client identify and shift cognitions and behaviors that maintain his or her PTSD symptoms” (p. 134).

TF-CBT was adapted by the Indian Country Child Trauma Center at the University of Oklahoma Health Sciences Center on Child Abuse and Neglect as an

intervention called “Honoring Children, Mending the Circle” (BigFoot and Schmidt, 2010). The researchers found that the underlying principles of CBT were consistent with many Native American tribal beliefs in the way they address the interplay between thoughts, feelings, and behaviors. Included in the treatment process of Honoring Children, Mending the Circle is the option to incorporate tribe-specific rituals, ceremonies, and language. This aspect is especially important to the purposes of this study in that the inclusion of such practices may be beneficial in the healing process for Native Americans affected by trauma.

***Mindfulness-based cognitive therapy.*** Another type of cognitive behavioral therapy is Mindfulness-Based Cognitive Therapy (MBCT). This approach practices intentionally focusing the attention on the present moment, without judgment. While not researched extensively for PTSD specifically, mindfulness-based practices have been proven to have positive effects for a variety of afflictions over the past 30 years (Makinson & Young, 2012; Sipe & Eisendrath, 2012).

***Eye-movement desensitization and reprocessing.*** Eye-movement desensitization and reprocessing (EMDR) is a therapy model developed in 1990 that is used to process traumatic memories which might be causing PTSD symptoms (Makinson & Young, 2012). Using dual-attention stimuli, the intensity of the unprocessed memories is lessened so that the client can access new adaptive information and create new neurological responses (Shapiro & Maxfield, 2002). This is done through eight phases of treatment, which move according to each client’s individual readiness.

***Prolonged exposure therapy.*** Prolonged Exposure (PE) therapy is based on the idea that fear and avoidance are learned through both classical and instrumental

conditioning and can therefore be changed through cognitive behavioral techniques. The goal is to habituate anxiety responses to trauma cues using CBT techniques. Over a series of nine to twelve 90-minute sessions, the response to cues associated with the trauma is re-learned and controlled by the client (Makinson & Young, 2012; McLean & Foa, 2011).

All these treatment methods are dependent upon the practitioner's ability to know when and how much to stimulate their clients, because over engagement or under engagement can affect the client's progress and even render the treatment ineffective (Makinson & Young, 2012).

**Holistic and alternative treatments.** Weis (2010) states that in addition to cognitive and behavioral elements, interventions for PTSD should also focus on experiential, emotional, relational, and spiritual elements of a client's life. This perspective can be referred to as holistic treatment, and is becoming more popular for disorders like PTSD. More and more Americans are also using complementary and alternative medicine (CAM) to treat disorders related to anxiety, meaning that they are using non-conventional methods either in lieu of or along with conventional medicine (Kessler et al., 2001; Libby, Pilver, & Desai, 2012; van der Watt, Laugharne & Janca, 2008).

Herbal supplements produced from plants such as kava and St. John's wort have been shown to be marginally effective for reducing anxiety, as has aromatherapy. However, the most promising alternative medicinal treatment for PTSD is acupuncture – a traditional Chinese method using needles and topical pressure points to restore a balance of energy in the body (van der Watt, Laugharne, & Janca, 2008).



Libby, Pilver, and Desai (2012) conducted a secondary analysis of data from three national health surveys regarding 599 individuals who had qualified for a PTSD diagnosis in the past year (using DSM-IV-TR criteria) and who also provided valid data for service use. This analysis showed that 39.8% of respondents had used CAM in the treatment of their PTSD symptoms. There were five types of interventions considered: mind-body, biologically-based, manipulative-body-based, alternative medicine, and other practices. Of these five types, mind-body treatments were the most widely used, including techniques such as relaxation and meditation, exercise therapy, and spiritual healing. Popular techniques from other categories were herbal therapy, massage therapy, and high-dose megavitamins. This analysis reveals the widespread use of CAM among individuals with PTSD, but is limited in that the data used are over ten years old, and social trends around alternative medicine methods are rapidly growing.

Kessler et al. (2001) found similarly high use rates of CAM among adults with self-defined “anxiety attacks” and “severe depression”. In their sample, more than half of those with these self-defined disorders used CAM as treatment, and in the majority of those instances CAM was self-administered. Given these growing trends around the use of complementary, alternative and holistic treatments, more research is needed to determine the efficacy of these interventions as compared to evidence-based therapies.

### **Spirituality**

Religion is any established tradition that comes out of a group with common beliefs and practices concerning the sacred (Koenig, 2009). Spirituality, on the other hand, is more difficult to define. In the world of mental health, there is no unique, distinct, agreed-upon definition (Koenig, 2009). Spirituality is often defined by whoever

is using the term. It can include anything related to belief in the purpose of life, faith in a Higher Power, or understanding of an unseen world. The author of this study uses the term in reference to that aspect of each individual which deals with meaning, purpose, morality, connectedness to self and others, and anything viewed as sacred.

Mental health professionals need to remain aware that the practice of psychotherapy was established out of a certain society and worldview, and is therefore limited in its understanding of many cultural aspects (Gone, 2004). It is important for clinicians today to validate and strive to understand not only their clients' cultural background, but also their spiritual background (Baetz & Toews, 2000; Charak, Sharma & Sharma, 2009). A therapist should be aware of their own biases when working with a client, because they may be likely to either underestimate or overestimate the potential role of their client's spirituality (Carr, 2000; Koenig, 2009; Verghese, 2008). In some cases, the therapist may be inclined to manipulate their client's beliefs, whether consciously or not (Dein, 2010). As professionals begin to give more credibility to client's spiritual experiences, they should remain neutral and aware that these experiences can be either positive or negative depending on what the client's needs are. Therefore, each individual case should be viewed uniquely, within the context of diverse cultural backgrounds and mental states (Charak, Sharma, & Sharma, 2009; Gilbert, 2007).

One area in which incorporation of spirituality is especially important is the treatment of PTSD among veterans. Most societies have some kind of supportive response to an individual dealing with acute trauma, be it a healing ceremony or financial and resource assistance (van der Kolk, 1996). However, outside of American Indian societies, religious institutions do not have ways of "sending young people to war,

reintegrating them back into society, honoring their contributions to our freedom, or making use of their experiences” (Gross, 2007, p. 401). It will be especially important as more and more veterans return from the 21<sup>st</sup> century wars in Iraq and Afghanistan to implement supportive reintegration systems that consider each individual’s spiritual traditions.

One example which is relevant to the purposes of this study is using the sweat lodge for warriors experiencing post-traumatic stress. The sweat lodge is one example of an individual spiritual practice that is carried out through community, in the presence of peers, and with the good of the wider community in mind. It is commonly used by indigenous people as a regular practice to maintain spiritual balance (Garrett et al., 2011). It also represents a common inter-tribal ceremony that is regularly used for spiritual cleansing. Gross (2007) gives a helpful description of its significance for re-integration of combat veterans:

The sweat lodge, like many American Indian ceremonies for warriors, builds up inner strength, reaffirms identity, and creates connections to a meaningful community. . . . While establishing individual and cultural continuity, the sweat lodge also transforms the warrior’s identity and promotes self-disclosure while bonded to others. The sweat lodge refigures the identity of the warrior by taking the attributes necessary for war – persistence, perseverance, patience, stamina, and aggression – and creating new “modalities” suitable for coping. That is, the characteristics necessary for survival on the battlefield are redirected toward creating a positive contribution to society. The sweat lodge ceremony is constructed to recognize war deeds but then forgive them and reassure the

individual, and so empower war veterans to use their experience to promote the common good (p. 380).

