CASE AND COMMENTARY: PEER-REVIEWED ARTICLE
Trauma-Informed Caring for Native American Patients and Communities Prioritizes Healing, Not Management
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Abstract
Addressing intergenerational trauma remains a public health priority in Native American (NA) communities. Clinicians working with NA patients must express humility, understand local culture, collaborate, and develop an insider’s perspective on NA past and present life in order to earn trust. This case considers an NA adolescent suffering from mental distress, possible substance use, and multiple traumas. The commentary argues that trauma-informed therapies are lacking in some current psychiatric and primary care practices in the Indian Health Service and that an interprofessional, trauma-informed approach that considers the interplay between relevant somatic and psychological factors can better motivate patient-centered care. Cultivating safe environments in which interventions are pursued within the patient-clinician therapeutic alliance is key to generating optimal outcomes and healing among NA patients.

Case
Dr L is a new attending physician in an Indian Health Service (IHS) facility on the Colorado River Indian Reservation who has an interest in serving minoritized communities with few resources in the United States. Dr L is introduced to JM, a 16-year-old who lives on the reservation. JM was brought to an emergency department (ED) last weekend after an apparent narcotic overdose and sees Dr L for follow-up. JM’s blood pressure is slightly elevated at 145/90 mm Hg. Dr L asks about JM’s family, with whom they interact only minimally.

Substance abuse on the reservation has resulted in many adolescents’ deaths in recent years. Dr L observes that JM has developed dysfunctional ways of coping with abundant stress, sources of which include having few resources and enduring grief over ancestral losses of land, status, and sense of a future. She also worries that JM might have tried to commit suicide last weekend and might try again.

Dr L wonders how to follow up.
Commentary

Over the course of the last century, anthropologists and mental health experts have seen their roles evolve when working with and within First Nation communities (used interchangeably with all Indigenous peoples) in North America. Psychiatrists, who were initially part of the colonial apparatus and diagnosed mental illnesses using first Freudian and then Western-based biomedical categories, were often complicit in removing Native peoples from their homes and aiding in their institutionalization at boarding schools and asylums.1,2

During the early 1900s and into the 1960s, anthropologists in the United States engaged in “salvage ethnography,”3 often treating Aboriginal communities as laboratories and as an opportunity “to study” non-Western forms of kinship, social structure, and healing or medical techniques. Native cultures were thought to be at risk of Westernization, forced assimilation, and ethnocide through missionary and government practices. Anthropologists framed Native life as a vanishing artifact that should be preserved through monographs and museum displays, rightly drawing the ire of Native American activists in the 1960s and 1970s,4,5 which initiated a robust critique and reflexive examination of ethnographic practices that continue today.6,7

Fortunately, anthropology has a more recent tradition of engaging with mental health diagnosis and treatment cross-culturally8,9,10,11,12 and examining the experience of trauma more critically.13 During the last several decades, anthropologists and mental health experts have shifted from seeing Indigenous peoples as study subjects to seeing them as community partners and working collaboratively to ameliorate Indigenous people’s mental distress and myriad traumas through innovative approaches and models of care.14

In the spirit of collaboration, we comment on this hypothetical case of JM and the mental well-being and treatment of Native North Americans more generally. We do this with the understanding that we have some knowledge, experience, and training in specific areas that might help Native peoples and the practitioners who work with them and care for them. Our goal is to help advance a Native-centered, collaborative ethos in the area of mental health and trauma-informed care (TIC).

Towards Clinical and Cultural Humility

Although JM’s case scenario is hypothetical, it is unfortunately typical of both Native and non-Native communities, especially those with limited resources and that are more vulnerable to exploitation by opioid manufacturers.15,16 The stakes are high for young patients and clinicians alike when clinical encounters see the convergence of addiction, mental illness, history of trauma, structural racism, implicit clinician bias, and dysfunctional family dynamics. We would start by suggesting that clinicians proceed with the following questions in mind:

- How should clinicians initiate conversations with traumatized and at-risk adolescent patients from vulnerable populations?
- How should historical trauma be accounted for in terms of treatment as well as building individual and community trust and a therapeutic alliance?
- What responsibility do clinicians and their teams have to navigate and understand history, culture, and context as these factors relate to everyday diagnosis and treatment of individuals under their care?
When working within a vulnerable community, all caregivers—especially those from outside that community or with little experience or ethnographic knowledge of that community—must take a deliberate step back and start to build their cultural competencies and knowledge, developing, as a first step, cultural humility (an ongoing, life-long process) based on cultural awareness. Cultural humility toward the people we work with is always an unfinished project. However, the goals of cultural humility in the medical context are concrete in the sense that clinicians strive to emphasize and put into action concepts such as diagnostic openness. Building cultural humility must be deliberate and can be difficult because of time constraints, yet it remains an essential responsibility.

