



National American Indian and Alaska Native

MHTTC

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# Mental Health

IN OUR NATIVE AMERICAN COMMUNITIES · VOL 2 ISSUE 1 SUMMER 2020

Caring  
for Our  
Relations:  
Post-Traumatic  
Stress Disorder  
in Indian  
Country



## DIRECTOR'S CORNER

Welcome to the National American Indian and Alaska Native Mental Health TTC Newsletter honoring the Mental Health Awareness Month of May. We recently dedicated five sessions of our webinar series to the curriculum, "Native American Veterans: Healing the Returning Warrior," and the series ended with a presentation focused on Post-Traumatic-Stress-Disorder (PTSD). It felt natural to focus our May issues of the newsletter on PTSD as the COVID-19 pandemic has activated PTSD issues in many Native community members. [Recordings of these sessions can be found at this link.](#)

In these trying times MH issues have come to the forefront of people's minds because of experiences with social or physical distancing. Many have been able to connect with family, friends and colleagues through virtual means, but for those who do not have access to the internet and a phone, social distancing has meant social isolation and loneliness. On the other hand, in many tribal communities, social distancing is challenging because more than one generation lives under the same roof, making it difficult to stay apart. Living situations like this increases the level of concerns and anxieties about contracting the virus from a family member.

In difficult times like this, it is important to remind ourselves of the purpose and meaning of living, and bring spirituality back into our lives. Our center has offered our Spirituality Round Table project to tribal and urban Indian communities. The program was originally developed for a face-to-face format, but in this COVID-19 pandemic, the program was changed into a virtual platform and is offered twice a month. A team of six professionals and spiritual leaders/traditional healers have discussed how mental illness has been understood from a traditional Native perspective and compared it to the current western way of understanding mental illness. We have had a steady number of participants with major contributions to this very important discussion.

In the beginning of the COVID-19 pandemic, our team did not quite know how to support tribal and urban Indian providers in the most productive way, so we decided to ask our tribal colleagues what they needed through weekly listening sessions called: Strategies of Support for Mental Health Providers. Our experiences through these sessions are that needs for support and resources have changed over time, and therefore we will continue to offer these sessions until the COVID-19 pandemic is more under control in Native communities. After each listening session we have created a resource document based on the requests raised during the discussions. [You can find the document at this link.](#)

We completed the second face-to-face session of our Leadership Academy program in Tamaya Casino and Resort, New Mexico, two weeks before the COVID-19 pandemic really hit the country. Needless to say, timelines for the program has changed. We have started recruiting for the next cohort of mentors and mentees, but the start date for the next round will depend on when it is safe to meet face-to-face.

Many of our programs have been adapted to a virtual platform after the COVID-19 pandemic has made it unsafe to gather in person. Our two-day workshop on Project Enhancement and Implementation had to be postponed and is now taking place virtually beginning this month.

We hope you will join some of our listening sessions going forward, and please check out our upcoming events covered at the end of the newsletter. I welcome any suggestions for topics to cover in our listening sessions, so let us hear from you so we can better serve you and support your efforts.

Regards,

**Anne Helene Skinstad, PsyD, PhD**



# Caring for Our Relations: Post-Traumatic Stress Disorder in Indian Country

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## **Introduction**

Many people who experience a tragic event, directly or indirectly, may experience lasting effects that can lead to a post-traumatic stress disorder (PTSD). As described in the DSM-5 (American Psychiatric Association, 2013), PTSD can be caused by a single, traumatic event (acute trauma), such as witnessing or being a victim of a crime, a natural disaster, or the death of a significant other; or by an ongoing traumatic event (chronic trauma), such as exposure to physical abuse or gang violence.<sup>1</sup> A traumatic event can take many forms: the event can be personally experienced, witnessed as it occurred to someone else, or as shared by a close friend or relative who experienced the event. Women with PTSD are more likely to report sexual assault, intimate partner violence, and the unexpected death of someone close as the worst traumatic experiences. Men with PTSD more commonly report military combat, seeing someone badly injured or dead, and their own serious or life-threatening accidents as the worst traumatic experiences.<sup>40</sup> Youth with PTSD are more likely to report victimization from physical or sexual abuse, or witnessing violence.<sup>10</sup>

The research on PTSD reveals a striking difference among genders. It is estimated that men are more likely to be exposed to traumatic events than women (perhaps due to the predominance of men in the military), yet women are twice as likely to develop PTSD, even after adjusting for trauma type.<sup>6</sup> Whether this finding is part of the general pattern that proportionally more women than men report symptoms associated with emotional distress across a variety of behavioral and mental distress (e.g., anxiety, depression) is a topic of debate among experts.

