Promoting Best Practices in Indian Country: Strengthening Traditional Medicine and Cultural Resilience

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Integrating Tradition Medicine Constructs and Principles within Western Medical and Mental Health Paradigm[1]

Key Questions:

How can Traditional Medicine Principles and Practices be integrated into Western Medical Models and specifically the Indian Health Service/Tribal Health Systems?

How can Traditional Medicine Practitioners be integrated into Western Medical Models and specifically the Indian Health Service/Tribal Health Systems?

How can Traditional Medicine Patients and Clients access comprehensive Traditional Medicine Practitioners, Traditional Approaches, and Principles within Indian Health Service/Tribal Health Systems?

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TRADITIONAL CULTURAL ADVOCACY PROGRAM
POLICY STATEMENT

The Indian Health Service (IHS) recognizes the value of traditional beliefs, ceremonies, and practices in the healing of body, mind, and spirit. The IHS encourages a climate of respect and acceptance in which traditional beliefs are honored as a healing and harmonizing force within individual lives, a vital support for purposeful living, and an integral component of the healing process. It is the policy of the IHS to facilitate right of American Indian and Alaska Native people to their beliefs and health practices as defined by the tribe's or village's traditional culture. This policy is meant to complement and support previously stated IHS policy for implementing the American Indian Religious Freedom Act of 1978 (Public Law 95-341, as amended).

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The need for effective and accessible health care for American Indian families, children, and communities is easily apparent. What has been historically less apparent within healthcare is the need for culturally grounded interventions that build upon the strengths inherent within American Indian cultures. This paper will outline the realities facing American Indian and Alaska Native communities and potential pathways to innovative healing methods. These healing methods integrate cultural foundations of healing within the framework of existing Western medical and mental health paradigms. Cultural resiliency will form the foundation of this approach and an examination of the potential policy implications of this construct will be presented. First it is important to gain an appreciation for the psychosocial and economic realities facing American Indian communities.

An estimated 31.6% of Native Americans live below the national poverty level in contrast to 13.1% for all other racial groups and nearly one half of all American Indian children live below this federal poverty level (U.S. Department of Health and Human Services, Indian Health Services, 2004). Many American Indian families, children, and individuals are resultantly left to cope with significant biological, psychological, and sociological challenges and adverse living situations.

Compared to all other United States racial groups from 1996-1998, the American Indian/Alaska Native death rates due to suicide is 91% greater than other groups, deaths

due to homicide 81% greater than other groups, and death rates due to alcoholism are 638% greater than other ethnic groups (U.S. Department of Health and Human Services, Indian Health Services, 2004). American Indians have a lower life expectancy than other groups and approximately 13% of deaths involve American Indians who are less than 25 years of age (U.S. Commission on Civil Rights, 2003). The rates of death due to heart disease, diabetes mellitus, accidental injuries, pneumonia, influenza, firearms, gastrointestinal disease, and cerebrovascular disease are all substantially higher for Native Americans than for any other ethnic group (U.S. Department of Health and Human Services, Indian Health Services, 2004). The infant mortality rate, often viewed as a sensitive indicator of general health of a population, has decreased recently but remains 24% greater for Native Americans compared to other groups. Consequently, the risk factors facing many Indian individuals encompass the holistic realm of biopsychosocial and economic adversity.

Trauma is a frequent antecedent to the psychological suffering observed within American Indian communities. Manson and his colleagues (2005) provided a comprehensive study in the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project and examined exposure to 16 forms of trauma within 2 American Indian communities (N = 3,098). The authors reported that American Indians sampled reported lifetime exposure rates are significantly higher than their White counterparts in the US. Indeed, 62.4-69.8% of the American Indians in the study reported having been physically attacked, witnessing a traumatic event, and having a close relative experience a significant traumatic event compared to 51.2%-60.7% rates of exposure for other US ethnic groups.

