ORIGINAL ARTICLE

The Urban American Indian Traditional Spirituality Program: Promoting Indigenous Spiritual Practices for Health Equity

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Highlights

- Some urban American Indians desire greater access to Indigenous traditional spirituality.
- Indigenous spirituality is often promoted as beneficial for health and relevant for health care.
- Our community-university partnership designed an Indigenous traditional spirituality curriculum.
- Developed "by Indians, for Indians," this curriculum was organized around the sweat lodge ceremony.
- Community psychology is uniquely positioned to advance health equity with urban Indigenous people.

Abstract Beginning in 2009, Detroit's urban American Indian health center entered into a collaborative and participatory partnership with a university research team. The purpose of the partnership was to incorporate Indigenous traditional healing practices into the health and wellness services at this center. Following extensive consultation with stakeholders at the center, we were commissioned by local decision-makers to develop a program tailored for members of the urban American Indian community that would introduce and orient these individuals to meaningful participation in Indigenous traditional spirituality. The Urban American Indian Traditional Spirituality Program is a structured curriculum for American Indian community members that introduces and orients participants to meaningful engagement with sacred practices associated with the sweat lodge ceremony. The signature innovation of this program was the recasting of traditional socialization practices into a structured, didactic curriculum that could initiate an enduring spiritual devotional life for American Indian participants toward improved health and well-being. Created primarily "by Indians, for Indians," the collaboratively designed curriculum draws on cultural strengths and spiritual empowerment to advance health equity for these marginalized populations.

Keywords American Indians · Indigenous spirituality · Sweat lodge ceremony · Integrative healthcare · Health inequities · Participatory research

Opening

As descendants of the Indigenous peoples of this continent, contemporary American Indians (AIs) contend with the ongoing legacy of European and Euro-American colonization. Marked by conquest, subjugation, impoverishment, assimilation, and (above all) dispossession of Indigenous lands and resources, the experiences of AIs in the USA have included immense social suffering (Gone & Trimble, 2012). Unsurprisingly, such intergenerational adversity finds expression in compromised health status, including documented patterns of health inequities that characterize virtually every AI community ever studied (Warne & Lajimodiere, 2015). Although much research focuses on AI reservation populations comprised of tribal members who reside in tribal homelands and exercise tribal sovereignty, the majority of AIs live away from traditional lands and dwell in urban settings. Many challenges confront these urban Indigenous communities as well, including poverty, unemployment, and discrimination (Yuan, Bartgis, & Demers, 2014). Indeed, urban AIs have been shown to exhibit a profile of health inequities that

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parallels that of their reservation-based kin (Castor et al., 2006), including distress and disability associated with disproportionately high rates of obesity, diabetes, cirrhosis, addiction, trauma, and suicide. In contrast, however, healthcare services that are deliberately designed for AI populations are much scarcer in urban settings, with only one percent of the federal Indian Health Service (IHS) budget being allocated to the 41 Urban Indian Health Programs that are distributed across the nation's major metropolitan areas (IHS, 2019).

One challenge of urban life for these populations is the reproduction of cultural traditions—especially Indigenous spiritual practices—for future generations owing to limited access to traditional knowledge keepers in comparison with reservation populations (Moghaddam, Momper, & Fong, 2015). Importantly, participation in such spiritual traditions has long been recognized as fundamental to health and well-being, as these practices are often deemed necessary for accessing sacred power and circulating *life* —the very antithesis of death, disease, disability, destitution, and despair (Gone, 2016). Although much has changed over the centuries with respect to AI religious traditions, there has been a remarkable revitalization of (formerly suppressed) Indigenous spiritual practices as a result of AI ethnic renewal stemming from the Red Power movement of the 1970s (Nagel, 1997). Grounded in relationships to a wide variety of nonhuman Persons who populate the cosmos, AI religious practices frequently entail the prayerful petition of status-distant nonhuman Beings—often enhanced by sacrificial forms of self-inflicted suffering designed to attract their compassion— who might "pity" lowly humans and gift them with power and life. These gifts are conducive to, and in some traditions necessary for, human longevity, abundance, and well-being (Anderson & Gone, 2009). For this reason, AI community health advocates routinely assert that a return to Indigenous traditional cultural practices—especially sacred and ceremonial practices—holds the greatest promise for improving AI health (Wendt & Gone, 2012).

In this article, we report on the collaborative development and pilot implementation of a formal Indigenous traditional spirituality program for urban AIs in a large metropolitan area of the Midwestern USA. Spanning 7 years, the partnership that gave rise to the Urban AI Traditional Spirituality Program (the "program") involved four stages of activity: (a) preparation for program development through participatory engagement of administrative leaders and staff at the IHS-funded Urban Indian Health Program (UIHP) in Detroit, MI; (b) consultation of relevant constituencies to solicit ideas and recommendations for integrating Indigenous healing practices into clinical activities and services; (c) creation of a structured curriculum for the clinic—centered on the widely practiced sweat lodge ceremony—that was designed to "teach tradition" to urban AI participants; and (d) implementation of the curriculum with an inaugural group of 10 urban AI participants for purposes of assessing and refining the program for future dissemination and evaluation. This report contributes to the broader literature on combating health disparities in Indigenous communities by demonstrating how robust participatory engagement of constituencies at an urban health center might harness locally meaningful sources of well-being for promoting health. Created primarily "by Indians, for Indians," our collaboratively designed traditional spirituality curriculum depended on cultural strengths and spiritual empowerment to advance health equity for these marginalized populations.