For a person to meet a DSM-5 diagnosis of PTSD, symptoms must be present for at least a month and have a deleterious effect on the person carrying out normal daily activities. Symptoms include periods of negative emotions (e.g., depression or anger), experiencing nightmares or flashbacks, have reoccurring and upsetting memories of the trauma, blaming oneself for the cause of the trauma, and avoiding reminders associated with the traumatic event. For some, important aspects of the event may be blocked from recall.

Some individuals experience some symptoms of PTSD but not enough to meet an official diagnosis. It is now recognized that “partial PTSD” can cause disruption in functioning that is equivalent to those with full PTSD.<sup>30</sup>

It is estimated that as many as two in three adolescents report having been exposed to traumatic stressors at some point in their lives, including directly experiencing or witnessing violence, abuse, injury, loss, war and terrorism, and life threatening disasters (see Masten & Narayan, 2012 for a review). Trauma-exposed adolescents are not only at risk for PTSD, but also for major depressive disorder and related behavioral and psychosocial problems (e.g., Ford et al., 2010).

### Timing of an Adverse Event

The age at which a person experiences a traumatic event can be crucial in a person's vulnerability to develop PTSD. For some, experiencing an early life stressor (ELS) as a child significantly contributes to a person's later vulnerability for PTSD. ELS has been found to account for a large proportion of those with PTSD, and has been linked to an overall reduction in life span.<sup>33,25</sup> The role of ELS and risk for PTSD has also been reported among Native Americans and Alaska Natives (NA/AN). Thayer and colleagues found that NA/AN adults who were exposed to trauma during youth were more likely to develop PTSD and poor physical health in adulthood.<sup>50</sup>

Because brain regions mature at different stages as a person ages into adulthood, coupled with the fact that each region possesses a unique and relatively brief exposure-sensitive period, the age at which an ELS occurs may differentially affect brain development and eventual risk for PTSD.<sup>49</sup> In this light, there is evidence to suggest that the earlier ELS is experienced, the more extensive its impact is on development and psychiatric outcomes, including risk for PTSD. Longitudinal clinical studies have shown that maltreatment (e.g., victim of physical abuse) occurring prior to the age of 5, as compared to individuals with maltreatment occurring later in life, confers higher levels of future mental health issues, including many symptoms of PTSD, such as poor control of emotions, increased suicidal ideation, and learning difficulties (e.g., Cowell et al., 2015). These findings are consistent with widespread views of developmental psychopathology that suggests that the earlier the stress occurs, the greater the likelihood of adverse outcomes in childhood, which then further interferes with mental health as a person ages into adulthood.<sup>9</sup> A major focus of current research is how genetic factors act as a mechanism that influence how ELS manifests in adverse outcomes. For example, two individuals that have experienced a similar ELS at the same developmental stage may have very different health outcomes (e.g., one develops PTSD as a teenager and one does not).

### Prevalence of PTSD

#### General Population

PTSD and substance use disorder (SUD) are prevalent across a diverse range of populations and settings. Data from the 2010 National Epidemiologic Survey on Alcohol and Related Conditions (N = 34,653) estimate that among individuals with PTSD, nearly half (46.4%) also met criteria for an SUD, and nearly half of those with PTSD/SUD report a severe level of a SUD (e.g., numerous SUD symptoms; longer duration of symptoms).<sup>40</sup>



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While not a national investigation, it is instructive to review a recent study by Cayir and colleagues of Native Americans aged  $\geq 55$  years from a tribe in the Southeastern US ( $N = 362$ ).<sup>7</sup> Twenty-three percent of the sample experienced a traumatic event without trauma-response symptoms, whereas 14% experienced a traumatic event with at least one trauma-response symptom. After adjustment for sociodemographic characteristics and social support, those participants who reported one or more trauma-response symptoms had higher odds of clinically relevant depressive symptomatology compared to the other groups. These data suggest the importance of mental health providers who are treating older NA/ANs for negative emotions to assess for trauma.

