Sanya Virani:

Hi, I'm Sanya Virani and I welcome you to Finding our Voice, fresh perspectives in psychiatry, a podcast series hosted by me. This podcast has been developed with the goal to address current issues as they pertain to psychiatry, with a special focus on including the viewpoints and opinions of younger groups, resident fellow members, and early career psychiatrists. Thank you for joining me as we continue our discussions on this segment of the podcast series about structural racism that affects patients and psychiatrists from minority and underrepresented ethnic groups. Today's episode will focus on the indigenous community and it is my privilege to introduce two psychiatrists with indigenous heritage, Dr. Mary Hasbah Roessel, and my colleague Dr. Stefanie Gillson. Dr. Roessel is a psychiatrist at the Santa Fe Service Unit in Santa Fe Indian Hospital working in the outpatient behavioral health clinic in Santa Fe, New Mexico. She is Navajo from the Southwestern US and has long since been recognized as a leader in the field and is the newly elected Area 7 trustee on the APS board of trustees. Welcome to the podcast, Dr. Roessel.

Dr. Roessel:

[foreign language 00:01:27] I am really happy to be here. Thank you.

Sanya Virani:

Thank you. And Dr. Stefanie Gillson is Dakota-Sioux and finishing up her fourth year psychiatry residency at Yale University and will start her child and adolescent psychiatry fellowship at Yale University in July. Welcome to the podcast Dr. Gillson.

Dr. Gillson:

[foreign language 00:01:48] Thank you for having me.

Sanya Virani:

I am just about halfway through reading 1491: New Revelations of the Americas before Columbus, and I must say this book has been eye-opening. Contrary to what so many have learned in school, Columbus did not land in a spatially settled, near pristine wilderness. Recent research has shown that Indians arrived millennia earlier than previously thought and shaped the lands around them in ways that we are only now beginning to understand. The astonishing Aztec capital of Tenochtitlan had running water and immaculately clean streets and was larger than any contemporary European city. Native cultures created corn in a specialized breeding process that has also been called man's first feat of genetic engineering.

Many researchers also believe that past Indian cultures created much of today's Amazon Forest. Charles Mann, the author of this book writes, "Arguably their greatest intellectual feat was the invention of zero." The first recorded zero in the Americas occurred in a Maya carving from 357 AD possibly before Sanskrits. The Olmec, Maya and other mesoamerican societies were world pioneers in mathematics and astronomy, but they did not use the wheel. Amazingly they had invented the wheel but did not employ it for any other purpose other than children's toys. Those looking for a tale of cultural superiority can find it in zero, and those looking for failure can find it in the wheel. But what is most important is that by 1000 AD Indians had expanded their neolithic revolutions to create a panoply of diverse civilizations across the hemisphere. And 500 years later when Columbus sailed into the Caribbean, the descendants of the world's neolithic revolutions collided with overwhelming consequences for all.

From my readings of this book thus far one thing is very clear. The Western hemisphere prior to 1492 has been portrayed to be a stunningly diverse place with a tumult of languages, trade and culture. And

as man puts it, a region where tens of millions of people loved and hated and worshiped as people do everywhere. Much of this world vanished after Columbus swept away by disease and subjugation. So thorough was the erasure that within a few generations, neither the conqueror nor the conquer knew that this world had even existed. Now though it is returning to view, it seems incumbent upon us to take a look. In recent news, Dr. Spero Manson, a leading authority with respect to American Indian and Alaska Native Health was awarded the 2021 Elizabeth Fry's Health Education Award this past April.

Dr. Manson is a distinguished professor at the Colorado Trust Chair in American Indian Health at the Colorado School of Public Health at the University of Colorado Anschutz Medical Campus, where he serves as the director for the Centers for American Indian and Alaska Native Health and is widely recognized as the premier venue for addressing population health matters faced by native communities. Attention should be paid to how one can draw upon the work from these centers and utilize it in clinical practice. Now, before starting out with the case that Dr. Roessel will share with us about her patient, Mr. Coriz, I would like to mention a study in 2002 by Beals et al in the Journal of Traumatic Stress, which found that American Indian Vietnam War veterans have higher rates of PTSD and PTSD symptoms than white veterans. Increased exposure to objective and subjective war zone stress largely accounted for this difference. And at this point, I want Dr. Gillson to tell us about her perspective on how indigenous veterans have struggled and dealt with multiple issues related to discrimination and their experiences during the war.

