Introducing Healing Circles and Talking Circles into Primary Care

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Abstract

We report on the incorporation of a North American aboriginal procedure called "the talking circle" into primary care in areas serving this population. Communication is regulated through the passing of a talking piece (an object of special meaning or symbolism to the circle facilitator, who is usually called the circle keeper). Twelve hundred people participated in talking circles in which 415 attended 4 sessions and completed pre- and postquestionnaires. Outcome measures included baseline and end Measure Your Medical Outcome Profile version 2 forms. Participation in at least 4 talking circles resulted in a statistically significant improvement in reported symptoms and overall quality of life ($p < 0.001$ and effect sizes ranging from 0.75 to 1.19). The talking circle is a useful tool to use with Native Americans. It may be useful as a means to reduce health care costs by providing other alternative settings to deal with stress-related and other life problems.

Introduction

Talking circles, peacemaking circles, or healing circles, as they are variously called, are deeply rooted in the traditional practices of indigenous people.[1] 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,[2,3] 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. *Hocokahs* may participate together in purification and other ceremonies and usually camp together when traveling to larger gatherings, such as the sun dance. Healing circles have been used for recovery from alcoholism in aboriginal communities,[4] especially when the traditional spirituality of those communities are perceived to conflict with the assumptions of Alcoholics Anonymous (AA).

The talking circle process is a unique instructional approach that can be used to stimulate multicultural awareness while fostering respect for individual differences and facilitating group cohesion.[5] The creation of the talking circle is often credited to the Woodland tribes in the Midwest North America, who used it as a form of parliamentary procedure. "The symbol of the circle holds a place of special importance in Native beliefs. For the North American Indian, whose culture is traditional rather than literate, the significance of the circle has always been expressed in ritual practice and in art. The lives of men and women, as individual expressions of the Power of the World move in and are nourished by an uninterrupted circular/spiral motion. This circle is often referred to as the Medicine Wheel. Human beings live, breathe and move, giving additional impetus to the circular movement, provided they live harmoniously, according to the circle's vibratory movement. Every seeker has a chance to eventually discover a harmonious way of living with their environment according to these precepts."[6] Traditionally, many Native American communities have used the talking circle as a way of bringing people of all ages together for the purposes of teaching, listening, and learning.[6] Talking circles were a traditional form of education from early childhood through adulthood and provided a way to pass on knowledge, values, and culture. This method of education instilled respect for another's viewpoint and encouraged members to be open to other viewpoints by listening with their hearts while another individual speaks.[7] Today, talking circles are used throughout the country in tribal inpatient and outpatient drug and alcohol centers, group homes, adolescent prevention and intervention programs, prayer circles, tribal and public schools, and college-based English as a Second Language programs. They effectively foster respect, model good listening skills, settle disputes, resolve conflicts, and build self-esteem.[8] Talking circles as a psychological technique provide a cathartic impact of publicly sharing problems or concerns.[9] This group intervention/activity provides participants with a structure that promotes self-exploration in an empathic and supportive atmosphere. In addition, talking circles have been compared in relevance to Network Therapy, which mobilizes members of the family and extended family into maximizing their resources and coping mechanisms.[10]

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The object used to designate the speaker is considered sacred.[5] In many Native American cultures, this object is often viewed as having a symbolic meaning to its owner. It is suggested that the group facilitator or instructor (for the first talking circle) bring an object that is symbolic to him or her. Members of the group can bring personally significant objects to use in subsequent talking circles. The convener sets the framework for the activity by clarifying the use of the talking circle as an educational group activity versus a therapeutic group format (which would require an agreement for participant confidentiality). The facilitator clarifies and models appropriate use of self-disclosure, such as staying within the topic, especially in educational settings. Furthermore, the facilitator/instructor identifies, models, and monitors the emotional content level in personal disclosures.

The circle process establishes a very different style of communication. Rather than aggressively debating and challenging each other, which often involves only a few of the more assertive individuals, the circle process establishes a safe nonhierarchical place in which all present have the opportunity to speak without interruptions. Rather than active verbal facilitation, communication is regulated through the passing of the object. The talking stick or other object fosters respectful listening and reflection. It prevents one-to-one debating or attacking. After brief opening comments by the circle keeper about the purpose of the talking circle, a listing of ground rules, and a request for additional contributions to the ground rules, the circle keeper says a few things about the talking object and then passes it to the person on the left, clockwise. Only the person with the talking piece can speak. If others jump in with comments, the circle keeper reminds them of the ground rules and refocuses on the person with the talking object.[5]