Exposure to traumatic events appears to be an important factor to consider in the discussion of negative self-concept development. American Indian adolescents may be primed to report lower self-esteem or negative self concepts in part due to the elevated exposure to traumatic events they report. Deters, Novins, Fickensher, and Beals (2006) recently examined posttraumatic stress disorder (PTSD) symptoms in a sample of 89 American Indian adolescents in a substance abuse program. They found that exposure to trauma was pervasive within this sample (98% of participants reported at least one significant traumatic event and 4.1 was the average reported traumatic events.) Respondents also reported high rates of PTSD symptoms within this study. Sexual trauma was found to be the most common predictor of PTSD symptoms.

Trauma is a frequent reality facing many American Indian individuals. "Deculturation stress" is a term proposed to describe potential American Indian identity development. As American Indian individuals face demands to integrate into and identify with a different, more dominant culture, they may begin to lose or perhaps devalue their historical traditions. This leads to what is termed deculturation stress (Mail, 1989). The idea is an outgrowth of research addressing the phenomena labeled historical unresolved grief and loss. This theory posits that due to the massive losses of lives, land, and culture from European contact and colonization American Indians have experienced a long legacy of chronic trauma, loss, and unresolved grief. These factors and the contemporary exposure to traumatic events are believed to influence current emotional status and identity development. This historically rooted notion is a direct legacy of the resulting self-inflicted or internalized racism that began in assimilation policies and boarding schools. It is believed that these experiences influence American Indians in an

intergenerational manner. Furthermore, these factors are believed to contribute to the current high rates of suicide, homicide, violence, child abuse, alcoholism, and social problems observed among American Indian people (Brave Heart & DeBruyn, 1998).

A tragic legacy of the boarding school era remains the fact that entire generations of Native Americans were deprived of living with their own families during their childhoods. This lasting legacy of historically pervasive trauma could be that later exposure to traumatic experiences encountered could be affected. Possible "kindling" or sensitization effects to stress could result because of inadequately developed coping skills. In addition, many American Indians were prevented from learning from their own parents how to be a parent themselves. American Indians were deprived of role models crucial to the development of positive ethnic identities due to forced removal and historical exposure to trauma, genocide, and forced assimilation programs (Brave Heart & DeBruyn, 1998).

Adolescence is a particularly difficult developmental period for most people to navigate this is particularly true for Native American adolescents. One of the main tasks of development is the formation of a personal identity or self-schemata. According to LaFromboise and Howard-Pitney (1990), American Indian adolescents are further challenged by (1) acculturation pressures; (2) poverty, which limits hope for the present and future; (3) the multigenerational effects of alcoholism; and the (4) frequent occurrence of deaths in the family and community. All of these factors can make it more difficult for the development of positive self-referent schemas and may negatively impact self-esteem. Research done on self-esteem and alienation done with American Indian adolescents suggest that they have more negative views of themselves than the norm for

Non-Indian teens (U. S. Congress, OTA, 1990). In a governmental review of the developmental status, American Indian adolescents were found to characterized themselves as friendly, helpful, easy-going, but not as being particularly smart, strong, or good looking (Development Associates, 1983). American Indian children may be more susceptible to developing negative self-concepts and feelings.

The most vulnerable among the tribes may be children and women. Duran (2004) found that 77% of American Indian respondents surveyed reported having had a history of abuse or neglect. Sixty-three percent of the respondents surveyed reported having experienced neglect, and of those respondents nearly 90% were also physically and/or sexually abused. In an urban sample, Saylors and Daliparthy (2004) found that 89% of American Indian women seeking substance abuse treatment at an urban clinic reported a lifetime history of physical abuse and 69% reported a history of sexual abuse.

Nationwide American Indian women are 50% more likely to be the victim of a violent crime that the next highest ethnic group, African American men (U.S. Commission on Civil Rights, 2003). American Indians are twice more likely to be victimized than all other U.S. citizens (U.S. Department of Justice, 1999). American Indians are also more likely to be victimized by members of other racial backgrounds and this has been attributed to the inadequately funded Tribal Law Enforcement. American Indians are also incarcerated at a higher rate than other ethnic groups and are estimated to have an incarceration rate that is 38% higher than the national rate (U.S. Department of Justice, 1999).

Despite the clear need for effective health care services for American Indian communities and families, the U.S. Commission on Civil Rights (2003) identified access

to healthcare as a primary barriers and the commission also highlighted the current inadequacies in available health care, mental health care, educational, personal safety, and economic opportunities.