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### **Among Native Americans and Alaska Natives**

PTSD has been described as one of the most serious mental health problems faced by NA/AN populations,<sup>45</sup> and there is general agreement that Native peoples experience high rates of trauma and PTSD. However, precise estimates are hard to come by. Among the US general population, the lifetime prevalence rate of PTSD is estimated to about 7%, although about 40% of such cases do not become chronic.<sup>47</sup> Regarding Native populations, data from the National Epidemiologic Survey on Alcohol and Related Conditions survey is informative. NA/ANs represented 3.2% of all US patients with full PTSD, as diagnosed by DSM-IV criteria.<sup>40</sup> This proportion is almost twice as high as the NA/AN share of the total US population, which according to the 2010 Census is 1.7% for people who self-identify as NA/AN, either alone or in combination with another race. In Bassett and colleagues' review of prevalence studies of PTSD among Native people,<sup>3</sup> the authors note that NA/ANs have a significantly higher risk of experiencing traumatic life events than any other ethnic or racial group, and that the rate of PTSD approximately doubles the rate in the general population. Yet regarding precise estimates, the authors conclude that "Although many studies in our review noted that rates of PTSD in NA/ANs are higher than those in other races and ethnicities, we did not identify population-level studies capable of defining an overall national estimate of the prevalence of PTSD among NA/ANs."

"Pinpointing how trauma affects brain structure and function and prescribing the most effective medications has presented challenges. Enter VA's National PTSD Brain Bank (NPBB), a brain tissue biorepository that supports research on the causes, progression, and treatment of PTSD. The bank is responsible for tissue acquisition and preparation, diagnostic assessment, and storage. It's currently storing tissue from 168 brains, most of which are from people once diagnosed with PTSD. Many of the other donors had major depressive disorder. Other brains are from healthy controls...The bank's main purpose...is to advance understanding of how PTSD affects the brain...researching the brain tissue from people with PTSD, new insights can be gained to develop new medications that treat the condition."<sup>44</sup>

## Impacts of PTSD/SUD Co-Occurrence

Among those with PTSD and SUD, regardless of race/ethnicity, a more complex and costly clinical course is likely to occur compared to people with either disorder alone. These additional problems include increased chronic physical health problems, poorer social functioning, higher rates of suicide attempts, more legal problems, increased risk of violence, worse treatment adherence, and less improvement during treatment.<sup>13,35,48</sup>

## Why the PTSD/SUD Co-Occurrence?

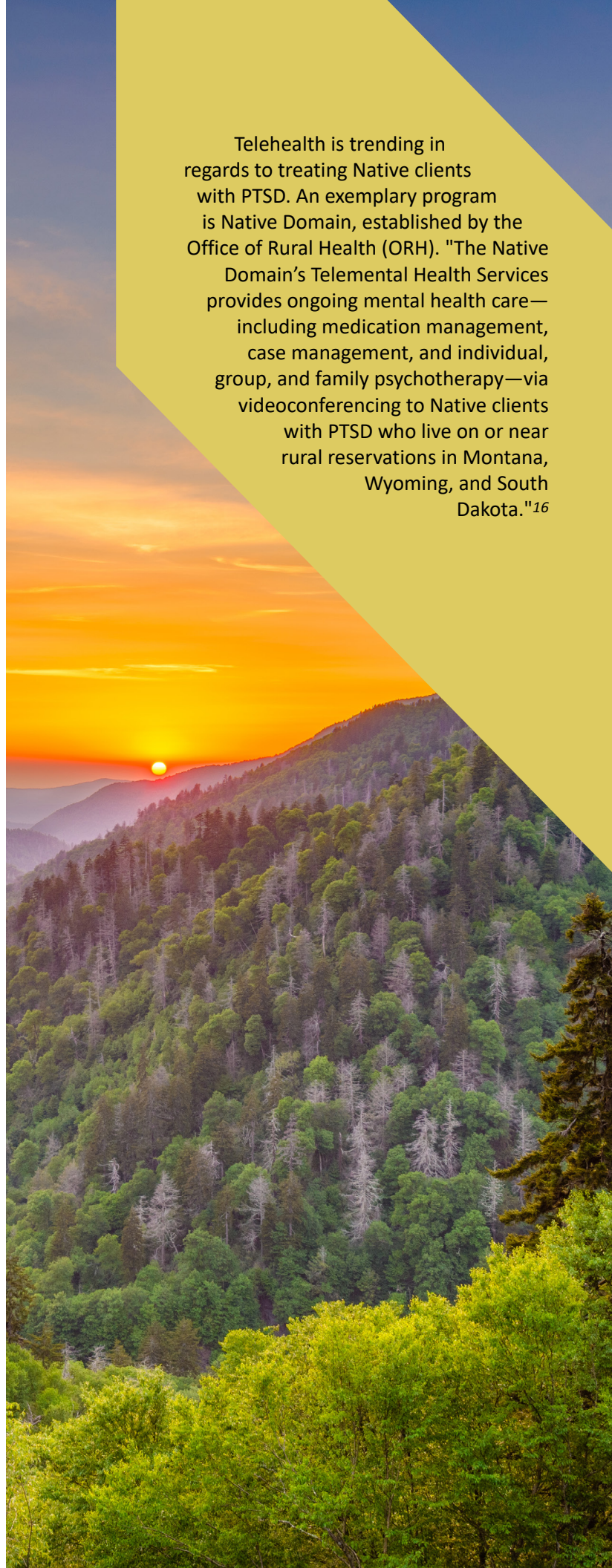
We highlight the three prominent theories to explain the functional association between PTSD and SUDs. Clarifying the etiological nature of PTSD/SUD is important because it can inform prevention and treatment approaches. The most prominent one in the literature is the **self-medication theory**.<sup>24,43</sup> This theory is based on the view that substance use serves as an attempt to alleviate PTSD symptoms. A major supporting line of research for this theory is that the use of alcohol, a known nervous system depressant, is the most common substance used among those with PTSD/SUD. A nervous system depressant may reflect an attempt to alleviate particular PTSD symptoms.<sup>34</sup>

