The Value of Lakota Traditional Healing for Youth Resiliency and Family Functioning

Brenda J. Freeman, Kenneth M. Coll, Rick Two Dogs, Ethleen Iron Cloud Two Dogs, Eileen Iron Cloud & Paul Robertson

To cite this article: Brenda J. Freeman, Kenneth M. Coll, Rick Two Dogs, Ethleen Iron Cloud Two Dogs, Eileen Iron Cloud & Paul Robertson (2016) The Value of Lakota Traditional Healing for Youth Resiliency and Family Functioning. Journal of Aggression, Maltreatment & Trauma, 25:5, 455-469, DOI: 10.1080/10926771.2015.1079282

To link to this article: http://dx.doi.org/10.1080/10926771.2015.1079282

Published online: 25 Jan 2016.

Article views: 59

View related articles

View Crossmark data
The Value of Lakota Traditional Healing for Youth Resiliency and Family Functioning

Brenda J. Freeman, Kenneth M. Coll, Rick Two Dogs, Ethleen Iron Cloud Two Dogs, Eileen Iron Cloud, and Paul Robertson

ABSTRACT

This article reports research findings on the impact of Oglala Lakota Sioux traditional healing on family functioning and youth resiliency where trauma, abuse, or violence are often present. Caregivers of Lakota youth struggling with serious emotional and behavioral problems participated in the study. The study included both quantitative and qualitative samples: 27 families for the quantitative sample and 8 families for the qualitative sample. Results from caregivers revealed that traditional healing and cultural practices, as well as the promotion of cultural identity, had statistically significant positive effects on the perceived familial and individual functioning of Lakota youth and their families. Effect sizes indicate that the results have strong practical significance.

Although causation in mental health is complex, with cultural, social, biological, and psychological factors contributing to the existence of a diagnosable mental health problem (U.S. Department of Health and Human Services, 2001), the Surgeon General’s report on mental health (U.S. Public Health Service, 2001) indicates that social context, cultural factors, racism, discrimination, and poverty are important contributors to the mental health struggles of Indigenous peoples. During the past two decades, the federal government, particularly the Substance Abuse and Mental Health Administration (SAMHSA), has recognized the importance of culture-based approaches and community-based planning for mental health services, as evident by initiatives such as Circles of Care and the Systems of Care, which encompass strong cultural competence components (G. Blau, personal communication, February 20, 2009). Therefore, the purpose of this study was to investigate the impact of traditional healing on Oglala Lakota children struggling with serious emotional and behavioral problems and their families. Traditional healing, in the context of this discussion, refers to Indigenous healing ceremonies, customs, and beliefs.
specific to tribes and clans within American Indian cultures, rooted in precolonization history, and practiced to foster holistic health (physical, mental, or spiritual), balance, harmonious relationships, and disease treatment and prevention (Johnston, 2002).

One key contextual factor for understanding serious emotional and behavioral problems within American Indian/Alaska Native (AI/AN) communities is the impact of colonization by European Americans. Whitbeck, Adams, Hoyt, and Chen (2004) indicated that a grassroots movement is growing on reservations and among urban American Indians that seeks to understand the intergenerational psychological consequences of more than 400 years of genocide, ethnic cleansing, and forced acculturation. Although empirical evidence supporting a relationship between historical events related to colonization and the current mental health challenges of Native youth is lacking, literature suggests that colonization marks the commencement of a series of historical consequences that forever changed the psychological world of Native families. Stone (2003) posited that these consequences include, among other factors, dispossession, disruption of culture, and relocation. Shelton (2001) expanded on the theme of the impact of the boarding school era, describing moving children hundreds of miles from home, denying them the right to speak their Native language, and shaming and severely punishing them for following Native traditions. Manson (2001) maintained that the ripple effects of assimilation policies are insidious, with an ongoing impact on Indigenous societies. This perception asserts that subsequent generations learn from and are affected by parents, grandparents, and other extended family adults who experienced unexpected or serious harm or death (e.g., genocide, sexual assault, torture, murder; Levine, 2001). This phenomenon involves learning to internalize an intense fear, helplessness, or horror through viewing another’s experience of trauma (e.g., anger, depression, and alcohol or drug abuse) and learning to act and react in a similar fashion (National Child Traumatic Stress Network, 2004).

