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American Indian Women Cancer Survivors' Spiritual and Religious Coping Practices

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Abstract

Despite AI women's cancer disparities being a public health concern, a dearth of research on this populations' spiritual coping poses a barrier to redressing such disparities. The purpose of this article was to explore AI women cancer survivors' spiritual and religious coping. This qualitative descriptive study included a sample of 43 AI women cancer survivors. Qualitative content analysis revealed that 93% of AI women cancer survivors used a variety of AI spiritual coping, religious coping, and/or a mixture of the two. Results reveal the prevalence of AI spiritual coping, with traditional AI spiritual practices being particularly common.

Keywords

American Indian or Native American; Spiritual and religious coping; cancer; women; qualitative

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Author Contributions Statement

Dr. Soonhee Roh is responsible for the overall content as guarantor. All authors (i.e., Dr. Catherine McKinley, Dr. Soohee Roh, and Dr. Yeon-Shim Lee) significantly contributed to the following article components: (a) conceptualization of the research goals and aims; (b) methodology, including its design and development; (c) validation, such as the adherence to the fidelity to the methodology and its reproducibility; (d) formal analysis, including data analysis of the raw data and its organization; (e) resources, including analysis tools and computing resources; (f) article writing, including the original draft and its revisions. Dr. Soonhee Roh oversaw supervision, project administration, and funding acquisition, whereas Dr. Roh and Dr. Lee were involved in the investigation of the research process, specifically the data collection component.

Conflicts of Interest:

Dr.s Catherine E. McKinley, Soonhee Roh, and Yeon-Shim Lee declare that they have no conflicts of interest.

The approvals of the following Institutional Review Boards were obtained prior to data collection: (a) University of South Dakota, (b) Avera McKennan Hospital, (c) Rapid City Regional Health, and (d) Sanford Research center. Informed consent was achieved prior to data collection from all participants.

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Ethical Approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

As stipulated by the US Bureau of Indian Affairs (Bureau of Indian Affairs, 2019), the Treaty Agreements between the United States and the 573 federal sovereign tribes include provisions to provide for the health and wellbeing of American Indian and Alaska Natives (AI/AN) (U.S. Commission on Civil Rights, 2004). However, AI/AN persons continue to be overburdened with many of the most severe health disparities in comparison with other races (U.S. Commission on Civil Rights, 2004). Cancer is the top cause of death among AI/AN women, whose prevalence is reported at 1.6 times the rate of whites (Espey et al., 2014). Given cancer rates vary by sex, it is important to understand the sex-specific factors related to AI women's cancer experiences.

Despite AI women's cancer disparities being a public health concern, a dearth of research on this populations' spiritual coping poses a barrier to redressing such disparities. Spiritual coping has been found to be an important component of cancer treatment and care among the general U.S. population (Kalish, 2012); yet, after a review of the literature, it was apparent research on spiritual coping among AI/ANs is virtually non-existent. This is particularly problematic, given the centrality of spirituality to many AI/AN peoples. Indeed, spirituality is known to be an important protective factor enhancing the quality of life among cancer survivors (Vallurupalli et al., 2012).

Literature Review

The context of cancer among AI/ANs is distinct and is situated in a broader context of historical oppression (Burnette & Figley, 2017). The concept of *historical oppression* captures the chronic, pervasive, and multigenerational imposition oppression that AI/ANs have experienced from colonization to the present date, which, over time may be normalized, imposed, and internalized into peoples' daily lives (including individuals, families, and communities) (Burnette & Figley, 2017). The concept expands upon historical trauma, a concept which encompasses the massive, and insidious trauma imposed on a group, which may include land dispossession, the loss of the AI population through warfare and disease, forced removal and relocation, environmental injustices, assimilative and oftentimes abusive boarding school practices, and the prohibition of religious or spiritual practices (Evans-Campbell, 2008; Harper & Entrekin, 2006). Unlike historical trauma, historical oppression focuses on *both* contemporary *and* historical forms of oppression (i.e., proximal stressors), which tend to perpetuate oppression, such as higher stress, discrimination poverty, and health disparities.

