Significant disparities in health status and access to health care have historically existed for American Indians (also known as Native Americans) in the United States, compared to other demographic groups. Following an overview of these demographics and challenges, this article focuses on efforts to draw on Native American healing traditions to improve the health of members of these communities and discusses the trend in Western medicine toward more culturally sensitive and culturally appropriate health care.

Native American Demographics

There are an estimated 4.9 million persons, in 565 federally recognized tribes, who are classified as American Indian or Alaska Native (AI/AN), alone or in combination with one or more other designated racial classifications. This demographic group comprises 1.6% of the U.S. population. The Indian Health Service (IHS) of the U.S. Department of Health and Human Services provides health services to approximately 1.9 million American Indians and Alaska Natives, the majority of who live on reservations and in rural communities in 36 states, primarily in the western United States and Alaska.

The rest of this population, which resides in urban areas, has less access to IHS programs and a documented high prevalence of, and risk factors for, numerous health problems. Factors limiting access to quality health care include cultural/linguistic barriers, geographic isolation, and low income.1

Shared Visions for Addressing Native American Health Challenges

The Association of American Indian Physicians (AAIP; see Resources) held its 40th annual meeting and national conference during August 8–15, 2011, in Portland, Oregon. While acknowledging historical American Indian health problems and tensions between their traditions and mainstream medicine, the main focus of “Shared Visions: Blending Tradition, Culture, and Health Care for Our Native Communities,” was on the strengths that traditional beliefs, practices, and resources can bring to healing contexts.2

Roger Dale Walker, MD, outgoing president of the AAIP and a professor of psychiatry, public health, and preventive medicine at Oregon Health & Science University (OHSU) in Portland, (see Resources), commented that: “American Indians in the United States are dying in large numbers from diseases they shouldn’t have to die from.” Dr. Walker welcomed American Indian health care and top U.S. health leaders to the conference, which included, for the first time, the president of the American Medical Association.3 (Dr. Walker, a member of the Cherokee tribe, is also the director of the One Sky Center at OHSU; this center is the American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health Services; see Resources).

In addressing members of the AAIP, Donald Warne, MD, of the Oglala Lakota tribe, and director of the Office of Native American Health in Sioux Falls, South Dakota, noted that the life expectancy for Native Americans is 63 years, compared with 74 years for the general U.S. population. The death rate among Native Americans for diabetes is 3 times higher than the general population, 6 times as high for alcohol abuse, and 60% higher for suicide. Native Americans also have higher rates of other chronic diseases and health problems, sudden infant death syndrome, and accidents (see Selected Native American Health Statistics). Lamenting that we have “gotten away from the art of medicine” in being “focused on the science of medicine,” Dr. Warne said: “Health providers could help reduce those disparities by adopting some traditional healing practices to balance physical, emotional, mental, and spiritual health.” Referring to the fragmented nature of much of Western medicine, Dr. Warne added that, as a family physician, he has seen many Native Americans suffering simultaneously from diabetes, depression, and alcoholism, and being treated by different providers who typically do not consult with one another regarding these linked conditions. Balance is the key to traditional Native American health practices.4 The principle...
of balance is also a core value of complementary and alternative medicine (CAM).

Jared Jobe, PhD, a Cherokee, who is a health science administrator at the National Heart, Lung and Blood Institute in Bethesda, Maryland, stated in his presentation: “We need to address the underlying wounded spirits, the loss of culture, the loss of land, and how that affects people’s spirits.” Dr. Jobe noted that public health leaders could help Native Americans improve their health by urging them to return to traditional diets, which included fish, berries, nuts, vegetables, and game meats, and physical activities such as lacrosse, a game they invented.

“Traditional ways of living are extremely healthy, and this is the antidote to the harms of losing land and a way of life,” he said. These losses have been termed “historical trauma” by the U.S. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, and is defined as: “the emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences.”

Principles of Native American Healing

- Identification with one’s cultural heritage
- Pursuit of a balanced life in relation to the interconnected mind, body, spirit, and environment
- Maintenance of family and community networks
- Inclusion of a traditional healthy diet and activities
- Use of traditional healers and interventions (e.g., spiritual ceremonies, drumming, sweat lodge purification)—alone or in combination with Western medicine

A study of Native American patients in an urban Native health center in Wisconsin, 38% reported that they see a traditional healer, and the majority said that they would consider seeing one in the future. These users of traditional healers rated the traditional healers’ advice more highly than the advice of their physicians (61% of the time), and only 15% informed their physicians about seeing Native healers.