Round One: Preparation for Program Development

This project emerged from a partnership that was formed in early 2009 between the first author (a research psychologist then on faculty at the University of Michigan) and Jerilyn Church, the former Executive Director of American Indian Health and Family Services of Southeast Michigan, Inc. A community health center that provides basic medical and behavioral health services, the organization addresses the substantial clinical needs of the urban multitribal AI population in the Detroit metropolitan area. The center also sponsors a variety of health education, youth prevention, and community outreach programs. Dennis, Momper, and the Circles of Care Project Team (2016) reported that the center serves seven counties with a resident AI service population numbering more than 40,000. Its stated mission is to "empower and enhance the physical, spiritual, emotional, and mental wellbeing of AI families and other underserved populations in southeast MI through culturally grounded health and family services" (p. 16). Severe funding constraints have long complicated this endeavor, leading the center to seek funding beyond its annual IHS allocation from local and state agencies. Dennis et al. reported that about 2,300 clients sought care through center programs in a given year, with 10 percent obtaining behavioral health services specifically. Given the cultural orientations and interests of its predominantly AI client base, the center routinely supports cultural and spiritual programming as well, an important resource for behavioral health services in UIHPs throughout the USA (Pomerville & Gone, 2018).

Our collaboration was occasioned by a funding opportunity at the university that supported community-university research partnerships. In response, the first author and former Executive Director met in February of 2009 at the

health center to identify a topic of mutual interest for a funding proposal to conduct subsequent action research. Following perhaps 20 minutes of discussion, we agreed to explore how best to incorporate Indigenous traditional healing practices into the health and wellness services of the center. This endeavor was motivated by a needs assessment that had just been completed at that time for the UIHPs by the Urban Indian Health Institute. The results for Detroit indicated that 92 percent of 389 AI respondents desired greater access to traditional healing, a higher proportion than the average for respondents across all UIHPs that were surveyed (Park, 2009; see also Moghaddam, Momper, & Fong, 2015). Incorporation or integration of Indigenous healing practices into AI healthcare services is a delicate and understudied domain, however, motivating our pursuit of funding to develop a *practical service integration model* that would tackle these complexities in close consultation with traditional healers, service providers, program administrators, and community members affiliated with the center. We anticipated that development of such a model would then be competitive for additional research funding for future implementation and evaluation of the model. Finally, owing to the sensitivities surrounding research about integrating formerly subjugated Indigenous religious practices into biomedical healthcare services, we formed a Traditional Teachers Advisory Council comprised of local elders and knowledge keepers to guide and direct the project. The proposal was funded, and a period of formal consultation commenced in the summer of 2009.

In sum, the program described in this article emerged from a collaboration between a university research team and administrative staff partners at the AI health center in Detroit. Catalyzed by a distinctive funding opportunity that was dedicated to supporting community-engaged health research, the specific purpose of the partnership—to develop a practical service integration model—stemmed from the overlapping interests of the former Executive Director and the lead university researcher, both of whom are AIs with longstanding dedication to tailoring health services for AI populations that contend with sobering health inequities. The findings from the then-current community health needs assessment underscored the importance of this endeavor, which (with pilot funding) afforded a unique opportunity to promote health equity by seriously considering a role for Indigenous healing practices in the formal health services and activities sponsored by the center. Given the reported desire by an overwhelming majority of AI community members in Detroit for greater access to traditional healing, the project sought to meet a pressing community need in participatory fashion by drawing on Indigenous community strengths (i.e., healing practices) for realizing a more vibrant and healthy community. This project promised to be empowering in at least two senses of the word. First, we would respond to, consult with, and learn from community members—as guided by traditional knowledge keepers—in designing a model for integrating healing into health services. This was designed to intimately engage community members in addressing their own health needs. Second, the Indigenous spiritual practices that produce healing are understood to depend on circulation of sacred or holy power for their efficacy. This was expected to em-power community participants through religious access to life-enhancing gifts from nonhuman Beings.

Round Two: Consultation of Relevant Constituencies

There were several constituencies at the center who maintained a stake in the process of integrating traditional healing with clinical health services. Between the summers of 2009 and 2010, the research team interviewed center administrators, service providers, community members, and AI healers. Three center administrators (two AIs, all women) were interviewed to ascertain their prior experience with traditional healing, their concerns surrounding integration of these practices into center services, and their recommendations for policies, staffing, and funding for the integration effort. Nine service providers (eight AIs, six women)—including two physicians, three behavioral health therapists, three youth program coordinators, and a maternal/child health worker—were also interviewed to assess their ideas about including traditional healing in the services they provided, their willingness to collaborate with traditional healers, and the ethical and legal liabilities that could arise from their doing so.

Twenty-six urban AI community members (17 women) who hailed from a variety of tribal backgrounds were convened in four focus groups to share their perspectives about Indigenous traditional healing and their recommendations for integrating these practices into center services. Focus group prompts included questions such as: *What kinds of traditional healing activities would most effectively meet the health needs of you or your loved ones?*, and *How regularly should traditional healing activities be available at the center?* One clear lesson from these focus groups was that, although participants expressed great enthusiasm for traditional healing, few really knew very much about these practices.