Healing circles have also been used for reconciliation justice within the criminal justice system and are then often called peacemaking circles:

> "Peacemaking circles use traditional circle ritual and structure to create a respectful space in which the crime victim, victim supporters, offender, offender supporters, judge, prosecutor, defense counsel, police, court workers, and all interested community members can speak in a shared search for understanding the event at issue; participants also identify the steps necessary to address the harm caused by the offense and to prevent future occurrences. The peacemaking circle process typically involves several steps that lead to the sentencing. An application by the offender to the circle process is followed by the creation of a support system for the offender and a support system for the victim. Other steps are a healing circle for the victim and healing circle for the offender. These steps are then followed by the sentencing circle. After the sentencing circle, there may be follow-up circles at appropriate intervals to review progress on the sentencing agreement. The circle process is not simply a process for finding more appropriate justice; it is an exercise in building community, because it brings community members together in a forum that allows exploration of the underlying causes of crime and encourages each community member to offer gifts or capacities to the process of finding solutions and implementing them. The circle process allows full expression of emotions and channels the energy of those emotions toward positive solutions. In the circles, decisions are based on consensus, and everyone involved must agree that the decision is one with which they can live. Circles draw on the life experiences of all the participants to understand the problem at hand and to devise workable solutions."[11]

Healing Circles Are Elements of Native American Spirituality

Circles draw on the life experiences of all the participants to understand the problem at hand and to devise workable solutions.

The healing circle/talking circle is an element of North American aboriginal spirituality, which has historically been an underlying concept that permeates every aspect of Native American life. This spirituality is closely connected to the natural world, with land and community having the highest possible meaning and being places for honoring and communicating with spirits.[12]

Native American spirituality is circular in nature,[4] encompassing the 7 sacred directions of West, North, East, South, Sky, Earth, and Center.[13] "West, North, East, and South are viewed as the sacred quadrants of the universe. Each quadrant contains special meanings, elements of power, spirits, and sacred teachings. The spiritual essence of all life forms—plant, animal, and human—resides in these four directions."[14] The fifth direction, Sky, is the upward direction that represents (in Lakota) *Wakantankan,* the sky spirits, many or one. Earth, the sixth direction, represents the Mother, the source of all life. The seventh direction, Center, is responsible for the connection and unification of all the sacred directions. Center is the spiritual essence of self, so that every living entity is also a Center. All of these directions in unison represent the Sacred Hoop, or Medicine Wheel.[13] When the 7 sacred directions are in harmony and balance, the Sacred Hoop is whole.[15] Similarities exist between talking circles and support groups and 12-step groups.

This article reports a "case study" of implementing this culturally appropriate healing tool within conventional primary care to learn whether outcomes could be improved. A total of 1211 people participated in talking circles in which 415 people attended 4 sessions and completed baseline and end Measure Yourself Medical Outcome Profile version 2 (MYMOP2) forms. These talking circles focused on drugs, alcohol, and mental health in the respective communities and how community members could work together to solve these problems.

Methods

LMM provided consultations to several Canadian aboriginal reserves and to urban Indian centers and facilities in the province of Saskatchewan. LMM implemented talking circles within and around 10 primary care health clinics, usually in the waiting room after hours. Posters and flyers were widely circulated to announce talking circles at the primary care clinic to explore solutions to problems of drugs, alcohol, and mental health in the community. No one was excluded. A total of 1211 people attended at least 1 meeting. Participants completed the MYMOP2 initial rating form on the first day of participation and the follow-up form on their fourth time of participation. A total of 415 participants submitted both an initial rating and at least 1 follow-up form. There were 234 people available for telephone interview at the completion of their eighth week of participation.

This project had institutional review board approval as part of a larger research project on spirituality and health. No identifying data were provided on the MYMOP2 forms. Respondents picked their own code names so that their first and second MYMOP2 forms could be correlated. The study lasted for 3 years and finished when LMM left Saskatchewan, so the study size was determined by factors external to the participants.

The MYMOP2 is a patient-centered, problem-specific outcome measure. Evidence suggests that it is a useful and sensitive measure of change in perceived symptoms and quality of life.[16-18] In the current study, participants used the MYMOP2 to choose the 1 or 2 symptoms of most concern to them, along with 1 activity of daily living that was restricted or prevented by these symptoms. The respondent scored these items according to their severity in the previous week using a 7-point Likert scale ranging from 0 (as good as it can be) to 6 (as bad as it can be). They also rated their general feelings of well-being. Measures were taken before the first treatment (baseline) and at follow-up 3 months later. Additional details collected included gender, age, occupation, and marital status.

