Traditional Healing & Suicide Prevention in Native American Communities:

Research & Policy Considerations

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Background & Significance

In February, 2006, the National Institute of Mental Health, the Indian Health Service, and the Substance Abuse and Mental Health Services Administration partnered with the Division of Behavioral Health, Health Canada and the Canadian Institutes of Health, Institute of Aboriginal Peoples' Health to sponsor an international conference in Albuquerque, New Mexico, concerning indigenous suicide prevention programming and research in the United States, the U.S. Territories, and Canada. The goal of the conference was for the roughly 200 invited participants to collectively formulate a research and program policy agenda for redressing the disproportionately high rates of suicide in Native North American communities.[1] Recommendations from conference participants spanned four interrelated domains: research, funding, health policy, and community initiatives. One resounding emphasis throughout these recommendations was the need for "cultural healing" to be pursued through "cultural best practices," based upon "cultural knowledge." The inclusion (and remuneration) of "traditional healers" in suicide prevention research and programming was one explicit recommendation. Subsequent to this meeting, the National Institute of Mental Health (NIMH) began planning a series of smaller-scale follow-up meetings designed to explore these recommendations in more detail. This report was commissioned to assist NIMH personnel in planning such a meeting dedicated to consideration of the possibilities for including Native American traditional healing in suicide prevention research. As such, we will here attempt to raise provocative questions about the integration of traditional healing within such efforts as one means to stimulate productive contemplation and vigorous discussion of this complicated matter.

There can be no doubt that suicide remains the scourge of "Indian country" (Alcántara & Gone, in press; Olson & Wahab, 2006). Although the prevalence of suicide varies widely between communities in Native North America (May & Van Winkle, 1994; Olson & Wahab, 2006), surveillance of suicide across these settings persistently yields overall rates far in excess of those for mainstream America. Reservation-based Native American adolescents in particular—and especially adolescent males in these communities—seem especially vulnerable to suicide. And yet, efforts to prevent suicide must grapple with the simple reality that suicidal behaviors themselves may be too far "downstream" in terms of unfolding life events to represent truly adequate points of intervention. Instead, suicide prevention must target risk factors and behaviors—Olson & Wahab (2006) list prior suicide attempts, family disruptions, cultural

identity loss, religious disaffiliation, and alcohol involvement as Native-specific predictors—that in most instances are unlikely to result in actual suicide. That is, because suicide remains such a low-base-rate phenomenon (even in Native communities), these psychological and behavioral predispositions in most circumstances will not actually lead an individual to this most aberrant of outcomes: taking his or her own life. As a result, programmatic efforts to prevent suicide in Indian country will typically need to target "broad-based antecedent conditions" rather than specific "pathogenic" developmental pathways that have not been shown to reliably result in suicide (Felner & Felner, 1989; Gone & Alcántara, in press). Not surprisingly, then, many suicide prevention programs in Native communities somewhat paradoxically target other forms of vulnerability and distress: substance involvement, depression, hopelessness, low self-esteem, identity confusion, and individual legacies of violence and abuse (Middlebrook, LeMaster, Beals, Novins, & Manson, 2001).

In the most recent review of the scientific literature regarding suicide prevention programs for Native American communities, Middlebrook et al. (2001) identified nine programs described in the published literature. Five of these were explicitly designed to curb Native youth suicide rates in their respective communities, while the remaining programs included suicide prevention as one of several targeted goals. As these authors acknowledged, however, almost none of the published studies included adequate descriptions of the actual intervention techniques employed or the procedures used (if any) to assess outcomes. The one exception to these conclusions was LaFromboise and Howard-Pitney's (1995) school-based suicide prevention program implemented and evaluated in collaboration with the Zuni Pueblo (for a summary and evaluation, see Gone & Alcántara, in press). Although each of these interventions emphasized the importance of cultural identity, continuity, and practice, none appeared to directly incorporate or assess the specific activities of traditional healers as part of the respective intervention effort. Nevertheless, the routine assumption (and ever-increasing assertion) by community-members that traditional healing may be more effective than conventional mental health interventions for the prevention of Native American suicide would seem to suggest an effective, but untapped, indigenous resource for combating the scourge of Indian country.

Reviewing the Literature

In order to survey the published literature concerning Native American traditional healing in relationship to suicide prevention programming and research, four computerized databases

(PubMed, PsychInfo, Social Sciences Citation Index, and the Native Health Research Database) were queried using terms meant to circumscribe the concepts "Native American" and "traditional healing" (among the variations used were the terms American Indian, Native, Indians, healing, traditional medicine, Native medicine, Native healing, folk medicine, and alternative medicine— we did not use the term "indigenous," as this refers to sundry peoples around the globe). Obviously, this search strategy cast a rather wide net, and so abstracts for the hundreds of articles identified in this manner were perused for any possible relevance to suicide prevention. Nearly 130 articles and chapters were collected for more thorough inspection, and of these, 68 were classified for purposes of broad contextualization and discussion (see Appendix).

It is important to recognize at the outset that no citations were identified that directly addressed the use of traditional healing per se to prevent suicide in Indian country. Moreover, no detailed descriptions of specific forms of traditional healing as provided to Native patients in health or mental health programs or service settings were discovered. Furthermore, no assessment of outcomes for traditional healing in Native communities for any health condition or concern was identified in this manner.[2] As a result, the citations classified in the Appendix all bear on the question of traditional healing's potential for suicide prevention research and programming in merely an oblique way. Clearly, to the degree that Native American traditional healing might find greater understanding, acceptance, and even legitimacy in health research, policy, and practice through inclusion in scholarly publication, additional research (variable-analytic or interpretive) would seem to be imperative.

