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On Spirituality and Mental Health Care Manageability in an Urban American Indian Community: A Decolonized Methodological Praxis

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Author
Chacon, Valerie

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Dr.
Department of

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Dr. Richard Cardullo, Howard H Hays Jr. Chair, University Honors

Abstract

Introduction

Methods of treating the most frequent mental health care concerns for those that seek mental health care management in the American Indian[1] community (AIC), including Western mental health care treatment models and ways that American Indian identity is integrated into treatment should be examined for effectiveness. Because the manner in which those in the AIC rate their mental health status can differ from dominant standards, the ways that American Indian culture is integrated into effective care should be assessed. Adapting Western models of mental health care treatment in ways that integrate American Indian cultural identity is important because of differing factors of wellness. On personal agency versus communal acclimation, a study by Sato (1998, p. 278) shows mental health care outcomes are affected by differences between Western individualistic society and collectivist society views. This study holds that in cultures outside of Western mental health perspectives, collectivist community approaches require incorporating oneself with the environment, where in Western individualistic culture, individuality and environmental dominance is paramount (p. 279-280).

A variety of key metrics inform health care trajectories of individuals who cull their beliefs from traditional cultural practices, spiritual beliefs, and contemporary standards and base objectives on an amalgamation of these ideals. Some determining characterizations of good mental health outcomes in the AIC have been outlined in regard to American Indian views on overall health. In one study on indicators of American Indian wellness, those in the community reporting good health did so over four aspects of wellbeing including mental, emotional, physical, and spiritual health (Hodge & Nandy, 2011, p. 792). Those reporting within the poor

[1] The designations "American Indian," "Native American," "Indian," "Indigenous," and "Native" are used here interchangeably and are used by modern Native and non-Native scholars alike. These terms may vary in their frequency of use historically (Nagel, 1996, p. xi).

health group experienced suicidal ideation at 29% where the good health group reported suicidal ideation at 17% (p. 795).

Reports on mental health diagnoses from rural, tribal-specific, and urban intertribal populations have shown anywhere from 70-80% of mental health care-seeking American Indian men qualify for Diagnostic and Statistical Manual- IV[2] (DSM-IV) lifetime disorders (Beals, & Manson 2005, p. 100; Brave Heart & Lewis-Fernández, 2016, p. 1033; Gone & Trimble, 2012, p. 140). The same reports found treatment-seeking American Indian women have a 37-63% rate of qualification for DSM-IV lifetime diagnoses. A 2002 study by the National Epidemiological Survey on Alcohol and Related Conditions, found 62% of non-Hispanic white men and 53% of non-Hispanic white women seeking mental health care treatment were eligible for DSM-IV lifetime diagnoses (as cited in Brave Heart & Lewis-Fernández, 2016, p. 1033). These numbers mark a significant divergence in American Indian mental health statuses from that of the general population, showing the importance of addressing this community and identifying any distinctions that may contribute to mental wellness.

The majority of studies on mental health care and the American Indian community (AIC) focus on highly limited population samples that are mostly tribal or rural based (p.1041). Tribal and rural-specific investigations allow for researchers to highlight the diversity of the AIC and publish comparative findings. However, pursuing effective mental health care treatment is urgent for the AIC in urban areas because of the likelihood of American Indians to live off-reservation and away from rural areas. For instance, a 2005 study by Beals et al. on DSM-IV disorders found posttraumatic stress disorder, depression, anxiety, and substance abuse were the most common

