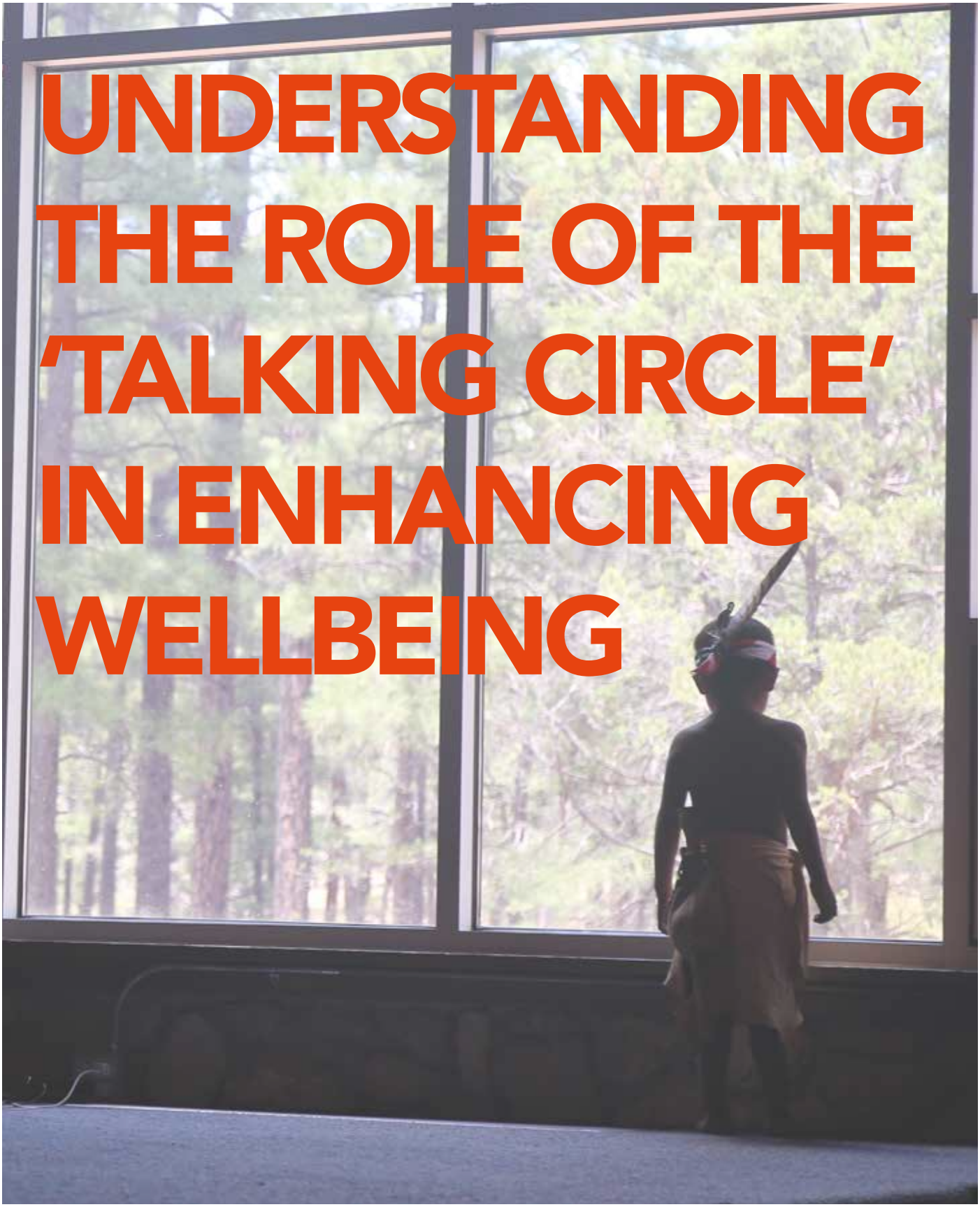

UNDERSTANDING THE ROLE OF THE 'TALKING CIRCLE' IN ENHANCING WELLBEING

Dr Sophie Redlin

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Acknowledgements

I cannot thank the Winston Churchill Memorial Trust enough for the opportunity to engage in such a professionally and personally life changing experience. Their unwavering support and belief in my ideas and hopes for the project have made the most incredible journey possible.

Similarly, nothing would have been achievable without the time, generosity, kindness and interest of so many in the United States:

Orono, Maine
The first mention must go to Dr Lewis Mehl-Madrona, a friend and mentor, who not only provided my first real introduction to American Indian culture but also provided the inspiration to develop the idea initially and the encouragement to follow it through. I would like to thank him and his wife Barbara for hosting me and the Wabanaki Clinic and Penobscot Indian Health Centre for allowing me into their space to observe. To all the physicians, healers, workers, beaders and community members; thank you for allowing me to learn from you.

Anchorage, Alaska
My time in Alaska was largely shaped by the fantastic team at SouthCentral Foundation. Everyone from their CEO Katherine Gottlieb to my fantastic fellow learning circle members; André, Danielle, Brenda, Harrison and Trésia, made me feel so welcome and created a conference unlike any I've experienced before. I would also like to say a special thank you to the community members who accepted me into their talking circles the following week. Hearing your stories, many so difficult, and having the opportunity to share my own was an honour I won't forget.

Oahu, Hawaii
To the many friends and connections I made in this beautiful place; thank you for pushing me and challenging my perceptions and ideas on healing. Every encounter was a joy. A special mention to Dr Kyle Chang at Waianae Coast Comprehensive Health Centre for allowing me the great privilege of being a part of the Substance Abuse Treatment Graduation ceremony and to Dr David Derauf and Jeffrey Acido at Kokua Kalihi Valley Clinic for sharing your inspiring work.

Tucson, Arizona
To my 'Arizona Family' Carlos and Deb, thank you for your incredible hospitality and belief in me and what I am trying to achieve. Along with Pete, you gave me the greatest gift in allowing me to share in ceremony with you all. The experience was truly transformative. A huge thank you also to Alberta, Miguel, Leila and Ingrid, Patrisia and Tommy for taking the time to speak to me and share your knowledge.

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Executive Summary

Background:
Psychosocial problems make up at least 20% of all GP consultations(1). Many of these do not require 'medical' intervention but people in distress are struggling to find support outside of the health system. As a GP I have seen this first-hand and am convinced that the weakening of community is undoubtedly contributing to the current mental health crisis in the UK.

While researching the relationship between community and mental health globally in 2016, I was exposed to the American Indian culture; indigenous values and an alternative approach to viewing and managing emotional distress. In the hope of seeking out practical ways to rebuild lost support systems and offer more effective care options for patients, I applied for a Churchill Fellowship to explore the impact of culture on wellbeing and the role of indigenous healing practices in mental health management.

I was introduced to the 'talking circle' through the work of Dr Lewis Mehl-Madrona. Many overseas indigenous populations practice 'talking circles'; a form of ceremony that empowers a community to provide collective support to individuals through the sharing of experiences. There is evidence to suggest that there are benefits to incorporating such practices into both native and non-native modern society and that the practice may serve as an alternative way of supporting those in emotional distress.

Methodology:
Hoping to make an assessment of whether such a practice would be transferable to a UK primary care setting; I travelled to Maine, Alaska, Hawaii and Arizona to meet healthcare professionals practising both traditional and Western medicine and serving both native and non-native populations. In each location I shadowed my hosts and conducted structured interviews. In Alaska I also participated in the NUKA Care Conference at SouthCentral Foundation.

Key Findings:
1. Spirituality impacts health and wellness
2. Holistic care is achieved through the use of the medicine wheel
3. Our perception of distress influences how we experience it
4. It is important to consider historical context when managing emotional distress today
5. Traditional 'healing' practices are not reserved for the sick and bridge the gap between healthcare and the community
6. It *is* possible to successfully integrate traditional practice into a western healthcare model
7. We've forgotten how to talk to each other: storytelling is important in healthcare
8. It is through the understanding of how hope has been lost that it can be put back

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Recommendations and Building a Solution

From my key findings I would recommend that an approach to improving emotional wellbeing in the population should comprise of the following three elements or channels:

1. Increase day to day wellbeing of the population: introducing the idea of 'spirituality'

As a health system and population we need to be more preventative and less solely reactive when it comes to maintaining our emotional health. My findings suggest that enhancing our sense of spirituality; namely how connected we feel to each other, our values, our roots and our environment, can bolster our mental wellbeing by providing a sense of meaning and hope.

2. Rebuild community support networks that have been lost

There is a wealth of life experience within our communities that historically would have seeded informal support networks and intergenerational mentorship. This resource currently goes largely untapped and yet, if reignited, could serve as an effective way of preventing and responding to the multitude of social and emotional problems seen within our population today.

3. Challenge the way we view and manage emotional distress within the health and social care setting

The connection between our story, namely what has happened to us and those who came before us, and why we experience emotional distress is poorly understood in the west and is certainly as a concept not given priority in healthcare assessment and management. If we were to take a more narrative-focused approach in primary care and view distress within the context of a person's story and not simply as a symptom in isolation, my findings suggest that the impact of the distress would be lessened and better tolerated. This change of mindset would also facilitate the cultural shift needed for new and more holistic management solutions to evolve.

I have designed an alternative and community-orientated approach to improving emotional wellbeing based on my fellowship learnings that seeks to address these three channels: **The Three Channel-Talking Circle (3C-TC).** Drawing on some of the underlying principles of American Indian and Alaska Native talking circles, the 3C-TC is both ***driven by*** and ***forms a response to*** the three key channels outlined above while remaining culturally relevant to a Western population. Whether facilitated as part of a regular programme or as an activity in isolation the 3C-TC provides a safe space for participants to share their experiences and offer each other peer support.

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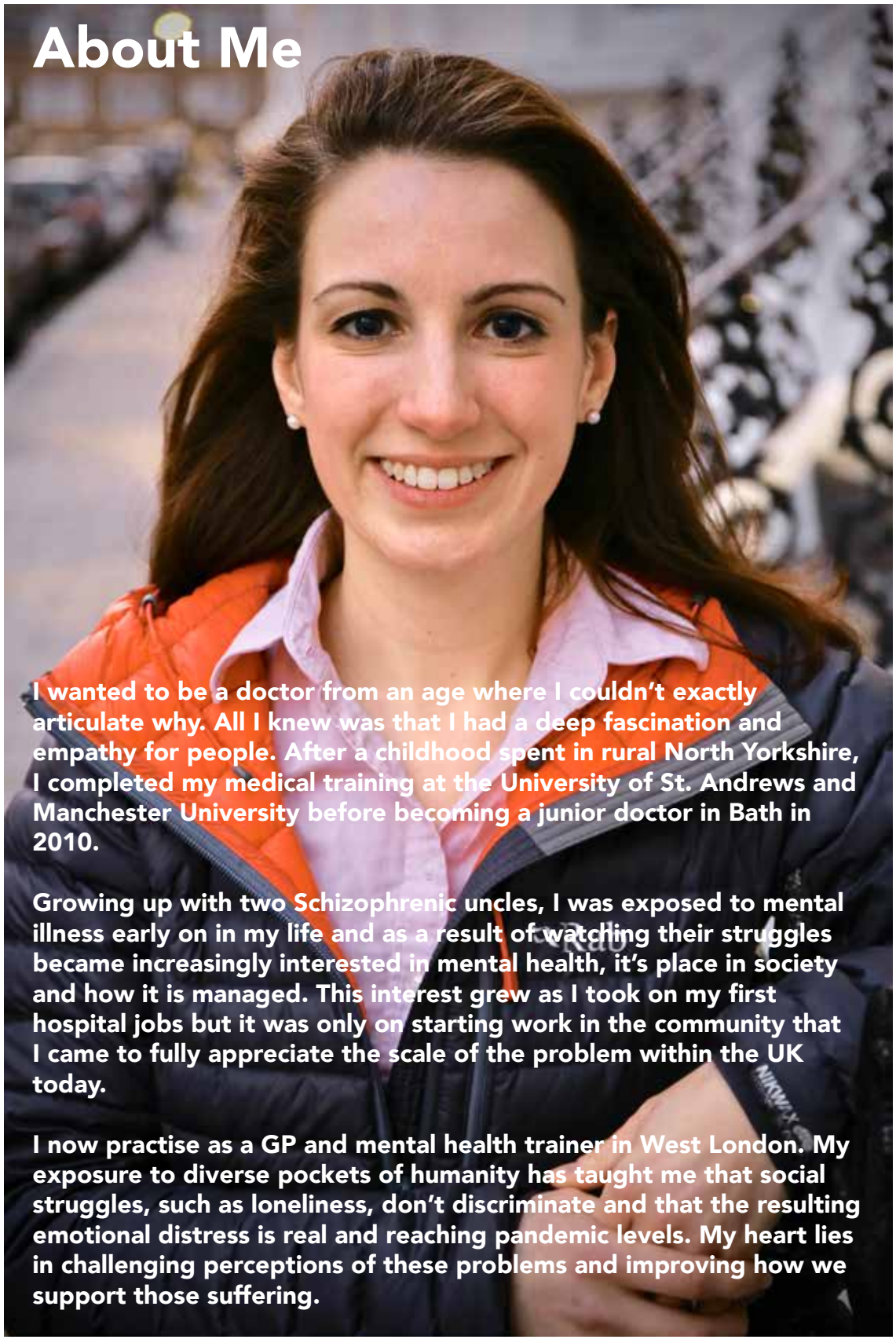
About Me



I wanted to be a doctor from an age where I couldn't exactly articulate why. All I knew was that I had a deep fascination and empathy for people. After a childhood spent in rural North Yorkshire, I completed my medical training at the University of St. Andrews and Manchester University before becoming a junior doctor in Bath in 2010.

Growing up with two Schizophrenic uncles, I was exposed to mental illness early on in my life and as a result of watching their struggles became increasingly interested in mental health, it's place in society and how it is managed. This interest grew as I took on my first hospital jobs but it was only on starting work in the community that I came to fully appreciate the scale of the problem within the UK today.

I now practise as a GP and mental health trainer in West London. My exposure to diverse pockets of humanity has taught me that social struggles, such as loneliness, don't discriminate and that the resulting emotional distress is real and reaching pandemic levels. My heart lies in challenging perceptions of these problems and improving how we support those suffering.

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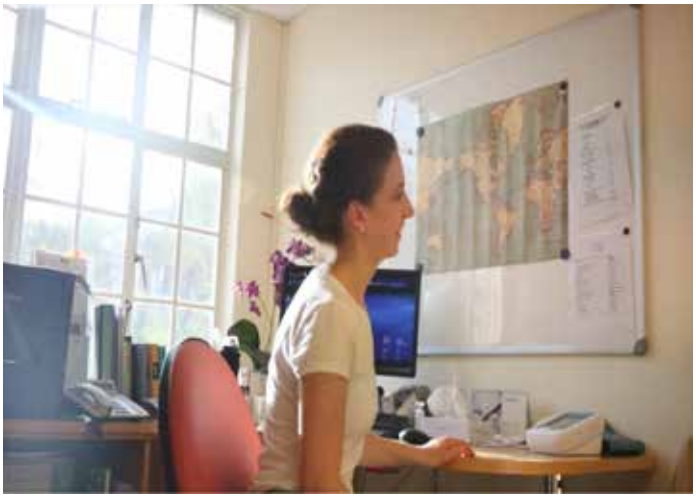
Introduction



It was 11am on a Tuesday morning and I'd already seen two patients complaining of loneliness that week; an 80 year old and a new mother respectively. My 11:00 patient walked in five minutes late and flustered. She was French, fairly new to London and spared me any further introduction before launching into her current concern: she was having difficulties with her house mates and struggling at work. As the minutes ticked by and the tale continued I kept waiting for the punchline; convinced we would get to her depressed mood or sleeping issues sooner or later. But we didn't, and quickly it became apparent that she was here because she lonely; isolated by a challenging life situation that was understandably causing her distress and in the absence of other mechanisms of support saw me, her GP, as the only source of help available to her.