Nevertheless, several articles and chapters were identified as possessing at least tangential relevance for the questions at hand (note, however, that we did not include the larger body of literature addressing cultural competency as opposed to traditional healing in health care, nor did we include freestanding descriptions of traditional healing that did not engage mental health or health care in some fashion). The most relevant of these appear under headings one through four in the Appendix. More specifically, under heading one, *Approaches to Suicide Prevention with Native Communities,* Thurman, Plested, Edwards, Foley, and Burnside (2003) described a theory-based approach known as the "community readiness model" that is tailored for the development and implementation of Native community-based preventive interventions targeting suicide or other social problems. Under heading two in the appendix, *Protective Effects of Traditional Activities Vis-à-Vis Suicide,* Crofoot (2002) and Pharris, Resnick, and Blum

(1997) provided assessments of traditional understandings and activities (but not traditional healing per se) that constitute protective factors against Native youth suicide. Under heading three in the appendix, *Mental Health Benefits of Traditional Healing,* Jilek (1974), Milne and Howard (2000), Mohatt and Varvin (1998), and Storck, Csordas, and Strauss (2000) all described tribally-distinctive healing practices in careful detail, often with reference to case studies in which these activities were impressionistically understood to have positively impacted the mental health status (but not suicidality) of particular community members (albeit outside of health-related programs and services). Finally, under heading four in the appendix, *Collaborations Between Mental Health Professionals and Traditional Healers,* Attneave (1974), Bergman (1973), Kahn et al. (1988), and Meketon (1983) all referenced collaborations between traditional healers and mental health professionals in the context of health care services, but none of these citations provided explicit details about the nature of the included healing activities, evaluation of healing-related therapeutic outcomes, or the bureaucratic arrangements through which healers were incorporated programmatically. It is important to note, however, that Scurfield (1995) offered perhaps the best description of any such collaboration in the context of a Veteran's-Administration-supported PTSD treatment program that included culture-specific additions in the form of sweatlodge ceremonies and powwow participation. It remains debatable, of course, whether the sweatlodge and powwow qualify as traditional healing per se[3]—Scurfield does not explicitly characterize the sweatlodge component of the program as "traditional healing" and refers to knowledgeable Native consultants as "spiritual leaders" rather than "traditional healers."

Beyond these four categories, additional literature testifies to the cultural dilemmas raised by certain kinds of traditional healing (heading five, *Cultural Dilemmas in Mental Health Service Delivery*). For example, Navajo healing ceremonies for epileptic seizures, grounded in local beliefs that such illness was the consequence for immoral sexual behavior, were deemed ineffective at best and possibly even harmful for afflicted patients (Levy, Neutra, & Parker, 1979). Beyond this, the literature is consistent in reporting relatively high use by Native American respondents of traditional healing for mental health problems (heading six, *Service Utilization for Mental Health Problems*) as well as general health problems (heading seven, *Service Utilization for General Health Problems*). Several citations described culturally-grounded approaches to Native wellness in general (heading eight, *Traditional Approaches to*

Wellness), Native mental health service alternatives (heading nine, *Culturally-Grounded Mental Health Service Alternatives*), Native human services alternatives (heading ten, *Culturally-Grounded Human Service Alternatives*), and community-based "healing" efforts (heading eleven, *Community-based Healing Projects*)—none of these discuss or describe specific traditional healing practices as such. The remainder of the literature concerned general overviews of Native American traditional healing (heading twelve, *Select Overviews of Traditional Healing*), comparisons of traditional healing and Western medicine (heading thirteen, *Comparisons of Traditional & Western Medicine*), descriptions of the interface between traditional practices and Western health care (heading fourteen, *Interface of Traditional Practice & Western Health Care*), reports of medical professionals and institutions engaged in dual roles and relationships relative to traditional healing (heading fifteen, *Dual Medical Roles & Relationships*), and critical analyses of traditional healing (heading sixteen, *Critical Analyses of Traditional Healing*).

Despite this body of cursorily-related scholarship, it is important to recognize what we could *not* find in the literature pertaining to Native American traditional healing and suicide prevention. We could not identify through this review any Native suicide prevention efforts that explicitly incorporated traditional healing practices within their program activities. We could not identify through this review even one detailed description of the kinds of collaboration (e.g., referral mechanisms, diagnostic practices, ritual descriptions, compensation schedules, outcome evaluations, and so forth) between traditional healers and reservation health care systems that have been mentioned in passing in published commentaries for decades (see Attneave, 1974). We could not identify through this review a single instance of a controlled outcome assessment for a specific form of Native American traditional healing administered to some subset of patients for a clearly designated problem. In fact, the only instances of any Native American traditional healing practices being assessed at all in terms of their therapeutic effects were brought to our attention outside of the database searches proper (P. A. May, personal communication, November 9, 2006).

More specifically, Gossage and his colleagues have assessed therapeutic outcomes pertaining to sweatlodge participation by Navajo inmates in the Window Rock jail (Gossage et al., 2003) and therapeutic outcomes pertaining to Peacemaking ceremonies for Navajo substance abuse treatment outpatient clients (Gossage, Alexius, Monaghan-Geernaert, & May, 2004). In

neither instance were the studies designed to afford confident inferences concerning cause-and-effect relationships between the traditional interventions and therapeutic outcomes (i.e., the designs were not controlled, the participants were not randomly assigned to treatment, nor were the measures especially refined), but pre- and post-treatment measures indicated some positive results, with others only approaching statistical significance. In any case, the primary contribution of these studies to the literature is simply their demonstration that, under the right conditions, Native American ceremonial or ritual interventions can be assessed in terms of therapeutic outcome. Nevertheless, the integration of Native American traditional healing into suicide prevention research and programming will presumably require a great deal more analytic attention to the potentially divergent cultural "discourses" that comprise modern medical and traditional therapeutic approaches respectively.