The **high-risk hypothesis**<sup>8</sup> makes the case that the lifestyle of a person with SUD, given the excessive amount of time engaged in high-risk behaviors while seeking drugs, as well as the deleterious effects of substance use, consequentially increases the likelihood that the person will experience a traumatic event or events and subsequently develop PTSD. In this sense, the excessive substance use puts the person in “harm’s way,” which can lead to PTSD.

The basis for the **susceptibility hypothesis** is that the increased anxiety and arousal that often accompanies drug abuse, in addition to the influence of poor coping skills and a person’s biological vulnerability to stress, may lead to PTSD after exposure to trauma.<sup>22</sup> This theory suggests that if a substance-abusing person has underlying assets that counter the susceptibility (e.g., good coping skills) he or she may be less vulnerable to developing PTSD.

It is worth noting that the three theories described above are not mutually exclusive. For example, some factors common to all theories (e.g., genetic factors; lack of environmental supports) may have a causal influence on some people with respect to PTSD/SUD.

Telehealth is trending in regards to treating Native clients with PTSD. An exemplary program is Native Domain, established by the Office of Rural Health (ORH). "The Native Domain’s Telemental Health Services provides ongoing mental health care—including medication management, case management, and individual, group, and family psychotherapy—via videoconferencing to Native clients with PTSD who live on or near rural reservations in Montana, Wyoming, and South Dakota."<sup>16</sup>