[2] The DSM-IV is the fourth edition of the Diagnostic and Statistical Manual released by the American Psychiatric Association in 1994. The DSM-IV is used by clinicians to uniformly classify mental disorders (Maniacci, 2002, p. 356.) The DSM-IV was revised in 2000 as the DSM-IV-TR, text revision and was updated in 2013 as the DSM-V, to reflect adjustments in diagnostic criteria (First & Pincus, 2002, p. 288; Highlights of Changes, 2013, p. 525)

concerns reported by those seeking mental health care treatment in two Southwestern American Indian reservation communities. Studies like these are important because they characterize mental health conditions in tribal specific ways. However, 78% of the overall AIC reside in urban areas, away from American Indian reservations and rural areas (US Census Bureau, 2011) where Indian identity is varied. A 2016 analysis of the most frequent mental health diagnoses and the AIC included a 60% sample of respondents residing in urban areas and 40% living in reservations or rural areas (Brave Heart et al., p. 1041), mirroring more accurately American Indian life. It is important to further this kind of examination and focus on the AIC when detailing mental health care concerns and what presents as effective in urban areas.

Because of the likelihood of diagnostic qualification for mental health disorders in the AIC, further examination would benefit from shifting sample populations accordingly. These differences in the overall research place importance on examining ways that American Indian mental health care treatment-seeking urban populations achieve good mental health care manageability. Because Native peoples have been shown to rate their overall health according to their collectivist connection associated with cultural identity and measure spiritual health as part of general wellness, the ways that cultural identity and spirituality factor in to mental health care manageability should be examined. When routine Western contemporary mental health care methods are employed, those seeking care in the AIC can find their cultural identities go unaddressed. However, this is a community that experiences suicide at twice the US rate and a substance abuse rate higher than any other population group 12 years of age and older (Bender, 2006, p. 6). Suicide was the second most common cause of death for Native Americans in all age groups in 2004 and death as a result of suicide among young people in the AIC between ten and fourteen years old was twice the US average at 13.5% (Sahota & Kastelic, 2014, pp. 78-79). A

closer look at this community reveals that finding effective methods that address this community in ways that recognize its distinct characteristics are vital to achieving good mental health outcomes in the AIC.

Method

I am a member of the Pechanga Band of Luiseño Indians located in the Temecula Valley in what is currently known as California. As Lakota philosopher and scholar, Vine Deloria, Jr. explained, "the fundamental factor that keeps Indians and non-Indians from communicating is that they are speaking about two entirely different perceptions of the world" (cited in Buckmiller, 2013, p. 7). My position as part of the AIC may result in more direct communication between Indian health care providers and Indian mental health care seeking individuals.

I believe that too many times Native peoples are studied using in ways that produce analyses that theorize Native peoples as singular abstractions. This study is based on interviews conducted with one mental health care provider that identifies as American Indian, and one that identifies as Indigenous. I also interviewed two American Indian identifying community members that are receiving mental health care treatment. The purpose of these interviews is to find how some people in the urban AIC in San Bernardino and San Diego Counties define, incorporate, and rate spirituality as a tool in treating mental health disorders, in an attempt to highlight and honor individuality and humanity of the participants of this study. All interviewees shared what they think about spirituality as an approach to treating mental health care diagnoses and offered their opinions on how spirituality and American Indian identity factors into mental health care management. The conclusion of this study will also offer some suggestions for non-Native mental health care providers working with the AIC. Sample questions for interviewees are provided here as two separate appendixes. Some of the quotes presented here are edited for brevity.

Analysis

Spirituality as a mental health care factor

On November 20, 2018, I talked to Julie Andrews, member of the Sicangu Band of Lakota Indians and licensed clinical social worker at Riverside-San Bernardino Indian Health Inc., in Grand Terrace, California. Andrews works at the Native American Resource Center (NARC) where she works to educate the AIC about available services and non-Native service providers on cultural competency. Andrews argues trauma experienced by the Native population is best repaired in ways that recognize cultural identity saying, “For Indian people, for us to be able to recognize that spirituality is a part of who we are and it's not necessarily something that we're taught, I think that that idea of spirituality and mental health treatment is so important for our communities to be able to heal.” Andrews continued, holding that some of the main disorders presenting in the AIC are a result of collective trauma. Andrews said, “We’re talking about historical trauma, which is the root of all evil for Indian people. Genocide, historical trauma, violence; those things are ongoing in our communities.” Andrews went on to describe these conditions as “soul wounds” and believes without addressing historical trauma still playing out in the AIC, manageability of mental health disorders will be difficult to achieve saying, “We’re not going to get there like that, and so many of our people don’t even know our history. But when you talk about it with people they are like ‘that makes so much sense, why my family does things my family does.’”

