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My Grandma Said, "Bring Her to Me": Healing Practices in Indigenous Communities

Emily C. Hicks and Jessica L. Liddell

Indigenous women use traditional healers and family members for health care for a variety of reasons including cultural desires to use traditional sources,[1] discrimination in Western health-care services,[2] and limited availability of Western health-care options.[3] Tholene Sodi and Olaniyi Bojuwoye note that "culture influences conceptualizations about illness, health, and health care"[4]; and because all cultures have their own ideas of what it means to be healthy and what healing entails, there can be no universal approach to care.[5] Indigenous communities may seek traditional healers for holistic healing that addresses many facets of health, including social, emotional, physical, and spiritual well-being, a culturally important aspect to health care for many Indigenous people. For example, research with traditional healers has noted the importance of balance across domains, including mental, physical, and spiritual.[6] Physical injuries and diseases are believed to be affected by historical trauma and oppression as well as by mental, emotional, and physical factors.[7] Traditional healers may better understand the historical trauma and oppression their communities have faced, which can lead to better holistic care and highlight the ways that Indigenous identity can serve as a protective factor for health and well-being.[8] Culture is often interwoven with healing through

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enculturation practices, as evidenced by a traditional healer who asserted that "our culture is medicine."[9] Other researchers have also noted the importance of cultural traditions and enculturation for facilitating and promoting the health of tribal members.[10] Many Indigenous people prefer traditional medicine to Western medicine due to this shared understanding and alignment with cultural history and cultural values. The World Health Organization defines traditional medicine as "diverse health practices, approaches, knowledge, and beliefs incorporating plant, animal, and/or mineral-based medicines, spiritual therapies, manual techniques, and exercises, applied singularly or in combination to maintain well-being, as well as to treat, diagnose, or prevent illness."[11] According to the National Cancer Institute, Western medicine is "a system in which medical doctors and other health-care professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery."[12]

Social support is integral to Indigenous communities, and Indigenous communities may seek traditional medicine to increase social and emotional support as well as to increase ties to culture and community. Social support is both emotional (i.e., listening, providing companionship, offering prayers) and instrumental (i.e., taking someone to the doctor, providing food, watching children).[13] The research has highlighted the impact of regularly scheduled social support, such as support groups and community events, on well-being.[14] Finding support in community members rather than through formal sources, such as mental health therapists, may be preferable in Indigenous communities due to the history of unsatisfactory, often exploitative, health care and social services that Indigenous communities have had to endure.[15]

Indigenous communities may also seek traditional healers because of barriers to accessing and utilizing Western health care, including racial discrimination. One research study found that more than one-third of Indigenous patients had experienced microaggressions in health-care settings, and these perceived microaggressions were related to negative health outcomes, including depressive symptoms and hospitalization.[16] A separate study found that 67 percent of American Indian women had experienced discrimination in health-care settings at some point in their lives, events that led to decreased utilization of health-care services.[17] This prejudice and lack of culturally responsive treatment in Western medicine may further encourage Indigenous women to seek traditional healers for their health concerns.

Traditional medicine may also be consulted due to a limited availability of health-care options. The majority of tribal lands in North America are in rural, remote areas, and research has found that individuals living in rural areas experience greater obstacles to securing health care.[18] Not only do Indigenous communities have higher rates of hospitalizations, but also, as one study found, the rate of avoidable hospitalizations was twice that of the general population due to rural location and lack of access to preventive care.[19] Traditional healers serve within their own communities, providing access to care when rural location precludes other health-care options.

Communication differences may also present impediments to health care for Indigenous communities.[20] Differences in primary language have been linked to reduced health-care quality and patient satisfaction;[21] however, even when language is shared, cultural values and experiences dictate how symptoms are expressed and how medical

advice is received.[22] Indigenous communities may seek traditional healers for their aligned cultural communication of symptomatology and treatment recommendations.

There is a dearth of literature about potential barriers to health care that state-recognized tribes, rather than federally recognized tribes, face. There are currently 574 federally recognized American Indian and Alaska Native tribes and villages,[23] and over 100 state-recognized tribes in the United States.[24] Tribes recognized only by a state do not receive the same benefits as tribes recognized on a federal level, including access to health care.[25] To receive health care from Indian Health Service (IHS), one must be a member of a federally recognized tribe.[26]

Tribal Context

The state-recognized Gulf Coast tribe at the center of this study has many strengths, including a strong focus on family, humor, interconnectedness with extended family and the broader community, connection to and knowledge of the land, preservation of traditional fishing, crafting, and cooking practices, a resilient approach to problems, and a tradition of Indigenous healers.[27] These healers often use a combination of prayers and natural medicines, usually made of plants and herbs, to heal others.[28] But these natural medicines are under threat from environmental shifts. Climate change has led to flooding, hurricanes, and extreme weather, which has caused problems for growing and gathering medicinal plants and herbs.[29] These environmental changes have weakened the social, emotional, spiritual, and economic ties to the land many Indigenous people have, in addition to undercutting Indigenous healing practices and traditions.[30] In addition to suffering from the consequences of climate change, this tribe has experienced loss of land as a result of oil company infrastructure and has been negatively impacted by oil spills along the Gulf Coast.[31] The rapid loss of land that has occurred due to climate change and catastrophic situations also undermines the intergenerational transmission of cultural knowledge.[32]

The lack of federal recognition for this tribe is an important context. In the 1700s, this tribe was forced to relocate from its ancestral lands to its current location.[33] Though documents outline the tribe's existence and relocation, it has not yet received federal recognition,[34] and is thus deprived of access to many helpful federal resources. In addition, this lack of recognition has an impact on tribal sovereignty. Tribal self-governance allows federally recognized tribes to tailor health and crisis interventions to meet the needs of the tribal community, and has been described as "the greatest benefit of the Tribal Self-Governance Program."[35] Unfortunately, tribes that are only state-recognized do not have the legal sovereignty to create health intervention and other programs specifically for their members.