Only 23% of American Indians have private insurance and 55% rely upon Indian Health Services for all health care needs. Indian Health Services is one among several federal agencies identified to have federal funding that is insufficient to meet the multiple unmet basic needs identified as healthcare, education, housing, rural development, and public safety (U.S. Commission on Civil Rights, 2003). American Indians made significantly fewer visits to physician's offices (54 visits per 100,000 American Indians compared with 293 visits per 100,000 Whites) and more visits to emergency rooms than other groups (U.S. Census Bureau, 2001). In a review of Indian Health Services, the Commission of Civil Rights concluded that "The unmet healthcare needs for American Indians remain among the most severe of any group in the United States" (p. 42.) Federal prisoners and Medicaid recipients receive twice the amount of federal funding than American Indians (U.S. DHHS, 2003).

Another factor lies within the nature of Western healthcare systems and the empirical basis for so called "Evidence Based Practices." As Gone & Alcantara (2006) review, some of the factors possibly confounding the identification of best practices for American Indian health care. In the area of psychopathology and psychotherapy the amount of scientific knowledge of cross-cultural differences in pathology, definitions of illness and wellness, definitions healers, expectancies, preferences in therapy, treatment application, and treatment outcome is questionable given the serious lack of empirical research within these realms (Zane, Nagayama Hall, Sue, Young, & Nunez, 2004).

Indeed the authors identified the lack of information about psychotherapeutic outcome a "serious problem" (pp. 779). Psychological and medical inquiry systems are based upon, and arguably biased by, western philosophies, ideologies, and scientific methodologies. As a result, western healthcare and mental healthcare applications is similarly biased to western ideas of illness, wellness, diagnosis, and treatment.

One issue that is particularly evident is the western emphasis upon internal validity, which is the hypothesized scientific strength of a particular research methodology. Internal validity is generally understood to be improved when particular controls are implemented within research. Some of these controls are the homogeneity of the research sample (i.e. same socioeconomic background, same diagnosis, no comorbidity, and a controlled research environment.) However, as Sue (1999) highlighted internal validity is often emphasized to the extent that the generalizability of research findings if often overlooked within psychological research. This factor combined with the inadequate funding of research results in the inhibited growth and development of ethnic minority research and practice. Iwamasa and Smith (1996) found that only 1.3% of articles in three psychopathology and psychotherapy research journals focused on ethnic minority groups. Graham found that only 3.6% of articles published between 1970 and 1989 analyzed race and included African Americans. The National Committee on Vital and Health Statistics (2003) concluded that data collection for American Indians and Alaska Natives is "seriously inadequate."

Comas-Dias (2000) eloquently described the racial "cold war" in the United States when examining the effects of oppression, racism, and political oppression on individuals groups and societies. She notes that Jungian psychology tends to represent

people of color as "the darker and evil side of personality," and that Jung (1957) observed that the "shadow" was represented by Black or Native people for his American patients. She described a novel ethnopolitical theory which also characterized the "post colonization stress disorder" that many members of ethnic minorities experience due to facing racism and cultural imperialism. The bias in psychological research is inherent throughout, Sue and colleagues (1999) wrote:

> *Euro-American psychologists are likely to perceive their worldview as normative, and as a result these biases may be reflected in criteria used to judge normality, abnormality, standards of practice, and codes of ethics.*

Science is "a way to know things" (Sue 1999) and currently psychology is in its infancy in terms of its ability to know things in differential or pluralistic ways. These authors have described the bias inherent in American psychology as monoculturalistic and termed it the "invisible whiteness of being." Native Americans have struggled through a history of genocide, forced assimilation, forced sterilization, and even the removal of the right to parent their own children.

