Using Traditional Spirituality to Reduce Domestic Violence Within Aboriginal Communities

Chassidy Puchala, B.A.,1 Sarah Paul,1 Carla Kennedy, M.A.,2 and Lewis Mehl-Madrona, M.D., Ph.D., M.Phil.3–6

Abstract

Objectives: We report the results of involving traditional healing elders (THE) in the clinical care of aboriginal families who were involved in domestic violence in the context of a clinical case series of referrals made for domestic violence.

Methods: Psychiatric consultations were requested from senior author L.M.M. for 113 aboriginal individuals involved with domestic violence as recipients or perpetrators (or both) between July 2005 and October 2008. As part of their clinical care, all were encouraged to meet with a THE, with 69 agreeing to do so. The My Medical Outcomes Profile 2 scale was being used as a clinical instrument to document effectiveness. Elders used traditional cultural stories and aboriginal spirituality with individuals, couples, and families to transform the conditions underlying domestic violence.

Results: For those people who met with the THE, a statistically significant change (p < 0.0001) occurred in symptom severity from baseline to final interview of 4.6–1.52 on a scale of 0–6. The most common presenting symptom was being beaten (39 people), followed by drinking (37 people), drugs (13 people), grudges and anger (12 people), sadness (9 people), hates self (8 people), fear (7 people), sleep problems (6 people), anxiety (5 people), and lost spirituality (2 people). Each person chose two primary symptoms to rate.

Conclusions: Including elders in the care of people who are the recipients of domestic violence is effective. We speculate that it helps by providing traditional stories about relationships and roles that do not include violence. Spiritual approaches within aboriginal communities may be more effective than more secular, clinical approaches. Research is indicated to compare elder-based interventions with conventional clinical care.

Introduction

Domestic violence is defined as physical violence carried out with the intention or perceived intention of physically hurting a spouse or intimate partner1 and is pervasive in North America. Domestic abuse has been defined as the use of physical violence in an intimate relationship. The term also includes emotional, psychological, and sexual abuse, as well as any other behavior one person in a relationship uses to control the other (p. xi).2

Research exists on the causes, effects, and upon effective prevention and intervention within primarily white, middle-class communities,3 as well as aboriginal communities within Canada.4–7 While family violence and abuse did occur prior to European contact, both historical and anthropological records indicate that it was unusual.8–10

Domestic Violence and Aboriginal Women

Nearly 40% of aboriginal woman will experience interpersonal violence within their lifetime.11 Aboriginal women in Canada encounter some unique obstacles and complexities compared to their nonaboriginal counterparts.12 Brayboy and Morgan5 reported how 4 Native American women struggled to maintain their traditional culture while living in a non-aboriginal society. Five (5) common themes emerged from these women’s stories: First was spirituality as a powerful source of strength, specifically differentiated from organized,

1University of Saskatchewan, Department of Community Health and Epidemiology, Saskatoon, Saskatchewan, Canada.
2Department of Anthropology, University of Manitoba, Winnipeg, Manitoba, Canada.
3Department of Psychology, Argosy University–Hawaii, Honolulu, HI.
4Department of Sociology and Behavioral Sciences, Johnson State College, Johnson, VT.
5Coyote Institute for the Study of Change and Transformation, South Burlington, VT.
6Departments of Family Medicine and Complementary and Alternative Medicine, University of Hawaii School of Medicine, Honolulu, HI.
Western religion. One informant imparted, “Spirituality means that there is a power or a being or thing that is greater than any of us mortals. I think it is something deep; it’s deeper than organized religion” (p. 347).

Second, “Indianness” was described as an internalized conflict unique to aboriginal people. Assimilation has affected mother–daughter bonding, the third theme of the aboriginal women’s experiences. Previously, a girl’s connectedness to her mother defined her identity as a woman and connected her to aboriginal culture and her female ancestors. Aboriginal women in modern society feel this bond has been weakened. Racial discrimination against aboriginal women, the fourth theme, has damaged their identity and continues to create a sense of disconnectedness within their communities. The fifth and final common theme in the experiences of aboriginal woman was “reciprocity and inclusiveness”—that is, embracing one’s clan, giving and receiving, and rejecting individualism. Kiyoshk14,* argues that aboriginal men “have been acculturated to the patriarchal norms of the dominant society through imposition of policy and legislation and religion that have over many generations minimized the significance of women’s roles. These power imbalances … are causal factors in family violence” (p. 15).

