

Insights from Native American Veterans on Developing a Patient-Centered, Integrative
Model for Mental Health Services

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Abstract

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Today's veterans face a unique set of challenges in meeting their mental health needs. Recent evaluations of the VA have shown that although services are widely available, these services may not adequately address mental health problems for all veterans. The changing nature of war has also placed additional mental health strains on veterans, through exposing service members to a high number of repeat deployments. Suicide incidence is increasing. Within this context, Native American veterans are in a unique position to offer perspectives on alternative approaches to mental health care, and to help close this health gap. Native Americans are the demographic with the highest per-capita rate of military service. Additionally, many Native American veterans access health services outside the VA and other hospitals. Native American perspectives on complementary and integrated care models are thus important to understand not only to ensure the health needs of this demographic are met, but may also assist clinicians in better meeting the mental health needs of all veterans in the future.

I. Introduction

In 2004, the Department of Veterans Affairs (VA) launched a five-year Mental Health Strategic Plan to expand services for veterans. In 2006, the VA commissioned two external evaluators, the RAND Corporation and the Altarum Institute, to evaluate the VA's mental health programs for the following five disorders: (1) schizophrenia, (2) bipolar disorder, (3) posttraumatic stress disorder (PTSD), (4) major depressive disorder, (5) and substance use disorder (SUD). The evaluation, conducted over four years, from 2006 to 2010, was the largest mental health evaluation ever undertaken (Watkins, 2011).

The evaluators found that VA services were comparable to or better than those of private providers. They also found that the VA had the capacity to address current mental health needs, and that the capacity was increasing. Basic services, including psychotherapy and pharmacology, were available at over 96% of VA Medical Centers. Suicide prevention coordinators were also found in 95% of facilities. 72% of veterans reported being helped by counseling or treatment received in the prior 12 months. However, only 32% of those surveyed perceived that their problems had improved (Watkins, 2011).

These responses are illuminating. This discrepancy between high levels of care and satisfaction with care, and a simultaneously low rate of perception of improvement in problems, may exist in part because many health conditions treated by the VA are chronic, and only improve over time. However, this also highlights the fact that there is a need to close the gap between level of services and improvement in problems. The VA's current models of care are not going far enough in addressing this gap. The fact that suicide incidence is increasing underscores the importance of strengthening models to

meet current health needs. Veteran suicide rates in 2010 were 50 per 100,000 (McCarten, 2015), nearly double the rate found in the general male population in the US (Kemp, 2014).

Starting with this context, there are several options for ways to improve care and reduce this health gap. The first way is simply to re-examine existing practices, ensuring that more services are available in more areas. However, since basic services and suicide prevention coordinators are already widely available, it seems the time is ripe for alternative options. One such option is to examine the health experiences of specific demographics of veterans, to determine whether culturally-specific practices may offer effective alternative or complementary approaches to care. Native Americans are one such population.

Examining the experience of Native American veterans is important for two reasons. First, Native American veterans have a disproportionately large representation in the US military. Although their total numbers are still small, Native Americans have made an outsized contribution to the US military historically and today. They serve in higher rates of combat and have higher rates of PTSD than other groups. Thus, it is important to ensure that their health needs are met.

The second reason this topic is important is because many Native American veterans seek care outside the VA, drawing on health traditions that are thousands of years old. Thus, they are well-positioned to offer perspectives on integrative health, and alternative ways to support veterans. The language that these veterans use to speak about health care may be unfamiliar to some providers. As Lamberg (2000) states, “To work effectively with their patients, clinicians must bridge cultural and racial divides, as well

as those of age and sex. Clinicians who see Native American patients may improve treatment outcomes by linking behavior choices to a patient's spiritual beliefs" (p. 1370). Spirituality may play an important role in health care for Native American veterans. These veterans may also use different terms to describe health problems than those found in the Diagnostic and Statistical Manual of Mental Disorders (DSM 5). However, in today's age of increasing suicide incidence and continued health problems among veterans, alternative models for health and healing are needed more than ever. This paper offers an opportunity for clinicians and other researchers to consider approaches to healing that may not be familiar, but may provide an important answer for ways to expand healthcare for veterans today.

The goals of this research are thus twofold. They are: (1) to determine what health models have been most helpful to Native American veterans in addressing mental health needs after return from active duty, to the end of ensuring that these veterans can continue to receive care in a way that aligns with their values (2) in doing so, to contribute to conversations about integrated health care options for veterans as a whole. Because clinicians referring to DSM 5 and Native Americans may use different language to talk about mental health, literature about how to integrate these approaches has only really begun to emerge in recent years. This thesis seeks to expand that conversation.

I will be using the terms "conventional allopathic" as well as "Western" medicine, as both of these terms were recommended by Native American health care providers during the design phase for this project, and used by veterans in their interview responses. I will use the terms Native American and American Indian and Alaska Native (AI/AN) interchangeably, because these terms were both used by veterans and found in the

literature. I will use the terms First Nations to refer to people from Canadian tribes, as this is the accepted term. Traditional medicine refers to any medicine offered by specific tribes, including attending a sweat lodge, attending ceremonies, using herbs according to tribal customs, or speaking with elders/healers.

This thesis begins with a brief overview of history of Native American military engagement, because in the practice of providing patient-centered care, it is first important to understand who the patient is when he or she walks through the door. This will assist in the process of determining what is important to the patient, and thus how to create a care model that aligns with their values. This approach, of situating health information in biographical data, was also an approach employed throughout the research process of this project. Questions for veterans alternated, between questions about military experience and questions about perspectives on healing. Not only did this approach acknowledge the importance of veterans' military service, but it also made the gathering of much richer data possible. That approach is also one reflected in the structure of this paper. Biographical and historical data are included, as a context for understanding health information.

History of Native American Military Engagement

Native Americans are the ethnic group with the highest percentage of participation in US military service. By the end of WWII, "one third of all able-bodied Indian men between the age of 18 and 50 had served [in the military]" (US Senate, 1997). Native Americans also served in WWI and WWII in high numbers, despite the fact that they were not considered US citizens until after WWI (Schilling, 2014). Native Americans greatly assisted the US military as soldiers and as code talkers, first as

Choctaw and Cherokee code talkers in WWI, and then as Navajo and Apache code talkers in WWII. The irony of this was that Choctaw and Cherokee soldiers were greatly assisting the US military at a time when Choctaw and Cherokee children were still in boarding schools, being told that they were not allowed to speak their native language (Winterman, 2014). Navajo and Apache tribal members were also unable to vote at the time they were serving in WWII. They were not given the right to vote until 1948 and 1962, respectively (Harada 2005, p. 782).