The IHS facility described here, a tribal center or a local clinic, will have at least some people from the community working at various levels, from practitioners to staff. Assuming that Dr L is a non-Native clinician, we would ask: Has she worked to meet local people and sincerely introduce herself to the community and clinical staff prior to meeting a patient like JM? Has she made the effort to reach out to local leaders via letter or email to more formally introduce herself, outlining what kind of medicine she practices and, of particular importance, why she wants to work within this community? Has she pursued understanding of how local institutions, such as health care, tribal governance, schools, social services, and law enforcement, operate? Has she visited a local cultural or historical center while on rotation? Clinicians should also seriously consider attending community events and gatherings, eating at local restaurants, or attending public ceremonies, such as powwows, even as an unobtrusive observer or casual participant. Finally, where has Dr L decided to live—within or near the community?

Of particular importance would be to seek out and meet the known healers and other respected figures within the community or surrounding area. The case presented here is a good reminder of the complexity of Native populations. The Colorado River Indian Tribal (CRIT) Reservation has over 4000 members and 4 distinct Native tribes with unique histories and cultures: Mohave, Chemehuevi, Hopi, and Navajo. Which tribe does JM and his family identify with? There will definitely be elders, medicine persons, mentors, and peer support specialists within each group whom a clinician should work to connect with and learn from. How are these specialists engaging with people when treating trauma, substance use disorders, mental illness, and so on? What kinds of practices (eg, initiation rites, fasting, and sweats) have shown efficacy within the community as alternatives to, or in synergy with, prescription medication and Western forms of care? For example, it was not uncommon for elders in Manitoba, with whom the first author (M.J.O) worked, to recommend sweat lodge ceremonies (with Aboriginal naming rites) and psychiatric care with antidepressants for young persons in distress. Has Dr L been able to observe and explore IHS clinic culture before entering practice, locating what some ethicists describe as “moral spaces” that are quiet and private and help to foster health agency for patients like JM who need to have sensitive conversations? These actions would create the kind of diagnostic openness that fosters trust with patients and the community, because other forms of knowing are actively being recognized and embraced.

Finally, we would stress how clinicians can develop a deeper understanding of Native life and culture by engaging with the literature. There is an emergent historiography of the River Basin and the resources of the Human Relations Area Files can be utilized to gain understanding of specific cultural practices and their history. Additionally,
perhaps one of medical anthropology’s most important contributions to clinical care is the reflexive awareness that poverty and pathological processes can be conflated (and confused) with culture. For example, researchers have documented how entire communities can be categorized as “sick” by overemphasizing epidemiological data on particular diseases or disabilities like type 2 diabetes. Clinicians then stress individual responsibility and medical compliance rather than stepping back to understand how dispossession of ancestral lands, economic factors, and structural violence have led to the lack of a healthy diet and reliance on processed foods. Dr L’s continuous learning would establish a baseline of cultural awareness of the CRIT community, thereby preventing her from pathologizing and racializing culture(s) and enabling her to practice cultural humility during clinical exchanges. As a result, Dr L would develop an ethnographic mindset, a cultural insider’s perspective (in anthropological terms), or, in a clinical sense, epistemic humility in embracing different ways of knowing.

Collaboration
In terms of the immediate care of a legal minor, Dr L must find a way of collaborating with him and his family that can ensure relationship building and trust. Older models, stressing medical compliance and mental health management by one clinician have been replaced with interprofessional models of Native care. This model stresses a patient-centered approach wherein the patient or family is part of the team (both theoretically and in practice), helping to make care decisions with other health and social care specialists. The information a patient and family can provide is now considered essential for everything—from making a culturally informed diagnosis to understanding the impact of social determinants and adverse childhood experiences (ACEs) on morbidity and mortality—and, in particular, for making TIC decisions.

JM’s perceived estrangement from his family and general sense of alienation will make establishing initial rapport a challenge, albeit a critically important one. Making JM feel comfortable during that first meeting is going to hinge on the answers to several questions: Is there any family member or trusted adult or guardian available whom JM wants (and should have) with him during the visit? Is language translation a factor in his care? Can Dr L (or a member of the clinic team) administer appropriate assessments during the initial visit and follow-up appointments in ways that are not overly stressful? It would be of the utmost importance for JM not to feel overwhelmed by the assessment process, and therefore only suicidal ideation would be assessed initially and an accompanying safety plan developed. Moreover, because of JM’s complex history of possible drug overdose and the spike of adolescent deaths recently in his community, the team will need to determine if a higher, more immediate level of care is required (whether in-patient treatment or intensive day treatment). After the suicide assessment and JM’s eventual stabilization, we would recommend that the clinic use the following types of tools administered ideally over the span of several sessions: a social determinants survey (with a family member), the ACE survey, Beck’s Depression Inventory, and clinic protocols for brief interventions, assessments, and referrals of adolescents with suspected opioid use disorder.

Before these assessments can be made, however, Dr L essentially has one opportunity to build enough trust and rapport with JM to ensure productive and meaningful follow-up visits. First impressions matter in terms of compassion and showing one cares about the person (vs the data), with continuity of care a close second (ie, patients having one clinician or team and telling their story only one time). A study on vulnerable HIV patients in the United Kingdom found that trust was built and patient anxiety reduced at the first
visit through 5 actions being taken: “1) provide reassurance to patients, 2) tell patients it’s okay to ask questions, 3) show patients their lab [survey and assessment] results and explain what they mean, 4) avoid language and behaviors that are judgmental of patients, and 5) ask patients what they want (i.e., treatment goals and preferences).” This kind of approach to JM would allow for the long-term work of healing to take place and help establish trust for a young patient who may be estranged from his family.