Among tribal members in this study, many elders speak a language other than English as a first language, and some are not as comfortable speaking English.[36] In addition, tribal members do not have a reservation, and thus live throughout the region.[37] Differences in language between elders and younger tribal members and the diaspora of members across the region create additional barriers to cultural knowledge transmission, including knowledge about traditional healing practices.

Historically, this tribe was matrilineal with shared gender roles.[38] Following colonization and relocation, systems became more patriarchal, leading to negative outcomes for women tribal members.[39] Despite the impacts of settler colonialism, women are still considered role models and are valued, central members of the family.[40]

Purpose of the Study

This article seeks to shed light on Indigenous women's health-care experiences, while recognizing that Western scientific literature is not necessary to "legitimize" traditional Indigenous knowledge and practices. Previous research has noted how help-seeking in Indigenous communities is usually characterized by a combination of formal and informal supports.[41] For example, a woman may simultaneously see a Western medical provider and consult a traditional healer for a health ailment. Indigenous women dealing with depression preferred to first seek help from family and community before turning to conventional services.[42] These extended family support systems provide both emotional and instrumental support for family members, in addition to fostering interdependence.[43] This study also aims to highlight the strengths and resilience of Indigenous communities.

Methods

Research Design

In all research, understanding the positionality of the researchers is valuable as this context influences the lens through which the researcher conducts the study and interprets the results. The first author is an American Indian, a cisgender woman, and a PhD student. She is a member of tribal communities and works within tribal communities as a clinician and researcher; however, she does not have tribal affiliation with the tribe involved in the present study. The second author is a white cisgender woman and an academic researcher with experience working with the tribe in the present study. The authors had discussions with one other and with tribal leaders to ensure that the study was guided by cultural knowledge and expertise. This study received institutional review board (IRB) approval from Tulane University (study #2018-467) and from the tribal council IRB.

This study drew upon data from a larger project investigating Indigenous women's experiences regarding sexual and reproductive health.[44] Consistent with best-practice guidelines regarding research within Indigenous communities, this study took a community-engagement approach that highlighted antioppressive methodologies.[45] For example, a community advisory board (CAB) consisting of tribal members collaborated with the researchers and provided advice on the recruitment, development, outcomes, and dissemination phases of the study.

As encouraged by best practices and the CAB, the study used semistructured qualitative interviews that included components of a life-history approach.[46] The semistructured interview guide was created in partnership with CAB members and was first piloted with them.[47] The study's use of a qualitative descriptive methodology

was the best way to honor the voices of the participants, allowing the nuanced experiences of participants to be understood and interpreted descriptively rather than categorically. This approach was also recommended by our CAB, as it has been used previously with the tribe. Because this approach prioritizes the words of participants to create and describe themes (rather than taking highly interpretative or abstract approaches), it also tends to produce research findings that community members can use and more easily translate into interventions. Qualitative descriptive methodology is particularly important when working with Indigenous persons, as researchers have historically taken advantage of marginalized communities.[48] Because quantitative research requires human experiences to be placed in categorical boxes, it has been used to identify general patterns that do not accurately represent the experiences of some people, including tribal communities. While this methodology is useful in many instances, it can diminish the complex, nuanced experiences of Indigenous communities, leading to inaccurate and misinterpreted data. On the other hand, qualitative descriptive methodologies allow individual voices to be heard and understood within specific contexts. In the present study, qualitative descriptive methodology enables women from a specific tribe to share their personal health-care experiences, and for these experiences to be interpreted within community and cultural contexts. Last, qualitative approaches can be more appropriate when exploring research topics on which little scholarship exists, as is the case with this particular tribe.

To best honor and understand the participant responses, we used a qualitative description study protocol that encouraged open and free communication and verbatim transcripts.[49] Open and free communication was facilitated through a responsive interviewing model, a discussion of confidentiality and procedures for ensuring interviewees would not be identified and the recording protected, and by building rapport with interviewees prior to starting the interview. This protocol emphasizes systematic yet flexible sampling, highlighting that context drives analysis.[50] The context of the present study was the participants' specific tribal and community culture. As best practices recommend when conducting research within Indigenous communities, participants were offered a summary of study findings before the data were published—a process known as member checking.[51] Three participants did not receive the summary, as one declined and two email addresses were returned as invalid when communication was attempted. Participants did not request or suggest any changes to the findings.

Setting and Participants

Thirty-one interviews were conducted with tribal members who self-identified as women at community locations of the participant's preference, which included homes, a community center, and a coffee shop. Participants first provided informed consent and were given information about the study and the option to not answer any question or stop the interview at any time. In order to participate, participants had to be at least eighteen years old, identify as a woman, and identify as a member of the tribe. To honor agreements made with tribal council leadership, the name of the tribe shall remain anonymous. Participants ranged from age eighteen to seventy-one, with a median age

of fifty-two. The majority of the women had at least one child (83.9 percent), and the median number of children was 2.2. The majority of participants had health insurance (93.3 percent), and a GED or high school diploma (81.7 percent), while approximately half of participants had additional education or training (51.6 percent).