Dr. Gillson:

Thanks for bringing that up. I think that there's been a lot of discussions about indigenous people, but a lot of times indigenous veterans at one time when they are at war are actually fighting two wars besides being on the front, the other one being the ongoing racism and stereotypes that they experienced being in an army that was not made for them, that was really founded on more colonization ideas. For example, some of their comrades thought that maybe the indigenous veterans had a natural connection to the land just by being indigenous. So couldn't this help them fight the enemy? And kind of some of the points that you've made to PTSD among vets, I also wanted to bring up that many of our indigenous veterans went to boarding school where they were taken away from their families and not allowed to practice their traditional values and culture and a lot of times, or their parents were as well. And we know that this research of boarding school really causes significant trauma, disconnection from culture, isolation, depression can be another risk to increase substance use and all of these things contribute to PTSD as well.

Sanya Virani:

It appears to me that this is giving us the perfect segue into Dr. Roessel's experience about treating her patient, Mr. Coriz. So over to you, Dr. Roessel.

Dr. Roessel:

Thank you very much. I am really honored to be able to share this experience that I had with this indigenous man who is indigenous to this area here, which is the Tewa territory. And they certainly, these lands are certainly unseeded territory and the Pueblo people really thrived here. Mr. Coriz was an 80-year-old Pueblo Indian man from New Mexico, also a Vietnam vet. He served in the army and I had been his psychiatrist for 10 years. He had grown to trust me over the years, partly due to both of us being indigenous or Native American. And also, just to let you know, I know in this podcast we're going to be interchanging Native American, American Indian, indigenous, those are all who we are, but we're really working towards indigenous in terms of how we identify, as personally how I identify myself.

So Mr. Coriz was in his twenties when he went to war and he was drafted and he, along with some of his friends were drafted to go to war. He experienced combat while he was in the war because he ended up being one of the medics in his unit. He was an asset to his unit because he was very innovative and resourceful and very brave, and especially in his role as a medic, he witnessed many of his fellow army soldiers die from enemy fire and he felt guilty over surviving while they didn't. And many of his colleagues and comrades didn't come home. And when he returned home, he related that he was haunted by the fact that he survived and they didn't, which is commonly called survivor's guilt.

Sanya Virani:

Please allow me to pause you there, Dr. Roessel for a couple of clarifying questions. Now, my understanding is that the indigenous community is a heterogeneous group within itself comprising of about 576 tribes that have federal recognition. Now, did Mr. Coriz have the same tribal heritage as you, and how often does that level of detail play into a professional or a therapeutic relationship? That's really my first question and then the other thing that you mentioned was that Mr. Coriz grew to trust you over the years, partly because you both are American Indian. Now, as a corollary to my mentioning that indigenous people are a diverse group comprising tribes, which are vastly different from each other, what do you think about the idea of ethnic matching that is supposed to solve cultural difficulties that a patient could experience with a provider from a different background?

Dr. Roessel:

Well, for me, when I work with my community and indigenous peoples, which I have done all of my career primarily, it is very common for myself to identify my background and heritage and it really sets the tone and the stage for that relationship. And I know many other indigenous physicians will do the same. For me as an indigenous psychiatrist we're trained in the Western model, but if you're going to be working with cultural differences and especially people that have been impacted with genocidal practices and issues around being mistrustful of the medical community, then we really have to establish trust and rapport. And so as an indigenous person it is really important for me to know that I'm not crossing a boundary, especially as a psychiatrist. It's something that is necessary to have that relationship and to create that bond with patients and have that rapport.

So the way I see it as well is if we're wanting more indigenous physicians and particularly psychiatrists, part of our role is to be able to share our background and be a role model for the community that we are serving. So establishing that rapport, showing our patients we have similar backgrounds goes a long way to engage and create that necessary bond with indigenous patients who have grown to mistrust doctors as I said earlier, because the Indian Health Service was the first place where we got healthcare and it was part of our treaty obligations and rights, but many of those doctors were not very sensitive and were often very racist against indigenous peoples. So we really have a high bar that is set for us in terms of working with indigenous peoples to create that rapport and diminish that mistrust. Now, the ethnic matching I feel is different with indigenous peoples because there is such a dearth of indigenous physicians.