Religious and spiritual suppression have been constant methods of historical oppression that have infiltrated the more than 500 years of colonization into present times (Irwin, 1997). Indeed, the legal suppression of religious and spiritual freedom was attempted to be redressed through the American Indian (AI) Religious Freedom Act of 1978, with many suppressive laws predating one of the most constrictive laws, the Indian Religious Crimes Code of 1883 (Irwin, 1997). This law prohibited tribal ceremonial activities under the penalty of prison sentences (Irwin, 1997) (for a history of AI Religious suppression and resistance see cited article by Lee Irwin). Multiple legal precedents forbidding AI/AN spiritual and religious practices have legitimized Judeo-Christian faith traditions, while de-legitimizing AI/AN traditions (Irwin, 1997). This de-legitimization is perpetuated in the

medical care arena when the centrality of AI/AN spiritual and religious practices are ignored, not spoken about, or deterred by medical practitioners (Shelley et al., 2009).

Spirituality and AI/AN healing practices have profound meaning to cancer survivors (Struthers & Eschiti, 2004). Although a systematic review has indicated that overall, patients prefer health practitioners discussing spirituality and alternative or complementary medicine (Best, Butow, & Olver, 2015), research with a subsample of AI participants indicates barriers to such discussions, namely clinician's receptivity (or lack thereof) to initiate conversations about such practices (Shelley et al., 2009). However, AI/AN health practices, which tend to be intricately tied to spiritual practices, are commonly used among AI/ANs, with one study indicating that 70% of urban AI/AN patients often used such practices (Buchwald, Beals, & Manson, 2000). Another study found that 38% of AI/AN patients used AI/AN healers, with more women than men reporting use, along with older patients being more frequent users than younger patients (Marbella, Harris, Diehr, Ignace, & Ignace, 1998). Of those who did not use healers, 86% expressed considering their use in the future (Marbella et al., 1998).

Indeed, many AI/ANs practice both AI/AN and Western medicine. The importance of collaboration and integration both forms of medicine in a spirit of genuine respect for AI/AN healing practices and beliefs cannot be understated (Portman & Garrett, 2006). Regarding reasons for use and types of AI spiritual practices, participants indicated they saw such healers for spiritual reasons, and healers included herbalists, spiritual healers, and medicine men/women, with many patients using multiple healers (Marbella et al., 1998). Despite heterogeneity across tribes and practices, some important concepts that are common across tribes include holistic conceptualizations of health and wellness, including the balance and harmony across physical, mental, spiritual dimensions of health and the environment (Portman & Garrett, 2006). Although the description of AI/AN healing practices is beyond the scope of this article, they have been discussed in detail in other articles (Portman & Garrett, 2006). Common ceremonies, such as sweat lodges and smudging, are practices to regain harmony and cleanse or purify AI/ANs for a fresh beginning (Portman & Garrett, 2006). Indeed, one study described sweat lodge ceremonies, spiritual healing, and herbal remedies as the most commonly reported healing practices (Marbella et al., 1998). Finally, patients rated healers' advice as higher than physicians 61.4% of the time, yet only 14.8% reported telling physicians about their use (Marbella et al., 1998).

If AI healing practices and spirituality are inseparable and frequently used by AI/AN patients, medical practitioners have a responsibility to facilitate discussions about their use among AI women cancer survivors' experiences. These practices have the capacity to complement care, or they may in some way be incongruent with conventional medicine; this information is highly relevant to cancer patients' and their care providers. Thus, the purpose of this article is to explore AI women cancer survivors' spiritual and religious coping practices.

