American Indian and Alaskan Native Strength-Based Health Promotion: Worldviews, Indigenous Knowledge, Cultural Competency, and Approaches

A Literature Review

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INTRODUCTION

Key Words

Health promotion; wellness, strength-based approach, worldviews; Indigenous; American Indian; Alaskan Native; health disparities; healthcare.

Background

As the minority groups within the United States continue to comprise a growing share of the population, more attention has been paid to the health care provided to these diverse populations. As a result, health care providers have increasingly taken account of an individual's linguistic needs (Brach, 2000). But what of their worldviews, culture, and beliefs?

Indigenous worldviews and knowledge have been disregarded and invalidated by the dominant culture in the Americas since the time of European colonization, and the trend still continues in the present-day United States. The perspectives of Indigenous worldviews and knowledge have been eclipsed by the Eurocentric worldview, becoming an archetype of how the dominant culture interacts with native peoples and communities, including within the U.S. healthcare system. Consequently, American Indian and Alaskan Native (AI/AN) individuals are often faced with the challenge of navigating healthcare systems within the realm of cultural integration based on the dominant views and culture (Hart, 2010).

France (1997) states that our worldviews influence our belief systems, expectations, decision-making ability, and our approaches to problem-solving. Within the practice of the healing professions, researchers (Bishop, Higgins, Casella, & Contos, 2002) have found that being receptive to the worldviews of care beneficiaries is essential "if we are going to do more good than harm" (p. 611). Olsen, Lodwick, and Dunlap (1992) describe the concept of the

worldview as a sort of psychological lens that is an ensconced way of perceiving the world. They are perceptual blueprints developed through experience and tradition, and we continually use them to make sense of the world around us. In any society, there is a dominant worldview that is held by most members of that society (Olsen et al., 1992). While alternative worldviews exist in a given society, they are not typically embraced by the majority of society; therefore, work with AI/AN people requires those in the healing professions to act outside of the dominant worldview and become culturally competent (Hart, 2010).

The Problem

For many Native Americans, their worldview and Indigenous knowledge involves an understanding of the wholeness of existence (Cajete, 2000). Cajete (2000) notes that the Native American view of the world is that the individual is part of the world with the understanding that all things are interrelated. Thus, existence is not experienced by a sense of independent living, but rather through communal involvement. Lovern (2008) notes that this worldview requires that individuals support and assist the community and its members as much as possible. Such commitments to the community have given rise to traditional Native American practices that place an emphasis on the endurance and enhancement of the community as a whole—which is, in turn, dependent on the endurance and enhancement of each person in the community. Despite this communal involvement perspective and other worldviews that are integral to the AI/AN populations, patients, healers, and practitioners are often forced to check their indigeneity at the door when either offering or receiving healthcare services within the dominant culture—including within urban areas. The results of which contribute to the well-documented health disparities faced by the AI/AN populations across a wide range of diseases, behavioral risk factors, environmental exposures, social determinants, healthcare access, and other social characteristics ("Minority Health," 2014).

Significance

While there is an increasing body of knowledge and literature regarding the exact nature and size of AI/AN health inequality, it is through the lens of understanding and appreciating the Indigenous AI/AN worldview, knowledge, and strength-based approaches that the health disparities may be best addressed. Health promotion continues to gain traction as a field of practice to offer strategies for improving health measures among Indigenous peoples (Brough et al., 2004).

Objective

This paper seeks to explain the importance of AI/AN worldviews in the development of health promotion strategies, the importance of cultural competence to address AI/AN health disparities, explore AI/AN strength-based health promotion. In order to better understand these themes, this paper will present a survey and synthesis of existing literature. I will conclude by summarizing the literature review as well as the importance of strength-based health promotion.