### **Mental Health Treatment Among Native Americans**

The Provider's Guide to Quality and Culture reiterates that many AI/AN people experience disparities in health and quality of life due to lower levels of education, employment, and equality than the majority population (Provider's Guide, 2012). These disparities have been evident for many years and yet persist, even with the scientific advancements and medical care of the 21<sup>st</sup> century United States. Lucero (2011) and BigFoot and Schmidt (2010) argue that federal policies and historical events are part of the reason for this persistence.

The Indian Health Service (IHS) is the main federally-funded program that is responsible for providing care to AI/AN people in the United States, and is currently the only source of health care for 55% of American Indians (Gone, 2004; Gone & Trimble, 2012). Another contributing factor to mental health disparities is that many AI/AN people live in rural areas, where mental health services can be especially scarce (Tsosie et al., 2011). Not surprisingly, 75% of AI/AN rural youth are not receiving needed mental health care (Goodkind, LaNoue, & Milford, 2010). IHS programs are the largest resource for Native-specific mental health treatment, yet in 2010 less than 10% of the funds allocated for clinical services were dedicated to mental health programs (including substance abuse treatment) and on average the expenditure per capita is less than half that of the general population (Gone, 2004; Gone & Trimble, 2012). Therefore, the only mental health programs available to many AI/AN people are severely underfunded (Duran et al., 2009; Gone, 2004; Lucero, 2011).

Additionally, culturally-sensitive mental health providers and programs are in high demand, but hard to find (Gone, 2004; Willmon-Haque & BigFoot, 2008). Many providers are well-intentioned, but lack an understanding of Native cultures to the point at which clients may not feel comfortable or even welcomed in the therapeutic setting. Lucero (2011) points out that even the methodologies used to establish a practice as evidence-based are often contrary to the needs of indigenous communities. Most of the research that exists on American Indian mental health is related to disparities rather than traditional interventions.

Gross (2007) explains that for many veterans, the traditional healing ceremonies of their respective tribe offer an alternative route to recovery other than psychotherapy or pharmacology. In a study of 20,284 veterans, Native Americans were no less likely than other racial/ethnic groups to receive treatment overall, but were less likely to receive a psychotropic (Spoont, Hodges, Murdoch, & Nugent, 2009). This indicates that American Indians may prefer to try various types of interventions before using medication, regardless of efficacy (Yurkovich, Hopkins, & Rieke, 2012).

Vernon (2012) describes sleep disturbances as a trade mark of PTSD, with 90% of cases experiencing insomnia, and 70% having nightmares. In a secondary analysis of the American Indian Vietnam Veterans Project data, Shore, Orton, & Manson (2009) found that sleep disturbance and nightmares were especially prevalent among a sample of 305 veterans from a Northern Plains tribe. One individual in particular was able to successfully treat these recurring nightmares by incorporating the use of a traditional healer, as illustrated below.

Approximately one week after stopping drinking, the patient began to experience a recurring nightmare 1-2 times per night. . . . This dream would often cause the patient to awake suddenly in a cold sweat. When asked by his psychiatrist the meaning and significance of the dream, the patient explained that he believed his friend's spirit was trying to communicate with him. The patient expressed frustration that he did not know why his friend's spirit was trying to contact him and increased the patient's guilt over feeling he had not done enough to protect his friend in the firefight. The psychiatrist prescribed an antihistamanergic sleeping medication, continued supportive therapy, and encouraged the patient to visit a traditional healer in the community with whom the patient had a relationship. The medication helped the patient get to sleep faster but did not change the frequency of the nightmares. The patient visited the traditional healer, who recommended several traditional treatments, including sweat lodge ceremonies. The patient followed and completed the healer's recommendations, as well as continuing supportive therapy with his psychiatrist. Over the course of 2 to 3 weeks, the nightmares gradually decreased and then ended. The patient felt that, through the treatments he had received, he had been able to comfort and put his friend's spirit at ease; he also reported a decrease in guilt over his friend's death. (Shore, Orton, & Manson, 2009, p. 33)

There are many examples of traditional healing ceremonies that are especially meant for warriors returning from battle. Purification before reentry into society is an important part of being a warrior (Brave Heart et al., 2012). The National Survey of Vietnam Era American Indian Veterans surveyed 116 American Indians who had served

in Southeast Asia between 1961 and 1975. Forty-three percent of them related that they had been involved in tribal ceremonies designed to prepare them for war, honor them for their service, and/or purify them when they returned. Sixty-nine percent of the group were certain that ceremonies like soldier dances, peyote meetings, and purification ceremonies could be of aid to returning veterans (Holm, 1985). Therefore, within just the veteran sector of the AI/AN population experiencing traumatic stress symptoms, there is evidence for the inclusion of traditional spiritual practices in treatment.

### **Conclusion**

Trauma-related symptoms occur in greater numbers among Native Americans for various reasons. Historical trauma gives way to increased family violence, loss of cultural and spiritual values, poverty, lack of education, and substance abuse. In addition, because of the tradition of serving in the armed forces, there are many more Native American men and women exposed to combat than other racial groups. All these things are factors in contributing to widespread trauma in the Native community, to the point at which lifetime rates of PTSD are two to three times that of the general population (Brave Heart et al., 2012; Goodkind, LaNoue, & Milford, 2010).

There is a need for culturally relevant treatment options which will contribute to healing the historical wounds that have created disparities in mental health disorders such as PTSD (BigFoot & Schmidt, 2010; Brave Heart et al., 2011; Garrett et al., 2011; Gone & Trimble, 2012; Goodkind, LaNoue, & Milford, 2010; Turner & Pope, 2009; Willmon-Haque & BigFoot, 2008). Beyond various adaptations of existing evidence-based practices, there is a need for further investigation into alternative practices that originate within the cultural setting (Garrett et al., 2011; Gone, 2004; Lucero, 2011; Willmon-

Haque & BigFoot, 2008). Many American Indians practice both traditional and western medicine, so it is important for health care providers to collaborate with traditional healers in providing more holistic care (Boone & Boone, 2007).

Among American Indian populations, spirituality is commonly viewed as the context for wellness, disorder, and healing, and informs all aspects of one's life (BigFoot & Schmidt, 2010; Garrett et al., 2011; Gone, 2004; Hodge & Limb, 2011). To be well or healthy has to do with living in balance and harmony. The concept of illness in any form is a disruption in this balance that must be restored through the use of traditional healers and ceremonies (Boone & Boone, 2007; Yurkovich & Lattergrass, 2008). Such ceremonies are "almost always to offer thanks in order to create and maintain a strong sense of connection through harmony and balance of mind, body, and spirit with the natural environment" (Garrett et al., 2011, p. 318).