Elsewhere, Hartmann and Gone (2012) reported additional findings from participants of these focus groups. These included recognition of two crucial contextual features (the legacy of colonial adversity that shaped this

community, and rampant dissatisfaction with the reductive nature of biomedicine); identification of four key components of a successful healing program (viz. ceremonial participation, traditional education, culture keepers, and community cohesion); and negotiation of four key tensions that challenge an integrative effort of this kind (e.g., multitribal healer representation vs. relational consistency with healers, integrity of healing traditions vs. appeal of alternative medicine).

Eight AI healers (five women, and all but one from the Midwest) were identified by the Traditional Teachers Advisory Council and center staff for project consultation. They represented Haudenosaunee, Anishinabe, Lakota, and Mexican Indigenous traditions, and included one father–daughter pair. Healers were primarily interviewed by the first author, with one interview being conducted by the former Executive Director of the center. Interview questions included: *What kinds of traditional healing activities are most suitable for integration with health services?*, and *What health outcomes might you expect from patients who participate in such traditional healing?* The shortest interview was just over 40 minutes in duration, while the longest lasted over three hours. Interestingly, the healers differed markedly in their outlooks, practices, and recommendations. For illustrative purposes, we briefly describe four healers and their perspectives on integration here.

One healer was fairly skeptical that Indigenous traditional practices could be introduced into the urban clinical setting at all. His recommendation was that urban AIs with an interest in such practices should travel to (typically) remote ceremonial gatherings, usually convened "in the bush" throughout the region, to learn about and participate in the necessary traditions. A second healer described his healing practice with routine references to ceremonies and "natural medicines" (i.e., herbal agents). He did not describe these in any detail, which is in fact consistent with Indigenous tradition—especially in the historical context of Euro-American colonial subjugation—that prescribes secrecy about such practices outside the formal context of apprenticeship.

A third healer conveyed a relatively well-formulated proposal to train center staff in the delivery of aural acupuncture (based on traditional Chinese medicine) for clients with substance abuse problems. She envisioned her role primarily as a trainer who would not need to be engaged with the center in any intensive, ongoing way. A fourth healer identified herself as a "seer" who would scatter tobacco during a client consultation and receive communications from the tobacco that enabled her to formulate the client's problem and recommend subsequent therapeutic actions. She already served AI clients throughout clinics in the region on a consultation basis, and so

conveyed a ready-made model akin to the referral and consultation of medical specialists more generally.

Through these consultations, we learned a great deal about the effort to integrate Indigenous traditional healing and AI health services, but these lessons evaded ready consolidation into concrete and actionable integrative programming. For example, no specific approach or structure emerged from focus group responses; rather, these consultations identified principles and trade-offs that were indirectly (more so than directly) useful in guiding key decision-makers at the center. Similarly, the insights gleaned from the healer interviews were illuminating and informative, but also strikingly diverse and even contradictory, thus presenting a sobering challenge to this effort.

For example, it was not uncommon (for both cultural and political reasons) for healers to be reticent about their healing knowledge and protocols. And yet, in the absence of more clear description and explanation, it remained difficult to design an integrative program when the parameters of the practices to be included seemed vague. Moreover, one original purpose for developing an integrative program was to pursue grant funding for implementation and evaluation of the practical service integration model. Much of the healing activities that were described, however, seemed extremely responsive to individual circumstance and thus did not appear to lend themselves to the specification of pre-designated health outcomes that could be targeted in advance for assessment.

Furthermore, most of the healers discussed their practices in terms of community obligation and responsibility, informal referral and compensation mechanisms, and circulation and consultation through a relatively broad geographical region. None suggested that they were amenable to being "hired on" as full-time staff at a health center. In consequence, any locally designed integrative program must afford wide flexibility for healer participation, but this concession to implementation in the face of such diversity would likely constrain the prospects for outcome evaluation. Finally, some healing practices that were described were either non-AI in origin (e.g., acupuncture) or suffused with "complementary and alternative" health practices more generally. Thus, some person or persons would need to exercise potentially controversial authority in determining criteria for inclusion or exclusion of practices on the grounds of local cultural acceptability.

In sum, despite conscientious consultation with a variety of constituencies at the center, each with a stake in the integrative endeavor, no consensual program or structure emerged from these interviews and focus groups. Rather, we obtained a complex plethora of ideas and recommendations, including (perhaps most significantly) a striking diversity in healing logics and practices even among a group of eight locally nominated traditional AI

healers. These included a few concrete prototypes (e.g., tobacco readings by appointment in keeping with the more familiar practices of medical specialists), but with some contradicting others and a few that would be difficult—perhaps impossible—to effectively evaluate. Thus, following an additional year for analysis of these findings, the research team turned to the staff partners, the Traditional Teachers Advisory Council, and community members themselves in a moment of grave uncertainty to obtain clarity about how best to proceed at this key juncture of the project.