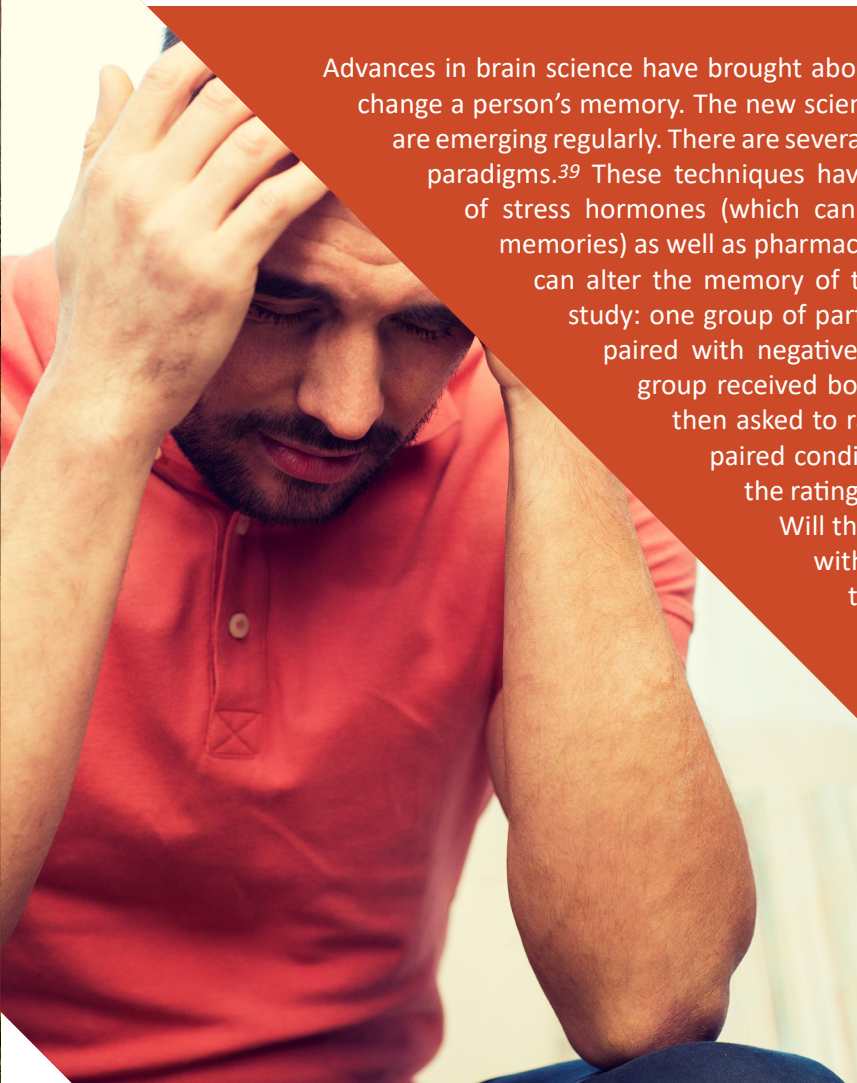
## Native Veterans and PTSD

Research on veteran populations demonstrates that, in comparison with the general population, veterans are at an increased risk for developing PTSD, and that the severity of combat exposure is directly linked to the development and chronicity of PTSD symptoms.<sup>21,23</sup> Moreover, the prevalence rate of SUD among veterans with PTSD is much higher than among non-veterans with PTSD (e.g., Petrakis et al., 2011). Among returning veterans, 5-17% suffer from combat related PTSD. PTSD symptoms among veterans are well documented: flashbacks, nightmares, hypervigilance, aggressive behavior, and severe anxiety.

Systematic research of PTSD among NA/AN veterans is rare. We located one detailed study – the American Indian Vietnam Veterans Project. As part of the Matsunaga Vietnam Veterans Project, this project surveyed a sample of Vietnam in-country veterans residing on or near two large tribal reservations, one in the Southwest and the other in the Northern Plains.<sup>51</sup> These populations had sufficient numbers of Vietnam military veterans to draw scientifically and culturally sound conclusions about the war and readjustment experiences.

Highlights from the study findings are the following:

1. American Indian veterans often joined the military as a way to obtain opportunities for education, jobs, and travel not otherwise available to them. In addition to wanting to serve their country, many wanted to become warriors to protect their families, to uphold the honor of their tribes, and to prove themselves as men.
2. Many faced racial prejudice and discrimination, often for the first time up close, and felt disillusioned when they or other Indians encountered racial hostility or disrespect.
3. Native American Vietnam veterans had relatively high levels of exposure to war zone stress and high levels of PTSD. More than one in two Native veterans experienced war-related trauma in Vietnam.
4. Participation in tribal healing and honoring ceremonies aided many veterans.
5. Native Americans, along with Native Hawaiians, received combat service medals more often than individuals in other ethnic groups.



Advances in brain science have brought about the real possibility that memory-editing techniques can change a person's memory. The new science of "memory editing" is rapidly progressing and insights are emerging regularly. There are several memory-editing techniques that are effective in laboratory paradigms.<sup>39</sup> These techniques have focused on editing episodic memory by manipulations of stress hormones (which can both impair emotional memories and enhance neutral memories) as well as pharmacological and behavioral interventions (e.g., updating events can alter the memory of the prior event). Another example of a typical laboratory study: one group of participants receive a neutral stimuli (such as an office scene) paired with negative emotional stimuli (such as an accident scene); another group received both sets of stimuli but that are not paired; participants are then asked to rate their attitude towards the neutral stimuli; those in the paired condition rate the neutral stimuli as more disliked compared to the rating of the neutral stimuli by those in the non-paired condition.

Will these approaches be applicable in the clinic to assist patients with PTSD? Could devastating human memories that continue to haunt a person be edited? Scientists are discussing the possibility that someday easily implemented and effective techniques to edit unique human memories in the clinic will be developed. A further understanding of how memory of trauma lingers to the point of contributing to PTSD will also be important in efforts to identify the nature of memory variability and its impact on emotions and behavior.



