Differences in Perspectives on Hearing Voices among Aboriginal Peoples and Conventional Psychiatric Services

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Abstract

Introduction

Aboriginal people have historically viewed voice hearing differently from conventional psychiatry, tending to normalize it or spiritualize it. This can lead to conflict when biomedical practitioners interact with aboriginal communities.

Methods

We summarize 12 community case studies arising from our visits to multiple aboriginal communities in which we dialogued about perspectives on hearing voices and the relationship of community members to conventional psychiatric services.

Results

In all the communities visited we found tension between traditional elders (TE) and indigenous knowledge keepers (IKK) and conventional mental health practitioners with resentment of the privileged position of the biomedical view. Including aboriginal elders as part of the health care team reduced these tensions and improved cross-cultural relationships.

Discussion

Mental health providers who work in aboriginal communities or with aboriginal people should have more understanding of aboriginal views of voices. Through dialogue, opportunities may emerge to explore the therapeutic utility of aboriginal views.

Relevance Statement

Psychiatrists are more often being asked to interface with cultures other than the mainstream. Many of these cultures have very different ways of perceiving psychological phenomenon that what is common for mainstream psychiatry. We review a series of aboriginal communities as case studies and suggest that psychiatry would do well to consider aboriginal views as legitimate, even if the bridge is the concept of metaphor. Contemporary biomedical practice appears to aboriginal people to be dismissive and disrespectful and is not encouraging of collaboration. Additionally, metaphor or not, aboriginal healers may have some useful techniques for the management of hearing voices.

Introduction

Aboriginal peoples under utilize available mental health and addiction services [1]. Four out of five people in Low and Middle Income Countries who need services for mental, neurological and/or substance use disorders do not receive them [2]. However, the first line of treatment recommended in many of the templates for intervention in these societies is psychotropic medication [3]. Aligning the treatment of mental health difficulties too closely to a biomedical model may have potentially detrimental effects for aboriginal people [3,4]. Medical care provided within aboriginal directed facilities is perceived very differently from that provided by government directed facilities [5] and provides a "culturally appropriate alternative to mainstream medical services as a means to address health disparit[ies]." Focus groups with aboriginal recipients of services have highlighted the pervasive influence of racism resulting in reduced healthcare seeking behavior, unhealthy lifestyles, and mental health issues [5]. Participants emphasized the marked health improvements seen due to the establishment of aboriginal medical services (AMS) in their communities and the importance of the AMS' role in addressing the negative effects of discrimination on Indigenous health. Culturally syntonic services improve Indigenous healthcare seeking rates, provide invaluable health education services, and address mental health concerns in communities. Community driven and culturally informed health services reduce health disparities.

Concern has been raised that Western treatments and conventional psychology have failed to address the needs of Aboriginal peoples because they do not understand traditional spiritual and healing methods that continue to persist in many Aboriginal communities [6-9]. In Australia, for example, Aboriginal people are more than

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twice as likely to experience serious psychological distress [10]. Exposure to Western psychiatric treatment and beliefs, appears to add causal models but not to replace the original beliefs about spiritual causality [11]. As part of a larger project in how to provide culturally appropriate health care in aboriginal communities, in this paper we aimed to explore the differences in understanding and treatment of “hearing voices”.

Methods

As part of a larger project for how to integrate local culture into health care delivery, we interacted with 12 indigenous communities in Australia, New Zealand, South Dakota, Washington State, New York State, and Saskatchewan. During our time in these communities, we kept notes about our discussions and observations with elders, mental health practitioners, and community members about their views on “hearing voices” and people who hear voices. These discussions were part of larger conversations on how to provide culturally appropriate mental health care. We reviewed our community case notes and summarized similarities and differences across communities.

The Australian community was in the far southeast of Australia, an area exposed to European infiltration earliest in the history. Communities in South Dakota were in the Pine Ridge Agency and the Cheyenne River Reservation. We interacted with the Lummi community in Washington State. Within New York State, we interacted with the Cattaraugus Reservation. In New Zealand, we interacted with a Maori community near Palmerston North, with two communities around urban Auckland, and with two communities in the far North of the Northern Island. In Saskatchewan, we interacted with a Dene community in the Far North and with a Cree community in central Saskatchewan. The number of people hearing voices, were as follows:

- Southeastern Australia: 16
- Pine Ridge Agency, South Dakota: 14
- Cheyenne River Reservation, South Dakota: 10
- Lummi Community, Washington, 18
- Cattaraugus Reservation: 5
- Palmerston North Area, New Zealand, 5
- Urban Auckland combined, New Zealand, 10
- Northern, North Island, New Zealand, combined, 17
- Northern Saskatchewan, 23
- Central Saskatchewan, 15

We used case study methodology [12], in which a “case” is considered to be a complex functioning unit, to be investigated in its natural context with a multitude of methods, and is contemporary. Crucial to case study research are not the methods of investigation, but that the object of study is a case: “As a form of research, case study is defined by interest in individual cases, not by the methods of inquiry used” [13,14]. Others [15] place more emphasis on the method and the techniques that constitute a case study. We appreciate the more inclusive definition: “case study is defined by interest in individual cases” [13].

Case studies combine other research strategies and can be said to be a meta-method. The ability to act within professional practice is based on knowledge of a repertoire of cases [16] based on either personal experience or model cases established within the profession. A designer’s work, for example, is based on comparisons between known cases from the repertoire and the actual design situation [17]. A case study normally focuses on one case, but simultaneously takes account of the context, and so encompasses many variables and qualities. This strategy has been called “explicative” [12] as opposed to “experimental” (one unit of analysis and a few isolated variables) or “reductive” (many units of analysis and a few variables) [18]. At minimum, a case is a phenomenon specific to time and space [12]. The boundaries, and even the focus of the case, can change through the research process.

The concepts of traditional elder (TE) and indigenous knowledge keeper (IKK) do not have parallels in conventional mental health services. Traditional elders are generally older individuals recognized by their community as having skills in healing either specific or multiple illnesses. Healing in aboriginal communities is always spiritual even when other modalities such as herbs or massage are involved. Indigenous knowledge keepers were individuals who had knowledge of the language, practices, songs, ceremonies, traditions, and customs of the people, but were not necessarily engaged in a healing practice. They could be of any age. Traditional elders were by definition also indigenous knowledge keepers, but IKK’s were not necessarily traditional elders. Unlike conventional services were leaders are recognized by educational status, TEs and IKKs were acknowledged by community members and may not have had any particular education or hierarchical position from a mainstream cultural perspective. Discussions were held with these TEs and IKKs, as well as with voice hearers and other community members.

Results

Similarities and Differences among the Communities

The communities most immersed in recovering and practicing their cultures were Central Saskatchewan, Lummi, all the Maori communities, and the South Dakota communities. The remaining communities were less culturally intact. Northern Saskatchewan was highly christianized with much loss of culture and tradition. Elders were hard to identify except in relation to the Roman Catholic Church. The Southeastern Australian community was also culturally fragmented, having had the longest contact with Europeans. Some crafts remained and elders could be found, but they were largely practicing crafts. If healing work was occurring, it was invisible. The Cattaraugus Reservation in Western New York was a complicated mixture of all the Iroquois Confederacy nations with relatives of part European heritage. Culture was being practiced in small enclaves, but the majority of resident were assimilated. Christianity was prevalent and prominent, mostly of Protestant denominations.
Similarities in Relation to Mental Health Services

1. Conventional mental health services in all the communities we visited were organized around the biomedical model accompanied by obvious tension among segments of the voice hearing community, TE's, and IKK's with the services. The tension centered on the question of whether or not hearing voices could be normal and even desirable and the ontological status of the voices that people were hearing. The IKKs saw the methods and theories of conventional mental health services as dismissive and disrespectful to their culture, values, and beliefs.

2. One or more conventional mental health practitioners existed in each community who were sympathetic to the perspectives of IK keepers. In all but one community in New Zealand, these practitioners worked in ways that were more compatible with the beliefs of the TE's and IKK's when they were alone with their aboriginal clients, but felt a lack of power and influence in relation to the perspectives of the conventional mental health services community, and feared verbalizing these differences in approach, specifically for being marginalized, ridiculed, and humiliated for their at least partial agreement with aboriginal beliefs.

3. Among voice hearers we met, the idea of demons and demonic possession emerged to the extent that voice hearers had adopted or been exposed to Christian belief systems. While all encountered cultures endorsed some variant of the concept of possession, instantiation, and/or visitation, the level of severity indicated by the word “demonic” appeared to require Christian contact.