Native Healing Philosophy, Traditions, and Attitudes

Although the recognized AI/AN tribes in North America do not comprise a monolithic group, their communities share many elements in their healing traditions. Native practices have been categorized as belonging to the realms of: “The Native American Pharmacy” (medicinal herbs and other plants); “The Native American Spa” (healing with heat in sweat lodges for purification, massage, drumming, dance, and nutrition); and “The Healing Spirit” (dream therapy, spirituality and prayer).  

As with other users of CAM modalities, Native people hold a holistic perspective on health based on a balance of the interrelationships of body, mind, spirit, and the environment. For example, the traditional Navajo “Walking in Beauty” worldview holds that everything in life is connected and influences everything else, and “sees illness as a result of things falling out of balance, on losing one’s way on the path of beauty.” Relationships with families, the community, the universe, and healers are paramount.

Connection with the Native community and participation in Native cultural practices has been found to be among the predictors of wellness in this population. For example, this was the case in a recent survey of 457 American Indian adults at 13 rural health care sites in California. The researchers therefore recommended culturally appropriate health education and interventions that emphasize cultural and community connectivity for improving wellness status.

Historical mistrust of mainstream medical practitioners and practices was among the culture-specific barriers cited for Na-
Selected Native American Health Statistics

Cancer
- American Indian/Alaska Native (AI/AN) men are twice as likely to have liver and colon cancer as non-Hispanic white males.
- AI/AN women are 2.4 times more likely to have, and twice as likely to die from, liver and colon cancer, compared to non-Hispanic white women.
- AI/AN women are 40% more likely to have renal/pelvic cancer as non-Hispanic white women.

Diabetes
- AI/AN adults were 2.3 times more likely as white adults to be diagnosed with diabetes.
- AI/ANs were twice as likely to die from diabetes as non-Hispanic whites in 2005.
- AI/AN adults were 1.6 times as likely to be obese as non-Hispanic whites.

Heart disease
- AI/AN adults are 1.2 times as likely as white adults to have heart disease.
- AI/ANs are 1.4 times as likely as white adults to be current cigarette smokers.
- AI/AN adults were 1.3 times as likely to have high blood pressure as non-Hispanic whites.

Stroke
- AI/AN adults are 60% more likely to have a stroke than their white counterparts.
- AI/AN adults are more likely to have the risk factors for stroke of being obese and/or having high blood pressure.

HIV/AIDS
- AI/ANs have a 40% higher AIDS rate than their non-Hispanic white counterparts (20% higher in men; twice as high for women).

Infant mortality
- AI/ANs have 1.4 times the infant mortality rate as non-Hispanic whites.
- AI/AN babies are 30% more likely to die from complications from low birth weight or congenital malformations, compared to non-Hispanic white babies, and twice as likely as non-Hispanic white infants to die from sudden infant death syndrome.
- AI/AN infants are 3.7 times as likely as non-Hispanic white infants to have mothers who began prenatal care in the third trimester or did not receive prenatal care at all.

Eating disorders
- AI young women reported significantly greater disordered eating behaviors than white women.a

Substance abuse
- AI/AN adults had the highest rate of substance abuse treatment needs (19.4%), compared to the overall rate of 9.7% of adults age 18 or older in a given year (2003–2007)b
- Compared with the national average for adolescents age 12–17, AI/AN adolescents had higher rates of past month cigarette use (16.8% versus 10.2%), marijuana use (13.8% versus 6.9%), and nonmedical use of prescription-type drugs (6.1% versus 3.3%).c

Suicide
- The prevalence rate of suicide within the AI population is 1.5 times the national rate. A sense of belonging showed a negative association with suicidal ideation.d
- Youth ages 15–24 account for 40% of all suicides in this population. Nonfatal injuries resulting from suicidal behavior may account for 13 events for every fatality.e

Source: Ref. 1, except where noted otherwise.

tive women not getting mammograms, despite a dispropor-
tionately high incidence of breast cancer and deaths from the
disease in this population. (Disincentive factors that they share
with non-Native women include cost, transportation, and fear
of the test and its potential results.)14

From a survey of low-income American Indian, African
American, and Caucasian women age 18 and older (N = 367)
relating to their food-related environment, health beliefs, and
behavior, investigators concluded that nutrition education
and intervention efforts require tailored approaches that take
into account racial/ethnic identity among the many environ-
mental, personal, and behavioral factors contributing to the
obesity epidemic.15