LITERATURE REVIEW

AI/AN Worldviews and Indigenous Knowledge

Worldviews

AI/AN worldviews among numerous Native populations are comprised of a holistic sense of connectedness of the person with his/her family, community, and natural environment, and this worldview is a strong factor in health promotion (Mohatt, Fok, Burket, Henry, & Allen, 2011). There is a strong focus of coming together to support one another. Graham (2002) refers to this as the relational worldview, which emphasizes a sense of spirit, spirituality, communitism, and respectful individualism. Communitism is the idea of the community being tied together through family relations and the family commitment to community; whereas, respectful individualism is where an individual can enjoy great self-expression because this expression is

recognized and supported by the community as opposed to the individual merely acting in self-interest (Hart, 2010). Communitism and respectful individualism represent a foundational assumption within AI/AN worldviews.

Indigenous Knowledge

There is a close connection between AI/AN worldviews and knowledge. Indigenous knowledge is defined as a cognitive legacy that has resulted from an interaction with nature in a communal way and the worldviews, customs, and traditions that direct AI/AN peoples (Maurial, 1999; Hart, 2010). This knowledge can be personal, oral, experiential, and holistic and can be relayed through story and metaphor (Hart, 2010).

Historically, health promotion, interventions, and outcomes have been approached in manners that are the least consistent with AI/AN worldviews and Indigenous knowledge (Lovern, 2008). This is largely a result of different worldviews. Hart (2010) notes that worldviews are not simply dualistic—consisting of the Indigenous and non-Indigenous. Rather, there is a certain amount of fluidity between various peoples and cultures, and some worldviews overlap and some do not. However, cultural variations between providers and patients can be barriers to effective health care (Sequist, Cullen, & Acton, 2011). Therefore, it is important that western, Euro-centric health professionals consider AI/AN culture when trying to apply an AI/AN strength-based approach to care.

Culture and Cultural Competency in Understanding AI/AN Health Promotion

Often, when attempting to address AI/AN health literacy concerns, Eurocentric professionals translate information and materials in such a way that the concepts are explained within the paradigm of the translator with no consideration of the cultural context of the AI/AN worldview of connectedness and community (Lovern, 2008). Researchers note that when health promotion efforts do make attempts to relay concepts in a manner that incorporates Native

beliefs, the result is often explanation of unhealthy behaviors in a superficial manner that reference AI/AN stereotypes (Brough et al., 2004).

Cultural competency, as it relates to AI/AN communities, is more involved than one may initially think (Cross, Earle, Echo-Hawk Solie, & Manness, 2000). This is the result of the contrasts between tribes as well as the differences between AI/AN people that lead a more traditional lifestyle versus those that do not. Further, individual families can have their own unique culture as well.

What is Culture and Cultural Competency?

In order to understand cultural competency as it relates to strength-based health promotion, we must establish an operational definition. However, we must define culture. Culture is defined as the consolidation of knowledge, beliefs, behaviors, and customs that includes such factors as personal identification, language, thoughts, communication, actions, values that are specific to a specific group (which can be ethnic, racial, religious, geographic, or social) (Cross et al., 1989). Culture can influence our beliefs about health, healing, wellness, illness, disease, and the delivery of services.

Cultural competency is not merely being acquainted with, or being receptive to, a given culture. Cultural competency within the healthcare setting can be defined as a set of consistent behaviors, perspectives, protocols, and policies within a system, agency or among professionals that allows them to effectively work in inter-cultural situations (Cross et al., 1989). It is used to reference a continued commitment to sufficient practices for diverse populations.

Importance of Cultural Competency

The goal of cultural competency is to deliver the best possible care to every patient impartial of ethnicity, race, nationality, religion, culture, or language ability (Bentancourt et al.,

2005). Cultural competency is needed on all levels of a healthcare agency or system, particularly within patient-doctor relationship. But, practitioners can only become culturally competent with the support of the health system of which they are part. Cultural competency is crucial to reducing AI/AN health disparities and improving access to health care, and it has a positive effect on patient care by enabling providers to deliver services that are respectful of, and responsive to the health beliefs, practices and cultural needs of the AI/AN populations. AI/AN patients also may present and express their symptoms in such a way that is drastically different than the dominant population or different from what is learned in medical school textbooks. Cultural competency allows for providers to incorporate an AI/AN worldview and apply Indigenous knowledge to inform their approach to AI/AN care—including the professional respect and financial support to integrate traditional wellness teachings and healing methods into their practice (Cross et al., 2000).