Andrews also talked about the importance of mental health care providers to have spiritual conceptions of their own. Andrews said, “I think that people that don't have it, it makes it harder to be able to make that connection. The way that mental health is taught in school lacks that level of spirituality, right? We talk about the whole person, but we don't know how to do

that spiritual piece. I think that's why if people already started laying that groundwork of creating a relationship of seeing the importance of spiritual recovery as part of who they are, that makes it easier to transition. The provider has to be on that path themselves of spiritual recovery in order to give that to their client."

Incorporating spirituality in treatment

Post-traumatic stress disorder, PTSD, is viewed as the "umbrella disorder" causing or aggravating mood and addiction disorders most commonly presented by members of mental health care treatment seeking members of the AIC (Gray & Nye, p. 73). On April 12, 2019, I interviewed Margie Anderson, an Indigenous identifying mental health care worker at the San Diego American Indian Health Center in San Diego, California. Anderson works with the urban AIC as a substance abuse counselor and discussed how she incorporates spirituality in mental health care treatment in the AIC. Anderson said of her clientele, "Some of them are still connected to going to church. Some of them are still connected to their own practices, which don't include sweat ceremony. Maybe it's a tobacco ceremony or something like that. So, we encourage ourselves to share about our wellness and if it's including our culture, if it is going to sweat lodge, if it is going to a pipe ceremony, if it is going to the Native American church or other churches, that's all positive because we're seeking wellness." Anderson said she starts with the understanding that though spiritual practice may be important in mental health care treatment in the AIC, each person should be addressed at an individual level first. Anderson said, "So for each individual it's going to be different. They can have family members too, that go to sweat and then they'll be the one to go to the Native American church. However that person feels good on that journey that that's feeding them."

General mental health is affected when a patient struggles with drug dependence and alcohol abuse. One study found that 70% of individuals seeking mental health care treatment from Indian Health Services[3], struggle with drug dependence and alcohol abuse (cited by Gray & Nye, 2001, p. 75). Anderson talked about how she incorporates Native spirituality in treating these concerns. Anderson said, "What I provide here as the substance abuse counselor, we call relapse prevention, but it's focused on the four directions, the emotional, mental, physical, and spiritual. So we work on balance, but we also encourage us to be who we are. Not to be afraid of being who we are, what is in our bloodline. So there's a lot of laughter that comes out of that room, which we considered that part healthy medicine for us, to help keep us socializing." For Anderson, participation in cultural activities, helps build community, an act that Anderson views as spiritual.

Spirituality and manageability

On November 24, 2018 I talked to a mental health care seeking member of the AIC that wished to go only by the name Joe. Joe has been participating in traditional spirituality to treat his mental health condition successfully for over two years. Joe talked about the problem of communication with mental health ideologies and the limitations of the English language when trying to describe his recovery from drug and alcohol addiction. Joe said, "How would you put words to something you always asked for? From a Red Tail or an Eagle and asked, 'bless me with a feather,' and one day you walk out your front door and see an Eagle feather. That's my spirituality. I bless myself with that feather to say thank you for my recovery and just being here." Joe offered that the spiritual aspect to his recovery is directly tied to the success of his

[3] "The Indian Health Service, an agency within the US Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives" (IHS.gov. n.d.).