Data Collection and Analysis

Research approval was granted by both the university and tribal council associated with the present study. Snowball sampling through word of mouth and flier distribution was utilized with the help of the community advisory board (CAB) to recruit participants. Interviews followed a chronological order through life events in order to understand overarching themes. For example, interviewees were first asked about their life growing up and experiences accessing health care (i.e., "Can you tell me about your family growing up?"); then about accessing reproductive and sexual health care and experiences in their early adulthood (i.e., "Can you tell me about the first time you needed sexual or reproductive health services?"); and finally about current experiences in accessing health care. Interviews were semistructured, recorded with permission, transcribed by a professional service, and examined for transcript accuracy. The average length of interviews was approximately one hour, though interviews ranged from thirty to ninety minutes. Participants were compensated with a thirty-dollar gift card for their time. All interviews occurred between October 2018 and February 2019. NVivo software and a qualitative content analysis method were utilized.[52] Broad themes were first identified by open coding, and then direct coding was used to determine subcodes. The results section uses anonymous identifiers to discuss themes identified across participants.

Results

Participants identified themes related to their first health-care experiences, going to family members for health care, going to Indigenous healers for health care, and generational changes in the transmission of traditional health-care knowledge. Going to family members or local healers for health care was described by nearly all of the women (n=29) and was referenced a total of 116 times. These experiences were generally remembered very warmly, and many women reported using some of what they had learned with their own children and families. The life-course approach used in this study allowed participants to reflect on experiences across the lifespan, including health-care experiences they had had as children, in early adulthood, and at the current time, allowing participants to reflect on changes in health care, community knowledge, and healing practices.

Theme 1—"I don't ever remember going to the doctor": First Health-care Experiences
Women's first health-care experiences were often related to either childhood injuries that required going to a doctor or being cared for by a family member or healer for a minor illness or injury. Participant 11 stated that she did not recall receiving formal medical care until she was ten; before then, her health-care experiences were at home. She described her first experience going to the doctor: "I don't ever remember going

to the doctor from one to ten . . . growing up, I don't remember the entire time going to the doctor with the exception of when I broke my leg and I had to spend several months in a hospital." She then stated that when she was seventeen, she started going to the doctor more regularly. She explained: "And then from thirteen to seventeen . . . I don't remember going to the doctor . . . from seventeen on up, I started going to a doctor regularly. I started going to a doctor because of mental health issues, because of depression, because of things like that. So, I started seeing a regular doctor, family doctor, who diagnosed me with depression, I think, at eighteen. And then that's when I started seeing a regular doctor and a counselor."

Participant 13 described her first experience with formal Western health care services taking place when a traveling eye clinic came to the community:

> I think the first time is when I was twelve years old. I could remember that it was because of the eye examination . . . some program came through and so they went to each individual school and they . . . we had some grant that we could go and get our eyes [checked] because that was a big part of my delay in learning skill . . . . And if you can't see, you can't comprehend what you need to, you cannot understand the things that needs to be presented to the brain to get you functioning in a normal way like the other children.

In her reflections, this participant attributed her early educational difficulties to vision problems that were not diagnosed until she was twelve. Participant 2 explained that her first experience needing medical care occurred when she was burned as a child and was taken care of by her grandmother:

> I was ironing some clothes and the iron slipped. I was burned from here to here [gestures length of arm]. And mom, my mom told my grandma that, you know, she had to take me to the doctor, she says "no, no, no." And my grandmother only spoke [local language]. Told her to bring her, me, over there. She put this salve on it. She wrapped it in banana leaves. I remember this and I might've been eight. I remember wrapping my arm with banana leaves. Yeah. And it looks, yeah, this is the only scar that I have. And it was like [a] second degree burn.

She proceeded to describe her first experience receiving Western medical care:

> I got in fire ants and didn't know that I was allergic to the fire ants. I had blisters this big around on my legs. My mama took me to the doctor. Doctors wanted to amputate my legs . . . Wanted to amputate my legs to the knee and my grandma said, bring her to me. I mean, I had welts. Boils, all over my legs. Yeah. Doctors wanted to amputate me at the knees. My grandma said no, bring her to me. I would [heal] her because my grandma was a [healer].[53] She was a [healer]. Yeah. And again, she sent my uncles in the woods told them exactly what to do, get. Came back, made a salve, put it on my legs. Yeah. I still got my legs.

This participant attributed being able to keep her legs to her grandmother's healing abilities, which saved her from the doctor's plan to amputate. Participant 24 recalled that her

first experience going to a Western doctor was when she had hurt her wrist: "The first time? . . . I remember when I sprained my wrist. I remember I fell on my arm. Uh, that's about the only one I can remember. I really didn't [go]." Participant 5 similarly described going to a doctor for the first time when she had injured her arm: "As far as I know, when I was growing up, I didn't ever went to the doctor. Not until maybe . . . Oh, when I broke my arm, that's the first time I remember going to a doctor, to the hospital." She proceeded to describe it as a bad experience because she was awake and felt the pain throughout her care: "That was bad, oh yes. Because they didn't put you to sleep back then, they just pulled that arm, put the cast. They didn't put you to sleep at all."

Like other participants, this participant highlighted that seeking Western medical care was not a frequent experience in childhood. Instead, many women went to traditional healers for care.

Theme 2—"We couldn't afford to go to the doctor, so we used . . . home remedies": Going to Family Members for Health Care

Almost all of the women spoke about first going to family members for remedies for minor injuries and aliments. Sometimes this family member was a mother, but it was also often an aunt or grandmother. Participant 1 noted that it was common for a family to have multiple healers within them, and that although some might be formal healers, some were more informal: "We didn't go to a doctor's . . . my dad's dad was a . . . healer . . . my mom's mom did a lot of herbal medicine and then I had, like, an aunt, she's still living today. She still [heals] people at home." This participant stated that although her aunt might provide care for her, she would not do so for all family members or outsiders:

> She won't [heal] you, [researcher], she won't [heal] you right. And she probably won't [heal] my sister, you know, because she didn't grow up as close as I did and that . . . she's eighty-six, about to be eighty-seven. So when you take on that role, you know, when when you . . . [heal] somebody, you [heal] their illness, but you carry that [the illness]. So, she's kind of old. So, she won't [heal] just anybody, not at all—not at all. She [healed] two of my nieces . . . When I had shingles, I didn't know what [it was]. When I went to the doctor, they said I had shingles—and I'm, like, I never heard of that. You always get [healed] [for it].