Spirituality is not only the context for health and wellness, but cannot really be separated from the physical because the two realms are deeply connected and inter-related in the Native world view. The aforementioned intervention Honoring Children, Mending the Circle takes the perspective that trauma is one of the possible ways a person can be thrown out of balance physically and emotionally (BigFoot & Schmidt, 2010).

Within this perspective, it is critical to utilize traditional healing ceremonies in the treatment of trauma. However, there is little research on how this is being done across Indian Country, and whether those clients and providers that are doing it are seeing the results they hope for. This study contributes to the existing literature by investigating the extent to which tribal healing ceremonies are seen as legitimate treatment options for PTSD, and what results clients are experiencing.



## **Conceptual Framework**

### **Holistic Health**

Holistic medicine is the practice of integrating physical, mental, spiritual, and emotional aspects in the treatment of a patient or client (Skinner, 2006). The goal of holistic medicine is to treat the whole person, rather than any single issue in isolation. Stensrud and Stensrud (1984) describe this concept in the context of counseling, in which case many different approaches are combined together for the most effective treatment plan, and the therapist has a healing presence which can be utilized in the healing process.

While the term “holistic” has been developed more recently, the practice of treating the whole person underlies various ancient medical traditions around the world. In fact, Andrew Weil, a pioneer in the modern field of holistic health, traveled throughout South America and Africa to learn about ancient ways of healing (Skinner, 2006). Chinese medicine and acupuncture are examples of ancient healing practices which are becoming more and more acceptable in western medicine. These and other indigenous healing practices emanate from the view that health issues must be considered within the context of the whole person.

The theory of holistic health is consistent with the bio-psycho-social-spiritual perspective of the social work profession in that a person’s wellbeing is seen as not only dependent on their physical health, but also on their psychological, social, and spiritual health. These dimensions interact together in ways that are not always seen or known.

According to Trivieri (2001), one of the core philosophies of holistic health is the idea that harmony and balance with one’s life energy can be restored, and that this is

ultimately what heals the presenting disease or issue. This perspective is fitting for the Native American client, whose tribal culture may also emphasize the restoration of harmony as the key to healing.

### **Strengths Perspective**

The purpose of social work is to promote human and community wellbeing (Shriver, 2010). The strengths perspective of social work practice is a widely accepted approach that has developed within the last twenty years. The idea of focusing on strengths counters a trend in today's society to emphasize pathologies and treat disorders from a lens of needing to solve problems (Saleebey, 2008). This is more than just positive thinking: it is starting from a place of hope and ability, rather than from what is wrong.

Four important aspects of a person's strengths are positive emotions, empowerment, resilience, and community (Saleebey, 1996). A client's positive emotions are important in their capacity to accept the issues at hand in their life and feel hope for the future. Clients should be encouraged to participate in those activities which generate positive emotions about their life. Empowerment is helping another person or group to utilize the resources at their disposal. However scarce, every person has assets, abilities, and resources that can be used as a starting point for their recovery or healing process (Saleebey, 2008). Miley, O'Melia and DuBois (2011) emphasize empowerment as one of the root values in social work. Individuals or groups who have experienced oppression especially benefit from empowerment. Resilience is one's capacity to persist and persevere despite challenges and injuries in life. This is important to the strengths perspective because resiliency will often be a strength of clients seeking help. Finally,

community membership represents all the groups that a client identifies as a part of, thus identifying possible sources of support and encouragement.

Social workers should be making assessments of client strengths starting with the first interaction or meeting. The precedent set is that social workers join with the client as a partner, looking for ways to use the client's own expertise and encouraging full participation in the change process (Miley, O'Melia, & DuBois, 2011).

The indigenous peoples of America are recognized for their cultural strengths and spiritual traditions (Hutchison, 2011). All tribes have ways of ceremonially restoring harmony in both the life of an individual and the life of the community as a whole. These practices look different across tribes and for treating different ailments, yet it is important that these aspects of existence and wellbeing be incorporated in social work practice with Native people, especially as related to treating mental health issues.

## **Methods**

### **Qualitative Research**

Two main types of social research are qualitative and quantitative. Quantitative research asks questions about the measures, amounts, and quantities of things, while qualitative research asks questions about the essence or nature of things (Berg & Lune, 2012). Qualitative methods explore a social issue or phenomena to promote greater understanding of the issue. This study will employ qualitative methods as a way of understanding how traditional healing practices are being used by individuals with post-traumatic stress.

**Recruitment**

Participants were recruited through snowball sampling, which is a method in which personal networks are used to share information about the study and potential participants are encouraged to contact the researcher (Monette, Sullivan, & DeJong, 2008). This sampling method was chosen because the topic was potentially sensitive for research. A history of research that highlights disparities in the Native American community requires that anyone conducting a study has rapport with leaders in the community and is known to be trusted to protect sensitive information. The researcher was aware of this barrier and therefore asked personal contacts and committee members for their help in recruiting participants. These individuals used an information sheet (Appendix A) with people they know personally who they thought would be appropriate for the interviews. Participants were also asked to refer anyone they thought would be appropriate for the study. Those who were invited to participate and decided to do so all contacted the researcher directly by phone or email. Interviews were then arranged either in person or over the phone at the location of their choice (see Appendix B for this script). Ten individuals responded to the invitation to participate, but two were unable to arrange an interview time. Eight participants completed the interview process and thus contributed to the findings.

**Data Collection**

Data were collected through semi-structured interviews, consisting of eight predetermined questions (Appendix C). Practitioners who agree to be interviewed were asked to choose a location where they feel safe and comfortable. Telephone interviews were avoided if at all possible, but in one case a telephone interview was arranged at a

time during which the process would not be interrupted or overheard. Interviews lasted between thirty minutes and one hour.

The formulation of interview questions gave respondents a chance to talk about symptoms and treatment of post-traumatic stress in their own words. To be culturally responsive, the researcher attempted to use the language used by each individual respondent to refer to ideas of ceremony, trauma, healing, and medicine.

### **Protection of Human Subjects**

All those who agreed to be interviewed signed a consent form (Appendix D). This consent form explains the risks and benefits of the study, as well as requesting permission to audio record the interview. Participants were verbally reassured that confidentiality was protected by guarding any identifying information, whether written or electronic, in locked or password-protected files. Digital recordings were transcribed by the researcher with the assistance of one outside party, who signed a confidentiality agreement (Appendix E). Confidentiality was also protected by presenting only group data and excluding any identifying information from this written report. The only people who had access to the working documents were the researcher and the research committee.

### **Analysis**

According to Monette, Sullivan, & DeJong (2008), data analysis in qualitative research is about “identifying themes, patterns, and regularities and, in some cases, stating propositions, causal connections, and developing theories” (p. 432). The analysis of data collected in this study was a dynamic process, conducted by open coding, theme identification, and grounded theory. Open coding was used first to find the themes that

accurately reflect participant experiences. Themes drawn from the coding process led the researcher to develop a theory about the use of traditional healing practices for post-traumatic stress. Grounded theory is the idea that while researchers may have a hypothesis about the findings, their goal is to create new theory based on what the data show. In this way, the theories developed are *grounded* in the data (Berg & Lune, 2012; Monette, Sullivan, & DeJong, 2008).