Cultural Competency Best Practices

AI/AN healthcare providers should build the following activity into their business model: (Bentancourt et al., 2005) to increase cultural competency:

1. Diversity among staff and providers, including AI/AN representation.
2. System capacities to include data collection to assess patient needs and track progress in improving outcomes.
3. Effective translation services if needed.
4. Documents, forms, brochures, etc. that are culturally relevant including terms, language, and images.
5. Engaging AI/AN community representatives in the decision making process.
6. Implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards).

AI/AN Strength-Based Health Promotion

The Strength-Based Approach and its Importance

Health promotion should detect assets within the community (Brough et al., 2004).

But, according to Hammond (2010), the medical community often focuses on health deficits for health promotion efforts where the emphasis is on what is lacking, such as healthy diets, exercise, motivation, etc. Health promotion can often revolve around a central message, usually targeting a specific behavior such as smoking, alcohol consumption, diet, exercise, health screenings, etc. (Brough et al., 2004). Such promotion efforts do little to engage the AI/AN populations. Often healthcare providers and physicians assert that they are working from a strength-based approach; however, Hammond (2010) notes that it is unlikely that they are "working from an underlying set of values, principles and philosophy of strength-based practice (p. 2). The strength-based approach to health promotion is a process and method of addressing problems experienced by a person and/or their community. It never discounts any health issues, disparities, or outcomes; however, it seeks to establish a positive basis of a person or community's resources and strengths will be the foundation for tackling the health problem (Hammond, 2010). Thus, individuals are seen as having potential for change as opposed to merely being seen as having risk. Risk behaviors take a backseat to potential. Quite simply, it offers hope instead of pessimism.

AI/AN people often characterize health and wellbeing more broadly than the absence of disease (King et al., 2009). A medicine wheel contains the four elements of life: the physical, the emotional, the mental, and the spiritual. These elements are intertwined to create balance within a strong and healthy person, but these elements extend beyond the individual. Good health and healing requires a balance with other people, the community, and the spirit world (King et al., 2009). This interconnectedness worldview is central to AI/AN health promotion, and poor health can result from a failure in any, or all, of the elements (Hodge & Nandy, 2011). Health promotion activities can include traditional ceremonies, storytelling, and traditional

medicine. The AI/AN concept of health promotion builds on these social and cultural understandings of health and illness, and it becomes a process that enables AI/AN people to increase control over their health.

Some AI/AN Strength-Based Approaches

Storytelling

Since the AI/AN concept of wellbeing includes a balance within the community, it would be appropriate for educational messages to be community-oriented. Storytelling has traditionally been the AI/AN teaching method of choice for the transmission of educational messages (Hodge, Pasqua, Marquez, & Geishirt-Cantrell, 2002). AI/AN stories are compelling because they convey information and values in an entertaining manner (Hodge, Pasqua, Marquez, & Geishirt-Cantrell, 2002). Characters in the stories engage in both positive and negative conduct, which encourages the listeners to arrive at their own understanding via personal reflection (Hodge et al., 2002). Hodges et al. (2002) also note that "because stories have been passed down through tribal communities for generations, listeners also have the opportunity to reconnect and identify with past tribal realities" (p. 6). Storytelling also encourages informal and formal help-seeking behaviors on the part of the listener.

Community-Based

Traditional AI/AN worldviews place an importance on the role of community in establishing balance. Community participation and involvement are necessary factors in effective health education and health promotion. Esteem, local control of their own affairs, and cultural continuity are all elements that influence AI/AN health promotion, yet AI/AN control over their autonomy and collective destiny can be at odds with the social, economic, and political realities with the dominant culture (King et al., 2009). AI/AN autonomy and self-determination

are related to self-esteem and respect; therefore, low levels of self-esteem and autonomy are related to poorer health (King et al., 2009).