Prevalence of Domestic Violence Within Aboriginal Communities

Brownridge6 compared the prevalence of domestic violence between aboriginal and nonaboriginal women in over 7000 telephone interviews. Twelve point six percent (12.6%) of aboriginal women had been victimized by their partner within the 5-year period preceding the interview compared to 3.5% of nonaboriginal women. Within 1 year before the interview, 8.1% of aboriginal women stated they had experienced domestic violence compared to 1.6% of nonaboriginal women. Aboriginal women were also seven times more likely to report being choked, threatened with a knife or gun, and being severely beaten.

A report by the U.S. Department of Justice revealed that the rate of violence among aboriginal people was more than two times that of the general population, with one in six victimizations taking place between intimate partners. Fairchild et al.15 found that 16.4% of 341 aboriginal women had been victimized by their partner within the 5-year period preceding the interview compared to 3.5% of nonaboriginal women. Within 1 year before the interview, 8.1% of aboriginal women stated they had experienced domestic violence compared to 1.6% of nonaboriginal women. Aboriginal women were also seven times more likely to report being choked, threatened with a knife or gun, and being severely beaten.

Precursors to Domestic Violence in Aboriginal Communities

Canadian governmental policies continue to encourage, if not force, the assimilation and marginalization of Canadian aboriginals.12,16 Consequently, aboriginal people are forced to depend on the government for sustenance and health care and, as a result, lose control over their own destinies.

There are several ways that the Canadian government has reduced the freedom of agency of aboriginal people12, beginning with removal from their own lands and placement upon reserves. Second, aboriginals have been denied self-determination as the government ultimately holds the rights to their land. Third, aboriginals did not gain the privilege of provincial voting rights until 1969. By placing stern restrictions on the decisions aboriginals were allowed to make, the government reduced their dignity. Aboriginals in Canada were historically denied educational, economical, and religious freedoms. Of particular importance were the government designed residential schools which lasted from 1860 to 1960. The Christian churches maintained responsibility for most of the schools and prohibited students learning any aboriginal history, language, culture, spiritually, traditions, customs, and ideologies. Changes to the Indian Act in 1920 made attendance at the residential school mandatory. Children were beaten for speaking their native language, forced to wear European attire, denied visitation with their family, and were often abused, both sexually and physically.17 The brutality of the residential schools has remains in the hearts of aboriginal people to the present day.

Duran18 describes how this oppression over several centuries has been internalized and, as a result, manifests itself in aboriginal thoughts, feelings, behaviors, relationships, and illnesses. Specifically, he believes that the internalized oppression experienced by aboriginal males is projected onto a related individual as a way to release some of their pain. The widespread historical trauma inflicted upon aboriginal people, as a whole, may have created a vicious cycle in which those who internalized their pain from the effects of colonization engage in violent behaviors toward available, proximate others, primarily domestic partners. Consequently, those who are the recipients of this violence also internalize their pain. Eventually, this internalized pain is released through violence onto another individual, who also internalizes this pain—and the cycle continues. The effects of colonization have intergenerational implications in that the pain and oppression experienced by aboriginal ancestors is passed on to future generations.

In addition to the demoralization of aboriginal people as a whole, colonization has specific consequences for women.16 Due to the large discrepancy between the roles of European women and the roles of aboriginal women, the Canadian government with the help of Christianity attempted to transform the role of aboriginal women to reflect the practices of the European culture. This undermined the more equally powerful traditional and spiritual roles of Native women within the community, which resulted in the deterioration of extended family practices, traditional child-rearing methods, and the dilution of aboriginal culture. By losing their roles within the community, aboriginal women lost their identity, self-esteem, and power. These losses bred victimization, as abusers saw the women as lacking control, without strength, highly vulnerable, and having low levels of familial support, all of which have been shown to be predictors of domestic violence victimization.19–21

Other consequences of colonization that may be risk factors for being in a relationship dominated by violence include alcoholism, low socioeconomic status, and high stress. Alcoholism is a prevalent illness within aboriginal communities, conceptualized to have arisen as a reaction to coloni-
zation, and results in several negative consequences for both the individual and the community.22 Suicide, depression, social disorganization, unemployment, alienation, and domestic violence have all been linked to alcoholism in Native Americans.23 Norton and Manson24 found that 31% of women at an urban Indian health center for domestic violence reported that their partners had been under the influence of alcohol at the time of the abuse. Fifty-six percent (56%) of women indicated that both they and their intimate partner had been drinking at the time of their most violent incident.