### **Strengths and Limitations**

The strengths of this study are that it focuses on a vulnerable population, and is a new area of research that will offer important insights for the field of social work. The population in this study is considered a vulnerable population because of their minority status, their higher probability of exposure to trauma, and the lack of Western scientific research that affirms their cultural healing practices. This study is one minor step toward bringing to light the experience of these individuals as they use their strengths to heal from emotional distress.

The limitations of this study are its small sample size, indirect data (perspective of practitioners, rather than clients), and bias of the researcher. Due to the constraints of time, both recruiting and data collection were limited. Bias of the researcher is based on an American Indian ethnic identity, which gives the researcher an interest in identifying cultural strengths in the context of persisting mental health disparities.

## **Findings**

### **Participants**

The eight participants in this qualitative study were practitioners of various backgrounds. The researcher recruited professionals or community leaders working with

individuals who identify as Native American and have expressed symptoms of post-traumatic stress. Examples of such symptoms are trouble sleeping, nightmares, re-experiencing a traumatic event, and avoiding people, places, or conversations that trigger memories of a traumatic event. Eligible practitioners were clinical social workers, psychologists, counselors, Native tribal leaders, elders, and spiritual leaders. Of the eight, four participants identified as mental health professionals, and three identified as other types of advisors, whether elders or spiritual leaders. These participants will be referred to as “cultural advisors.” One participant did not identify himself as both, but his employment position and role in the community indicate that he does both types of work. Their years of experience practicing ranged from three and a half to forty. Although being Native American was not a requirement for participation, only one participant did not self-identify as Native American. In addition, three respondents who were practicing in mental health explicitly mentioned their desire and passion to work specifically with American Indian people. Participants quoted in this section will not be identified by pseudonym, agency, or tribe in an effort to fully protect their confidentiality.

### **Themes**

Using the open coding process, four main themes emerged from the data. These were the widespread rates of trauma among American Indian people, the importance of community, the spiritual realm as the context for healing, and a lack of appropriate mental health services in the American Indian community. These themes are consistent with the existing literature, and expand the discussion by offering important insights on healing within a Native American context for today’s mental health professionals. The theory developed from these findings is that healing from trauma in the American Indian

community is a delicate walk that bridges two worlds – the spiritual world of healing within one's cultural context and the more physical world of modern mental health services.

### **High Rates of Trauma**

The first major theme to emerge from the data was the extremely high rate of reported trauma among respondents' clients. Four of the eight participants directly said that one hundred percent of the people they work with are traumatized. This is exemplified in statements such as "Everyone I've worked with has had some sort of major trauma", "All of them. Yeah, every one of them. One hundred percent report trauma", "whether it's young clients, you know as young as four, to my oldest client, an elder in the community, close to 70, everybody reports trauma. Lots of it", and "I believe that everyone in Indian country is either a primary or secondary victim of sexual violence." One respondent estimated that of people she sees, it is about nine out of ten:

Often times they come in talking about pressure and anxiety, substance abuse, but I end up tying a lot of these symptoms into trauma, because as you probably know, so many native clients who we see do have a history of trauma...  
...Probably, to be honest, nine out of ten.

Rates of trauma were also referred to in less direct ways, suggesting that everyone is affected in one or way another, whether or not they are direct victims or develop PTSD. These ideas were best expressed in the following two quotes: "If you're looking in the urban area, it's harder to pin down, but if you go back to the reservation communities, the environment, it's almost as a trauma-scape."



“Our Indian communities are really struggling, really bad. And there is the talk about, you know, high rates of this, and high rates of that, and it’s not high – it’s epidemic.”

### **Importance of Community**

The second major theme, importance of community, was formulated from a list of codes that referred to a communal aspect of healing, a community context for ceremony, the importance of rebuilding trust with other people, and addressing broader community needs in response to trauma. The communal aspect of healing was referred to by one participant as a connection: “when somebody can connect with both their community and their culture, there’s huge healing in that.” Another participant saw the value of community in group work: “the group piece has been my favorite, because as much as I try to bring this in on a one-on-one basis, we’ll never be able to get at that collective sort of healing that you have in the group.” A third quote exemplifying the communal aspect of healing related to the benefits of group identity:

It’s bigger than you, it’s bigger than who you are. And I think that also takes that weight off. On the one hand you welcome the responsibility but it relieves you of thinking it’s all on you. That there’s a community that will support you, there’s a community that makes this happen. That you can draw energy from other resources beside yourself.

Related to this is the idea that ceremony happens within a communal context, even if performed for an individual, everyone who participates is part of the process. The best description of this phenomenon came from one of the cultural advisors:

And when they experience, when they do that ceremony, there's no mistaking what they came to understand. And it's an individual awakening, and it deals with those things that happen at that ceremony. However, that ceremony's conducted is for everybody there, but also for that man or woman or child or whomever's seeking that help. Everybody shares in it. So even if they might be having a ceremony for somebody, everybody that partakes in that shares in that healing. There's not a little separator, dividing them from everybody else. So that's again, goes against concepts of Western thought – North American [Indian] thought is that everything's communal. Even if in that community might be five people, it might be three people, but it's communal. Might be five thousand, but it's communal. So where one gets prayers, everybody gets prayers.

The importance of rebuilding trust and addressing broader community needs were also codes that point to the importance of community. These quotes less directly addressed communal healing, but raised the idea that community plays a role and must be considered as part of the process. One participant noted, "It's helping them find the strength to believe in themselves and find ways to connect with their community. You know, you have to trust that community." This trust was specifically referred to as important but especially difficult in some American Indian communities:

If they can understand some of their own process, then take that back and check in with, whether it's a member within their community or another family member, then that's powerful. I see a lot of disconnect in communication, and isolation, within the community. Especially in the Indian communities, a lot of disconnect from being able to process and talk about things.

In reference to the community's need for healing, one participant said, "From my experience, it's not an individual trauma, as it is a group or community trauma that's shared." This is a powerful summary of the unique experience of historical trauma.

### **Spiritual Context of Healing**

The third major theme found in this project is the spiritual context of healing. This is a broad theme, but encompasses most of the participants' responses to questions of what helps alleviate symptoms of trauma, what healing ceremonies might offer that mental health treatment does not, and why clients find healing in traditional practices. There were no direct references to spirituality in the interview questions, but all eight respondents incorporated the theme into their answers in some way. This speaks to the centrality of spirituality in the healing process. Three groups of codes that will be represented here are the importance of the spiritual realm, the efficacy of traditional healing practices, and the role of nature in health and healing. The importance of the spiritual realm is represented in the following three quotes:

But unless you address the spiritual, which I think our cultural, tribal ways do, you can address the emotional and that may get you to a certain point, but it's not going to be integrated into your being until you have a spiritual understanding with that. And that spiritual connection is where trust is – where you have that with other people.

"There's something sacred happening there that doesn't feel that way in an office."

"You know there's that medical piece to it, but at the same time, forgiveness and things like that that's a spiritual thing. And there's no getting around that."