The MYMOP2 has been used in clinical audits in the United Kingdom (UK) to improve patient care,[19] to show that acupuncture benefited people with chronic illness,[18] and to assess overall outcomes in a complementary care clinic.[20] In all these contexts, the MYMOP2 provided an opportunity to assess overall improvement in symptom severity, the degree to which symptoms restrict participation in desired activities, and overall quality of life in cases in which the symptoms themselves may be radically different. The use of symptom-specific scales in these cases would result in insufficient numbers of participants for comparison purposes and also prevent across-illness comparisons. Paterson and Britten,[18] Rees,[19] and Harris et al[20] have argued that the MYMOP2 is more useful than other tools for the "real-world" situation in which clinicians apply the same treatment methods (group therapy, talking circle, acupuncture) to a variety of different patients and conditions, all with the same goal of reducing their suffering and improving their quality of life.

LMM typically participated in the first talking circle and encouraged participants to continue to meet on their own. LMM or an associate appeared regularly to distribute MYMOP2 follow-up forms and to provide support to the continuation of the talking circles. The talking circles consisted of a kind of "leaderless leadership" in which the person who had originally convened the talking circle welcomed new members (whom anyone could invite), led the opening prayer, and oriented members to the task or question for which the talking circle had been convened. No fees were charged and no professionals were intentionally involved in leadership roles. The opening invitation usually related to exploring how alcohol, drugs, and mental health issues affected participants and their families in their home communities. No attempt was made to personalize the invitation to those people who came. The MYMOP2 was introduced as a tool to assess how participation might have an impact on participants' own health and sense of well-being. The rationale for this lay in their participation in problem solving for the community in a uniquely Native American (First Nations) manner. Support groups and 12-step groups were also available in the communities involved in this study.

We wondered whether having the opportunity to meet in this culturally appropriate manner with others would reduce the primary complaints that people had (as reported on the MYMOP2). Even with the best resources, mental health services cannot meet the need for mental health care in the community.[21] We wondered whether culturally syntonic practices could help fill that gap. This could be important in health care systems such as the UK's in which primary care has considerable power to fashion the development of services locally, through both service provision and commissioning. In the UK, primary care trusts are able to provide locally any form of service they choose, including mental health care.[21]

Statistical Analyses

Descriptive statistics were compiled in the standard method provided by Statistical Product and Service Solutions (SPSS) version 17 (IBM, Armonk, NY). Paired *t* tests were used to compare pre- and postbaseline and end data on the MYMOP2 scale for the 2 most prominent symptoms, their effect on activities of daily life, and the person's overall well-being. Participants who provided only one MYMOP2 were not included in the analysis.

Sources of Bias

The results of this study are biased toward people who came at least four times. We do not know the reasons why people came fewer than four times. We picked four attendances as a minimum number expected to produce change in participants. Psychotherapy outcome studies tend to require a minimum of six visits. We cannot provide an intent-to-treat analysis because all circles had open enrollment, and no one was referred specifically to the circle. All who came were welcome. Follow-up data was collected only on the fourth time that a person attended the circle, and a person could attend without providing any data.

Results

The mean age of the participants was 40.5 years. Of the participants, 65.5% were women (mean [standard deviation (SD)] age, 42.1 [15.9] years), and 66% of those were married. For men, 35.1% were married.

Table 1. The number of patients reporting the most common symptoms upon arrival at the talking circle (N = 415)

Symptom	Men (n = 143)	Women (n = 272)
Musculoskeletal	37	90
"Family problems"	22	75
Headaches	21	63
"Stress"	25	56
"Children"	15	39
"Marriage"	19	31
"Depression"	13	30
Worry/fear/anxiety	12	13
Financial/money	47	15
"Work"	33	14
Other	42	118
Total	286	544

Of the respondents, 21.6% reported taking prescription medication for their main symptom; the majority of which included analgesic and anti-inflammatory drugs for musculoskeletal complaints, headaches, and migraines. Other medications commonly reported by participants included antidepressants, antihistamines, anti-anxiety agents, sleep-promoting agents, and narcotic pain medications. Of participants taking medication, 72% had experienced their main symptom for more than a year. All participants were asked if cutting down or avoiding medication was important to them; 29.8% reported this was "very important," whereas 29.8% indicated it was "not important."

Table 1 shows that most people were suffering from experiencing what could be called the problems of ordinary life.