The historical pattern of high participation by Native Americans in the US military is one that continues today. Native Americans are the demographic with the highest per-capita involvement in the US military. “In 2010 22,569 enlisted service members and 1,297 officers on active duty were American Indian” (Schilling, 2014). Native Americans thus have a strong history of military service that continues today. Military service is highly regarded among tribes, and warriors are often honored through ceremonies and community gatherings. It is important that providers understand this, so that they are best able to offer models of care that align with these values.

II. Positionality and Audience

This thesis provides perspectives on integrative medicine. Integration is difficult for many reasons, including differences in language used. It is also difficult because there is a delicate balance to strike between acknowledging other practices and not appropriating them in a culturally insensitive way. As researchers, as clinicians, it is essential to take time to consider one’s personal vantage point, before moving forward in this integration process. Because of this, I am including a large section on positionality, in hopes that this not only provides greater insight into my own research process, but that

it provides a framework for other researchers and clinicians who are not Native, in considering their own perspectives when approaching integrative healing with Native Americans.

I conducted this research from an outsider's perspective, as someone who is white, female, and has never been to war. There is an obvious and inherent tension that exists within this dynamic. I have a high level of respect for the military as a whole, as well as for the sacrifices that all veterans make. I also feel empathy for those who face the unique set of challenges found in the military. However, Gair (2012) points out that even the concept of empathy within qualitative research is complex, and difficult to navigate.

Gair notes that while the idea of empathy is very much embraced within the help literature (psychology, social work, counseling), there is a great amount of debate among qualitative researchers about the role of empathy, given the fact that the researcher/community relationship is very much that of outsider/insider, and any discussions of empathy should cast doubt on "our capacity [as researchers] to know" (Lather, 2009, p. 20). Part of the difficulty around the concept of empathy in qualitative researcher is because of a paradox noted by Watson (2009) and Shields (1996), who both explain that originally researchers advocating for greater empathy did so because of a desire to make qualitative research more universal and accessible across disciplines (concepts which were both seen as positive). However, this desire to increase accessibility obscures the inherent individuality of experience. As Watson stated, this advocacy may even amount to "empathetic colonialism" (2009, p. 107).

It is difficult for any outsider, regardless of whether they are approaching a community as a clinician or a researcher, to not project one's own biases and

understanding on that community. This presents problems specifically in the context of health, because it can lead to either delivering a health model that does not align with the community's values, or appropriating culturally-specific practices in a way that is not respectful. One way to reduce the likelihood of either of these instances happening is to consider very specific definitions of empathy when approaching this work. While there are several definitions of empathy in the literature (Hojat, 2007; Shields, 1996; Hojat, 2005), I believe Rogers' definition of empathy most closely parallels what qualitative researchers should seek to emulate. Rogers (1959) described empathy as an ability to "perceive the internal frame of reference of another with accuracy as if one were the other person but without ever losing the 'as if' condition" (p. 210). Through this project, I sought to align with this, while remembering that I am not Native American and will most likely never go to war.

Gair (2009) also notes that in the helping literature, empathy is quite often used interchangeably or in tandem with other words such as "sympathy, imagination, understanding, kindness, intuition, pity, compassion, rapport building, spirituality, emotional intelligence, and intimacy" (p. 135). I would like to advocate for "openness" as an expression of empathy within qualitative research. Here I would like to expand the definition of "openness" beyond what Corbin Dwyer (2009) discusses as the ability to share not only one's membership identity, to also include sharing one's experiences. This should only be done in recognition of the often deeply personal experiences that participants may share, rather than as an attempt to elicit more information from participants.

In my process of embracing openness, I sought not only to share information about my education and intended future goals, but also experiences from my own life which are deeply related to the focus of this paper. The information I communicated was as follows: (1) When I was much younger, I developed several health problems. No doctor I saw was able to identify the cause of my health problems, and because of that, I sought help from many practitioners of traditional medicine disciplines throughout the world. Through this process, not only did I heal, but I also gained a deep appreciation for perspectives on health and healing throughout the world. (2) I have experienced a large amount of trauma in my life. I have worked intensively with a trauma specialist, and want to become a traumatologist after completing my MPH. Thus, trauma and integrative medicine are both areas in which I intend to work for the duration of my professional career. Both of these pieces of information were included in conversations, and on the participant agreement form for this project.

I shared these details openly and willingly with community members because: (1) I wanted people to understand why I was interested in this topic, (2) I believe that qualitative researchers should only ask questions of participants that they are also prepared to answer. The sensitive nature of this topic – mental health and well-being among Native American veterans – only compounded the importance of sharing this information. As explained by Corbin Dwyer, this process of sharing and openness is becoming increasingly common. She states, “Postmodernism emphasizes the importance of understanding the researcher’s context (gender, class, ethnicity, etc.) as part of narrative interpretation (Angrosino, 2005). By extension, researchers are increasingly making known their membership identity in the communities they study” (2009, p. 55).

Veterans who participated responded very positively to the fact that I shared these details. One man stated after reading the participant document in which I shared details about my own history, my education, and my interest in this project, “Now usually I don’t talk to quacks that never been in the Army. But I read what you said here about your education and what you’re doing. And the big thing is, I never trusted nobody” (D, Alaska Native Member). This man went on to share a great deal of information about his time in the military. Several others echoed his sentiments.

In terms of audience for this work, my intention is to speak directly to other non-Native researchers and clinicians. As a non-Native person, I believe it most appropriate that I speak to other non-Native people, as someone who seeks to further models for integrated healthcare within Western medicine. I hope that this work contributes to an increasing body of literature about patient-centered health care that would be applicable for these settings.

III. Literature Review

Villa (2010) notes that most studies on Native American veterans thus far have focused on the prevalence of mental health problems, such as PTSD. She notes that these studies have found that Native Americans have a higher prevalence and more severe forms of PTSD when compared to other demographics, including Whites, Hispanics, and African Americans. Beals (2002) attributes this to greater war zone stress exposure, and the fact that Native American veterans have faced more intense situations of combat.

Beals (2003) states that although American Indians often have populations that are too small to be included in epidemiological studies, focusing research on these populations is important for two reasons: (1) these populations may have a heightened

level of need, (2) such efforts can inform science more generally, specifically through testing established theories to see whether they truly are universally applicable or not (p. 264-265).

