

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

**Trauma-Informed Caring for Native American Patients and Communities
Prioritizes Healing, Not Management**

Michael J. Oldani, PhD, MS and Deidre Prosen, MFA, MS

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-culturally^{8,9,10,11,12} 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.^{17,18} 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*.¹⁹ 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.²⁰ 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 Basin²¹ and the resources of the Human Relations Area Files²² 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.²³ 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.²⁴ 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.^{25,26} 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)²⁷ and enabling her to practice cultural humility during clinical exchanges.²⁸ 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.¹⁹

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.^{29,30} 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),³¹ the ACE survey,³² Beck's Depression Inventory,³³ and clinic protocols for brief interventions, assessments, and referrals of adolescents with suspected opioid use disorder.³⁴

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).”³⁵ 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,^{36,37} and contemporary TIC has worked to fully integrate the body into treatment planning, techniques, and psychotherapy.^{38,39,40} The impact of **intergenerational trauma** is an everyday reality within Native communities.²⁷ 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).^{41,42} 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.⁴³ 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.⁴⁰ Somatic modalities (eg, 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 (eg, 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.^{44,45,46} 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,⁴⁷ 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 (eg, 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 violence⁴⁸ and gendered violence against women,⁴⁹ 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.⁵⁰ 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.^{51,52}

We emphasize that clinicians must understand the body through a trauma-informed lens.⁵³ Clinical training and medical school teaching has begun to rethink the physical examination through this approach, while assessing its impact on practice and learning.⁵⁴ 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,⁵⁵ 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.⁸ 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.⁵⁶

References

1. Richards R. The nation's only insane asylum for Indians was in South Dakota. *Indianz*. September 28, 2018. Accessed July 22, 2020. <https://www.indianz.com/News/2018/09/28/the-nations-only-insane-asylum-for-india.asp>
2. US Office of the Surgeon General; Center for Mental Health Services; National Institute of Mental Health. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General*. Substance Abuse and Mental Health Services Administration; 2001:chap 4.
3. Gruber JW. Ethnographic salvage and the shaping of anthropology. *Am Anthropol*. 1970;72(6):1289-1299.

4. Deloria V. *Custer Died for Your Sins: An Indian Manifesto*. University of Oklahoma Press; 1969.
5. Deloria V. *Red Earth, White Lies: Native Americans and the Myth of Scientific Fact*. Fulcrum Press; 1997.
6. Gone J. Introduction: mental health discourse as Western cultural proselytization. *Ethos*. 2008;36(3):310-315.
7. Starn O. Here come the anthros (again): the strange marriage of anthropology and Native America. *Cult Anthropol*. 2011;26(2):179-204.
8. Kleinman A. *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*. University of California Press; 1981.
9. Young A. *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton University Press; 1995.
10. Biehl J. Vita: life in a zone of social abandonment. *Soc Text*. 2001;19(3):131-149.
11. Martin E. *Bipolar Expeditions: Mania and Depression in American Culture*. Princeton University Press; 2009.
12. Kitanaka J. *Depression in Japan: Psychiatric Cures for a Society in Distress*. Princeton University Press; 2011.
13. Lester R. Back from the edge of existence: a critical anthropology of trauma. *Transcult Psychiatry*. 2013;50(5):753-762.
14. Hinton DE, Kirmayer LJ. Local responses to trauma: symptom, affect, and healing. *Transcult Psychiatry*. 2013;50(5):607-621.
15. Hoffman J. In opioid battle, Cherokee want their day in tribal court. *New York Times*. December 17, 2017. Accessed July 16, 2020. <https://www.nytimes.com/2017/12/17/health/cherokee-opioid-addiction-pharmacies.html>
16. Quinones S. *Dreamland: The True Tales of America's Opiate Epidemic*. Bloomsbury; 2015.
17. Hasbah Roessel M. Working with Indigenous/Native American patients. American Psychiatric Association. Accessed July 7, 2020. <https://www.psychiatry.org/psychiatrists/cultural-competency/education/best-practice-highlights/working-with-native-american-patients>
18. Yeager KA, Bauer-Wu S. Cultural humility: essential foundation for clinical researchers. *Appl Nurs Res*. 2013;26(4):251-256.
19. Stone JR. Cultivating humility and diagnostic openness in clinical judgment. *AMA J Ethics*. 2017;19(10):970-977.
20. Oldani MJ. *Filling Scripts: A Multi-sited Ethnography of Pharmaceutical Sales Practices and Family Life in North America*. Dissertation. Princeton University; 2006.
21. Zappia NA. *Raiders and Traders: The Indigenous World of the Colorado Basin, 1549-1859*. University of North Carolina Press; 2014.
22. Human Relations Area Files website. Accessed July 15, 2020. <https://hraf.yale.edu/>
23. Hansen H, Bourgois P, Drucker E. Pathologizing poverty: new forms of diagnosis, disability, and structural stigma under welfare reform. *Soc Sci Med*. 2014;103:76-83.
24. O'Neil J, Reading J, Leader A. Changing the relations of surveillance: the development of a discourse of resistance in Aboriginal epidemiology. *Hum Organ*. 1998;57(2):230-237.

