National American Indian and Alaska Native
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Mental Health

IN OUR NATIVE AMERICAN COMMUNITIES · VOL 1 ISSUE 2 FALL 2019

First Episode and High-Risk Psychosis

National American Indian & Alaska Native Mental Health Technology Transfer Center
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Photo: Michael Kreiser

DIRECTOR'S CORNER

Welcome to the second issue of the Newsletter for the National American Indian & Alaska Native Mental Health Technology Transfer Center. The publishing of this newsletter coincides with the Native American Heritage Month, and we would like to acknowledge the importance of celebrating the proud heritage of Native American and Alaska Native communities. This month also coincides with the Thanksgiving holiday in the US, which is a holiday the Native communities at best have an ambivalent relationship with. It is important to celebrate our harvest and remember the less than positive history around Thanksgiving. Please see page 10 for some resources on the true history of this holiday.

The focus of this newsletter is on early onset and high-risk psychosis. Roger D. Walker, MD, Western Band of the Cherokee Nation, and Ken Winters, PhD have written an article introducing the diagnostic characteristics of psychosis, progression of psychotic episodes, as well as treatment and assessment of psychotic disorders, and highlighting the importance of involving families in treatment of psychotic disorders. However, these medical and psychosocial approaches to treatment of psychotic disorders are based on western research. Hence, the authors have included suggestions for cultural adaptation and understanding of symptoms of psychosis in light of cultural considerations. It is also important to understand that cultural ways can influence the expressions of psychotic symptoms. The focus on psychosis is the first section of an extensive curriculum we are in the process of developing.

We always like to update you about some of our other activities in the MHTTC. One source of pride for our TTCs is the Native American Leadership Academy. Eleven Native providers with desire to take leadership roles in their communities and agencies are working closely with Native mentors from across the country. We look forward to listening to their project presentations during the second face-to-face meeting taking place in February in Albuquerque, NM.

Our Returning Veteran Project has been presented several times across the country, and our upcoming webinar sessions will offer several modules of this curriculum, starting in December. Returning Native veterans often report more serious and chronic PTSD symptoms, because of prior traumatic experiences before joining in the armed forces, and accordingly our webinar series will be focused on PTSD.

I hope the harvest fest and the rest of the holiday season will be filled with family and happy experiences.

Regards,

Anne Helene Skinstad, PhD

Understanding First Episode and High-Risk Psychosis

Ken C. Winters, PhD
R. Dale Walker, MD
Contributions from MARY K. WINTERS, MEd

The authors' research for this column was aided by the presentation provided by Australian Psychiatrist, Patrick D. McGorry, MD, "Early Intervention for Psychosis: A new Architecture and Culture of Care," given during the conference "Early Intervention in Psychosis: Current Knowledge and Future Directions," held at the Douglas Mental Health University Institute in May 2013. The presentation can be accessed at https://www.youtube.com/watch?v=uHwquf2ffyQ.

Introduction

It is a sobering fact that there is great disparity across ethnic groups with respect to the prevalence of mental and behavioral disorders among adults in the US. Native Americans have a greater prevalence of depression, suicide, alcoholism and drug abuse than other ethnic/racial groups.[1] Moreover, they have much less access to culturally relevant treatment and often lack social supports. While the epidemiology is unclear, it is assumed that the incidence of psychotic episode are at least as high as the general population. In this column we will focus on one of the most debilitating mental disorders – psychosis. Because it is important to detect and treat psychosis as early as possible, we will focus on first episode psychosis and the related topic of high-risk or "ultra risk" psychosis.

What is First Episode Psychosis?

This simply refers to the first time someone experiences psychotic symptoms or a psychotic episode. People experiencing these symptoms for the first time may not comprehend what is occurring. This is understandable given that these symptoms can be extremely distressing and significantly impact a person's daily functioning. Affecting about 1-2% of the population, the age of onset can vary, although the typical age when symptoms of psychosis first begin is during adolescence or early adulthood.[11] Unfortunately, negative myths and stereotypes about psychosis are still common in the community. Those afflicted are not any more dangerous than those in the general population and having the disorder does not carry with it certain dismal outcomes. Treatment works, especially when accompanied by support from family and friends.