Evidence suggests that indeed, established theories such as the Stress-Vulnerability Theory or Problem Behavior Theory will not be applicable to Native American populations, because language and concepts related to mental health differ across populations. Beals articulates:

“For instance, Manson and colleagues (1985) demonstrated that meanings given words such as depression and anxiety do not occur in many Native languages, nor do these descriptors correspond to indigenous categories of illness. Moreover, even when English-language terms such as depression are used, as they were in O’Neill’s (1996) study of depressive-like experience on the Flathead reservation, they may have very different meanings” (Beals 2003, p. 264).

To understand Native American veterans’ health needs, it is first important to understand how trauma has historically and continues to impact Native American populations. Historical trauma can be defined as, “cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences” (Hill, 2010, p. 41). Evans-Campbell (2008) stresses the need for a historical trauma framework when examining the traumatic experience of American Indians. She explains that although Post-Traumatic Stress Disorder was developed as a diagnosis that characterized response to both acute and chronic trauma, it does not go far enough in explaining the compounding effects of inter-generational trauma. The fourth edition of the Diagnostic and Statistical Manual states that symptoms for PTSD include, “intrusion (e.g., dreams, thoughts that remind one of the event), detachment, avoidance, and hyperarousal (e.g., difficulty sleeping, irritability) and meet the criteria for PTSD if experienced for at least 1 month.” Historical trauma is unique in

that it is most often viewed as a collective experience borne by a specific ethnic or cultural group, and that descendants may continue to emotionally identify with trauma experienced by earlier generations (Evans-Campbell, 2008).

Native American and First Nations tribes have experienced a variety of traumas perpetuated by settlers and by the US and Canadian governments. Traumatic experiences include losing land, the boarding school experience (which often coincided with physical and sexual abuse), outlawing Native languages and religion, physical violence, and the spread of disease, among others. The systemic perpetuation of violence against tribes was carried out with the intention of assimilating tribes to white culture, and eradicating Native traditions. Gone (2013) characterizes the boarding school experience as intended to “kill the Indian, save the man” (p. 683).

The repercussions of these experiences are far-reaching. The poverty rate for American Indians and Alaska Natives is 26%, roughly equal to Hispanic and Black populations (Krogstad, 2014). As cited in Gone (2013), one elder who spoke with the author noted, “...all American Indians are [suffering from] post-traumatic stress...The programs we have now are Western cultural programs. We’re just beginning to develop our [traditional] ways and means” (p. 684). The suppression of Native culture, including Native healing practices, only compounded the difficulty in developing resilience and healing in the wake of extreme social upset. The legacy of trauma is still very much present with tribes today.

Despite the historical, logistical, and social challenges of providing care to Native American veterans in a way that aligns with their priorities and values, many of these veterans seek care in VA facilities. Thus, there is the need within VA facilities and other

hospitals to provide this level of care. Seeking insights and recommendations directly from Native American veterans is one way to ensure the quality of care continues to align with Native veterans' priorities.

IV. Methods

The scope of the study was established after an initial conversation with Native American researchers at the Seattle Indian Health Board (SIHB), in the spring of 2015. The group expressed that asking Native American veterans about their experiences with different healing practices would be helpful for service providers, including the VA and other hospitals. The Greater Seattle Area is a particularly important place to do this research. Tacoma, WA, is in the top 10 cities with the highest percentage of Native Americans and Alaska Natives (Schilling, 2013). Seattle also has organizations like the Seattle Indian Health Board and the Chief Seattle Club, which are unique. These organizations are privately funded and serve Native American populations. Finally, VA hospitals in the Seattle area have already begun integrating Native American practices with their health care offerings. Thus, Seattle is potentially a model for the rest of the nation in offering integrated care with Native American populations.

This study included 11 participants, representing 12 different tribes (one participant was affiliated with two tribes). However, two members who chose to participate in the focus group/talking circle did not want their words included in the final product. Five people participated through the focus group/talking circle, and four people participated through individual interviews. One person was a member of the focus group/talking circle, and wanted to continue the conversation as an individual interview

afterward, so this thesis includes a total of 10 interviews with nine people in the Greater Seattle Area.

Sandelowski (1995) and Dworkin (2012) both note that recommendations on adequate sample size in qualitative literature vary greatly. Sandelowski notes that smaller sample sizes may fail to achieve saturation, while larger sample sizes may fail to achieve the in-depth analysis sought by qualitative research. Responses from participants in this research showed several parallels with responses from Native American veterans interviewed in the literature, suggesting that many of these sentiments expressed here reflect those held by other Native Americans. Focus group participants also agreed with statements shared by other participants in the group, suggesting a general consensus around several ideas related to the nature of military experience and perspectives on different types of medicine. The data each veteran provided was incredibly rich, in part because of the format suggested by members of the Elders Council. Veterans shared deeply personal information from their own histories, their perspectives on spirituality and mental health, and how they approach healing as a Native American veteran in and outside a Western medical context.

The participants were identified through agencies providing health services to Native American veterans, through community events, and through Native American elders working with the VA to create integrative health care programs for Native American veterans. Leadership members within the Seattle Indian Health Board were instrumental in opening doors to community events, and in facilitating these connections, which were developed over the course of a year. I attended several community events,

such as pow-wows, sweats, and traditional medicine meetings, to meet tribal members, learn, and share my own experience and reasons for my interest in this area of study.

The structure of this study was designed collaboratively, as recommended by Joyce et al. (2005). Questions were suggested by Native American elders who oversee health programs for veterans. I had prepared a potential list of questions prior to speaking with these elders, and quickly learned that a different series of questions would be more in alignment with topics Native American veterans would wish to talk about. The final list of questions I asked Native American veterans was submitted to the UW IRB board after receiving approval from these elders. I will not seek publication at specific journals without input and collaboration with the individuals and organizations that informed and guided this project.

The focus group/talking circle for this project was facilitated through the Seattle Indian Health Board. I am using the term focus group/talking circle, because the structure for the event was that one question was asked and each person in the circle would take a turn responding. I provided food for the event (through a Native American-owned catering company), as well as small gifts (such as pouches of tobacco and small tokens representing my own heritage) for participants in appreciation for their thoughts, insights, and contributions. These were all measures suggested by tribal elders/healers. Approval was received from the Seattle Indian Health Board before administering the focus group/talking circle, and a counselor from SIHB attended the discussion.