Contrasting Modern Medical & Traditional Therapeutic Discourses

The overarching challenges confronting the integration of traditional healing efforts and contemporary health care practices in Native American communities are the formidable divergences in epistemology and discourse that structure indigenous healing traditions and modern health care respectively (for much of what follows in this section, we are generally indebted, in no particular order, to Anderson, 2001; Bird-David, 1999; Darnell, 1981; Hallowell, 1955, 1976; and Morrison, 2000). It is by now a cliché in the literature to enumerate a laundry list of dichotomous cultural contrasts in order to illustrate these differences (see heading thirteen in the Appendix; see also chapter ten of Waldram, 2004, for a critical review). The most important of these remain worthy of careful attention, however, as conscientious consideration will make evident the potentially profound obstacles to achieving therapeutic integration. Such obstacles originate in the philosophical legacy of the Enlightenment and the subsequent advent of modernity, in which hope for humanity was rekindled by secular humanism and the instrumental sciences in the face of a progressive disintegration of age-old structures of authority and tradition. That is, cultural divergences between traditional healing and modern medicine can be located across this philosophical divide with evident implications for present-day efforts toward integration. In the context of this sweeping historical transformation, then, we suggest here that the three most important cultural contrasts to keep in mind in regard to these distinctive therapeutic discourses are an interrelated set of differentiations, namely *secular-sacred*, *rational-mystical*, and *technical-relational* divergences respectively.

The most obvious cultural contrast between modern medical and indigenous therapeutic practices is that contemporary medicine embraces a *secular* epistemology while traditional healing requires a *sacred* cosmology. That is, modern medicine assumes that therapeutic knowledge and practice are essentially dependent on naturalistic understandings and materialist explanations of the human body. Thorough knowledge of these domains (e.g., physiology, histology, biochemistry, and so forth) is thus prerequisite to becoming a physician, and scientific proficiency in the investigation of these domains is required for the generation of innovative medical knowledge. Such innovative knowledge thus emerges from publicly-vetted and skeptically-scrutinized advances in naturalistic understanding and materialist explanation regarding how both normal and pathological bodies function in predictable, deterministic, and universal terms. In this view of the therapeutic endeavor, secular, public, vetted knowledge fuels endless optimism for the possibility of medical progress.

In contrast, traditional healing assumes that therapeutic knowledge and practices are essentially dependent on revealed understandings and religious explanations of the human condition. Thorough knowledge of ritual mediation and ceremonial supplication (in the context of potentially dangerous interactions with Powerful other-than-human Persons) is thus prerequisite to becoming a healer, and apprenticed instruction in the nuances of religious practice as it illuminates diagnosis and treatment of individual dysfunction leads to the historical reproduction of these traditions. Relatively idiosyncratic configurations of ritual knowledge, however, are gifted to individual healers from specific other-than-human Persons, so epistemological progress over time is neither of interest nor concern. In this view of the therapeutic project, religious, clandestine, and potentially dangerous knowledge requires prudent containment within an exclusive set of circumspect contexts affording appropriate and effective ritual exercise.

One extension of this secular-sacred divergence is a second cultural contrast between modern medical and indigenous therapeutic practices, namely that contemporary medicine participates in a *rational* approach to knowledge while traditional healing invokes a *mystical* approach to understanding. That is, modern medicine assumes that therapeutic knowledge and practice are essentially dependent on the powers of creative and clever human reasoning to define fields of inquiry, identify methods, classify phenomena, deduce principles, infer relationships, and solve what are fundamentally intellectual problems. Few medical experts

would claim, of course, that the *unaided* powers of human reason are independently sufficient for these important tasks, however, as the limits of human rationality have themselves been rationally demonstrated by psychologists, philosophers, and others. As a result, these limited powers of human reason have been augmented by the development of research designs and statistical procedures that control for the fallibilities of human cognition even as they extend the realm of rational human knowing. From the perspective of modern medicine, then, authoritative answers to pressing therapeutic questions will depend less upon compelling anecdote or illuminating illustration and more upon empirical results from systematic, progressive, and rigorous research designs.

In contrast, traditional healing assumes that therapeutic knowledge and practices are essentially dependent on the Powerful activities of other-than human Persons whose motivations and actions remain largely inscrutable to human beings. Knowledge in this context is thus mystical rather than rational in at least two senses. First, the intrinsic or essential nature of other beings—including other humans—is understood to determine their motivations and actions, but this essence cannot easily be known by others owing to the perennial prospects for metamorphosis (whether literal or figurative). In other words, outward appearances can be deceptive (as revealed by innumerable myths in which other-than-human Persons assume a variety of forms to trick others), so tremendous caution in arriving at conclusions about the essential but mysterious natures of others is warranted (and remains evidenced in the use of considerable indirection in speech and non-interference in interaction). Second, the means by which other–than-human Persons exercise Power remain mysterious. That is, the essential nature of Powerful Others happens to include the ability to exercise such Powers by means which can never be rationally understood or mechanistically described by humans. In other words, the workings of Power—even when harnessed by knowledgeable humans entrusted with healing gifts from these Beings—retain ineffable and mysterious qualities. From the perspective of traditional healing, then, authoritative answers to pressing therapeutic questions will depend less on searching intellectual efforts to systematically characterize associated phenomena in rational terms and more on revelatory gifts and partially disclosed understandings that retain an inherent mysticism in which as many questions remain unaddressed as answered (see Gone, 1999, for a case study).

An extension of this rational-mystical divergence yields a final cultural contrast between modern medical and indigenous therapeutic practices, namely that contemporary medicine construes its salutary efforts in *technical* terms while traditional healing construes its salutary efforts in *relational* terms. That is, modern medicine assumes that therapeutic knowledge and practice are essentially dependent on transportable skills, procedures, remedies, and techniques for the assessment and treatment of patients that any competent expert should be able to utilize. Therapeutic efficacy is grounded in mechanistic accounts of pathology or dysfunction whereby causal pathways and etiological processes are circumvented, interrupted, or rehabilitated through expert application of authorized procedure or technique. The entire endeavor depends, of course, on patient presentation for assessment and compliance with treatment, but the efficacy of technical intervention is primarily a function of materialist knowledge of the body rather than the phenomenological subjectivities of either physician or patient.