It makes a big difference when patients know they have another indigenous person in front of them. These cultural differences need to be understood by the psychiatrist, whether indigenous or not, since it also creates better rapport when the patient knows you have made it a point to ask about their heritage and to understand some of what their background is, where they come from, their cultural practices and things like that. In the Southwest where I practice, Pueblo Indians are the original inhabitants of Santa Fe, and I know that there are many cultural differences between the Navajo and the Pueblo, such as being very secretive and closed around talking about religion and culture, especially to non-indigenous

peoples. So for the Navajo, we are very open and we'll share willingly as you see here, to talk about ourselves and to share what we have to offer because I think that's partly how we've been able to continue and really have very adaptive practices in the way that we've come to have our own culture and ceremonies.

But then on the other hand too, the Pueblo people have really beautiful ceremonial practices and heritage, but because that's how they were able to maintain when the Spanish came to be able to continue their practices, they had to basically take it underground and this is common with a lot of indigenous tribes here in our country and across the world really. So getting back to Mr. Coriz, when he returned state side to San Francisco, he was surprised and shunned because he was ridiculed when he returned to that city. He recalled a scenario soon after arriving in the city wearing his clean uniform proudly, he soon was confronted by residents throwing garbage and eggs at him because he had served proudly in Vietnam. He recounted to me that the memories of this experience never left him and contributed to him feeling devalued and shunned most of his life. He had never been aware of the controversy of the USA's involvement with the Vietnam War and had no inkling about why he was being treated this way.

He returned home to his home Pueblo, 45 minutes from Santa Fe, and again, did not feel welcome back. To avoid these feelings of shame and confusion he started drinking first in San Francisco and continued to drink after coming home. After some time he married, he became sober. When he was selected to be the governor of his Pueblo, and a governor is like being the president of a community or a mayor or that type of thing, if you want to understand what that means, and it's a high honor. Success as a governor helped him regain pride. He was also a rancher and had cattle, and he realized that spending time alone and away from people helped him endure the nightmares and flashbacks from the war. He gradually reintegrated into his community and got involved with the religious and cultural activities, which included Pueblo dances, what they might call corn dances, which is ceremonies that will call the rain so that they could have good crops and things like that.

He began to feel some peace and quiet from the PTSD in his mind. Dancing during feast days also helped. He was very devoted to his role and took his tribal obligations very seriously. Just before seeing me, he saw a non-indigenous therapist from the tribal program in his Pueblo. In her referral to me she stated he was bothered by insomnia and anxiety and used to be an alcoholic. He saw also the tribal program psychiatrist, but didn't feel he listened to him and he spent only 30 minutes on the initial intake and 15 minutes in follow-ups. In reviewing the psychiatrist and therapist notes they both suspected he probably still drank because there was a prevailing stereotype that indigenous people are heavy drinkers and that this was the source of his anxiety and insomnia. They both commented, they didn't really think he had PTSD because he never complained about it, and he never complained of nightmares and thought he just wanted, they thought he just wanted service connection and these were in the notes as well.

Sanya Virani:

That's very interesting. So thank you for that background and detailed story about Mr. Coriz. And for all of our listeners not familiar with the term service connection, let me just explain. Service connection means that a veteran's medical condition was directly caused by their military service. Both the Veterans Affairs and the Department of Defense only give disability benefits for service connected conditions. Now, tell me, Dr. Roessel, the psychiatrist that the patient saw, were they non-indigenous as well? It appears that they might not have had the appreciation of the coping strategies, which were consistent with the patient's background. That might have been actually helpful to Mr. Coriz. That's making for a very obscure and limited view of people. Both the therapists and the psychiatrists seem to have only grazed the surface of the issues that Mr. Coriz had been experiencing, no.

Dr. Roessel:

Yes. The psychiatrist that Mr. Coriz first saw was non-indigenous. Despite working within a tribal community it didn't appear that from what the notes were stating that he took into consideration that there were some cultural issues or background. And then also the therapist was non indigenous as well. And so I think that maybe they were not sure how to incorporate into the presentation or into look assessing and seeing where he was coming from, these cultural issues. And so then he didn't feel that he could establish a relationship with these two folks, even despite the fact that they were wanting to work within his own community and be in the tribal mental health clinic and that type of thing.