Selection criteria were simply that the individual identified as Native American, and that they were a veteran. No additional criteria about the terms surrounding their discharge (honorable vs dishonorable) were included.

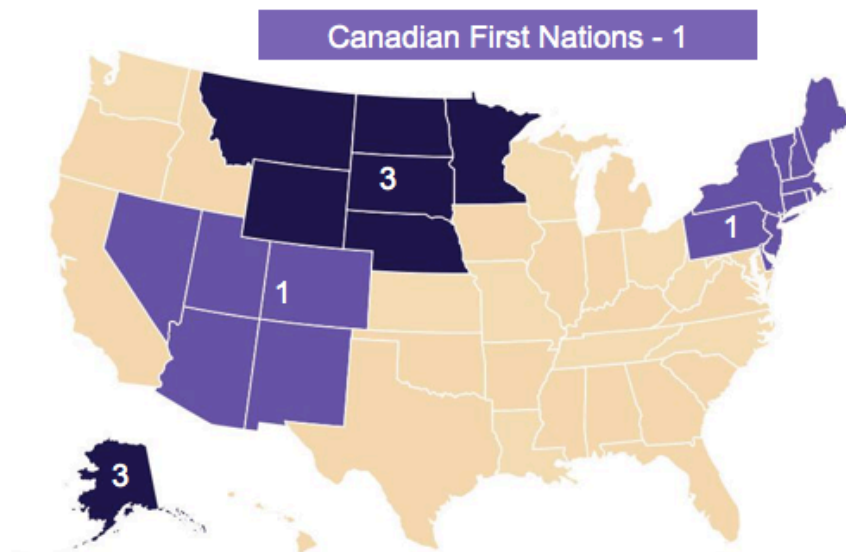
I recorded all interviews, transcribed them, and hand-coded them. Data was open-coded according to common themes. Some of these themes were expected, because questions explicitly asked about them. Because several of the questions were based around biographical information and military experience, many of the narratives centered on time spent in the service. Questions also explicitly asked about traditional medicine and conventional medicine, so these were also common themes in responses. However, no question explicitly asked about trauma, and trauma was a common theme that emerged in responses both when discussing military experience, as well as health care sought after return from active duty.

V. Results and Discussion

Biographical Profiles of Participants

Of the nine Native American veterans who chose for their words to be included, six had served in the Army, one had served in the Marine Corps, and two had served in the Navy. Time served ranged from 6 months to 27 years, with the average being 9.7 years. Six had served in combat. Of those, two had served in Korea, one had served in Vietnam, one had served in Korea and Vietnam, one had served in Kuwait, and one could not specify because of security details around his service, but spent a great deal of time in Southeast Asia. All veterans were enlisted, although three were non-commissioned officers, with the highest ranking member as Master Sergeant Promotable. This meant that the veteran had achieved an E9 ranking, but chose to retire because he had served for many years, and did not think the pay increase merited staying in the military.

The veterans represented 10 different tribes (one person was from two tribes, both in the same region). In this paper, I will not use specific names of tribes, but rather refer to tribes on a regional basis, in order to protect tribal confidentiality. This is the approach recommended by Norton (1996), and by the Native researchers I spoke with. Three of the veterans interviewed were members of plains tribes, three were Alaska Natives, one was Canadian First Nations, one was a member of a Northeast tribe, and one was a member of a Southwest tribe.



Veterans gave a variety of reasons for joining the military. Of the nine, one had been drafted. Two chose to join as a pre-emptive measure, because there was a draft at the time, and they had heard that volunteering would afford them the ability to have greater choice over what they did. One person said that he had known since he was a boy that he was going to join the military. Four people listed general life factors, such as friends or a desire to see the world, as their reason for joining. One summarized this reason, saying, “I wanted maybe something different with my life. At the time I wasn’t doing anything” (F, Plains Tribal Member).

One person said that he wanted to be a part of something, because he had never had that. He explained,

“Maybe my reason was I just wanted to be able to identify with the United States. To be able to say, yeah I fought that war with these guys. To be part of something. I was never a part of something, and I wanted to be a part... You know, I wanted to fight for our country. I would have sacrificed my life” (H, Alaska Native Member).

This person lamented the fact that he had not been sent to a combat zone, as that was something he was willing to do. Two people also mentioned that they had a history of military service in their family, although they did not give this as a primary reason for joining.

In the Harada study (2005), Native American veterans reported reasons for joining the military that for the most part closely aligned with reasons given by veterans in this study. “A lack of jobs,” “going and seeing the world,” “meeting new people and finding out things about different parts of the world,” and “going to school on the GI Bill and getting a house on the veterans” were reasons in the Harada study that closely mirror reasons given by veterans in this thesis. In addition, participants in this study echoed Harada’s findings about the positive perception of tribal community members on military service.

Trauma

Before service

Several people spoke of trauma and instability in their family lives before the military. Two people had been adopted, one as an infant and one as a child. The veteran who was adopted as an infant did not know he was Native American until he was given the opportunity to look up his original birth certificate for medical reasons. He had

reconnected with his tribe later in life. Another person had also discovered his Native American roots later on in life, because his mother didn't talk about where they came from. He said, "I started out as a kid from a nomadic life with no trust in anybody...because my mother never talked about [our history]. We just knew we were somebody that moved a lot" (E, Northeast Tribal Member).

Two veterans mentioned they had been in prison, one person before, and one person both before and after military service. One person mentioned his mother had been in prison, and that he had two sisters who were adopted and left his family at a young age, although he explained that his family didn't talk about the circumstances surrounding their departure. He stated, "I needed a lot of psychological and mental health work done [at the VA]. Not just because of no war, but the war out here in the streets" (H, Alaska Native Member). These statements and experiences reflect the fact that many veterans had already faced a great deal of difficult and challenging circumstances before military engagement.

That said, it is important to note that many veterans also had very positive experiences before joining the military. One person spoke of having the opportunity to go to wonderful schools. Another person talked about being quite close with his family, and another person mentioned having family close by as one reason he moved where he did. Like others serving in the military, the stories of the Native American veterans prior to joining the service are complex and reflect a variety of experiences.