Concepts Relevant to Health Care Integration

When considering how to integrate Native American tradi-
tions into Western settings, a number of concepts are particu-
larly helpful:

• **Heritage consistency**—This is the degree to which one’s
lifestyle is consistent with his or her traditional culture; it
influences health-related beliefs and behavior.16

• **Culturally adapted and culturally based health interven-
tions**—A distinction has been made between these two
interventions in efforts to address historical disparities
in Native service utilization and intervention outcomes.
Whereas culturally adapted interventions adapt an exist-
ing evidence-based intervention to a particular cultural
context, culturally based interventions are designed spec-
ifically for a cultural group.17

• **Cultural safety**—This concept was first applied to protect
the identities of indigenous minorities working in domi-
nant-culture health institutions and is being increasingly
used in honoring traditional worldviews and ways of life
in Western health contexts.18 An example of culturally
sensitive care in an end-of-life setting was a study of inter-
views with bereaved family members of a First Nations
patient in a hospital-based setting.19 The family members
had expressed a wish for space to accommodate a larger
number of visitors than is typical of mainstream Western
facilities. The family members also expressed a desire for
respectful directness in communication.20

• **Cultural identity**—Although Native cultural identity show-
ed no direct effect on population-specific protective pro-
cesses in treating alcohol and drug abuse in one analysis of
data from the Sacred Mountain Youth Project (N was not
specified), a secondary analytical model found that the fac-
tors of social support and family and peer influences were
associated with cultural identity as buffers between stressful
life events and these risky behaviors.21

• **Cultural competency**—Mainstream medical schools are
increasingly incorporating cultural competencies in
their curricula. In March 2001, the Office of Minority
Affairs, of the U.S. Department of Health and Human
Services, issued National Standards for Culturally and
Linguistically Appropriate Services (CLAS), required
for all health care organizations that receive federal
funds. Private practitioners were also encouraged to
incorporate these standards into their practices. Com-
priised of 14 standards, the CLAS recommendations
entail provision of patients with: respectful care in a
manner compatible with their cultural health beliefs,
practices, and preferred language; a diverse staff and
leadership that represent the demographic character-
istics of the area; and staff trained in culturally appro-
riate care. Patient empowerment and “authentic” com-
mmunity involvement are also part of the guidelines.22

Examples of Health Integration Efforts

**A Native Clinical Perspective**

In a memoir of her path in becoming the first Navajo wom-
an surgeon, Lori Arviso Alvord, MD—a former professor of
surgery and psychiatry and associate dean for student and mul-
ticultural affairs at Dartmouth Medical School in Hanover,
New Hampshire—addresses the difficulty of, and need for,
combining the best of Western medicine with Native values
and customs. Dr. Alvord described her work when she was a
surgeon at the Gallup Indian Medical Center, which served
people in the Navajo reservation and surrounding areas, in
Gallup, New Mexico, in creating culturally competent heal-
ing environments: “As I adapted my practice to my culture, my
patients relaxed in situations that could otherwise have been
highly stressful to them,” resulting in better outcomes.

For example, Dr. Alvord saw the vital signs of an elderly
patient who had undergone standard treatments for advanced
cancer stabilize upon hearing a medicine man’s singing (the
Navajo word for healer literally translates as “singer”) outside
of his hospital room, which evoked hope and a will to live in
him. When scheduling surgery, Dr. Alvord consequently al-
lotted time for such Native rituals or ceremonies requested by
patients to be conducted first.12

When Dr. Alvord served on the NCCAM’s National Ad-
visory Council for Complementary and Alternative Medicine
in 2007, she advocated further for applying the traditional
reciprocal, respectful patient–healer relationship to improve
conventional Western health care. According to Dr. Alvord,
scientific studies have validated some of these traditional Na-
tive mind–body practices to the extent that the National Insti-
tutes of Mental Health had, at one time, funded the training
of Navajo medicine men/women, to address their dwindling
numbers. Dr. Alvord has also worked to counter less-helpful
aspects of Native health-related beliefs and attitudes (e.g., the
belief that cancer is contagious).12

**Treatment, Training, and Research Partnerships**

According to Lewis Mehl-Madrona, MD, who is of Cher-
okee and Lakota heritage, Native American healing prac-
tices are being sought out by non-Natives as well as Native
Included the simultaneous provision of medical, psychologic, and spiritual care. Reasons for this result were given as including increased social support, stress reduction, more-positive health beliefs, and collaborative care serving as a kind of naturalistic biofeedback.24