Cultural Resiliency: Roots of survival

Surviving this history has not occurred without substantial costs. However, cultural resiliency is also inherent within the history of Native peoples. This history is deeply rooted within traditional practices, ceremonies, languages, spirituality, and healing methods. Jones, Dauphinais, Sack, and Somervell (1997) proposed that, due to the poverty, unpredictability, disruption, and overall more frequent experiences with environmental stressors, Native Americans sampled may be experiencing the exposure to trauma as less "outside the range of usual human experience. It may be that the chronic

nature of trauma occurring in Native American communities result in some subsyndromal PTSD symptoms, but to reduce the relevant processes to this characterization would be a mistake. It is clearly evident that American Indian individuals and communities have demonstrated a considerable amount of resiliency.

Some of the outcomes resulting from historical antecedents have unquestionably led to the significant levels of diverse risk factors facing American Indian people as individuals and as tribal entities. Philip May (1987) found that Indian communities with the highest rates of rapid change and acculturation stress generally had the highest rates of suicides. Van Winkle and May (1986) also found that acculturated tribes had the highest rates of suicide. More traditional American Indian tribes had the lowest and transitional tribes had intermediate rates. This speaks to the potential important presence of protective cultural factors and challenges historical assumptions that assimilation produces positive outcomes. Adolescence is a time in which young people are sometimes desperately attempting to form an identity and are faced with many difficult choices. It follows that Indian youth seem to be the group most severely impacted by acculturation stress.

Cultural resiliency is a descriptive term proposed to denote the psychosocial factors and processes that promote adaptively resilient reintegration and coping within American Indian populations (see Belcourt-Dittloff & Schuldberg, 2006). Cultural differences are slowly beginning to be accepted as the rule rather than the exception within contemporary psychological research. Researchers are currently working within diverse cultural groups in efforts to unravel the complexities inherent in cross-cultural

psychological and psychopathological functioning in the hope that healthcare practices can be improved for the benefit of patients and practitioners alike.

Garroutte et. al. (2003) recently reviewed data from a comprehensive cross – sectional sample of 1456 American Indians and found that individuals with higher levels of cultural spiritual orientation (as measured by an index of spiritual orientation) had a reduced prevalence of suicide attempts compared with individuals with lower levels of cultural spiritual orientation. In addition, the researchers found that commitment to cultural spirituality was significantly related to a reduction in suicide attempts.

Acculturation is viewed to represent the extent to which an American Indian individual identifies with his or her Tribal Culture, worldview, and beliefs. Five basic levels of acculturation have been identified for American Indians (Garrett & Herring, 2001; Little Soldier, 1985). The levels include (a) Traditional, (b) Marginal, (c) Bicultural, (d) Assimilated, and (e) Pan-traditional. Traditional individuals are believed to speak primarily their native language and to practice traditional customs and beliefs. Marginal individuals may be bilingual or not and are believed to be fully committed to either their Native culture or to mainstream culture. Bicultural individuals are generally accepted by the dominant society and in their Tribal culture this group is generally knowledgeable about both cultures. Assimilated individuals generally are accepted by mainstream society and embrace only mainstream cultural values and practices. Finally, "Pan-traditional" individuals may not have been raised in Tribal based culture however subsequently adopt and learn about the culture and its practices of other Tribal cultures; however, they may also only participate in "pan-traditional" practices such as pow-wows or even more Tribally based ceremonial practices (such as sweat lodges and other

ceremonies.) Cultural displacement and erosion of historical ceremonial practices can also be an unintentional byproduct of some of the participation of "pan-traditional" practices. Bicultural individuals are believed to display higher levels of resiliency and a stronger sense of themselves, unlike marginal individuals who are believed to be the most likely to experience cultural conflict and difficulties. In fact, Little Soldier (1985) says that marginal individuals are often in a state of conflict with regard to cultural affiliation and this state of conflict often leads to significant problems and potentially serious identity crises.

Recent research findings and reviews have clearly highlighted the emerging trend of increasing rates of disordered eating patterns and symptoms in Native American populations. Specifically, Crago, Shisslak, and Estes (1996) found eating disturbances to be more common among Native Americans when compared to Caucasian, Black, Hispanic, and Asian American females. They found that the risk factors for eating disorders were found to be more prevalent among minority females who were young, heavier, more educated, and more strongly identified with majority group and middle class values.