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Symptoms

The psychotic symptoms experienced during a person's first episode are all characterized by one salient feature: a very noticeable change in his or her thinking, mood and behavior. Given individual differences, not all afflicted will show an identical symptom picture, and symptoms may change over time. Characteristic symptoms can be grouped into the following categories:[17]

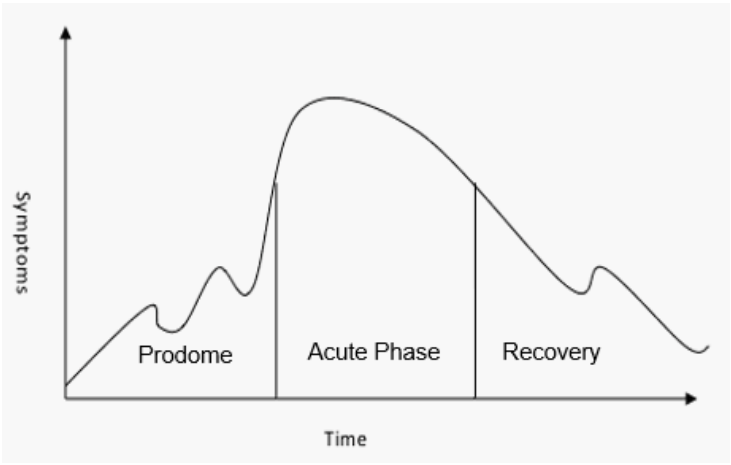
- **Confused thinking and muddled speech:** Speech may not make sense as a result of muddled or confused thinking. The person may complain that their mind is racing and has trouble concentrating.
- **Delusional thinking:** A delusion is a belief that is most certainly false. Yet the person is so convinced of the reality of their belief that he or she resists arguments to the contrary. Common examples of delusional thinking: police are watching them; the person is receiving special messages from the media or a computer.
- **Hallucinations:** A hallucination is when a person sees, hears, feels, smells, or tastes something that is not actually present. Examples include seeing or hearing things that are not there.
- **Changed affect:** Rapid and dramatic mood swings can occur during a first episode. These changes can range from depression to excitement. At times the person's affect may be neutral or flat and incongruent with the situation.
- **Changed behavior:** A person suffering from a first episode psychosis will show behaviors that are very uncharacteristic of their normal behavior, and these changes will impair one's daily functioning. Many observed changes in behavior are linked to the symptoms described above (e.g., a paranoid delusion may lead the person to stop affiliation with someone).

Phases

A first episode psychosis does not abruptly manifest. Rather, the symptoms occur in three phases, with the length of each varying from person to person.

1. **Prodome phase:** This early phase is characterized by "soft" signs which may be minimally noticeable and emerge for brief periods. Typical symptoms of the prodome phase include reduced concentration; decreased motivation (e.g., loss of interest in usual activities; depressed mood or anxiety; sleep disturbance; odd beliefs and thinking (e.g., suspiciousness); and a gradual decline in functioning (e.g., withdrawal from social activities).
2. **Acute phase:** Clinical-level and debilitating symptoms of psychosis begin to emerge in the "critical" or acute phase. The person begins to experience hallucinations and delusional thinking, and as expected, this is very distressing to the individual and family members. Symptoms often escalate and are persistent. Concerned others often begin to seek help for the person at the beginning of this phase.
3. **Recovery phase:** Most individuals suffering from a first episode and who receive effective treatment will recover, and some may never have another episode.[4] Thus, when treatment is received early, the likelihood of a favorable course is greatly increased. Recovery can be mixed, though; some symptoms may linger for a period during treatment. An illustration of the three phases of psychosis is shown below.

Photo: Shutterstock



Causal Factors

Extant research supports the view that a person's risk for developing psychosis is due to a combination of biological and environmental factors.[10] A number of brain chemicals, particularly the neurotransmitter known as dopamine, likely plays a vital role in the etiology of psychosis. Dopamine is an important signal in the brain's neural circuits. If the dopamine signal or activation is too strong or random, a person will start to receive confusing and subtle alerts about the significance of otherwise ordinary events. This aberration in a person's dopamine signaling explains some of the most prominent features of first episode psychosis.

Also, a stressful event, or an accumulation of them, may trigger psychotic symptoms in a person who is biologically vulnerable. There is growing concern that heavy use of cannabis during youth may be an added risk factor in the presence of a genetic risk for psychosis.[14] Risk factors linked to psychosis is still a field of study with many unanswered questions and issues.

Incorporating adapted therapeutic components shown to be evidence-based elsewhere. Programs typically included content and exercises proven to be effective with non-Native youth experiencing mental or behavioral problems based on rigorous studies published in the peer-reviewed literature. Many features of cognitive-behavioral therapy, family-based treatment, and motivational enhancement techniques are included in Native trauma programs for youth.