There is a growing body of evidence that the consequences of colonization are real and that its consequences are prevalent in historically oppressed or colonized peoples (Pupavac, 2002; Stone, 2003; Whitbeck et al., 2004). Evidence of multigenerational trauma has emerged in studies of multigenerational Holocaust survivor families (Levine, 2001), refugee families, and families around the world dealing with multigenerational effects of genocide, mass killing, and other collective violence (Pupavac, 2002; Stone, 2003; Whitbeck et al., 2004). Levine (2001) referenced a number of Holocaust family studies with several recurring themes, including chronic and severe depression, disturbances in memory and cognition, feelings of guilt, marked anxiety, and sleep disturbances.

For American Indian populations, these effects of colonization include significantly higher rates of substance abuse compared to other ethnic
populations (Beauvais, 1996; Burns, 1995; Novins, Fickenscher, & Manson, 2006; Novins, Spicer, Fickenscher, & Pescosolido, 2012), and 50% to 70% higher rates of suicide (Aguirre & Watts, 2010; Dorgan, 2010; Goldsmith, Pellman, Kleinman, & Bunney, 2002). In addition, American Indian populations report over twice the rate of depression (Kinzie et al., 1992; Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997), PTSD, and other forms of trauma (Robin et al., 1997). Higher rates of domestic violence (Dickerson, Spears, Marinelli-Casey, Rawson, Li & Hser, 2010; Halinka & Duran, 2004; Robertson, 2012), and large parenting skill deficits also exist compared to the U.S. population as a whole (Beals et al., 1997; Berlin, 1987).

If traumatic historical events are antecedents of tribal mental health problems, perhaps some of the solutions to these mental health problems are embedded within tribal culture and history as well. Culture in mental health interventions is a complex issue (Moodley & West, 2005), particularly in light of the movement toward science-based (and sometimes culture-free) interventions. Some authors maintain that the restoration of culture and culturally based interventions are key healing factors because strong cultural identity has been positively correlated with better mental health outcomes (Johnston, 2002; Moodley & West, 2005). Historical accounts of various tribal cultures show strong evidence of a myriad of approaches to healing that preceded the introduction of Western medicine in tribal communities (Moodley & West, 2005). Although many tribal healing practices have been lost, traditional healing remains a primary culture-based intervention, coexisting with Western medicine, in some tribal communities.

The widely divergent meanings of traditional healing reflect the diversity of Native cultures. Traditional healing, in the context of this discussion, refers to Indigenous healing ceremonies, customs, and beliefs specific to tribes and clans within AI cultures, rooted in precolonization history, and practiced to foster holistic health (physical, mental, or spiritual), balance, harmonious relationships, and disease treatment and prevention (Johnston, 2002). Although in the Western mental health model traditional healing is referred to as an alternative treatment (implying alternative to the Western medical model), traditional healing is hardly alternative in the history of AI/AN peoples (Whitbeck, Chen, Hoyt, & Adams, 2004). Traditional healing ceremonies have been used for purposes such as ushering young men into manhood, purifying, and doctoring to help heal trauma. Although biomedical Western mental health practice is often seen as the gold standard for mainstream U.S. culture, Native peoples are long accustomed to choices in biomedical and traditional approaches, with some preferring biomedical treatment, some choosing native remedies for native problems and White medicine for White diseases (Powers, 1986), and others accessing blends of biomedical services and traditional healing. Traditional healing for mental health purposes is not part of the historical tradition in some tribal cultures, whereas in other cultures it is a lost
tradition or traditional healers are unavailable. However, for those tribes where
traditional healing is part of the tribal culture, it represents a historical root—
the confluence of language, history, tradition, and symbolic cultural archetypes
—in the healing of emotional and behavioral suffering (Johnston, 2002).

