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Determinants of Relapse and Opportunities for Growth: Perspectives on Substance Use Among American Indian Community Members

Monica C. Skewes,[1] Julie A. Gameon,[1] Rachel Hallum-Montes,[2] and Adriann Ricker[3]

[1]Department of Psychology, Montana State University

[2]Spark Ideas, LLC

[3]School of Nursing, Johns Hopkins University

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Abstract

Resulting from generations of historical oppression and systemic racism, American Indian and Alaska Native (AI/AN) communities experience serious health disparities associated with substance use disorders (SUDs). As part of a longstanding community-based participatory research intervention development project, our partnership of academic and community co-researchers conducted seven focus groups ($N = 35$) to understand community stakeholders' perspectives on substance use, relapse, and recovery on a rural AI reservation. Participants included cultural leaders ($n = 10$), SUD treatment providers ($n = 5$), people with SUD ($n = 10$), and affected family members ($n = 10$). Cultural leaders viewed relapse as symptomatic of historical oppression, whereas other stakeholder groups attributed relapse to individual and interpersonal risk factors such as peer influence, lack of family support, and traumatic stress. All participant groups recognized relapse as a normative aspect of recovering from SUD that presents new opportunities for learning and growth. Specifically, regaining humility, learning to ask for help, recognizing one's triggers, and strengthening commitment to change were identified as learning outcomes for people with SUD. For family members, relapse provided the opportunity to practice forgiveness and compassion, two important cultural values. All groups emphasized the importance of grounding interventions in cultural values and traditions.

Keywords: American Indian/Alaska Native, substance use, relapse, recovery, CBPR

Word count: 4,175

Introduction

Although there are high rates of current and lifetime abstinence among American Indian and Alaska Native (AI/AN) populations relative to other racial groups in the United States (U.S.; Cunningham et al., 2016), there also is evidence of greater rates of substance use disorders (SUDs) among AI/ANs compared to non-Native U.S. populations (Grant et al., 2015, 2016; Riekmann et al., 2012; Spicer et al., 2003). Observed health disparities in substance use and alcohol use disorder among AI/ANs are attenuated when adjusting for socioeconomic variables (Atkins et al., 2013; Brave Heart et al., 2016), suggesting that greater poverty, greater unemployment, and lower educational attainment in AI/AN communities, among other inequities, likely contribute to health disparities observed in national epidemiological studies. Inequities in the social determinants of health, limited access to evidence-based treatment, and exposure to trauma and racism are factors that affect substance use in AI/AN communities (Brave Heart et al., 2016; Castor et al., 2006; Skewes & Blume, 2019; Whitbeck et al., 2004; Whitesell et al., 2012). These risk factors are compounded by the effects of historical trauma (Brave Heart, 2003; Brave Heart & DeBruyn, 1998) and limited options for culturally congruent, empirically supported SUD treatments (Greenfield & Venner, 2012; Novins et al., 2004; Skewes et al., 2020).

Historical Trauma

In AI/AN communities, historical trauma stems from violent colonization practices and racist policies that removed people from traditional lands and forced them to assimilate into dominant society (Brave Heart, 1998; Evans-Cambell, 2008). The removal of AI/AN children from their families to be placed in government-operated boarding schools where abuse was rampant and cultural practices were prohibited also contributed to historical trauma among

AI/AN peoples (Bombay et al, 2014). Mass trauma exposure is shared by diverse AI/AN ethnic groups, resulting in physical and mental health problems not only among those who experienced the traumatic events but also among their descendents (Brave Heart, 2003; Brave Heart & DeBruyn, 1998; Brave Heart et al., 2011; Evans-Campbell, 2008).