Importance of Early Detection and Treatment

As noted above, recognizing and addressing these symptoms with effective treatment during the early warning signs of a first episode psychosis are vital to the course of the disorder. These warning signs during the prodome phase include a sudden decline in functioning, withdrawal from family and friends, unusual thoughts and atypical emotions. With the onset of these warning signs, it is important for the individual to have a thorough medical and psychological assessment to rule out a physical illness, neurological problem, or the acute effects of drug uses that may be the cause of the psychosis.

Be Cautious of False Positives

The warning signs of first episode psychosis can be difficult to distinguish from occasional or temporary problems with mood, thinking or behavior. Bona fide signs and symptoms of early psychosis meaningfully disrupt the person's daily functioning. When these symptoms persist, distress often occurs in the individual and significant others. A comprehensive assessment can rule out these superfluous factors: the effects of drug use; variability in beliefs due to political views, culture or religion; or the context or the situation does not explain the behavior (e.g., a person's suspiciousness is real because they are being harassed by another person). Also consider the issue that because first episode psychosis often onsets during adolescence, some characteristics of "normal" adolescence may be confused with warning signs. Normal adolescence often reveals features that may lead someone to falsely believe that the young person has an impending mental problem (e.g., increase in conflicts with family members; irritability; emotional mood swings).[16]

Photo: Unsplash

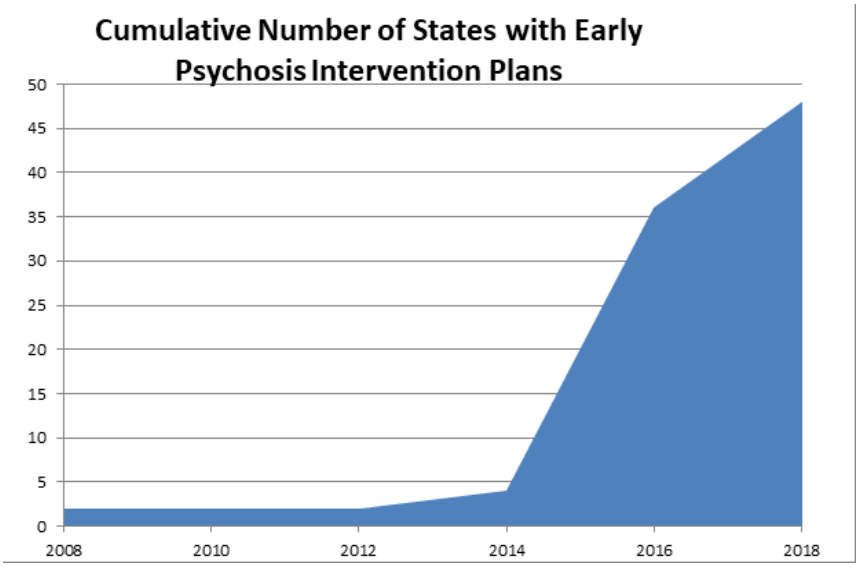
Assessment Tools

Evaluating a person to determine if they are in a prodome or acute phase of a first episode psychosis requires great clinical skill. The use of a standardized assessment instrument to assist with the evaluation process is recommended. We have listed four prominent and well-researched assessment instruments below.

- Structured Interview for Prodromal Symptoms (SIPS)[9]
- Comprehensive Assessment of At-Risk Mental State (CAARMS)[18]
- Early Recognition Inventory for the Retrospective Assessment of the Onset of Schizophrenia (ERIraos)[12]
- Basel Screening Instrument for Psychosis (BSIP)[13]

RAISE: Recovery After an Initial Schizophrenia Episode

In 2008, the National Institute of Mental Health launched the Recovery After an Initial Schizophrenia Episode (RAISE) project. RAISE is a large-scale research initiative that began with two studies examining different aspects of coordinated specialty care (CSC) treatments for people who were experiencing first episode psychosis. One study focused on whether or not the treatment worked better than care typically available in community settings. The other project studied the best way for clinics to start using the treatment program. These studies and others reported very favorable results of the program; one major index of success was that CSC was most effective when the client had a shorter duration of untreated psychosis. RAISE findings influenced states' adoption of evidence-based care programs for first episode psychosis and federal funding accelerated implementation of those programs. The graph below shows this upward trend; the number of operational CSC programs increased 15-fold over the 10 year period of 2008-2018.