Methods

Research Design

We use a community-based participatory research approach (CBPR), with a community advisory board (CAB) of AI community leaders, and health care professionals who work in the two AI communities. The responsibilities of the CAB's were to: (1) identify research-related community needs and concerns; (2) guide participant recruitment and result dissemination; and (3) enhance community support and research involvement. We employ a qualitative descriptive study methodology, a naturalistic and inductive inquiry which provides a rich account of experiences in easily accessible language (Sullivan-Bolyai, Bova, & Harper, 2005), to examine the experiences AI women cancer survivors as they related to familial social support. Our over-arching research questions were: "What are AI women cancer survivor's spiritual and religious coping practices?" Qualitative description was chosen as it has been found to be especially useful in working with vulnerable populations to understand cultural nuances, as it prioritizes the voices of participants themselves rather than the highly abstracted interpretation of researchers (Sullivan-Bolyai et al., 2005). Because abstracted interpretation is limited, the straightforward suggestions of participants in qualitative description is considered "a fine-tuned research design" resulting translatable knowledge applicable to real-world contexts, such as what roles family supports play in AI women's cancer experiences (Sullivan-Bolyai et al., 2005).

Setting and Sample

This collaborative research was conducted with an eastern and western community-based hospital in the Northern Plains region, in South Dakota: (a) the Avera Medical Group Gynecologic Oncology in Sioux Falls and (b) the John T. Vucurevich Cancer Care Institute, Rapid City Regional Hospital in Rapid City. These are the primary health facilities for AI women in the eastern and western parts of South Dakota.

The sample included 43 AI women cancer survivors ($n=14$ breast cancer, $n=14$ cervical cancer, and $n=15$ colon and other types of cancer survivors). We included cancer types to assess the primary universal spiritual and religious coping across cancer-types. We used purposeful sampling to determine who is best able to answer research questions (i.e. AI women cancer survivors), and at what point the data reaches *saturation*, (i.e., when no new meaningful information/redundancy is gained) (Sandelowski, 1995). Inclusion criteria for participants were: (a) having any type of cancer in the last 10 years; (b) completing of cancer treatment without recurrence; (c) female sex; (d) being adult (over 18 years); (e) residing in the state of South Dakota; and (f) self-identifying as American Indian (enrollment in federally recognized tribe). As stated, participants self-reported as belonging to an AI tribe.

Regarding participant demographic characteristics. Ages of participants ranged from 32 to 77, ($M=56.33$ years, $SD=12.07$). For educational attainment, 97.7% of participants achieved a high school degree/GED. Almost half (49%) of participants reported a monthly household income of less than \$1,499. Although 32.5 % of participants described their health as *poor/fair*, 67.5% described their health as *good/excellent*. Participant cancer-types included: breast ($n = 14$, 32.6%); cervical ($n = 14$, 32.6%); colon ($n = 5$, 11.6%); lung ($n = 2$, 4.7%);

Non-Hodgkin Lymphoma ($n = 2, 4.7\%$); and others ($n = 6, 13.9\%$). Most respondents ($n=39, 90.7\%$) described a religious affiliation, and 93% reported having medical insurance. The average time participants had cancer was 2.42 years ($SD= 2.19$).

Data Collection

The approvals of the following Institutional Review Boards were obtained prior to data collection: (a) University of South Dakota, (b) Avera McKennan Hospital, (c) Rapid City Regional Health, and (d) Sanford Research center. Informed consent was obtained from all individual participants included in the study. An author and two trained research assistants with backgrounds with AI populations and cancer survivors completed data collection. Recruitment included: mailed fliers distributed to cancer survivors across the hospitals, posted fliers at community agencies, new and radio advertisements, and local agencies and/or churches distributing information. Three of the total of 46 potential participants who had more than 10 years of cancer history were excluded due to inclusion criteria, resulting in a sample of 43. Data were collected where participants' preferred (e.g., private conference room at hospital, homes of participants, churches, or researchers' office) between June of 2014 and February of 2015.