During service

One reason cited for trauma experienced during military engagement was a loss of friends. One man who had participated in the focus group/talking circle reflected on the group afterward. He expressed,

“In this meeting, I wish I would have talked, because they would have understood where I was coming from. I talked to my counselor today and she opened my eyes...I don't mind crying...Yes, I mean it took a lot of years to be able to do that. Cuz you learn not to cry as a man. Men don't cry! I don't know who came up with that. Men do cry when it's upsetting. When there's certain emotion that would bring about tears. You just don't lose a friend, close relative, family, and think you're not going to have emotion” (H, Alaska Native Member).

There were several times in the focus group/talking circle when participants became emotional. Another man echoed this sentiment about the difficulty of losing friends, saying, “I lost a few friends. And that was during peace time, sheesh” (G, Southwest Tribal Member).

In addition to losing friends as a source of trauma in war, another person pointed out that the nature of military engagement is fundamentally complicated for Native Americans, due to the history surrounding the US military and tribes. He stated, “I also found out that I was involved in killing...people for no good reason. It took me a lot of years before I understood that, that I was doing the exact same thing that the American government did to my people...they killed us and...there I was in Vietnam doing the same thing” (E, Northeast Tribal Member). While military service is highly valued among tribes, some Native American veterans described internal conflict with serving in the military of a government that historically repressed their people.

Despite this complicated relationship with participation in the military, veterans stated that they were always well received and honored by their tribe for their service. One veteran said that when he returned from Vietnam, like many others, he'd been

negatively received by many people. He said that he'd grown his hair long like a hippie to try and disassociate himself from the military, but that the reception he received from his tribe was vastly different from the US population as a whole. "Oh yeah, they treated me much warmer. I had lost all those feelings and they were so warm. [One of the] most important people is a warrior...So they treat me a lot better" (A, Plains Tribal Member). For some Native American veterans, it may be difficult to reconcile participation in the US military (a body with a historically fraught relationship with tribes) with a simultaneous high level of honor and respect placed by tribes on military service. For others, reconciling these two things may not be difficult.

One person also noted that the structure of war itself is changing, which exposes soldiers to additional trauma. He said, "Some of the younger generation, I know some of them are 13, 14 tours. Yeah that's insane!" (I, Plains Tribal Member). The lack of a draft today means that the military is smaller, and that each service member is required to serve more tours. This also highlights the fact that a health care provider's job is made more difficult when the structure of the military and engagement in combat changes. This is of particular importance for Native American veterans. As Beals (2002) notes, Native American veterans already have higher rates of PTSD, which she attributes to greater war zone stress exposure. The high rate of combat faced by participants in this paper is consistent with that. In a 2001 VA survey, 38.9% of US veterans reported serving in combat (Department of Veterans Affairs, 2011, p. 49), in contrast to 66% reported by Native American veterans who participated here.

Trauma – Drugs and Alcohol

Drugs and alcohol were recurring themes. Participants in the focus group/talking circle talked about drugs and alcohol as a common part of military culture in general, and something that most service members would be exposed to. One person summarized this saying, “Yeah, like anybody else I drank, did drugs. I got busted 4 times for selling drugs. One AWOL. Managed to come out. I don’t know how I managed to do that, but I did. I worked hard” (G, Southwest Tribal Member). Two people mentioned they had been treated for alcoholism at the VA.

One person attributed their time in the military as one reason why they ended up in prison, saying, “...I was in the service at the age of 17, came out age 20, and all I knew was how to handle a gun...so I was shooting dope, drinking...and pretty soon I end up killing this cop” (D, Alaska Native Member). The man mentioned the fact that he began to do drugs heavily after he began his military service.

Trauma Within a Larger Context

Despite the incredible demands of military service, as well as traumas experienced in and outside the military, most veterans interviewed said that they were glad to be veterans. Although all service members will most likely experience trauma to some degree, it is also important that researchers and clinicians see veterans not simply as people who have undergone deeply traumatic experiences, so as not to project one narrative on them or see them simply as a cluster of symptoms related to exposure to trauma. It is important that they also understand the whole person, which can be seen through recognizing the complexity and nuance of military engagement. As one veteran explained, “...That was a pretty good experience. You had to be suited up, ready to go...Anyway it was a good experience. I’m just glad it’s over with” (First Nations Tribal

Member A). Another person said, “My father was sick with cancer at the time, he was dying. [His death] was pretty hard on me, so I went and joined the Army. And it was a good thing for me at the time” (F, Plains Tribal Member).

Other veterans recounted good times they had shared with other servicemen in their unit. One man shared a story of a day that his platoon leader told him and the other men to bring civilian clothes to a training exercise in the Southwest desert. After the exercise, he told them to put on the civilian clothes, and they walked 1.5 hours through the desert to Ciudad Juarez, where they spent several hours enjoying a minor break and having a good time (F, Plains Tribal Member). This was an experience he looked back on as a positive one. Thus, while trauma is important, it is not the only lens through which service members should be seen. In providing patient-centered care to veterans, it is important that clinicians continue to see the whole person, beyond simply someone who has experienced a high degree of trauma.

Experience with the VA

Generally veterans were quite complimentary of the VA, for a wide variety of services. Almost all veterans interviewed reporting using the VA. Only one veteran in this project interviewed reported using Indian Health Services, and this was only when he was away from a large urban center, most likely visiting the reservation where he is a member of the tribe. Several veterans interviewed reported using health and service centers specifically targeted to Native Americans.

Almost all veterans spoke about their satisfaction of care for physical illnesses. One person stated that because he was wheelchair bound, he thought it was great that VA practitioners would come to his house and provide care.

“I have therapists, I have physical therapists, I hurt my right arm. And they come right to my house and work me out! I tell you what. I have the best medical care through the VA” (A, Plains Tribal Member).

Another person also stated that they were happy with their experiences at the VA for mental health services.

“I went to American Lake twice for inpatient treatment [for psychological treatment]. I was there 30 days. The VA has a new therapy program. They changed it – I was there in 2013. I couldn’t believe how much they had changed it. It was so good, they changed it for the better. It just amazed me, why didn’t they do this the first time?” (H, Alaska Native Member).

This participant went on to explain that they had separate support groups for combat and non-combat-related psychological trauma. He also stated that he realized people from both groups were talking generally about the same themes, but that he liked the format.

Only two people were not enrolled in the VA, one by choice, and one because he said he had been dropped from the program (he cited federal budget cuts as the reason). The veteran who was not enrolled in the VA cited too much paperwork as the reason he wasn’t interested in enrolling. This person summarized his feelings saying,

“Yeah I hear a lot of bad things about the VA hospital. And I hear just as many good things....I think if you’re nice to people and not yelling and screaming, they’ll be nicer to you” (C, Alaska Native Member).