In part because it is believed that healers take on or "carry" the weight of the illness after caring for someone, not all healers were willing to provide care for everyone. Participant 14 stated that although her mother more frequently used Western medicine, her grandmother would use traditional healing practices:

> She [my mom] was more a medicine person, but my grandma . . . she's Native American and . . . if we had a wart on our hand, she would cut the potato and in the sky make the crosses and then she would rub it on us and say a prayer and it'd cure us . . . She's actually telling me all kinds of things now. Now, with babies . . . if she was sick, put the potato in her sock while she's sleeping, and it's supposed

> to pull all the cold out of her. Just little things like that. And they all have the, you know, the old wives' tale. [Laughs].

This participant explained that she also tried to avoid taking medicine:

> Yeah, cause I really don't like taking [Western] medicine myself, so if I cannot give it to her [daughter], that's something I want to avoid . . . I just don't like medicine, I don't . . . I know it works sometimes, but you know, I just don't believe in it too much. Home remedies is what we [use] . . . they [elders] grew up in a different time than we did, so they know more, and have experienced more. They know what works and what doesn't work.

This participant, in part, hoped that this knowledge would be passed down because of her concerns that, in the case of possible extreme hardship in the future, tribal members might need this knowledge to survive. She added that although her grandmother was not a formal healer, she had learned from her grandfather, who was. As she explained:

> No, but her . . . I think her grandfather was. So that would have been my great-grandfather . . . so she picked up some ways of her family through the culture. And so, she picked up, but she didn't [heal] other people. She would just, just [heal] us immediate family . . . if it was like internal, we would go to a [healer] in the local community. That also used prayer. Not only did they use . . . all the local plants and stuff . . . they also believed in prayer, healing prayers."

This participant, like others, also made the connection between using prayer in combination with the use of plants and materials from the environment for healing. These remarks demonstrate the resilience and adaptation of tribal members, who often took care of family members because of limited access to Western health care, or because of its prohibitively high cost. As before, Indigenous members often acted to fill in existing health-care gaps. They also placed a high value on health, traditional medicine, and taking care of family and community members.

Theme 3— "We went to [healers] first . . . we had one down the street, and then we had one next door": Going to Indigenous Healers for Health Care

As mentioned previously, going to healers was a common experience for many women, especially elder tribal members. Sometimes the healer was also a family member, though often it was a neighbor or other community member. Participants described both men and women acting as healers and providing a wide range of services, from attending to minor colds and cuts to helping with childbirth. Participant 30 stated that because of the long distance between her home and the nearest city while growing up, she and her family went to healers: "[Going to a doctor,] that meant a seventeen-mile trip or longer—seventeen, twenty miles to [city name], which is the nearest city. So we went to [healers]. We went to [healers] first . . . you know, fevers, headaches, infections . . . leg infections or some kind of infection. We went to [healers]. And luckily we had, where I lived, a [healer] just down the street . . . and then we had one next door." This woman noted that although healers did not have formal medical degrees, they were

well-respected, and their advice was followed: "They were known, they didn't have the degrees and so on, but they were respected just as much. And whatever they said is what we follow. [They were] very effective, very effective."

Participant 15 also highlighted the immense respect that was afforded to healers, and stated that she was taught to trust whatever the elders and healers said or did: "In my family . . . we were taught to trust our elders and that whatever they would tell us, that that was the truth . . . So yeah, I think, you know . . . the old way was probably the better way." Individuals explained that both male and female tribal members and nontribal members were able to be healers. Participant 18 described her experience of going to a male healer: "I went to a [healer] . . . he's very nice. He's very patient with me. Which I like, I really like because I was freaking out because I didn't know what was going on. And he . . . explained a lot to me. Like, what the process of it was . . . for my hives, because I was breaking out 'cause of allergies. I'm allergic to grass."

Participant 12 described her grandmother as an important female healer in the community: "So my grandmother was a healer and she lived next door to us. People from everywhere . . . would ride their boats and they would come in the little canal. My grandmother lived next to the little canal, and people would come." Participant 3 described going to a male healer:

> Then, I had strep throat really bad. I went to a [healer]. Again, I do not know what he did. But, it [the strep throat] was gone when I left. [Another time] I had what they used to call a sunstroke. I still do not know what the heck that is. You get a headache so bad; you cannot even open your eyes. I went to another one [healer]. The only thing I really recall from that one is that he told my mom to use egg whites. Mix them up like a merengue, put it on my forehead, and put a towel over it. It would help to draw it out. So, I did. And, he did whatever else he did. The next day I was okay.

This participant described the effectiveness of the services she received from these healers. Although Western medicine has historically and most frequently been the purview of white men, tribal members valued the healing expertise of both men and women.