Round Three: Creation of a Structured Curriculum

By the summer of 2011, the research team had synthesized the conclusions from the series of consultations with center administrators, service providers, community members, and AI healers. In July, the team met with the staff partners at the center to review these findings and, owing to the uncertainty already described, solicit their guidance about how to proceed. The research team presented a handful of concrete possibilities for future directions, including adoption of culturally tailored empirically supported treatments in the behavioral health program, or formal evaluation of the youth substance abuse prevention program. As one option, the team also proposed to develop an orientation program centered on Indigenous traditional spirituality that would be tailored for those urban AIs with limited prior exposure to these practices, even as it would be structured for formal outcome evaluation. Related to this, the team reported that focus group participants had identified the sweat lodge ceremony as a primary example of ceremonial participation that seemed especially pertinent for this possibility. Staff partners quickly and fervently identified the traditional spirituality program—to be centered on the sweat lodge ceremony—as their primary choice and invited the research team to undertake additional consultation to develop such a program. Interestingly, of all the options presented to the staff partners by the research team, formal design of a traditional spirituality program seemed the least likely to effectively garner additional research funding; nevertheless, the deeply participatory nature of the collaboration mandated pursuit of the staff partners' priorities irrespective of this consideration.

The sweat lodge ceremony is an Indigenous rite that was widely distributed throughout North America prior to European contact. Since the Red Power movement of the 1970s, the sweat lodge has circulated even more widely and is now recognized as a pan-Indian tradition. Although the details vary both within and between tribal communities (for a detailed overview of the Lakota version, see Bucko, 1998), sweat lodge ceremonies typically involve group prayer within a dome-shaped lodge crafted of willows and covered in blankets. A pit in the center of the lodge contains heated rocks that are sprinkled with water during the ceremony, leading to copious steam, high heat, profuse sweating, and deliberate discomfort inside the sealed and darkened lodge during each of the ceremony's four sessions (or "rounds"). Singing and the burning of sacred plants such as sweetgrass or sage (known as "smudging") accompany each round, and many "sweats" involve the communal smoking of a sacred pipe. The entire experience aims for utterly sincere communication with nonhuman Persons (e.g., the Grandfather spirits) in petition or thanksgiving for blessings, as facilitated by the sacrificial offering of one's embodied discomfort. Sweat lodge ceremonies have been a routine feature of reservation-based, IHS-funded addiction treatment programs for decades (Hall, 1985). Their function as therapeutic activities has been described in the health literature (Garrett et al., 2011; Smith, 2005; Walkingstick & Larry-Osborne, 1995). Indeed, the center already sponsored intermittent sweat lodge ceremonies whenever it could be arranged for a ritual leader to conduct the ceremony.

In July and August of 2011, the research team crafted a rudimentary outline for a traditional spirituality curriculum that could feature the sweat lodge ceremony and then presented this, first, to a public gathering at the center, and then to the Traditional Teachers Advisory Council for feedback. The proposal was greeted with general enthusiasm, but there were two major challenges to successfully designing such a program. One was the challenge of integrating the normative practices surrounding traditional Indigenous spiritual teachings with the conventions of program development suited for scientific outcome evaluation. Another was the challenge of undertaking sensitive and extensive consultation with a knowledgeable AI ritual leader who could guide the development of a detailed curriculum based on sacred ceremonial knowledge. Just as solutions to these challenges were being pursued, the former Executive Director announced her pending departure and the search for a new leader for the center got underway. Indeed, it was not until the late spring of 2012 that the second author joined the health center as the new Executive Director, learned about the project, and sanctioned renewed progress in developing the program. Thus, in June of 2012, the search for a knowledgeable consultant proceeded, ultimately resulting in a referral from members of the Traditional Teachers Advisory Council to a middle-aged Anishinabe ritual leader, Paul Syrette, from the region who could guide the development of the curriculum. In response, the research team invited Syrette to

consult with us regularly (and privately) on campus during the Fall of 2012 and Winter of 2013.

The research team's consultations with Syrette occurred in a small research lab in the psychology department at the university. Usually, there were 3–5 individuals gathered during these meetings, including Syrette, the first author, and 2–3 of the first author's students (two of whom were AI undergraduates volunteering in the research laboratory). The first meetings were concerned with cultivating a shared frame of reference for the consultation, such as negotiating the grounds for a respectful exchange, recognizing the kinds of knowledge that would and would not be documented, and explaining the purpose and desirability for designing a portable and formally structured curriculum. Then, we embarked on additional preliminary discussions about the philosophical underpinnings and religious understandings of traditional teachings and the sweat lodge ceremony. Next, we compiled a list of spiritual practices (e.g., smudging, singing, drumming) and sequenced them starting with basic activities (e.g., prayer) before proceeding to more complex ones (e.g., the sweat lodge ceremony, which incorporates several distinct practices). Then, we organized these into a provisional 12-session curricular structure that entailed deliberate repetition of key teachings, as punctuated by actual participation in the sweat lodge ceremony. This structure afforded the development of a detailed curriculum guide for each proposed 3-hour session. These session outlines included standard information (e.g., Summary, Session Overview, Objectives, Materials Needed) as well as a detailed list of sequential activities with accompanying descriptions and timeframes for each session activity. Finally, many sessions included associated materials such as published stories, informational brochures, and illustrative videos that we gathered and included for use in the curriculum.