recovery. I asked Joe about the difference between his spiritual practices that aid in his recovery and Western modalities of treatment that he rejects like therapy and medications. Joe connected why he thinks conventional Western treatment does not work for him with the idea of being Indigenous, belonging, and achieving long-term wellness and what they both have to offer to him. Joe explained, “It’s like you have a home. Everybody else has a house. A house is meant to be occupied, not to be adored, loved, cherished. But a home, you care, you believe, you participate, you become one; you feel, I feel, you hurt, I hurt.” To Joe, he stressed the importance of finding a place he felt he belonged. I asked Joe about his experience with contemporary mental health care treatment. He shared about a difference in communication style saying, “if you look at Indian country in relation to how to speak; you say it with a few words. To say anymore would be, ‘you're lying to me. You're trying to make yourself good.’ That's it.” Anderson talked about this difference describing a care group that she facilitates that can be viewed by Western practitioners as a version of cognitive behavioral therapy. Anderson shared, “There’s definitely some CBT going on, but I'm not one to use those big words for our community. How do we understand each other? How do we connect, is the language that is being spoken here.” Andrews also believes that appreciating the differences in the AIC and recognizing the shortcomings of Western approaches to care are important saying, “I know we’re putting Band-Aids on bullet wounds.” Andrews continued, “Mental health wants you to be in resiliency right now. We are resilient people, we wouldn’t still be here if we weren’t but, you have to help a person to be able to recognize that they have the capacity to heal despite devastation. You have it in you to survive. We have to bring the sacred into the room with every encounter.”

Spirituality in mental health care and the urban Indian community

Because spirituality is stressed when it comes to effective treatment of mental health diagnoses in the AIC, the way that spirituality looks for urban Indians is important to pursue. On November 30, 2018, I interviewed Cheyanne, a mental health care-seeking member of the AIC about her experience with mental health care as an urban Indian. Cheyanne has been struggling to achieve mental health manageability for five years. She said of the intertribal nature of the urban AIC, “I struggle sometimes with that. You know, you see a lot of mixed-tribe spirituality and I wonder if that is right for any one of us sometimes. But, there’s more of you in town, people like you, Indians trying to get better. Hopefully then, you can go back home and help out there, because there’s no way, you go home and help people in town. People there don’t want to listen to you, but at home on the reservation, people see what you do, and I really think that helps them out.”

Urban Indians are a mixed population from many Native American communities with a variety of tribal specific spiritual practices. I asked Joe about intertribal spirituality in mental health care treatment and how spiritual practices are shared in urban Indian communities. Joe explained, “It’s like prison, you do what you have to to survive.” Andrews holds a similar view saying “For me, I think it’s personal. As a Native person, that hurt that our people carry, the reality is, we’re related to each other, right?” Anderson concurred when discussing intertribal spirituality and treatment saying, “I think it's really important for us as Native people to not get lost out there and to circle back to help each other. That's the most important thing. Practicing healthy things for our people. There's nothing wrong with gathering together and to go in there and be a part of.”

Seeking and accessing care

One barrier for people in the AIC to addressing their mental health care concerns is the comfort level regarding seeking care. Creating a safe environment for mental health care treatment seeking members of the AIC for Native and non-Native care providers is another challenge to finding effective mental health care models. Andrews currently works at NARC under a grant program with the San Bernardino County Department of Behavioral Health to reduce the stigma of accessing mental health services within the AIC. Andrews attributes the stigma associated with seeking mental health care in the AIC to the paradox of Native identity which she associates with a factor in wellness saying, "I think that stigma of mental health comes from that lack of trust for those outside services." Andrews also believes community members may also feel exposed by seeking help from Indian Health Services saying, "my cousin works there, my sister works there, my family goes there' and so there's a hesitancy to access services." However, Indian health care institutions often utilize culturally oriented health services in behavioral health treatment that are spiritual in nature. Andrews sees this as an important aspect of care in the AIC. In order to diminish the stigma of seeking care, and what Andrews calls "internalized shame," Andrews thinks that it is important to not only address the AIC on mental health care access, but to also educate non-Indian care providers in order to build better relations between the two communities and foster better experiences for mental health care treatment seeking American Indians.