**Trauma-Informed Healing**

We argue that the practice of TIC by clinicians within First Nation communities should be guided by a deep understanding of embodied trauma. Embodiment as a concept has a long history in anthropology, and contemporary TIC has worked to fully integrate the body into treatment planning, techniques, and psychotherapy. The impact of intergenerational trauma is an everyday reality within Native communities. First Nation families are often one generation away from the forced removal of children from homes to attend boarding schools in the United States and Canada (the last of which closed in Canada in 1996). There are rich sources on TIC, and practicing clinicians should routinely review tools such as the “Trauma-Informed Care Fact Sheet” (TICFS) by the Substance Abuse and Mental Health Services Administration and National Indian Child Welfare Association, which are essential starting points. JM may have embodied the convergence of all 4 forms of trauma outlined by the TICFS—cultural, historical, intergenerational, and current.

Peer support for JM and expertise in TIC are critically important to JM’s healing. Dr L and the care team must be careful not to inadvertently retraumatize the patient in the first or subsequent interview sessions so that the chance of successful therapeutic alliance is enhanced instead of thwarted. TIC ethically mandates that individuals receive care in a safe, compassionate, and collaborative environment that seeks to build upon both the strengths and the resiliency of the individual seeking care. With this in mind, in subsequent treatment, it would be helpful to consider appropriating modalities used in psychotherapy, such as somatic and polyvagal strategies. Somatic modalities (e.g., Levin’s body-oriented techniques and Dana’s polyvagal exercises) help to calm and regulate the nervous system. Using basic techniques like “grounding” through simple breathing exercises (e.g., box breathing), breath map exercises, and sensing the body-boundary or body as a container helps patients like JM feel safe and learn to self-regulate. Nurturing a sense of calm and well-being helps create an environment and conditions that are less threatening and more receptive for treatment. Furthermore, any strategy should include a TIC treatment plan, which aims to ensure that an individual has been able to establish basic coping skills that they can use in order to remain grounded and present when processing aspects of their traumatic experiences. Once coping skills are in place (e.g., self-regulation) and somatic interventions are routinely practiced, a safe environment can be established so that an individual, such as JM, is able to accept and receive other forms of treatment necessary for the long-term processes of healing to occur.

**Discussion**

First Nation peoples, like other historically oppressed groups, such as African Americans, have experienced centuries of marginalization through the tactics and techniques of settler colonialism and exploitative and racialized capitalism. Native Americans continue to face some of the same problems, such as police violence and gendered violence against women, as other vulnerable communities. Nevertheless, Native Americans live, work, and continue to heal in vibrant communities that over the last several
decades have witnessed a revitalization of culture and language. Psychotherapists and anthropologists often have the luxury of time when building rapport, trust, and long-term relationships with the people they work with. Clinical encounters today, where the stakes can be extremely high for patients like JM, are not structured for this kind of relationship building. However, there are novel, emergent, and historically sound ways to build healing relationships with communities in need of trauma-informed approaches to care that would benefit patients and clinicians alike. Interprofessional collaboration with empathy and openness is foundational in this regard, with the patient, family, and caregiver being key members of and contributors to the team— their voice(s) and their ways of knowing must matter.

We emphasize that clinicians must understand the body through a trauma-informed lens. Clinical training and medical school teaching has begun to rethink the physical examination through this approach, while assessing its impact on practice and learning. Moreover, we advocate for daily collaboration, whether in person or through the electronic medical record, between practicing primary care specialists and mental health experts, such as social workers, psychologists, addiction specialists, and clinical counselors, as well as peer supporters, all of whom are advancing TIC and body-informed healing ahead of medicinal practice.

Mental health care itself can be marginalized when the care of a patient is referred out to specialists, who in turn may not communicate with clinicians on a regular basis because of the logistics of modern medicine (eg, different electronic medical records or health organizations). There remains a curious siloing of mental health care, wherein psychiatrists and primary care clinicians continue to prescribe robust levels of psychotropic medication while relegating more complex psychodynamic treatments for patients, such as TIC, to other specialists. Medical anthropologists, such as Kleinman, when assessing the state of global mental health resources, have noted the imbalance between overprescribing of psychotropics in White, wealthy countries and communities and the lack of care for serious mental health issues in poorer, more marginalized countries and communities. Ironically, it is the nonpharmacologically based clinicians who have brought the traumatized body back into focus for biomedicine by listening to their patients and advancing TIC. Complex patients like JM, who embody and live with myriad forms of trauma, must receive safe, Native-centered care in a trauma-informed clinical environment with appropriate resources. Healing will depend on effective collaborations, diagnostic openness, and clinical humility that provide an opening (or opportunity) for patients to trust that the care they receive can lead to a more meaningful and healthy life.

References


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