In defining the context of healing, it is also important to mention that most respondents directly addressed the efficacy of traditional healing practices. This is included under the theme “Spiritual Context” because there was some consensus that the reason traditional healing practices are effective is that they draw on spiritual power, and they address the spiritual realm of a person’s life, which mental health treatment models do not always do. All eight respondents were able to give an example of someone they worked with who successfully relieved symptoms of post-traumatic stress through traditional healing practices. Six participants discussed whether they knew of anyone who did *not* find such practices helpful. Overwhelmingly, they agreed that either they did not know of anyone, or if they did there was a clear reason why it was not helpful. These reasons were related to disconnectedness, distrust of the practitioner, or miscommunication about the root problem. Demonstrating their belief in the efficacy of traditional healing practices, one participant said, “So for me, that healing came through sun dance and ceremony. And actually, for many of the women that I work with, survivors of sexual and domestic violence, that’s true as well” and another said, “Ah, I haven’t heard of anybody saying that they did not help. On the contrary, I’ve heard of a lot of people say that those things are the first things that they recommend, that they go through.”

One of the cultural advisors specifically referred to the sweat lodge as effective:  
The other one is going into the sweat lodge. I have a sweat lodge right here at my home, so I take them in there one at a time, or maybe two or three people. Then again, I have it planned where every Wednesday and Thursday I have sweats over

at my house. So then they come over and through that kind of meditation, I think that's probably the strongest course that can help someone.

Another cultural advisor referred to a power that is felt or seen:

But I think it's just the realization that the individual or their family gets reminding them that there's something out there bigger than them that's come in there to help them. That's there now to help them, because they asked for it. So I think that's real powerful, real powerful. I know Episcopal priests that have put away their cloth, and Catholic priests, you know based on what they've seen or heard or experienced. And that's not what has to happen, it's just that's the way the world is, things are different for different people.

With one participant, the researcher paraphrased the idea that "there seems to be a sort of a, like a spiritual strengthening. . . . Participating in something like a sun dance may build up some spiritual capacity that helps cope with the other things that come along" and received this confirmation from the participant "Yes. Definitely. And have I seen that? Yeah, I've seen that."

One participant nicely summarized all such beliefs by saying, "But anyway, it's those cultural ways. Those are very healing. So whether it's the sun dance or the ceremony, but it's those cultural ways, they're all healing. Very healing."

A third category of codes that fits within the spiritual context theme is the role of nature, or using nature as a basis for healing. This is being shared as part of the findings because it was not referred to at all by the researcher in the interview questions, but was brought up separately by three participants when talking about how to treat trauma. One person referred to animals and plants:

I think that animals, and dogs and cats and horses are very helpful in treatment. . . . Those are helpful ways to deal with people who are having emotional stress. . . . Even if you have a plant in your home, you take care of that, you try to communicate to the plant. Try to communicate to the animals, to the horses or to the dog or cats, and you know use the traditional way of healing – I think I’ve already said all that stuff.

Another person referred to nature and how people automatically are influenced by it: When you’re outside, when you’re doing something, it comes out. And so, that’s what happened – it was a talking circle. I could not get women to a talking circle on sexual violence at our organization, but take them out into the deep woods and it just happens naturally. And just naturally there is a value about confidentiality, you don’t have to say that. That’s what’s expected when you’re, I mean, that’s where societal laws originate, from natural law. And when you’re outside in nature, you function from the place of natural law.

A third person referred to the energy that stems from nature:

A lot of it is, for me, I’ll say energy. I’m a big energy person. I’m very connected to nature. I’m very connected to, you know the sun, I think it affects all of us, it affects our mood, it affects how you move in the world.

The role of nature in these participant’s opinions, relates to an aspect of life that is tied to health and healing. While this may not be the case for all Native American clients, it is emphasized here a way of recognizing the importance of a holistic approach to treating trauma.

**Lack of Appropriate Mental Health Services**

The fourth theme, lack of appropriate mental health services, addresses not only the lack of attention and funding for American Indian mental health programs, but also a lack of access to existing services and a lack of trust of providers. This theme incorporates ideas from the previous three themes: given the high need, given the role of community, and given the role of spirituality, there is a huge gap in mental health services that effectively address those conditions. Most participants voiced their opinions about this subject when asked if there was anything else they thought was relevant to the discussion on trauma. One participant shared his opinion by stating that “Mental health in Indian country is the red-headed step child. It’s under-funded. And this is an incredibly high-need area. And I don’t know who cares. I don’t know who’s going to step up and do something.” The same person later specified that “We need more Native therapists. And the wonderful thing about this is these things aren’t so different. Mental health and all that stuff is completely, I feel, completely in line with traditional [tribal] way of living.”

Two other participants shared these thoughts:

I mean, I worked with over 4,000 women since 1978 so I can give you an opinion, but it is an opinion that arises out of a context where mental health services are non-accessible for Native women, and Native mental health providers, there are so few in proportion to the need.”

I mean what does a psychiatrist out in [the suburbs] know about boarding school?

What do they know about the sexual abuse that’s rampant in our community?

What do they know about these things? And so I think it goes back to who they

go see and the type of care they get. And I think the closer to home they get, the better off they are.

Participants that are mental health professionals alluded to the discrepancy in their professional training with understanding the needs of Native clients. One held up a manual saying, “This is from the [State] Board of Psychology, nothing about spirituality is in here. Nothing about holistic healing is in here. This is what you do and what you can’t do.” Another referred to the difficulty of diagnosis using the DSM-IV:

As a clinician, I’m real disappointed, actually disgusted would be the appropriate term, with the DSM, and how trauma’s identified because I think it’s very limiting. The clients I see, when I give them PTSD, I talk about how growing up is like a war zone because I think trauma, the definition clinically only speaks to I think six months period of time. My clients we’re talking about historical, we’re talking about generational, maybe even developmentally, or complex, so for me it’s complex.

A third professional participant added to this idea of dilemma in diagnosis:

I think we have a lot of work to do still as far as Western mental health and being able to use it and offer it in a way that’s culturally meaningful. And I think that oftentimes we can go to school and get as much as can out of that, but I think people who plan on working in Native communities almost have to go above and beyond, in a way, what you learn in school. Because so much of that is not going to apply the same. Take diagnosis alone: you take the DSM, right? And we don’t have a diagnosis that fits historical trauma. . . . What we have is just not applicable. It’s close, in some aspects, but I think we have to be really, really



careful with it. And that's part of the reason, is because we can take and we can use different assessments, but that's only going to over-pathologize or classify somebody as psychotic or having a personality disorder.

The last idea represented under this theme is a disconnect and incompatibility between the approaches of traditional healing practices and Western medicine. In addition to this gap in philosophy, three respondents expressed concern about over-medication and over-pathologizing of Native people. They specifically referred to negative side effects of medication that can interfere with spiritual wellbeing, and talk about spirituality being categorized as schizophrenic. One respondent specifically said the two practices are in conflict: "We wanted to establish having Indian medicine being practiced here, but it's in conflict with Western medicine, still not accepted yet." Another respondent referred to the bias of Western medicine against the validity of traditional healing:

My experience is there's a large amount of bias as [to] whose medicine is validated. . . . So I would like to see that bias be softened. And when you have these traditional healers, that their advice, that their input is looked at as valid, helpful ways to help this person get through life. And they say well, this isn't proven, this isn't proven, how can you prove this? Well, I've known a lot of people who've seen therapists for many years and still commit suicide, seen therapists for many years that still murder people, seen therapists for many years that still cut themselves, so how is your medicine proven? So to sit there and say, again, it doesn't use the scientific method, that's kind of not our teaching. But I'd just like to see a level playing field.