Semi-structured qualitative interview guide were developed in collaboration with the CAB. Interview guides were created to coincide with the research topics and community needs reported by the CAB, who reviewed the guide, paying particular attention to the wording and cultural appropriateness of each question, ensuring cultural relevance to AI women cancer survivors. Participants responded to questions such as, "Do you have spirituality, religious connections, ceremonies of sorts that have helped you cope with your cancer? Is there anything in your religion or your beliefs that help you cope with cancer? Can you tell me about that?" The audio-recorded interviews were transcribed verbatim by graduate students, ranging from 30-120 minutes. Participants were \$50 for their time, along with a gift card to cover travel and participation expenses. Transcribed interviews were entered into NVivo data analysis software (QSR International Pty Ltd., 2015).

Data Analysis

Using qualitative content analysis, which is recommended for qualitative descriptive studies (Milne & Oberele, 2005; Sandelowski, 2000; Sullivan-Bolyai et al., 2005), which allowed inductive themes to emerge directly from the data (Milne & Oberele, 2005). The process involved: (a) immersion in the data by listening to and reading interviews multiple times to understand data holistically; (b) line-by-line coding with notes to capture key concepts; (c) 430 preliminary codes, or *meaning units* were identified; preliminary codes were sorted large themes with subcategories under each; (e) co-authors discussed and validated clusters and subcategories and explored whether any significant variation existed across cancer types. No such differences were found; (f) emergent categories were used to organize codes into meaningful clusters, creating a definition for each cluster; (g) clusters with respective quotes were presented to participants in member checking. Author's reached out to all participants up to three times, to be invited to engage in member checks. More than half ($n=23, 53.5\%$) engaged in the process, with close to half ($n=21, 46.5\%$) having disconnected

phones, and thus being unreachable. Thus, virtually all reachable participants participated in member checks. No changes/amendments were requested by participants.

Strategies for rigor.

We used Milne and Oberele's (2005) strategies for rigor specific to qualitative descriptive studies (Milne & Oberele, 2005), which ensured (a) *Authenticity* or fidelity to the goals of this study; (b) *credibility*, or the level of trustworthiness of the results; (c) *criticality*, or purposeful decision-making strategies. Strategies were operationalized through the semi-structured and flexible interview guide (not being overly rigid), prioritizing participants' voices, asking clarifying questions, conducting member checks, utilizing inductive analysis for coding to emerge from the data (i.e., conventional content analysis). We enhanced authenticity through analyzing potential bias and engaging in peer review across the research team to promote study integrity (Milne & Oberele, 2005).

Results

Among participants, only three mentioned not practicing any spiritual practices. Over half (57%) participated in AI/AN spiritual beliefs and practices, whereas approximately four out of ten participated in organized religion. Finally, 36% integrated both AI/AN and non-AI/AN spiritual/religious practices. In this section, we will describe participants' reports of each type of practices. Details of ceremonies that are more private to communities are not revealed to honor such preferences. Participants were given anonymous numbers to demonstrate that quotes arose from across the continuum of women.

Tribal Spiritual Beliefs and Practices

Over half (57%, n=24) of participants expressed being involved in traditional AI spiritual practices and beliefs as part of their cancer recovery and coping strategies. Participant 25 talked about how her spiritual beliefs gave her strength and hope, stating the benefit of:

Just talking to the Creator and the spirits. Um, because I'm a strong believer in, um, that the spirits are there to help you. ... Spirits are all truth. The creator is all truth, that's my belief. ... Makes me not feel alone.

Many participants had specific spiritual practices that went with their beliefs. Smudging, in particular, was mentioned many times. Participant 29 explained this practice of smudging as:

It's a little shell and you can go to prairie edge and get your sage and they sell the sweet grass there. And all you do is just burn it [the sage]. You can burn it in this little shell they have there. And you just smudge it all the way down to your feet and the same way with the sweet grass. Also you can take that around in your home and you can smudge your whole home and keep the spirits or whatever out.