Many aboriginal communities have a high rate of unemployment, which leads to low socioeconomic status, which plays an important role in predicting domestic violence within aboriginal families. Over 46% aboriginal women reported being on government assistance during the time of domestic violence incidents (Fairchild et al., 1998).13

Bachman assessed the contribution of alcohol consumption and stress to violence in both American Indian and non-American Indian families.23 Drinking and high stress levels had a significantly stronger, positive relationship with domestic violence for aboriginals than nonaboriginals. If aboriginals engaged in high levels of alcohol consumption, then an increase in domestic violence occurred even higher than that for nonaboriginals who also engaged in alcohol consumption. Likewise, if aboriginals encountered high stress levels, then a higher increase in domestic violence occurred when compared to nonaboriginals. An even stronger relationship was found for aboriginals between stress, drinking, and domestic violence. As the levels of stress and alcohol intake increases and socioeconomic status (SES) decrease, the level of domestic violence between intimate partners elevated. Therefore, the factors of drinking, stress, and SES, when combined, appeared to exert a strong influence on incidents of domestic violence within aboriginal communities.

Possible Explanations

Bopp et al.25 mapped the complex web of factors that create and sustain domestic violence at the level of individuals, extended families, community systems, and the socio-environmental context within which they exist. They argued that aboriginal family violence and abuse (1) is a multifactorial social syndrome and not simply an undesirable behavior; (2) resides within aboriginal individuals, families, and community relationships, as well as within social and political dynamics; (3) typically manifests itself as a regimen of domination that is established and enforced by one person over one or more others, through violence, fear and a variety of abuse strategies; (4) is usually not an isolated incidence or pattern, but is most often rooted in intergenerational abuse; (5) is almost always linked to the need for healing from trauma; (6) is allowed to continue and flourish because of the presence of enabling community dynamics, which as a general pattern, constitute a serious breach of trust between the victims of violence and abuse and the whole community; and finally, (7) the entire syndrome has its roots in aboriginal historical experience, which must be adequately understood in order to be able to restore wholeness, trust, and safety to the aboriginal family and community life.

They describe 12 key community determinants of family violence and abuse: (1) absence of consequences and personal immunity, (2) prevailing male beliefs and attitudes regarding women, (3) past history of domestic abuse, (4) levels of personal and community wellness, (5) professional support services, (6) community leadership, (7) public policy, (8) policing and the justice system, (9) poverty and unemployment, (10) community awareness and vigilance, (11) geographical and social isolation, and (12) spiritual and moral climate. These factors do not usually operate in isolation, but rather as a mutually reinforcing system of factors.

For these reasons, we speculated that traditional elders could have a major impact upon domestic violence. This article reports the results of involving traditional elders with conventional psychiatric care to reduce domestic violence.

Methods

In 2005, the senior author (L.M.M.) implemented a plan of involving traditional elders in his psychiatric work with aboriginal clients whenever possible as part of his routine clinical care. He was consulting to aboriginal communities in Saskatchewan for which domestic violence was usually chronic and unrelenting. He is an aboriginal psychiatrist (Lakota/Cherokee) who has strong cultural ties including participation in sundance and other traditional ceremonies. In this context, any reduction in exposure to violence would be considered an improvement. Referrals came to LMM from local family physicians, Mental Health and Addictions Services, the courts, and NADAPP workers (Native Access to Drug and Alcohol Prevention Programs). All referrals were included in this case series.

This article presents a clinical case series resulting from our making available and suggesting involvement with the THE to 113 consecutive aboriginal people referred for domestic violence related consultations. It was not constructed as a research project, but rather an effort to improve clinical care. Clinical case series are an important first step in generating clinical research. The accumulation and discussion of a retrospective experience can inform potential clinical trials and direct researchers toward pitfalls and difficulties in designing research. This case series is presented in that spirit.

