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Deconstructing the DSM-5: Cultural Considerations

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DIRECTOR'S CORNER

Welcome to the latest issue of *Mental Health in our Native American Communities*. This time we venture into a very important but challenging topic: what mental health and mental well-being are and how mental well-being is experienced in Native communities. The psychiatric nomenclature reflected in the DSM system is grounded in Western-based research and focuses on the "challenges and deficits" a person with mental illness experiences. Mental illness from a Native perspective (Jacque Grey, PhD, Choctaw/Cherokee descent, past president of the Society of Indian Psychologists), emphasizes understanding the cultural context surrounding the person with mental health issues and the impact historic and generational trauma has on Natives suffering from mental illness. Integrating Western-based approaches into a cultural context and including a strengths-based approach to treatment has been shown to be the best and most effective way to treat Natives suffering from mental illness. Cultural considerations are included in both the DSM-5 and the DSM-5-Text Revision, but they are not well integrated into the whole DSM system.

A child's first laugh is an important milestone for any Native child, and it is also a time for celebration. The first laugh signifies that the child is developing well with a supportive family around them. C. Allison Baez, PhD, Tap Pilam Coahuiltecan Nation, Aquateca Paguame Clan, writes very personally about her grandson's first laugh and goes on to discuss mental health and well-being across Native communities. Many Native children unfortunately are exposed to Adverse Childhood Experiences (ACE). It is crucial for mental health professionals to understand the diversity of how feelings are expressed in different Native communities. Furthermore, Native medicine can be an asset to understanding a child's mental health issues. Early diagnosis of mental health issues can prevent the development of serious problems later in life. Culture is prevention and so are traditional healing systems, and helping a child find a purpose in life, grounded in a sense of culture, will give the Native child better control over their destiny and increase their resiliency. As Dr. Baez notes: It is in our youth's DNA to find strength through culture and tradition!

We are very fortunate to be able to share an overview of the Gerald L. Ignace Indian Health Center, serving the Milwaukee, WI, urban Indian community. The center offers culturally responsive trauma treatment and suicide prevention and has expanded its services to include forensic health care for treatment of sexual assault -- all within a Native cultural framework. The center also shares with us one person's successful MH treatment story. Among the many challenges to successful MH care are access to transportation, access to wrap-around care, case-management, and a case coordinating team, which is what the Gerald L. Ignace Indian Health Center has worked hard to develop.

Losing a child regardless of age is one of the most difficult things a parent can experience. Sean Bear, Meskwaki Nation of Iowa, has written a poem focused on what it means for a parent to lose a child, including stressing the importance of maintaining the memories of all the good times they had together.

Elsewhere, we have been celebrating Pride Month with a series of posters profiling Native LGBTQ+/Two Spirit individuals. Check out our weekly event emails for the latest, or click *here* and *here* for the first two posters.

Summer is right around the corner, and midsummer signifies the longest day in the year. In Scandinavia, as well as northern states like Alaska, we celebrate the long evenings and the beginning of growth, and start planning the harvest, fishing, hunting, and berry picking season in preparation for the fall and winter. Subsistence living is a community event and often includes getting Native families together and sharing with family members living in urban areas. This is also a time when many celebrations are taking place in Native communities across the country. Enjoy the summer and let us celebrate the gifts and strengths of our Native communities.

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Describing, Defining, and Classifying Mental Health Issues for American Indians and Alaska Natives