It was very important for him to feel connected and at least feel validated and feel that his culture was very important and he felt like it was just kind of put aside and not really discussed or talked about in terms of what his roles were maybe in the community. And so that didn't really create a very good relationship at the outset it felt like to me. And he did talk about that kind of the comparison with our relationship and the relationship you had with the other psychiatrist and the therapist.

Sanya Virani:

Right. So that's very useful accompanying information. Now, would you please go on and tell me about your evaluation and opinion of Mr. Coriz and how you dealt with him in your own clinical encounters?

Dr. Roessel:

So every time when I met Mr. Coriz, and this is usually especially with elder indigenous patients, I was very respectful of his status as an elder. And again, this is a very maybe nuanced cultural approach, but it's a very significant one because as indigenous peoples we recognize the status of indigenous elders and respect that we need to give them. And I also recognize knowing that I had a familiarity with his culture and with the Pueblo societies and religious practices that he probably was involved in a religious traditional society and had tribal obligations, and he relaxed considerably when I thanked him for his service to his community and country as a veteran. And when I shared some personal history as well, introducing myself as Navajo and a psychiatrist from Arizona and who my parents were and being familiar with his own community because we had family friends from years ago and that my parents worked and came and consulted with many of the Pueblo when they did their work in education.

And again, in a world of working and being among indigenous peoples and their communities, we always introduce ourselves, especially by clan, especially if you're Navajo, you've established a relationship immediately. And then also if we have family and parents we always introduce our parents as well because there also is some connection often made and where we're from and that type of thing. And so it always really establishes a really good relationship and familiarity with where we've been, who we are, where we've grown up, and all of that. Even though I'm a psychiatrist, oh, am I crossing a boundary? Well, like I said before we need to have this relationship. It's so essential to have the rapport and us showing respect as an indigenous person to continue those kinds of traditions and protocols.

Sanya Virani:

It appears that at the outset you picked on something of great importance to Mr. Coriz like you were pointing out, recognizing and respecting his age, which may have even paved the path to improving the therapeutic relationship because you were viewing it through a cultural lens. In fact, I would go so far as to say that the success of this relationship lies somewhere at the confluence of shared culture and age, and its open acknowledgement, really. And I would imagine that a stronger relationship would've also made him more comfortable with opening up and sharing more intricate details about his life, no.

Dr. Roessel:

Yes, it did. I mean, what he did share, because he knew that I was familiar with his roles and kind of the stressors around that, he was able to acknowledge that he was having quite a bit of nightmares, trouble sleeping, and we developed a close bond. And at the beginning he would graciously thank me for being his doctor and seeing him and spending that time with him. So acceptance and validations of his multiple roles was significant. It enabled him to seek support without feeling guilty. As trust developed he was able to share the full range of the PTSD symptoms that he was hiding. We also explored how he was not able to show this weakness with many of the settings in his tribal roles and obligations, but that he was suffering significantly from the PTSD. So this kind of put him in the middle, and those were issues that we discussed in our sessions. He did eventually obtain service connection when I helped facilitate and work with the VA doctors and so he was very grateful for that.

Sanya Virani:

Thank you so much for your work on this case, Dr. Roessel, and for describing it to us. Let me switch over a little bit and tell you again about my recent readings of the 1491 book, which really opened my eyes to the importance that Native Americans slash indigenous peoples place on spirituality and community or religious roles. And I will say one thing from my observations, practice and experience in training thus far, and with the book serving as knowledge in the background, some psychiatrists do not stop to think that religious and spiritual assessments are vital parts of a psychiatric evaluation. Now, Dr. Gillson, I would like to hear your thoughts about what could potentially be done to incorporate some of this more often into our clinical practice and even early on in our training.