When she booked a third appointment in two weeks for the same problem my supervisor called me into his office afterwards to discuss her frequent attendances. On discussing the case and in particular whether any of the pathways we had available to us, such as NHS counselling, would be suitable, he advised me that he didn't feel I had much to offer her in a medical sense and while he and I both believed in the benefits of providing a listening ear alone I was reminded that the justifiability of the time spent in the current NHS atmosphere had to be a consideration.

And so with my meagre suggestions that she 'take up a hobby' and look up mindfulness online, I let her go. Over a year later I happened to see her name on an emergency telephone call list and opened her file to see how she had been. I was saddened to see that she had presented distressed by suicidal thoughts only a few weeks ago to another GP. She had, of course, at this stage been channelled into the mental health pathway, been offered assessment and started on an antidepressant.

Looking at this objectively, I couldn't fault the care that she had received in the end; she had presented with a set of symptoms and had been managed as per protocol. However, I couldn't help but feel that she had been failed in the early stages; both by an inflexible health model that is simply not equipped to acknowledge the importance of social determinants and emotional distress on the progression of mental health problems but perhaps more so by a society that has forgotten how to talk and how to support one another.

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How it all began...

In the healthcare world I'm not alone in having experienced this clinical scenario. Studies suggest that psychosocial complaints play a part in at least 20% of GP consultations(1) while MIND's latest study finds that 40% of GP appointments involve a mental health complaint(2).

Research also finds that psychosocial problems and somatic problems that have a psychological background make heavier demands on the GP's workload than other consultations(1) and that consultations are longest for women patients seeing GPs in urban practices about problems that doctor and patient perceive as psychosocial(3).

In the public arena, awareness of emotional distress and poor mental health is also growing, but where is this rise in emotional distress rooted and what are the gaps both in our society and healthcare system that are enabling its growth and lack of resolution?

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Page last updated at 12:00 GMT, Monday, 1 December 2008

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Life in UK 'has become lonelier'

Latest news | Isolation map | League table | Streets apart | North po

By Mark Easton
BBC Home Editor

Community life in Britain has weakened substantially over the past 30 years, according to research commissioned by the BBC.

Analysis of census data reveals how neighbourhoods in every part of the UK have become more socially fragmented.

The study assesses the health of a community by looking at how rooted people are in their neighbourhood.

Edinburgh's Holyrood district is among the loneliest places to live, the study says

Changes in society lead to community breakdown

With the rise of globalisation and technology the world has become smaller, more accessible and more attainable. However, the flip-side of the coin of opportunity is a cultural shift that has made way for the 'ills of modernity': disconnection, isolation and loneliness (4). In a capitalist society that increasingly values individualism over collectivism; family and community structures now appear very different to how they did even 50 years ago. As the number of single-person households in the UK increases (to 7.7 million in 2017), so do feelings of isolation and the emotional distress that accompanies them and as we increasingly focus our interactions online with real and tangible support networks dwindling, as westerners we now find ourselves in a lonely world of our own design.

Seeking support

The options for getting help when in emotional distress are not as multiple as they once were. In many areas of society we have moved away from behaviours that brought with them a sense of community and mentorship, such as religious routines. Research suggests that such practices not only provide people with a sense of belonging but also play a role in how people experience and deal with difficult life situations(5). With a reduction in these informal community-based support pathways alongside a growing distance between friends and family, people in distress are turning more and more to the health system for help.

theguardian

Faith no more: how the British are losing their religion
Andrew Brown

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What can our health system currently offer and where is it failing?

The Doctor-Patient Consultation

When consulting with patients, the need for a 'person-centred' approach that takes into account social factors potentially contributing to distress, has been historically recognised and is increasingly a part of medical school and postgraduate training. Psychoanalyst Michael Balint, working in the 1950s, coined the phrase 'the doctor as the drug' when trying to help GPs understand the importance of offering an emotional connection to patients and today the Royal College of General Practitioners outlines in its educational priorities the need for trainees to have a 'willingness to enter their patient's "life world" and to see issues of health and illness from a patient's perspective; considering social, cultural and educational differences.'(6)

Research also confirms the 'unquestionable importance' of the physician empathy and patient empowerment that likely results from a patient-centred approach (7), and yet in reality this element of the doctor-patient consultation is usually the first to suffer or be absent as time constraints and pressures increase within the NHS. This therefore likely becomes the first place where people in emotional distress fall through the health service net.

The 'Mental Health' Pathway

Despite an increasing acknowledgement of the impact of psychosocial factors on health, emotional distress in its early stages remains a common and yet difficult presentation to manage in General Practice, due to the lack of available resources and support on offer. Strategies such as social prescribing are on the rise but until this practice becomes commonplace, many GPs remain unable to offer anything in between their own conversation and a more 'medicalised' pathway such as medication or psychological therapy. This 'lack of middle ground' leads by default to an often inappropriate labelling of distress and risks the initiation of treatments that are ineffective and the over-satiation of therapy services resulting in poor availability for those who require that level of care.

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Embarking on the journey towards solutions

As a training GP working in central London, I found myself inundated by patients similar to the young woman described in the case study above and, like many of my colleagues, I found myself questioning what role I could or should take in situations such as hers. I knew that in the absence of other support I had to play a part in their journeys and yet deep down I was aware that as a doctor with limited time and resources I wasn't the ideal person to be doing it. The solution, at least in part, had to come from outside the healthcare system.

Working in an urban setting amongst a transient and disconnected population, the roots of ills such as isolation and loneliness were obvious and yet it was the untapped potential of that same community that really interested me. I saw people every day, young and old, who all had one thing in common: a wealth of life experience. But for the most part, this experience was going largely underutilised and I was aware that in the past this likely wouldn't have been the case. It would have been a source of support.

I decided that I wanted to look to the rest of the world; to try and really unpick how the structure of a community impacts the mental wellbeing of those living in it and at the same time search for examples of alternative community-based methods of supporting those in distress. In 2016 I took time out of training to travel to a series of geographically and culturally contrasting communities across the globe. Through time spent with doctors and patients in **Orkney**, **Norway**, **Japan** and the **United States**, I learned that community and culture were crucially intertwined and that both had a great influence on mental and physical well being. In communities that were more cohesive, either because of geography or cultural values, I observed informal support networks

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and mentorship that undoubtedly enhanced and protected the mental health of the people living there. While I might have made this assumption before travelling, I had not foreseen how large a role culture would play in the perception and management of distress in the places I visited. It was in the combination of these two factors that I saw the potential for learning and change-making in our own environment.

While on the United States leg of my journey three years ago I had the privilege of spending time with an Indian Health service doctor familiar with the American Indian culture. He described their traditional values, common among many indigenous populations, and how those values shaped the interpretation and management of emotional distress in the American Indian population. The idea that our approach to relieving distress might be influenced not only by the resources to hand but also by how we frame it in the first place fascinated me. In American Indian culture, distress is often viewed in terms of its social determinants rather than as a 'medical problem' per se. This attitude gives rise to a number of management techniques for supporting those in distress that are more holistic in nature and more community-based in practice.

It was in reading about these techniques, particularly the 'talking circle': an American Indian practice used for a number of reasons ranging from healing to resolving conflict, that I saw the real potential for learning on my journey to seek out alternative ways of supporting those in distress. Might there be elements of traditional indigenous practices that could be used within a western population to bridge the gap between health and social care, offer people a non-medicalised alternative approach to solving their issues and empower communities to once again support each other through their own lived experience? I had to find out.

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The 'Talking Circle'

In 2018 I came across Dr Lewis Mehl-Madrona's work describing healing practices from Lakota, Cherokee and Cree traditions, and how they intersect with conventional medicine. Lewis is of Lakota and Cherokee heritage himself and practises family medicine in the United States. In his paper, *'Introducing Healing Circles and Talking Circles into Primary Care'* he describes the North American Aboriginal talking circle:

"Talking circles, peacemaking circles, or healing circles, as they are variously called, are deeply rooted in the traditional practices of indigenous people. In North America, they are widely used among the First Nations people of Canada and among the many tribes of Native Americans in the US. Healing circles take a variety of forms, but most basically, members sit in a circle to consider a problem or a question.

The circle starts with a prayer, usually by the person convening the circle, or by an elder, when an elder is involved. A talking stick is held by the person who speaks (other sacred objects may also be used, including eagle feathers and fans). When that person is finished speaking, the talking stick is passed to the left (clockwise around the circle). Only the person holding the stick may speak. All others remain quiet. The circle is complete when the stick passes around the circle one complete time without anyone speaking out of turn.

The talking circle prevents reactive communication and directly responsive communication, and it fosters deeper listening and reflection in conversation. It also provides a means for people who are prohibited from speaking directly to each other because of various social taboos to speak and be heard. Healing circles are often called hocokah in the Lakota language, which means a sacred circle and is also the word for altar. The hocokah consists of people who sit together in a talking circle, in prayer, in ceremony, and are committed to helping one another and to each other's healing."

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Lewis goes on to relay how the talking circle has traditionally been used 'as a way of bringing people of all ages together for the purposes of teaching, listening, and learning' and 'today is used throughout the country in tribal inpatient and outpatient drug and alcohol centres, group homes, adolescent prevention and intervention programs, prayer circles, tribal and public schools, and college-based English as a Second Language programs.'

Lewis's work, *'Introducing Healing Circles and Talking Circles into Primary Care'*, details the results of a case study exploring the impact of instigating a traditional talking circle within a conventional primary care setting. In this study he found that 'talking circles provide an opportunity for people to help each other without reliance on professional expertise and could potentially reduce health care costs by providing a low-cost forum for people to manage and to resolve stress-related and other life problems'. He also reflects that talking circles 'could become a useful adjunct to conventional health care and may fill gaps in meeting the need for mental health services'.

Aims and Objectives of the Fellowship:

Context:

Psychosocial problems make up 20% of all GP consultations. Many of these do not require 'medical' intervention but people are struggling to find support outside of the health system. As a GP I have seen this first-hand and am convinced that the weakening of community is undoubtedly contributing to the current mental health crisis in the UK. I am determined to seek out practical ways of rebuilding the support systems that we have lost in the hope of providing alternative and more effective care options for patients

Many overseas indigenous populations practice 'talking circles' which empower communities to provide collective support to individuals. There is evidence to suggest that there are benefits to incorporating such practices into modern Western society and primary care.

Aims:

1.To understand the role of the 'talking circle' within the day to day life of each population through immersion, observation and where possible participation and explore its impact on the wellbeing of the community.

2.To understand the mental health and psychosocial problems experienced in each population and how American Indian and Alaska Native culture impacts the perception and management of such problems.

3.To explore the potential for incorporating such a practice into western society in the UK as an alternative approach to mental healthcare.

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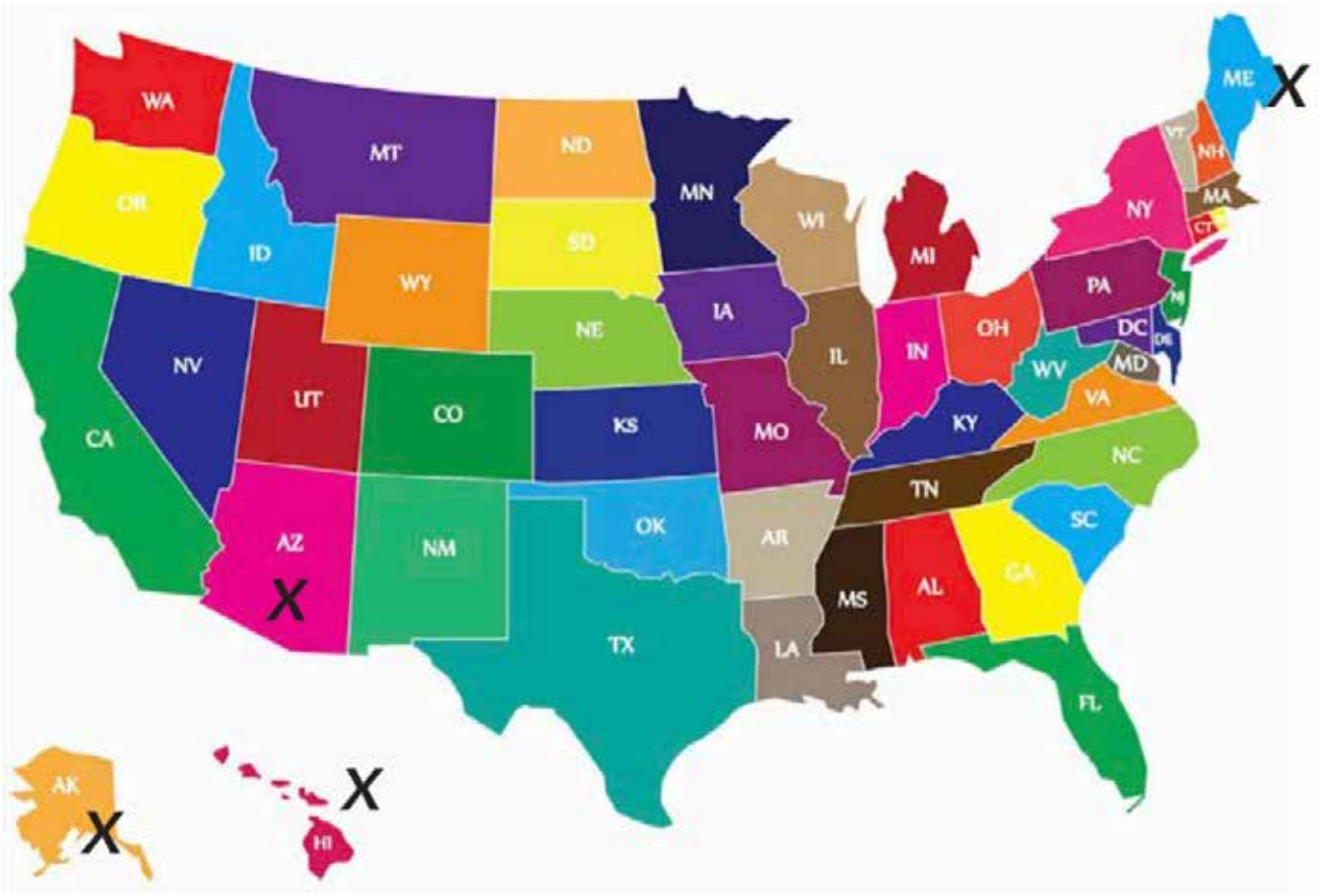
Locations



1. Orono, Maine: hosted by Dr Lewis Mehl-Madrona and Barbara Mainguy. Time spent at the Wabanaki Health and Wellness Centre and Penobscot Indian Health center

2. Anchorage, Alaska: hosted by SouthCentral Foundation for the NUKA Care Conference and community talking circles.

3. Oahu, Hawaii: hosted by Dr David Derauf at Kolua Kalihi Clinic and Dr Kyle Chang at Waianae Coast Comprehensive Health Centre