## Conclusion

Whether or not respondents saw mental health services as understanding of their culture, they all seemed to agree that Native people are in a unique position when it comes to healing from trauma. For individuals who are removed from their cultural roots, finding a therapist is often the first step. That therapist may or may not encourage their client to re-connect with their community, but it is better if they do. For some individuals, there will be no interest in participating in traditional healing practices, so therapy will be the best way for them to heal. One cultural advisor commented on his relationship with therapists that can go both ways:

I've have some that want to see both. I'll have one that'll want to do the traditional route, I'll have one that won't want to touch tradition with a ten foot pole. But more often than not, I've had folks see therapists, and I've had therapists contact me.

On the other hand, people who are strongly tied to their culture may have strong distrust of mental health providers, especially if their spiritual needs are not addressed. One such participant said he would not advise people to use both a therapist and a medicine person. However, when it came to the medical setting, he was in support of incorporating traditional healing into hospitals. For these individuals, finding healing through ceremony may be the most effective route. But the largest group of people who are doing healing work are truly walking in two worlds. The following two quotes best represent this idea:

If I draw on experience I would say that oftentimes it's a both/and, it's not an either/or. It's that there's both. When somebody can connect with both their

community and their culture, there's huge healing in that. And, sometimes getting away from it is also important. Having a different space is also important. But to me, I don't see it as a complete separation . . . because they walk in a world where you're in both. Or in a both/and, you know? Whether it's somebody who's living on a reservation or not on a reservation, the healing happens. So when you say is there something more they're getting here or more they're getting there, I think it's both. They get something when they can really connect with their community, can really connect with some of those practices, and they're getting something when they can really process some of that trauma, and maybe there isn't room for it in the community to process.

“I think it's a continuum. Some people are going to solely respond to therapy. Others are solely going to respond to cultural ways. But the majority of us are going to be somewhere in the middle of that spectrum.”

As one participant remarked, therapy can be effective preparation for participating in a more intense spiritual experience such as a sun dance. Another participant pointed out that therapy can also provide a space to process trauma, if that space is not provided in the community. But in the end, many American Indian clients will find something not available in therapy when they are integrated into a community setting, and address the sacred aspects of health and wellbeing. All eight participants agreed that there is something about traditional healing practices that meets the spirit on a deeper level, and nurtures a community in a way that Western mental health treatment cannot do. Finding this balance of meeting one's need for inner harmony will for most people be a

combination of cultural practices and making use of health care services in the context of their modern American lives.

## **Discussion**

### **Connection to Literature**

Three of the four themes found in this project are consistent with the existing literature on trauma in the American Indian community: high rates of trauma, the role of spirituality, and a lack of appropriate services were ideas that are reinforced by the respondents in this study. However, the importance of community was a new theme that emerged, and is one that deserves more attention in mental health treatment.

**Historical trauma and high rates of direct trauma.** While previous publications have reported a higher than average rate of post-traumatic stress among Native Americans (Brave Heart et al. 2012; Tsosie et al. 2011), all previous estimates are seen as understatement by the participants in this study. Participants focused on different types of trauma throughout their interviews, but if asked about the idea of historical trauma, all agreed that this was an issue that affects every Indian community and individual. Some respondents brought up historical trauma on their own, stating it as the most pervasive form of trauma in the Indian community. As is pointed out by Willmon-Haque and BigFoot (2008), it also perpetuates causes of direct trauma within families.

**Spiritual context of healing.** There is a growing recognition among practitioners that spirituality is as relevant an issue to consider as culture (Baetz & Toews, 2000; Charak, Sharma, & Sharma, 2009). All respondents seemed to agree with this perspective, although some who are mental health professionals expressed that there is

still a long way to go. The new idea that is not a theme of the literature is that the spiritual world is actually a healing space for many clients. The subjectivity of spirituality and spiritual experience makes this a difficult idea to write about. But from this study, it is clear that to be open to clients' experiences in this area is a key component of therapeutic work with American Indian individuals, especially those who are closely tied to their cultural traditions.

**Lack of appropriate services.** Mental health services for AI/AN people are provided by a wide variety of federal, tribal and private agencies. Adaptations made for culture and tribal norms are up to each governing body, so it is impossible to say that appropriate resources are completely absent. It must be acknowledged that there are some (mostly private) health organizations which effectively address the needs of the people they aim to serve. However, as is pointed out by Gone (2004), federal programs including the Indian Health Service are a main source of health care for Indian populations, and do not effectively meet the needs of these people when it comes to mental health. This disparity was noted by participants in this study, and was expanded upon to make the point that by and large, Native people do not feel welcomed or understood when they go to a non-Native mental health provider. Similar to the lack of providers that effectively address spiritual issues, there are not enough providers making AI/AN people feel understood and comfortable in the therapeutic setting from the beginning.

**Treatment of post-traumatic stress disorder.** The two strongly supported evidence-based practices for treating PTSD therapeutically are cognitive behavioral therapy (CBT) and eye-movement desensitization and reprocessing (EMDR) (Foa,

Keane, Friedman & Cohen, 2009; Makinson & Young, 2012; Wisco, Marx, & Keane, 2012). Neither of these two practices were mentioned by any of the respondents, although narrative therapy and storytelling were referred to as useful therapeutic interventions. Narrative therapy is a post-modern technique that is growing in popularity because of its effectiveness with people of all ages and cultures (Besley, 2002).

In regard to complementary and alternative medicine (CAM) being used alongside therapy, most participants in this study felt as though traditional healing practices were not validated enough. This may be because most ceremonial practices are more difficult to study empirically than practices such as acupuncture or massage. Recent writings about the use of the sweat lodge specifically (Garrett et al., 2011; Gross, 2007) are in agreement with participants' opinions and may contribute to a wider acceptance of this practice among providers.

**Importance of community.** The important role of community has not been a theme in the literature on healing from trauma. Often, clients are treated individually, at best with some mention of their community or cultural context outside the presenting issue. What this study reveals is that with most Native American clients, individual healing will at some point include outside parties or may even be most effective in a group context. Two participants who lead therapeutic groups said that the communal aspect of the group process offers more concrete support than individual treatment when it comes to understanding historical trauma.

### **Implications for Social Work Practice**

**Incorporation of spirituality into therapeutic setting.** One of the clear messages from these data is that social workers need to do a better job of being spiritually

sensitive and incorporating client spirituality into clinical practice. According to Canda and Furman (2010), “spiritually sensitive practice is a way of being and relating throughout the entire helping process” (p. 214). These same authors provide a model for doing so, for those readers who are interested in learning more. This means not just asking clients as part of assessment if they have a spiritual or religious practice, but remaining aware and responsive to their spiritual needs in every interaction. Holistic social work practice means considering the *whole* person and their environment. While this is a core value of social work today, it should be noted that American Indian clients are not reporting a sense of respect for their whole self and cultural beliefs. The disparity in AI/AN clients completing treatment in typical mental health models was first noted as early as 1978 (Gone & Trimble, 2012), making it clear that this is a persisting issue that is consistently ignored by society as a whole. It is long overdue that the mental health professions not only recognize the impact of culturally insensitive practice, but begin to make changes to reduce that impact. Part of this change is increasing clinicians’ ability to help clients access the healing that is offered by their individual spiritual practice. Practitioners should also remain aware that this will be different for each unique client, even within the same population. This study focuses specifically on American Indian populations, but the implications of spiritually sensitive practice expand to all clients, especially those of any ethnic or religious minority.