Dr. Gillson:

Yeah, yeah, that's a really good point. I think that it's actually more than religious and spiritual assessment that's needed. We talked a little bit, Dr. Roessel mentioned it too as kind of this idea of boundary crossing, but who defines the boundaries? And really that's Western medicine or our training, indigenous people or really any other culture has different boundaries. There's a large disconnect between what we learn in medicine and the people that we serve. So I talking a little bit about Dr. Roessel's individual that she's been working with, it kind of exemplifies that. And I think I've heard multiple times that from elders that they won't talk to a doctor who doesn't even address them by their first name. That's not considered, it's considered rude in a sense if a doctor just comes in and starts talking and doesn't say, hi, my name is so-and-so, what is your name?

Or when you think about how we're trained on the mental status exam, and one of the first things we say is good eye contact, bad eye contact, when really there's some tribes who making eye contact is considered rude. So I guess I think the term that's more recently in favor is cultural humility. Some people still use the term cultural competency, but really being competent in something implies that there's an endpoint, something that you can achieve while cultures are just really evolving all the time. And as an indigenous person, I can't say I'm culturally competent in Dr. Roessel's communities, it's not something... I know a little bit about it, but I couldn't say, even though I'm indigenous entering at a different indigenous community, I am a guest and I'm there to learn from them.

And so that's where I think cultural humility is more of a lifelong process, focusing on acknowledging what we probably don't know about the other groups. And so I think as psychiatrists we need to really learn from our patients and what they need and not what we think they need based on our training. And it's also important to recognize that our training in medicine and in education is largely based on white cultural and white norms. And most of the research that we cite does not include indigenous populations.

Sanya Virani:

Actually, I was also thinking back to my earlier days in training, especially to a time when cultural competence and cultural humility were never really discussed that rampantly. And I can reflect on how most psychiatrists by default would've taken the stance of, I'm here to help me. I'm sorry. I'm here to help you if you tell me what's bothering you. Although I'm putting it rather crudely. And this had the potential of placing the onus of disclosing symptoms completely on the patient without regard to how the psychiatrist attitudes and cultural identity play an essential role in the cultural features of the relationship between the clinician and the patient. So to me this was a little bit of structural racism playing out in our psychiatric practice if we completely ignore and become totally oblivious to the problems of trust building with the patients in the manner that you did and expected them to articulate everything when the rapport is not that strong.

So on top of that, there is always the risk of the patient being psycho pathologized, even for their reluctance to talk about their problems. Finally, I wanted to point out before moving on to the next narrative that Mr. Coriz in the previous case was met with a lot of stereotyping and maybe even implicit bias, especially as it came to the assumption that he might even be lazy and seeking benefits and financial compensation in the form of service connections and on account of his reported symptoms, quote unquote. Working with a patient through such stereotypes is a practice diametrically opposite to the duty of accurately diagnosing and treating them. Now also, if the patient gets wind of the fact that he or she is being blamed or seen suspiciously, this will naturally not be conducive to building a therapeutic relationship. Finally, I wanted to mention that the BSM 5s outline for cultural formulation has one section which points out specifically the cultural features of the relationship between the patient and clinician, if anyone wants to look that up. Now let's proceed to an example that Dr. Gillson will share with us. Over to you, Dr. Gillson.

Dr. Gillson:

Yeah. Thank you. And I think as we already mentioned that there's just such a vast difference in the hundreds of tribes that are in the United States culture, tradition, different rates of mental health and really significant differences in substance use. So I think talking a little bit about that, also, a lot of these really terrible health inequities are also really rooted in colonization, historical trauma and the ongoing oppression that our communities face. And so when we talk about historical trauma we really need the accumulation of purposeful imposed traumas that have been experienced by a group of people over time, and that they're actually carried forward to impact future generations. So indigenous people in the United States, they faced so many versions of attempted genocide, frankly, starvation, biological warfare with smallpox's, forced relocation, government relocation 1970s. And another thing that we've already touched upon is boarding school where indigenous children were forcibly taken away from their homes.

They endured all types of abuse, not allowed to practice their traditional culture, and were shamed. And this went on until the late 1970s. This is a recent thing. And so I think all of these colonization policies have been linked to poor health outcomes, increased substance use, suicidality, and what's important, it's not just for the survivors of the boarding school, but also the subsequent generations. So this really is, we see this kind of on the continued oppression today where indigenous people maybe don't have access to water, don't have access to good education, don't have access to good healthcare systems, but despite all that indigenous people are still alive and thriving today, and actually one of the fastest growing minorities in the United States.