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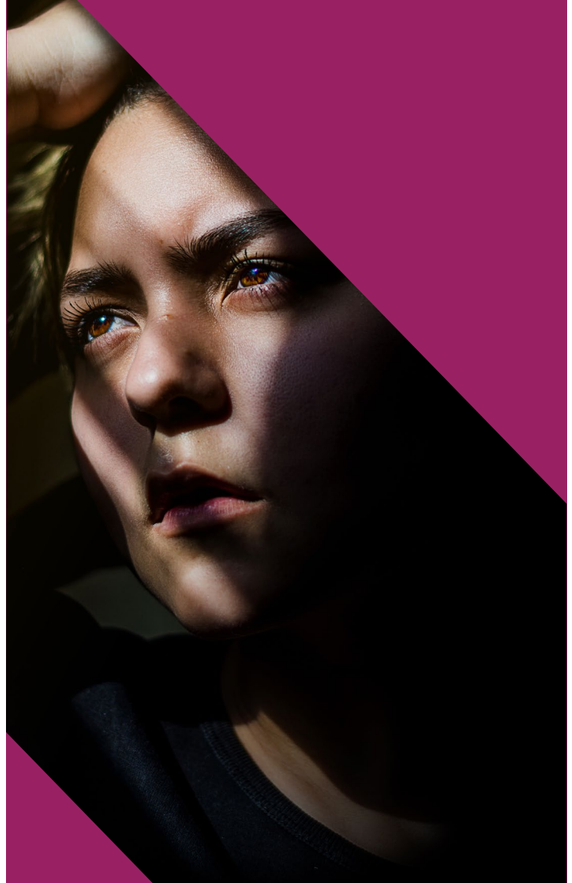


The task of describing, defining and classifying mental disorders has been characterized by challenges and controversies for centuries. Early history includes numerous writings of attempts to understand what differentiated so-called "healthy" behavior from those who were displaying unusual behaviors. And ascribing the cause of those who exhibited abnormality was fraught with misconceptions and myths, with the witch trials in England and the U.S. in past centuries being one prominent example.

When scientific methods were introduced in the 19th century, the understanding of mental illnesses moved from descriptive observations to classification systems. The U.S. government became interested in classification for statistical purposes and in the 1880s census listed 7 mental illnesses. In 1918, the American Medico-Psychological Association (forerunner of the American Psychiatric Association, or the APA) published the Statistical Manual for the Use of Institutions for the Insane.

It listed 22 disorders and was primarily used to gather uniform statistics from mental institutions. Several classification schemes were subsequently developed by various health organizations (including the Veterans Administration), but eventually APA's Diagnostic Statistical Manual (DSM) became the benchmark national system for the classification of mental illnesses.

The title *Diagnostic and Statistical Manual* is a bit misleading. The manual is primarily a compendium that describes symptoms of and criteria for more than 300 mental disorders. It is not a statistical-based publication. The title originated from its early use by mental institutions to base their statistical reports on the prevalence of mental disorders they were treating.

Photo: Richard Jaimes, Unsplash

Pros and Cons of the DSM

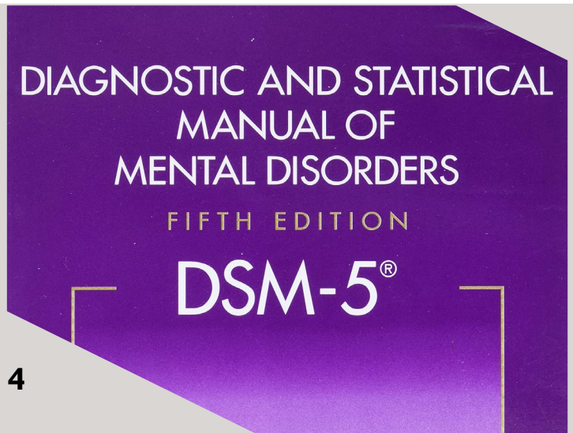
The DSM favors the vast record-keeping systems and those doing research by providing a basis to define mental illnesses by diagnostic categories. This categorical approach promotes communication across health systems and researchers, is convenient for health care payers, and has research support, although significant gaps exist (e.g., Gray, Wheeler, & Bender, 2022; Wakefield, 2015). Individuals are assessed and classified as to whether a disorder is present (a “label”) on the basis of a number of underlying symptoms identified as typical of the disorder. The individual either has a diagnosable mental disorder or does not have a diagnosable disorder (although severity levels can be assigned to many disorders).