Participant 29 went on to explain the benefit of her frequent smudging practices, as stated:

When you smudge it kind of lessens things off of your chest. I mean it makes you feel good. And that's sage and that's the sweet grass. And you can smudge every morning. Even at nighttime you can smudge.

Participant 34 went on to describe the cleansing process of smudging:

What I usually use is sage from the prairie. You pick it in July and then you dry it out. Usually our family will go out and pick, it's a certain kind you have to pick, the one with the long leaves. There's another one but that's just- the male one is the one we usually use. We dry it and then when you want to go to smudge you just take a branch and takes the leaves off, roll it in the palm of your hand. ... You burn it and you smudge from head to toe.

Participant 38 similarly recalled,

Well I pray every morning. I smudge. It only takes a few minutes to burn some sage. And I put out food and coffee if I've got it, you know, um, or water. And I pray for my relatives. I pray for healing, and wellness.

Participant 15 went on to say, "I wouldn't of ... been able to have the strength to get through the radiation and the chemo if I didn't really believe that somebody else was helping me... that Higher Powers weren't there. ... Taking some of the load."

Religious Coping

Approximately 43% ($n=18$) of participants remarked upon being involved with a specific religious congregation, namely Christian, with the most frequently cited religion being Catholic, with some also being Episcopal. Participant 1 described the religious make-up of most of her tribal people, explaining,

A lot of my people, some of my people are real traditional they go to Indian religion which I believe in, and my son practices, and but some us when they were put in boarding schools years ago over 200 years ago; they got the Catholic religion in them or the Episcopal religion.

Participant 22 was a practicing the Baptist religion but didn't engage in tribal spirituality, stating, "I go to church, and I get prayer. I get prayer and go to church, and that helps me to cope." When participant 30, who explained, "We're not active members of any particular church. We just believe in the Bible. Every word in the Bible." When she was asked whether she practiced any traditional spirituality she replied, "No, absolutely not." Participant 19 also felt her faith gave her life meaning, stating,

I belong to the Episcopal Church. And I really, really believe that you should, you know, I believe there's a purpose for all of us for this life. I feel like life is not for nothing. ... I've had a good support system. And I just feel like I've been able to fall back on my church.

As participant 1 stated, "I'm a practicing Catholic and so I depended on my religion a lot." Participant 1 mentioned, she practiced both tribal spirituality and Catholicism, stating, "I'm kind of both, and I talked to a medicine man once who was both." The focus now turns to participant reports of the integration of religious and AI/AN spiritual coping.

An Integration of Native and Religious Coping

Almost 36% of participants ($n=15$) mentioned being involved with both traditional Native spirituality and Christianity, with the same amount ($n=15$) emphasizing being spiritual. Only three said they weren't involved in spiritual practices. Participant 18 practiced both Catholic and traditional Native spirituality, and felt, "The power of prayer is very strong." Participant 28 mentioned, "I have a lot of people praying for me, like the medicine man, the church way, the medicine way—both." Participant 33 explained her spiritual coping, "I would go to the church with my kids and pray, and at night we would go to ceremonies and pray over there too. They made that medicine, and I feel better whenever I take that." Still, Participant 29 described how she practiced both tribal spirituality and also attended a religious congregation:

Spirituality is where you smudge yourself every morning and I think, 'My Father I want to live. I mean I want to be here for maybe another 10, 15 more years to watch my grandchildren.' And I go to church every Sunday, and I pray the same thing, I want to be here for my kids and my grandkids.

Participant 29 added, "I have a friend, she's a pastor, I go to her church a lot. But then she's not there a lot so I have another church to fall back on. I go to Native sweats [sweat lodges], and ceremonies that um, they have, for healing too. So I do both." She added this spiritual leader, "She really encourages the sweet grass and the smudging. She really does encourage that. She really is a wonderful woman. We're really blessed to have her." Participant 33 stated, "I have both connections to the Catholic way and the spiritual or traditional way." When asked how these practices were different, she replied

Well with the Catholic way I think we pray to the same God because it's just the same way because you're praying to God only here and then you're praying to our spiritual leader. We still say the same prayers to them, both of them. In the Catholic way we go to church and the traditional way we go to ceremonies.