There are some studies using medications in the treatment of co-occurring PTSD and SUDs. There are two groups of medications that have been investigated: anti-depressant medications (SSRIs) and medications for alcohol abuse (e.g., naltrexone and disulfiram). McCauley and colleagues' review of this literature concluded that "further investigation of the use of medications as an adjunct to psychotherapeutic treatment in the treatment of co-occurring PTSD and SUDs is needed."<sup>27</sup>

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## Treatment for PTSD

Experts make the case that treating PTSD for NA/ANs generally falls into either Westernized approaches versus traditional healing strategies. A population-based study found that the use of tribal healers for treating NA/AN women with PTSD was common.<sup>14</sup> A small study of urban NA/AN women found that 77% of those who experienced rape preferred traditional Native healing afterwards.<sup>15</sup> Because many NA/AN veterans experience nightmares, it has been suggested that the importance of dreams in Native cultures should be considered in treating NA/AN veterans with PTSD.<sup>45</sup>

The bulk of the PTSD treatment research literature focuses on Westernized strategies that address both PTSD and the common co-occurrence of a substance use disorder (SUD). We will review this literature next.

## Treatment of Co-Occurring PTSD and SUD

Historically, the prevailing clinical view was that for people with PTSD/SUD, the standard of care was to treat the SUD first and defer treatment of PTSD.<sup>31</sup> Yet as it became clearer that trauma exposure is commonplace among SUD patients, and that symptoms of SUD and PTSD co-vary concurrently, clinical practice has shifted to implementing coordinated treatments.<sup>27</sup> Thus, a sequential model, in which SUD is treated first and trauma-focused work is deferred until a period of sustained abstinence (e.g., 3–6 months), is not considered state of the art.<sup>46</sup>

Rather the integrated model is preferred. This treatment model, which is closely linked with the self-medication hypothesis, suggests that treating the trauma early will likely improve recovery from the SUD.<sup>5,20,35</sup>

One type of integrated treatment is referred to as nonexposure-based. This approach does not emphasize revisiting the traumatic memories by either imaginal exposures or confrontation of safe but anxiety-producing situations in real life that are avoided by the patient. Instead, treatment focuses on the person's responses to and the impact of the trauma. The psychoeducational content aims to have the patient explore the relationship between PTSD symptoms and substance use, and to learn skills related to self-management of symptoms, addressing negative emotions, and developing coping skills. Treatment programs vary as to the specifics of integrating the PTSD and SUD treatment components. A common approach: treatment phases are distinguished, with the first phase dedicated to stabilizing the SUD in preparation for the second phase of working on the trauma.<sup>27</sup> Examples of nonexposure-based integrated treatments include:

- Addictions and Trauma Recovery Integrated Model (ATRIUM);<sup>29</sup>
- CBT for PTSD;<sup>28</sup>
- Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET);<sup>19</sup>
- Trauma Exposure and Empowerment Model (TREM);<sup>17</sup>
- Transcend;<sup>12</sup> and
- Seeking Safety.<sup>32</sup>



Whereas these nonexposure programs have been researched, McCauley's review of this literature suggests that the most rigorously studied is Najavits' Seeking Safety program.<sup>27,32</sup> Seeking Safety is a 24-session, manualized therapy that prioritizes establishing and maintaining safety. Key concepts include anticipating dangerous situations, setting boundaries, anger management, and affect regulation.

The other major type of integrated treatment is exposure-based. This approach is based on the research that addressing trauma and PTSD symptoms more directly is both tolerable and effective.<sup>52</sup> In addition to prolonged exposure to trauma-related stimuli, imaginal homework assignments are included.

A recent meta-analysis of prolonged exposure therapy for PTSD found large effect sizes for prolonged exposure in comparison with control conditions.<sup>42</sup> Recently, prolonged exposure has been incorporated into existing residential SUD treatment with promising preliminary results.<sup>4</sup>

Examples include: Substance Dependence Posttraumatic Stress Disorder Therapy (SDPT),<sup>2</sup> Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE),<sup>37</sup> and Get Back to Life (GBL).<sup>41</sup> All three share the feature of being organized around cognitive-behavioral therapy techniques that help patients understand the relationship between PTSD and substance use, normalize common reactions to trauma, reduce PTSD symptoms via exposure techniques, and help patients recognize and manage substance use cravings and "high-risk" situations that may contribute to relapse. A unique feature of GBL: it is delivered in group format.