Yet there are several weaknesses to the DSM system:

1. There is significant overlap between symptoms across diagnostic categories, which creates unreliability in diagnostic assignments.
2. Mental health and illness are best characterized on a continuum of symptom severity rather than as being “present” or “absent."
3. Diagnoses can lead to labeling and stigma, which can be a barrier to seeking services, an issue that is particularly relevant to Indigenous people who tend to shun diagnostic labels and find it a barrier to treatment.
4. The role of cultural context in mental health and symptoms of mental health issues is minimized (see Gray et al., 2022; more on this latter issue below).

One Alternative to the DSM: The Dimensional Approach

In contrast to the categorical approach of determining the presence or absence of a disorder based on the presence or absence of a set of symptoms, the dimensional approach asks the question, “How many of the symptoms and at what level of severity are they present”? (Krueger et al., 2014). In this light, fewer symptoms equate to lower impairment and more equate to higher impairment. The advantages of the dimensional approach are that more detailed information for a given disorder is available; this approach is more aligned with the reality that disorders in real life are best characterized along a severity continuum rather than being present or absent; and a client profile is created instead of applying labels. Weaknesses are that this approach may be more time consuming for clinicians, and it is not yet accepted by health care providers for the purposes of determining reimbursement for services.



The DSM is the authoritative guide to diagnosis and classification of mental disorders for health care professionals. Clinicians and researchers internationally use the DSM to diagnose and classify mental (or behavioral) disorders affecting mood, personality, identity, cognition, and more. It standardizes diagnoses by psychiatrists, psychologists, social workers, nurses, and other health and mental health professionals, but it also informs research, public health policy, education, reimbursement systems, and forensic science. First published as DSM-I by the American Psychiatric Association (APA) in 1952, the most recent version, DSM-5, was published in 2013 (American Psychiatric Association, 2013) (DSM-6 is in the works).

Another Perspective: The Strength-Based Approach

Negative diagnostic labels may communicate a belief that clients are unable to change and can undervalue clients’ personal strengths and environmental resources. Focusing on clients’ strengths, including positive aspects of cultural identity, rather than deficiencies helps to empower clients to address their mental health issues. When counselors promote strengths and resilience in their clients, behavior change and recovery may be enhanced as the counselor helps clients identify, take pride in, and use their character strengths and virtues to enhance well-being. Such use of positive talk can move clients away from a perspective of deficiency and illness toward encouragement and motivation for change (Seligman, Rashid, & Parks, 2006). A strong predictor among AI/AN clients for successful treatment outcomes for a wide variety of behavioral health issues is the development and fostering of a strong and positive connection to one’s Indigenous culture (Substance Abuse and Mental Health Services Administration, 2018).

Diagnosing Mental Disorders and AI/ANs Clients

All non-White groups have been underrepresented in the development of the DSM system and its editions. Whereas the DSM-5 notes that multicultural and contextual factors need to be considered when diagnosing clients, there are no separate criteria for disorders for any racial/ethnic group, including AI/ANs.

Cultural and contextual factors need to be considered when using the DSM system. Critical to understanding clients and their possible mental health problems is the nature of the client’s interactions within their sociocultural context. Symptoms often occur within a cultural context. Lack of consideration of culture and context may lead to falsely pathologizing behavior. Also relevant for counselors to consider is that many AI/AN clients find the use of diagnostic terminology in clinical work problematic; the process of “naming” or “labeling” can have spiritual significance and may influence how a client perceives the label and negatively impact receptiveness to treatment.

For our readers who are counselors and therapists, the challenge of distinguishing normal behaviors from symptoms of a mental disorder may resonate with you. Consider this list of various DSM-5 symptoms, each of which is included in at least one mental disorder in the DSM. Which so-called symptoms are often observed among “normal” teenagers?

1. Tendency to act unexpectedly and without consideration of the consequence.
2. Unstable and chaotic interpersonal relationships.
3. Distorted self-image.
4. Interrupts or intrudes on others, for example in conversations, games, or activities.
5. Avoids/dislikes tasks that require sustained mental effort, i.e., schoolwork or home chores.
6. Bullies, threatens, or intimidates others.
7. Breaks rules.
8. Lies to adults.
9. Expresses ideas that are unusual or likely false.