The term serious emotional behavioral disturbances (SEBDs) was not gen-
erally used in the AI/AN community. Caregivers in the community determined
an alternative local definition, Tawacin Sagye Wokakije, which translates as
“strong suffering of the mind and heart” (Coll, Freeman, & Robertson, 2005,
Freeman, Iron Cloud-Two Dogs, Novins, & LeMaster, 2000). The Lakota
Mental Health Manual (Two Dogs & Moves Camp, 2005) used to guide
practitioners in the treatment process from a Lakota perspective. As a
natural part of the process into traditional Lakota healing, the parents or
guardians of the youth identified for services were asked to describe the
troubling behavior or emotional attributes of their children. The most
common descriptions noted in the clinical files were a history of ineffectual
learning (evidenced by poor school attendance, underachievement,
poor concentration, or learning problems), depression, and struggles with
disruptive, acting out behavior.

Purpose of the study

As stated earlier, the purpose of this study was to investigate the impact of
traditional healing on Lakota children struggling with serious emotional and
behavioral problems and their families. The research questions guiding the
study were (a) What is the impact of Lakota traditional healing on family
functioning from a caregiver perspective? (2) What is the impact of traditional
healing on youth strength and resiliency from a caregiver perspective?
Resiliency, as used in this study, is a term that refers to a natural movement
toward positive mental health and a strong capacity to overcome.

Over the past 25 years, the SAMHSA has funded several AI/AN sites to
develop culturally appropriate mental health systems of care for youth
struggling with SEBDs and their families. The Nagi Kicopi program, a
family-centered mental health services program located on the Pine Ridge
reservation in South Dakota, was part of the Systems of Care initiative to
serve these youth and their families.

Methods

Participants

Eighty families were served by the Nagi Kicopi program. One primary
caregiver from each family was invited to participate in the evaluation research
study. Of the 80 families served by the program, 54 primary caregivers were
available to participate in the study (one youth per family also participated in this study). Because of the urgent need for services and the inability of the data collectors to complete some survey instruments due to constraints such as weather, time, family crises, caregiver availability, and work conflicts, 27 of the youth were given services prior to the administration of the tools and are represented in posttest data collection only. Therefore, 27 caregivers completed only posttests, with 27 caregivers taking both the pre- and posttests. The other 26 of the 80 families were deemed unable to participate due to a variety of factors (e.g., moved from the area, moved to an undisclosed location in the area, were not responsive to inquiries).

Participant caregivers were primarily female (80%). Caregiver participants were of an average of 40 years old, with the average age higher than might be expected because of the presence of grandmothers raising young children. All participants reported a Lakota tribal affiliation.

All of the Lakota youth who served in this program were struggling with serious emotional and behavioral problems. All youth served in the program met all of these criteria associated with the Federal Systems of Care for definition for SEBDs: (a) under the age of 22; (b) eligible for a Diagnostic and Statistical Manual of Mental Disorders (4th ed. [DSM–IV]; American Psychiatric Association, 2000) diagnosis (often conduct disorder, depression, or anxiety); (c) suffered from impaired functioning in school, home, or community environments; (d) often had a history of psychiatric or mental health problems; and (e) showed high need for services from more than one agency.