**Cultural assessment.** As part of creating a more culturally sensitive practice, social workers can use assessment tools that help in understanding the degree of connection that clients feel to their ethnic identity. This is important because not all American Indian people practice tribal cultural ways, and some may even be averse to

discussing the topic. In urban areas, AI/AN clients will come from a variety of tribal affiliations, including multiple affiliations. Those who grew up far from their home reservation or were adopted may have little to no knowledge of traditional values or ways of life. Others who recently relocated to the city or whose families maintain close ties with their tribe may feel very strongly about their cultural identity, but may or may not share this with a non-Indian practitioner. For these reasons, it can be helpful to do a formal or informal assessment of cultural identity in order to meet the client where he or she is and effectively build a therapeutic alliance.

### **Implications for Social Work Policy**

**Lack of resources.** The lack of resources for mental health services affects not only the American Indian community, but has recently created a “new normal” for both public and private health care providers. However, in considering the AI/AN communities specifically, there is even less basic access to services where they are provided. This is a systemic issue that must be addressed at the federal level. The Indian Health Service specifically should be working to create relevant mental health and substance abuse programs that effectively meet the need in AI/AN populations in both rural and urban areas. In an era of limited funding for mental health programs, we must work even harder to ensure that programs in place are efficiently using resources in ways that best meet individual communities’ needs. Recent reviews of the status of such services imply that this goal is far from being accomplished in American Indian communities (Gone & Trimble, 2012; Lucero, 2011).

**Shortage of Native American therapists.** More than one respondent commented on the fact that there are very few therapists within the American Indian community.



This is a concern that could be addressed at a societal level, through funding for education and encouragement of minority populations in general to enter the mental health professions. This shortage could be a result of the general distrust of the Native community toward mental health, influencing young people to pursue other career paths. On the other hand, a growing awareness of concepts like historical trauma and systemic injustice may encourage AI/AN students to begin considering mental health professions more often. This possibility would have to be confirmed by recent and future numbers of graduates in these fields.

### **Implications for Social Work Research**

Lucero (2011) has shown that due to the sovereignty and self-determination rights of Indian nations, traditional healing practices ought to be treated equally under the medical model of practice for treatment of AI/AN individuals who prefer to use them. This is based on the idea of practice-based evidence, and the long history of successful treatment of physical and mental illness using these practices. Social work professionals should at a minimum be aware of the benefits of traditional healing practices for their Native clients. Further qualitative research is needed to share the efficacy of such practices with health professionals, while preserving and respecting practitioner's rights to protect sacred knowledge. One way that mainstream society can move toward supporting self-determination is to offer insurance reimbursement for certain treatments used by Native clients that are not found to have major risks. This may take time to implement, but has already been done in select parts of the country and can grow in acceptance by exploring the issue and sharing the opinions of practitioners and clients who use them, as is demonstrated by this small sample.

### **Strengths and Limitations**

The strengths of this study are that it focuses on a vulnerable population, is culturally responsive, adheres to informed, voluntary consent and confidentiality, and is a new area of research. The population in this study is considered a vulnerable population because of their minority status, their higher probability of exposure to trauma, and the lack of Western scientific research that affirms their cultural healing practices. This study is one minor step toward bringing to light the experience of these individuals as they use their strengths to heal from emotional distress. For this reason, it was important to remain responsive to individual and cultural norms throughout the research process. The researcher took steps to help participants feel honored, respected and safe. Throughout interviews, language was used which reflected participants' own words for concepts such as tradition, ceremony, and Native/Indian/indigenous. All but one interview was conducted face to face, at the location of the participant's choice. To ensure confidentiality, no information was included in the findings that could possibly give away participants' identity, including the use of pseudonyms for person, agency, or tribe. The approach used to tell the stories of these eight participants is easily replicable, and adds to a growing body of literature which affirms the cultural practices of minority people in the mental health setting.

The limitations of this study are its small sample size, indirect data (perspective of practitioners, rather than clients), limited time frame, incompatibility with cultural norms, and bias of the researcher. Due to the constraints of time, it was most feasible to collect data from a small number of participants, and recruit practitioners who have experience with the research question, but might be more likely to respond to a research study than

clients themselves. With more time, it would be possible to recruit individuals of more varied backgrounds and conduct more interviews. The recruiting process itself was also a limitation because participants were asked to trust an unknown individual with their experience, which may have deterred some potential participants. Historically, academic research has not always upheld the cultural values of Native American people, or has only served to spread negative images of Native people. Whether this played a role in the process of this particular study is unknown, but must be considered as a possibility. Finally, bias of the researcher is based on an American Indian ethnic identity, which gives the researcher an interest in identifying cultural strengths in the context of persisting mental health disparities.

### **Conclusion**

With the growing awareness of the need for culturally-sensitive and spiritually-sensitive practice, discussions on such topics can begin to seem redundant. However, the findings of this study are an important reminder that there is still a lot of work to be done in the healing professions. The subjective healing experiences of clients often occur within the context of spiritual and cultural practices, which may or may not be brought into the clinical setting. As trauma is addressed at a community level for indigenous people, professionals ought to honor and celebrate these practices that so often get overlooked. By doing so, we will not only build relationship with a diverse community, but also further the objectives of dignity and social justice that are part of our profession.

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### **Appendix A: Recruiting Sheet**

You are receiving this invitation because of your reputation as a valued practitioner in the Native American community. We are humbly requesting your support for the following study:

***“How are traditional healing practices being used in the treatment of post-traumatic stress among Native Americans?”***

Counselors, therapists, elders, and traditional healers who respond will be interviewed in a confidential setting at the location of their choice. Opinions and experiences collected for this study will be valuable for the fields of social work, counseling, and human services, where cultural healing practices are often overlooked. Your experience as a practitioner can contribute to the wellbeing of others in the Native community, and will remain completely confidential.

The individual conducting the study is Sierra Yazzie Asamoa-Tutu, a Navajo/Diné social work student at St. Catherine University and the University of St. Thomas in St. Paul, Minnesota. You do **not** need to live in the metro area or be a member of any specific tribe. For your protection, the researcher cannot contact you directly unless you contact her first. Sierra can be reached at (XXX) XXX-XXXX or (email).

Thank you for your consideration. Please pass this notice on to others who may be able to help.

**This study is being conducted under the supervision of Catherine Marrs Fuchsel, an Assistant Professor at the University of St. Catherine. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact John Schmitt, the Chair of the Human Subjects Institutional Review Board, through St. Catherine University at (651) 690-7739.**

**Appendix B: Initial Contact Telephone Script**

Hello, thank you for getting in touch. As you know, my name is Sierra, and I'm a graduate student at the St. Catherine University and University of St. Thomas School of Social Work.