All persons referred signed consent for treatment, which included consent to retrospective chart review and inclusion of their information (devoid of identifying data) in quality improvement projects or chart review research. All persons referred received a standard psychiatric interview supplemented by additional narrative-style inquiry.26 All persons continued to be followed by L.M.M. as often as they would come, using narrative-style interviews to determine what had changed in their lives. At follow-up visits, L.M.M. inquired about what had happened with the THEs and about what had changed in the lives of the participants. Generally, initial interviews were 90 minutes and follow-up interviews ranged from 30 to 60 minutes.

The MYMOP2 (My Medical Outcomes Profile 2) was already routinely being used by L.M.M. in his clinical practice to monitor change in symptom severity. In this scale, people identify the two symptoms or problems that bother them the most and rate how severe that symptom is on a 0–6 scale. They assess how much those symptoms interfere with their quality of life. On each follow-up administration, they assess whether or not the original two symptoms still bother them, and by how much. New symptoms may appear as the
primary focus of clinical concern, replacing old symptoms, as old symptoms/problems are resolved. The MYMOP2 was developed in the United Kingdom and has been used widely with demonstrable reliability and validity.\(^{27-29}\) The scale helps people focus upon whether or not the symptom that brought them to seek help is actually improving. L.M.M. gave the MYMOP2 at each clinical visit as a way of focusing the discussion/intervention on the most current and pressing problems. The MYMOP2 was administered interactively as a clinical tool to become aware of what two major problems were most pressing at the moment of the clinical encounter.

L.M.M. maintained a confidential set of notes with only identifying numbers that were deleted when the files were given to S.F. and C.K. to analyze, as has been his standard practice. The decision to review these cases came only after L.M.M. and the THEs realized that something quite extraordinary was happening in terms of life transformations and people stepping away from lives of violence.

The results of narrative analyses are presented. The paired samples, two-tailed, \(t\)-test procedure was used to compare initial MYMOP2 ratings with final MYMOP2 ratings. Statistical significance, then, refers to substantial change occurring for each client. It does not compare elder intervention to any other intervention, though L.M.M. saw no or little clinically observable change among those who did not work with elders. No statistically significant changes occurred in their initial and final MYMOP2 scores.

Referred persons came from the aboriginal community of Saskatoon, Saskatchewan, from a combination of Cree and Dakota reserves in a 200-km radius around Saskatoon, and from Northern Saskatchewan reserves (which were Dene). The average age of persons referred was 34.5 ± 6.2 years. Of the 113 aboriginal individuals who were involved with domestic violence, 12 were male and 101 were female. All had been involved in violent family situations for more than 1 year; the average was 6.8 years.

**Results**

Seventy-six (76) people agreed to meet with an elder. Sixty-nine (69) followed through on that contact. L.M.M. accompanied people to the elder's home in 7 cases for the first meeting. In 6 cases, the women went alone to meet with the elder. In 7 cases, family members accompanied the person to meet the elder. In another 7 cases, family members were elders and the affected individual reached out to that family member. In 5 cases, friends went with the woman to meet the elder. In 10 cases, L.M.M. and/or others accompanied the person to a ceremony (usually a sweat lodge) to meet the elder. In the remaining 34 cases, the elder came to the clinical setting to meet with L.M.M. and the affected individual. Eight (8) of the women were Salteaux, 7 were Dakota, 18 were Dene, 10 were aboriginal from out of province, and 26 were Cree. Two (2) elders were Dene (and were also practicing Roman Catholics), and the remainder were Cree. A total of 9 elders were involved.

Review of the narratives of those who refused elder involvement showed no change in experience of violence. Minimal transformations occurred.

Forty-nine (49) of the individuals reported dramatic reductions in domestic violence during the course of their involvement with elders. Nine (9) reported no change in violence. Eleven (11) found that the violence continued to escalate and other measures were required or they were lost to follow-up. Of the 49 women reporting a reduction in violence, for 29 of these individuals, the violence had virtually disappeared.

Table 1 shows the results of the MYMOP2. The 10 most common initial complaints are listed (each person picked 2) along with the beginning score of severity on a 0–6 scale and the ending score of severity. The average change was 3.08 units of distress and the difference between initial and ending MYMOP2 symptom severity scores was statistically significant at \(p < 0.0001\).

**What did the elders do?**

In each case, the elders began a gentle kind of contact unusual for medical settings. They showed kindness and compassion and offered no judgment or premature advice giving. They typically began with prayer and with hearing the person’s story of their life and of the violence. I did not see them judging the violent person or making this person bad or wrong. They continued to show compassion toward this person also.