Fifty-four of the youth in this study met criteria for DSM–IV diagnoses including acting out (e.g., oppositional defiant, conduct disorder; 24%), depression (33%), significant school difficulties (13%), and substance abuse (15%). Thirty-seven percent of the youth had recurring or chronic physical health problems, asthma being the most common condition, with 60% taking related medication. Twenty-two percent went to the emergency room within the last year. Almost all (95%) of the youth used mental health services within the previous 12 months (including assessment, diagnosis, and treatment), primarily outpatient mental health counseling and school-based counseling. Other issues included physical or sexual abuse (35%), running away (38%), suicide attempts (27%), and prior psychiatric hospitalizations (25%) within the last 2 years. Most of the participants were not involved in school activities (67%). The average age of the youth represented in the sample \( n = 54 \) was 12.44 years, with a median age of 12.50 and a range of 8 to 21 years.

Demographics on the 54 families show that 55% of the youth included in this study were male (45% female), 100% were Lakota, and 77% were referred to the program by parents and caregivers. Eighty-two percent of the youth included in this study had lived with their legal guardian during the previous
6 months. Fifty-eight percent lived with their biological mothers, 22% lived with their grandparent(s), 17% with another relative (typically an aunt), and 3% lived with nonrelatives. An average of 6.2 children and 2.9 adults lived in each household. Fifty percent of the households had an average annual income below $8,000, with the overall average household income at about $18,000. Seventy-one percent were on Medicaid.

**Instrumentation**

All caregivers in the program were administered assessments at admission and posttest by a Lakota data collector trained to administer these instruments using prescribed national protocols (ORC-MACRO, 2005), typically after 6 months in the program. The instruments used in this study were the Family Adaptability Device (FAD), which measures family functioning, and the Behavioral and Emotional Rating Scale (BERS), which measures resiliency. Both instruments were administered as part of the required national evaluation process (ORC-MACRO, 2005) and were reviewed for cultural appropriateness by project staff and Lakota elders prior to administration. Both are short in duration, each taking approximately 15 minutes to complete. ORC-MACRO (2005) reported acceptable reliability and validity of both tools with minority populations (predominantly Latino or Latina and African American). Scores for both measures are calculated by the sum divided by number of items.

The instruments—the FAD and the BERS—were used as part of the federal evaluation protocol per the Nagi Kicopi grant. This evaluation protocol was a required part of SAMHSA’s support for Nagi Kicopi and consisted of a structured interview process where a trained Lakota interviewer sat down with a Lakota parent (or caregiver) and youth and asked a series of questions based on standardized instruments approved by SAMHSA’s evaluation contractor—ORC-MACRO. The FAD and BERS were deemed the most culturally appropriate by the project staff and Lakota Elders. Parents and grandparents (caregivers) signed informed consent forms to participate in the study per the tribal institutional review board (IRB) approval. A brief sociodemographic questionnaire was also used as part of the protocol. Aggregating all assessment results and keeping the raw data in a secure location with numbers, not names, used as identifiers assured confidentiality.

**Family adaptability device**

Sample questions from the FAD include “Planning family activities is difficult because we misunderstand each other,” and “We can express our feelings to each other.” The response options for each item are on a scale of 1 (high adaptability) to 5 (low adaptability). There are no subscales for the FAD.
Results per family functioning are presented in areas such as family communication, acceptance of family members, ability to discuss fears and concerns, expression of feelings, family decision making, conflict resolution, and willingness to confide in other family members, as measured by each of the 12 items, per the instructions of this instrument. The FAD consists of score ranges as follows: low family functioning scores, 1 through 20; midrange scores, 21 through 40, and high scores, 41 through 60.

**Behavioral and emotional rating scale**

BERS subscales measure intrapersonal strength, school functioning, and affective strength. The response options for each item are on a scale of 0 (not like me), to 4 (very much like me). The BERS is a psychometrically sound, norm-referenced, standardized instrument designed to aid in the process of strength-based assessment. Sample questions for the BERS include “Youth trusts a significant person,” and “Youth participates in community activities.”