The goal of my project is to share the experiences of healing from trauma from your perspective as a practitioner. You would be one of several people that I interview. The hope is that by collecting your stories, I will be able to write about the various cultural healing practices that Native people are already using for symptoms of trauma. Do you have questions about the topic? Would you like to commit to participate?

I am hoping to set up meetings with participants as soon as possible. This will be for about an hour to conduct the actual interview. I would prefer to meet with you in person, but if that is not possible we can try to do it over the phone, too. Will a meeting with me be possible for you? Would you like to set up a date and time now?

Can I get your contact information to be in touch?

Thank you so much for contacting me, I really appreciate your support.

Goodbye.

**Appendix C: Interview Questions**

1. Please briefly describe your title or type of work, and how long you have been practicing.
2. What are the people you serve usually looking for when they come to you for help?
3. What would you call a condition where someone has nightmares, flashbacks, and hypervigilance, and is always afraid that something bad might happen, to the point where they don't live like they used to? What usually helps relieve these symptoms?
4. What percentage of the people you work with report trauma as one of the reasons they are seeking help?
5. What is your experience with Native American clients choosing traditional medicine or western mental health treatment?
6. How do you as a practitioner feel about blending western mental health treatment with non-western, traditional tribal healing practices?
7. Can you give an example of someone you worked with that found traditional healing ceremonies to be effective for their symptoms of post-traumatic stress?  
Can you give an example of someone who found them ineffective? (provide list)
8. What was their understanding of why the ceremony was effective or not effective?
9. Did the ceremony provide something not available in mental health treatment models?  
  
Is there anything else you'd like to add?

## **Appendix D: Consent Form**

### **HEALING FROM TRAUMA IN THE AMERICAN INDIAN COMMUNITY**

#### **RESEARCH INFORMATION AND CONSENT FORM**

##### **Introduction:**

You are invited to participate in a research study investigating the use of traditional healers in the treatment of post-traumatic stress among American Indians. This study is being conducted by Sierra Asamo-Tutu, a student in the Master of Social Work Program at St. Catherine University and the University of St. Thomas. You were selected as a possible participant in this research because of your experience working with Native Americans who might be experiencing post-traumatic stress. Please read this form and ask questions before you decide whether to participate in the study.

##### **Background Information:**

The purpose of this study is to discover how and why Native Americans who are experiencing post-traumatic stress include tribal healing ceremonies as part of their treatment. Approximately 8 people from mental health or healing professions are expected to participate.

##### **Procedures:**

If you decide to participate, you will be asked to respond to 8 interview questions from the researcher in a semi-structured interview, either in person or over the phone, and to allow the interview to be digitally recorded for analysis. The interview will take approximately one hour, and will be conducted at the location of your choice. Once the interview is completed, no further contact will be necessary unless you choose to follow up on the results of the study or questions about the study.

##### **Risks and Benefits:**

The study has minimal risks. You may experience slight emotional or psychological discomfort in response to questions that ask about spirituality, tribal beliefs, and client experiences. If this occurs, you should verbally express your discomfort to the interviewer so that the question causing discomfort may be avoided.

There are no direct benefits to you for participating in this research. Indirect benefits include contribution to the field of culturally-relevant mental health and support of Native American scholarship.

##### **Confidentiality:**

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

Digital recordings of interviews will be kept on a digital voice recorder and locked in a cabinet in my home office. These digital files will be erased at the completion of transcription. I will keep the research results in a password-protected computer and backed up on a password-protected external hard drive in my home office. Only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 1, 2013. I will then destroy all original reports and identifying information that can be linked back to you.



**Voluntary nature of the study:**

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University or the University of St. Thomas in any way. You may refuse to answer any question in the interview. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

**Contacts and questions:**

If you have any questions, please feel free to contact me, Sierra Asamo-Tutu at (XXX) XXX-XXXX. If you have any additional questions later, the faculty advisor, Catherine Marrs Fuchsel, PhD, LICSW will be happy to answer them. She can be reached at (651) 690-6146. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

**Statement of Consent:**

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

---

I consent to participate in the study and I agree to be audio-recorded.

---

Signature of Participant

Date

---

Signature of Researcher

Date

### **Appendix E: Confidentiality Agreement**

This Confidentiality Agreement (this "Agreement") is made effective as of \_\_\_\_\_, between Sierra Asamo-Tutu, of \_\_\_\_\_, and \_\_\_\_\_, of \_\_\_\_\_.

In this Agreement, the party who owns the Confidential Information will be referred to as "the researcher", and the party to whom the Confidential Information will be disclosed will be referred to as "transcriber or coder".

\_\_\_\_\_ (transcriber or coder) is engaged in transcription or coding of confidential data transcription or coding. The researcher has requested that transcriber or coder will protect the confidential material and information which may be disclosed between the researcher and transcriber or coder. Therefore, the parties agree as follows:  
**I. CONFIDENTIAL INFORMATION.** The term "Confidential Information" means any information or material which is proprietary to the researcher, whether or not owned or developed by the researcher, which is not generally known other than by the researcher, and which transcriber or coder may obtain through any direct or indirect contact with the researcher.

**II. PROTECTION OF CONFIDENTIAL INFORMATION.** The transcriber or coder understands and acknowledges that the Confidential Information has been obtained by the researcher by the investment of significant time, effort and expense, and that the Confidential Information is private, personal information disclosed by the study participants, and needs to be protected from improper disclosure. In consideration for the disclosure of the Confidential Information, transcriber or coder agrees to hold in confidence and to not disclose the Confidential Information to any person or entity without the prior written consent of the researcher. In addition, transcriber or coder agrees that:

*i. No Copying/Modifying.* transcriber or coder will not copy or modify any Confidential Information without the prior written consent of the researcher.

*ii. Unauthorized Disclosure of Information.* If it appears that transcriber or coder has disclosed (or has threatened to disclose) Confidential Information in violation of this Agreement, the researcher shall be entitled to an injunction to restrain transcriber or coder from disclosing, in whole or in part, the Confidential Information. the researcher shall not be prohibited by this provision from pursuing other remedies, including a claim for losses and damages.

**III. RETURN OF CONFIDENTIAL INFORMATION.** Upon the written request of the researcher, the transcriber or coder shall return to the researcher all written materials containing the Confidential Information. The transcriber or coder shall also deliver to the researcher written statements signed by transcriber or coder certifying that all materials have been returned within five (5) days of receipt of the request.

IV. GENERAL PROVISIONS. This Agreement sets forth the entire understanding of the parties regarding confidentiality. The obligations of confidentiality shall survive indefinitely from the date of disclosure of the Proprietary Information. Any amendments must be in writing and signed by both parties. This Agreement shall be construed under the laws of the State of Minnesota. This Agreement shall not be assignable by either party, and neither party may delegate its duties under this Agreement, without the prior written consent of the other party. The confidentiality provisions of this Agreement shall remain in full force and effect after the effective date of this Agreement.

IN WITNESS WHEREOF, this Agreement has been executed and delivered in the manner prescribed by law as of the date first written above.

Information Owner:  
Sierra Asamo-Tutu

By: \_\_\_\_\_

Recipient:  
\_\_\_\_\_

By: \_\_\_\_\_