Histograms were used to confirm that the results followed an approximate normal distribution, which they did. The paired-samples *t*-test procedure of SPSS, version 18 (IBM) was used to test the hypothesis that statistically significant improvement occurred in symptoms, activities of daily living, and overall well-being during the time that participants attended the talking circles.

The reporting of specific medications taken was spotty and not judged reliable, so it was not analyzed. Although the majority of patients served were aboriginal, nonaboriginal people also attended the talking circle. As we did not ask about ethnicity, no analysis was possible on that variable.

Table 2 presents the results of paired *t*-test analyses. Both the participant's primary symptom and his or her secondary symptom showed a statistically significant decrease in severity from the beginning of participation in the talking circle to the end of the fourth visit. The extent to which symptoms interfered with daily life was also statistically significant, decreasing from baseline through the fourth visit. Ratings of overall well-being also statistically significantly improved (lower ratings equal better well-being). Effect sizes ranged from 0.75 to 1.19, indicating that participating in the talking circle had a robust effect.

Conclusion

Culturally derived practices may work well in the primary care setting. One-third of the people came for 4 or more sessions, which is remarkable in this population. Historically, community mental health centers have reported that more than 40% of their clients attend only one or two outpatient visits[22-25] when referred. Less than one-fourth of outpatients attend even brief psychotherapy's minimum criterion of 10 visits for effective treatment.[22] This has only gotten worse over time.[26]

For patients who engaged in primary care counseling services, the average "declared" rate of unplanned endings was calculated at 32%, with a high rate determined as 40% and a low rate as 21%.[23] The average "estimated" rate of unplanned endings was

Table 2. Comparison of baseline and end data

Result	Symptom 1	Symptom 2	Effect on activities of daily life	Overall well-being
Difference from baseline to end	-1.9	-1.2	-1.9	-0.9
SD	1.6	1.6	1.8	0.9
95% CI of the differences of the mean	-2.179 to -1.621	-1.479 to -0.921	-2.2288 to -1.5712	-1.0644 to -0.7356
Significance	p < 0.001	p < 0.001	p < 0.001	p < 0.001
Effect size	1.19	0.75	1.06	1.00

CI = confidence interval; SD = standard deviation.
The statistical power to detect an effect was 100%.

Table 3. Comparative primary care referral rates for counseling services

Study authors	Finding	Percentage	Location	Type of care
Ciarlo JA[1]	Outpatients who complete 10 psychotherapy visits	< 25%	US	Primary care
Connell J, Grant S, Mullin T[2]	Declared unplanned endings for primary care counselings	32% (range, 21% - 40%)	United Kingdom	Primary care (National Health Service)
Passey ME, Laws RA, Jayasinghe UW, et al[3]	Estimated unplanned endings for primary care counseling	50% (range, 38% - 58%)	United Kingdom	GP Practice, National Health Service
Passey ME, Laws RA, Jayasinghe UW, et al[3]	Accepted referral to a free lifestyle modification program	27.1%	Australia	Primary care
Gifford H, Paton S, Cvitanovic L, McMenamin J, Newton C[4]	Accepted referral to alcohol counseling	36%	New Zealand	Primary care

GP = general practitioner.

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calculated at 50%, with a high rate determined as 58% and a low rate as 38%.[24] Declared therapy endings are where the practitioner has provided data; estimated therapy endings take into account missing data where clients are more likely to have had an unplanned rather than a planned ending to therapy. Table 3 summarizes other studies' findings for primary care referral rates to counseling services.

The Native American concept of the talking circle and its use is similar in some ways to 12-step programs, including AA. Morgan-Lopez et al[27] found greater reductions in alcohol use over time for women who followed-up with a 12-step group compared with women who didn't after the completion of an intervention program (Seeking Safety). They found no effect of follow-up with a 12-step group on reducing cocaine use.

A Consumer Reports Study[28] found that people with mental health and substance abuse problems who went to AA did especially well, with an average improvement score of 251 (range = 0 to 300), significantly bettering mental health professionals. People who went to non-AA groups had less severe problems and did not do as well as those who went to AA (average score = 215). Thus, peer-led group programs may have an important role in primary care settings.

… people sitting together and talking about the ordinary problems of life may be as beneficial or more beneficial than actually consulting the general practitioner.