Theme 4— "I don't know nobody that [heals] anymore. The old healers they died. Nobody picked it up": Generational Changes in the Transmission of Traditional Knowledge

Changes in the transmission of knowledge between elders and younger tribal members was of particular concern for many women. Though many women described learning about traditional practices and healing medicines from family members, the majority of women felt that knowledge about the environment, especially the use of plants, was not being taught to younger generations. They also mentioned that the presence of healers was becoming less common. Participant 19 described a healing practice she learned from her mother, an informal healer: "I'm a strong believer in home remedies. Whenever people have, like, an earache, I use coconut oil and olive oil—over prayers, too, now. You have to have the prayer with the [medicines or remedy]." This participant

highlighted the importance of holistic healing as well as generational transmission of healing knowledge. Participant 11 also reported learning traditions from her family that would be passed down within families while also expressing concern that these traditions were no longer being taught: "But we all have our own family . . . healings that [were] passed down, you know, that they just kind of know." When I asked if this information was still being passed down, she responded: "I don't know . . . it's hard to tell, you know, it's hard to tell. I don't know, . . . it was given to me, but it wasn't taught to me. So, I'm not able to teach further than that." Although she was cared for with traditional healing methods, this participant was not necessarily taught these practices in a way that she could then pass on and use in her own family. Several participants explained that the traditions of healing were not being passed down, partly due to a generational loss of the ability to speak their traditional language.

Although the majority of participants recalled childhood experiences going to healers, many noted that this practice was no longer as common, and discussed changes they saw in this tradition. Participant 12 explained that going to healers was not as commonly practiced in the present day: "I think some people might still use it but not as widely as it was used in those days. Because it's a dying art, more or less. So I think, something [it] is passed [down] from generations or something like that. Or you might remember something they used to tell you to do and stuff like that. So that's passed on. And so, it could be dying, it's not at the point where it was."

She added that she still offered healing prayers for family and community members: "I'll pray on people. And a lot of people are going to say they're sick or something and I'll tell them I'm going to put them on the prayer list. And I have a prayer list . . . I'll pray for them almost every day." This participant expressed that the healing tradition may be being passed on in other forms, such as through her son who pursued medical school training:

> Well, my [oldest] son went to medical school, he's a doctor, he's a cardiologist. So he wanted to know [some of the traditional practices], because he was writing different stuff and everything, so I told him. He knows about it. And then my youngest son, I tell him different stuff that I knew. Will they remember it or would they . . . ? Or they'll call and I'll tell them different stuff to do. But now my oldest son, even though he's a doctor, he's still interested in the traditional, the natural medicine—he wanted to know. the natural medicine, he wanted to know.

Participant 1 also believed that this information was not being passed down, partly due to increased utilization of Western medicine: "Nope. No. I mean very few people . . . pass it down . . . and I think people have access to go to a regular [Western] doctor versus [before]." She added that she had been told "I had the gift" though she had not practiced healing formally.

These interview responses suggest that traditional healing was historically held in high regard, though today this knowledge is being passed down with less frequency. These quotes also highlight the value placed on health—that the ability to care for and heal others is viewed as a gift, which is in sharp contrast to the frequently transactional Western view of providing health-care services—that being a doctor is just

an occupation. Some participants attributed this generational shift to the increasing access to Western health care, lending support to the idea that, for at least some participants, the use of healers helped to fill in previous health-care gaps.

Discussion

Using a life-course approach allowed participants to reflect on their health-care experiences throughout their lifespan. These findings highlight the important role these healers have historically played for participants when growing up. These findings also indicate that many tribal participants continue to rely on family members and traditional healers for their health-care needs. The use of traditional medicine and healers, in some cases, filled in existing structural and institutional gaps that limited the options available to Indigenous communities. This finding is in line with previous research noting the limited availability of Western health-care options in rural, Indigenous communities, the use of traditional health care due to communication barriers, and discrimination in other healthcare settings. The preference for holistic and traditional medicine reflects community values about health and well-being and supports research into traditional healers that notes the importance of holistic, balanced care.[54] Preference for traditional medicine approaches further demonstrates the importance of transmitting knowledge to future generations and underscores tribal and family values about taking care of family members. Women described finding both emotional social support, such as prayers and companionship, and instrumental social support, such as taking someone to a healer, from family and community members, which has been described as important to health and well-being.[55]

Resistance to the Western medical system in some cases reflected negative experiences that had caused distrust. This finding is commensurate with the literature that describes the importance of community members as sources of support and care, as Western services have often been exploitative.[56] Women also demonstrated their agency and resilience in standing up to doctors and acting as advocates for themselves and family members during medical appointments. The life-course approach also yielded findings related to generational changes, especially when participants were asked about their first health-care experiences, which for elder tribal women almost always meant first going to a family member or a healer. Although this was still common among younger generations, they less frequently mentioned going to healers.

Women spoke about first going to family members for healing of minor injuries and ailments. Sometimes this family member was a mother, but it was also often an aunt or grandmother. Going to family members for health care was described fondly and with respect, and many women expressed that they used family healing practices with their own children. Though family members who provided care were generally women, participants discussed going to both male and female healers in the community—especially elder tribal members.

Exploring life-course experiences also highlighted changes in the transmission of knowledge between elders and younger tribal members, which was of particular concern for women. Though women spoke of learning about the use of traditional medicines from

their mothers and grandmothers, many were worried that this knowledge was no longer being passed down to younger generations. They also mentioned that traditional healers were becoming less common and expressed concerns that the tradition was beginning to disappear. Research has discussed the risks of cultural tradition and language loss as tribal leaders pass away, a concern that resonated with the women in the present study.[57] These findings also emphasize the strength of using a life-course approach, as only focusing on current experiences may obscure important changes happening in the community.