The authors reviewed four studies in reaching their conclusions regarding eating disturbances and behaviors in Native American females. Rosen and colleagues (1988) surveyed 85 Chippewa women and girls living on or near a reservation in Michigan and found that 74% were trying to lose weight and 75% were using one or more pathogenic weight control methods. These methods included purging (25%), diet pills (41%), and prolonged fasting (33%). They also found that the heavier females were most likely to use these methods. Similarly, Smith and Krejci (1991) surveyed 129 Native American

adolescents in New Mexico and found that Native Americans (particularly heavier individuals) scored higher than Caucasian and Hispanic peers on two measures of eating disorders. In addition, Snow and Harris (1989) found that increased weight was associated with more disturbed eating patterns in 51 Native American girls in New Mexico and that 8% of their sample met the diagnostic criteria for bulimia nervosa. They also found that 88% worried about being too fat, 43% fasted for extended periods, and 53% engage in binge eating episodes. Yates (1989) also reported that anorexia nervosa among Navajo girls in Arizona occurred most frequently in girls who had moved off the reservation and had "upwardly mobile" families.

Cultural Resiliency New Pathways to Healing

The word resiliency describes Native North Americans. They have had to adapt over and over. They laugh, smile, and joke even though they come from generational alcoholism, poverty, violence, and many other hardships. They bounce back from trauma with resilience. They endure. They are tolerant, even though they get no justice in life. I believe the creator is carrying them. He knows what they have been thru. He hears their sorrows and prayers.
(American Indian Research Participant, Belcourt-Dittloff & Schuldberg, 2006)

Historically, Native Americans were diverse hunter-gatherer societies who relied upon the natural environment for sustenance. Traditional diets were high in protein and fat and low in complex carbohydrates. Native Americans held traditional views with regard to food and these views were reflected in their ceremonial practices and spiritual beliefs. Among the Blackfeet, bison were the central food source and the bison therefore held great importance in terms of ceremonial centrality. In fact, the medicine lodge, which is the most important ceremony for the Blackfeet, revolves around bison. Percy Bullchild, a tribal elder, said that bison provided the food, clothing, shelter. Therefore,

bison were revered ceremonially and bison skulls and most importantly the buffalo tongue used as the host or sacrament of the medicine lodge (Bullchild, 1985). Because the survival of Native American groups was so intricately linked to the animals and resources in the environment many Native Peoples held distinctly different views of their world and ecological landscape. Many Natives held beliefs that all living (and non-living things) had "souls" or were animated, this belief allowed the hunt or harvest to be viewed in the context of a social relationship (Bullchild, 1985). In this world-view there would then be no conceptualization of "good or bad" foods.

It has been over five hundred years since Europeans have begun to colonize the Americas. This process of contact and colonization has led to many radical changes for Native Americans. These changes continue to impact the way many American Indians live their daily lives, interact with others, cope with loss, and work toward future goals.

At the heart of the issue of contemporary healing for American Indians lies the question of spirituality and culture. Goodluck (2002) recently adopted a strength-based perspective in attempting to identify possible well-being indicators specifically relevant to Native Americans. In reviewing 22 psychological publications (descriptive, quantitative, and qualitative) by both Native and Non-Native authors, she identified 24 Native American strengths. The themes of these strengths included the power of the group or communal interdependency and support, spirituality and related ceremonial participation, humor, cultural identity, political relationships and factors (i.e. political involvement, activism, and affiliation), language and stories, tribal values, children, education, and the land or environment. Other authors (Belcourt-Dittloff & Schuldberg, 2006; Buchwald, Beals, & Manson, 2000; Cross, 1995, Walters, & Simoni, 2002;

Marbella et. al., 1998) have begun to highlight the empirical and clinical importance of spirituality within traditional healing methods.

In a large urban American Indian sample (N = 869), Buchwald, Beals, and Manson (2000) found that 70% of the sample used traditional health practices and 52% reportedly felt that this use significantly improved their health. In a reservation sample of Northern Plains community college students (N = 164), Belcourt-Dittloff and Schuldberg (2006) found that culture, hope, communal mastery, and spirituality were all significantly related to ratings of psychosocial status and adaptive coping following exposure to stressors and/or traumatic events. Subsequently, factors that promote adaptive coping following exposure to traumatic or stressful events within American Indian communities are believed to represent cultural resiliency factors.