Relapse and Recovery

Substance use relapse is often viewed in a stigmatizing way that treats relapse as a personal failure or a failure of treatment (Barry et al., 2014; McGinty et al., 2015). However, addiction researchers conceptualize relapse as a normative part of recovery (National Institute on Drug Abuse [NIDA], 2018). One study found that 40-60% of people in SUD treatment will relapse; interestingly, this is comparable to relapse rates for people in treatment for hypertension and asthma (McLellan et al., 2000; NIDA, 2018). This suggests that recovering from SUD is comparable to recovering from other manageable chronic illnesses (Kelly et al., 2017; NIDA, 2018). Moreover, similar to other chronic illnesses, SUDs can be managed through medication, counseling, and behavioral interventions (Kelly et al., 2017; NIDA, 2018). Factors such as low socioeconomic status, unemployment, lack of social support, chronic life stressors, other psychiatric conditions, and greater cravings have been shown to increase the risk for relapse, whereas greater social support, adaptive coping skills, and self-efficacy increase the likelihood of recovery from SUD (Holt et al., 2012; McKay et al., 2006; Moore et al., 2014; Nordfjaern, 2011; Waters et al., 2012; Witkiewitz & Marlatt, 2007). However, little is known about how AI community members view relapse and recovery from a cultural perspective.

Current Study

In this manuscript, we report findings from one study conducted as part of a seven-year community-based participatory research (CBPR) project that aimed to understand substance use

and recovery among tribal members from a rural AI reservation with high rates of SUD and limited opportunities for treatment. Previous phases of our *Substance Use and Resilience Project* included a key informant interview study (Skewes & Blume, 2019; Skewes et al., 2019) and a survey conducted with tribal members with self-identified substance use problems (Skewes et al., 2020; Gameon & Skewes, 2021; Gonzalez & Skewes, in press). The key informant interview study helped our team understand factors believed to contribute to SUD on the reservation, including traumatic experiences, systemic racism, and insufficient opportunities for culturally relevant treatment. Participants reported that off-reservation treatment was often helpful, but maintaining treatment gains over time was difficult after returning to the environment that gave rise to the problem (Skewes et al., 2019). In the subsequent survey study, we examined risk and protective factors identified by key informants (e.g., historical trauma, ethnic identity, systemic racism, beliefs about alcohol problems) as they relate to substance use behavior (Gameon & Skewes, 2021; Gonzalez & Skewes, in press) and pilot tested our assessment instruments and data collection methods (Skewes et al., 2020).

Using findings from these preliminary studies, our partnership engaged in a series of discussions to identify empirically supported treatments that, if culturally adapted, may be acceptable and useful for tribal members. As many participants in our earlier studies reported initial success with treatment but difficulty maintaining changes over time, we homed in on relapse prevention (Marlatt & Donovan, 2005) as an evidence-based treatment with the potential to benefit the community. Through these discussions, our partnership recognized the need to understand views on relapse and recovery among diverse groups of community stakeholders who may have differing perspectives and priorities. To better understand the nature of relapse and recovery in the reservation context and to assess attitudes toward a relapse prevention

intervention, we conducted the present qualitative study.

Methods

Community Involvement

This project benefitted from the involvement of a long-standing community advisory board (CAB) that advised this study as well as previous phases of the project (see Skewes & Blume, 2019; Skewes et al., 2019; & Skewes et al., 2020). The CAB included community leaders from both tribal groups represented on the reservation as well as men and women, older and younger members, and members from both Christian and Traditional spiritual orientations. The CAB was involved in all aspects of this research, including specifying the project's goals, selecting participant groups, nominating potential participants, approving the focus group questions and study methods, interpreting the findings, and approving this manuscript. A local project manager, employed through a subcontract to the tribal college, extended invitations to participants, coordinated data collection, led the group discussions, and co-authored this manuscript.

Participant Recruitment and Procedure

The project manager recruited participants based on recommendations from the CAB. Participants were 35 AI men and women over the age of 18 residing on the reservation. We conducted separate focus groups with cultural leaders (two groups, $n = 10$), potential intervention recipients (i.e., people trying to recover from SUD; two groups, $n = 10$), family members of people with SUD (two groups, $n = 10$), and SUD treatment providers (one group, $n = 5$). Through discussions with the CAB, we selected these participant groups as a way to gather information from stakeholders who would be affected by the intervention we were developing. In particular, we aimed to gather data to inform an intervention that would be well-received by

potential participants as well as by family members whose support would be needed, cultural leaders who would be involved in the intervention, and treatment providers who would provide referrals to the intervention.