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## Summary

Native Americans and Alaska Natives experience high rates of PTSD, both among the general population and veterans. Despite a 30-year history of sustained research on PTSD, much remains unclear about how culture and ethnicity/race backgrounds shape the clinical presentation of PTSD, and accordingly, how interventions for PTSD need to be culturally tailored to optimize outcomes. Further study is needed to better understand how Native traditions can assist Native clients with PTSD. The role of cultural identity may be a key to treatment effectiveness.

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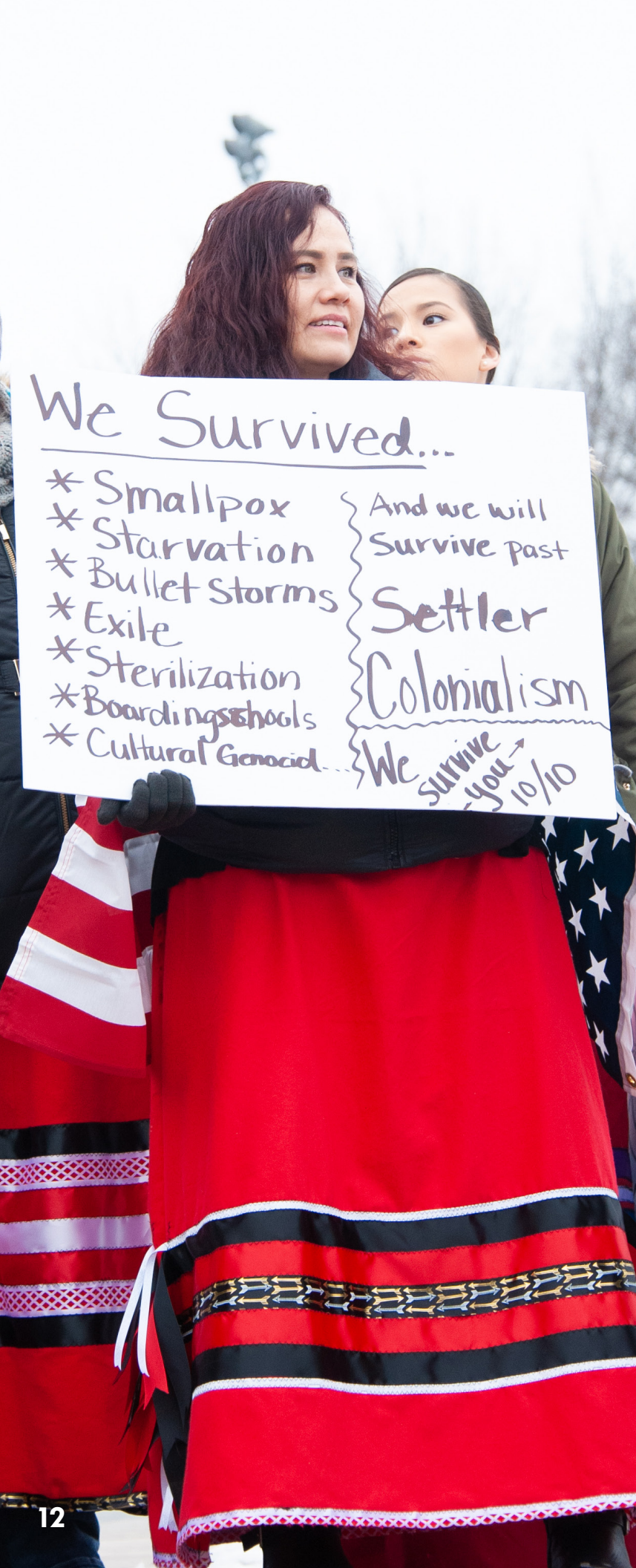
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# INDIGENOUS HISTORICAL TRAUMA

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When writing about Post-Traumatic-Stress-Disorder (PTSD) in indigenous communities in the US, it is impossible to avoid looking at the broader picture of Indigenous Historical Trauma (IHT). Historical trauma is defined by Brave Heart as “cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma.”<sup>1</sup> Historical trauma also consists of unresolved grief accompanying that trauma. Most populations in the world have, throughout history, experienced traumatic events with huge impacts on the psychological wellbeing of its inhabitants. Having been born in a country that was occupied by the German Army for all five years of the second World War and having had family members on both my mother’s and father’s side actively involved in the Norwegian resistance, I totally understand what impact traumatic historic events can have on the psyche of its countrymen and women. That was 5 years of terror, and combined with Danish occupation for 450 years, followed by the union with Sweden for 91 years, I understand the fierce need for independence my Norwegian countrymen and women express in their desire to choose their own destiny.