The BERS, which consists of 52 Likert-type items, provides five factor-analytically derived subscales that assess important areas of functioning. The subscales include (a) Interpersonal Strength (e.g., reacts to disappointment in a calm manner), which measures ability to control emotions and behaviors in social situations; (b) Family Involvement (e.g., participates in family activities), which measures participation and relations with the family; (c) Intrapersonal Strength (e.g., demonstrates a sense of humor), which assesses self-perception of competence and accomplishment; (d) School Functioning (e.g., pays attention in class), which addresses competence in classroom tasks; and (e) Affective Strength (e.g., acknowledges painful feelings), which focuses on the ability to give and receive affect. Each item is rated on a scale of 0 (not at all like the child) to 3 (very much like the child). Scores are calculated for each strength dimension and are then combined to provide an overall strength index. Higher scores reflect greater perceived strengths. Technical adequacy has been addressed with respect to content validity, convergent validity, discriminant validity, interrater reliability, and short- and long-term test–retest reliability. The BERS underwent a rigorous validation process (Epstein, Mooney, Ryser, & Pierce, 2004). The BERS’s general scoring ranges is as follows: low scores, 0 through 52, midrange scores, 53 through 104, and high scores, 105 through 156.

**Procedures**

As previously mentioned, trained Oglala Lakota Sioux tribal members collected all outcome evaluation data. Although the instruments usually require 30 minutes for administration, following Lakota protocol of respectfulness toward participants (e.g., waiting to be invited into the home, sharing the hospitality of the caregiver, pacing the questions, listening to anecdotal
stories), the data collection process averaged 90 minutes per administration. The tools were primarily administered to caregivers in person (97.8%; 2.2% telephone administration).

Caregivers signed informed consent forms and were also given a modest stipend ($50), as prescribed by national guidelines (ORC-MACRO, 2005). Posttests were completed approximately 6 months after the individual family started the program. Some families (31%) were still receiving services when the posttest was administered. The youth were an integral part of the healing services but did not fill out the measures due to potential violation of Lakota protocol related to protecting the young against unwanted or unnecessary intrusions. The noncompleting families did not demographically differ from the participants, typically reporting a willingness to participate but logistical problems in doing so. This study was approved by the IRB of Oglala Lakota College.

**Traditional Lakota services**

Serving as treatment services, an average of 13 traditional Lakota healing ceremonies for each caregiver(s) and youth together were provided during enrollment. A brief description of the ceremonies is provided next. The program acquired the services of four Lakota traditional healers as spiritual advisors for community education and training purposes, with one of the four providing ongoing traditional services. As part of Lakota protocol, the families were involved in the planning and implementation of services to the youth, which is considered a crucial factor in the success of the delivery of traditional healing services.

Most traditional services offered to youth (and sometimes their families) were conducted through the traditional tiospaye (extended family) network, in that the tiospaye was consulted and had approved the ceremonies. Common Lakota protocol is for the traditional healer to talk with the head of the tiospaye (a designated elder), as well as the caregiver, and then decide which healing ceremonies are appropriate for each youth. These services included the seven sacred Lakota ceremonies—the *inipi* (sweat lodge), the *hanblecheya* (vision quest), the *wiwanyak wachipi* (the sun dance), the *ishnati alowanpi* (making a girl into a woman), the *hunka kagapi* (making relatives), the *tapa wakayapi* (throwing the ball), and the *nagi whapi* (soul keeping). An individual intervention plan designed for each child from the seven ceremony options was used. Lakota identity development and cultural practices were also taught to youth and their families as appropriate. These ceremonies vary in terms of length and frequency of offering. The *inipi* (sweat lodge) is the most commonly offered ceremony, accounting for 60% of the total of 170 ceremonies provided. The range of ceremonies provided was 3 to 32 ($M = 13$). Typically, youth participated in two to three ceremonies per month.
To explore the meaning of the statistical results further, posttest interviews were conducted with eight volunteer caregiver participants. The eight participant families were volunteers from the participant families in the study. The qualitative approach used is narrative (Creswell, 2006), with the interviewing approach focused on one phase in narrative data gathering: problem solution, a linear structure of describing the problem and solution. The eight caregivers came to a meeting called for participants to discuss the value of the Nagi Kicopi program. The interviews were conducted at that time. Consistent with Lakota culture, food was provided. The eight participants did not receive any monetary incentives to participate.