It is worth mentioning that this man also had a very positive experience with the VA when he went to visit a friend. Through some administrative difficulties, he was having trouble finding the room number where his sick friend was hospitalized. However, a woman was walking by the front desk, asked about his problem, and personally took him room to room to find his friend. He learned later that this woman was chief

administrator for the entire facility, and thought it was great that she cared about his question.

Veterans also stated that the VA provided health services they couldn't access elsewhere. The one person who had lost his VA benefits stated,

“I still want medical, because I'm at an age now where things are falling apart inside of me. And you know, you just get better medical care, that's what I want. It's...not like I can't get it nowhere else, I can. I come here [to a health and social services center for Native Americans], I can go other places. But I like the VA. They spoiled me. They put a hook in me and spoiled me” (H, Alaska Native Member).

All veterans were able to access health benefits in some capacity. All those who accessed VA health care seemed generally quite happy with the services and quality of care they received.

Veterans interviewed did make some suggestions for improvement in VA services, but they were all related to logistical and bureaucratic issues, or greater social services for family members. No person made a suggestion for improvement in mental health services at the VA. Suggestions provided included: (1) More help for veterans' families, especially if veterans are having an operation; (2) Decreased paperwork: One person summarized this, saying, “I think if you were a veteran, and you got your veteran ID card, you should just be able to go up to the VA hospital and have someone see you, and not have to worry about paperwork” (C, Alaska Native Member); (3) Self-defense classes, for those who are wheelchair-bound; (4) Better communication about support groups specifically for Native American veterans.

These suggestions are perhaps reflective of the fact that participants were recruited from the VA and other health service centers. Had participants been recruited who were not currently accessing VA services, their responses could have been different.

Noe (2014) notes that AI/AN veterans often report a lack of cultural understanding within the VA, a preference for using traditional medicine, dissatisfaction with the VA, and a lack of knowledge about VA services and their benefits as reasons why they do not choose to or are unable to obtain VA care.

Medical Care Outside the VA

Six of the nine veterans accessed health services through health clinics/service centers targeted to Native Americans, such as the Seattle Indian Health Board and the Chief Seattle Club. The person who had made the choice not to enroll in the VA said that he was able to access all the health services he needed at the facility he visited outside the VA. Another man spoke about the fact that he was able to access care faster at the Seattle Indian Health Board than at the VA. He also spoke very highly of his mental health counselor at the center, and encouraged others to speak to their counselors, and share their emotions. He explained:

“I went to the veterans’ clinic, and I had to wait, wait in line, so that was a bunch of BS. And I came down here to the Indian Center, because I was a Native. And I get my medication quicker. And the thing is I’m on Medicare, Medicaid. And I got kidney problems, high blood pressure problems. Heart problems, it’s unbelievable. And the thing is I’m a recovering alcoholic. I go to AA meetings. I’m 33 years clean...And the thing is, I try not to repeat myself because I know a lot of these guys go to the same meetings. And the thing is, what you stay here will stay here. That’s the most important thing, as I said, when you walk out that door you’re going to be a better person because you got all that shit out. And you can carry it, but you won’t be able to talk about it no more. Because everything that you said stays here. And the emotion in the tears is very important, because you let that shit out. This is going to make you a better man, believe it or not” (D, Alaska Native Member).

This man was very happy with the breadth of services he had found at the service center.

Traditional Medicine

Of the nine veterans, only one had not ever used traditional medicine. Everyone else had used some type of traditional medicine in the past, or was currently using traditional medicine. No one used only traditional medicine to the exclusion of health services at the VA or other health facilities. This is consistent with the literature. Fuchs (1975), found that use of traditional medicine did not detract from use of conventional allopathic medicine among Native Americans living in an urban center.

It is important to note that traditional medicine is not a monolithic entity. One veteran stated that he didn't like the name "traditional medicine." He stated rather that, "I would go with a tribal affiliation, [that] would be more appropriate." He explained,

"Most people would prefer natives from their own tribe, because customs and traditions are so different from tribe to tribe. Especially out here. I don't know if someone mentioned before but we got like 166 tribes. So not talking just the local Coastals, but also talking those that have come from other tribes across the country, and the world, as far as that's concerned" (I, Plains Tribal Member).

The same veteran noted the complementarity of traditional medicine and conventional allopathic medicine,

"It would be foolish of me not to be using the VA. [I also have Tricare and Medicare.] But I also use traditional medicine too, because there are things that Western medicine can't deal with. So I revert to traditional medicine – and that's mostly for sicknesses that Western medicine can't handle. The spirit, for the feelings" (I, Plains Tribal Member).

Another veteran echoed this explanation of the fact that different types of medicine were appropriate for different types of healing. He explained he used the VA and Tricare for "certain types of physical healing," and that he followed more traditional ways for other types of healing, such as spiritual and emotional (E, Northeast Tribal Member). While almost all veterans used both traditional and Western medicine, these

two veterans were also directly involved in providing traditional services to others, and were currently working with the VA to do so.

Other veterans also noted a strong spiritual element that was important in their healing. One person stated,

“Yeah I use both [traditional and Western]...That’s the way I was raised. Prayer is strong healing. I don’t go to church very much, but I’ll go. And I pray every day. I try and take advantage of it all. That’s what it’s there for” (G, Southwest Tribal Member).

Another person also talked about the importance of faith, saying:

“I’ve actually decided I’ve lost my faith in the government. I’ve lost my faith in the state. So the only one I can really trust is God - God is the only one who’s going to lead us straight...I make decisions, I pray for Grandfather to give me that power of my own self...I believe in coincidences, but if it happens more than once, it’s something else. I believe that everything is connected together, that we become one with our Grandfather, grand light, water light, nature, everything is connected. If you have all those things going, in your mind and in your body, I believe things will go right for you” (H, Alaska Native Member).

While talking about spirituality within the context of health and healing may be unfamiliar to many non-Native researchers and practitioners, the responses here show that this spiritual element is very much important to mental health and wellness for some of these veterans. The first participant, who explained that traditional medicine was good for “the spirit, the feelings,” demonstrates that feelings (a realm familiar to Western mental health practitioners) and spirituality, are very closely bound for many of these veterans. Although certainly not every veteran will share this same value in spirituality, these responses demonstrate that for some veterans, there are specific areas of health for which VA programs are highly effective, and areas where other approaches may be needed.