So despite all these adversities, we're still here and we're still going. So that leads you into, I want to tell you a little bit about this indigenous woman who lived on the Plains Reservation near the oil pipelines,

which have recently been in the news. So the oil pipelines they bring hundreds of people temporarily to what are more commonly known as man camps to live and work on the oil pipelines until that section is up and then they move. And so it's more of like a shanty type living quarters. And many of these camps are in really remote areas where law enforcement is already pretty stretched beyond its limits. So this woman, I want to tell you a little bit about she actually didn't want to come and get mental healthcare given the historical mistrust of the medical community.

Her mother actually reached out and was really concerned about her experiencing nightmares. She was having trouble sleeping, and she was just crying a lot. Her mother also let us know that she had recently made friends with some of the new arrivals to town, but after a few weeks she became really withdrawn. Her mother was really concerned that something serious had happened to her, and she had heard a lot of the stories of indigenous women being sexually assaulted, raped, or gone missing or even human trafficked kind of as a result of what's been happening with these man camps. And the mother was wondering if she had any options to press charges.

Sanya Virani:

Brief pause here, Dr. Gillson for some clarifications and questions, and thank you for starting out on that narrative about the indigenous woman. Before my questions though, I was thinking I would take this opportunity to revisit the concept of historical or transgenerational trauma that you alluded to. Now, Rachel Yehuda wrote in Words World Psychiatry in 2018 that the concept of intergenerational trauma acknowledges that exposure to extremely adverse events impacts individuals to such a great extent that their offspring find themselves grappling with their parents post-traumatic state. Now, a more recent and provocative claim on top of that is that the experience of trauma, or more accurately, the effect of that experience is passed down from one generation to the next through non-genomic, possibly epigenetic mechanisms affecting DNA function or gene transcription. Now the genocide of indigenous people in the US I was thinking would've had transgenerational traumatic effects, somewhat analogous to the reported transgenerational traumatic effects of the Holocaust on the second generation of survivors.

But more importantly, and for the purposes of this episode, I think it is important to focus on the work and the viewpoints of indigenous scholars to reflect on the fact that they have their own lens to look at trauma, colonization, and experiences with psychiatric and psychological diagnoses. So I think that on that note, it's really timely to mention Dr. Maria Yellow Horse Brave Heart Lakota, who first described historical trauma as Dr. Roessel was pointing out to me as cumulative, emotional and psychological wounding across generations, including one's own lifespan. Now, while historical trauma is the result of centuries of colonization and abuses, Brave Heart highlighted the effects of the separation of families and forced assimilation on the boarding school experience that we mentioned at the beginning of the episode.

The reaction to this wounding, which she recalls, which she calls as the historical trauma response often includes survival guilt, depression, PTSD symptoms, physical symptoms, psychic numbing, anger, suicidal ideation, fixation to trauma among other features and behaviors. William Faulkner, one of his best known lines coming from Requiem for a Nun summarizes this concept beautifully. He said, "The past is never dead, it's not even the past." So Dr. Gillson, you mentioned earned mistrust of the medical community, and Dr. Roessel did earlier as well. Was there an incident that took place in this case before that led to the development of this mistrust?

Dr. Gillson:

Yeah, that's a really good question. And I don't think that it's just one incident. Indigenous communities similar to really all of the marginalized communities of the United States experience poor health outcomes. And I think that indigenous people have really just historic, there's a lot behind what the Indian Health Service does and the history behind it and that's something probably for a later time, but even just one example would be in the 1970s, at least 3000 indigenous women were involuntarily sterilized by the Indian Health Service. So how can we expect that, expect them to trust us, where women would find out years later that they weren't able to have children and weren't aware that they had a partial hysterectomy, were told maybe they had a bad reaction to a vaccine, and then they woke up with some kind of symptoms that didn't make sense.

So I think just another thing to consider is that healthcare is one of the things that were promised to indigenous people in the many, many treaties, these treaties where indigenous people gave up land, and part of the promise was that they would receive healthcare and education and our Indian health services chronically underfunded, are many of the facilities are falling apart and haven't been updated in 40 or 50 years. And so I think to answer your question, it's not just one thing, it's multiple things.