4. Tucson Arizona: hosted by Dr Carlos Gonzales at the University of Arizona

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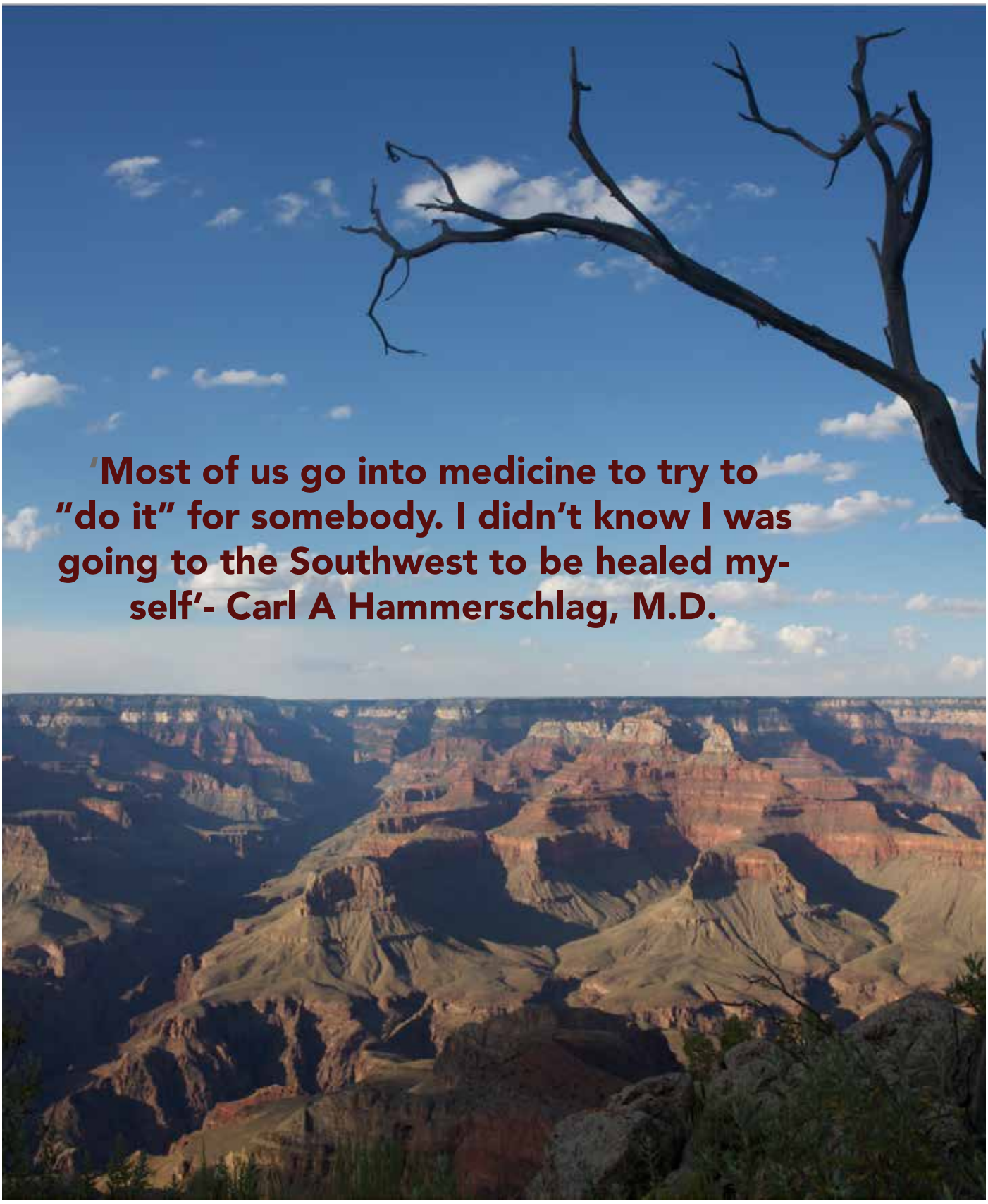

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Findings

In 1994 New York-based Psychiatrist Dr Carl Hammerschlag travelled to New Mexico to work with Pueblo Indians. He describes in his first few months there, a growing awareness that his need to be healed and to learn was as great, if not more so, than the skills and knowledge he could share with his patients.

Like him, I entered the American Indian culture with certain preconceptions that had been shaped by a Western upbringing and mindset. Little did I know on setting out that my fellowship would unravel into a journey of personal healing and a new perspective that would challenge many of my pre-held beliefs about both medicine and humanity.

I also knew little of how quickly my aims and objectives would stand out as limited and one dimensional against the richness of the cultures within which I was about to be immersed. Practices I'd spent months researching on paper, in the flesh contained so many more layers and complexities. Concepts were so much bigger than the few sentences I had attempted to squeeze them into and at times it was difficult to put all of the pieces together, to take on so much information and be patient for the puzzle pieces to come together.

With time I came to see that my initial agenda; to unpick the nuts and bolts of a traditional healing technique, would be meaningless without an understanding of the foundation on which such a technique sits. It is within this base layer, a collection of fundamental human values, that I found my learning. It is here that my ideas on healing were challenged and developed and it is here that I found the hope that change within our own society and health system is possible.

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Part i: How does culture impact health?

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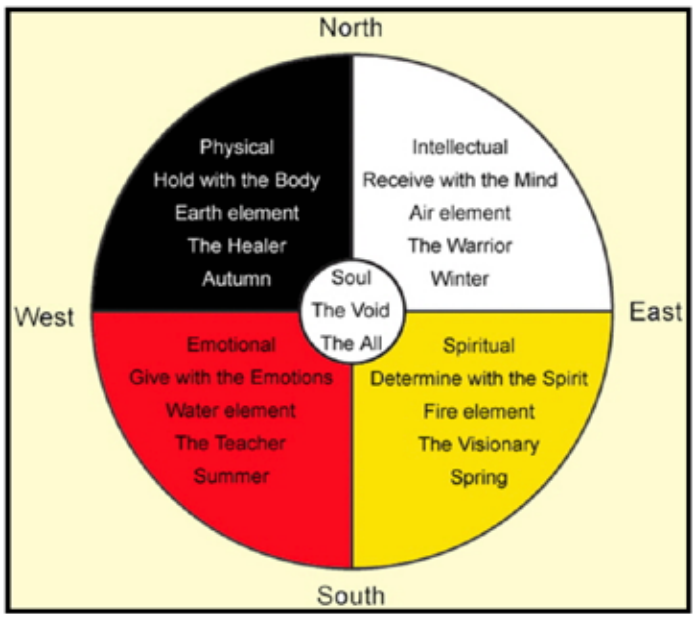
1. Spirituality

"Native spirituality is a belief system, an understanding of how we're connected to everything. Not just to people, our family and community, but also to nature and the elements. It's an understanding of how life works"

- Miguel Flores jr



Lewis Mehl-Madrona describes North American aboriginal spirituality as 'an underlying concept that permeates every aspect of Native American life' and in many ways this echoes the experiences I had myself when talking to people about what spirituality means to them and how, as a way of being, it impacts the health of the population. Coming from a Western society; at the beginning of my journey, my perceptions of 'being spiritual' were limited to, I'm ashamed to say, practising religion or living a somewhat 'alternative' lifestyle. The idea that spirituality could encompass and underpin not only a form of worship but also a way of being and living one's life was a new concept for me. I would come to learn that across all of the cultures I visited the idea of spirituality and how it impacted well being would be universal.

Learning about the American Indian medicine wheel was my introduction to the idea that in American Indian culture physical, emotional, spiritual and intellectual aspects of an individual are all connected and each play a vital role in the wellbeing of a person. Within the American Indian culture, living a 'happy' and fulfilled life is about striking a balance between these elements. They believe that the key to achieving this is to find meaning in life through the values that underpin their culture, namely; a connection to the people around you as well as those who came before and those who will come after; a connection to your environment and appreciation for the planet that supports us; a connection to your own history and the history of your people told through stories passed down through generations and for many a belief in a higher being. To be deficient in any of these areas is to be imbalanced and to run the risk of experiencing poor health.

How does spirituality, as an element of indigenous culture, impact wellbeing and how is it honoured in healthcare settings?

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"I'd been surprised on walking through the clinic doors that morning to be told almost immediately, 'let's get out of here and see where the real healing happens'. Now, standing amidst forested volcanic peaks and low hanging mist without a consultation room in sight, it did indeed feel like I was exactly where I needed to be to learn something new.

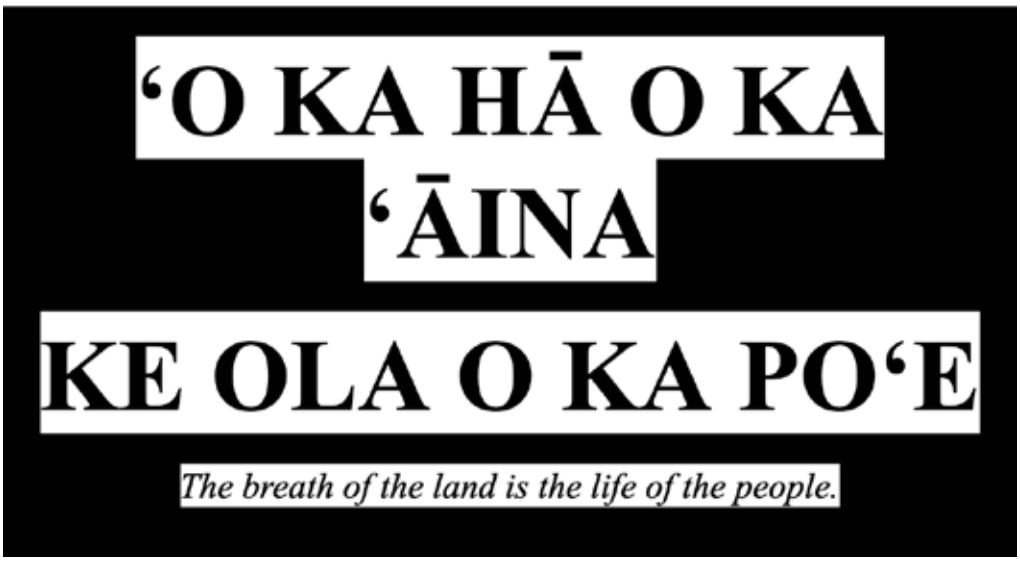
Gardens growing indigenous plants flanked me on both sides while next to the canoe- building workshop the final pieces of the native healing centre were being erected. Everywhere community members were scattered; planting, sanding, teaching.

My guides were David and Jeffrey, a psychologist and academic working in the clinic, who had grown up on Oahu but was Philippine by heritage. As we walked the land, they talked about Ho`oulu `Aina being more than a community garden; more than simply a place to bring people together. It was a space where people could find a connection to the history of their surroundings, they said, and through that connection find meaning and healing."

- Excerpt from my fellowship blog (www.thepatientsvoiceproject.com)

Ho`oulu `Aina, Kokua Kalihi Clinic, Hawaii

My time spent at Kokua Kalihi Clinic was a vibrant exploration of Native Hawaiian culture and an introduction to how spirituality formed the basis of both life and approaches to healing there.



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The primary care 'clinic' consists not only of rooms or offices as one might expect but stretches much further to encompass an area of land that has been purchased in order to include other more traditional forms of healing. Crucially, though, this land known as 'Ho`oulu `Aina' is not simply for the sick; it is for everyone and serves as a reminder of how living and staying well relies heavily on being connected to one's environment, history and community. In their own words:

"Ho'oulu 'Āina, means "to grow the land" and "to grow because of the land," based on the value that the health of the land and the health of the people are one"(8)

My host David Derauf, lead GP at the clinic, was not Native Hawaiian himself but believed implicitly in the power of the space and the activities going on there. A fundamental part of the idea behind Ho`oulu `Aina is its inclusivity. They believe that it is not only possible for Native Hawaiians to find meaning from the land but for all cultures to feel a connection to its history.

Community members are encouraged to tend the indigenous plant beds; to find meaning in the past that they represent and nutrition and connection in the present day dishes they fuel in the clinic's cafe, 'Roots'.

Alongside the abundant nature there are traditional structures such as the Hale, a Native Hawaiian thatched house and place for learning and reflection, as well as a traditional medicine centre where Native healers work alongside Western-trained medics to offer care that is truly holistic.

Daily learning activities take place on the site, with the purpose of offering the community further connection to the history of the land. I was lucky enough to stumble across a canoe- building workshop during my visit.

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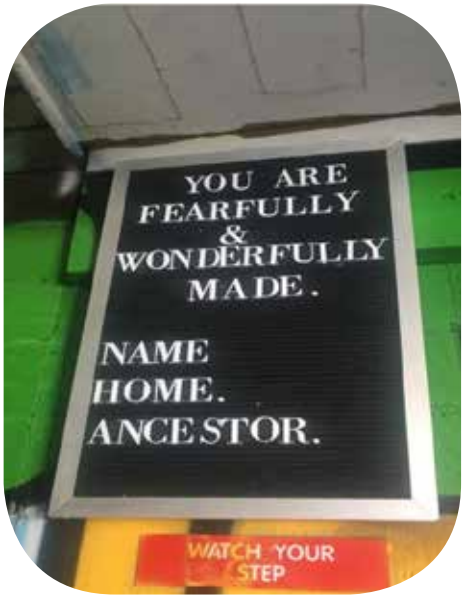
These workshops engage especially the younger members of the community in becoming a part of the heritage of Hawaii. It was wonderful to see again multiple cultures taking part, all finding their own relationship to what they were doing.

Healing through the reconnection to culture would become a key theme of my fellowship and at Kokua Kalihi Clinic particular emphasis is put on forging this connection for those who perhaps have not felt it before; for example, younger members of the community or those from other cultures. A way to start this process seemed to be the frequent invitation for anyone entering the clinic to share a little of their own history.



It is the custom in Kokua Kalihi Valley clinic to greet each other 'in circle' at the beginning and end of each day. The format of this practice is a 'talking circle' of sorts, however brief, and is an opportunity for each participant to share part of their story in turn and for others to listen. The 'subject' may be a hope for the day or a reason to be thankful but the crucial ingredient to all of the circles in this particular clinic is the acknowledgement of the importance of ancestry and roots.

One of the core concepts of Native Hawaiian spiritual belief is the power of the connection to ancestors. This is honoured in every circle that happens at the clinic through the 'bringing forward of an ancestor' when it is your turn to speak. Some believe this action evokes the actual presence of an ancestor in that moment while for others it is more symbolic; a way of feeling grounded and rooted to something in a world where it is so easy to feel lost. For those who take part, it doesn't matter because the result on the psyche is the same. In the mentioning of a family member's name you are at once connected to those who came before you, carrying with you their support but also the responsibility of honouring their memory.

This practice is commonplace among the youth programmes taking place at the clinic, such as 'KVIBE' and 'Pacific Voices'. The former started out as a bicycle repair exchange allowing young people to earn a bike by putting work into it's repair. The programme has now developed and offers a number of support structures to participants. On the day of my visit I found them learning about ethical contracts from a volunteer lawyer. Pacific Voices participants come together in the 'aloha circle' during their sessions, during which the young people introduce themselves and an ancestor, where they are from and how they are feeling. The after school club serves as a safe space for children to explore traditional culture and encourages mentorship between older and younger members. When I had first arrived at the clinic, my requests for people to define 'spirituality' for me were met with smiles. As I came to the end of my stay, I realised that the question to them must have sounded odd, a little like asking someone to define 'love' in one sentence and all it encompasses. Like love, I was beginning to see how it could mean something very different to all of us and yet universally be important and longed for.

Dr Sophie Redlin

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2. Perceptions of distress

"How do we help people who are simply suffering the slings and arrows of an outrageous life?"
- Dr Lewis Mehl-Madrona

I found the ongoing conversation within UK General Practice around what constitutes a 'medical problem' and what our role should be in supporting social issues echoed by the doctors I met in the US who were working at least in part with a Western population. We all shared frustrations around the lack of suitable pathways for people presenting in emotional distress and the often inappropriate medicalisation of complaints as a consequence. We spoke also of the growing Western preoccupation with the idea of 'being happy' and how it encouraged a lack of engagement in the realities of life and the building of self-resilience.