4. TE's and IKK's saw voices as potentially originating from beings with full ontological validity and did not view voices as necessarily pathological. They recognized multiple potential sources for voices - departed ancestors, nature spirits (trees, mountains, rivers, lakes), one's own thoughts, and other beings. Voices could belong to sacred beings specific to each culture's cosmology and creation stories, including Raven in the Pacific Northwest of North America, Coyote in the Southwest, and Rabbit in the Southeast. Determining and validating the source of the voice was not as important as hearing the message of the voice, and determining what should be done with that message. For example, among Maori communities in New Zealand, voice hearing was considered desirable and was cultivated. People who heard voices were thought to potentially be bringing important messages to the person, family, and community. The point of differentiation was not whether or not someone heard voices, but whether or not he or she was “well” or "unwell". Being unwell was associated with hearing more negative voices, while being well was associated with hearing more positive voices. Of course, some non-indigenous traditions also claim ontological validity for voices, such as that of Jesus among some Christian sects.

The concept of “unwellness” appeared to be a potential bridge between the two factions. The TE's and IKK's recognized that the voices of “unwell” people could be quite negative, similar to those voices typically addressed by conventional mental health services – demeaning, belittling, commanding the hearer to kill his or herself, destructive. A variety of explanations existed for these voices, which did not appear to be unique to any particular community except that the "bad" voices had full ontological status. Some of the explanations included:

(a) The “bad voice” is a fragment of a being, a collection of negative energy, similar to the Dine concept of chinle, which is the badness of a person who dies which cannot travel with him or her to the spirit world and must remain behind in this earthly world. Dine people go to great lengths to avoid contact with someone's chinle, even to the extent of boarding up the house where someone has died and never entering again.

(b) The “bad voice” is an entity from another dimension, allowed access to this world through inter-dimensional rifts created by trauma, genocide, greed, evil acts, and so on.

(c) The “bad voice” is a part of another person who has entered into the hearer and continues to speak for that other person, long after they are gone or have disappeared. The Lakota would say that a small bit of anyone who has been a part of one's life remains with that person in the nagi, or the swarm of beings and stories surrounding the person's physical body. This nagi makes them who they are.

(d) The “bad voice” is a malevolent spirit, one who holds ill will for the hearer or for human beings in general.

(e) The “bad voice” is the reified words to a curse, which, when made, take on a life of their own, becoming a kind of minor entity, which seeks out and attempts to destroy the person who is cursed.

(f) The “bad voice” is a ghost, a person who is stuck in the earthly plane and unable to make the journey into spirit world. Being stuck makes them grumpy and angry, and some are stuck because of evil they have done or that has been done to them. Some elders believed that people who commit suicide get stuck in this manner.

We recognized that a bridge for dialogue could form between conventional services and aboriginal people if those in the conventional services could accept aboriginal explanations, even if they privately believed these explanations to be metaphors. Everyone could agree that “unwell people” could hear quite disturbing and destructive voices. “Unwellness” was thought to draw malevolent or mean entities - the idea that like attracts like.

1. Similarities existed in what to do about “bad voices”:

a. Dialogue: Voices could be contained through confronting them with the support of elders and other helpers. They could be challenged to prove their statements, which typically they could not do.

b. Ceremony: Voices were contained through ceremony, in which good spirits came and “doctored” the unwell person and removed the “bad voices” or quieted them.

c. Love: Being surrounded by loving family and friends was seen as weakening “bad voices”, through building ties with ancestors and through the healing power of relationships.

d. Prayer: Asking Creator, spirits, and other supernatural beings for help works.
further south.

Frankincense and Myrrh, in the same manner as sage was burned conducted in the Dene language. Some burned herbs, especially Hail Mary’s, Our Fathers, burning of candles. The ceremony was More Catholic-like behavioral prescriptions would result, including which the bad voice is commanded to leave by the power of Jesus.

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approaches with which we were familiar from our practices in the talking through the afflicted person and our hearing the dialogue the afflicted person’s being expected to talk, or rather, with the entity would ask the spirit why it had come and what it would take to make it leave the afflicted person alone. The leaders behaved as if they were receiving answers from the entities “we believed they were”, though we couldn’t hear what the entities were saying. Eventually a behavioral (and sometimes herbal and nutritional) prescription would emerge for what to do to make the bad voices go away or behave.

Dialogue with the Entity

In New Zealand, we observed actual dialogue with the bad voice with the afflicted person’s being expected to talk, or rather, with the entity talking through the afflicted person and our hearing the dialogue between the leader and the voice. This resembled psychodrama approaches with which we were familiar from our practices in the United States and Canada. The questions and answers also often led to commitments and behavioral prescriptions.