The development of the traditional spirituality curriculum was utterly dependent on effective consultation with Syrette. Knowledgeable, accessible, personable, and flexible in his thinking (whether on abstruse philosophical matters or practical recommendations), Syrette proved to be an amazing collaborator in this respect. Moreover, the two AI undergraduate laboratory assistants who were tasked with translating our consultation notes into draft curricular format achieved this with remarkable aplomb. By early 2014, the resulting curriculum had been drafted, comprised of twelve 3-hour sessions that would be offered weekly (see Fig. 1). Starting in the first session with a program orientation and general introduction, four didactic sessions were to follow (with some sessions to include brief ceremonies such as a water ceremony and pipe ceremony). The sixth session would involve participation in a sweat lodge ceremony. Then participants would reflect on the ceremony and receive additional didactic instruction during four subsequent sessions. The eleventh session was to involve a second sweat lodge ceremony. The final session was to include a community gathering in which participants would be recognized and honored for their completion of the program. It is worth noting that the eighth session was to focus on language in ceremony. Language revitalization is occurring in many AI communities, and use of Indigenous heritage language in ceremonies is one of the drivers of this commitment. In developing the curriculum, this session was the most difficult to plan, as we could not anticipate whether designated program facilitators would speak their heritage languages. Finally, gender issues were addressed at various points throughout the curriculum, as masculine and feminine social identities remain key features of ceremonial practice in most AI communities. For this reason, we envisioned that the curriculum would be co-jointly facilitated by a man and a woman as co-leaders to ensure that sacred gender complementarity would be preserved and that diverse gender perspectives would be reflected throughout the program.

Curriculum development was guided by a few key commitments. First, the program was designed for urban AI community members with limited exposure to Indigenous traditional spiritual practices. Thus, we aspired in developing the curriculum to make no assumptions about participant familiarity or prior experience. This was important because social interactions in AI communities sometimes involve a relative positioning of self and others with respect to cultural knowledge and authenticity, and we hoped to eliminate these dynamics from the program. Second, the design of this program entailed a signature innovation: the recasting of traditional (informal) socialization processes that frequently prevail in reservation communities into a (formal) didactic curriculum in this urban setting that could initiate an enduring spiritual devotional life for AI participants toward improved health and well-being. In consequence, we committed to documenting general information and teachings in the curriculum but *not* detailed ceremonial information. Moreover, owing to widespread non-AI interest in accessing and appropriating Indigenous spirituality, we adopted the explicit program motto, "By Indians, for Indians" to signal our intent that the program should always remain under AI authority and control. Finally, each session in the curriculum was to begin with certain reminders to participants. Program participation required tolerance for the diversity of Indigenous practices because spiritual traditions do vary by tribal community and there was no way to ensure that every tradition would be adequately represented. Participation also required positive attitudes and open hearts because of the ceremonial significance of collective thinking (Gone, 2019) and the desire to maintain community cohesion (as conveyed in the

Urban American Indian Traditional Spirituality Program (UAITSP)

University of Michigan Community-University Research Partnership
Gone Team & AIHFS staff in consultation with Mr. Paul Syrette
As Guided by Traditional Teachers Advisory Council
(Gerald Cleland, Bruce Elijah, Jose Marcus, George Martin, and Mona Stonefish)
With a special linguistic contribution by Dr. Margaret Ann Noodin

1st Session- Program Orientation; Introduction to Ceremony; Traditional Prayer; Traditional Medicines; Smudging; American Indian Religious Freedom Act; Aside About Ceremonial Preparations & Women's Cycles

2nd Session- Pipe Teachings & Pipe Ceremony #1

3rd Session- Water Teachings; Water Ceremony #1; Gender & Ceremony; Drumming & Singing; Traditional Dances

4th Session- Sweat Lodge Teachings (origins, practices, roles); Sacred Fire Teachings

5th Session- Fasting & Visions, Tobacco Ties; Approaching an Elder; Lodge Review (origins) & Preparation; Feast Preview

6th Session- Sweat Lodge Ceremony #1 (4-5 hrs) (participants invited to come early and assist with the lodge preparation; different men and women lodges/times?); [Feast Reminder]

7th Session- Talking Circle #1 (reflections, questions, program feedback); Feast Traditions & Traditional Foods; Give-Away Orientation; Feast

8th Session- Language & Ceremony

9th Session- Pipe Ceremony #2; Water Ceremony #2; Overview of Other Ceremonies

10th Session- Making Medicine Pouches; Review of Medicines; Drug & Alcohol Abuse; Talking Circle #2 (in preparation)

11th Session- Sweat Lodge Ceremony #2 (4-5 hrs)

12th Session- Community Gathering; Feast; Give-Away; Honor Song

Additional issues: Program motto: "By Indians, for Indians"; Male and female co-leaders; Record general information/teachings but not ceremonies

Fig. 1 Cover sheet of the traditional spirituality curriculum detailing its session structure

earlier focus groups). Beyond this (with respect to gender issues), participation required observance of ceremonial restrictions concerning women's menstrual cycles in keeping with longstanding multitribal traditions and the sacred potency of women's reproductive powers that might disrupt ceremonial functions.