25. Farmer P. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. University of California Press; 2003.
26. Kidder T. *Mountains Beyond Mountains: The Quest of Dr Paul Farmer, A Man Who Would Cure the World*. Random House; 2003.
27. Oldani MJ. Uncanny scripts: understanding pharmaceutical emplotment in the Aboriginal context. *Transcult Psychiatry*. 2009;46(1):131-156.
28. Chang ES, Simon M, Dong X. Integrating cultural humility into health care professional education and training. *Adv Health Sci Educ Theory Pract*. 2012;17(2):269-278.
29. Association of American Medical Colleges. Reshaping the journey: American Indians and Alaska Natives in medicine. Johns Hopkins Medicine. October 2018. Accessed July 1, 2009.
https://www.hopkinsmedicine.org/diversity/_documents/aamc-reshaping-the-journey.pdf
30. Goodrich DE, Kilbourne AM, Nord KM, Bauer MS. Mental health collaborative care and its role in primary care settings. *Curr Psychiatry Rep*. 2013;15(8):383.
31. SDOH and practice improvement. Agency for Healthcare Research and Quality. January 2020. Reviewed October 2020. Accessed July 15, 2020.
<https://www.ahrq.gov/sdoh/practice-improvement.html>
32. National Crittenden Foundation. The Adverse Childhood Experiences (ACES) Survey: a toolkit for providers. Accessed February 3, 2021.
https://www.acesconnection.com/g/Parenting-with-ACEs/fileSendAction/fcType/5/fcOid/431258360817204230/fodoid/431258360817204229/ACEs_Toolkit.pdf
33. Beck Depression Inventory (BDI). American Psychological Association. January 2011. Updated June 2020. Accessed August 1, 2020.
<https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/beck-depression>
34. Levy SJL, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics*. 2016;138(1):e20161211.
35. Dang BN, Westbrook RA, Njue SM, Giordano TP. Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study. *BMC Med Educ*. 2017;17(1):32.
36. Scheper-Hughes N, Lock MM. The mindful body: a prolegomenon to future work in medical anthropology. *Med Anthropol Q*. 1987;1(1):6-41.
37. Csordas TJ. Embodiment as a paradigm for anthropology. *Ethos*. 1990;18(1):5-47.
38. Van der Kolk B. *The Body Keeps Score: Brain, Mind, and Body in the Healing of Trauma*. Penguin Books; 2015.
39. Dana D. *The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation*. W.W. Norton; 2018.
40. Levine P. *Healing Trauma: A Pioneering Program for Restoring the Wisdom of Your Body*. Sounds True; 2012.
41. Smithsonian National Museum of the American Indian. Boarding schools. In: *Code Talkers*. Accessed July 20, 2020.
<https://americanindian.si.edu/nk360/code-talkers/boarding-schools>
42. Miller JR. Residential schools in Canada. Canadian Encyclopedia. October 10, 2012. Updated September 2, 2020. Accessed February 3, 2021.
<https://www.thecanadianencyclopedia.ca/en/article/residential-schools>

43. Trauma-informed care fact sheet. National Indian Child Welfare Association. April 2014. Accessed July 10, 2020. https://www.nicwa.org/wp-content/uploads/2016/11/2014_TraumaInformedCare_FactSheet.pdf
44. Dana D. *Polyvagal Exercises for Safety and Connection: 50 Client-Centered Practices*. W.W. Norton; 2020.
45. What is square breathing? *Anahana Wellness* blog. Accessed January 3, 2021. <https://www.anahana.com/wellness-blog/breathing/square-breathing>
46. Levine P. Treating Trauma: 2 Ways to Help Clients Feel Safe. National Institute for the Clinical Application of Behavioral Medicine. YouTube. June 2, 2017. Accessed January 3, 2021. <https://www.youtube.com/channel/UCK2LkP7IgOsRoADQ7v8tCcw>
47. Substance Abuse and Mental Health Services Administration. *Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol Series 57*. HHS publication SMA 13-4801. Accessed February 3, 2021. <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf>
48. Porter K. Chief beaten by police is longtime fighter for Native rights. *New York Times*. June 28, 2020. Accessed July 7, 2020. <https://www.nytimes.com/2020/06/28/world/canada/allan-adam-indigenous-alberta.html>
49. Violence against women. National Congress of American Indians. Accessed July 7, 2020. <http://www.ncai.org/policy-issues/tribal-governance/public-safety-and-justice/violence-against-women>
50. Brockie T. Building a trauma-informed tribal nation. Keynote address presented at: Federal Partners Committee on Women and Trauma; September 29-30, 2015; Sacramento, CA.
51. Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL, eds. *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*. Jossey-Bass; 1993.
52. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press; 2001.
53. Menakem R. *My Grandmother's Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies*. Central Recovery Press; 2017.
54. Elisseou S, Puranam S, Nandi M. A novel, trauma-informed physical examination curriculum for first-year medical students. *MedEdPORTAL*. 2019;15:10799.
55. Luhrmann T. *Of Two Minds: An Anthropologist Looks at American Psychiatry*. Vintage Books/Random House; 2001.
56. Menschner C, Maul A. Issue brief: key ingredients for successful trauma-informed care implementation. Center for Health Care Strategies; Robert Wood Johnson Foundation. April 2016. Accessed July 21, 2020. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Michael J. Oldani, PhD, MS is a medical anthropologist and professor of pharmaceutical sciences and administration as well as the director of Interprofessional Practice and Education at Concordia University Wisconsin in Mequon. He has worked with Aboriginal communities in Manitoba, Canada, and Wisconsin in the areas of mental health, psychotropic prescribing, and Indigenous healing processes, and his scholarly work has focused on the intersection of pharmaceutical sales and marketing, psychiatry, and vulnerable populations.

Deidre Prosen, MFA, MS is a licensed professional counselor in Shorewood, Wisconsin, specializing in psychotherapy through psychodynamic, trauma-informed, and

somatic/bodily care approaches to treatment. Part of her training took place at the Healing Center in Milwaukee, Wisconsin, which provides advocacy, free access, and culturally appropriate care for survivors of sexual abuse.

Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2021;23(6):E446-455.

DOI

10.1001/amajethics.2021.446.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.