Exorcism

Northern Saskatchewan practices appeared similar to what we have observed in documentaries to be Roman Catholic exorcisms in which the bad voice is commanded to leave by the power of Jesus. More Catholic-like behavioral prescriptions would result, including Hail Mary’s, Our Fathers, burning of candles. The ceremony was conducted in the Dene language. Some burned herbs, especially Frankincense and Myrrh, in the same manner as sage was burned further south.

Prayer

The Lummi and the people of southeastern Australia mostly used Christian-style (more Protestant in appearance) to pray for intervention with the bad voice and for its removal.

In our debriefing discussions with community members, we shared that our own approach was a combination of the ceremonial practices of the Lakota/Dakota and the dialogical practices common to psychodrama, similar to what we observed in New Zealand.

Community Case Studies

Southeastern Australia

The aboriginal community with which we worked had organized a not-for-profit cooperative to manage their health and social services. The cooperative had a Board of Directors, which employed community members and others to manage the daily operations. As is often the case in indigenous communities that have adopted European management strategies, several large families vie for control of the Board, which is desirable because whoever controls the Board controls who is hired and where contracts go. This dynamic existed to some degree in every community we visited. Unlike the United States or Canada in which tribal lands exist, however small, no such focus existed in this community, similar to what is found in Hawaii for its aboriginal people. The cooperative owned some land, including an ancestral burial ground, but this was not land on which people lived or communities existed.

Within the health services, mostly foreign, contract physicians provided medical and psychiatric services, primarily at a regional hospital and outpatient clinic. Many had difficulty speaking English, had no grasp of aboriginal culture or language, and had no sense of the history of colonial relations or the events leading to disparities between aboriginal people and colonials - residential schools, relocation, forced removal of aboriginal children into non-aboriginal families, lack of employment, and lack of land. Many brought the prejudices of their country of origin to Australia with regard to skin color and people of poverty. In this community, mental health workers were poorly trained and supported with the exception of drug and alcohol counselors and youth workers, many of whom were working to bring culture into their practice. The cooperative leadership was initially positive about our theme of “culture is medicine”, but a charismatic leader moved to a higher position in State government, the Board leadership changed, and new leadership was uninterested, provided little support for the inclusion of culture. We observed the cycle of a new family taking charge of the Board, and abrogating most of the policies of the previous family, often regardless of value. Throughout our time working with this community, health care was driven by a biomedical philosophy with little inclusion of culture. While some community health nurses were interested in including culture, the majority of nurses were travelers who were unfamiliar with the community. Hospital admissions for both medicine and psychiatry were managed at a facility two hours distant from the community and by hospitalists. Communication between hospital and clinic/community staff was poor or non-existent and prejudice exists in
the hospital toward aboriginal patients with the usual stereotypes existent.

Nevertheless, we found elders and IK holders in this community. Our work began as a series of community events on a peninsula in a lake, only accessible by boat. Elders and other strategic community members were invited to come, either for the day, or for all or part of a week. Sleeping accommodations were available for most who wanted to attend. The house had belonged to the community for years, but our contract had inspired its renovation, primarily by community members, who owed hours of community service, and who continued to work on the house after their service hours were completed.

We encountered a shyness to discuss traditional cultural practices, so we used a strategy of quietly performing our own with pauses to hear reactions and discussions. Over the course of time, stories began to emerge about historical healing practices, both told and observed. A genuine cross-cultural exchange ensued. Eventually ceremonies were going both ways.

People in this community were the most reticent to broach the idea that some people heard the voices of the ancestors and that spirits still talked to those who would listen. They were especially shy because they didn't want anyone to think they were "crazy". They were well aware of the conventional perspective that only "crazy people" heard voices, so kept their experiences tightly guarded. Trust in the conventional mental health system was virtually non-existent. "Those people can't help our people," one elder said. "They don't know anything about us; what we've come through; what we've survived. We're just another case to be processed". Care was delivered quietly by elders and IK holders, but only when asked. Many did not ask; nor did they have family to ask, and didn't receive any care until court mandated due to charges - disorderly conduct, domestic violence, alcohol and drug related, other conduct disturbances, and the like.

High points for the community consisted of [1] an elder who had turned an abandoned auto-body shop into an art studio to teach and support people to do traditional arts. This was thriving despite a complete lack of funding with various users donating supplies or buying their own supplies so that they could take advantage of the knowledge of the elder about how to produce the art of their culture.