In sum, in 2011 the research team received direction from staff partners to develop a program tailored for members of the Detroit urban AI community that would introduce and orient these individuals to meaningful participation in some basic practices of Indigenous traditional spirituality. Through sustained consultation with a designated regional ritual leader into the Winter of 2013, we created the Urban American Indian Traditional Spirituality Program, a curriculum consisting of twelve 3-hour sessions that would inaugurate for future participants a meaningful engagement with sacred practices associated with the sweat lodge ceremony. The signature innovation of this program was the "teaching of tradition" to urban AIs through a structured, didactic curriculum that would contrast markedly with the less formal socialization into these practices that routinely occurs in AI reservation settings. Creation of this innovative format was necessary for two reasons. First, traditional socialization processes surrounding Indigenous spiritual practices were not routinely available to large numbers of AIs in the Detroit metropolitan area, which was a primary motivation for developing the program in the first place. Second, the partnership retained interest in formally evaluating the program. This necessitated a structured format that could ensure consistency across multiple offerings of the program and portability to other urban AI communities that might desire to participate in the evaluation of the program. Key commitments of the curriculum included AI control of the program, and participant willingness to engage in structured activities with tolerance, open hearts, and observance of restrictions associated with women's menstrual cycles. Consideration of salient gender issues was featured throughout the curriculum (e.g., the Pipe Ceremony is gendered as masculine and the Water Ceremony is gendered as feminine, and teachings pertaining to gender and ceremony were included). The curriculum was finalized by 2014.

Round Four: Implementation of the Curriculum

The finalization of a traditional spirituality curriculum provided a crucial blueprint for the project, but nothing would substitute for a pilot implementation of the program with urban AI participants from the health center. A project hiatus ensued while the first author temporarily relocated for the 2014–2015 academic year to another university, but upon his return in the Fall of 2015 preparations resumed for this "proof of concept" trial run. As Executive Director of the center, the second author designated the third author to serve as the center's staff lead for the program implementation. Both the research team and staff partners marshaled resources to contribute to the implementation effort. The most challenging task was to

identify, recruit, and orient a man and woman who could serve as effective co-facilitators of the program. Obviously, these individuals would have to possess the requisite spiritual and ceremonial knowledge, but also express willingness to adhere to a detailed curriculum while interacting with novices in an approachable and personable fashion. Fortunately for the project, staff partners attracted Joe and Joan Jacobs to serve in this role. The Jacobs proved to be especially effective facilitators owing to their openness, friendliness, flexibility, knowledge, and patience. As middle-aged individuals, they effectively bridged the life experiences of younger participants and the cultural authority of more elderly knowledge keepers. The Jacobs resided some hours' drive away from Detroit, so their commitment to the project was evident each week that they faithfully arrived to facilitate the program. It should also be noted that one element of the Jacobs' appeal was that they, too, were still learning these traditions. In fact, the actual sweat lodge ceremonies were conducted by Anthony Davis, a former counselor at the center who traveled even farther to Detroit to serve in this role.

The next task was to select participants for the pilot implementation of the program. The project partners developed selection criteria that emphasized limited prior exposure to Indigenous spiritual traditions and eagerness to attend program sessions on Saturdays for the duration of the 12-week program. Recruitment flyers and screening forms were circulated through the center's communication networks, and 21 applicants submitted their completed screening forms to staff partners. A number of these reported familiarity with Indigenous spirituality and the sweat lodge (and a few others opted to defer their applications), so 10 adult participants (seven women) who met our criteria were included in the pilot implementation of the program. These participants hailed from several tribal backgrounds, with an equitable age distribution across their 20s, 30s, and 40s (with one in his 50s). Most were employed during the week. A notable minority was struggling with chaotic life circumstances, which is not uncommon for the center's service population. About half of the participants required supportive assistance in the form of transportation and/or child care to remain in the program, which staff partners were able to provide through the center. Nevertheless, the barriers to regular participation were formidable, despite incentives that encouraged consistent engagement. For example, one component of participation was the opportunity to respond to various survey measures as part of a pilot assessment protocol. Participants were eligible to receive compensation of up to $300 if they attended at least 10 of 12 sessions, completed surveys at three time points, and sat for a post-program interview. Although none of the participants withdrew from

the program, just five met the requirements for full compensation (with nine completing post-program interviews).

The program was implemented between mid-February and mid-May of 2016. Gone et al. (2017) published a "First Person Account" in this journal that provides diverse perspectives on the experience of this pilot implementation written by three project partners, one facilitator, and two program participants. These published reflections offer a textured feel for engagement with the program. The pilot implementation was crucial for demonstrating proof of concept, given that (to our knowledge) no action research partnership has ever before created and implemented an Indigenous spirituality curriculum designed to "teach tradition" to AI participants. Moreover, the pilot implementation afforded an opportunity to assess and refine the curriculum. For example, it became apparent in the early sessions of the pilot program that the co-facilitators exhibited difficulty following the detailed session outlines while attempting to interact effectively with program participants. In response, the research team—which dispatched representatives to observe each session—decided to distill the curricular outlines into a PowerPoint slide presentation that could be projected during the non-ceremonial portions of the sessions. This enabled a much smoother flow in session activities and afforded more ready access to required curricular materials such as brochures and videos. Beyond this, individual participants would sometimes request additional information that delved much more deeply into session teachings than time constraints would afford. In response, the research team made available notecards to be distributed to each participant at the beginning of every session so that they could write down their individual questions for further exploration outside of the structured sessions proper.