I was interested to learn that distress seemed to be viewed differently in many indigenous cultures and, as a consequence, those suffering were living a different experience of it.

'There is a sense that life has a lot of suffering in it so it's less the case of 'you have an illness' and more 'she has a lot going on, cut her some slack'
- Barbara Mainguy

With perhaps more recognition of the 'heartaches of life', many communities still feeling the legacy of historical traumas, distress seemed to be in comparison more accepted and accounted for. Even afflictions that have ravaged many native communities, such as alcohol abuse, are in some cases more tolerated than they would be elsewhere, as people are able to see the reasons behind it.

In terms of mental health I had not considered fully before how the perception of a 'symptom' might impact how it is experienced by the sufferer. Yet there were comparisons I could draw between emotional distress and 'physical health symptoms'. For example when it comes to pain; a headache when it is known to be due to tension can be experienced very differently than one known to be due to a tumour.

I was most interested to see how this followed through to what we would consider more serious symptoms of mental health and, in truth, this did challenge me. Long have I campaigned for a changed perspective on emotional distress in its mild forms but the idea of looking at symptoms of psychosis, for example, in a similar light was new to me.

"I had the privilege of spending a morning there, talking to staff and some of the community members who frequented the clinic. Unknowingly and not really meaning to, I took my 'British NHS doctor hat' into the room with me. Used to having to define people by their symptoms and whether they fit criteria in our current system, on being shown the centre's list of group sessions and activities I found myself asking the peer support workers about their 'roles and training' and the 'common diagnoses' they see. I could have kicked myself as soon as I'd said it as it quickly became apparent that those things weren't of importance here. My reaction was met with patience but firmness: 'those questions aren't asked at the centre and the answers aren't relevant."
- Excerpt from my fellowship blog (www.thepatientsvoiceproject.com)

Wabanaki Health and Wellness, Orono, Maine.

Wabanaki Health and Wellness Centre sits in downtown Orono and is a haven for Native Penobscot people in the area. It's generally accepted that people coming to the clinic will have experienced some form of trauma and may in conjunction be suffering with addiction. All forms of distress are expected and in turn tolerated. People are not defined by these details when they walk through the door; they are seen as a person needing to tell a story, not a patient with an illness.

While I know I would have claimed to be a preacher of this methodology before and an impassioned campaigner for a person-centred approach when talking to patients, my initial reaction to the centre's style tells me that certainly in my professional life I am not used to the luxury of being able to treat patients in this way. I want to know their story, believe me, but in the current way we have to work, finding a way of allowing them to tell that story in full can sometimes seem impossible.

As conversations continued in the centre my attention was drawn to a group activity on the schedule called 'sharing visions'. I assumed this was a group for people experiencing psychotic hallucinations but again my Western mindset was met with the explanation that 'this was not how the group was seen'; I was advised that it was not about defining people in terms of a diagnosis but about seeing them as people with a certain kind of story who might benefit from sharing that experience with others. Help for them, they explained, didn't come in a 'one-size fits all' package, it came in a variety of forms, unique to each individual. The agenda wasn't to 'fix people' but to help them live their lives in a meaningful way.

While excited by their ethos, I couldn't help but get stuck on the idea of symptoms such as hallucinations being seen as purely 'an experience' rather than a diagnosable mental illness. Having grown up with Schizophrenic twin uncles I'm not a stranger to the chaos and dysfunction such problems can bring about and whilst I completely agree that for many people in distress medical diagnoses are made inappropriately, I can't help but think that in the case of severe psychosis there is a need for the term 'illness' and the response that triggers.

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" We know that 1 in 10 people will experience some form of 'hearing voices' in their lifetime. In Native American culture, such experiences are often seen more as a 'spiritual emergence' than an illness. There are Native American musicians who have albums called 'Inner voices' for example. I've worked with people with a diagnosis of Schizophrenia so I'm aware of that way of looking at it. But that seems to be the dominant paradigm. I'd like to see Westerners expand their minds and not necessarily see it as 'what's wrong with you' but maybe 'what's trying to get out'"
- Peer support worker, Wabanaki Health and Wellness Clinic

The concept of psychotic symptoms really being the communication of spirits is hard for us, as Westerners, to swallow; we have not been brought up in the American Indian culture. But the seed this idea plants, the encouragement to think bigger and more 'out of the box' when it comes to mental health is a useful one.

The value in being at the centre, for me, was not necessarily in learning about the idea of voices as spirits trying to emerge but in the reminder that how we frame a 'symptom' or 'experience' in our minds directly influences how we respond to it. Through the framing of auditory hallucinations within a cultural context in this way, the distress associated with them was lessened. They were an accepted subject to discuss and through the sharing of these experiences people were able to be open to actual tangible help that made a difference in their lives. 'Treatment' for them wasn't simply about 'stopping voices', it was about living with them and improving their quality of life in other ways. Wabanaki Health and Wellness focuses on this idea of quality of life and, for those still looking for meaning behind their experiences, draws on traditional and cultural beliefs to serve as an anchor to give them hope.

"When it comes to poor mental health there can be surprising trends in recovery when you compare industrialised nations and under-developed nations. This isn't just down to issues around resources but more about how we approach problems and how they are labelled. In under-developed nations often the first response isn't drugs or diagnoses, it's more about how can we help this person with what is going on in their life."
- Peer support worker, Wabanaki Health and Wellness

Fundamentally, by calling visions or hallucinations a 'spiritual emergence' you allow something to be expressed, whatever that might be, via a story that makes sense to a person at that time. American Indian culture is, at its heart, about sharing story and while I'm still getting my head around this way of framing of psychosis, how they use story to frame and interpret less 'severe' forms of emotional distress is something I can definitely get on board with.

"There's more tolerance of 'strange' behaviour in Native American culture. People are more accepting; if you're weird uncle Fred you're still family, and you still have a place."
- Dr Lewis Mehl-Madrona

Emotional distress is deemed part of the story of the person experiencing it; a product of and response to the things they have been through. Depression, anxiety, suicidal ideation are all very real and sadly incredibly prevalent in native culture but in the traditional view, they are not seen as isolated 'illnesses', but as reactions and coping mechanisms around trauma.

This acknowledgement of what many people have been through coupled with a lingering sense of the 'community protecting its own' leads to a higher tolerance and acceptance of distress and a reduction in ostracisation and stigma.

3. The importance of historical context in managing today's emotional distress

"As the week has progressed in Orono, I've come to learn more each day about the native people living in the area and have in turn been able to make some sense of the lack of welcome at the beading group. The Penobscot peoples' story as a tribe and as a wider nation is a tragic one and having been made aware of some of the details, whilst I have not personally wronged them, I can more than understand their lack of trust. Frankly, I'm astonished I received the kindness that I did; I'm not sure it would have been unreasonable to leave me struggling with that needle and thread all night."
- Excerpt from my fellowship blog, www.thepatientsvoiceproject.com

Gaining insight into the history of the people I spent time with, in particular the traumas that many tribes have faced and continue to feel the repercussions of today, was the most difficult but probably the most important part of my journey. Although some of the stories were 'historical', they were ever present in the lives of the people I encountered and getting to know them was crucial in not only forming deeper connections but in order to fully understand how history has impacted the wellbeing of the people and shaped the health problems some experience today.

The impact of past traumas on present day American Indians and Alaska Native people is complex and multi-factorial; firstly, it's important to note that many of these 'past events' actually occurred very recently in historical terms. For example, Indian children were still being removed from their parents and forced into white foster care as late as the 70s and it wasn't until 1978 that a law was passed deeming it acceptable for American Indians to 'believe in whatever God or spirit they so choose'.

In terms of death tolls through war and disease, as a result of colonisation, there are horrific figures to be found. However, as many American Indians alluded to in conversation; it is perhaps the killing of cultural habits and practices that has had the most profound and damaging effect. The cultural genocide, as I often heard it called, evolved sometimes subtly with the gradual depletion of land and instigation of land ownership restrictions. At other times the moves made by Western settlers were dramatic and devastating; removing Indian children from their families, banning the use of Native languages and religious practices and displacing whole populations to lands that were not familiar to them and where they could not sustain life in a way they were used to.

I was familiar with the concept of 'historical trauma' in terms of 'inherited' mental health

problems before embarking on my fellowship but I hadn't previously considered the idea that seemingly 'modern' issues and behaviour patterns can also be directly related to the influence of past events. It was both fascinating and disturbing to explore and come to understand the historical roots of these issues and to put into context many of the stories I had heard and witnessed on my journey.

Decades of being penalised for their beliefs and culture and having to rely on handouts to sustain life has devalued many American Indians' views of their own worth and the worth of those around them, mirroring how others have perceived them historically. This in turn has enabled devastating abuse within tribes, often repeated with every new generation, as well as tolerance of abuse inflicted by those outside of the culture.

" The hula used to only be danced by men in Hawaii. When Westerners came to Hawaii, they brought with them the idea of hypermasculinisation as well as a more sexualised view of the female body. As traditional dances became commercialised for visitors, women replaced men, and male native Hawaiians became disconnected from this part of their culture and identity and from an all male community that had provided a source of peer support. Many feel now that the impacts on gender identity triggered by such events directly led to an increase in issues such as domestic violence and sexual abuse; problems that devastate many indigenous populations today."
- Jeffrey Acido

Rates of domestic violence, sexual abuse, suicide and substance abuse are much higher in indigenous populations worldwide and much of this abuse goes unreported, an example of this being the number of native women murdered each year; cases that are rarely investigated in some parts of the US.

"In their lifetimes, more than 3 out of every 4 American Indian and Alaska Native women are physically assaulted" (9)

"Alaska Native and American Indian people in Alaska had a suicide rate in 2014 of 29.6 deaths per 100,000 population, 2.3 times the national average for all ages and races"(10)

With a greater awareness of how modern day ills link to past traumas, it's easy to see how distress is perceived in a different and more story-focused way in indigenous culture. As discussed previously, perhaps where we fall down in Western culture is that in the absence of such obvious trauma, we neglect to see afflictions such as substance abuse as coping strategies, or depression and anxiety as distress triggered by events and instead label people with conditions or illnesses that then go on to determine their 'treatment'.

After considering this concept further, I couldn't help but feel that we are missing a trick in Western society. While I nor any Native person I encountered would wish the traumas their ancestors experienced on anyone else, there is much to be admired and learned from the way knowledge of those traumas is being used to shape solutions.

In the acknowledgement that many of these problems are rooted in the eradication of traditional culture, many of the projects I observed are working to improve wellbeing by reconnecting, or connecting people for the first time, to cultural elements that have been lost, as a way of healing. This might involve using practices based on indigenous values, such as talking circles to resolve conflicts or ceremonies such as sweat lodge to connect people to the traditionally held appreciation for ancestors, nature and the community. For younger American Indians, there is an increasing drive to educate them on tribal ways, especially in knowing that their parents' and grandparents' generations have likely experienced direct trauma and so are often unable to pass down traditions as once would have happened.

4. The impact of trauma on hope

"My companion was explaining her role as a learning aid in the reservation schools. She travels to Navajo Nation in northern Arizona regularly to assess for any special learning needs in the children and to help the teacher put those needs into a cultural context (e.g. is a child slow to read English because they have only spoken a native language previously?). She mentioned that during her last visit she had been made aware of four suicides at the school, two teachers and two pupils, all in the space of a month. That's four suicides in one school, in one month. Such a devastating statement triggered many questions in my mind but only one came out: why? She replied, "They don't have any hope""

- Excerpt from my fellowship blog(www.thepatientsvoiceproject.com)

Research shows that hope can reduce the possibility of suicide attempts(9) and inducing hope in people may be a promising avenue for suicide prevention(10). As a doctor, I've questioned people in distress on whether they feel hopeless more times than I can recount and as a suicide response trainer I've emphasised to trainees how the key to intervention is through the instillation of hope. Yet I'm not sure, before my fellowship, I could have told you what being hopeless really meant or how to put hope back where it has been lost.

The dictionary defines hope as ‘grounds for believing that something good may happen’ or ‘a feeling of trust’, but do either of these definitions fully explain the part it plays in our everyday wellbeing?

Tucson, Arizona

Arizona was perhaps the most rewarding of the places I visited on my fellowship journey. Being my last stop, I arrived there having gained some grounding in the American Indian culture and this new knowledge allowed for a better understanding of some of the more challenging topics that arose that week.

It is a powerful place with a large Native presence; 22 American Indian tribes call the state home. Yet, despite its makeup, it sees a concentration of the problems faced by many indigenous populations and still little meaningful integration between ethnic groups. Many of the places believed to be most sacred by the American Indian people are found there; Sedona and the Grand Canyon to name a few, and to be in these spaces in the knowledge of their troubled indigenous histories is simultaneously awe-inspiring and tragic. In this vein, I felt torn for much of my time there and never more so than during a conversation about suicide in native children as I sat looking out at the beautiful Catalina mountains in Tucson.

I’ve discussed how historical events triggered a cultural genocide within the American Indian and Alaska Native populations and how the associated trauma shaped modern behaviour in terms of abuse and addictions. But, how has this cultural erosion impacted hope for indigenous people living today?

On hearing my companion describe the key to the horrifically common occurrence of self harm and suicide in young American Indians as a lack of hope; I knew I needed to sit up and pay attention. Partly because this was another important part of the tapestry of problems facing modern day native people but also because I knew there was learning for the UK to be found in the exploration of the tragic facts themselves as well as in how the problem is being tackled in indigenous communities and health systems. As I’ve alluded to now a number of times, while the problems we face and the levels of distress we experience as a population in the UK vary widely in comparison to Indigenous people living in the US, fundamentally we are all human beings responding to our lives around us. In this particular context, therefore, I was anticipative that by unpicking the loss of hope in these young people I might be better armed to try and understand where hope and the lack of it played a part in the epidemic of depression and anxiety I was seeing in young people at home.

I started my exploration by joining forces with a number of Native scholars in Arizona, each seeking an answer to what it is within a culture that instils hope or gives meaning to a life. The conclusions so far seemed to point to the importance of close family and community connections, a sense of belonging to something, an awareness of your roots and a recognition of your place in the world. These were all qualities I knew to be present in American Indian culture, a society that traditionally promotes connection to the land and a higher power through ceremony, encourages close relationships with family and community through story-telling and circles and a belief system that facilitates, through the teachings of the medicine wheel, a feeling of ‘wholeness’ and individuality.

But why then despite many attempts to reignite these values among tribe members today, is there still such a feeling of hopelessness and

such high levels of distress?

With my companion, a Navajo professor and learning aid, I started by exploring the barriers to 'reconnection'. Although, as I'd seen first-hand, there is plenty of work going on which attempts to reconnect young people to each other and to a cultural identity, many young American Indians are torn, some growing up with no traditional teaching at all and some hearing in one ear the benefits of the old ways and in the other feeling all the pressures of a modern, western society. "They are 'lost'" she told me and "feel neither connected to the old or the new. To try to engage a person in a ritual that has no meaning for them is at best irrelevant and at worse alienating".

I could easily relate this to many of the young people I see in practice; struggling with the ever increasing pressures of a success-focused and technology-driven world while trying simultaneously to live up to expectations more fitting of previous generations.

Native ceremony brings many of the values that seem to fuel hope and meaning together in one space and can be used both to sustain wellbeing and to heal imbalance. Again, though, despite ceremonies such as sweat lodge being on the rise after years of repression; the psychological ailments facing modern day tribe members are, if anything, also increasing. Could the problem be that traditional ways are no longer relevant; can today's problems be addressed purely through ceremony?