In contrast, traditional healing assumes that therapeutic knowledge and practice are essentially dependent on *relationships* with more Powerful Others who compassionately share gifts of healing in exchange for respectful offerings and ritual observance. Traditional healing is thus fundamentally concerned with interpersonal interaction extending well beyond the dyadic patient-healer relationship to the necessary inclusion of particular other-than-human Persons, ritual helpers (e.g., drummers and singers), family members, and so forth. Its chief characterization would be *mediation* between vulnerable individuals who suffer and Powerful Beings Who can restore humans to wellness. Therapeutic efficacy becomes a function of interpersonal relations in which strict adherence to ritual protocol by the mediating healer helps to assure a favorable hearing by Those Who are petitioned even as it prevents harm that might result from inadvertent disrespect or interpersonal offense. Ritual healing protocols are gifts of knowledge from other-than-human Persons to human mediators for the purposes of accessing Power, but these protocols are neither efficacious in and of themselves nor readily transportable to others. In sum, the efficacy of traditional healing depends wholly on the interpersonal rather than on the mechanistic, on the relational rather than the technical, and indeed typically reinforces cosmologies in which instrumental manipulation of naturalistic mechanisms (as opposed to social engagement in interpersonal interactions with all "things" animate) is largely unknown.

Additional Considerations Regarding Divergent Discourses

Even with relatively brief consideration of these divergences between the discourses of traditional healing and modern medicine respectively, the challenges to therapeutic integration would appear to be formidable. Before turning to any consideration of more specific challenges, however, a few additional points of clarification are in order. First, we have chosen above to characterize the discourses of modern medicine for the purposes of more general contrast even though the immediate concern of this report is research and policy regarding suicide and its prevention in Native American communities. Our justification for doing so is simply that interest by the National Institute of Mental Health (or any other of the Institutes and Centers that comprise NIH) in questions of Native suicide prevention will necessarily construe the issue as a matter of *health*—whether in terms of health status, health policy, health research, or health services—rather than as a matter of, say, abstract philosophical interest or postcolonial political critique. As a result, consideration of Native American suicide in this context will necessarily participate in much of the same medical discourse (as principally expressed through psychiatry) that dominates health services and the health sciences more generally in the 21st-century United States (with its emphasis on the secular, rational, and technical as discussed above).

Second, we have chosen to characterize the discourses of traditional healing with broad strokes of the conceptual brush, identifying and describing common aspects of these exceedingly diverse practices as they perhaps functioned prior to and in spite of the depredations of Euro-American colonization in this hemisphere. Obviously, a great deal has changed—and dramatically so—for Native American peoples and their cultural practices during these past centuries, including resultant shifts in "traditional" healing practices. The ideological dilemma here is to support the many (though by no means all) Native people who are choosing to engage in community-based projects of cultural reclamation and revitalization without succumbing to a postmodern nostalgia for some pristine and untainted "authentic" pre-modern indigenous tradition by which all subsequent modifications and adaptations are found wanting in comparison. Processes of cultural change are endemic to the human condition, and despite much Native grief in the face of sudden and pervasive colonial disruptions, exiling indigenous peoples to the conceptual state of eternal pre-modernity will not serve Native interests in an increasingly globalized world.

On the other hand, it is crucial to recognize that many Native communities evidence vigorous expressions of cultural contestation regarding these practices, whether between evangelicals and traditionalists, or among traditionalists. Thus, *active belief* in traditional healing practices might be articulated as either evidence of ongoing, authoritative ritual tradition, or alternately as evidence of diabolical and deceptive Satanic influence in the world. Similarly, *active skepticism* toward traditional healing practices might be articulated as either a rejection of a given healer's authority and credentials (in contrast to genuinely trustworthy or effective healers known within the community), or alternately as a rejection of the claim that *any* forms of traditional healing (and the rather esoteric kinds of knowledge that accompany them) have managed to survive the colonial encounter. Beyond these alternatives, most Native communities also acknowledge particular instances of exploitation in which an occasional tribal member supposedly engages in "traditional healing" for flagrantly manipulative and self-serving purposes. Add to this complexity the fact that ritual access to Power for the purposes of healing typically entailed some risk to those involved, as well as the fact that Power might also be accessed for a variety of intentionally malevolent purposes, and the politics of traditional healing in contemporary Native communities can seem overwhelming (but see the special issue of *Medical Anthropology Quarterly* for a sophisticated and illuminating treatment of these politics among the Navajo [Csordas, 2000]).

Finally, we wish to call attention to the fact that any consideration of therapeutic integration in the context of modern health care implicitly remains a one-way affair. That is, some combination of political advocacy by tribal leaders and progressive encouragement by the medical establishment has on occasion resulted in a set of circumscribed prospects for integrating Native American traditional healing *into* established heath care services. In short, this movement does not seem to be other than incidentally concerned with integrating established medical procedures and practices into traditional healing. As a result, a host of dilemmas arise from the fact that traditional healing—a set of cultural practices that American society has explicitly sought to eradicate from Native communities for more than two centuries—might be construed as requesting entry, acceptance, and legitimacy from a radically divergent discursive domain, that of modern medicine, which continues to wield extremely asymmetrical power vis-à-vis indigenous therapeutic traditions throughout much of the world today.

Perhaps the most significant of these dilemmas stems from the emphasis on official sanction and resultant accountability within modern health care, especially in what we have elsewhere labeled the "therapeutic triad" within typical clinical activities involving mental health professionals:

> This rationale [of accountability] applies to professional interactions involving what we designate as the "therapeutic triad," in which *credentialed clinicians* provide *costly services* to *vulnerable clients* suffering from clinically significant psychological impairment or distress. The therapeutic triad recognizes that clinicians are *credentialed* (usually through Master's or doctoral level training in accredited programs, plus professional licensure in the state in which they practice) precisely because they provide professional services that presumably require expertise beyond the facility of the general public to evaluate independently. In such instances, the philosophy of "caveat emptor" is trumped by the quality control efforts of relevant civic and professional bodies. Furthermore, these expert professional services are understood to be relatively scarce and, therefore, *costly*. Indeed, the majority of individuals experiencing diagnosable psychological distress in their lifetimes do not obtain specialized mental health treatment for their problems (Kessler et al., 1994), owing in part to the limited availability and high cost of these services (U.S. Department of Health & Human Services, 1999, 2005). Finally, persons who obtain such services are typically contending with rather serious psychological disruptions in their lives and livelihoods. If ever individuals are in need of quality control and assurance to inspire their trust, bolster their confidence, and protect their interests, it is in these particularly *vulnerable* moments when sometimes even life and liberty are at stake. Thus, in instances properly characterized by the therapeutic triad, the professional obligation to provide the most effective therapeutic services available would seem beyond controversy or dispute. (Gone & Alcántara, in press, p. 109)