As we have already noted, the purpose of the Indigenous traditional spirituality program was to inaugurate an enduring devotional life for urban AI participants. We have also observed that Indigenous ceremonial practices are traditionally understood to circulate *life* among participants and, indeed, the broader AI community, which is believed to promote robust health and well-being. In our assessment protocol, we aspired to test survey measures that might capture shifts in psychosocial and behavioral processes and outcomes for individuals associated with improvements in health. More specifically, we hypothesized that program participation would enhance positive cultural identity, spirituality, ceremonial knowledge, and cultural engagement; reduce psychosocial symptoms and distress; improve emotional regulation and life satisfaction; and increase community-mindedness, coping skills, social support, help-seeking attitudes, and service utilization. Obviously, with just five participants completing the entire assessment protocol, nothing can be substantively concluded from this pilot implementation about our hypotheses. Nevertheless, we have demonstrated that an orientation to Indigenous traditional spirituality through a didactic curriculum could attract knowledgeable AI co-facilitators. These co-facilitators were able to effectively engage urban AI community members in formally structured learning and guided participation with respect to these vital and valued traditions. Importantly, participants in the program reported positive—even transformational—experiences from their engagement with this curriculum. Now that the program exists, it remains for our project team to determine whether and how to invite other urban AI health centers to adopt the curriculum for purposes of larger scale implementation and evaluation in service to a distinctive strengths-based and empowering form of Indigenous health promotion.

Closing

In this participatory collaboration spanning seven years, we developed an Indigenous traditional spirituality program for AI community members who obtain services from an urban AI health center. Along the way, we encountered many challenges. One challenge was the need to reconcile widespread community enthusiasm for traditional healing practices alongside the relatively limited knowledge by community members about these healing traditions. Another challenge was the aspiration to design a practical service integration model in the absence of clear precedents in the literature. An additional challenge was the mandate to harness esoteric and sensitive ritual knowledge into a portable curricular format. Yet another challenge was the commitment to distill what in other settings would have been organic processes of community socialization into this programmatic "teaching of tradition."

Once the program curriculum was designed and ready for pilot implementation, the recruitment and retention of participants for this pilot effort was also challenging. The AI community in Detroit is scattered throughout the metropolitan area. AI community members who frequent the center are typically lower-income individuals. Too many contend with chaotic lives that include uncertain employment, insecure housing, unreliable transportation, unaffordable childcare, domestic violence, substance abuse, and mental health crisis. It is precisely this segment of the urban AI population that the center was designed (and funded) to assist, but these realities severely complicate service delivery. Thus, unsurprisingly, our pilot implementation encountered fluctuations in consistent engagement, even as participants continued to express enthusiasm for the program (and none withdrew from formal participation).

In contrast, what did surprise us was that the Urban AI Traditional Spirituality Program came into existence at all.

Indeed, its significance for advancing Indigenous health equity is profound. Although spirituality and health are routinely integrated in the lives of many peoples throughout the world, the conventions of biomedicine tend toward a relentless secularism. What is to be gained in terms of health promotion, some might ask, from harnessing spiritual practices in programmatic fashion? For AIs in the contemporary USA, the answer depends on recognition of health as a *political domain* that encompasses enduring relations of dominance and subjugation. Such recognition follows from awareness that contemporary AI lives have long been structured by circumstances of coloniality.

More specifically, the legacy of European and Euro-American colonization lingers on in structural arrangements, power differentials, discursive forms, and inhabited (and felt) subjectivities that coalesce to deprive many AIs of the possibility for good lives. The health disparities that routinely characterize Indigenous communities around the globe include addiction, trauma, and suicide, and—within affluent nation-states—obesity and diabetes. These conditions stand out for their psychological and behavioral underpinnings. They are self-evidently tied to desperation, demoralization, and despair wrought of poverty, discrimination, and absence of opportunity. They are, in short, postcolonial disorders (DelVecchio Good, Hyde, Pinto, & Good, 2008).

In response, unsurprisingly, AI health clinics in the USA frequently promote programs and services expressive of anticolonial politics. Such a politics centers on the expression of agency and self-determination to reverse long histories of dominance and subjugation. It refutes the dismissive denigration of AI knowledges and traditions as primitive, backward, or unenlightened by instead asserting the contemporary relevance of tradition and the revitalizing capacity of ceremony. It resists the radical reductionism of biomedicine by instead insisting that healing entails more than mere restoration of bodily functions. Indeed, an anticolonial politics finds hope and help in the possibility for redressing legacies of postcolonial anomie by championing renewed identity and belonging toward discovery of communal continuity with a proud past.

In this light, health promotion is revealed as so much more expansive and encapsulating than disease prevention and, indeed, can scarcely be captured by words other than *spirituality*. Irrespective of one's religious orientations and convictions, however, the therapeutic potency of re-moralization has long been recognized (Frank & Frank, 1993). One implication of such recognition is that therapeutic benefit is cast squarely in the realm of *human meaning-making*. In stark contrast to the technical-scientific concern with "mechanism," meaning-making opens up possibilities for creative responses to dire predicaments. Rather than restoration to a pre-existing state of health in curative fashion, meaning-making can afford transformations of the self in service to improved health and life (Waldram, 2013).