Interviewees also discussed how identifying as a tribal member impacted their own view of self, and their belief that tribal women were strong, resilient, and acted as the teachers and culture-bearers of their communities. Participants described grandmothers in particular acting as healers and matriarchs in the family. This tribe, like many other tribes, was traditionally matrilineal and matrilocal, with female leaders acting as healers, and spiritual and community leaders.[58] Although participants described a tradition of both male and female healers, female healers were more frequently mentioned, and female relatives were more frequently referred to as providing informal care. These findings highlight the tribal value of women in leadership positions, including roles as healers, and indicate that, although settler colonialism (through "patriarchal colonialism") has undermined some of the Indigenous values that historically empowered women in this tribe, women continue to hold important leadership positions in the home, and act as healers and leaders in the community.[59] Women described their identity as Indigenous women as a source of strength. Although none of these participants explicitly characterized themselves as feminists, their description of the role of female leadership within the tribe is consistent with Native American feminist thought.[60] As Luhui Whitebear writes, "Since contact with European colonizers, Indigenous women . . . have been defending our bodies and connections to lands as well as reclaiming our identities and knowledges. Our identities are tied to these lands. The violence toward both have been fueled by settler colonialism. As such, the healing both require is based in our Indigenous knowledge systems and practices."[61] Based on Indigenous feminism, these remarks highlight the role of traditional Indigenous healing knowledge, connection to the land, and the role of Indigenous women in fighting for healing and perpetuating Indigenous practices—ideas upheld by the study's participants.

Limitations and Future Research

The present study discusses the health-care-related experiences of women from a state-recognized Gulf Coast tribe. Thus, findings from the study may not be generalizable to other groups or tribal communities. Information was self-reported and limited by cross-sectional design. One limitation of the study is that all interviews were conducted in English, as many tribal elders speak a language other than English as their first language. Thus, limitations relate to first-language accounts and experiences that were not included. The present study focused on women's experiences, and future research must seek to understand the health-care experiences of tribal members who identify as male, two spirit, or nonbinary. Future research should also look at other tribes and villages, as cultural values and experiences differ across Indigenous communities. Additional studies are

needed to understand the variability of health-care options and service utilization among members of state-recognized tribes and of federally recognized tribes due to differences in health-care benefits. Finally, future research should consider how knowledge about Indigenous women's health-care experiences may influence current health-care utilization and outcomes. Culturally responsive, strengths-based health-care programs are needed in order to improve the health and well-being of Indigenous communities.

Contributions to the Literature

The present study contributes to the extant literature by outlining the health-care practices of Indigenous women from a state-recognized Gulf Coast tribe. This research highlights the value of seeking to understand people's stories and to consider the specific contexts of the tribe at the center of the study during data analysis. In addition, this study adds to the literature by describing the use of both traditional Indigenous healers and Western medicine in current tribal health-care. This research can be used to encourage integrated health-care systems that include Indigenous healers and cultural practices. Finally, this research contributes to the literature on Indigenous feminism and the role of women in tribal communities, highlighting the important roles of women in their families, communities, and health systems.

Conclusion

The present study sought to better understand the health-care experiences of Indigenous women from a nonfederally recognized Gulf Coast tribe using a qualitative descriptive analytic approach. Participants identified themes related to first health-care experiences, going to family members for health care, going to Indigenous healers for health care, and generational changes in the transmission of traditional knowledge. Findings from the current study underscore the importance of traditional healing practices in Indigenous communities and tribal members' concerns about the continued transmission of traditional healing knowledge. Women described going to both family members and traditional healers for health care, and indicated that healers are held in high regard and that their knowledge is respected and valued. Healers have historically been sought due to both cultural preference and systemic barriers in Western health care. The findings suggest that, despite the impacts of settler colonialism, Indigenous women continue to occupy positions of influence as leaders, including as traditional healers, in tribal communities. However, participants also noted their concerns that some of this knowledge was no longer being passed down, which may require community-based interventions to promote the continued transmission of health-care knowledge. These findings begin to fill the knowledge gap about the health-care experiences of Gulf Coast and nonfederally recognized tribes.

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Notes

1. Deborah Bassett, Ursula Tsosie, and Sweetwater Nannauck, "'Our Culture Is Medicine': Perspectives of Native Healers on Posttrauma Recovery Among American Indian and Alaska Native Patients," *The Permanente Journal* 16 (December 2012): 19–27.

2. Kelly Gonzales et al., "Perceived Racial Discrimination in Health Care, Completion of Standard Diabetes Services, and Diabetes Control among a Sample of American Indian Women," *The Diabetes Educator* 40, no. 6 (December 2014): 747–55, https://doi.org/10.1177/0145721714551422.

3. Sonia Marrone, "Understanding Barriers to Health Care: A Review of Disparities in Health Care Services among Indigenous Populations," *International Journal of Circumpolar Health* 66, no. 3 (June 2007): 188–98, https://doi.org/10.3402/ijch.v66i3.18254.

4. Tholene Sodi and Olaniyi Bojuwoye, "Cultural Embeddedness of Health, Illness, and Healing: Prospects for Integrating Indigenous and Western Healing Practices," *Journal of Psychology in Africa* 21, no. 3 (January 2011): 349, https://doi.org/10.1080/14330237.2011.10820467.

5. Bassett, Tsosie, and Nannauck, "Our Culture Is Medicine," 19.

6. Ibid., 21.

7. Ibid., 22.

8. Nicole Redvers and Be'Sha Blondin, "Traditional Indigenous Medicine in North America: A Scoping Review," *PLOS ONE* 15, no. 8 (August 2020): e0237531, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0237531.

9. Bassett, Tsosie, and Nannauck, "Our Culture Is Medicine," 23.

10. Catherine E. McKinley et al. "Community-Engaged and Culturally Relevant Research to Develop Behavioral Health Interventions with American Indians and Alaska Natives," *American Indian and Alaska Native Mental Health Research* 26, no. 3 (2019): 79–103, https://doi.org/10.5820/aian.2603.2019.79; Jessica Liddell and Catherine E. Burnette, "Culturally-Informed Interventions for Substance Abuse among Indigenous Youth in the United States: A Review," *Journal of Evidence-Informed Social Work* 14, no. 5 (October 2017): 329–59, https://doi.org/10.1080/23761407.2017.1335631.