**Results**

Demographically (e.g., age, socioeconomic status, gender, number of people living in the household), there were no significant differences between those who completed the follow-up assessments (post) only and those who completed both the pre- and posttests. There were also no significant changes in the results per Table 1 between the 27 who completed the follow-up assessments (post) only and those who completed both the pre- and posttests (27). To address the two research questions, independent sample t tests were run on SPSS with equal variance not assumed. These t test analyses were appropriately used to determine if two sets of data were significantly different from each other and were applied as the data followed a normal distribution and the value of the scaling in the test statistic was known. Table 1 shows the results of the independent t test analysis for Research Question 1.

**Table 1.** Independent t Test Analysis of Caregiver Reports of the Impact of Lakota Traditional Healing on Family Functioning of Troubled Youth.

<table>
<thead>
<tr>
<th></th>
<th>Baseline (n = 27)</th>
<th>Follow-up (n = 54)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall family functioning</td>
<td>2.70 .421</td>
<td>3.02 .501</td>
<td>2.37</td>
<td>.021*</td>
</tr>
<tr>
<td>Planning family activities is difficult because we misunderstand each other</td>
<td>3.19 .627</td>
<td>3.54 .582</td>
<td>2.352</td>
<td>.021*</td>
</tr>
<tr>
<td>In times of crisis, we can turn to each other for support</td>
<td>3.00 .741</td>
<td>3.31 .928</td>
<td>1.587</td>
<td>.117</td>
</tr>
<tr>
<td>We cannot talk to each other about the sadness we feel</td>
<td>2.40 .700</td>
<td>2.08 .997</td>
<td>−1.614</td>
<td>.111</td>
</tr>
<tr>
<td>Individuals are accepted for what they are</td>
<td>3.04 .759</td>
<td>3.42 .809</td>
<td>2.076</td>
<td>.041*</td>
</tr>
<tr>
<td>We avoid discussing our fears and concerns</td>
<td>2.25 .677</td>
<td>1.72 .737</td>
<td>−3.109</td>
<td>.003*</td>
</tr>
<tr>
<td>We can express feelings to each other</td>
<td>2.92 .730</td>
<td>3.46 .706</td>
<td>3.106</td>
<td>.003*</td>
</tr>
<tr>
<td>There are lots of bad feelings in the family</td>
<td>2.42 .750</td>
<td>2.04 .958</td>
<td>−.942</td>
<td>.056</td>
</tr>
<tr>
<td>We feel accepted for what we are</td>
<td>2.98 .779</td>
<td>3.40 .913</td>
<td>2.089</td>
<td>.040*</td>
</tr>
<tr>
<td>Making decisions is a problem for our family</td>
<td>2.28 .769</td>
<td>1.81 .849</td>
<td>−2.494</td>
<td>.015*</td>
</tr>
<tr>
<td>We are able to make decisions about how to solve problems</td>
<td>2.83 .672</td>
<td>3.24 .597</td>
<td>2.602</td>
<td>.011*</td>
</tr>
<tr>
<td>We do not get along well together</td>
<td>2.11 .847</td>
<td>1.69 .884</td>
<td>−2.046</td>
<td>.044*</td>
</tr>
<tr>
<td>We confide in each other</td>
<td>2.83 .753</td>
<td>3.24 .779</td>
<td>2.219</td>
<td>.029*</td>
</tr>
</tbody>
</table>

Note: Effect size (ES), t = 2.37, p = .021; ES = .76.