Resiliency

Resiliency, in the context of health promotion, can be defined as "markedly successful adaptations to negative life events, trauma, stress, and other forms of risk" (Fraser, Richman, & Galinsky, 1999 p. 136). Resiliency is built upon individual, family, and communal strengths, and these strengths can support and/or protect people when facing adversity or change. Consequently, these strengths promote family and community cohesion while the promoting the well-being of the individual (Goodluck & Willeto, 2009). AI/AN view resiliency through the lens of "culture, traditions, language, spirituality, family, and survival" (Goodluck & Willeto, 2009 p. 3). It becomes the facility to allow them to prevent, mitigate, or overcome the negative impact of hardship. This cultural resilience in AI/AN communities can support healing, and it becomes a "message of hope, courage, faith, and persistence…it is at the core of why somebody decides to heal" (Heavyrunner & Morris, 1997 p. 1).

Traditional Activities and Rituals

AI/AN people often use traditional activities and rituals to promote wellness. Goodluck and Willeto (2009) that there are at least twelve traditional activities and rituals that can be incorporated into strengths-based health promotion: beadwork, drumming, talking circles, sweat lodges, dancing, smudging, prayer, visions/dreams, pow wows, naming ceremonies, canoe journeys, and cultural camps.

Effectiveness

Research suggests that the integration of traditional methods and true strengths-based approaches with western medicine results in more effective health promotion for Native American patients, and many Native American express interest in accessing care from both

traditional healers and physicians (Marbella, Harris, Diehr, Ignace, & Ignace, 1998). AI/AN patients often seek care from both traditional healers and physicians, and studies indicate that at as much as 38% of the urban Native American population use healers in conjunction with physicians (Marbella, et al. 1998). In such cases, patients often rate the advice of the healer higher than that of the physician 61.4% of the time (Marbella et al., 1998).

The holistic model is an effective approach to AI/AN health promotion, addressing the whole person and community (Nebelkopf & Wright, 2011). The focus of this approach is on self-help, empowerment, and a healthy community, which incorporates AI/AN culture and relationships. The Holistic System of Care for Native Americans in an Urban Environment (HSOC) provides community-focused interventions for health promotion (Nebelkopf & Wright, 2011). The holistic, community-based approach to AI/AN care empowers Native communities in creating and executing health promotion strategies based upon Native values including traditional and historical teachings, storytelling, ceremony, and spirituality (Nebelkopf & Wright, 2011). As a result, unity within the community is strengthened.

There is a body of empirical literature that supports the effectiveness of this holistic approach to health promotion (Nebelkopf & King, 2003; Gone, 2009). However, the challenge is to express and document the efficacy of incorporating cultural activities in such a way that is meaningful to western practitioners, scientists, and researchers (Wright et al., 2011). HSOC also integrates western science/medicine with AI/AN culture, resulting in evidenced-based practices that include Positive Indian Parenting and Gathering of Native Americans (GONA). GONA is a four-day “journey” that increases the strengths of Native youth and community (Gathering of Native Americans, n.d.). The GONA curriculum is designed to empower Native communities in creating a cultural approach to health promotion, treatment, prevention, and community-building.

Central to HSOC, and the reason for the success of such programs, is the emphasis placed upon culture, cultural recognition, and cultural reconnection with mainstream, western methods of healing (Nebelkopf & Wright, 2011). In fact, SAMHSA has recognized HSOC as a best-practice in Native health promotion (Capers, 2003).

Need for Collaboration

Often, agencies working with AI/AN populations have both limited resources and unsupported roles. It is imperative to have collaboration among different care providers that embrace the same philosophy of cultural competency and strength-based health promotion. Staff skill sets should be developed to enable effective engagement and collaboration (Hammond, 2010). As a result, community agencies will also require sources of reliable, long-term funding.