Sanya Virani:

Wow. I'm sure a lot of us had no idea about these pieces of history, but a couple of questions and then some tidbits that I wanted to share. So back to the indigenous woman that you were working with and her symptoms of nightmares and insomnia, et cetera. So how long did she have them? That's one question. And then what led her mother to believe that she had been sexually assaulted?

Dr. Gillson:

Yeah, it's hard to say how long she was experiencing them, but long enough for her mother to realize that she needed some help. And I really think that her mother knew because she had alluded that she herself had experienced sexual assault and recognized the signs and symptoms, the withdrawing, kind of closing off, the crying. And I think the heartbreaking truth is that in Indian country, many of the conversations among indigenous women are not if you get raped, but when you get raped. It's pretty common to hear that everybody knows somebody who's experienced sexual violence in indigenous communities.

Sanya Virani:

That's really heartbreaking. But thank you for explaining. This reminds me about the image and the ideas that a lot of us have when we think about issues particular to indigenous tribes, like the 2017 film Wind River, for example, that shed light on the issue of sexual violence faced by a number of indigenous women, both on and off reservations. However, I must point out that this is a Hollywood movie, one that probably feeds into stereotypes. And without dwelling on that any more I wanted to highlight the work that has been done and is being done to combat sexual violence instead by mentioning the national inquiry into missing and murdered indigenous women and girls, the MMIWG. So the final report was published in two volumes and included chapters dedicated to centering relationships to end violence, indigenous recognition of power and place, colonization as gender depression, and confronting it by exercising the rights to culture, health, security and justice, wellness and healing, valuing lived and frontline experiences. And before I get back to you, Dr. Gillson, I'm going to ask you, Dr. Roessel to tell me your thoughts about this.

Dr. Roessel:

Thank you. I think all of this information and what we're talking about is really significant, and sometimes people don't want to hear these kinds of statistics and issues that indigenous peoples are going through. So what I feel is that the essence of Dr. Gillson's case stands alone in terms of what she was dealing with and that portrayal. And our statistics that we're discussing really brings the awareness of the fact that there is a crisis with missing and murdered indigenous women and girls. And much of what we need to be doing and what we're going towards is getting a database because we don't really even know that what the numbers are at this point. And that's what the national inquiry in Canada has recommended as well. They even have a chapter in appendix talking about man camps because they recognize that this is a real issue.

And so the other things that were recommended and that I think that we need to really reinforce and help encourage is that traditional roles of feminine and masculine for indigenous peoples really needs to be reinforced and supported because this is something that we've been dealt with and a portrayal of that colonization that we've gone through. And as well, just traditional practices ceremony, we really need to get back to that and all of that can be helpful too, to address this crisis and to be proactive as we're doing now, to share this information, talk about it. It's something that we need to have that awareness of, but because of how things are structured in organizations, in our country, because we are perceived as even maybe not even existing any longer as indigenous peoples, these kinds of issues are really not discussed or talked about. So I really appreciate that this is a discussion we're having today.

Sanya Virani:

Thank you, Dr. Roessel and that's a very fair point. Now, back to you, Dr. Gillson.

Dr. Gillson:

Yeah, and I think another thing when we're talking about the sexual violence in Indian country, kind of like Dr. Roessel had commented, is really the, there's so much traditional knowledge that's being passed on from generation to generation to combat sexual violence. And it looks very different from what maybe the mainstream United States government would consider. But one of the things is that this, our traditional culture and our traditional knowledge helps us fight and work on the issues that we find important, like the pandemic, for example. So sexual violence is similar, where there's a lot of grassroots initiatives. There's a lot of advocates really working on this because indigenous women experience the highest rates of sexual violence. The most compelling statistic is one in three native women will be raped in her lifetime. This figure is originally from the National Violence Against Women's Survey in 2000, which actually showed 34.1% of participants experienced sexual violence.