Certainly, conditions defining the therapeutic triad—*expertise, scarcity, and vulnerability*—would seem to be further exacerbated in regard to suicide prevention in Indian country, which implies that the measures for assuring efficacy should become more stringent as well. In other words, once *any* given therapeutic approach is incorporated into the health care establishment, in which there is simply not enough effective intervention to go around, its proponents are obligated to play by the rules that invite and require professional scrutiny and public

accountability. In short, the price of admission is *evaluation*. In this light, what then are the prospects and predicaments in terms of health research and policy for the therapeutic integration of Native American traditional healing into established Western health care systems and institutions when it comes to the prevention of Native American suicide?

Challenges to Therapeutic Integration

There are at least four kinds of challenges that will confront any systematic effort to integrate traditional healing into professionally-mandated and/or NIH-supported suicide prevention research or programs within contemporary Native American communities. These challenges emerge primarily from the cultural divergences in epistemology, discourse, and practice described above. They are classified here as those pertaining to description, translation, integration, and evaluation respectively.

Description. Despite the existence of a small (but increasing) literature on Native traditional healing provided in relation to institutionalized health services more generally, it is in fact almost impossible to find detailed descriptions of what traditional healing in many of these settings actually entails. From the perspective of suicide prevention research and policy, it would seem to be professionally, ethically, and fiscally necessary to learn more precisely which specific healing operations are being provided (or proposed) by what kind of practitioners to which subsets of distressed (and possibly suicidal) Native American service recipients (echoing here, of course, Gordon Paul's (1967) classic question regarding psychotherapy outcomes: "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?"). The principal challenge here is that many traditional healers may be reluctant (for the reasons noted earlier) to describe their activities or predict ritual outcomes in the kind of detail required for scrutiny and accountability (remember the conclusions drawn by Levy, Neutra, & Parker, 1979?). What ethical and professional alternatives might serve both the needs of the healer for privacy and the needs of the health care system for accountability?

Translation. Even if cogent description of the healer's prescribed activities and targeted outcomes were readily afforded, incorporation into the institutions of modern heath care will require some articulation of these efforts across discursive domains. In other words, some portion of the healer's efforts must be approximated to the activities and interests of health professionals so that decisions can be made about which kinds of traditional healing interventions ought to be supported or included, and which are best left beyond the purview of

health interventions more generally. For example, would exorcism of a "spirit of suicide" from the community (perhaps not even involving any actually suicidal participants) be appropriate for integration? What about exorcism of this same spirit from a troubled individual? What about ritual use of peyote for substance abusing community members who remain at risk for suicide? Perhaps most importantly, careful attention must be devoted to translating targeted outcomes so that healers are not held accountable for results that were never promised. The principal challenge here is that many traditional healers may describe their interventions in terms that require careful translation so that established professionals might better negotiate inclusion of the most promising practices. Who is best positioned to accomplish this kind of translation, and what criteria should they use in approximating diverse practices and understandings?

Integration. Once a set of traditional interventions has been described, translated, and designated for inclusion within extant health care activities, the details of integration have to be sorted out. Issues of healer selection, patient referral, training, resourcing, coordinating, confidentiality, record-keeping, compensation, and quality control relative to the activities of designated traditional healers must all be addressed. Naturally, a good many of these issues are foreign to the discourse of traditional healing and will require accommodation, revision, or rejection by participating healers. The principal challenge here is that many traditional healers may object to the kinds of intrusive surveillance and regulation that accompany the delivery of modern health care services. Which of these aspects of systemic surveillance and regulation are necessary as opposed to optional with regard to inclusion of traditional healing, and what are the cultural consequences for traditional healing in terms of accommodation to these?

Evaluation. The hallmark of contemporary health care discourse is the grounding of practice in evidence concerning efficacy and outcome. Increasingly within health care services, "evidence-based" practice is promoted, supported, and even required of health care professionals. As a result, it is difficult to imagine that integration of traditional healing into such services would be exempted from the requirement to demonstrate efficacy. Moreover, demonstrations of efficacy are likely to require evaluation using scientific designs and measures owing to the predominance of scientific epistemology in the health sciences. Thus, scientific evaluation of traditional healing relative to stated outcomes would appear to be crucial for the sustainability of any integration effort. The principal challenge here is that many traditional healers may object to the scientific assessment of their activities, mistrusting scientific research,

rejecting a scientific epistemology, and fearing the impact of unfavorable results on their reputations. How might traditional healing be properly evaluated in the context of modern health care, and what are the implications of such evaluations for enduring discourse and practice in traditional healing?

Conclusion

The purpose of this review has been to propose a series of challenging questions— grounded in the scientific literature and driven by critical analysis—that might provoke thoughtful consideration and spirited discussion in a possible future NIMH-sponsored conference. Such a conference would be explicitly devoted to consideration of the integration and evaluation of traditional healing as one promising form of suicide prevention in Native American communities. We have chosen to ground our questions within a conceptual framework that highlights the *differences* between traditional healing and modern medicine. Clearly, there are *similarities* between these practices as well (e.g., consider the common features of all healing encounters discussed by Frank & Frank, 1993). We expect that the most productive discussions of these matters will occur across these respective conceptual strategies—highlighting differences or emphasizing similarities—in considering these fascinating questions pertaining to the future well-being of contemporary indigenous peoples and their communities.

References

Alcántara, C., & Gone, J. P. (in press). Reviewing suicide in Native American communities: Situating risk and protective factors within a transactional-ecological framework. *Death Studies*.

Anderson, J. D. (2001). *The four hills of life: Northern Arapahoe knowledge and life movement*. Lincoln, NE: University of Nebraska Press.