Considerations for Urban Health Center Strength-Based Health Promotion

Millions of AI/AN live in urban or semi-urban areas. In fact, as of the 2010 census, 71 percent of the total AI/AN people in the United States live in urban areas—the majority of which are younger, poorer, and less educated compared to all races (Urban Indian Health Institute, 2013). Many urban AI/AN individuals attempt to construct and negotiate their cultural identity from afar (Lucero, 2010). In addition, AI/AN cultural identity is often thought to be negatively impacted when living in an urban environment (Lucero, 2010). Rural and reservation AI/AN people can view urban AI/AN individuals as being somehow diminished or “less Indian” (Lucero, 2010). Urban AI/AN people are often characterized as being conflicted about their identity or as developing an identity that melds the beliefs and customs of various tribes while lacking an identification with a specific tribe or nation. In reality, urban AI/AN may simply identify with both AI/AN values and the dominant, mainstream culture. The degree to which an urban AI/ANs have integrated with the dominant culture and/or made meaning of their cultural

identity cannot be overlooked in developing strengths-based approaches to health promotion. Also, the ways and the degrees to which urban AI/AN individuals develop a sense as being part of a Native community have often not been explored or considered. However, health promotion strategies that incorporate a connection to other AI/AN people that are perceived as understating their culture and cultural identity can reinforce positive feelings about being AI/AN. While traditional activities and rituals can be used to promote wellness, health centers should also offer programing that relates to urban AI/AN cultural identity and cultural identity integration. The opportunity to connect with other AI/AN people is important to cultural identity integration.

The increased individualism that may accompany residential migration to urban areas also needs to be taken into consideration. AI/ANs living in urban areas, particularly since they are often younger, may not be interested in connecting with their past, their community, and traditions. There is certainly not a "one-size fits all" approach, and it is important that a combination of Native and western practices is offered to fit needs of a given urban health center. Regardless of the population to whom services are offered, a true strength-based approach to health promotion should contain the following principles (Hammond, 2010):

1. The view that everyone has potential and their own unique strengths should guide interventions instead of focusing on limitations, ineffective health behaviors, or diagnosis labels.
2. The belief that all patients want to better their health and the health of their communities, but that they may not know how to do so—or, more importantly, they may not be ready to do so for any number of reasons, including fear.
3. Positive change is rooted in the context of unconditional authentic relationships with providers. The emphasis should be on capacity-building and encouragement—NOT "fixing".
4. The patient's life story and experiences determines their worldview, and the individual's perspective must be the starting point for change—NOT with what is important to the doctor.
5. The understanding that people are more likely to change, which can be a frightening journey into the unknown, when they are allowed to start with what they already know.
6. Change is a process and a journey, and it is not static. It is important to allow for slow change and relapses into unhealthy behaviors without judgment and criticism.
7. Change for the individual, and the community, is collaborative, inclusive, and participatory.

Implications

Strength-based health promotion is an approach to care that starts with what is right with people, and not what is wrong with them. External resources and interventions are added in such a way that helps change occur via reinforcing people's strengths and goals. True strength-based health promotion should be evident in all levels of care, and it should guide practice and be "evident in the language of interactions with people we serve, the language of service, team and organizational interactions, and the written documentation of service-provision activities—assessment, service delivery, training, etc" (Hammond, 2010 p. 6). Often, agencies working with AI/AN persons have both limited resources and unsupported roles. It is imperative to have collaboration among different care providers that embrace the same philosophy of cultural competency and true strength-based practice. Staff skill sets should be developed to enable effective engagement and collaboration (Hammond, 2010).

CONCLUDING THOUGHTS

Traditional teachings, knowledge, and strength-based health promotion can encourage a positive self-image and a healthy identity among AI/AN people. So many programs and research initiatives, however, focus on disease and treatment (Eurocentric) as opposed to wellbeing and health promotion, which are more congruous with traditional AI/AN beliefs. Urban health center programs may struggle with resources; however, resources are not merely financial in nature. Rather, connections and support from other programs and agencies help build efforts to support AI/AN urban communities in creating their own blend of strategies and solutions to health promotion in an urban environment. This strengthening of community is central to many traditional AI/AN teachings and worldviews. The strengths-based approach to urban AI/AN care is a system of practices and beliefs that moves away from a focus on

procedures, techniques, and knowledge as the instruments of improving health disparities. Both the individual and the community possess the ability for transformation and change; however, the challenge becomes the willingness for providers to embrace actual, true strength-based health promotion strategies.

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