So it's actually more than one in three. And it's really difficult in general to get data on indigenous people because a lot of times they're excluded from research. They experience a lot of blatantly wrong reporting. 40% of indigenous people who die are actually misclassified by coroners. The other really interesting thing is that most rapes in the United States are interracial, meaning that victims are attacked by the person who shares their race. And an exception to this rule is indigenous people who report their perpetrators are non-native. And some studies actually suggest it's up to 70% of the perpetrators are white. And so a lot of this we already talked about has been increasing in popular press. We're getting a little bit more traction on it. We even have a day to commemorate missing and murdered indigenous women. And Sarah Deer, who's a Muscogee Creek lawyer, she points out sometimes we talk about this issue as an epidemic, and really that way of looking at it absolves the blame on society and suggests that it's more a biological problem. But really this is a crisis of human origin.

Sanya Virani:

That is very illuminating, and thank you for sharing that there is a day to commemorate. I just looked it up and it happened to be May 5th. But back to our discussion, I think it brings us to questions about intersectionality of cultural identity a little bit, how a person would view themselves and how they would interact in dominant society. So question is really do they try to integrate themselves or just keep up their background? And then the flip side of facing all of the suppression is that some people would just turn potentially distrustful and begin to isolate on reservations. So on that note, what do you think Dr. Gillson could have been done to help this indigenous woman? And then what could have been done to the perpetrator?

Dr. Gillson:

Yeah, those are both really great questions. And I think a lot of the historical documentation that we have going back prior to colonization really shows that there probably still was some sexual violence experience in indigenous communities. A lot of it is really rampant when colonization happened, but what we can see from some of these, some of the documents is that when an indigenous woman experienced sexual violence she was prioritized. What did she think that the perpetrator, what did she think that was the best way to deal with a perpetrator? And so I think now thinking about that is really more an indigenous lens, and it also sounds like she needs some mental health care, whether that's from a psychiatrist or traditional healing. I think the other thing that she needs is justice like we mentioned and so this is kind of a sticky subject. Tribal governments were stripped of their power to prosecute and punish non-natives for crimes that were committed on indigenous land.

This was in 1978 by the Supreme Court ruling Oliphant and Suquamish Indian tribe. So this essentially made it so tribal courts have no authority over non-native people if the crime was committed on indigenous land. So we saw a lot of non-native men who maybe would rape our indigenous women on tribal lands, they would completely be absolved of this criminal activity. This specific goal was addressed in 2013 after years of indigenous grassroot organizations and advocates protests, and now there's a federal legislation for tribes to be able to prosecute victims of domestic violence but not rape. And so the loophole here is that the perpetrator must have quote, sufficient ties to the tribe. So this is a huge improvement in the legislation, but it still has a long way to go. So kind of answering your question on what can we do for justice for our woman here? And it really depends how well she knew this man or if she knew him at all. And also, very few non-native people have actually been on trial with this new law.

Sanya Virani:

And it took people only 35 years, 1978 to 2013 to make this improvement in the law. Anyway, what is your take on these laws and the way they have been structured and revised Dr. Roessel?

Dr. Roessel:

Well, to me, it really takes the perpetrator off the hook, and the indigenous people are really not considered so I feel that the indigenous person's viewpoint and experience is really not taken into consideration with these laws, despite that we have an Indian law section when lawyers go to law school. It is very complicated Indian law. And so those are the things that we need to think about as well. The law really helps the perpetrators get off the hook. That's why there are repeat offenses often with some of these perpetrators because they know that they won't be perpetrated. And the federal law, it's called the Violence Against Women Act, and it was first, well, it was reauthorized in 2013, but in terms of recent, like last year in 2019 only the Senate didn't reauthorize it. So again, this is probably why it's taken so long to have some of these laws passed, is there's really no interest in our Senate, in our

Congress to move forward and have justice served for indigenous peoples, especially when it comes to violence against us.

Sanya Virani:

Thank you for sharing that. This is all very interesting, and I, for one, has certainly learned a lot from whatever it is that you both have shared on this episode. So with that we come to the end of our seventh episode of Finding Our Voice, the final one of this very first segment dedicated to issues of structural racism among minority and underrepresented ethnic groups. Our deepest gratitude to our guests. Finding Our Voice would not have been possible without help. From Dr. Jeffrey Borenstein, who is the editor in chief of Psychiatric News. I'd also like to thank Dr. Francis Lu, my mentor, who has been on this project with me, guiding me at every step along the way. And finally, I'd also like to thank APA Publishing for being instrumental in recording, editing and releasing this podcast.

Speaker 4:

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