One Creator

Many participants expressed their spirituality through many practices, which they felt was appropriate, given an underlying belief there was only one God or Creator. Participant 33, "I believe that they are connected because there's only one God in the world." Similarly, when asked who she prayed to, Participant 3 explained,

To God, the only, the one and only God. Mr. [x], the medicine man that was dealing with my brother, he said that the parallels between the way he practiced and the Catholic Church were side by side. He said that his spirits that he uses to heal are the same as the saints that we ask intercession from. And he said when you get to the end, he said you're both praying to the same god. The exact one and only same God. Only one.

Still, Participant 20 described her expansive view of God:

I believe we have one God. We just have other different ways of [practicing]. I think that God is very diverse and very bilingual, trilingual, multilingual,

multicultural. ... I guess what I'm getting at is it's one God. We just all use Him, or Her.

Participant 29 also reaped the benefits of both Christian and tribal spirituality, explaining, "My belief--and with both religions, I can go and ask for prayers of healing at both places." She called her higher power, "The great spirit, the great keeper, the great one, or the father." She added,

Through the church I believe that Jesus will heal me, you know? He healed me a lot, and I know that. Because through prayers through the church I saw him. I went and seeked [*sic*] him out and with all the prayers and how we pray out there at the church, um, they heal you. I experienced it and I experienced a lot of things in life where they took the sickness out of me.

In closing, AI women described a multitude of emotional, spiritual, and physical benefits associated with their faith practices.

Discussion

Women coped in various ways, with the majority practicing traditional AI/AN practices, especially smudging, ceremonies, and sweat lodges. Relatedly, women spoke about "God" in many ways, such as "Creator", "Father", "Great Keeper," among others. Engaging in spiritual practices tended to offer women comfort, relaxation, a lessening of the burden of cancer, offered hope, and made women feel less alone in their journey through cancer. As noted, smudging was a very common practice and was described by participant in detail. Importantly, the process of gathering the sage and other plants could involve family, which contribute to greater social support and support networks. Many women also engaged in religious institutions, and although most of these women were not opposed to traditional AI/AN spirituality, a few were. This may be related to some religious institutions promoting exclusivity, along with the legacy of historical oppression that deterred or outlawed AI/AN spiritual practices (Irwin, 1997). Finally, many women engaged in both AI/AN and Judeo-Christian traditions. Believing that there is "one God" made these faith traditions a compliment to each other, supporting women's wellness through the cancer experience.

Limitations

Given the lack of studies examining spiritual and religious coping among AI/AN cancer survivors more research is needed. These self-report from this study do not determine the efficacy of any specific practice, and this could be examined in future research. Results from this non-representative qualitative sample are not generalizable. Although this study did not find support for differential coping by cancer types, future research can further investigate and identify distinct coping for specific cancer types. AI/AN c spiritual and religious coping and experiences can vary considerably across heterogeneous tribes, individuals, and regions.

Implications

Results reveal distinct spiritual and religious coping experience across AI women cancer survivors. Healthcare practitioners can gain familiarity with some of the more common

practices and practices and faith traditions of AI women. AI cancer survivors may describe “God”, “Creator”, “Great Spirit” or other terms, and sensitivity around language is important to be mindful of. Practitioners can gain familiarity and comfort with discussing these practices and preferences openly with patients to offset the stigma they may have experienced from health practitioners regarding alternative or complimentary healing practices (Shelley et al., 2009). Women overwhelmingly expressed strength, hope, meaning comfort, and relief from spiritual and faith traditions. These practices may pose as potential protective factors, offsetting the stresses and the strains of cancer experience.