Source: Mental Health Block Grant Plans: https://bgas.samhsa.gov/

Photo: Shutterstock

High-Risk Psychosis

Some individuals, by virtue of possessing several risk factors, are at high risk or ultra-high risk of developing a first episode psychosis. It is estimated that a first episode psychosis will occur among 15-30% of high-risk individuals within 12 months, and over 36% after 3 years. These "transition rates" are several hundredfold above that of the general population.[11]

Risk factors typically emerge during the teenage years and are manifested by these signs: attenuated or transient prodrome signs of psychosis; widespread cognitive deficits (e.g. sudden drop in school performance; unusual thoughts, particularly suspiciousness); substance abuse; and an overall decline in social functioning (e.g., social withdrawal). Also, a family history of psychosis is a risk factor. Because the presence of risk factors does do not always lead to a first episode psychosis, the cautions about not rushing to judgement discussed above apply here as well.[4]

Benefits of Early Intervention

It is undesirable to have a long delay before treatment begins for the first episode. The longer the illness is left untreated, the greater the disruption to the person's family, friends, studies, and work; when psychosis is detected and treated early, many problems can be prevented.

Research has found that early intervention specifically has the following benefits:[17]

- Less treatment resistance and lower risk of relapse
- Reduced risk for suicide
- Reduced disruptions to work or school attendance
- Retention of social skills and support
- Decreased need for hospitalization
- More rapid recovery and better prognosis
- Reduced family disruption and distress

Photo: Shutterstock

Treatment Approaches and Strategies

As we noted above, effective and early treatment can lead most individuals to recover from their first episode of psychosis, and many without a return of severe symptoms. Unfortunately, studies have shown that it is common for a person to have psychotic symptoms for more than a year before receiving treatment.[7] When a first episode is not treated early, a vicious cycle can occur: disruption of crucial social and neuro-biological developmental process and experiences; loss of or disconnection from important protective factors in the person's social networks; and the likelihood of a poorer prognosis (e.g., more and severe episodes over time). Thus, reducing this delay in treatment is vital to the client's overall health. This approach has led to the theory of identification of ultra-high risk psychosis in order to identify patients at the earliest point for treatment and prevention intervention.

Core Components

Research supports the clinical practice that a variety of coordinated treatment components provide the optimal treatment plan for first episode psychosis.[5] It is important for those afflicted to have input in the treatment planning; when the client's needs and goals are heard and addressed, treatment engagement is likely. There are several important goals when treating a client with psychosis. Many objectives pertain to basic life functioning – improving one's vocational skills, career and financial planning, being involved in fun activities, staying involved with family and peers, attention to physical health and addressing other emotional issues (e.g., depression). Staying free of substance use and complying with the treatment plan are also important treatment goals. Essential components of effective treatment are the following:

- Individual and/or group counseling. Typically based on cognitive behavior therapy (CBT) principles, this type of counseling helps a person cope with and find solutions to current problems by teaching skills to identify distorted or unhelpful thinking patterns, recognize and change inaccurate beliefs, relate to others in more positive ways, and change problematic behaviors.
- Family support and education. Family members are educated about psychosis and taught skills related to communication and problem-solving strategies that will support their family member's support.
- Medications. Pharmacotherapies are vital to reduce psychosis symptoms. But like all medications, the group of antipsychotic drugs have the risk of side effects that also accompany their benefits. Effective medication management requires a knowledgeable health care provider and cooperation by the client. There is general agreement that due to their side effect profiles, some medications should not be the first ones prescribed (e.g., olanzapine, clozapine and haloperidol), whereas examples of good first line agents are risperidone and ziprasidone used in low doses if indicated.

- Services to support employment and education. These services help the client return to work or school and to make progress with their personal goals.
- Case Management. A case manager helps clients with solutions to address practical problems, comply with the medication plan, and coordinate social services across multiple areas of need. Keeping an individual involved in social, educational, and vocational activities will enhance outcome.

Suggestions to Others from Clients

The National Association on Mental Illness conducted a survey in 2011 of over a thousand individuals who had experienced psychosis and asked them to provide helpful suggestions to others in a similar situation. The list is provided below. You will see that a theme running through many of the suggestions is to get treatment early and to stick with it.