Andrews said that American Indians can face misunderstandings with "outside services" early on in care-seeking experiences. Andrews shared, "I had a client that I referred to them, (a non-Indian treatment facility) and this provider said 'well, let the Indians pay for it. They have a lot of money,' and how ignorant is that?" Andrews says it is important that non-Native service

providers know that, “not all of us have money, not all of us have insurance.” One non-Native therapist with experience in treating the AIC said that the identity of care providers may not be as important in fostering good experiences with care-seeking American Indians as much as it is important to be, “skilled, kind, empathetic, and professional” (Gray &Nye, 2001, p. 75).

Conclusion

The high-risk status for mental health disorders in the AIC may be aggravated by the hesitancy people in the AIC can have in seeking care. Julie Andrews shared that she believes educating AIC on accessing mental health care is just as important as educating non-Native health care providers on the AIC. In terms of non-Indian care providers, Andrews suggests, "Humility. As a provider, if I know my own culture, I can respect that I'm never going to know everything about your culture, but I can have humility in that." Andrews also recommend that non-Indian mental health care providers actively engage clients about their backgrounds saying they, "should be asking if they're (clients) Native Americans because we have services that are available to help. Native people a lot of times seek Native services."

A difference in communication style between care seeking individuals in the AIC and non-Indian care providers can be alleviated when the initially ambiguous nature of Native identity is addressed. Both Andrews and Margie Anderson suggested that mental health care providers ask about a person's connection to their community as a starting point for care. Anderson also makes herself available to non-Native service providers in offering suggestions and solutions to service providers outside of the AIC. Anderson said of a non-Native service provider in San Diego, "We had an incident here where they were trying to reach out to an Inuit family but they were using Navajo traditional ways. And I said, 'well, they won't know what you're talking about. There'll be a disconnect there.' So it's important to bring the family in and ask. It's okay to ask. It's okay to have that conversation. It will make them feel more comfortable, more heard and a feeling that there's care for if them here."

Treatment models that highlight holistic ideals of American Indian culture stress integration of the individual with the community thereby positively affecting both patient and

their environment in ways that heal communities as well as the individual (Legha & Novins, 2012, p. 686). It is important to evaluate ways that mental health care treatment-seeking members of the AIC react to these approaches. The AIC, as global citizens with access to both Western and traditional methods of care, should be asked about their experiences with utilizing both methods. Andrews notes, "We have people that have been on anti-anxiety medication forever, like their whole adult life. But we have to bring the prayer. We got to teach our young people. We have to sing the songs. We have to practice the ceremonies. Because we're prayerful people, right?" The pan-Indian nature of the urban Indian community means that integrating intertribal cultural tools like spiritual practices and community building, with contemporary mental health care treatments like therapy and medications in the AIC, is important to successfully treating care-seeking individuals with mental health disorders in this community.

Limitations

The definition of spirituality is often presented here as a general term describing American Indian cultural methods of care such as talking circles, sweat lodge, and other sacred ceremonies experienced on a communal level. Other times, it is described as a personal experience with things like prayer or practicing abstinence from substances as a spiritual practice. Because of the ambiguous nature of this term, further examination on what may result in the best care outcomes should be explored. Further, the individual care clients interviewed are talking about their experiences with mental health care wellness, having experienced some success for two years or less. Examples from those in the AIC with more long-term experience should be assessed.

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Appendix A

Questions for American Indian Mental Health Care Providers on Spirituality as a Factor in Mental Health Care Manageability for Urban American Indians

1. How do you think cultural identity factors into mental health for Native people?

2. How do you describe spirituality in terms of how it applies to Native American mental health care, if at all?

3. How do you think people benefit from intertribal spiritual practices? How do you think people benefit from tribal specific practices?

4. How does spirituality effect mental health manageability in the community?

5. Are there any spiritual practices that you think are especially important for treatment seeking people in the community?