American Indians have the right to access adequate health care and to give voice to their own truths, to ask their own questions, and to find the most effective healing methods. Recently (2002) the APA published guidelines on multicultural education, research, practice, and organizational change. It encourages psychologists to have cultural awareness of themselves and others and to foster the spirit of multicultural prioritization throughout psychological research and practice. It directly quotes Comas-Diaz (2000) who writes that, "Psychologists are uniquely able to promote racial equity and social justice. This is aided by their awareness of their impact on others and the influence of their personal and professional roles in society." In order to eliminate the current health disparities and research disparities federal, state, and academic agencies can begin by adopting and adhering to these guidelines in the full spirit of each of the principles.

The kind of research and clinical practice needed on underrepresented groups includes the entire spectrum of psychological scientific and applied study particularly clinical psychology. This should include scientific investigations of cross-cultural and cross-tribal differences in pathology, wellness, personality, as well as applied studies of treatment outcome and differential application matters. In distinguishing between what types of research should and should not be conducted I believe that research that helps to increase the holistic understanding of both members of minority groups as individuals and as members of larger communities should be prioritized. This includes both applied clinical studies of outcome and theoretical understandings of pathology, etiology, course, development, and inherent cross-cultural differences.

Future Directions: Promising approaches

Currently, attempts are beginning to be made at the levels of a tribal individual members and communities to advance the understanding and fostering of resiliency among Native Americans. This resurgence has taken the form of revitalization of traditional Native American languages, ceremonial practices, religions, cultural practices, healing strategies, and mentorship programs, and these have occurred throughout Indian Country. Numerous applied projects have emerged aiming to promote health and wellness within American Indian Communities (Anderson, Belcourt, & Langwell, 2005). This is a common programmatic effort seen in many tribal communities today (e.g., Blackfeet, Salish, Kootenai, Crow, and Navajo).

Prominent American Indians have also joined this struggle for health and wellness. N. Scott Momaday, a Pulitzer-prize winning Indian author, has established the

Buffalo Trust, an elder mentorship program for Indian children, to combat the spiritual degeneration experienced since the time of initial western contact. Language immersion schools have emerged in many tribes, including the Blackfeet and Arapaho. Such schools have increased interest in Native Languages and helped to fuel resurgences of interest in Native American traditional culture. In addition, The Navajo Healing Project is a collaborative effort between Navajo and non-Navajo researchers to improve healthcare by understanding the nature of the therapeutic process in Navajo religious healing (Csordas, 2004).

LaFromboise and Howard-Pitney (1994) have developed a curriculum designed to facilitate psychological resilience to prevent suicide. This curriculum is currently (2006) being implemented within multiple American Indian communities and appears to be a promising psychological intervention. The Circles of Care Initiative (Freeman, Iron cloud-Two Dogs, Novins, & Lemaster, 2004; Thurman, Allen, & Deters, 2004), funded by the Center for Mental Health Services, is designed to research culturally appropriate mental health services models for children with emotional disturbances. Each of these clinical approaches collaborates closely with Tribal communities to develop, research, and assess psychological interventions for American Indians.

Collaborations such as these open up important new avenues for the development of a more effective mental health care system for Native Americans. Thus, the journey has begun toward a better understanding of Native Americans and human kind in general. This journey will hold challenges, in that it will cause the field of psychology to question underlying assumptions that have been held for years about American Indians and American Indian communities as well as challenging some Western views about

psychological reality. Native Americans do deserve to be accorded the fullest respect as human beings in research, practice, and throughout psychology in general. This process has only just begun and will likely be led by the American Indian communities themselves. Providing scientific, clinical, and professional voice to the narratives of American Indian resiliency and hope will provide a psychological science that is more representative and inclusive of all peoples.

The heart and soul of scientific research is the search for the truth. This quest is the soul of research and at the heart of effective health care. Problems facing American Indians are significant and multifaceted. The best practice for American Indians would be for health care providers of all nations and training background, Western and Tribal, to come together and learn from each other. Both sides of this discourse have much to offer towards the alleviation of psychological suffering. As Sue (1999) indicated, "Cost is not an acceptable reason for exclusion of minority groups in scientific inquiry." There is much to be gained for every person.