Participants were referred through nomination by CAB members and were invited to join the study by the project manager. It is important to note that the participant groups did overlap—that is, all participant groups had family members with SUD, and some of the treatment providers also were cultural leaders. When composing the focus groups, we categorized participants struggling with substance use as potential intervention recipients, regardless of their fit with other groups; treatment providers were placed in the provider group, regardless of their other roles in the community; cultural leaders who did not work in SUD treatment were categorized as cultural leaders; and the family member groups consisted of participants who had relatives who engaged in substance use, were not struggling with substance use themselves, were not treatment providers, and were not cultural leaders. These group assignments allowed our team to lead more focused discussions and to discern similarities and differences in perspectives among diverse stakeholders. As recommended by the CAB, no other demographic information was collected to ensure confidentiality and privacy.

Focus group questions were designed to elicit stakeholders' perceptions about substance use and relapse and generate suggestions for a culturally tailored relapse prevention intervention. Participants were asked about triggers that lead to lapses (or "falling off"), specific actions individuals should take following lapses, how future lapses can be prevented, and feedback on our plan for a future Indigenous relapse prevention program, including recommendations for cultural traditions or practices that could be incorporated into the intervention. Focus groups took place at the local tribal college, lasted one to two hours each, and were audio-recorded. All

participants signed an informed consent form and agreed to have the discussions recorded. After data collection, participants received $35 gift cards for their contributions. Study materials and methods were approved by the CAB, tribal IRB, and university IRB.

Data Management and Analysis

We used an evolved grounded theory approach to analyze the data. As described by Corbin & Strauss (2008), grounded theory attends to meanings, themes, and patterns in qualitative data and allows a theory to "emerge" from the data. Using techniques of grounded theory aligns with the principles of CBPR (e.g., Wallerstein & Duran, 2006), as this approach privileges the voices and perspectives of the participants. For this study, data analysis began with line-by-line open coding of focus group transcripts. Three researchers independently coded the data using Atlas.ti qualitative analytic software and compared codes. Discrepancies in assignment of open codes were discussed and resolved through consensus, with all researchers discussing code assignment until agreement was reached. After finalizing open codes, related codes were identified through constant comparative analysis and linked to form broader core categories, or axial codes. Through this process, coders also assessed categories for theoretical saturation to identify any areas that required further explanation (Corbin & Strauss, 2008; Birks & Mills, 2015). Once these core categories were finalized, they were linked and organized through the theoretical coding process to form overarching categories addressing the study objectives.

Findings

Determinants of Relapse

Key themes emerged related to historical and cultural determinants of relapse, which cultural leaders viewed as a symptom and consequence of historical trauma. These historical and

cultural factors were described as interconnected with individual and interpersonal triggers for relapse. However, individual triggers were referenced more frequently by people with SUD, family members, and treatment providers. Key individual and interpersonal risk factors included negative peer influence, lack of family and social support, and emotional pain from past traumas, which were thought to result from and interact with underlying historical trauma. All groups viewed relapse as an opportunity for learning and growth and supported the development of culturally tailored interventions to prevent relapse and facilitate recovery. Table 1 shows a summary of key themes and subthemes.

[Table 1 about here]

Cultural and historical factors. Cultural leaders, in particular, described substance use as symptomatic of the historical and cultural trauma the community has endured from centuries of colonization, genocide, and racist oppression. Historical oppression has led to what many viewed as a loss of Native identity, driving individuals to turn to substance use as a way of coping and finding a sense of belonging.