- Find the right doctor, keep appointments and take your medication
- Find your spiritual strength
- Know what "triggers" your psychosis; avoid them
- Learn stress reduction and management
- Keep a sense of humor
- See a doctor right away when it starts
- Receive cognitive behavioral therapy
- Be selective about whom and what you tell, but stay connected to others
- Do what you can incrementally
- Do puzzles and read books
- Yoga
- Don't look back; move forward
- Take care of all the areas of your life: sleep, proper diet, spiritual and social needs, relaxation
- Listen to or read stories of positive role models; people who have had similar experiences
- Learn to trust and cooperate; don't fight

Expressed Emotion

Expressed emotion (EE) refers to a caregiver's attitude and communication style towards the afflicted person. A vast body of research validates that EE is a powerful characteristic of the family milieu because it has a direct association with the recurrence of and recovery from psychosis.[2] When family members commonly display "desirable" EE, the rate of relapse from schizophrenia is approximately 20%, yet that rate rises to 50% when the family milieu typically shows "undersirable" EE.[3]

Research has identified these five undesirable (high) EE characteristics:[6]

- Criticism: comments about the behavior or characteristics of the patient are harsh enough that they elicit annoyance or resentment by the patient
- Hostility: patient receives generalized criticisms and perceives rejection by family members
- Emotional over-involvement: caregivers show over-emotionality and extreme overprotective behavior with the patient (e.g., excessive self-sacrifice)
- Warmth (absence): lack of kindness, concern, and empathy from the caregiver
- Positive comments (absence): lack of verbal appreciation and supportive behavior by the caregiver

The presence of high EE produces a negative effect on the client because these inter-personal characteristics are believed to impair the ability to cope, contribute to social withdrawal, and lead to the perception of poor family support.[3] Teaching low EE to caregivers involves education about the importance of this issue and teaching communication skills that promote less criticism, increased warmth and family solidarity, and managing the direct contact with the client reduce the direct contact to less hours per week). These are lessons for treatment staff as well.

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My spirit was forged in the fire of the One, came into being and grew into a boy;

My mettle was tempered by the fire within man, as I became rough and refined.

My whole being was then reshapen and polished into manhood;

This world did not break the boy within me, but tempered his mettle into a man.

- Sean A. Bear 1st

Adapting Treatment for Native American and Alaska Native (NA/AN) Clients

Mainstream treatment approaches for first episode psychosis are influenced by westernized life experiences; failure to take into account "indigenous traditional knowledge" can be culturally alienating.[15] We recognize that some traditional aspects of treatment are important in treating first episode psychosis among NA/AN clients, but it is vital to culturally adaptive treatment strategies and approaches to support pride in Native cultural heritage.[8]

Some considerations with respect to blending traditional and culturally-relevant treatment strategies:

- Validated and well-researched interview schedules can accurately assess mental illness among NA/AN clients, but clinicians should adjust their use accordingly to reflect cultural heritage and experiences.
- The possible negative stigma of using medications as part of the treatment plan should be directly addressed. Proper management of a pharmacotherapy regimen is vital to the treatment of psychosis.
- Group therapy, family therapy and cognitive-behavioral strategies are mainstays of counselling for psychosis; their use in conjunction with traditional NA/AN therapies (e.g., the talking circle; sweat lodge) is advisable.

Summary

The word psychosis is used to describe conditions that affect a person's thinking and behavior and where there has been some loss of contact with reality. Whereas it is rare to suffer from psychosis (about 1-2% will experience psychosis at some time in their lives), this disorder is devastating to the person. A first episode psychosis often begins in one's late teens to mid-twenties. Symptoms include disordered thoughts and speech, paranoia or delusions (believing in something that is not real even when presented with facts) and hallucinations (seeing, hearing, smelling, tasting or feeling something that is not real). Psychosis affects people from all walks of life; its cause is a combination of biological (e.g., genetic risk) and environmental (e.g., highly stressful event or events). A person with psychotic symptoms is not dangerous. It is more likely that the afflicted person will harm oneself than someone else. Finally, treatment can work, especially when it starts at the outset of the prodome phase, the family shows favorable expressed emotion (EE), the medication plan is well managed, and overall treatment plan is integrated with the client's culture.

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The Real Thanksgiving

We would like to acknowledge the difficult history that is often overlooked this time of year. We recognize that the true events have been mostly forgotten in the celebration of Thanksgiving, and we would like to share these reflections on our history, and honor the cultures that have experienced pain and suffering at the hands of others.

