3 Case Study: Building Trust Among American Indian/Alaska Native Communities—Respect and Focus on Strengths

Janet R. Katz and Darlene P. Hughes

Maria, a community health registered nurse, was living in rural Northwestern USA. She was seeking a position in an Indian Health Services (IHS) clinic. Maria knew that Native Americans suffered some of the worst health disparities in the USA, as did most indigenous peoples around the world (Katz et al. 2016), and she wanted to help. Maria had met several Native American nurses when she was in school but had never talked to them about their communities. She would later see this as a great missed opportunity.

In her new job, Maria noticed a high rate of diabetes, hypertension, heart disease, depression, and alcohol misuse similar to other clinics in which she had worked. But, one family represented a turning point for her. She realized she did not know much about the people, culture, setting, and community that the clinic served. The family included a grandmother (Sadie), Sadie's daughter (Violet), Sadie's grandchildren (Kyla, age 5 years; Charles, age 6 years; Martha, age 8 years; and John, age 15 years), and the children's father (Raymond). After multiple visits, Maria learned the grandmother and both parents had diabetes, obesity, hypertension, and expressed signs of depression. Maria would often see the three younger children for common cold viruses, minor injuries, and common health issues that is nothing out of the ordinary for growing children. The children were always cheerful when they came to the clinic; however, Maria did notice their clothes were often threadbare. The older son, John, seldom came to the clinic, but when he did, he said he was okay. Maria was concerned; she knew alcohol and drug misuse was prevalent in this area. Raymond worked seasonally as a smoke jumper and a trucker the remainder of the year. Due to his schedule, he rarely came to appointments. When he did, Maria noticed he stood quietly in the background.

On one visit, Sadie came to the clinic alone. She confided that she was very tired and was feeling overwhelmed. Her daughter was traveling searching for work and was leaving the grandchildren with her more often, sometimes for multiple days at a time. She said she might have to take the children into her home permanently if her daughter could not find work locally. Sadie also confided that Kyla was not Violet's biological child but her cousin's. Sadie knew her daughter was trying hard to be a good parent to all of the children. Raymond was away every 2 weeks and so was unable to help much. Sadie stated she no longer had the energy to care for young

J. R. Katz, R.N., Ph.D., FAAN (✉)
D. P. Hughes, M.S.N., R.N.
College of Nursing, Washington State University, Spokane, WA, USA
e-mail: jkatz@wsu.edu; darlene.hughes@wsu.edu

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children. She also voiced concern about John. She stated that he was home less often and appeared to have been drinking. She told Maria she had struggled with alcohol misuse several years ago.

Over the next month, Maria saw the grandmother several times for uncontrolled hypertension and medication changes. This made her more fatigued. Maria was concerned that Sadie was at increased risks for stroke or heart attack. Maria decided she really needed to talk to Violet. At first, Violet was unable to come in. When Violet was able to make it to the clinic, Maria noted she appeared tired and frustrated. She seemed depressed and overwhelmed. She was unable to find work, Raymond was often away, Sadie was not well, John was partying with his friends more, and she didn't have money to buy the children new school clothes. There had been several suicides in the community this last winter, and Violet was very worried about John. Maria asked her if she wanted to speak to a mental health provider. Violet stated, "Oh, I don't need that; they can't help me anyway; they don't understand what we go through, how hard it is; and they talk all the time, but talk doesn't find us jobs." Maria did not want to breach Sadie's confidentiality, so she tried to ask Violet about care of the children. Violet said, "I am worried about the kids, I know mom is having a hard time." "I wish I knew what to do."

3.1 Cultural Issues

There are 562 federally recognized tribes in the USA (Bureau of Indian Affairs 2015). American Indian or Alaskan Native identity does not imply a homogeneous but instead is represented by unique cultures from multiple regions and tribes (Champagne 2014). However, there are some general cultural principles tied to a common history of colonization, boarding schools, loss of culture, trauma, exploitation by researchers and academics, broken treaties, poverty, and under funded health care (Evans-Campbell 2008). It is important to understand that the exploitation, broken agreements, and negative stereotypes imposed on American Indian/Alaska Native (AI/AN) people have led to much mistrust in institutions and non-native people. A community nurse, like Maria, needs to learn and understand cultural specifics to adequately care for the people in her clinic service area. Although native people experience many health, economic, and social disparities, tribal family and community structure often provide advantages for their members' community ties, family bonds that span centuries, and a persistence for survival translate to deep resiliency and strength (Kicza and Horn 2016). Building trust and relationships with a tribal community and its members is essential. Understanding the impact of historical and sociopolitical harms on present-day life includes a solid understanding of how broken cultural traditions impacts present-day childcare.

Communication is predicated on trust and follows sociocultural norms. When erroneous generalizations are made by the nurse or other health-care providers, trusting communication can break down. For tribal communities in the northwestern area of the USA, a handshake may be most often used when greeting people. Remember that many stereotypes or generalizations, such as handshaking, may or may not be true for any one individual; taking cues from the person being greeted is important (Mihesuah 2013).

Another factor to be cognizant of is the concept of family and the extensive familial relationships within communities. It is not uncommon to be told a person is a cousin, sister, or auntie, when there is no biological connection. This does not diminish the familial bond. Over many hundreds of years, extensive family networks have developed. You may find people with the same last name who are distant cousins. Although there are close family ties throughout a community, privacy and confidentiality are imperative to build trust (Evans-Campbell 2008; Lonczak et al. 2013). Greetings and introductions often begin with establishing what family a person belongs to rather than in European/American society where the first question is "What do you do?" the questions may be "Who are your parents, grandparents, great-grandparents." And "Where you are

from?" These are important questions for establishing connections. People often identify themselves with their name, tribal affiliation, and family connections.