11. "Traditional Medicine—Growing Needs and Potential," World Health Organization, last modified 2002, https://www.who.int/westernpacific/publications-detail/WHO-EDM-2002.4.

12. "Definition of Western Medicine," National Cancer Institute, last modified 2011, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/western-medicine.

13. Jessica L. Liddell, Catherine E. Burnette, Soonhee Roh, and Yeon-Shim Lee, "Health-Care Barriers and Supports for American Indian Women with Cancer," *Social Work in Health Care* 57, no. 8 (September 2018): 656–73, https://doi.org/10.1080/00981389.2018.1474837; Jessica L. Liddell, Catherine McKinley, Hannah Knipp, and J. Miller Scarnato, "'She's the Center of My Life, the One That Keeps My Heart Open': Roles and Expectations of Native American Women," *Affilia* 36, no. 3 (September 2020): 1–19, https://doi.org/10.1177%2F0886109920954409; Janette Beals et al., "Prevalence of DSM-IV Disorders and Attendant Help-Seeking in Two American Indian Reservation Populations," *Archives of General Psychiatry* 62 (February 2005): 102, https://doi.org/10.1001/archpsyc.62.1.99; Dedra Buchwald, Janette Beals, and Spero Manson, "Use of Traditional Health Practices among Native Americans in a Primary Care Setting," *Medical Care* 38, no. 12 (December 2000): 1191–99, https://doi.org/10.1097/00005650-200012000-00006.

14. Liddell et al., "Health-Care Barriers and Supports," 656.

15. Barbara Broome and Rochelle Broome, "Native Americans: Traditional Healing," *Urologic Nursing* 27, no. 2 (April 2007): 161; Catherine Burnette, "Historical Oppression and Intimate Partner Violence Experienced by Indigenous Women in the United States: Understanding Connections," *Social Service Review* 89, no. 3 (September 2015): 538, https://doi.org/10.1086/683336; Catherine

Burnette and Charles Figley, "Historical Oppression, Resilience, and Transcendence: Can a Holistic Framework Help Explain Violence Experienced by Indigenous People?" *Social Work* 62, no. 1 (January 2017): 37, https://doi.org/10.1093/sw/sww065; Mary Canales et al., "Multigenerational Perspectives on Health, Cancer, and Biomedicine: Northeastern Native American Perspectives Shaped by Mistrust," *Journal of Health Care for the Poor and Underserved* 22, no. 3 (August 2011): 894–911, https://doi.org/10.1353/hpu.2011.0096.

16. Melissa Walls et al., "Unconscious Biases: Racial Microaggressions in American Indian Health Care," *The Journal of the American Board of Family Medicine* 28, no. 2 (March 2015): 231, https://doi.org/10.3122/jabfm.2015.02.140194.

17. Gonzales et al., "Perceived Racial Discrimination," 755.

18. Marrone, "Understanding Barriers," 190.

19. Carol Korenbrot, Sara Ehlers, and James Crouch, "Disparities in Hospitalizations of Rural American Indians," *Medical Care* 41, no. 5 (May 2003): 634, https://doi.org/10.1097/01.MLR.0000062549.27661.91.

20. Marrone, "Understanding Barriers," 192.

21. Hilal Al Shamsi et al., "Implications of Language Barriers for Health Care: A Systematic Review," *Oman Medical Journal* 35, no. 2 (March 2020): 122, https://doi.org/10.5001/omj.2020.40.

22. Marrone, "Understanding Barriers," 193.

23. "Frequently Asked Questions," Bureau of Indian Affairs, accessed October 11, 2021, https://www.bia.gov/frequently-asked-questions.

24. Christina Swoope, "The Role of Medicare and the Indian Health Service for American Indians and Alaska Natives: Health, Access, and Coverage," *KFF* (blog), December 2014, https://www.kff.org/report-section/the-role-of-medicare-and-the-indian-health-service-for-american-indians-and-alaska-natives-health-access-and-coverage-report/.

25. Martha Salazar, "State Recognition of American Indian Tribes," last modified October 2016, https://www.ncsl.org/legislators-staff/legislators/quad-caucus/state-recognition-of-american-indian-tribes.aspx.

26. "Frequently Asked Questions for Patients," Indian Health Service, accessed November 2021, https://www.ihs.gov/forpatients/faq/.

27. Catherine McKinley et al., "Community-Engaged," 101.

28. Shanondora Billiot, ""How Do Environmental Changes and Shared Cultural Experiences Impact the Health of Indigenous Peoples in South Louisiana?" (PhD diss., Washington University, St. Louis, 2017), https://doi.org/10.7936/K7WM1BTS.

29. Jessica L. Liddell and Sarah G. Kington, "'Something Was Attacking Them and Their Reproductive Organs': Environmental Reproductive Justice in an Indigenous Tribe in the United States Gulf Coast," *International Journal of Environmental Research and Public Health* 18, no. 2 (January 2021): 666, https://doi.org/10.3390/ijerph18020666.

30. Billiot, "How Do Environmental Changes," 1; Kirsten Vinyeta, Kyle Powys Whyte, and Kathy Lynn, "Climate Change through an Intersectional Lens: Gendered Vulnerability and Resilience in Indigenous Communities in the United States," *General Technical Report PNW-GTR-923, Portland, Oregon: US Department of Agriculture, Forest Service, Pacific Northwest Research Station,* 72 (2015), 92, https://doi.org/10.2737/PNW-GTR-923.