One of the veterans who is deeply involved in integrating traditional and conventional allopathic health services explained more specifically what traditional practices had done for his health.

“And one of the things having spent more time finding my way with the native ways was, I was able to let go of something I’ve been carrying around with me for a very, very long time, and that was my anger” (I, Plains Tribal Member).

This statement reflects the fact that many of these practices can be therapeutic in terms of assisting in the release of anger and other emotions that are a result of military service.

It is also interesting to note that two veterans interviewed mentioned that they used traditional medicine not affiliated with any Native American tribe, but instead from elsewhere in the world. The two modalities mentioned were acupuncture and tuning forks/healing bowls, which both come from Asian healing traditions. This suggests that traditions from one culture can be helpful and supportive for individuals not from that culture. One veteran mentioned that a group he works with that provides traditional medical services to Native veterans will most likely make these programs available to non-Native veterans in the future, although their first priority is to serve the needs of Native veterans.

Traditional Medicine – Sweat Lodge

One type of traditional medicine that several veterans spoke about specifically was the sweat lodge. A sweat lodge is a dome covered with blankets or other materials. Hot rocks are placed inside, and then one person pours water over the rocks, which fills the dome with steam. The room can get very hot. Each region has a different style of

sweat lodge, and sweat lodges today may also differ greatly between urban and rural areas.

One person explained the purpose of a sweat lodge, and preparation process before going. He stated,

“Yeah, I used to run a sweat lodge. But when I’m not in the right frame of mind, I don’t even go near it. So what I do is wait six months clean. And then like me, before I go in the sweat lodge, I fast for four days. Stay away from all negativity, all negativity people. And clean my mind and body out. All I do is drink water for four days. And then I go into the sweat lodge. There’s a lot of people who don’t know that” (H, Alaska Native Member).

Participants’ perspectives on sweat lodges varied greatly. One person stated, “I do the steam room daily [at the West Seattle YMCA.] So that’s my sweat lodge. I’m not really all that interested in going” (B, First Nations Member). This response is reflective of the fact that the participants here were from an urban population, and may embrace traditional practices to varying degrees. Robert Palmer is a psychiatrist of Plains and First Nations descent. He incorporates traditional practices into his work as a psychiatrist and states, “With Indians, all healing involves spirituality” (Palmer, qtd in Lamberg, 2000). The veteran quoted above may not agree with this statement. Native veterans used different types of traditional services to varying degrees. While spirituality was relevant to many, it is also important that each individual be given the opportunity to access services in the way that he or she wishes.

Another person stated, “I’m involved in 3 different sweat lodges...[The men in one of the sweat lodges] grew up thinking they were crazy and have no place to go. They’re still out there. That nagging feeling that you just don’t belong, anywhere. So I try and work and help them in the best way” (E, Northeast Tribal Member). This suggests that aside from enabling participants to find a sense of community, a sweat lodge may

serve a strong mental health purpose. It can help address deep feelings for those who feel displaced, uprooted, or distanced from others, all sentiments which are common among veterans, especially after return from active duty.

Another person who also currently leads sweat lodges explained, “I have been to a sweat lodge many, many times. I actually even pour them too. Do the fires for them” (I, Plains Tribal Member).

Two of the people here are involved with sweat lodges that are adjacent to a VA facility, and are used by veterans seeking care at this VA. This is unique, but could prove more widely replicable, if it is desired by Native American veterans accessing care at other locations. All the traditional practices and programs for Native American veterans mentioned here are overseen by other Native American veterans and/or practitioners, which should remain the case if these programs are implemented elsewhere.

VI. Strengths and Limitations of the Study

One strength of this study was that the in-depth, qualitative interview format allowed for a deep exploration of many topics addressed in other publications. Because of the longer, open-ended format, veterans had the opportunity to speak about what was important to them, and touched on many sensitive topics that have important health implications for those working in and outside the VA. For example, the question of “Could I ask what you did in the service?” sparked a huge amount of discussion in the talking circle. Another strength was that the mixture of individual interviews and focus group/talking circle discussions allowed for veterans to express ideas in multiple settings.

The limitations were that veterans interviewed generally came from urban populations, and their experiences may not be illustrative for other populations,

particularly in rural areas. Noe (2014) notes that roughly 40% of American Indian and Alaska Native veterans live in rural areas, such as reservations and tribal lands. Urban Native American veteran populations generally have greater access to health centers, such as VA hospitals.

VII. Conclusion

Only 0.5% of the US population today serves in the military, as opposed to 12% during WWII (Eikenberry, 2013). The stories shared in this paper highlight the sacrifices that a small group of individuals make on behalf of the US as a whole. The fact that Native Americans have a disproportionately high rate of representation in the military highlights the fact that this is a group worthy of special recognition, especially in light of the history and legacy of which they are a part. The high rate of exposure to combat reported by veterans in this paper, in addition to the impact of historical trauma, underscores the need to ensure that VA health services are responsive to Native American veterans' health needs.

The changing nature of war also reinforces the need to ensure these services are available today. Kang et al. (2015) report that before the Iraq and Afghanistan wars, suicide rates among active duty and former military personnel for the Vietnam and the Persian Gulf Wars were actually equivalent or lower for veterans than the general population. The authors note that overall mortality risk is lower for Iraq and Afghanistan war veterans than the general population, which the authors attribute to intense physical screening processes prior to enlisting, a demanding physical training regimen, and greater access to healthcare for veterans than a comparable sample from the general US population. However, this "healthy soldier effect" does not protect against suicide (p. 99).

When today's veterans are asked to go on 13-14 tours, the risks of developing mental health disorders only increases. This is especially important for those outside urban centers, where VA health services are not as readily available.

The 2006-2010 RAND evaluation of the VA concluded that the VA was offering a wide variety of services at a consistent and high level, and yet, this model was failing to adequately improve mental health issues for the majority of veterans. Yet the majority of veterans report feeling helped by their treatment at the VA, highlighting the complexity between symptom improvement and feeling helped. The responses given by Native American veterans in this paper offer insights into alternative ways to think about health and healing, which may aid in the process of expanding services for veterans in order to close this important gap.