Targ and Levine[29] examined outcomes for 181 women with breast cancer randomized to either a 12-week standard group support or a 12-week complementary and alternative medicine (CAM) support intervention. Participants in the CAM group were taught the use of meditation, affirmation, imagery, and ritual. The standard group combined cognitive-behavioral approaches with group sharing and support. Both interventions were statistically significantly associated with improved quality of life, decreased depression, decreased anxiety, and increased "spiritual well-being." Only the CAM group showed statistically significant increases in measures of spiritual integration. The standard group was associated with decreased confusion and decreased helplessness/hopelessness, whereas the CAM group was associated with decreased avoidance. At the end of the intervention, the CAM group showed higher satisfaction and fewer dropouts compared with the standard group. The CAM group had an 8% dropout rate, whereas the standard group had a 19% dropout rate, although this was a population who had already agreed to participate. Whiting et al[30] found a 40% dropout rate from cognitive-behavioral therapy and a 32% dropout rate from support groups for people with chronic fatigue syndrome.

Limitations of this current study must be acknowledged. Perhaps anything that enabled people to sit together for four or more times would show high levels of effectiveness, although this would potentially be one of our points: that people sitting together and talking about the ordinary problems of life may be as beneficial or more beneficial than actually consulting the general practitioner. Certainly we cannot say that the talking circle format is the cause of the changes observed since there was no control group, but we can suggest a beneficial effect of bringing people together with a structure that allows them to speak and be heard. Preliminary data from another study underway suggest that the effect size for change for clients receiving conventional psychiatric care in the US is small (Mehl-Madrona, manuscript under editorial review, 2014). The clients in our study experienced large effect sizes. We should, therefore, walk through the door of exploring peer-to-peer support and mutual help in primary care and, of course, aim to make primary care even more culturally appropriate to the population it serves.

The talking circles were peer-led after the first introductory circle. Peer leaders were not paid and participants were not charged. Thus, the cost-benefit ratio is potentially favorable. Professionals were not involved except to initiate the circle. The initiator's attendance was not required for these circles to continue. After the first session, the only costs were that of heating and lighting the building. Effect sizes equaled or exceeded what is seen for other common interventions in primary care and/or mental health care.

Talking circles or similar peer-counseling interventions may have an important role in these days of escalating health care costs. They provide an opportunity for people to help each other without reliance on professional expertise. Talking/healing circles or other forms of peer support and/or peer counseling could become a useful adjunct to conventional health care. For Native Americans, talking circles may be a particularly culturally syntonic way to receive help from other people.

Among 57 patients who attended a complementary medicine clinic in the UK, significant changes were found in MYMOP2 scores for symptoms 1 and 2 and for effect on daily activity scores, but not for overall well-being scores.[20] They would have needed 43 more subjects to have had adequate power to detect an effect on well-being. Their effect size for changes in symptoms was also 1.0, similar to what was found in this study.

Talking circles have been used successfully in other contexts, including Native American communities, to successfully increase the rate of screening for cervical cancer,[26] and to improve receptive and expressive language functions in English as a Second Language classrooms.[31] Talking circles were successfully used as culturally sensitive mitigation strategies for Alaskan Native people negatively affected by the 1989 *Exxon Valdez* oil spill, taking advantage of this traditional social activity of Alaskan Natives.[32] The talking circles in this last example were organized and implemented by members of the Village of Eyak in Prince William Sound, AK. The 2-day event resulted in many testimonies about personal experiences with the oil spill. Activities by Eyak village members after the talking circle event indicated increased cultural awareness and political mobilization. The use of talking circles appeared to promote cultural consciousness among victims experiencing chronic disaster impacts and resulted in a "transforming activity" for the Village of Eyak. Talking circles have been used to foster positive psychology and cultural appropriateness for Native Americans with alcohol problems.[33] Talking circles have been used to foster awareness of healthy eating and to improve eating practices among Native Americans.[34]

Talking circles or other peer activities may fill gaps in meeting the need for mental health services. According to a report in 1992 by Howard et al,[35] in the US, people in need of mental health services had available no more than an average of three treatment sessions from a mental health professional in any

given year.[35] A small proportion of such individuals actually sought service, and each individual who consulted the specialty mental health sector had available no more than an average of ten treatment sessions. The most needy, particularly those lacking in education, are the least likely to receive treatment in the psychotherapeutic service delivery system.[36]

Further research is warranted to determine the acceptability of talking circles or more generic peer counseling groups to broader population groups. Talking circles 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.

Our remarks are limited to people who came to at least four sessions and were willing to complete two questionnaires. Although our retention rate was higher than that of people receiving psychotherapy and people being treated for depression in primary care, we still lost more people than we retained. This is a common problem in human services delivery. Future research could examine the effects of attending two or three sessions and could also explore the reasons why people came once and did not come back. We also do not know whether these results would generalize to nonindigenous populations, which could be a topic of future research. ❖

Disclosure Statement

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