So it is that administrators and staff at an AI health center would seek to harness Indigenous traditional spirituality as a potent form of health promotion. Indeed, their commitment was so persistent and strong that it endured throughout the activities described in this article for seven years, and in fact endures today. Moreover, community psychology represents the only subfield of the discipline that recognizes, values, enacts, and sustains the kind of deeply participatory engagement with community members that is required for the development of novel and innovative health programs and services in anticolonial fashion. It is precisely because such collaborative program development enlists "ordinary" citizens in collective action to solve their own problems that favorable outcomes can be produced and re-moralizing empowerment can be realized.

Conflict of Interest

The authors have no conflicts of interest to report.

References

Anderson, J. D., & Gone, J. P. (2009). Native American religious traditions. In R. A. Shweder, T. R. Biddell, A. C. Dailey, S. D. Dixon, P. J. Miller & J. Modell (Eds.), *The child: An encyclopedic companion* (pp. 670–672). Chicago: University of Chicago.

Bucko, R. A. (1998). *The Lakota ritual of the sweat lodge*. Lincoln, NE: University of Nebraska.

Castor, M. L., Smyser, M. S., Taualii, M. M., Park, A. N., Lawson, S. A., & Forquera, R. A. (2006). A nationwide population-based study identifying health disparities between American Indians/Alaska Natives and the general populations living in select urban counties. *American Journal of Public Health*, 96, 1478–1484.

DelVecchio Good, M. J., Hyde, S. T., Pinto, S., & Good, B. (Eds.) (2008). *Postcolonial disorders*. Los Angeles: University of California.

Dennis, M. K., Momper, S. L.& the Circles of Care Project Team (2016). An urban American Indian health clinic's response to a community needs assessment. *American Indian and Alaska Native Mental Health Research*, 23, 15–33.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore: Johns Hopkins University.

Garrett, M. T., Torres-Rivera, E., Brubaker, M., Portman, T. A. A., Brotherton, D., West-Olatunji, C., ... & Grayshield, L. (2011). Crying for a vision: The Native American sweat lodge ceremony as therapeutic intervention. *Journal of Counseling and Development*, 89, 318–325.

Gone, J. P. (2016). Alternative knowledges and the future of community psychology: Provocations from an American Indian healing tradition. *American Journal of Community Psychology*, 58, 314–321.

Gone, J. P. (2019). "The thing happened as he wished": Recovering an American Indian cultural psychology. *American Journal of Community Psychology*, 64, 172–184.

Gone, J. P., Blumstein, K. P., Dominic, D., Fox, N., Jacobs, J., Lynn, R. S., Martinez, M., & Tuomi, A. (2017). Teaching tradition: Diverse perspectives on the pilot Urban American Indian Traditional Spirituality Program. *American Journal of Community Psychology*, 59, 382–389.

Gone, J. P. & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology*, 8, 131–160.

Hall, R. (1985). Distribution of the sweat lodge in alcohol treatment programs. *Current Anthropology*, 26, 134–135.

Hartmann, W. E. & Gone, J. P. (2012). Incorporating traditional healing into an urban American Indian health organization: A case study of community member perspectives. *Journal of Counseling Psychology*, 59, 542–554.

Indian Health Service (2019). Fiscal year 2019 Indian Health Service justification of estimate for Appropriations Committees.

Available from: https://www.ihs.gov/budgetformulation/congressionaljustifications/ [last accessed June 8, 2020].

Moghaddam, J. F., Momper, S. L., & Fong, T. W. (2015). Crystalizing the role of traditional healing in an urban Native American health center. *Community Mental Health Journal*, 51, 305–314.

Nagel, J. (1997). *American Indian ethnic renewal: Red power and the resurgence of identity and culture*. Oxford, UK: Oxford University.

Park, A. (2009). *Bemidji area urban American Indian/Alaska Native needs assessment—Detroit results*. PowerPoint slideset, Seattle, WA: Urban Indian Health Institute, Seattle Indian Health Board.

Pomerville, A., & Gone, J. P. (2018). Behavioral health services in urban American Indian health organizations: A descriptive portrait. *Psychological Services*, 15, 1–10.

Smith, D. P. (2005). The sweat lodge as psychotherapy: Congruence between traditional and modern healing. In Moodley, R. & West, W. Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 196–209). Thousand Oaks, CA: Sage.

Waldram, J. B. (2013). Transformative and restorative processes: Revisiting the question of efficacy of indigenous healing. *Medical Anthropology*, 32, 191–207.

Walkingstick, M., & Larry-Osborne, G. W. (1995). The Native American sweat lodge as metaphor for group work. *Journal for Specialists in Group Work*, 20, 33–39.

Warne, D., & Lajimodiere, D. (2015). American Indian health disparities: Psychosocial influences. *Social and Personality Psychology Compass*, 9, 567–579.

Wendt, D. C., & Gone, J. P. (2012). Rethinking cultural competence: Insights from indigenous community treatment settings. *Transcultural Psychiatry*, 49, 206–222.

Yuan, N. P., Bartgis, J., & Demers, D. (2014). Promoting ethical research with American Indian and Alaska Native people living in urban areas. *American Journal of Public Health*, 104, 2085–2091.