Several veterans spoke about the strengths of both conventional allopathic and traditional medicine in its many iterations. This project shows that the national conversation around health and healing ought to be an expansive one. There is much room for growth in ways to integrate different approaches to healing, both on a physical and an emotional level. Words by participants here also underscore the importance of looking beyond the physical in healing, and the importance placed by many individuals on a spiritual/feeling component to healing. The fact that the vast majority of veterans here use both traditional as well as conventional allopathic medicine supports the notion that these approaches to health and healing should indeed be viewed as complementary, not antithetical to one another.

This thesis was conducted with the goal of adding to the discussion about alternative and broader ways to approach mental health care for veterans. Any further

discussions of program planning for specifically how to do this should be done very much in consultation and collaboration with traditional practitioners and elders. For non-Native clinicians and researchers, this process should be done with an understanding of the history and current state of Native American military engagement, and with a sense of awareness in one's own position as a non-Native person working with another culture. Implementing integrative medicine models often presents challenges, particularly for mental health, because of differences in language and how mental health-related illnesses are conceptualized. However, the perspectives offered by veterans in this thesis underscore that such a model is not only possible, but also important in light of the reality in mental health services for veterans today. Some of these services offered in the Greater Seattle Area highlight the fact that these programs could potentially serve as a model for the rest of the nation. The process for doing this should be driven by tribes and traditional practitioners, as they are best able to speak to what instances these models might be appropriate for other veteran populations.

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VII. Appendices

Appendix A: Questions Asked

The questions I asked for one-on-one conversations are as follows:

1. Thank you for your service. Could I ask you which branch of the service you were in? (Army, Navy, Marines, Air Force, Coast Guard) *(if you did not serve, but have a family member who served, please move to question 10)*

2. Where did you grow up? What state?

3. How many years did you serve?

4. Where did you enter into the service?

5. What was your highest rank?

6. Could I ask you what you did in the service?

7. Could I ask why you chose to enter the service?

8. Is there anything else you would like others to know about your service?

9. Do you have any additional family members who have served?

10. Are you married? Do you have children?

11. Do you identify with any Ethnic group?

a. If Native are you enrolled or descendant?

12. Which if the following do you use (please choose all that apply):

Indian Health Clinics

The VA

Traditional medicine

None

Other

- a. Can you tell me in what instances you would choose these options?
- b. What are we missing about providing care to Veterans?
- 13. Are you enrolled in the VA System? Would you like to be?
- 14. When did you have your last check-up? Are you having any health problems?
- 15. Do you participate in any Tribal activities connected to health or healing?
- 16. Have you ever been given a diagnosis for illness?
- 17. Are there any Tribal Ceremonies for your returning Veterans?
 - a. Did you get to participate in any of these Ceremonies?
- 18. Would you like to talk to a Tribal Elder?
- 19. Have you ever been to Sweat Lodge?
 - a. Would you like to?
- 20. What else, if anything, would you like to talk about?

The questions I asked for group conversations are as follows:

- 1. Could I ask you what you did in the service?
- 2. Could I ask why you chose to enter the service?
- 3. Do you have any additional family members who have served?
- 4. Which if the following do you use (please choose all that apply):

Indian Health Clinics

The VA

Traditional medicine

None

Other

- c. Can you tell me in what instances you would choose these options?
- d. What are we missing about providing care to Veterans?
- 5. When did you have your last check-up? Are you having any health problems?
- 6. What else, if anything, would you like to talk about?

Appendix B: Introductory Letter/Interviewee Agreement

Agreement for Participation in Project to Help Grow Integrative Health Care Programs Designed By and For Native American Veterans

Hello,

Thank you for your interest in participating in this project. It is only through your insight, expertise, and contributions that this project will be a success. For ensuring we can create this together, thank you.

My name is Leah Spelman, and I am currently completing my Masters of Public Health at the University of Washington. My intention is to create a project that is truly collaborative, and strengthened through teamwork. This project will enable me to complete my thesis, but to me this is far more than a research project. I hope to devote my life in part to helping to bridge the gap between conventional allopathic and traditional medicine from around the world. Although I am not Native American, traditional medicine has played a huge role in my own life. When I was younger, I started experiencing a lot of health problems. I went to several allopathic specialists who were not able to provide answers for me. Thus began a very long journey through other types of medicine and approaches to health from around the world. Through this process, I not only healed, but gained a huge amount of respect and appreciation for different and complementary approaches to health and healing. This is one reason why I am in a global health program today.

I have not served in the military, but I have experienced a large amount of trauma in my own life, and have worked intensively with a trauma specialist in order to heal that trauma. Although every story and every person's experiences are unique, I believe that to know and understand pain is universal. For anything you choose to share in conversations related to this project, I got your six.

What I hope to accomplish through this project is a strengthening of health programs to support Native Veterans, by ensuring voices of Native veterans are clearly heard. As someone who is deeply committed to trauma healing and integrative medicine, this is something I seek to help facilitate through this project.

The information presented by you and others through this project will be shared in a written document with health practitioners and administrators in the VA, and potentially with other health centers supporting Native veterans. I will also give a 10-minute presentation to the Department of Global Health in June, and it would be an honor to have you there, should you like to attend.

As a participant and co-creator of this project, you will be given transcripts from your one-on-one conversations. (This project will include both one-on-one conversations, and group conversations. Transcripts from group conversations will be shared if all members of the group agree this should be done.) You will also be given a copy of the final project to share with whomever you wish.

All of the questions included in one-on-one and group interviews are optional. You do not have to answer any questions you don't wish to. Signing below does not mean you are agreeing to answer all the questions. It just means that you would like for your words to be included in the final project.

As a co-creator of this project, your words are your own. You of course may choose how much of what you say you would like to be shared publicly after the completion of this project. If you do not wish for something you say during a one-on-one conversation or group conversation to be included in the final project (which will be shared publicly), you absolutely have the right to choose for that not to be included.

1. Yes, I would like to have any words or stories I choose to share included as part of this research project.
2. I understand the research project will be presented in a publicly-available written document, and shared with providers at the VA, and the UW Department of Global Health.
3. I understand that the final paper may be submitted for publication to a journal related to health in the future, for the purpose of improving health services and support for Native American veterans, and for continuing to strengthen integrative and holistic care offerings both in and outside the VA.
4. I understand that I may choose for specific things I share in one-on-one conversations or group conversations not to be included in the final written document. If I have something I do not want publicly shared, I will let facilitators know.
5. I understand that my name, tribe, and any other identifying characteristics will be kept anonymous.

Printed Name

Date

Signature

Email

Phone number