> "I never knew any of my grandparents, I never got an education on what it meant to be Indian, nobody ever told me any of that. My dad never grew up with any of that. We have people who are in homes where they're never being shown anything about their identity, their path…we have to put some foot tracks down for them. And if we don't, they're going to have a real huge tendency to go off wherever that road is we're intending for our people to go." – *Cultural leader*

Cultural leaders also explained that historical oppression has led to the internalization of a 'colonial mindset' that leads community members to turn against one another and perpetuate lateral oppression, undermining recovery. As one participant stated:

> "Oppression is a form of nonphysical violence that [has impacted us] over time due to this generational trauma…where we had to assimilate, where we had to adapt. We developed defense mechanisms to cope with that change. And those defense mechanisms were these microaggressions…where if one individual wants to change, like 'I'm going to stop smoking' or 'I'm going to quit drinking,' someone says, 'I don't think you can do that,' or 'you ain't gonna be able to do it.' That's oppression." – *Cultural leader*

Individual and interpersonal factors. A majority of family members, treatment providers, and those with SUD explained that the negative influence of peers is the primary driver of relapse. Within small, interconnected reservation communities, distancing oneself from others who encourage substance use or otherwise hinder recovery is challenging. It also may be culturally inappropriate to avoid one's relatives in close-knit communities, even if doing so is helpful for recovery.

> "Sometimes it's our surroundings we keep around us…even if you stay away from [substance using friends], they still tend to pop up, you know? You do your best to stay away from them, and they pop up and say, 'have this and that' and they wanna do it with you, you know? That's one thing that's pretty tough…just getting away from that [influence]." – *Participant with SUD*

Related to the presence of negative peer influence, participants noted a concomitant lack of positive influence and support from family, friends, and others within the community. Participants with SUD strongly emphasized the need for support from others, noting that the journey is too difficult to manage alone. As one participant stated, "No mental, emotional support [and] I'll go back to my old behaviors."

Participants also explained the role of interpersonal and childhood trauma in relapse.

Cultural leaders and treatment providers viewed substance use as self-medication of personal trauma, which was thought to exacerbate underlying historical trauma to create overwhelming stress. Traumatic stress then leads to relapse in the absence of healthy coping skills.

> "I think it's hard when you're trying to recover, you know, just some of the things that you may have encountered in your life, it's just hard to deal with. That's why they lean towards drugs and alcohol. They can't cope with the past, you know, it's just too tough. Things they've been through, things they've done. All that stress just adds up to where it feels like drugs and alcohol is the only thing you can do." – *Cultural leader*

> "The reason why people use drugs and destroy themselves is because they hurt. They're hurting somehow, somewhere in their system…what they're using the alcohol and drugs for is to medicate the hurt, the pain." – *Treatment provider*

Opportunities for Growth

Across groups, participants acknowledged that relapse represents a valuable opportunity for learning and personal growth and that positive outcomes often result from relapse.

Regaining humility and asking for help. In collectivist AI communities, the opportunity to increase one's reliance on others aligns with the central Native value of interdependence (Garrett, 1999; Mohatt et al., 2004). Participants with SUD and treatment providers shared that relapse can serve as an important reminder to practice humility, which they contend is foundational for recovery. Relapse can serve as a reminder that people cannot accomplish sustained recovery on their own and lead them to humbly seek support from others. As one participant explained, "When you relapse, you have to learn to ask for help. It's really hard, but you have to do it. It's the first step. It's really important."

Recognizing triggers. Recurrent relapses, while especially frustrating for family

members, may help those in recovery learn to recognize their patterns of use and relapse triggers. Understanding one's triggers is crucial for learning to avoid them or cope with them in healthier ways. This was seen as one of the most valuable lessons of relapse.

> "Like, for me, when I see something that I know that's gonna trigger me, you know, I'll blare it out louder than heck, and they know I'm joking but [also] serious, and I'll point it out, and I'll say 'Trigger! Trigger!'" – *Participant with SUD*

Becoming fatigued…and motivated. Participants with SUD described becoming fatigued with recurrent relapses, which helps strengthen their commitment to recovery. This fatigue was described as a catalyst for making a conscious decision to choose long-term recovery and find the motivation needed to actively pursue this goal.