Tommy Begay, a Navajo Psychiatrist and scholar, was keen to tell me that no, in his opinion, it was not a case of the traditional ways being outdated. Tommy has written extensively on the psychological and physiological impacts of trauma and states that while generational trauma plays a large part in the loss of hope, fundamentally it comes down to the loss of culture that resulted from that trauma.

"Native American culture is about more than sweat lodges and talking circles, it is about who you are in the world and who and what you are connected to. To be invested in the belief system is to have a completely different perspective on how you should experience life and the largest and most devastating impacts of the past have resulted in the loss of that concept."

He used the example of grief. A challenge many who are trying to reintroduce traditional culture are facing is an apparent incompatibility between the comfort people in distress are seeking and what they feel ceremony can offer. This is seen commonly as problems such as youth suicide remain rife. In traditional American Indian culture, grieving for the loss of a loved one is a formal process like many others. The mourning period lasts four days and then people are expected to resume normal life activities. Tribe members who are perhaps not aware of traditional ways seem to be struggling with this idea that their grieving must 'be limited'. Tommy explained it differently:

"Traditional teachings promote a sense of positivity and a connection to the circle of life. A limited grieving period is not about preventing mourning or denying an outlet for emotion but is about the awareness of the need for the return of celebration. When a life is lived regularly in ceremony, for every event, moment or milestone, death is considered simply a part of that journey and not an abrupt end to it."

So, if the lack of hope is directly related to the loss of cultural ideology; the loss of a sense of who we are and what we are connected to, how can that be put back?

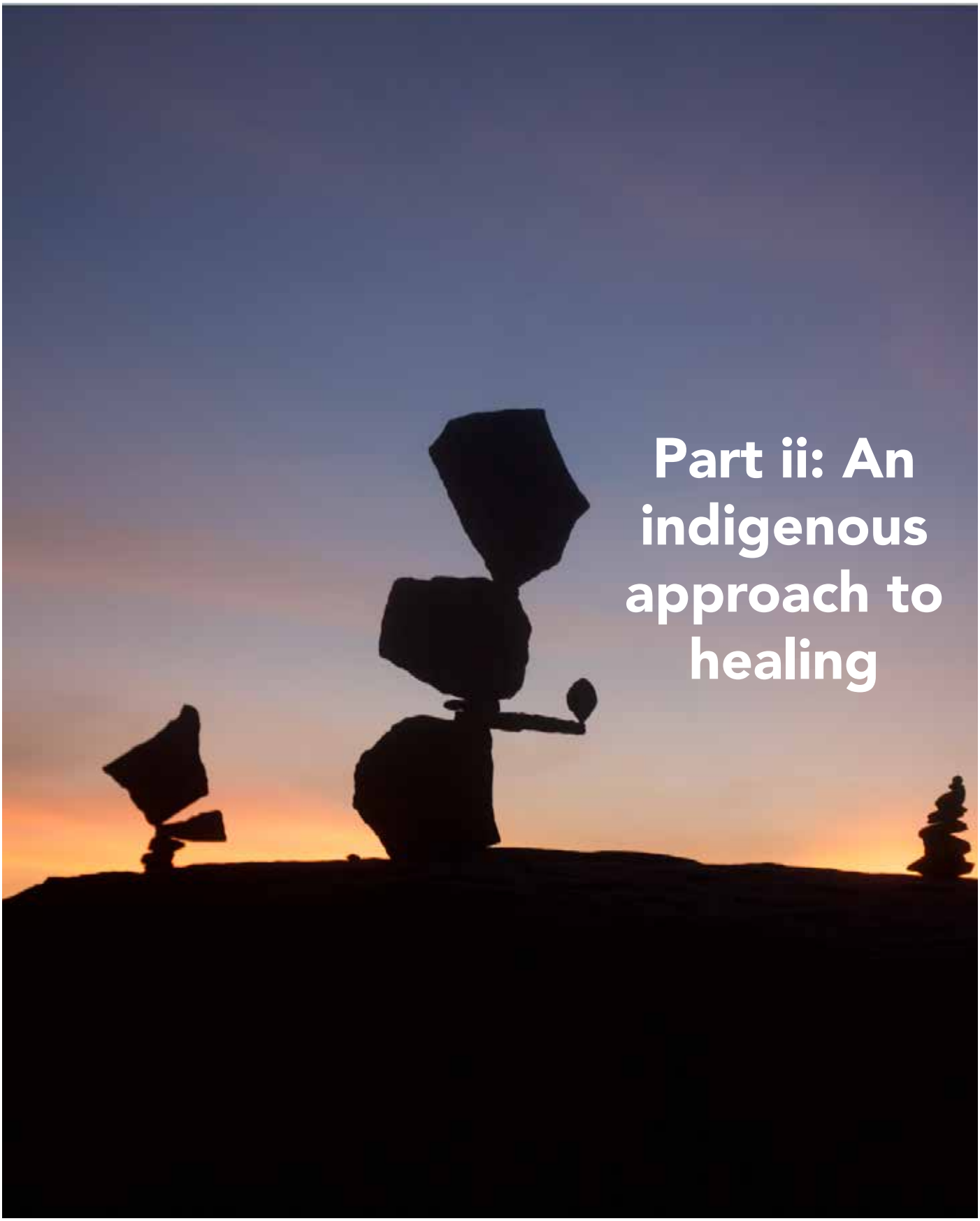
"I think the next step is collecting saliva samples"

Tommy went on to explain his current research; his interest lies in de-constructing the changes that occur in the human brain as a response to trauma.

He explained that the psychological phenomenon of altered behaviour patterns as a result of trauma is fairly widely accepted and documented, but in terms of actual physiological or chemical change in the brain that occurs, the evidence is scanty. Tommy has found that life experiences are having an impact on inflammatory markers circulating in the body, giving rise to both mental and physical health symptoms. This explained, he told me, amongst other things, the well documented trends of increased inflammatory chronic disease in the America Indian population.

Aware of this chemical change, his plan now is to assess the physiological impact of ceremony as a healing tool by measuring the change in the same inflammatory markers, known to be influenced by traumatic life events, before and after a ceremony. He hopes that this may provide a more 'scientific' evidence base for the benefits of traditional practices and help to further unpick exactly what hope is and how it can be increased.

We have plenty of stories already, he wanted to make clear, plenty of examples of how these processes have helped people. But to really answer that question, of how we put back the things that have been lost, he believes the next step may be to look deeper into the biology behind it. **The biology of hope.**



Part ii: An indigenous approach to healing

Dr Sophie Redlin

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Anchorage, Alaska

I attended the 9th annual NUKA care conference at SouthCentral Foundation(SCF) in Anchorage, Alaska as part of my fellowship and this leg of the journey really came to serve as the backbone to much of my learning over the two months. In comparison to many of my other experiences in the US which involved the exchange of information through a more organic type of conversation, the conference in many ways delivered a 'step by step' guide to indigenous values and practices with the specific aim of making SCF's work accessible and transferable to other health systems.

SouthCentral's NUKA system of care is recognised as one of the world's leading models of health care redesign and is a two-time recipient of the Malcolm Baldridge National Quality Award. 'NUKA' is an Alaska Native word that means strong giant structures and living things and it is the name given to SCF's whole health care system, which provides medical, dental, behavioural and traditional health care to more than 65,000 Alaska Native people.

Nuka is built upon the simple but revolutionary belief that understanding peoples' stories and building relationships is the key to successfully improving the overall wellness of a population. It's transformation came about over twenty years ago at a time of struggle, inefficiency and poor care delivery in the area. Spurred on by the need for change, founders of the new system chose to go to the community itself and ask what they wanted from a clinic. This was a community still suffering the repercussions of past traumas, living within an environment where they felt their traditional cultural values were not being honoured, and a result of this outreach, the new health care model was built around concepts

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that are intrinsic to indigenous culture and processes that honour traditional values while simultaneously addressing the issues that have arisen due to the loss of those values. It is a living testament to how **culture can positively influence health care delivery**.

The conference was divided into two parts; the first three days being dedicated to understanding the 'core concepts' of NUKA or the 'secret sauce' as they call it and the end of the week to how their core values are translated into modern health care delivery. I would come to see how the latter very much relied on an understanding of the foundation laid out on those first days.

1. Storytelling and the art of conversation

'Core concepts' Conference aims:

1. To learn how to articulate your story from the heart
2. To understand your personal and professional aspirations; and
3. To learn methods for good dialogue and productive conversations

The NUKA care conference was a turning point for me in understanding tangibly the importance of a person's story. It had been a prevalent theme in every conversation up to that point but my days in Anchorage taught me for the first time how sharing stories impacted wellbeing and how storytelling could and should play a role within a health system. One of the first things I learned was that sharing our experiences with each other consists of not only telling a story but just as importantly of listening and responding to it.

In the first few days we worked in small groups or 'learning circles'. Considering myself to be an

already open person with decent listening skills honed in General Practice; in my arrogance, it took me a while to buy into the need to break these skills down and examine the components. It was only on the third day, as I found myself sharing personal memories with a group of strangers in my own talking circle, that the necessity of the foundation we'd spent two days prior building really dawned on me.

The positive experience of sharing a little of myself highlighted for me that our inhibition in sharing likely derives from feeling the space is unsafe to do so and that our perceptions of a sharing space are highly dependent on what we predict the response to our story will be. Fearing that we might be dismissed or judged or simply ignored can be enough to put a wall up and shut down a conversation. In this scenario we may feel safer staying in the 'comfort zone' or 'swimming in the shallows' as they say in Alaska, giving rise to a one word response to the question 'How are you?', when in reality we have a lot more we would like to say.

As I began to break down the elements of conversation under the guidance of my Alaska Native mentors, it became all too apparent where we are lacking in UK society when it comes to talking to each other and how this is likely impacting the mental health and wellbeing of the population. Many of us living in an increasingly social media-driven and disconnected world are simply out of practice when it comes to these skills, however basic they may seem in theory. But more than that, I think we are afraid to acknowledge that responding in a meaningful way to someone's story often requires us to put our own agenda and discomfort aside and give a little of ourselves back and this isn't always easy.

i. Learning how to share a story

"I'm interested in the person within. Introduce me to the real you and that will impact me. It will encourage friendship. I will share the real me. Relationship will have a nest to be birthed"
- Katherine Gottlieb, CEO SCF

In Alaska Native culture, sharing of story is done to show values, pass on skills, and in some instances show why and how something is or came to be; thus storytelling was a living and breathing part of the conference curriculum. The conference was punctuated by stories throughout the week as members of the staff team took to the stage to walk us through a part of their journey. Some talked for ten minutes, some for over an hour and while many had, I'm sure, shared before they served as effective examples of how it was possible to be vulnerable while staying within a zone that felt comfortable.

Achieving this balance between being out on your own and sharing a bit of yourself while feeling safe and supported is at the heart of the storytelling ethos at SCF and they feel it is dependent on two things:

1. When talking, the depth of the story you share is always up to you
2. When sharing you have permission to go wherever you are comfortable going

They illustrate this through the analogy of talking at certain heights or depths:

30,000 feet
For example:
A story about what happened to you at the supermarket

10,000 feet
For example:
A story about a difficult situation with a friend

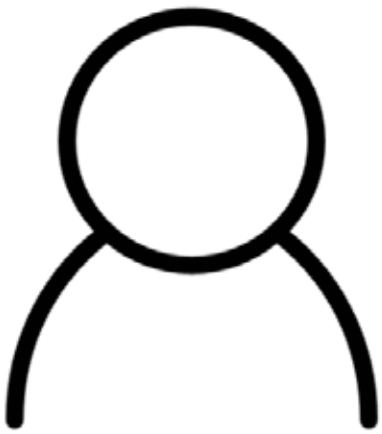
Ground-level or below
For example:
A story about a profound moment or memory that affects you today

Going to the very deep waters they refer to as 'swimming with the whales' and their ability as a health community to provide a safe space for such disclosure has proved invaluable in activities unique to SCF such as 'Beauty for Ashes'; a programme that creates a platform for Alaska Natives to talk about their past traumas.

ii. Learning how to respond to a story

The fear around listening and responding to a story is real. How many of us have asked a colleague how they are while secretly hoping the answer is brief, or looked away from a crying person on the bus afraid that if called upon to, we would say the wrong thing? I was interested to see how SCF would tackle this.

They began by introducing the idea that in order to create a safe listening space one had to try and be a 'safe person'.



A safe person...

- Takes responsibility and works to change behaviours that are unhealthy
- Continues to grow and learn
- Welcomes honest feedback without blaming others or deflecting
- Keeps what is shared in confidence
- Provides mutual respect and is non-judgemental
- Is aware of his or her own shortcomings and is facing them
- Understands that trust is a process
- Is able to live from his or her heart

After addressing the qualities one might need to actively and empathically listen to a story, we then explored both healthy and unhealthy ways of replying to it. We were asked to watch a series of role plays, staff members taking it in turns to offer a response to a story that had just been shared, and offer up our opinions on which might be most meaningful and therapeutic and in contrast most ineffective or detrimental. Some were obvious, some subtle, but in every response I saw myself at some point in time.

Healthy Responses	Unhealthy Responses
Matching your response to the level of the story that is shared	Saying too much
Giving a response that is genuine and real	Offering trite answers
Speaking from your heart	Drawing attention to your own story
Giving responses that make it safe for the person to tell more of their story	Giving advice
Keeping responses without judgement	Saying nothing; staying silent
Connecting responses to feeling words	Telling the person how they should feel
	Telling someone to stop crying
	Asking for more details

This exercise was particularly humbling for me because, as a doctor, I've been taught 'the correct response' to give in a number of scenarios. While in medicine we preach the importance of empathy, being a part of such a one-dimensional model many of us reject the idea that we might have to engage in an actual human to human conversation with a patient and certainly recoil at the prospect of having to share something of ourselves or take on someone's distress personally. Yet deep down we know that, while of course there have to be boundaries in professional conversations and indeed in personal ones, it is often in the grey areas where barriers are lowered that true connection and healing occurs.

SCF doesn't take for granted that people within its organisation are well-practised in the art of conversation; they make it a part of their mandatory training. Through the teaching of skills such as those described above as well as an understanding around mental models, cultural filters and relational styles, they ensure that relationship building between colleagues and patients based on healthy story sharing is a priority.

"Stories lay down the blueprints for living, they offer solutions to our everyday problems and they model behaviour that works. They instil hope."
-Katherine Gottlieb, CEO SCF

Dr Sophie Redlin

2. The talking circle in practice

"I am sitting in a warmly lit room tucked away not far from the bustle of downtown Anchorage. I am nervous and fidgeting with my bag, placing it on the floor then on my knee, then on the floor again. Slowly other participants enter the room and join the circle, most say hello to each other presumably familiar while each seems surprised to see me. When the circle is complete, there are twelve of us; eleven Alaska Native men and women and me.

Our circle is opened by the facilitator, a volunteer from the local community. The circle 'rules' are read aloud before the talking stick is passed around and we are invited to say a little bit about ourselves and why we are here. I am the last to go and so before I speak I listen to eleven stories; some short snippets, a name only, and some longer and more detailed."