The community did have a funded museum, which offered instruction at various times in activities like making a canoe, making boomerangs, hearing and telling traditional stories, eating traditional foods. This also provided some sense of community. Neither of these efforts was intentionally or directly connected to mental health service delivery, though in practice, patients and potential patients were using these resources.

The strongest part of the community consisted of youth services, in which many young, vibrant aboriginal adults were funded to work with children and youth in the community, primarily focused around those who were homeless, on the wrong side of the law, misusing drugs and alcohol. No intentional, primary mental health prevention programs or services existed.

North Island, New Zealand

Voice hearing is acceptable and desirable in Maori culture. One wishes to hear the voices of the ancestors and the voices of nature or other spirits. Healers cultivate this ability to speak with non-physical entities.

We worked in five different Maori communities, all relatively similar in having a strong will to control their own health care and to infuse their culture into that health care. Urgency and a kind of militancy were present in these Maori communities that were unrivaled elsewhere. Unlike the Australian situation, and more resembling of the U.S. or Canada, ancestral homelands did exist with a continual flow of people between these more rural locations and the urban environment where more jobs and opportunities for education existed. Communities were organized around a Mairai, in which traditional greetings took place, tribal business was conducted, ceremonies happened, and cultural education and language instruction occurred. When entering a community, one enters through ceremony conducted in the Mairai, in which both sides greet each other in song and speech and explain their purpose. If the purpose is accepted, the visitors are welcomed and feasting occurs, which could be as small as cookies and coffee. A strong spiritual organization surrounded the Mairai, with more or less ties to Christianity depending upon the locale.

Again, conventional services were largely organized in accordance with a biomedical model, but the members of the New Zealand communities verbalized a willingness to operate a separate, parallel system for mental health care using tradition and elders, sometimes excluding conventional services and sometimes using them as deemed fit for as long as seemed helpful. This strategy proved especially irritating to those involved in providing conventional services, the difference being that each side believed strongly in their own approach's being best.

Some supportive nurses, counselors, and nurse practitioners bridged the conventional world and the Maori world and were predominantly of Maori heritage. Unique to the Maori communities we visited in New Zealand was the alliance that had been formed with the Hearing Voices Network, a European-initiated, now worldwide group, started in Maastricht, The Netherlands. This had come about through one of the Maori voice hearers becoming associated with the Network and training within the Network to run groups, and her recognizing that the message was essentially the same, and that the Network could provide additional support for avoiding conventional services. Members of voice-hearing groups typically took care of each other, providing extended visits when someone became unwell, with the aim of helping each other to avoid the psychiatric system. Our informants believed that they were largely successful in preventing acute hospitalizations.

In this community, tension existed between conventional psychiatric services and the Maori voice-hearing group. We met a Maori healing elder who worked closely with a sympathetic psychiatrist, but were not able to visit that community, for it was in
the far South of the country.

Pine Ridge Reservation, South Dakota, USA

This reservation in South Dakota is one of the poorest communities in the United States. Unemployment is greater than 80%, suicide is common, and drug and alcohol misuse is rampant. The area is quite rural and most health care is provided at a government facility in Rapid City, which is 90 to 180 minutes from where people live on the reservation. Some small clinics exist on the reservation along with a dialysis center. The Indian Health Service (IHS), which is part of the U.S. Public Health Service, provides medical and psychiatric care to Pine Ridge inhabitants and has yet to acknowledge any value to traditional healing or beliefs. On Pine Ridge we found a complete lack of connection and even an antagonism between traditional elders and IHS providers. Local people were struggling to create a Master's level program in counseling at the local college to train inhabitants of the Reservation to provide mental health services, but that program was failing, due to lack of staff with sufficient credentials for such a graduate program to be accredited.

Lakota nurses, who worked for the IHS, provided some minimal bridging between the biomedical world and the people, but these were few. Traditional practitioners used conventional health services as needed, but did not identify themselves or their roles in the community to the providers of those services. Nor did conventional service providers ask about traditional givers of care. Mental health patients were usually shipped to larger facilities far from home for psychiatric admissions.