Bird-David, N. (1999). "Animism" revisited. *Current Anthropology*, *40*(Suppl), S67-S91.

Csordas, T. J. (2000). The Navajo healing project. *Medical Anthropology Quarterly*, *14*(4), 463-475.

Darnell, R. (1981). Taciturnity in Native American etiquette: A Cree case. *Culture*, *1*(2), 55-60.

Felner, R.D. & Felner, T.Y. (1989). Primary prevention programs in the educational context: A transactional-ecological framework and analysis. In L.A. Bond & B.E. Compas (Eds.), *Primary prevention and promotion in the schools,* (pp. 13-49). Newbury, Park, California: Sage.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University.

Gone, J. P. (1999). "We were through as Keepers of it": The "Missing Pipe Narrative" and Gros Ventre cultural identity. *Ethos*, *27*(4), 415-440.

Gone, J. P., & Alcántara, C. (in press). Practice makes perfect?: Identifying effective psychological treatments for mental health problems in Indian country. In E. H. Hawkins & R. D. Walker (Eds.), *Best practices in behavioral health services for American Indians and Alaska Natives*. Portland, OR: One Sky National Resource Center for American Indian and Alaska Native Substance Abuse Prevention and Treatment Services.

Gossage, J. P., Alexius, R., Monaghan-Geernaert, P. G., & May, P. A. (2004). Peacemaking ceremonies for substance abuse treatment. In E. Nebelkopf & M. Phillips (Eds.), *Healing and mental health for Native Americans: Speaking in red* (pp. 127-136). Walnut Creek, CA: Altamira.

Gossage, J. P., Barton, L., Foster, L., Etsitty, L., LoneTree, C., Leonard, C., & May, P. A. (2003). Sweat lodge ceremonies for jail-based treatment. *Journal of Psychoactive Drugs*, *35*(1), 33-42.

Hallowell, A. I. (1955). *Culture and experience*. Philadelphia: University of Pennsylvania.

Hallowell, A. I. (1976). *Contributions to anthropology: Selected papers of A. Irving Hallowell*. Chicago: University of Chicago.

LaFromboise, T. D. & Howard-Pitney, B. (1995). The Zuni life skills development curriculum: Description and evaluation of a suicide prevention program. *Journal of Counseling Psychology*, *42*(4), 479-486.

May, P. A., & Van Winkle, N. (1994). Durkheim's suicide theory and its applicability to contemporary American Indians and Alaska Natives. In D. Lester (Ed.), *Emile Durkheim: Le suicide 100 years later* (pp. 296-318). Philadelphia: The Charles Press.

Middlebrook, D.L, LeMaster, P.L, Beals, J., Novins, D.K, & Manson, S.M. (2001). Suicide prevention in American Indian and Alaska Native communities: A critical review of programs. *Suicide & Life-Threatening Behavior, 31* (suppl.), 132-149.

Morrison, K. M. (2000). The cosmos as intersubjective: Native American other-than-human persons. In G. Harvey (Ed.), *Indigenous religions: A companion* (pp. 23-36). London: Cassell.

Olson, L.M., & Wahab, S. (2006). American Indians and suicide. A neglected area of research. *Trauma, Violence, and Abuse, 7*(1), 19-33.

Paul, G. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting and Clinical Psychology*, *31*, 109-118.

Notes

[1] Terminology used to describe indigenous North Americans varies by region, preference, and political commitment. For simplicity's sake, we adopted the term "Native American" to refer to the American Indian, Alaska Native, First Nation, or Aboriginal peoples of the United States and Canada.

[2] The case could be made that the Levy, Neutra, & Parker (1979) article ought to qualify as an outcome study pertaining to epileptic and hysterical seizures among the Navajo, but the method is case-based and retrospective in nature and lacks the kinds of controlled designs preferred in contemporary health outcomes research. In addition, the article by Mehl-Madrona (1999) provided an evaluation of traditional healing approaches that were adapted into a treatment program for non-Native patients suffering a wide array of chronic health conditions.

[3] Most of the literature canvassed in this report uses the term "traditional healing" without defining it. One exception is Johnston (2002), who described Native American traditional medicine as "indigenous healing beliefs and practices of a particular Native American society in contradistinction to the biomedical or 'Western' medical system" (p. 197). Johnston allowed, however, that contemporary instances of traditional healing may have evolved substantially throughout the long period of cultural contact and exchange. As a result, satisfying definitions of traditional healing may be difficult to identify. We choose not to define traditional healing in this report, but anticipate that questions of definition maybe one fruitful point of departure for structuring a conference devoted to these questions.

Appendix
Classification of AI Traditional Healing Literature

1. Approaches to Suicide Prevention with Native Communities
  Thurman, P. J., Plested, B. A., Edwards, R. W., & Foley, R., & Burnside, M. (2003). Community readiness: The journey to community healing. *Journal of Psychoactive Drugs*, *35*(1), 27-31.

2. Protective Effects of Traditional Activities vis-à-vis Suicide
  Crofoot Graham, T. L. (2002). Using Reasons For Living to connect to American Indian healing traditions. *Journal of Sociology and Social Welfare*, *29*(1), 55-75.
  Pharris, M. D., Resnick, M. D., & Blum, R. W. (1997). Protecting against hopelessness and suicidality in sexually abused American Indian adolescents. *Journal of Adolescent Health*, *21*(6), 400-406.

3. Mental Health Benefits of Traditional Healing
  Jilek, W. G. (1974). Indian healing power: Indigenous therapeutic practices in the Pacific Northwest. *Psychiatric Annals*, *4*(11), 13-21.
  Milne, D., & Howard, W. (2000). Rethinking the role of diagnosis in Navajo religious healing. *Medical Anthropology Quarterly*, *14*(4), 543-570.
  Mohatt, G. V., & Varvin, S. (1998). Looking for "a good doctor": A cultural formulation of the treatment of a First Nations woman using western and First Nations method. *American Indian and Alaska Native Mental Health Research*, *8*(2), 79-96.
  Storck, M., Csordas, T. J., & Strauss, M. (2000). Depressive illness and Navajo healing. *Medical Anthropology Quarterly*, *14*(4), 571-597.