-Excerpt from my fellowship blog,www.thepatientsvoiceproject.com

Over the course of my time in the US I observed and participated in many talking circles. While the format of each varied in some way, the components that were universal echoed what I had read about at the very start of my journey. Namely, the creation of a safe space where participants spoke each in turn and where hierarchies that might have existed in the rest of the world were irrelevant. In theory it sounds like a simple idea, and perhaps not one dissimilar to some of the already existing group therapies in the UK, take Alcoholics Anonymous for example. Yet I had been struck by there being something different about what I was seeing and experiencing here and I was struggling to articulate exactly what that was until hearing my own voice tell my story on day three of the SCF conference and later on joining an Alaska Native circle speak of their experiences of generational trauma.

The common thread running through these two encounters was not only the sharing of some very moving stories but, more importantly, the lack of anxiety around holding space for such stories. Coming from an environment where the worry around how we will deal with or manage a situation often seems larger than the benefits that may come from allowing someone to share, I was struck by the calm and collected way in which the circles operated. Where was the fear of conflict or the anxiety around a difficult disclosure? Where the professionals?

How to keep a sharing space informal and not necessarily professional but still safe, in the knowledge that such a group might naturally invite disclosure of distress, was a question I'd posed to many along my journey and it was often met with confusion. My anxieties around the 'dangers' of sharing stories were alien to the majority of the native people I met and I began to worry that perhaps these spaces were only possible within a culture where being open and vulnerable was inherently ingrained or at least had been traditionally. But then I came to SouthCentral Foundation in Alaska and met people who, like me, believe that these techniques are transferable if only they are taught in the right way and so, building on our knowledge of how to conduct healthy conversation, we began to learn the art of circles…

Dr Sophie Redlin

WINSTON
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MEMORIAL
TRUST

A Safe learning circle will…

JOIN together with you to walk side-by-side with others on the journey to wholeness and deeper relationships.

HOLD CONFIDENTIALITY as a high priority. Members of the circle endeavour to be worthy of one another's trust. They understand that you are the only one who should tell your stories.

INVITE you to feel whatever is inside, to talk about it, and not tell you how you should feel.

REMOVE the hats that you normally wear as a manager, counsellor, friend, leader etc.

CONNECT with you as those who have been on the journey and have not yet arrived. We are together.

ENDEAVOUR to talk through offenses that may occur in group and bring resolution.

VALUE the giving and receiving of words spoken from the heart

The talking or learning circle agreement that SCF outlines is designed to hold members mutually accountable to the purpose and values and to keep the circle on track. These 'rules' serve to encourage healthy conversation and, on being asked to help them read aloud, I was impressed to see how many of my previous anxieties about a group of this sort were addressed.

Points such as keeping confidentiality and attendance were covered, as might be expected, but the agreement also asks participants to reflect on how their language in such a setting might impact others; they are encouraged for example to avoid graphic detail which might serve as a 'trigger'. While members of the group are allowed to go to whichever height or depth they feel comfortable when sharing, they are requested to be genuine and themselves at all times. In turn, when responding to each other participants are asked to commit to listening actively and avoid rescuing people or sharing their own story as a direct reply to another's.

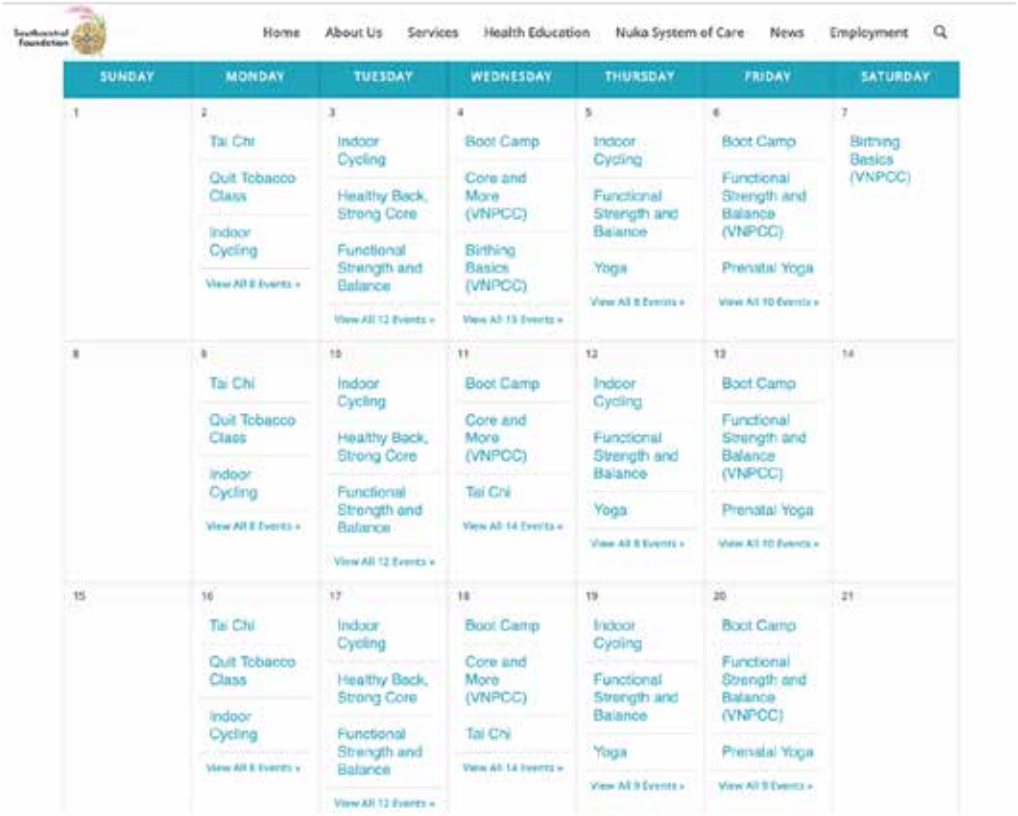
The end of the agreement addresses the need for certain limits to confidentiality and clearly outlines the scenarios in which a learning circle leader may have to break confidence to keep someone safe.

Gaining such a clear understanding on how a circle is set up and facilitated, at least within the SCF community, excited me greatly. It was in learning how this practice is integrated into the health system in Anchorage, however, that the possibility of transferring this technique to my own community seemed for the first time, very tangible.

'Learning circles are opportunities for people to connect and build relationships through a variety of wellness activities. They are a core part of upholding SouthCentral Foundation's mission of working together with the Native Community to achieve physical, mental, emotional, and spiritual wellness. Learning circles bring small groups of people with similar needs together to talk, share story, and learn from each other. Customer-owners and employees are encouraged to attend learning circles.'
- SouthCentral Foundation

I was blown away by how this simple technique has been utilised to form a foundation on which both the community and health system sit, forming a bridge between. Over the course of a week, around ninety learning circles take place on the clinic campus, offering support for a huge array of issues; everything from help with breastfeeding and nutrition to anger-management and dealing with the inheritance of generational trauma.

Below is the monthly programme of circles dedicated to physical fitness alone. Circles also operate on all aspects of emotional wellbeing, spirituality, reconnecting to traditional culture and recovering from addictions. The circles serve as a way for the community to support each other. While there may be health professionals participating, the facilitators are volunteer community members and the sessions are not seen as 'medical treatments'. That being said, they are an invaluable resource for medics to refer people to, patients who perhaps are not in need of psychological therapy but would benefit from a space in which they can share their story and feel listened to.



Dr Sophie Redlin

WINSTON CHURCHILL MEMORIAL TRUST

Thursday evenings are 'wellness evenings' at SCF; the session starts with the sharing of a meal and the circles on this day particularly focus on emotional issues that may have arisen as a result of past trauma and the loss of indigenous culture in Alaska. They are, as always, an opportunity for people to share story but also an example of how past hurts can be healed through coming together and honouring traditional values.

A wise friend at SCF described to me the loss of Alaska Native culture as the 'root of the problem but also the root of the solution'. When the founding team originally reached out to the wider community over 20 years ago, many of the requests that came back centred around addressing problems such as domestic violence and addiction. Most Alaska Natives believe that issues such as these stem at least in part from the cultural genocide that occurred as a result of colonisation. They are now working to heal these wounds through the optimisation of cultural traits such as storytelling and also by reconnecting people to a sense of cultural identity. This is seen most obviously in SCF's Family Wellness Warriors Initiative which uses the traditional symbolism of 'the warrior' to empower native men to seek help where they need it in order to provide better living situations for families.

3. The sweat lodge

'The first thing to say is that the ceremony is an all-day commitment; the preparation for going in the lodge being as symbolic as the time spent inside itself. Lewis lit the fire around 11am; I knew he'd left for work an hour earlier than his usual 7am in order to get the ward rounds done and be back in time. As we gathered wood and kindling he sang Lakota songs and his contentedness was contagious. Joining us for the 'training lodge' were two of Lewis's residents from the hospital. They would be accompanying him to Sundance Festival the following week and had been advised they would have to know what to expect when called into the lodge. I felt a connection with them; fellow western medics about to embark on an unknown journey, and later would come to feel very grateful for their presence there. As Lewis explained the significance of the 28 stones he was placing on the fire, 7 for each of the 4 directions, I could feel his pride at showing this side of himself to his juniors and to me. It felt very humbling to be allowed this close experience with him, having met him only a few days before. The fire was offered tobacco and sage, the pipe was set up, and then we waited. At the time this felt odd, to be sitting in lawn chairs in the New England afternoon drizzle watching a fire and the swarm of mosquitoes around it. Looking back now, though, I realise how important this time was in providing a space for us to tune in to what was happening immediately around us and to let go of everything else.'

-Excerpt from my fellowship blog, www.thepatientsvoiceproject.com

Orono, Maine

"Real healing comes from being embedded within a community and ceremony is really a way to bring a community together."
- Lewis Mehl-Madrona

The sweat lodge is a form of revitalisation ceremony in American Indian culture. Like other traditional practices, between tribes there will be variations, but the values underpinning the elements are again largely universal. My perceptions of the sweat lodge prior to starting my fellowship were fairly limited and in honesty, while I was delighted to be invited to join a ceremony, I did not think the experience would play a large part in my exploration. I was wrong.

The sweat lodge or inipi takes place in a circular hut structure built low to the ground. In Lakota tradition, the roof is very low and, crucial to the ceremony, there must be complete darkness. In traditional settings men normally sweat naked whilst women wear specially prepared 'sweat dresses'. The ceremony is a process of cleansing and rebirth, the lodge representing the mother's womb, and consists of four rounds which in turn honour connection to the earth, to our ancestors and to each other. Each round serves a different purpose and can change depending on the nature and meaning of the lodge.

I had the honour of participating in two lodges during my fellowship; one in Maine and one in Arizona. Despite having read quite a bit about the ceremony, before experiencing it myself, I had pictured it as an isolated act of worship that would be unique to itself and perhaps not connected to other practices that I was exploring. I quickly came to see, however, that in reality sweat lodge is an extension of the values that underpin everything in American Indian culture. As Lewis beautifully put, it is about bringing people together and forming a community.

"The power lies in everyone looking in the same direction for someone on their behalf, holding the intention and the desire for them to be well and creating this field of energy together."
-Lewis Mehl-Madrona

For those who participate in lodge, though, the sense of community it creates surpasses perhaps our common understanding of the concept. Contrary to probable outside perceptions, in most indigenous ceremonies, the actual 'healing power' is believed to arise from the energy of the participants coming together rather than from a mystical individual, object or substance of some kind. It's interesting to consider how this compares with the Western mindset on healing.

Dr Sophie Redlin

"I think the big disconnect between dominant culture and indigenous culture is that dominant culture is individualistic. They want a fabulous, powerful being, who performs like they are a superhero and really, it's more collectivist and cumulative, and complementary, and all inclusive."
-Lewis Mehl-Madrona

"Lewis had explained he was pitching the temperature somewhere between 'intense' and 'wimpy' when picking the stones, the larger ones obviously having the potential to emit more heat. But as I sat melting through the second round I knew we were experiencing one end of the spectrum rather than the other and indeed at one point Lewis confirmed 'it was hotter than he'd anticipated'"
- Excerpt from my fellowship blog, www.thepatientsvoiceproject.com

When everyone is seated in the lodge the stones are brought in, each representing sacred elements and directions. Having been heated in the fire for hours before, when sage water is poured over them, an intense heat is created. Having experienced this myself, now twice, I can attest to the fact that the heat is intoxicating and unlike anything I've felt before. While I certainly felt discomfort initially; as I acclimated, the heat became focusing and, for me, emotional.

During one of our conversations in Maine, my hosts described ceremonies also as an outlet; intended to give people a space to experience and express emotions that we don't get the opportunity to in everyday life. This is perhaps most true in the case of the Sun Dance; the most important ceremony for the Great Plains Indians. The Sun Dance involves a gathering of people and sweat lodge ceremonies, but the main event is a four day fast and continuous dance, often associated with rituals such as piercing of the skin. Conditions are extreme with dancers sleeping where they dance and only when absolutely necessary.

I reflected on this idea of a ceremony enabling a sense of release; of fulfilling a need, where the rest of life doesn't, and considered what in western society might be comparable. Interestingly, some sun dances are attended by non natives and among this group, there tends to be a high percentage of people who have experienced trauma such as veterans.
Not having a way of expressing ourselves or an outlet to do so is a well documented contributor to poor emotional health and I was interested to see a remedy for this in indigenous culture that again seemed to bridge the gap between healthcare and the community.

It is traditional to share a meal after a ceremony and this time serves as an important moment in which to reflect on how the experience felt for everyone involved. As I broke bread with my companions in Arizona after my second sweat lodge, our sweat lodge leader asked me how, if there weren't tribes in the same way in London, I might take learning from such a culturally-specific practice and make it relevant to the problems we see at home?

I was so thankful for this question and for the opportunity to explore it with him; a person I have such great respect for. I explained to him that this question really formed the basis of my entire journey and the answer to it, my conclusion.

In terms of the sweat lodge specifically; while the content of the ceremony may be difficult for people who haven't grown up in the American Indian culture to relate to, though I would argue personally that it is possible for anyone to find meaning in it, how they are used to support wellbeing and where they sit as part of a holistic health model is a useful thing to consider.

Sweat lodge ceremonies are usually accessible to anyone within the culture who feels a desire to partake in one; this is becoming more the case as the culture regrows following its depletion as a part of colonisation. Although they are used as healing practices in many scenarios and are encouraged and facilitated by traditional healers, people can choose to sweat for a variety of reasons and it can form very much a part of day-to-day life to maintain wellness rather than simply 'treating' problems as they arise. This is another example of how the medicine wheel methodology is put into practice; linking emotional health to both physical and spiritual health as part of the same picture. Many indigenous people believe that physical health complaints should be managed in ways that explore the emotional aspect also. While we might be aware of these links in the Western world, consider our understanding of 'the stress cycle' for example; rarely do we have the opportunity to address problems in this way.

4. The integration of traditional and western practice

"I don't think it needs to be one or the other; western or modern medicine can work together with our traditional practices. They can compliment each other"
- Peter Flores Jr, Native healer

I could not have asked to be shown greater respect than to be allowed to observe and partake in traditional healing ceremonies as part of my fellowship. On these occasions, where I feared I might be met with suspicion, I was welcomed and this was perhaps my most treasured finding. While many of the Native people I met were understandably careful in what they disclosed in an effort to preserve the sanctity of the processes they were describing; most were also keen to share their knowledge, in the hope that as a Western healer I might come to understand that all forms of medicine can exist harmoniously and that there is a place for everything. They urged me to think back to the medicine wheel and to see that a person with so many needs might need, in turn, many kinds of therapy. One type of healing is often not enough, they told me.

A key element of my fellowship was the seeking out of case studies that demonstrated the successful integration of traditional and western practices within native populations and, where possible, examples of traditional methodology being used in non-native society.