Storytelling, a traditional Native mode of sharing lived experience, has been shown to play a role in healing. In obtaining narratives from 47 patients with cancer with a poor prognosis who survived beyond the predicted 5 years, before and after their work with a traditional Native healer, Dr. Mehl-Madrona found increases on the dimensions of a scale used to measure a sense of meaning and purpose, faith, and hope, after the patients worked with the Native healers.25

This traditional healing approach was also shown to be effective for treating Native youth with substance-abuse problems (with abusing inhalants specifically) in a residential treatment facility.26 A community substance-abuse treatment center for First Nations (Canadian indigenous) people incorporated the traditional symbol of the medicine wheel, representing harmony and spirituality, into its program with other Native and Western therapeutic approaches.27

The medicine wheel is a sacred symbol that represents all knowledge of the universe. The circle represents the pattern of ongoing life and death, and horizontal and vertical lines drawn through the center represent the sun and the human’s sacred path. The lines present the cardinal directions, and each is associated with a color and a particular messenger. For example, East is associated with yellow and the brown eagle. An eagle feather attached at the center is a sign of the Great Spirit’s power over everything.28

Traditional healers and elders have rarely been consulted on what mental health practitioners should be taught to be effective and appropriate in treating indigenous people. In preparation for developing a crosscultural training program for human service providers, healers and elders were consulted in identifying values and principles important to working with traditional healers. Elders in the project were also to be asked to serve in the roles of community mentors and adjunct faculty with equal status as academically trained faculty members.29

With respect to conducting academic health research with American Indian tribes, it has been recognized that informed consent needs to go beyond the conventional institutional review board because of the potential for adverse consequences at the community level. Tribal nations themselves are believed to be the best ones to identify potential negative outcomes. In addition, the principles of indigenous rights and sovereignty should be applied in agreements with participating tribes regarding study assumptions, methods, interpretation, and publication.30

Community-based and tribally based participatory research approaches have been developed to inform such research partnerships among academic institutions, tribes, and Native organizations, to develop strategies to understand, prevent, and treat substance abuse better in this population. On their side of the collaboration, indigenous participants can identify unique challenges, resources, and culturally ap-
appropriate approaches. For example, in conjunction with a First Nation community, the Canadian Institutes of Health Research is conducting a study to evaluate whether a traditional high-protein diet or an intervention based on the current Canadian dietary recommendations (high carbohydrate, high fiber) has a greater impact on risk factors for type 2 diabetes mellitus and/or cardiovascular disease.

In a step toward a randomized controlled trial, a study protocol is examining a culturally tailored smoking cessation program for American Indians, who have the highest prevalence of smoking (40.6%) in the United States and high tobacco-related mortality. In another example of incorporating a traditional component into a health education and intervention program, a study had recently been completed that examined an existing social network–based lay advisor intervention—an intergenerational one—to determine whether such an approach increased the effectiveness of a program to mobilize a Native community to participate in a program to reduce detrimental mental exposure from mining among their children.

The “Blending Two Worlds Study” seeks to provide a culturally sensitive, supportive treatment environment for children, adolescents, and families in the Native community who are experiencing stress, anxiety, and depression. Researchers also seek to gain insight into, and validate the role of, traditional healing options for the management of these health problems, and to encourage Native clients to seek treatment earlier from a culturally supportive system. In addition, consulting highly trained Native healers, when attempting to integrate any kind of traditional healing together with conventional care, is essential.

Outreach with New Technologies

Like many other youth, AI/AN teenagers and young adults are avid users of media technologies including the internet and smart phones. In a survey of 405 AI/AN youths, 13–21 years old, living in tribal and urban communities, to identify health information–seeking patterns, 75% of respondents reported searching online for health information. These data are being used by Northwest tribes in conjunction with the Northwest Portland Area Indian Health Board in Portland, Oregon, to design culturally appropriate, technology-based health interventions targeting AI/AN youth.

Conclusion

Despite the many health challenges historically experienced by persons in Native American tribes, they also have rich traditions to draw upon to promote wellness and holistic healing. As with other CAM approaches, the distinctive practices of Native Americans are based on the principle of achieving balance of the mind–body–spirit–environment. Traditional practices as part of an overall cultural revival are increasingly being respected and incorporated into mainstream medical settings, which are, conversely, beginning to cultivate cultural competencies in serving a diverse population.

Researchers are confirming the perception that connection to one’s culture and community enhances health. Both CAM and biomedicine need to continue to work in partnerships with ethnic minority populations to remove historical barriers to providing culturally safe and culturally appropriate health care.

References


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