Elders are given added respect by all members of the community (Braun et al. 2014). If Elders are present, younger people may defer to them rather than talk for themselves. At family and community events, elders are always served first. It is not uncommon for a community to regard a community health nurse over 50 years of age as an elder. Patients may want to talk to family or even tribal elders before making health-care decisions.

The use of medicinal plants remains a common practice by many tribal people (Wendt and Gone 2016). To determine if a patient is using traditional plant medicine, questions must be asked in respectful ways to understand non-Western treatments. Spirituality and religion also vary greatly among tribes and individuals. A community's religion is likely influenced by colonization. The religious order that is dominant in the community may have been determined by first contact or by the practices of original religious leaders. In many Alaska Native villages, the Russian Christian Orthodox Church remains a strong influence due to the humanitarian actions the original priest showed the Alaska Native peoples (Oleska 2010). There are also people and bands (groups that now make up larger tribes) who practice traditional spiritual ways.

3.2 Social Structural Issues

Tribal sovereignty was present among all North American tribes long before European contact. It is estimated in 1492 there were about 75 million indigenous people in North and South America, representing 15% of the world's population (Thornton 1997). Yet, with colonization came a policy of conquest and control that lasted to the early 1800s, severely reducing the population. It is estimated today AI/AN make up 2% of the US population or about 5.4 million people (U.S. Census 2015). Beginning in the early 1800s, treaty making was predominantly US policy. Treaties were based on taking over vast tracts of land in exchange for services such as food and health care (Barbero 2005). Health-care funding was first appropriated in 1832, specifically for small pox epidemics (Shelton 2004). Treaties promised these services "in perpetuity" (Shelton 2004).

Boarding schools were enforced to ensure assimilation. Many children were taken from their homes and sent to distant boarding schools where they were forbidden to practice traditional ways (clothing, prayer, language, food, or medicine) and were severely punished when they did so (Bigfoot and Schmidt 2010; Charbonneau-Dahlen et al. 2016). Boarding schools have left a legacy of emotional, sexual, and physical abuse which are regarded today as factors in high suicide rates, depression, substance misuse, and domestic violence (Heart 2003; Thomas and Austin 2012). Assimilation may have been well-intentioned by some, but it leads to a rupture in culture, disconnection in knowledge of traditions, and a profound sadness that is being felt today. Many cite boarding schools and general assimilation policies as directly related to today's social determinants of health disparities.

Assimilation policies were followed by laws that allowed non-native people to buy land on reservations leading to what is called checker boarding (Deyo et al. 2014). Many communities are working on buying back that land to make their reservations whole again. The Indian Health Service was officially formed in the early 1900s; it had formally been under the War Office (Barbero 2005). In 1975 the Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act were enacted to protect native people's rights to education and health care, essentially to fulfill treaty promises made years earlier (Barbero: Indian Health Services 2007).

3.3 Culturally Competent Strategies Recommended

Health disparities and historical atrocities greatly impact individual and community health outcomes. AI/AN people have made tremendous

strides in healing. They continue to realize more tribal sovereignty through controlling their own health services, acting as their own gatekeepers, and educating their children to become community leaders.

3.3.1 Individual-/Family-Level Interventions

- Familiarize yourself with health disparity issues relevant to tribal communities.
- Learn about historical and intergenerational trauma without making assumptions about individuals or their families. Just be aware.
- Upon meeting your client for the first time, be patient, *don't appear rushed*. Offer your hand to shake, don't force it. If appropriate for culture, make eye contact, nod, and welcome them to your office. Ask general questions about how they are doing.
- Assess family structure through introduction beginning with yourself. Acknowledge elders with respect asking them if they would like to sit or need anything. When asking questions in a group, be sure to ask elders first.
- Obtain a detailed assessment of any unique cultural needs, i.e., religious and language preferences; normal health-care provider; childcare options, if applicable; environment (home and community); and occupation (training, education, and work opportunities). Allow client/s the opportunity to decline giving information.
- Respect patient's privacy and potential reluctance to share information with a non-native health-care provider.
- Ask most pressing questions relevant to specific visit. Don't try or expect to get all background information at first visit. *Be patient. Know you will need to build trust.*
- Provide a thorough explanation of confidentiality.
- When appropriate, provide information about transportation to a more comprehensive health-care facility for testing if elder (Sadie) needed.
- When appropriate, gently discuss concerns about teenage son, recent community losses to suicide, and inquire if parents would like you or another provider to talk to son such as a teacher or a counselor.
- Provide education and resources on job opportunities, parenting classes, alcohol or drug misuse programs, adolescent support programs, childcare services, and CNA services (for elder if needed).

3.3.2 Organizational-Level Interventions

- Be familiar with current politics that may be impacting the tribe.
- Establish a cultural competency program. Do not assume your facility has cultural understanding for the client base, even if it is an IHS clinic.
- Advocate for hiring a community member to consult on unique tribal culture and traditions.
- If some elders still speak the native language, enlist them to help translate some health information.
- Propose to host an elder men or women's group meeting monthly.
- Develop a committee to design and produce education materials inclusive of traditional foods, practices, dress, and activities.

3.3.3 Community Societal-Level Interventions

- Determine the strengths of community to include cultural practices and traditions, family support and caring, and events to attend.
- Collaborate with elder men or other men's groups to learn about fathering and steps to assisting fathers in becoming more involved in parenting.
- Don't be afraid to ask questions about the local culture and how the tribal members would like your help. Be humble and respectful.

Conclusion

Working with a Native American tribe as a non-native nurse requires learning a great deal of new information about Native American culture. Most importantly, be aware of the comfort level of each individual in the family to speak with you. Don't push, be patient. Develop a trusting relationship. Be comfortable with admitting you do not know everything about their culture. Use and accept humor.

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