Human beings of all nations and cultures have long experienced suffering, grief, and loss. Many have been able to rise above, adapt to, and overcome extraordinary traumatic losses. Pain, grief, loss, and trauma are an unfortunate reality for many American Indians today. Harnessing the spirit of Cultural Resiliency through science and practice can provide American Indians with untold renewal and regeneration. Emotional healing through cultural resiliency, hope, and spiritual practices and beliefs holds promise for this growth. Trauma and loss may continue to be a reality facing American Indians daily. Through cultural resilience, communities can heal. Lessons can be learned. Hope can be shared. This is the process of healing and of hope.

One potential proposal to continue to promote community based participatory discourse is for an Inter-Tribal Spiritual Summit to be convened to discuss the topic of integrating Traditional Medicine into Western Medical Models. Currently, plans are being developed to invite spiritual leaders from tribes in the Northwest to discuss issues related to the integration of Traditional Healing Methods into Western Healthcare. Potential discussion items are included below as potential agenda items. The inclusion of spiritual leaders is crucial in the development of innovative pathways toward understanding and healing for American Indians. Clinicians working within an American Indian community or with American Indian clientele would benefit from considering the inclusion of cultural resiliency factors (such as social support, hope, spirituality, communal mastery, enculturation/ethnic pride, and resilient coping strategies) within intervention plans for families and individuals experiencing traumatic losses or stressors. This also provides particularly strong rationale for the inclusion of family and community members in the treatment of American Indians who have experienced traumatic experiences or losses (Attneave, 1989).

One American Indian participant in a recent study on Cultural Resiliency (Belcourt-Dittloff & Schuldberg, 2006) wrote about her experiences of recovery after experiencing years of loss, trauma, and violence. She wrote:

When I finally had had enough we completely split apart. I wanted no more and I also had to think about my children. I didn't want them to see anymore of what I was going through. But, I also had to think about myself. What would my children do if something happened to me? Because they would have no one. Also, I was and still am somebody.

She finished by describing how she and her children held each other up. They inspired each other. They saw and validated the abilities and potential in each other. They helped each other and they loved each other. In the end she went on to explain in writing "I have a future to look forward to, as do my children." It is this spirit of hope, determination, bravery, courage, and ferocious love that creates resilient people and resilient recovery from loss and trauma. It is this spirit that will help American Indian people today and tomorrow. Psychological science would be well served to continue investigating and facilitating resiliency within American Indian communities. Together is where strength lies.

If we have been researched to death, maybe it is time we start researching ourselves back to life."

-Native elder from Alberta,

(Quoted in Castellano, 2004-Ethics of Aboriginal research)

Potential questions for Spiritual Summit:

Should we work to integrate traditional medicine into western medical care for American Indian peoples?

How can the erosion of ceremonial practices be addressed?

How do we define traditional medicine and recognize the importance of specific tribal histories, ceremonies, and rituals?

How can traditional medicine be incorporated into existing methods of treatment or health care?

How do we consider ethical issues of cross cultural applications of traditional medicine?

Who should be at the forefront of this application?

Who would benefit the most from the integration of traditional medicine into western health care?

How can we create sustainable traditional medicine? (i.e. Ceremony apprenticeships, cultural mentorship programs, immersion programs for health, training of health professionals, & research)

Questions for all healthcare providers (traditional, western, and both)

What are the Perceptions and Perceived Barriers of Western Medical?

What are the Perceptions and Perceived Barriers of Indian Health Service?

What Interventions and Tools combining Western Medicine and Traditional Medicine to address Pandemic and Epidemic Problems facing American Indians:

Future areas for consideration of traditional medicine integration:

Violence and Trauma

Culturally based prevention and treatment programs aimed at addressing Intimate partner violence, child abuse & neglect, PTSD

Suicide and Suicide Ideations

Culturally based Prevention and Intervention

Substance Abuse (Prevention, Intervention, and Treatment)

Alcohol, Cocaine, Marijuana, Methamphetamine

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