Below is a selection of **key findings** in this area:

Orono, Maine

•'Well-briety' programme at 'The Wab' wellness Centre, Wabanaki Clinic. This 'White Bison' programme is a Native-focused peer support service for Penobscot people recovering from addiction and incorporates both indigenous cultural elements and western model detoxification processes.

•Talking circles used to support patients of both native and non-native heritage suffering with chronic pain

Anchorage, Alaska

•SouthCentral Foundation actively integrates Alaska Native cultural elements into every aspect of its modern healthcare delivery. Particular strengths are its comprehensive talking circle programme, its Family Warrior initiative; both key programmes in tackling social stressors impacting health and it's incorporation of a traditional healing centre.

•SCF has revolutionised the format of primary care; aware of the importance of values such as storytelling and relationship in healthcare, staff at SCF assess a patient by 'their story', not 'their symptoms' and prioritise mental health or psychosocial problems above all else.

Oahu, Hawaii

•Waianae Comprehensive supports people in conflict with family members through Hooponopono offered by in-house traditional healers. Patients are often referred by primary care workers who feel their social situations are negatively impacting on their physical and mental health.

•Kolua Kalihi Valley Clinic offers cultural exposure and learning to people of all backgrounds and both native and non-native heritages at their indigenous garden, 'roots cafe' and through their youth programmes.

Tucson, Arizona

•Native mental health support workers are actively using traditional practices to enhance the support they offer distressed patients in the Tucson area. This involves talking circles with elements of spiritual ceremony for both native and non-native patients in recovery.

•Native faculty at the University of Arizona are leading the way in bridging the gap between traditional and Western medicine. An awareness of the local indigenous people is essential for all graduating doctors and exposure to traditional healing is encouraged.

Conclusion

I set out on my fellowship journey aware of a number of things:

• I was seeing far more than the research-quoted 20% psychosocial problem-focused consultations in my London practice.

• Community support networks in my local area were weak; meaning problems such as loneliness were common and in the event of distress, patients often had nowhere to turn but their GP for support.

• Having sought help through the health system, due to a lack of resources and better alternatives, patients were either being offered very little or being inappropriately labelled and their distress over-medicalised.

Many Indigenous cultures view wellbeing and distress differently. Their largely story-based and holistic approach to both living and healing undoubtedly impacts the population. Through my fellowship I wanted to explore how indigenous culture might positively shape mental healthcare and in particular whether elements of traditional healing practices might be transferable to a Western population. It was a joy to learn from the experiences of so many while on my journey. As a Western 'healer' myself, hearing the stories of doctors, psychologists and medicine men all with the same hope and aim as me was an incredibly powerful and humbling experience. I would say, though, that I learned at least as much, if not more, about being a human being and came to see that while patients across the world might be different in terms of how they view their illness and how they expect to be treated, as people we are all the same. We all crave meaning and we all need hope. In knowing this I have found my window of opportunity, for with every practice I observed, however culturally-specific the ceremony, underlying them all I found a set of values that I believe are transferable and relevant to us all.

Key Learning Points

1. Spirituality impacts health and wellness

American Indian and Alaska Native cultures hold at their hearts values that are known to promote wellbeing and give people a sense of meaning in their lives. These values include close connections to their family, friends and community; an understanding of their place in the universe; a connection to their ancestors and heritage; and an appreciation for the natural world around them. Spirituality for them is not about the worship of a certain God but rather an underlying concept that permeates every aspect of daily life. Traditional ceremonies bring all of these elements together in one space and wellbeing is enhanced by regular participation.

The observation of a culture that values connection above all else brings into harsh comparison the values of modern Western society. As a culture we have moved away from activities that bring us together, often opting for online communications instead; we have moved into more urban areas that separate us from the natural world and without the awareness of how knowing where we come from might benefit us, we feel few connections to the past and are lost in the present. It is easy to see how our emotional wellbeing as a population has declined as a result.

2. Holistic care is achieved through the use of the medicine wheel

In the West we often view healthcare as reactive rather than preventative. In contrast both the American Indian and Alaska Native cultures view healing or healthcare as simply a part of living. They do not separate elements of a person's wellness e.g. physical or mental health, but see a person as a whole and illustrate this through the model of the medicine wheel. Concepts such as the influence of psychological distress on physical symptoms such as pain are well documented in western medicine and yet rarely does our approach focus on this.

An indigenous approach to assessing a person in distress seeks to obtain information about the whole person, covering all aspects of the medicine wheel. Details such as support system and social situation are often prioritised as there is a greater understanding of how these factors influence both the current complaint and how it can be best supported. While in the west we understand the importance of taking a social history, it features in the GP curriculum for example, current time restraints within our system require a more 'tailored down' interview and unfortunately psychosocial history is still deemed as less of a priority than other elements.

3. Our perception of distress influences how we experience it

American Indian and Alaska Native cultures see emotional distress predominantly as a reaction to a traumatic life event. Therefore in assessment, healers are more interested in a patient's story than a set of symptoms; where we in western society might ask 'what is wrong with you?', they want to know 'what has happened to you?'. Even symptoms that would be indicative of 'severe mental illness' in the west such as auditory hallucinations, while sometimes still diagnosed as a disorder, are treated as part of a bigger picture and as a part of that person's story.

Distress is seen within a cultural context; it is understood for example that some American Indians and Alaska natives view hallucinations as a communication with spirits. This is not fought against by healers but worked with. Stigma around emotional distress is less within indigenous populations because it is generally tolerated more. A stronger sense of community results in greater acceptance and problems such as substance abuse are often much more tolerated as they are seen as the consequence of a difficult life story.

Crucially, because emotional distress is viewed far less as an illness in indigenous culture, peoples' experience of living with it is different. Approaches to treatment are about improving quality of life, sometimes in very challenging circumstances, and it is accepted that this journey might look different from one person to the next.

In the West, we have a growing number of people who are more at ease with talking about mental health and reaching out for help. Of

course in principle this is a good thing but my concern remains that while we still describe our states of being as either 'mentally ill' or 'fine', we miss out on the understanding that difficult life events trigger difficult emotions and that this is normal. Emotional distress needs to be supported and taken seriously but in a way that is effective and empowering for that individual, not further depleting.

4. It is important to consider historical context when managing emotional distress today

The impact of historical or inherited trauma on present day generations is not as well understood in the West as it is in indigenous populations where, in general, traumas could be deemed more significant or obvious. The lasting effects of past events can be both psychological and physical and crucially can translate themselves into damaging modern social behaviour patterns.

Often the greatest impact is seen where historic events have led to an erosion of cultural identity in the following generations. This can result in a disconnection to the elements of meaning as discussed above and can leave people with a lack of hope.

In the West, while mental health issues are put into more of a social context than comparably physical health complaints are, little attention is paid to the patient's historical legacy. If we were to consider a patient's presentation with alcohol abuse not simply as a current affliction but perhaps as a behaviour pattern resulting from inherited trauma, it might very well change the way we and they view it, improve treatment outcomes and offer more opportunities for therapies that are effective and meaningful to that individual.

5. Traditional 'healing' practices are not reserved for the sick and bridge the gap between healthcare and the community

Indigenous healing practices take place usually in the form of ceremony. These processes gather people together and utilise the combined experience of a community. Many Westerners believe the power of these ceremonies lies in mystical objects, substances or an all powerful being when in actuality it is the group energy that does the healing.

Practices such as talking circles and sweat lodge are not reserved for the sick; they serve a multitude of purposes from healing to conflict resolution to general wellness, and tribe members are encouraged to partake regularly. In this way the line between preventative and reactive healthcare is transcended and the gap between community and healthcare bridged.

The ceremonies are not only beneficial for a person in distress but serve to empower communities to offer better support to each other. Talking circles in particular draw on the healing power of shared experience thus facilitating the evolution of informal mentorship.

6. It is possible to successfully integrate traditional practice into a western healthcare model

In every location I visited I saw examples of the successful integration of traditional practice within a western healthcare model. I observed this mostly in native populations but saw examples of traditional methods being used in non-native populations also. The key to healing is to find something that is meaningful to the person in need and by providing more options to patients, including some that are culturally-orientated, a positive outcome is much more likely.

The integration of traditional practices relieves the burden on Western practitioners in being

well placed to support patients with complex needs who have found Western medicine limited. This might be the case for patients with unexplained physical symptoms for example or problems such as chronic pain and mental illness. Traditional practices can also provide a more community-based backbone to the formal health system, take the talking circle programme at SouthCentral Foundation for example. This weekly programme of shared experience groups not only provides connection for the community but serves as an alternative and often more appropriate service for doctors to 'refer' patients to, when they present with psychosocial complaints at GP appointments.

7. We've forgotten how to talk to each other: why storytelling is important in healthcare

Sharing stories between generations is not a tradition limited to American Indian and Alaska Native culture. However, many of us living in the modern west have forgotten the importance of stories and sadly have lost the ability to have healthy conversations even with each other. Sharing and responding in a healthy and meaningful way is crucial to both the assessment of emotional distress in a professional setting but as importantly to maintaining wellness in everyday life. SouthCentral Foundation in Anchorage has proven how prioritising the arts of storytelling and relationship building has transformed their health system. From the clinic rooms to the community circles to the boardroom, people are given time and a safe space and it has changed lives.

Much of our energy in terms of mental healthcare in the west goes into increasing access to secondary care specialists and formal psychological therapies. While these elements are important, I am convinced that we could radically reduce levels of distress simply through empowering people to share their stories with those around them and giving those listening the confidence to respond.

8. It is through the understanding of how hope has been lost that it can be put back

We know that hopelessness directly correlates with poor mental health outcomes. We are trained in the West to ask people about hope as part of a mental health or suicide risk assessment and yet as a concept it is not well understood.

Native academics have been working to unpick how hope is lost and now know that trauma and the loss of a person's cultural identity are key. This not only gives them a greater understanding of why a person might present in a certain way but crucially gives them an opportunity to focus their healing in an area that is meaningful.

I was told several times that 'traditional culture is both a blessing and a curse', the loss of it being the root of some devastating modern day problems and it's reintroduction being the solution. With this understanding many modern day programmes hoping to support indigenous people in their current struggles focus their activities on reconnecting people to parts of their culture that have been lost. I had the privilege of witnessing this first-hand many times, most memorably at a Penobscot beading group. In other settings, traditional ideology is used as a form of healing; for example at the Family Warrior initiative at SouthCentral foundation. In the West, particularly in London, we are blessed by cultural diversity. It can make it challenging, however, to identify opportunities for reconnecting a person with their culture as a form of healing when their culture is unfamiliar to us. As I learned during my time in Hawaii,

though; it is possible to find meaning in traditions that perhaps aren't familiar as, frequently, the underlying values are the same.

And finally; would the format of an indigenous 'talking circle' be transferable to a UK primary care setting?

Yes, absolutely. The key to the traditional 'talking circle' is the safe creation of the space. If set up in a way that stays true to the values behind it, I believe it would be an effective support resource for people in distress. Initiating a 'talking circle' programme within primary care initially would likely increase participants' 'buy-in' to the concept and such a programme could be used to take some of the burden off GP time and psychology services. The 'talking circle' operates on the principle that shared experience is a powerful healing tool and serves to both support and empower a community.

Recommendations

From my key findings I would recommend that an **approach to improving emotional wellbeing** in the population should comprise of the following three elements or channels:

1. Increase day to day wellbeing of the population: introducing the idea of 'spirituality'

As a health system and population we need to be more preventative and less solely reactive when it comes to maintaining our emotional health. My findings suggest that enhancing our sense of spirituality; namely how connected we feel to each other, our values, our roots and our environment, can bolster our mental wellbeing by providing a sense of meaning and hope.

2. Rebuild community support networks that have been lost

There is a wealth of life experience within our communities that historically would have seeded informal support networks and intergenerational mentorship. This resource currently goes largely untapped and yet, if reignited, could serve as an effective way of preventing and responding to the multitude of social and emotional problems seen within our population today.

3. Challenge the way we view and manage emotional distress within the health and social care setting

The connection between our story, namely what has happened to us and those who came before us, and why we experience emotional distress is poorly understood in the west and is certainly as a concept not given priority in healthcare assessment and management. If we were to take a more narrative-focused approach in primary care and view distress within the context of a person's story and not simply as a symptom in isolation, my findings suggest that the impact of the distress would be lessened and better tolerated. This change of mindset would not only radically change our conversations with patients but would also facilitate the cultural shift needed for new and more holistic management solutions to evolve.

Dr Sophie Redlin

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Next steps

Sharing Findings

1. As an independent practitioner:

Objectives:
- Utilise my findings to inform and enhance my own practice as a GP
- Utilise my findings and connections as a platform from which to engage in further learning

Progress to date	Future plans
The incorporation of learned techniques into my GP consultations: • Gathering a richer patient story through narrative consultation techniques • Providing a more individualised response to emotional distress • Centering consultations around a patient's familial history and social context • Taking a trauma-informed approach to assessment with phrases such as , 'what has happened to you?' rather than 'what is wrong with you? • Regular telephone and e-mail contact with fellowship connections Dr Tommy Begay, Dr David Derauf and Dr Lewis Mehl-Madrona around introducing traditional ideas into a modern medical model • Development of a 'Wellbeing during COVID-19' document for patients within my practice which draws on ideas and techniques learned during my fellowship	**In order to expand my knowledge and skills in blending the traditional and modern approach to emotional health as a practitioner I have:** • Enrolled in a 'Two-eyed Counselling' course with Dr Lewis Mehl-Madrona and Barbara Mainguy (my Maine hosts) • Initiated e-mail conversation with Elder Albert Marshall of the Institute for Integrative Science and Health on his 'two-eyed seeing model' for practitioners **In order to develop a role as an independent practitioner with a holistic focus on emotional wellbeing I am exploring:** • Further training in integrative medicine via the Osher Center, USA • Further training in narrative medicine via Columbia University, USA • Further training in logotherapy via the Viktor Frankl Institute of Logotherapy, multiple locations worldwide

Aims:
- To develop a role as an independent practitioner using a holistic model combining modern and traditional ideas with a focus on emotional health

Dr Sophie Redlin

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2. With the medical community:

Objectives:

- Share findings in written and oral form with members of the national and international medical community
- Maintain regular contact with my fellowship mentors to support my continued learning and the development of future projects

Progress to date	Future plans
• Presentation at the Abingdon Medical Practice monthly meeting- March 2020 • Discussions by e-mail with Dr John Wynn-Jones, chair of WONCA (Worldwide GP Network) Rural Working Group around opportunities for sharing findings within the WONCA network • Face to face discussion with Dr Lucy Johnstone, Clinical Psychologist and Senior Lecturer at UWE, Bristol around developing alternative approaches to mental healthcare in the UK • Discussions with Pulse magazine and the British Medical Journal(BMJ) around contributing an article or opinion piece • Discussion with 'Mad in the UK' ', an organisation 'fundamentally re-thinking UK mental health practice and promoting positive change' around contributing an article or blog piece • Initial telephone contact with the King's Fund around potential opportunities for sharing findings and collaboration • Monthly telephone contact with Dr Tommy Begay, Navajo academic psychiatrist, around a potential research collaboration	• Presentation to local GP training group • Article for WONCA(Worldwide GP network) Rural Working Group and contribution to the 'Rural Seeds' blog • Opinion piece for Pulse magazine • Article for the British Medical Journal (BMJ) • Talk for TEDXNHS • Presentation at the Royal College of General Practitioners' (RCGP) annual conference • Presentation at WONCA (Worldwide GP Network) World 2021 conference • Article for 'Mad in the UK', an organisation 'fundamentally re-thinking UK mental health practice and promoting positive change' • Article for UC Berkeley's 'The Greater Good' online magazine focusing on finding meaning through the sharing of stories • Approach The Wellcome Trust for discussion around pilot project funding and opportunities for sharing findings • Re-establish contact with NHS England