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References

- Best M, Butow P, & Olver I (2015). Do patients want doctors to talk about spirituality? A systematic literature review. *Patient Education and Counseling*, 98(11), 1320–1328. [PubMed: 26032908]

- Buchwald D, Beals J, & Manson SM (2000). Use of traditional health practices among native americans in a primary care setting. *Medical Care*, 38(12), 1191–1199. [PubMed: 11186298]
- Bureau of Indian Affairs. (2019). Mission Statement. Retrieved from <https://www.bia.gov/bia>
- Burnette CE, & Figley CR (2017). Historical oppression, resilience, and transcendence: Can a holistic framework help explain violence experienced by indigenous people? *Social Work*, 62(1), 37–44. [PubMed: 28395035]
- Espey DK, Jim MA, Cobb N, Bartholomew M, Becker T, Haverkamp D, & Plescia M (2014). Leading causes of death and all-cause mortality in american indians and alaska natives. *American Journal of Public Health*, 104(S3), S303–S311. [PubMed: 24754554]
- Evans-Campbell T (2008). Historical trauma in american indian/native alaska communities. *Journal of Interpersonal Violence*, 23(3), 316–338. [PubMed: 18245571]
- Harper SS, & Entrekin CM (2006). Violence against native women: A guide for practitioner action. (No. (Grant No.) 96-VF-GX-K005). Washington, DC: Office on Violence Against Women and the National Center on Full Faith and Credit.
- Irwin L (1997). Freedom, law, and prophecy: A brief history of native american religious resistance. *American Indian Quarterly*, 21(1), 35–55.
- Kalish N (2012). Evidence-based spiritual care: A literature review. *Current Opinion in Supportive and Palliative Care*, 6(2), 242–246. doi:10.1097/SPC.0b013e328353811c [doi] [PubMed: 22498837]
- Marbella AM, Harris MC, Diehr S, Ignace G, & Ignace G (1998). Use of native american healers among native american patients in an urban native american health center. *Archives of Family Medicine*, 7(2), 182–185. [PubMed: 9519925]
- Milne J, & Oberele K (2005). Enhancing rigor in qualitative description: A case study. *Journal of Wound Ostomy, and Continence Nurses*, (November/December), 413–420.
- Portman TA, & Garrett MT (2006). Native american healing traditions. *International Journal of Disability, Development and Education*, 53(4), 453–469.
- QSR International Pty Ltd. (2015). NVivo qualitative data analysis software, version 11
- Sandelowski M (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334–340. doi:10.1002/1098-240X(200008)23:43.0.CO;2-G [PubMed: 10940958]
- Shelley BM, Sussman AL, Williams RL, Segal AR, Crabtree BF, & Rios Net Clinicians. (2009). ‘They don’t ask me so I don’t tell them’: Patient-clinician communication about traditional, complementary, and alternative medicine. *Annals of Family Medicine*, 7(2), 139–147. doi:10.1370/afm.947 [doi] [PubMed: 19273869]
- Struthers R, & Eschiti VS (2004). The experience of indigenous traditional healing and cancer. *Integrative Cancer Therapies*, 3(1), 13–23. [PubMed: 15035869]
- Sullivan-Bolyai S, Bova C, & Harper D (2005). Developing and refining interventions in persons with health disparities: The use of qualitative description. *Nursing Outlook*, 53, 127–133. [PubMed: 15988449]
- U.S. Commission on Civil Rights. (2004). Native american health care disparities briefing: Executive summary. Washington, DC: U.S. Commission on Civil Rights.
- Vallurupalli M, Lauderdale K, Balboni MJ, Phelps AC, Block SD, Ng AK, ... Balboni TA (2012). The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. *The Journal of Supportive Oncology*, 10(2), 81–87. doi:10.1016/j.suponc.2011.09.003 [doi] [PubMed: 22088828]