4. Collaborations Between Mental Health Professionals and Traditional Healers
  Attneave, C. L. (1974). Medicine men and psychiatrists in the Indian Health Service. *Psychiatric Annals*, *4*(11), 49-55.
  Bergman, R. L. (1973). A school for medicine men. *American Journal of Psychiatry*, *130*(6), 663-666.
  Kahn, M. W., Lejero, L., Antone, M., Francisco, D., & Manuel, J. (1988). An indigenous community mental health service on the Tohono O'odham (Papago) Indian reservation: Seventeen years later. *American Journal of Community Psychology*, *16*(3), 369-379.
  Meketon, M. J. (1983). Indian mental health: An orientation. *American Journal of Orthopsychiatry*, *53*(1), 105-110.
  Scurfield, R. M. (1995). Healing the warrior: Admission of two American Indian war-veteran cohort groups to a specialized inpatient PTSD unit. *American Indian and Alaska Native Mental Health Research*, *8*(3), 1-22.

5. Cultural Dilemmas in Mental Health Service Delivery
  Debruyn, L. M. (1990). Tewa children who have epilepsy: A health care dilemma. *American Indian and Alaska Native Mental Health Research*, *4*(2), 25-41.
  Levy, J. E., Neutra, R., & Parker, D. (1979). Life careers of Navajo epileptics and convulsive hysterics. *Social Science and Medicine*, *13B*(1), 53-66.

McShane, D. (1987). Mental health and North American Indian/Native communities: Cultural transactions, education, and regulation. *American Journal of Community Psychology*, *15*(1), 95-116.

Miller, B. G., & Pylypa, J. (1995). The dilemma of mental health paraprofessionals at home. *American Indian and Alaska Native Mental Health Research*, *6*(2), 13-33.

6. Service Utilization for Mental Health Problems

Beals, J., Novins, D. K., Spicer, P., Whitesell, N. R., Mitchell, C. M., Manson, S. M., & the AI-SUPERPFP Team. (2006). Help seeking for substance use problems in two American Indian reservation populations. *Psychiatric Services*, *57*(4), 512-520.

Beals, J. Novins, D. K., Whitesell, N. K., Spicer, P., Mitchell, C. M., Manson, S. M., & the AI-SUPERPFP Team. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental health disparities in a national context. *American Journal of Psychiatry*, *162*(9), 1723-1732.

Buchwald, D., Beals, J., & Manson, S. M. (2000). Use of traditional health practices among Native Americans in a primary care setting. *Medical Care*, *38*(12), 1191-1199.

Gurley, D., Novins, D. K., Jones, M. C., Beals, J., Shore, J. H., & Manson, S. M. (2001). Comparative use of biomedical services and traditional healing options by American Indian veterans. *Psychiatric Services*, *52*(1), 68-74.

House, L. E., Stiffman, A. R., & Brown, E. (2006). Traditional healers as service providers to Southwestern American Indian urban and reservation youths. Manuscript submitted for publication.

Kim, C., & Kwok, Y. S. (1998). Navajo use of native healers. *Archives of Internal Medicine*, *158*(9), 2245-2249.

Novins, D. K., Beals, J., Moore, L. A., Spicer, P., & Manson, S. M. (2004). Use of biomedical services and traditional healing options among American Indians: Sociodemographic correlates, spirituality, and ethnic identity. *Medical Care*, *42*(7), 670-679.

Stiffman, A. R., Striley, C., Brown, E., Limb, G., & Ostmann, E. (2003). American Indian youth: Who Southwestern urban and reservation youth turn to for help with mental health or addictions. *Journal of Child and Family Studies*, *12*(3), 319-333.

7. Service Utilization for General Health Problems

Arcury, T. A., Bell, R. A., Snively, B. M., Smith, S. L., Skelly, A. H., Wetmore, L. K., & Quandt, S. A. (2006). Complementary and alternative medicine use as health self-management: Rural older adults with diabetes. *The Journals of Gerontology: Social Sciences*, *61B*(2), S62-S70.

Cook, S. J. (2005). Use of traditional Mi'kmaq medicine among patients at a First Nations community health centre. *Canadian Journal of Rural Medicine*, *10*(2), 95-99.

Fuchs, M., & Bashshur, R. (1975). Use of traditional Indian medicine among urban Native Americans. *Medical Care*, *13*(11), 915-927.

Grzywacz, J. G., Arcury, T. A., Bell, R. A., Lang, W., Suerken, C. K., Smith, S. L., & Quandt, S. A. (2006). Ethnic differences in elders' home remedy use: Sociostructural explanations. *American Journal of Health Behavior*, *30*(1), 39-50.

Hsiao, A. F., Wong, M. D., Goldstein, M. S., Yu, H. J., Andersen, R. M., Brown, R. E., Becerra, L. M., & Wenger, N. S. (2006). Variation in complementary and alternative medicine (CAM) use across racial/ethnic groups and the development of ethnic-specific measures of CAM use. *Journal of Alternative and Complementary Medicine*, *12*(3), 281-290.

Mackenzie, E. R., Taylor, L., Bloom, B. S., Hufford, D. J., & Johnson, J. C. (2003). Ethnic minority use of complementary and alternative medicine (CAM): A national probability survey of CAM utilizers. *Alternative Therapies in Health and Medicine*, *9*(4), 50-56.

Marbella, A. M., Harris, M. C., Diehr, S., Ignace, G., & Ignace, G. (1998). Use of Native American healers among Native American patients in an urban Native American health center. *Archives of Family Medicine*, *7*(2), 182-185.

Waldram, J. B. (1990). The persistence of traditional medicine in urban areas: The case of Canada's Indians. *American Indian and Alaska Native Mental Health Research*, *4*(1), 9-29.

Zubek, E. M. (1994). Traditional Native healing. Alternative or adjunct to modern medicine? *Canadian Family Physician*, *40*, 1923-1931.