In almost all situations, elders invited the perpetrator of the violence to join in the discussions about the violence. This made sense, since most women continued living with the

<table>
<thead>
<tr>
<th>MYMOP symptom</th>
<th>Initial 1</th>
<th>Beginning</th>
<th>Ending</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking</td>
<td>37</td>
<td>5.2</td>
<td>2.2</td>
<td>3</td>
</tr>
<tr>
<td>Drugs</td>
<td>13</td>
<td>6</td>
<td>1.2</td>
<td>4.8</td>
</tr>
<tr>
<td>Sadness</td>
<td>9</td>
<td>5</td>
<td>0.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Being beaten</td>
<td>39</td>
<td>6.1</td>
<td>1.8</td>
<td>4.3</td>
</tr>
<tr>
<td>Hates self</td>
<td>8</td>
<td>2.6</td>
<td>1.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Anxiety</td>
<td>5</td>
<td>4.2</td>
<td>1.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Fear</td>
<td>7</td>
<td>3.1</td>
<td>1.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Sleep problems</td>
<td>6</td>
<td>5.1</td>
<td>0.8</td>
<td>4.3</td>
</tr>
<tr>
<td>Lost spirituality</td>
<td>2</td>
<td>4.4</td>
<td>1.2</td>
<td>3.2</td>
</tr>
<tr>
<td>Grudges and anger</td>
<td>12</td>
<td>4.3</td>
<td>2.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Average change</td>
<td>138</td>
<td>4.6</td>
<td>1.52</td>
<td>3.08</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>1.13137085</td>
<td>0.502881</td>
<td>1.27349</td>
<td></td>
</tr>
<tr>
<td>(T) test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MYMOP2, My Medical Outcomes Profile 2.
person who administered the violence. Sweat lodge ceremonies were used frequently along with “doctoring,” which is a kind of spiritual/energy healing. Talking circle type discussions were common along with prayer, pipe ceremonies, and occasional shaking tent ceremonies.

Elders were able to involve the family on both sides of the couple in ways that medical professionals cannot. Elders can connect to the violent individual(s) in a family (sometimes both partners are violent – sometimes at the same time, sometimes alternating) and invite them to a discussion in ways that medical professionals cannot do. Their sense of “no blame” is helpful as is their attribution of causality. The elders did not lay blame upon the person committing violence; rather, they laid it upon the stories that this person had grown up hearing about (usually) how to be a man or about alcohol (the women who were violent in this series were only violent when drinking heavily). The elders offered healing stories to all parties, offering them to drop the white cultural stories about drunken Indians and being no good and being worthless and thinking that a man has to boss his woman around and make her obey, and learning the traditional stories about what it was to be “an Indian man,” as one said. “We show our women respect,” another said. Since alcohol use was often involved in violent episodes, the elders also told stories about walking away from alcohol. (Chronic drinking as is typically associated with alcoholism was not the problem in this series of patients; rather, violence tended to occur in episodic periods of binge drinking with sometimes long periods between bouts.).

The elders appeared to be engaged in a social process of reconstructing self-narratives into redemptive scripts for the future as a process of “making good.” They accomplished this through the transformative power of stories and storytelling. The people who consulted them learned to define their gender relationships differently as a result of “talking story” with the elders. They learned a different way to conceive of men’s duties to women, respect for women, and other similar core aboriginal values as demonstrated in the traditional stories that have been being told for centuries. The elders appeared to be helping the clients construct redemptive narratives that allowed them to move beyond binge drinking and episodic violence toward a climate and community of respect for women as givers of life and avoidance of violence as a means for resolving problems. Instead, they learned to bring their problems to the elders for discussion and resolution. Within “Indian country,” most elders maintain several concentric circles of families for which they feel responsible to help. Participation in these circles provided an alternative conflict resolution approach rather than violence, which was all that many of the clients had previously known due to the exigencies of residential schools, the harshness of the Indian Act, and the other traumas of colonization.

The elders were overseeing a process of identity exchange in O’Reilly’s terminology. In the same way that O’Reilly described for Alcoholics Anonymous, clients were helped to mine their own pasts for buried themes and alternative interpretations that defy the expression of violence. Similar to Thune, the elders encouraged clients to develop new, redemptive stories that reorganized their lives beyond violence.