Walkingtimes.com: Celebrating Genocide: The Real Story of Thanksgiving

Uaine.org: The Suppressed Speech Of Wamsutta (Frank B.) James, Wampanoag

Bustle.com: 9 Myths About Thanksgiving & The Real Facts Behind Them

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Leadership Academy - updates from the field

Pictured from left, third row: Jacquelynn Engebretson, Carly Blemmel, Roy Pack, Kristina Pacheco, Angie Wilson, Ray Daw, Virginia Daniels, Melanie Johnson, Anne Helene Skinstad, Nelda Huskie, Jeff Ledolter, Sunny Goggles, Sean Bear, Monica Dreyer Rossi; second row from left: Jason Butler, Melanie Hazle, Mashaya Engel, Donica Conseen, Chenoa Crowshoe-Patterson, Jay Abeyta, Bridget Valenzula; front row from left: Monica Yellowowl, Maria Molina, Cianna Rabbithead, Jayne Talk-Sanchez

MONICA DREYER ROSSI, Cand. Polit.

The American Indian and Alaska Native Leadership Academy 2019-2020 is well on its way. The 22 mentors and mentees from mental health, prevention, and addiction fields are an excellent group of earnest and highly motivated behavioral health professionals. We kicked off the one year program with a five day immersion training at the Meskwaki Settlement in August. Throughout the week we focused on topics such as recognizing personal strengths, delegating responsibility, addressing conflict, and putting mentoring skills into practice. We were honored to have Rose Weahkee from IHS spend several days with us. She spoke to the group about "Leadership in Tribal Systems of Care." Professor Amy Colbert from the Tippie Business College at the University of Iowa also visited us and spoke about "Using Feedback to Grow as a Leader."

We took a field trip to the Meskwaki Tribal Center at the invitation of Leah Slick-Driscoll and Delonda Pushetonequa. After a visit to the Tribal Center Museum, Ms. Driscoll conducted a simulation for the group illustrating the historical journey and trauma experienced by Native Americans. We were grateful to be gifted a wonderful meal of beef hominy, fry bread, sweetcorn and fruit prepared by Ms. Driscoll and Ms. Pushetonequa.

Between our three collective meetings we offer monthly support and follow up conversations for mentors. Dr. Dale Walker leads these sessions. We also hold monthly follow up and training sessions on topics identified as important by mentees. To date we have discussed "Multidisciplinary Teams and Collaborating with Tribal Programs," and "Experiences developing and disseminating Native LGBTQ/Two-Spirit Curriculum."

In February we will hold our next in-person training in Santa Ana Valley, New Mexico. We are working on a very exciting program with presentations from leading experts in Native country. The mentees will get the opportunity to talk about the progress of their Leadership project, and receive feedback from the other participants.

Psychology: The Study of the Soul

Not all people learn life lessons the same way. Some learn very quickly, while others struggle with the same experiences. People see according to how they believe. If people believe the world is hostile, they focus on the hostility of others, even when the surroundings are safe. If the people believe the world is loving, they focus on the love around them, even in the midst of danger. Through this, people may experience a life-altering occurrence that changes their beliefs of similar experiences.

From teachings: Only as a human being can we experience pain at the levels that are possible. Our first teacher is Love, with the patience and comfort that love brings even when we have done wrong. The second, third, and fourth teachers each in descending levels of comfort, provide lessons when the student cannot or is unwilling to learn from the previous teacher.

When all else fails, the final teacher emerges who can get through when no other can. This teacher is Pain. Through this, the student will learn to avoid pain.

Sean A. Bear 1st, BA; Co Director, Meskwaki Tribal Member

UPCOMING ACTIVITIES & EVENTS

Date	Event	Location
12/4-6	American Indian Justice Conference - *consultants will be presenting on Historical Trauma at this conference*	Santa Ana Pueblo, New Mexico
12/11, 1/15, 2/12, 3/11, 4/8	Webinar: Healing the Returning Warrior - this will be a five part series continuing into 2020	Online - *register*
March - date TBA	Training of Trainers for the LGBTQ/Two-Spirit curriculum: "Honoring Our Relations: Increasing Knowledge of LGBTQ/Two Spirit Wellness"	TBA
TBA	Training of Trainers on Historical Trauma	Montana
TBA	Culturally Adapted Mental Health DSM-5 Curriculum project	TBA
TBA	Tele psychiatry - Video Conferencing with NFARtec - development beginning on this project	TBA
TBA	Project Enhancement and Implementation - development beginning on this project	TBA

For additional events in our Prevention and Addiction programs, please visit their websites:
PTTC: *pttcnetwork.org/native*; ATTC: *attcnetwork.org/native*