Aims:

- To initiate and inform discussions within my local primary care network around making changes to our current mental health pathways
- To inform policy on a local and wider level
- To contribute to the larger conversation around perceptions and management of mental health within the national and international medical community
- To seek support/collaboration from other professionals/organisations in developing the Three Channel-Talking Circle(3C-TC) Project

3. With the general public:

Objectives:

- Share findings across multiple media forms with a targeted and focused approach using existing networks in the hope of engaging community, societal, cultural and professional groups

Progress	Future plans
• Fellowship blog (www.thepatientsvoiceproject.com) • Speaker for the Royal Society of the Arts(RSA) America virtual lounge-July 2019 • Guest speaker on KZFR Radio in California-April 2020 • E-mail discussion with the Royal Geographical Society(RGS) around sharing findings with other fellows and members • Discussion with 'The Yes Tribe': an adventure-focused social community group, leading to the development of a mental health focused arm of the society. As part of this new venture I have initiated a fortnightly virtual **talking circle offering peer support during the COVID-19 pandemic** • Face to face Meeting with Alain De Botton around a potential collaboration with 'The School of Life'	• Royal Society of the Arts(RSA) video blog and presentation • Monday night lecture for the Royal Geographical Society (RGS) • Talk for TEDXNHS • Application for a TED Fellowship and the opportunity to present at the TED annual conference in 2021 • Talk for the AirBnb Group on the power of community in healing, I have presented to the London Headquarters before and have been asked to deliver a further talk • Article for UC Berkeley's 'The Greater Good' online magazine with a focus on finding meaning through the sharing of stories • Approach the BBC for discussion around sharing my findings as part of their mental health agenda • Approach MIND for discussion around opportunities to share my findings

Aims:

- To raise awareness around the importance of taking a holistic approach to health and the potential benefits of a spiritual element to wellbeing
- Introduce ideas on how to achieve this within differing cultural contexts through written and oral presentation
- To raise awareness of the importance of social and community support networks
- To make a contribution to the global conversation around the perceptions of emotional health and management of distress in the west
- To seek support/collaboration from professionals/organisations outside of the medical field in developing the Three Channel-Talking Circle(3C-TC) Project

Building the Solution: The Three Channel Talking Circle(3C-TC)

Drawing on some of the underlying principles of American Indian and Alaska Native talking circles, I have developed the Three Channel-Talking Circle(3C-TC) which is both ***driven by*** and ***forms a response to*** the three key channels outlined above while remaining culturally relevant to a Western population. Whether facilitated as part of a regular programme or as an activity in isolation the 3C-TC Project provides a safe space for participants to share their experiences and offer each other peer support.

The 3C-TC aims to facilitate the rebuilding of community support networks by bringing people together in a group that transcends generational and societal gaps. The space allows participants to share stories and respond to each other and thus for dynamics of support and mentorship to develop as communities might have experienced in the past. The 3C-TC involves education around active listening and responding for participants that can be utilised in the circle but also taken out into daily life. The hope would be therefore that these connections while perhaps initially forged in this formal space would go on to deepen organically outside of the circle encouraging the growth of more robust informal support networks within our communities.

Through the sharing of stories, the 3C-TC challenges participants to view emotional distress differently; less as an isolated 'medical symptom' and more as an understandable response to challenging life events. The healing comes from finding resonance with another's experience, from the realisation that we are not alone in our struggles and from the knowledge that our own ability to help ourselves may be larger than we think. For the health professional, the 3C-TC challenges the ways in which we perceive emotional distress within our modern medical model by providing an alternative avenue of support for patients that is both individual and community empowering.

Drawing on values rooted in indigenous culture but relevant to Western society, the 3C-TC enhances the participants' sense of spirituality in a variety of ways. The physical or virtual gathering of the group in and of itself forges person to person connections, while aspects of life known to hold meaning such as a person's roots or heritage are actively explored through 'themes' such as the sharing of an ancestral story. A sense of belonging and connection to 'the bigger picture', is promoted using an opening unifying piece of literature.

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Three Channel-Talking Circle(3C-TC) Core Elements

(See Appendix 1 for more detail on creating a safe space)

The logistics

- The 3C-TC could be facilitated as a 'one off' activity or as part of a longer programme
- The 3C-TC facilitates story sharing around a theme linked to wellbeing
- The equality of both participants and facilitator is key to keeping the circle meaningful and sustainable; while facilitators would receive training around safety and signposting they would participate as community members rather than as professionals

Procedures and safety

- **Check in**: A way of gauging immediately the general atmosphere of the group.
- **Facilitator and participant introductions**: The introductions are a way of bringing every person into the circle as an equal, focusing on something other than the current situation and promoting connection to the people and world around us.
- **Explanation of the aims and principles of the circle**: Many participants will be unfamiliar with talking in this format and so this short explanation will touch on the principles of collective energy and healing through finding resonance in others' experiences.
- **Creating a safe space**: To establish a safe and meaningful space a series of 'ground rules' will be read aloud by participants followed by an invitation for anyone to add anything they feel is missing.
- **Education around meaningful listening and responding**: This section will touch on keeping yourself safe and comfortable while sharing and in turn will highlight helpful and less helpful responses to a story. If the circle is part of a longer programme this element could be extended and delivered as an individual session.
- **Introduction to the theme with a moment of unity**: The sharing part of the circle will be opened with a culturally resonant poem, piece of literature song or prayer that links to the circle theme. The aim of this is to unite the participants while stimulating the later sharing of individual perspectives and stories.
- **Story sharing**: Participants will be invited in turn to share their experiences around the theme, perhaps prompted by the opening reading. There will then be space for other members of the circle to respond. Participants are encouraged to share but there is no obligation to.
- **Summary of any salient points**: 'thank yous' from facilitator and closing comments
- **Final 'check in' and reiteration of safety advice**: The 'ground rules' will include guidance on emotional safety and will signpost the facilitator as a point of contact should a participant feel distressed during or after the circle.

The Three Channel Talking Circle(3C-TC) Project: Progress and Future Plans

1. Introduce the idea of spirituality to enhance day to day emotional wellbeing

Objectives:

- Solidify knowledge around introducing a culturally relatable spiritual focus to the circle through further discussion with my fellowship mentors and exploration of other group models
- Develop and trial a preliminary talking circle structure
- Trial a healthcare-associated 3C-TC programme to address anxiety around the many stressors related to the COVID-19 pandemic

Progress to date	Future plans
• Regular telephone contact with Dr Tommy Begay, Navajo Psychiatrist and academic, around developing the spiritual aspects of the talking circle model • Regular E-mail contact with Dr David Derauf, Clinical lead at Kokua Kalihi Valley clinic, around his experience in creating a culturally relatable talking circle model • Regular telephone contact with Olegario Carillo, Physician at SouthCentral Foundation, around his experience in using talking circles in Alaska Native communities as a non-native clinician • Video conversation and participation in integrative community therapy (ICT) online sessions with Dr Adalberto Barreto, founder of ICT in Brazil, around finding a 'focus of unity' for a community who may be unfamiliar with the concept of spirituality • Development of a preliminary talking circle structure including the introduction of a unifying opening activity that touches on spiritual aspects of health	• Participation in a 'two-eyed counselling course' with Dr Lewis Mehl-Madrona and Dr Barbara Mainguy to further enhance my knowledge around bridging modern and traditional ideas on mental health management and relaying these to an indigenous healing-naive group • Participation in a formal Integrative Community Therapy (ICT) programme with Dr Adalberto Barretto • **Talking circle trial** in collaboration with Dr Tommy Begay. Dr Begay has kindly offered to join an online circle and make an introduction to the spiritual aspects of the talking circle in American Indian culture and how these aspects might be transferable to a Western society. This experience will further enhance my understanding of the need and application of spiritual wellbeing in talking circles and will inform the evolution of my own model going forward

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• **Talking circle trial**- weekly online circle for young European GPs in collaboration with the Vasco da Gama Young Doctors Network (March-June 2020) • **Talking circle trial-** fortnightly online circle for members of 'The Yes Tribe' community group in collaboration with two other professionals training in Psychology. Participants are asked to complete an evaluation form after each session (March-ongoing) • E-mail discussion with Dr Mayara Floss and Dr John Wynn-Jones around engaging members of the WONCA Rural Working Group in a trial online talking circle with a focus on doctors working in diverse environments sharing their experiences	• **Trial 3C-TC programme to address anxiety around the many stressors related to the COVID-19 pandemic. Every circle within the programme will include aspects of spiritual wellbeing.**

Aims:

- Through the 3C-TC Project, introduce aspects of spiritual wellbeing such as connections to ancestry, nature and the community, and demonstrate the positive impacts of these elements on emotional wellbeing

2. Rebuild community support networks

Objectives:

- To further develop the 3C-TC Project, enhance my knowledge around talking circle participant recruitment through contact with my fellowship mentors and exploration of other existing group models
- To further develop the 3C-TC Project, enhance my knowledge around the role of mentorship within communities through the exploration of already established projects
- Explore and consider the participant 'make up' of the 3C-TC in the hope of optimising potential for the building of community support networks
- Identify communities and societal groups where there is the most need
- Source connections within these communities to explore the potential for a 3C-TC Project trial
- Trial a healthcare-associated 3C-TC programme to address anxiety around the many stressors related to the COVID-19 pandemic

Progress to date	Future plans
• Video conversation and participation in Integrative Community Therapy (ICT) online sessions with Dr Adalberto Barreto, founder of ICT in Brazil, around how Dr Barreto engaged with and 'recruited' community members to the ICT programme in its early stages • E-mail discussion and reading around Dr Mayara Floss' Doctor Mentorship Programme • Regular E-mail contact with Dr David Derauf, Clinical lead at Kokua Kalihi Valley Clinic, around the integration of community members from differing cultural backgrounds in group work • Exploration of local community support groups including group therapy options offered by Community Living Well, West London Psychology service • **Talking circle trial**- weekly online circle for young European GPs in collaboration with the Vasco da Gama Young Doctors Network (March-June 2020) • **Talking circle trial-** fortnightly online circle for members of 'The Yes Tribe' community group in collaboration with two other professionals training in Psychology. Participants are asked to complete an evaluation form after each session (March-ongoing)	• Participation in a formal Integrative Community Therapy (ICT) programme with Dr Adalberto Barretto • Seek out collaboration to assist in identifying and connecting with communities/societal groups in need for a trial talking circle programme • **Trial 3C-TC programme to address anxiety around the many stressors related to the COVID-19 pandemic.**

Aims:

- Through the 3C-TC Project, harness untapped support resources within diverse communities and demonstrate the positive impacts of rebuilding community support networks on emotional wellbeing

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3. Challenge the current view and management of emotional distress

Objectives:

- Further enhance my knowledge around introducing an alternative and community-orientated management tool for emotional distress into a predominantly medicalised health system
- Develop an educational element to the 3C-TC around 'safe listening and responding' in order to build skills in meaningful conversation both in and outside of the circle
- Provide an alternative and non-medicalised approach to addressing emotional distress for both circle participants and referring clinicians

Progress to date	Future plans
• Regular contact with the SouthCentral Foundation Behavioural Health team via their fortnightly 'fireside chat' webinars. These include discussion around their Learning Circle Programme, how it has evolved and how it has been adapted during the COVID-19 pandemic • Development of a preliminary talking circle structure including 'safe listening and responding guidance' and education around conversation skills (See Appendix 1.) • Talking circle trial- weekly online circle for young European GPs in collaboration with the Vasco da Gama Young Doctors Network (March-June 2020) • **Talking circle trial**- fortnightly online circle for members of 'The Yes Tribe' community group in collaboration with two other professionals training in Psychology. Participants are asked to complete an evaluation form after each session (March-ongoing) • Specific **Talking circle trial session** focusing on conversation skills (August 2020)	• Participation in a 'two-eyed counselling course' with Dr Lewis Mehl-Madrona and Dr Barbara Mainguy to further enhance my knowledge in bridging modern and traditional ideas around mental health with an aim of then feeding my experiences back to colleagues • Clinician focus group to explore the potential interest in a talking circle programme from a referral/management point of view • Online video discussion with members of my core concepts talking circle from the NUKA Conference, SouthCentral Foundation. • Seek out collaboration and support in identifying healthcare communities from which participants may be recruited • **Trial talking circle programme to address anxiety around the many stressors related to the COVID-19 pandemic.**

Aims:

- Through the 3C-TC Project, challenge the current predominant narrative around emotional distress within UK public and healthcare settings and demonstrate the positive impacts of this shift in thinking on emotional wellbeing

The Three Channel-Talking Circle(3C-TC) Project: Evaluation

Objectives:

- To explore and identify suitable methods for the evaluation of the 3C-TC Project

Progress to date	Future plans
To aid consideration around evaluation methods for the 3C-TC Project I have: • Discussed evaluation methodology with Dr Adalberto Barretto, founder of Integrative Community Therapy(ICT). The evaluation of his programme involves measuring changes in referral rates to mental health services following ICT • Explored standardised Wellbeing Scores such as the 'Warwick-Edinburgh Mental Wellbeing Score' for evaluation of the general impact the 3C-TC project has on emotional wellbeing • Explored options for evaluating the individual channels; such as measuring the impact on community support networks through the 'Inclusion of Community in self score' or the 'Two way social support assessment' and evaluating the introduction of spirituality through structured interviews • Asked participants of the 'YesTribe' **talking circle trial** to complete an evaluation form after every session	• Continue to explore evaluation methodology used in group work models • Identify the best evaluation tools for the 3C-TC Project

Aims:

- To evaluate the 3C-TC Project on its effectiveness and impact on delivering the desired objectives and aims for the three channels

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Appendix 1.

Creating and maintaining a safe sharing space

A talking circle **IS**:

An **EQUAL** space
- The space functions because we are all here as equals. There will be a facilitator but they will participate in the same way as everyone else.
- It is a time to remove all of our 'hats' that we perhaps wear at work or at home and meet together as equal human beings.
- Every voice heard and story shared in the circle is as valid and important.

A **SHARING** space
We can keep this a safe and respectful sharing space by:
- Only going as 'deep' as we feel comfortable
- Avoiding 'over-sharing'; give others the time to talk too
- Being sensitive to topics or words that may be distressing or triggering to others
- Being genuine; there is no need to perform or be anything other than yourself

A **LISTENING** space
We can keep this a space that has meaning and feels healthy by:
- Giving people time to talk; try to avoid speaking all at once or over others
- Responding thoughtfully; avoid 'rescuing', giving advice inappropriately or immediately responding with your own story

A **CONNECTING** space
- We are here to build hope and resilience by finding a place of commonality and relatability; our individual circumstances may be different but it is likely that we will find connection through shared emotions.
- Try to focus less on what happened and more on how it made you feel

A **CONFIDENTIAL** space
- We will respect each other and honour the connections we make by keeping anything shared to ourselves outside of the circle
- There are rare circumstances which would necessitate the breaking of confidentiality; for example, if it was felt a participant was at risk of harming themselves or others or if story sharing included disclosure around active abuse

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A talking circle **IS NOT**:

A **FORMAL THERAPY** space

- The circle is not a source of formal psychological therapy
- By participating in the circle, we must all acknowledge and take responsibility for our own physical and emotional health; this includes seeking appropriate support elsewhere if needed
- While in the circle, if you should feel overwhelmed or distressed, please do contact one of the facilitators so that we can help where we can and direct you to more formal support if necessary.
- Should you have to leave the circle early, please give us a quick wave, thumb's up or private message to let us know you are ok

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