**Representative Stories**

1. **Thomas and Tammy.** This couple was in their early 40s. They had married as late teens and had problems with domestic violence for more than 20 years. Tammy came to clinical attention because of anxiety. She had been prescribed almost every known psychotropic medication (including low doses of the three major atypical neuroleptics available in Canada). During this 12 years of medication prescribing, no physician had ever asked about violence in the home. When L.M.M. asked if there were good reasons for her to be fearful, she broke into tears and told about how she couldn’t sleep because her husband would come home sometimes in the middle of the night and awaken her for a beating. Tammy was Dene and also Roman Catholic and did not believe she had the option of leaving Thomas. Marriage was for life in her view, even though 3 priests of the 4 she had consulted had told her she could leave Thomas, since his behavior had broken the marriage contract. Nevertheless, more importantly, Tammy’s community’s views were more conservative than those of these 3 priests, so she could not leave Thomas because of how her community would view her. L.M.M. encountered once again the limitations of the biomedical model in its assumption that anxiety is a disease entity requiring treatment rather than sometimes an appropriate response to inappropriate conditions.

In this situation, a Roman Catholic female elder who had managed to integrate Catholicism and traditional spirituality came to the reserve on a monthly basis. L.M.M. was able to enlist her help. She joined forces with a nun who also visited the community, and together they approached the couple. They sat with the couple and prayed together and did a ceremony. L.M.M. was not invited to any of their ceremonies, but did attend couples meetings and family sessions with this couple, their children, and the elders. We identified the problem as a defective story about Indians and alcohol—one that sanctions and even encourages the behavior of drinking everything in sight when alcohol is around. We worked together on a story about being able to walk away from alcohol. In the family sessions, we worked on resolving the grudges and animosity built over more than 20 years of violence. The elders worked on confession and forgiveness from their conception of the term. Over the course of 18 months, a dramatic change (when seen from the initial presentation) had occurred and violence had stopped along with drinking. The couple became more active in their church and began going to Catholic-sponsored retreats and other personal growth workshops. The identified patients stopped all drugs except for an occasional zopiclone for sleep.

2. **Faye was being regularly beaten by her son.** She lived on the reserve and he lived in the house next door to her. Her son was 23 years old and had a long history of using multiple substances, including alcohol, inhalants, solvents, marijuana, and others. When he ran out of money for drugs, he would come to her house and would kick in the door if she did not let him inside. He would demand money for drugs. If she didn’t give him money or didn’t have money, he would beat on her with his fists or hit her with any objects at hand. Her
extended family was tired of this situation and ignored these two. Faye herself sometimes drank and when she was especially drunk, they would beat up each other.

At one of her “complaining sessions” with L.M.M., an elder was asked to also attend. Faye somewhat reluctantly agreed. The elder began to tell stories about mothers and sons, especially traditional stories from the time when people were being made to appear on the earth. He suggested she needed to learn more about how to be a Cree mother in accordance with the old tales and that if she began to be a Cree mother, her son might get curious. He might want to know more. The elder invited her to come to his next ceremony and to come early for a doctoring and for some further discussions with the elder’s wife. Faye agreed and the elder told her that a neighbor of hers was also coming and would give her a ride.

Faye did go to the ceremony and did get doctoring and did connect with some women who wanted to support her to live in a traditional way. Her change was linked to something that seems universally desirable in Indian country—to become more Indian. Everyone seems to be seeking an elusive “Indianness” that can be used to encourage participation in traditional cultural activities and roles.

Over the course of 6 months, Faye changed the story about who she was to be one that was more traditional. She was regularly attending ceremonies, eventually even in a helper/supporter role. Finally she began setting limits for her son. One night when he broke into her house and threatened her, she called the police. He was arrested and charged, and she let him manage it on his own. She did not interfere this time. Her son eventually spent 4 months in jail. The elder whom Faye was seeing knew the elder who worked in the jail and encouraged that elder to find Faye’s son and to approach him and offer him assistance. At first the answer was an angry “no”, but, as he neared his release date, he became more curious, and asked to talk to the elder. Before he was released, he actually attended a sweat ceremony.