*p < .05, df = 49.
The results show statistically significant \((p = .05)\) results for the impact of traditional healing on overall family functioning in the areas of family communication, acceptance of family members, ability to discuss fears and concerns, expression of feelings, family decision making, conflict resolution, and willingness to confide in other family members. Effect sizes (Cohen’s \(d\)) were calculated to assess the magnitude of the differences from pretest to posttest (Cohen, 1998). Analyses revealed that caregivers \((t = 2.37, p = .021; \ d = .76\) indicated significant gains in overall family functioning. Cohen (1998) suggested that effect sizes of .20, .50, and .80 be considered small, medium, and large, respectively. The effect sizes reported here indicate medium to large practical significance. Another way to interpret effect sizes is by transforming them into percentiles (Gall, Borg, & Gall, 1996), which equates to gains ranging from 8 (small) to 16 (medium) to 22 (large) percentage points. This study demonstrated a 22 percentage point average gain for caregiver overall perception of family functioning, supporting the practical significance of traditional healing for improving family functioning.

The results of the independent sample \(t\) test for the second research question, examining the effect of traditional healing on youth strength and resiliency, are shown in Table 2. Statistically significant differences were found from pretest to posttest in overall strength and resiliency. Positive outcomes, significant at or beyond the .05 level, were found for the BERS subscales of Intrapersonal Strength, School Functioning, and Affective Strength.

As with Research Question 1, effect sizes were calculated for Research Question 2 regarding resiliency to assess the magnitude of the differences from pretest to posttest (Cohen, 1998). Analyses revealed that caregivers \((t = 2.52, p = .015; \ d = .83\) perceived significant gains in caregivers’ overall perception of youths’ strengths. The effect size here indicates large practical significance (Cohen, 1998) with the overall BERS scores reflecting an average 22 percentage-point gain. These results also support the practical significance of traditional healing in improving youth strengths.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Independent (t) Test Analysis of Caregiver Reports of the Impact of Lakota Traditional Healing on Youth Strengths and Resiliency.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline ((n = 27))</td>
</tr>
<tr>
<td></td>
<td>(M)</td>
</tr>
<tr>
<td>Overall BERS</td>
<td>45.59</td>
</tr>
<tr>
<td>Interpersonal Strength</td>
<td>8.53</td>
</tr>
<tr>
<td>Family Involvement</td>
<td>9.30</td>
</tr>
<tr>
<td>Intrapersonal Strength</td>
<td>9.71</td>
</tr>
<tr>
<td>School Functioning</td>
<td>8.37</td>
</tr>
<tr>
<td>Affective Strength</td>
<td>9.72</td>
</tr>
<tr>
<td>BERS strength quotient</td>
<td>93.84</td>
</tr>
</tbody>
</table>

Note: BERS = Behavioral and Emotional Rating Scale; effect size (ES), \(t = 2.52, p = .015; \ ES = .83\).  
*p < .05; df = 49.
Exploratory follow-up

The results from exploratory follow-up, in-depth, narrative problem-solution interviews (Creswell, 2006) yielded strong agreement that traditional healing had a positive impact on families. As illustrated in quotes from eight program participants, their descriptions of the nature of traditional healing included establishing deeper connections with culture, helping provide positive role models within the family system, resolving conflicts, and teaching spiritual practices. Such qualitative information might be particularly important here because this study lacks a control condition; that is, no causal relationship can be established between the intervention and the outcomes, but with the testimonies of the participants, the potential causative relationship might exist. Although clear themes emerged (e.g., less acting out, better school performance), the sample size was too small for more formal qualitative analysis of the data. Quotations from several caregivers are included here:

The long-term connections that are being made between the ceremony and the way we live are very important. We are learning to apply the learning to our daily life. I learned to take care of myself.

My extended family did not agree with the way we were raising our child, but the program helped the tiospaye (extended family) to understand the importance of ceremonies. The program has also mediated with the tiospaye, which really helped. Now we are all behind my child and the child is unable to manipulate the family.