However, Native communities have less of an opportunity to decide their own destiny, even though tribal communities are sovereign nations. Despite their sovereignty, the tribal nations are deeply affected by the decisions of the federal government, including a long history of broken promises and treaties. Furthermore, Native communities have experienced oppression, genocide, displacement from their original place of living (the Trail of Tears), loss of language and culture, loss of food, forceful loss of children to boarding schools etc.; it is no wonder that generation after generation are influenced by this traumatic history.

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IHT has an impact on emotional health, self-worth and wellbeing of a community and its members,<sup>3</sup> such as 1) alcoholism, substance use disorders, depression, suicide, and 2) physical health such as diabetes, obesity, heart conditions etc.<sup>4</sup> There is also a known relationship between Adverse Childhood Experiences (ACE) and historical trauma in children living on reservations.<sup>2</sup>

Elders and spiritual leaders have several different suggestions for healing the communities, like: 1) focus on the positives and the strength of the community, 2) raise awareness and educate tribal and nontribal community members about IHT, 3) return to cultural and spiritual ways of life, and 4) learn the language.<sup>4,5</sup> Two spiritual leaders had different perspectives on the healing of their communities; 1) communicate the “spiritual perspective” on distress and the need for healing in the reservation community, or 2) engage in a nation-building discourse that shifted attention away from past colonial military violence toward ongoing systemic oppression and the need for socio-structural change.<sup>5</sup>

The National American Indian and Alaska Native ATTC held a symposium in 2015 entitled, “Reclaiming our Roots: Rising from the Ashes of Historical Trauma.”<sup>6</sup> A proceedings document was published following the symposium and was focused on historical trauma and boarding school experiences, including the impact on emotional and physical health, with suggestions for treatment and healing.

At this time in American history with the COVID-19 pandemic, social distancing, unemployment, police brutality, health disparities, and racism, we find ourselves in the middle of a wave of unrest in many cities inside and outside the US. People of color, including American Indians and Alaska Natives, have experienced similar historic events and these current situations easily reactivate symptoms of PTSD. The pandemic has revealed the health disparities in communities of color, and especially Native American Communities. I hope we can solve these issues in a peaceful way, and make a difference in people’s lives.

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# The Role of Warriors

Through teachings passed down, there are those about life and its mysteries. One which comes to mind involves the world of man and the concept of metal. Within this comes the teaching that metal brings war, but also the road, and role of warriors.

Within the world and state as a warrior, there must be a sense of compassion and love for the ones they fight and the ones they fight for. Because of how man has become influenced by the darkness within, and the darkness outside oneself, there are times in our lives that the need for protecting others is essential to survival. Therefore, throughout time, fighting and defending one's lands, the people have evolved, becoming a force with the capacity to destroy the world and mankind.

In the earliest days of Native ancestry, a warrior's first goal was to accomplish overcoming oneself by realizing the importance of seeing the connection of all of Creation as part of the self and the removal of self-importance. This required fasting and going within oneself to face his worst enemy, the self. Love should be conceptualized within all life's work, not just for the Creator or self, but for all others and all of Creation being steadfast in reducing harm.

Peace is not a place, but rather a state of being.

**S.A. Bear**



## RECENT ACTIVITIES & UPCOMING EVENTS

Date	Event	Location
05/13	Introduction to Peer Support in the Era of COVID 19 webinar	<a href="#">View the recording</a>
05/14	Native Youth Telehealth Initiative	<a href="#">View the recording</a>
06/09	Strategies of Support for Mental Health Providers - Empowering one another during times of crisis (weekly on Tuesdays)	<a href="#">Register</a>
06/10	Understanding Suicide: Introduction and General Knowledge webinar	<a href="#">Register</a>
06/10	Virtual Project Enhancement and Implementation Training (weekly on Wednesdays)	Online
06/12	Native American Summit on Spirituality: Cultural Inclusion into Mental Health Assessments for Native Americans	<a href="#">Register</a>
06/26	Native American Summit on Spirituality: Cultural Inclusion into Mental Health Assessments for Native Americans	<a href="#">Register</a>
07/08	Understanding Suicide: Adolescents and the Changing Brain	<a href="#">Register</a>
08/12	Understanding Suicide: Holding on to Hope	<a href="#">Register</a>

For all of our COVID-19 related programs across Mental Health, Prevention, and Addiction projects, [please visit this page.](#)





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