Over the course of the next 2 years, Faye became stronger in her “Indianness” and her son slowly got involved. He did not completely get off drugs and alcohol, but he was attending some ceremonies and he had stopped bashing her door down to get money or alcohol or drugs in the middle of the night. Faye did stop using alcohol to excess. L.M.M. did not know if she was abstinent or moderate, but the harm in her drinking disappeared, and she led a much more peaceful life. In time perhaps her son will become even more involved in his traditional culture and even less involved in drugs and alcohol.

3. Kelly was a 32-year-old woman with two children, ages 6 and 9, who lived with her common-law husband on a reserve. He worked 2 weeks at the mine and was off for 2 weeks. Sometimes when he would return, he would binge drink. If he got drunk enough, on one of those binges, he would become violent and hit Kelly. On one episode of being very drunk, he punched Kelly and unintentionally grazed her eyebrow giving her a little cut. Neighbors called the police who came and arrested him for domestic violence. They took Kelly to the hospital for her cut, which did not require more than a band-aid.

Nothing happened legally for the next 15 months. However, much change happened within the family. Kelly’s husband felt terribly shamed at having been arrested for domestic violence while he was drunk. He apparently had enough identification with a traditional story about being a husband and a man that he found humiliation in what had happened to him. L.M.M. met him at a sweat in which he was formally renouncing alcohol and drugs and pledging to “wellbriety” (a model created in Colorado that combines the sobriety movement with the wellness movement and one that uses the four directions and other pan-Indian concepts that has become popular in Indian country these days). L.M.M. continued to follow his progress through chats with him at sweats.

L.M.M. became involved with Kelly when the judge, 15 months after the incident, issued a restraining order requiring no contact between Kelly and her husband. This devastated Kelly emotionally. In her view, the house in which they lived had belonged to her husband before they met and she could not ask him to vacate his own house. She left and went to live with her chronically alcoholic parents who drank all night and tortured her until dawn. She left the children with her husband since they had always lived in the house. At 20 weeks pregnant, she came to see L.M.M. clinically because she was breaking down. She could not function at work, she had no energy, and she cried for her children.

L.M.M. wrote a letter on her husband’s behalf for the courts, wondering about the logic of instituting a restraining order 15 months after the incident when all had gone well during those 15 months with no further contact with the police. He urged the judge to rescind the order. This eventually did happen, though not right away, and was a good example of how the court systems do not help reduce or prevent aboriginal violence. In Saskatchewan, at least, they have appeared to C.K. and L.M.M. as being an afterthought that generally meddles in unhelpful ways and criminalizes people who should be engaged in a more reconciliatory justice system.

Conclusions

We report the results of a clinical case series in which the involvement of traditional healing elders appeared to make a significant impact upon harm reduction for aboriginal individuals involved in domestic violence. While not classical research, clinical case reports such as this serve the purpose of what has been called “early phase” or “stage I” research37 in which phenomena are identified that could merit further, more rigorous study. This is clearly the case for the use of traditional elders as key players in reducing domestic violence. Health practitioners may benefit their patients through gaining elder involvement. There are caveats, however.

When we discussed the possibility of a research protocol with the elders, none would agree. They saw the concept of randomization as unethical and sacrilegious. In their worldview, anyone who asks for help should receive it, and anyone who asks should receive the best possible help. They could understand and accept the concept of randomization when comparing two drugs to see which works better, but not for relieving human suffering from domestic violence. Hence, none of our elders would have ever agreed to participate in a rigorous, controlled trial, highlighting the diffi-
could help restore balance, as well as increase the self-efficacy and empowerment of aboriginal people so that domestic violence no longer needs to hold a place within their story. Traditional spirituality has been the best addition to psychiatric practice with people affected by domestic violence that L.M.M. has seen to date.

Disclosure Statement

The authors state that no competing financial interests exist.

References

17. LaFromboise TD, Choney SB, James A, Running Wolf PR. Bringing cultural diversity to feminist psychology: Theory,


33. White WL. Pathways from the Culture of Addiction to the Culture of Recovery, 2nd ed. Center City, MN: Hazelden, 1996.


Address correspondence to:
Lewis Mehl-Madrona, M.D., Ph.D., M.Phil.
Coyote Institute for the Study of Change and Transformation
P.O. Box 9309
South Burlington, VT 05407
E-mail: mehlmadrona@gmail.com