Appendix B

Questions for American Indian Mental Health Care Clients on Spirituality and Mental Health Care Manageability

1. What kind of mental health care treatment are you seeking?

2. What motivated you to try to get mental health care?

3. What do you find most effective in treating your condition?

4. Do you participate in any cultural activities to improve your mental health condition?

5. What do you think about non-Indian mental service providers?

6. What do you think about Indian mental health services providers?

7. What is it like being an urban Indian in mental health care treatment?

References

Beals, J., Manson, S. M., Whitesell, N. R., Spicer, P., Novins, D. K., & Mitchell, C. M. (2005). Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. *Archives of General Psychiatry*, *62*(1), 99–108. https://doi.org/10.1001/archpsyc.62.1.99

Bender, E. (2006). APA, AACAP suggest ways to reduce high suicide rates in Native Americans. *Psychiatric News*, *41*(12), 6. https://doi.org/10.1176/pn.41.12.0006a

Brave Heart, M. Y. H., Lewis-Fernández, R., Beals, J., Hasin, D. S., Sugaya, L., Wang, S., Blanco, C. (2016). Psychiatric disorders and mental health treatment in American Indians and Alaska Natives: results of the National Epidemiologic Survey on Alcohol and Related Conditions. *Social Psychiatry and Psychiatric Epidemiology*, *51*(7), 1033–1046. https://doi.org/10.1007/s00127-016-1225-4

Buckmiller, T. M., & Cramer, R. A. (2013). A conceptual framework for non-native instructors who teach adult Native American students at the university. *Multicultural Learning and Teaching, 8*(1), 7-26. http://dx.doi.org/10.1515/mlt-2012-0009

First, M. B., & Pincus, H. A. (2002). Impact on clinical practice rationale for the DSM-IV text revision objectives of the DSM-IV text revision, *Psychiatric Services 53(3).* 288-292.

Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology, 8(1),* 131-160. https://doi.org/10.1146/annurev-clinpsy-032511-143127

Gray, N., & Nye, P. S. (2001). American Indian and Alaska Native substance abuse: Co-morbidity and cultural issues. *American Indian and Alaska Native Mental Health Research (Online), 10*(2), 67-84.

Highlights of Changes From DSM-IV to DSM-5. (2013). *Diagnostic and Statistical Manual of Mental Disorders*. American Psychiatric Association. https://doi.org/doi:10.1176/appi.books.9780890425596.changes

Hodge, F. S., & Nandy, K. (2011). Predictors of wellness and American Indians. *Journal of Health Care for the Poor and Underserved*, *22*(3), 791–803. https://doi.org/10.1353/hpu.2011.0093

Indian Health Service. (n.d.) https://www.ihs.gov/aboutihs/

Legha, R. K., & Novins, D. (2012). The role of culture in substance abuse treatment programs for American Indian and Alaska Native communities. *Psychiatric Services*, *63*(7), 686–692. https://doi.org/10.1176/appi.ps.201100399

Nagel, J. (1996). American Indian ethnic renewal: Red power and the resurgence of identity and culture. New York: Oxford University Press.

Maniacci, M.P. (2002). The DSM and individual psychology: A general comparison. *Journal of Individual Psychology,* 58(4), 356-362.

Sahota, P. C. & Kastelic, S. (2014). Tribally based suicide prevention programs: a review of current approaches. *Wicazo Sa Review* 29(1), 77-99. University of Minnesota Press.

Sato, T. (1998). Agency and communion: the relationship between therapy and culture. *Cultural Diversity and Mental Health*, *4*(4), 278–290. https://doi.org/10.1037/1099-9809.4.4.278

US Census Bureau (2011). Overview of race and Hispanic origin: 2010. Unites States Census 2010, Washington. http://www.cencsus.gov/prod/cen2010/briefs/c2010br-02.pdf.

Westermeyer, J. (2001). Alcoholism and co-morbid psychiatric disorders among American Indians. *American Indian and Alaska Native Mental Health Research. 10*(2), 27-51.