> "It's just, I got tired of it. I mean, when you use…you have to do so much and so much and so much, you know, just to get to that point…and even then it's like, how're you gonna get it, you know? You can get money or you gonna rob somebody, you know, stuff like that. Finally, I just told myself, 'I'm done!' You know?" – *Participant with SUD*

Practicing forgiveness and compassion. Participants with SUD, family members, and treatment providers recognized relapse as an important opportunity to learn and practice forgiveness and compassion. For people with SUD, relapse represents a chance to practice self-compassion, which treatment providers viewed as critical for recovery.

> "I think a key part [of recovery] is letting go and forgiving yourself…to realize that I've acknowledged this traumatic thing in my past, I've accepted it, and this is part of me letting it go." – *Treatment provider*

Family members and treatment providers described relapse as an opportunity to demonstrate forgiveness without shame or judgment, which was seen as central to supporting

loved ones in recovery.

Developing Future Interventions

Grounding interventions in Native culture and values. Across stakeholder groups, participants recognized relapse as a normative part of the recovery journey that offers needed lessons and insights. As one family member stated, "Like, we know that it's probably gonna come, let's prepare for it." Participants explained that interventions tailored to AI communities should be grounded in Native culture and values. In particular, reconnecting with one's Native identity through traditions, ceremonies, and spirituality was described as a critical cornerstone of recovery for AI people, and a way to learn from relapse and draw strength for recovery.

"This is my tribe, you are my people. I belong to you and you belong to me. And all these teachings, they're for everybody…it's just, it's there. If they just can embrace that…it's identity. That's who you are. You don't need an invitation, you don't need to be approved, you don't have to wait in line. You don't need an invitation to your culture, or to a ceremony. Very powerful—there's some very powerful things that will heal you." – *Cultural leader*

Re-connecting with Native identity, culture, and spirituality. Cultural leaders viewed reconnection with culture and spirituality as the most important avenue for reducing harm from substance use and recovering from SUD.

> "I think our culture is the way... I think harm reduction is great, and I think that our culture is a perfect example of harm reduction…I think that every sweat [ceremony] we go in is harm reduction. Every time we pray is harm reduction. Every time we raise our pipe is harm reduction. And I think that we have to start thinking like that, that everything we do carries energy." – *Cultural leader*

It is important to note that full participation in traditional ceremonies is incompatible with

substance use, as ceremony requires people to be free from substances. This may lend additional strength to those wishing to engage in traditional spirituality during their recovery journey.

Connecting individual with communal recovery. Finally, participants explained that recovery is not an individual process but a communal one. They recommended involving sober relatives and community mentors in future interventions to help build a strong social support network for those in recovery. Family members expressed the need for more support to help them interact with their relatives in productive ways. For example, one participant stated, "[We need] community enablers' awareness, like a meeting or something…like a way to learn to help each other." Notably, participants emphasized the importance of including people with SUD in the community and embracing them rather than rejecting them for relapsing.

> "One of the biggest things is…you can still be a part of the community. You have family, a support system. Another outlet [is] in finding your spiritual family, or your mentor." – *Cultural leader*

Discussion

Empirically supported SUD interventions are critically needed for reducing health disparities associated with substance use in Native communities. With the greatest need for SUD treatment among all racial groups in the U.S. (Chartier & Caetano, 2010), AI/AN communities are calling for new approaches that embrace Native culture, traditions, knowledge, and values (Gone & Trimble, 2012; Larios et al., 2011; Novins et al., 2004). As part of a CBPR intervention development project, we conducted focus groups with diverse groups of stakeholders from a rural AI reservation, including cultural leaders, SUD treatment providers, tribal members with SUD, and affected family members. Participants shared valuable knowledge about substance use and relapse and made recommendations for a culturally grounded relapse prevention

intervention. In general, cultural leaders focused more on the historical and cultural determinants of substance use (i.e., historical trauma, lateral oppression, loss of cultural identity), whereas other stakeholder groups focused more on individual and interpersonal risk factors. All groups, however, viewed relapse as a normative part of recovery that provides new opportunities for learning and personal growth.