31. Liddell and Kington, "'Something Was Attacking Them,'" 666.

32. Stephanie Fitzgerald, *Native Women and Land* (Albuquerque: University of New Mexico Press, 2017).

33. Liddell and Kington, "'Something Was Attacking Them,"" 666.

34. Ibid.

35. "Tribal Self-Governance," Indian Health Service, accessed July 29, 2022, https://www.ihs.gov/newsroom/factsheets/tribalselfgovernance/.

36. Catherine McKinley et al., "Community-Engaged," 102.

37. Liddell and Kington, "'Something Was Attacking Them,'" 666.

38. Ibid.

39. Ibid.

40. Ibid.

41. Catherine E. Burnette et al., "American Indian Women Cancer Survivors' Coping with Depressive Symptoms," *Journal of Psychosocial Oncology* 37, no. 4 (2019): 494–508, https://doi.org/10.1080/07347332.2018.1525467; Beals et al., "Prevalence of DSM-IV Disorders," 100; Buchwald, Beals, and Manson, "Use of Traditional Health Practices," 1192.

42. Burnette et al., "American Indian Women Cancer Survivors," 495; Catherine E. Burnette et al., "American Indian Women Cancer Survivors' Perceptions and Experiences with Conventional and Non-Conventional Mental Health Care for Depressive Symptoms," *Ethnicity & Health* 26, no. 2 (February 2021): 186–205, https://doi.org/10.1080/13557858.2018.1493439.

43. John Red Horse, "American Indian Elders: Unifiers of Indian Families," *Social Casework* 61, no. 8 (1980): 490–93, https://doi.org/10.1177%2F104438948006100808; Hilary Weaver and Barry White, "The Native American Family Circle: Roots of Resiliency," *Journal of Family Social Work* 2, no. 1 (April 1997): 67–79, https://doi.org/10.1300/J039v02n01_05.

44. Liddell and Kington, "'Something Was Attacking Them,'" 666; Jessica L. Liddell, Catherine E. McKinley, and Jennifer M. Lilly, "Historic and Contemporary Environmental Justice Issues among Native Americans in the Gulf Coast Region of the United States," *Studies in Social Justice* 15, no. 1 (February 2021): 1–24, https://doi.org/10.26522/ssj.v15i1.2297; Liddell et al., "She's the Center of My Life," 357; Catherine McKinley et al., "All Work and No Play: Indigenous Women 'Pulling the Weight' in Home Life," *Social Service Review* 95 (June 2021): 278–311, https://doi.org/10.1086/714551

45. Catherine Burnette et al., "A Toolkit for Ethical and Culturally Sensitive Research: An Application with Indigenous Communities," *Ethics and Social Welfare* 8, no. 4 (October 2014): 364–82, https://doi.org/10.1080/17496535.2014.885987; Susan Strega and Leslie Brown, *Research as Resistance*, 2nd ed. (Toronto: Canadian Scholars' Press, 2015).

46. Burnette et al., "A Toolkit for Ethical and Culturally Sensitive Research," 374; McKinley et al., "Community-Engaged and Culturally Relevant Research," 84.

47. To see a full list of interview guide questions, please see Liddell and Kington, "'Something Was Attacking Them,'" 666.

48. Norman Denzin, Yvonna Lincoln, and Linda Smith, *Handbook of Critical and Indigenous Methodologies* (Thousand Oaks, California: Sage Publications, 2008); Strega and Brown, *Research as Resistance*.

49. Jill Milne and Kathleen Oberle, "Enhancing Rigor in Qualitative Description: A Case Study," *Journal of Wound, Ostomy, and Continence Nursing: Official Publication of the Wound, Ostomy and Continence Nurses Society* 32, no. 6 (December 2005): 417, https://doi.org/10.1097/00152192-200511000-00014.

50. Milne and Oberle, "Enhancing Rigor," 415.

51. Yvonna S. Lincoln and Egon G. Guba, *Naturalistic Inquiry* (Beverly Hills, California: Sage, 1985).

52. Milne and Oberle, "Enhancing Rigor," 415.

53. The words heal(s) and healer(s) will be used throughout in place of terms that the participants used due to concerns that these terms may identify the tribe.

54. Bassett, Tsosie, and Nannauck, "Our Culture Is Medicine," 21.

55. Liddell et al., "Health-Care Barriers and Supports," 657.

56. Broome and Broome, "Native Americans," 161; Burnette, "Historical Oppression," 538; Burnette and Figley, "Historical Oppression," 37; Canales et al., "Multigenerational Perspectives," 894.

57. Michelle Sauve, "Testimony of Michelle Sauve on Native American Languages and Cultures," 2021, accessed November 10 2021, https://www.acf.hhs.gov/olab/testimony/testimony-michelle-sauve-native-american-languages-and-cultures.

58. Andrea Smith, "Not an Indian Tradition: The Sexual Colonization of Native Peoples," *Hypatia* 18, no. 2 (2003): 73.

59. Liddell et al., "She's the Center of My Life," 666; McKinley, Liddell, and Lilly, "All Work and No Play," 279.

60. Andrea Smith, "Beyond the Politics of Inclusion: Violence against Women of Color and Human Rights," *Meridians: Feminism, Race, Transnationalism* 4, no. 2 (April 2004): 120–24, https://doi.org/10.2979/MER.2004.4.2.120; Andrea Smith, "Beyond Pro-Choice versus Pro-Life: Women of Color and Reproductive Justice," *National Women's Studies Association Journal* 17 (April 2005): 119–40, http://www.jstor.org/stable/4317105.

61. Luhui Whitebear, "Disrupting Systems of Oppression by Re-Centering Indigenous Feminisms," accessed July 29, 2022, https://uw.pressbooks.pub/happy50thws/chapter/disrupting-systems-of-oppression-by-re-centering-indigenous-feminisms/.