8. Traditional Approaches to Wellness

Begay, D. H., & Maryboy, N. C. (2000). The whole universe is my cathedral: A contemporary Navajo spiritual synthesis. *Medical Anthropology Quarterly*, *14*(4), 498-520.

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, *9*(2), 56-78.

Coyhis, D., & Simonelli, R. (2005). Rebuilding Native American communities. *Child Welfare*, *84*(2), 323-336.

Dapice, A. N. (2006). The medicine wheel. *Journal of Transcultural Nursing*, *17*(3), 251-260.

Dufrene, P. M., & Coleman, V. D. (1994). Art and healing for Native American Indians. *Journal of Multicultural Counseling and Development*, *22*(3), 145-152.

Garrity, J. F. (2000). Jesus, peyote, and the holy people: Alcohol abuse and the ethos of power in Navajo healing. *Medical Anthropology Quarterly*, *14*(4), 521-542.

Johnson, D., & LaDue, R. (1995). A cultural and community process. *American Indian and Alaska Native Mental Health Research*, *6*(1), 34-38.

Silver, S. (1994). Lessons from child of water. *American Indian and Alaska Native Mental Health Research*, *6*(1), 4-17.

Topper, M. D. (1987). The traditional Navajo medicine man: Therapist, counselor, and community leader. *The Journal of Psychoanalytic Anthropology*, *10*(3), 217-249.

Voss, R. W., Douville, V., Little Soldier, A., & Twiss, G. (1999). Tribal and shamanic-based social work practices: A Lakota perspective. *Social Work*, *44*(3), 228-241.

Watts, L. K., & Gutierres, S. E. (1997). A Native American-based cultural model of substance dependency and recovery. *Human Organization*, *56*(1), 9-18.

9. Culturally-Grounded Mental Health Service Alternatives

Abbott, P. J. (1998). Traditional and western healing practices for alcoholism in American Indians and Alaska Natives. *Substance Use & Misuse*, *33*(13), 2605-2646.

Edwards, Y. (2003). Cultural connection and transformation: Substance abuse treatment at Friendship House. *Journal of Psychoactive drugs*, *35*(1), 53-58.

Heilbron, C. L., & Guttman, M. A. J. (2000). Traditional healing methods with First Nations women in group counselling. *Canadian Journal of Counselling*, *34*(1), 3-13.

Saylors, K. (2003). The women's circle comes full circle. *Journal of Psychoactive Drugs*, *35*(1), 59-62.

10. Culturally-Grounded Human Service Alternatives

Connors, E. A., & Oates, M. L. B. (1997). The emergence of sexual abuse treatment models within First Nations communities. In D. A. Wolfe, R. J. McMahon, & R. D. Peters (Eds.), *Child abuse: New directions in prevention and treatment across the lifespan* (pp. 223-247). Thousand Oaks, CA: Sage.

Nebelkopf, E., & King, J. (2003). A holistic system of care for Native Americans in an urban environment. *Journal of Psychoactive Drugs*, *35*(1), 43-52.

11. Community-Based Healing Projects

McBride, B. A. (2003). Aspects of community healing: Experiences of the Sault Sainte Marie Tribe of Chippewa Indians. *American Indian and Alaska Native Mental Health Research*, *11*(1), 67-83.

12. Select Overviews of Traditional Healing (Recency, Visibility, or Comprehensiveness)

Avery, C. (1991). Native American medicine: Traditional healing. *JAMA*, *265*(17), 2271-2273.

Cohen, K. B. (1998). Native American medicine. *Alternative Therapies in Health and Medicine*, *4*(6), 45-57.

Johnston, S. L. (2002). Native American traditional and alternative medicine. *Annals of the American Academy of Political and Social Science*, *583*, 195-213.

13. Comparisons of Traditional & Western Medicine

Arnold, O. F., & Bruce, A. (2005). Nursing practice with Aboriginal communities: Expanding worldviews. *Nursing Science Quarterly*, *18*(3), 259-263.

Camazine, S. M. (1980). Traditional and Western health care among the Zuni Indians of New Mexico. *Social Science and Medicine*, *14B*(1), 73-80.

Deuschle, K. W. (1986). Cross-cultural medicine: The Navajo Indians as case exemplar. *Daedalus*, *115*(2), 175-184.

Locust, C. (1995). The impact of differing belief systems between Native Americans and their rehabilitation service providers. *Rehabilitation Education*, *9*(2-3), 205-215.

Morse, J. M., Young, D. E., & Swartz, L. (1991). Cree Indian healing practices and Western health care: A comparative analysis. *Social Science and Medicine*, *32*(12), 1361-1366.

14. Interface of Traditional Practice & Western Health Care

Abel, E. K., & Reifel, N. (1996). Interactions between public health nurses and clients on American Indian reservations during the 1930s. *Social History of Medicine*, *9*(1), 89-108.

Evans, L. (1972). Medical school for medicine men. *The Sciences*, *12*, 10-11.

Mehl-Madrona, L. E. (1999). Native American medicine in the treatment of chronic illness: Developing an integrated program and evaluating its effectiveness. *Alternative Therapies in Health and Medicine*, *5*(1), 36-44.

15. Dual Medical Roles & Relationships

Huttlinger, K. W., & Tanner, D. (1994). The Peyote way: Implications for Culture Care theory. *Journal of Transcultural Nursing*, *5*(2), 5-11

Kelm, M. E. (2004). Wilp Wa'ums: Colonial encounter, decolonization and medical care among the Nisga'a. *Social Science and Medicine*, *59*(2), 335-349.

Kutenai, K. (1996). A Native-American nurse's view. *Advanced Practice Nursing Quarterly*, *2*(2), 59-61.

Wheatley, M. A. (1991). Developing an integrated traditional/clinical health system in the Yukon. *Arctic Medical Research*, Suppl, 217-220.

16. Critical Analyses of Traditional Healing

Brady, M. (1995). Culture in treatment, culture as treatment: A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science and Medicine*, *41*(11), 1487-1498.

Waldram, J. B. (2000). The efficacy of traditional medicine: Current theoretical and methodological issues. *Medical Anthropology Quarterly*, *14*(4), 603-625.