Participants described several opportunities provided through relapse, many of which aligned with cultural values from this community. For example, humility, interdependence, reliance on extended family, patience, and forgiveness are important cultural values (Garrett, 1999; Mohatt et al., 2004) that can be strengthened through learning from relapse. Native ways of knowing emphasize the cycles of natural processes (Rybeck & Decker-Fitts, 2009), and participants understood relapse and recovery as part of a natural cycle as well. They expressed support for interventions aimed at ending the cycle and restoring balance for tribal members struggling with SUD. Family members expressed the need for additional support for themselves and the community as well.

Regarding recommendations for interventions, cultural leaders strongly advocated focusing treatment on reclaiming Native identity and spirituality, which they contend will indirectly resolve SUD as substance use is incompatible with traditional ways of life. They also reported that historical trauma has manifested in lateral oppression from community members who sabotage or thwart recovery efforts. Connecting with a “lodge” or spiritual family could help overcome this barrier. Participants with SUD, family members, and treatment providers expressed support for incorporating culture into interventions as well, but did not believe that cultural practices alone would be sufficient. These stakeholders recommended that interventions focus on culturally appropriate ways to resolve pain from childhood trauma, teach clients to

avoid relapse triggers, build social support for recovery, and teach new coping skills. All participant groups emphasized that involving the family in treatment is a crucial aspect of relapse prevention for AI people, and that helping the family to avoid enabling and support their loved one's recovery in productive ways is necessary.

Strengths, Limitations, and Future Directions

Strengths of this research include our equitable community partnership and commitment to CBPR—a necessary approach to health disparities research with AI/AN communities (e.g., Skewes et al., 2020). Using CBPR helps ensure that research benefits rather than blames and stigmatizes AI/AN peoples, which is necessary for building trust and engaging AI/AN communities in future research. Limitations include non-random sampling of participants and overlap of participant categories. Participants in all stakeholder groups also were family members of people with SUD, and there was overlap between the treatment providers and cultural leaders groups as well. However, conducting separate groups with tribal members who were most connected to their roles as cultural leaders, treatment providers, family members, or potential intervention recipients allowed for greater understanding of diverse viewpoints among community stakeholders. Also, as all participants were from the same reservation, these findings may not generalize to other Native communities.

In future directions for this research, our partnership has collaborated on the development of a culturally grounded SUD intervention that will be implemented on the reservation. Using data from this study and two earlier preliminary studies, we have incorporated family support, cultural lessons, and Native spirituality into the curriculum. Participants will have opportunities to reconnect with their families, community, and culture as they complete exercises to identify their relapse triggers and learn coping skills needed to overcome them. Importantly, tribal

members who may have difficulty avoiding substance-using friends and relatives in small, close-knit reservation communities will have the opportunity to build a healthy social support network through the intervention.

Conclusion

Community stakeholders from an AI reservation shared knowledge about determinants of substance use, relapse, and recovery. All participant groups recognized relapse as a normative, cyclical aspect of recovering from SUD that presents new opportunities for learning and growth. Cultural leaders focused on historical oppression as the key driver of substance use and recommended strengthening cultural identity and Native spirituality to promote recovery. Treatment providers, family members, and people with SUD focused on individual and interpersonal risk factors and recommended building coping skills and social support for recovery. All participants recognized the importance of grounding interventions in cultural values and strengths. Future research is needed to test culturally grounded interventions to reduce health disparities associated with substance use in AI/AN communities.

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Table 1. Summary of key themes and sub-themes

Key theme	Sub-themes
Determinants of relapse: Cultural and historical factors	• Historical and cultural trauma • Internalization of colonial mindset
Determinants of relapse: Individual and interpersonal factors	• Negative peer influence • Lack of positive support from family and friends • Interpersonal and childhood trauma
Opportunities for growth	• Regaining humility and asking for help • Recognizing triggers • Becoming fatigued and motivated • Practicing forgiveness and compassion
Opportunities for future interventions	• Grounding interventions in Native culture and values • Re-connecting with Native identity, culture, and spirituality • Connecting individual with communal recovery