A complex mixture of Christianity and traditional beliefs existed on the Reservation. Some traditional people believed in the historically more Christian concept of possession by an evil spirit and had ceremonies to exorcise that spirit. Those who were more aligned toward Catholicism used priests for exorcism. The Native American, or Peyote Church, was also strong, and provided another kind of blending of Christianity and traditional spirituality. All believed in purification or revitalization and in the intervention of the spirit world to calm the mind and protect the individual. Some elders spoke to spirits they perceived occupying the afflicted person. So long as the suffering person could be contained by family and friends on the reservation and kept from coming to the attention of authority, capacity existed for people to recover without encountering the medical system. However, not everyone could be contained and the mixture of alcohol and drugs with mental illness led to some volatility, since not all the elders would work with someone who had used alcohol and/or drugs.

Discussion

Clear differences in perspectives on voices and voice-hearing exist between staff of conventional mental health services and members of indigenous communities. In relation to these differences, we can make several proposals. The first is that it is important for indigenous workers to be part of mental health teams; this is a best practice model and is applied in mental health services where possible. Second, that the ongoing and long-lasting trust issues between indigenous people and government services continue to affect the provision of all mental health services (voice-treatment being affected to the same extent as other treatment and services), and that dialogues based on partnerships and respect may act to benefit fruitful discussions. Third, the results should be compared with the literature on hearing voices in nonwestern cultures so that the findings may be compared and analyzed.

At minimum, it would appear that mental health workers who interact with aboriginal people would do well to dialogue with traditional elders to understand their perspective on voices, whether or not they agree. Traditional elders and knowledge keepers may have much to contribute to conventional mental health services about the management of voice hearing. Especially important is the focus on the dimension of wellness vs unwellness. When voice hearing contributes to unwellness, collaborative interventions that move the person toward wellness can be welcomed. When voices are heard in association with wellness, intervention or diagnosis may not be indicated.

Patel [19] has called our attention to the diversity of models for mental illness that exist in the world. For example, spiritual models of illness causation are common in Africa. In Zimbabwe, half the respondents held spiritual models of illness and had higher levels of mental disorders by conventional diagnostic methods, and were more likely to have a mental illness as judged by care providers. The symptoms of such patients resembled the construct of anxiety. Such patients were more likely to consult traditional healers and to have a chronic illness. He believed that spiritual models of illness represented an indigenous model to explain the distressing symptoms of non-psychotic mental illness.

Watters [20] has described the chaos of importing U.S. concepts of post-traumatic stress disorder into Sri Lanka after the tsunami disaster. He first describes the results of imposing the U.S. view in the form of questionnaires upon the Sri Lankan population and contrasts this approach to the more narrative approach of Dr. Gaithri Fernando, a Sri Lankan native and a psychologist, who began her research in the language of the people she was studying by first asking “participants to think of someone they knew who had experienced some type of suffering but was now functioning well. After that story was finished, the subject was asked to describe a person who was functioning poorly after atrauma (pp. 90-91).” She used this data to conduct a larger study, finding that “Sri Lankans were much more likely to experience physical symptoms after horrible events. [They] were more likely to complain of aches in the joints or muscles or pain in the chest. [They] reacted as if they had experienced a physical blow to the body….By and large Sri Lankans didn’t report pathological reactions to trauma in line with the internal states (anxiety, fear, numbing, and the like) that make up most of the [predetermined U.S. originated] PTSD symptom checklist. Rather Sri Lankans tended to see the negative consequences in terms of the damage it did to social relationships. Those who continued to suffer were those who had become isolated from their social network or who were not fulfilling their role in kinship groups (p. 91).” Fernando exemplifies the approach...
that we would see fitting best into the indigenous communities we studied - that one best begins by asking local people how they view the phenomena of interest rather than impose pre-determined constructs onto these people, regardless of how scientifically established these constructs appear to be.

Studies exist from contemporary literature to support the indigenous view that recovery is possible. Williams [21] (Loc. 1070) summarized the published longitudinal studies of psychosis outcomes that went at least 15 years. Full recovery ranged from 20 to 53%. Recovered or improved ranged from 30 to 84%. Marsh, et al. [22] describe a philosophical, theoretical, and methodological approach that recognizes the need for both Western and Indigenous ways of knowing in research, knowledge translation, and program development, which has been called Two-Eyed Seeing [23].

While not assessing treatment for psychotic disorders, a 2011 study did survey parents’ perceptions of efficacies of interventions for youth with substance abuse and conduct disorders [24]. “Talking to a family member” was rated very or extremely effective by 71.7% of those interviewed; while 59% found talking to an elder to be effective, and 39.9% found traditional healing to be very or extremely effective. Only 27.5% of parents found a psychologist on the reservation to be helpful, and 27.2% found the help at their local government-sponsored clinic to be effective.

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