This learning is helping our family in understanding more and more. For example, the healer is helping in providing much-needed father figures to mentor my daughters. (My uncle made a beautiful powwow outfit for my daughter recently!)

We’ve known about these things in our family, but the traditional healing has helped us bring the practices to everyday life.

Traditional healing brought out the cultural knowledge that has always been there. It has really helped the children be stronger in school and with non-Native peers.

It has changed my way of parenting, and I will pass on this new way of parenting to my children and their children. The program has helped my child so much that now other youth look to him as a leader. My child is more positive now. He does not rob, cuss, or steal, and he is overcoming the bad label he had at school.

The changes in my daughter and in the family have been very positive. For example, my daughter was crying almost all the time when she entered the program. Now she is not, and she is more confident and assertive. My oldest daughter’s grades are up and my son is acting more responsibly as well. We are experiencing lifetime changes, not just quick fixes we have had from some mental health programs.
**Discussion**

The purpose of this study was to investigate the influence of traditional healing on Lakota children struggling with SEBDs and their families. Further exploration of the results included eight caregiver interviews (note: the eight voluntary participants all had positive experiences). Specifically, the research questions guiding the study were (a) What is the impact of Lakota traditional healing on family functioning from a caregiver perspective? (2) What is the impact of traditional healing on youth strength and resiliency from a caregiver perspective? The results of the study show perceived positive changes for youth participating in traditional healing. There have been very few empirical studies conducted on the efficacy of traditional healing using outcome studies. However, the quantitative and qualitative results of this study indicated consistency with the hypotheses of Stone (2003), Moodley and West (2005), and Whitbeck, Chen, Hoyt, & Adams (2004), among others, that traditional healing could contribute significantly to psychosocial strength building and family functioning. As previously referenced studies indicate, the intrinsic value of renewed understanding and attachment to cultural traditions gained from using traditional healing provides not only an empirical benefit, but perhaps more important, a philosophical one. Policymakers should seriously consider a greater infusion of cultural information and education perhaps as part of formal curricula for schools serving predominantly native youth. Although it is extending beyond the results of this study to conclude that traditional healing caused the positive changes in youth, and no causal inferences can be made at this time, there is a strong association between the two. The interview results support this relationship.

The supporting interview data reference the tiospaye. As previously mentioned, this Lakota term describes a community way of life that is patterned on Lakota values: rules for social interaction, and rituals for transition, identity acquisition, and healing. The leaders of the tiospaye are elders and sometimes wapiyawicasa (healers). The effective tiospaye emerges when people choose to work together to build a style of life based on common desires. Its balance, interpersonal dynamics, and spirituality are the elements of congruence of which Black Elk (1953) spoke, specifically noting the sacred hoop (and ceremonies) that can shelter all Lakota children. Black Elk said, “We should understand well that all things are the works of the Great Spirit. We should know that He is within all things” (p. 20). There is a need for more research in understanding specific ways in which the tiospaye and traditional healing can positively influence troubled youth. The results of this study suggest that it has a positive influence on healthy family functioning and youth resiliency.
Limitations

The results presented here should be interpreted in light of the mentioned study’s limitations, plus issues such as small sample size and no control group. Additionally, although the eight follow-up interviewees were volunteers and received no additional incentives, they might not have represented all participants.

Another specific limitation is that participants who were in the program longer might have received more services and therefore possibly had better outcomes for youth. It is unclear if any participants in the study as a whole had negative experiences. An additional limitation is that youth were not interviewed and did not participate in the surveys. Their voices need to be heard in future research especially if we are to more deeply understand the influence of traditional healing on youth. Further exploration is needed about the influence of which youth were given what types of ceremonies and in what order. In this way, not all youth were given the same “treatments,” which can have an effect. Additionally, data were gathered over a 3-year period and therefore history and maturation could have affected results.

Acknowledgment

This article has been approved for publication by Wakanyeja Pawicayapi (Children First), Inc., Porcupine, South Dakota.

References