Answer: All of them.

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POSITIVE PSYCHOLOGY: CORE VIRTUES

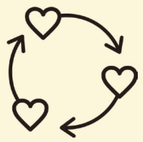
A major effort to advance a strength-based approach to describe and categorize mental health issues is Positive Psychology (Rashid, 2015; Seligman, Rashid, & Parks, 2006). Six core virtues have been identified by Seligman and colleagues as a basis to characterize clients based on strengths and assets (Peterson & Seligman, 2004):

1. Wisdom and knowledge (creativity, curiosity, open-mindedness, love of learning, and perspective)

2. Courage (bravery, persistence, integrity, and vitality)

3. Humanity (love, kindness, and social intelligence)

4. Justice (citizenship, fairness, and leadership)



5. Temperance (forgiveness and mercy, humility and modesty, prudence, and self-regulation)

6. Transcendence (appreciation of beauty and excellence, gratitude, hope, humor, and spirituality)

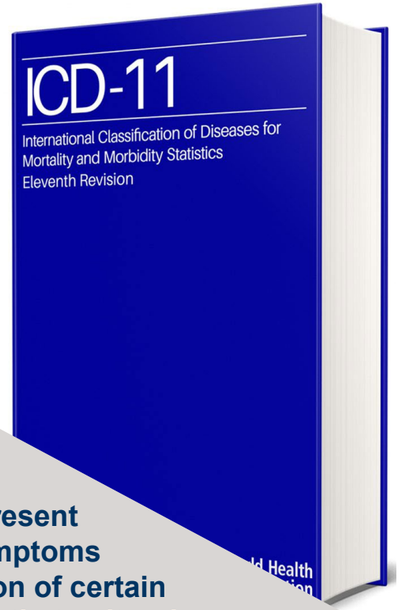
Views of the DSM-5 from the Society of Indian Psychologists

The Society of Indian Psychologists (SIP) is a professional society of psychologists, medical professionals, social workers, drug and alcohol counselors, marriage and family therapists, and community counselors who work in areas related to American Indian psychology. The governing board of SIP expressed several concerns about DSM-5 that could contribute to "an alarming artificial increase in mental health disorders in a population that already has the highest rates of mental health disorders in the United States, or that otherwise distorts our understanding of the problems and strengths that co-exist among these populations." (*https://www.nativepsychs.org/_files/ugd/6c5978_8f0d77d61e734f1cbf4d182bbe43719f.pdf*)

SIP identified a number of general and specific concerns with the DSM-5 in a letter to the Chair of the DSM 5 Task Force, David J. Kupfer, M.D. More details of the concerns can be found at *https://www.nativepsychs.org/_files/ugd/6c5978_8f0d77d61e734f1cbf4d182bbe43719f.pdf*.

The central problem noted by SIP is that the role of cultural context in identifying mental illness has been ignored in the DSM-5. More specifically: (1) no Native Americans were members of the Cross-Cultural Issues Study Group, nor among the 1,500 mental health and medical experts from around the world that contributed to the development of the DSM-5; (2) social, political and cultural contributors to symptoms in the diagnostic criteria are ignored, despite the vast literature on the importance of those factors in mental health; and (3) the absence of a rating option to consider cultural fit and cultural context for a diagnosis.

A better diagnostic system than the DSM with respect to cultural considerations is the International Classification of Diseases (ICD; World Health Organization, 2022).



ICD recognizes that some mental health issues may represent a cultural syndrome, that is a collection of signs and symptoms that is restricted to a limited number of cultures by reason of certain psychosocial features that have a special relationship to that cultural setting. Also recognized by the ICD: cultural idiom of distress, which are ways of communicating emotional suffering that do not refer to specific disorders or symptoms, yet provide a way to talk about personal or social concerns; and cultural explanation or perceived cause, viewed as cultural explanations or perceived causes that indicate culturally recognized meaning of behaviors.

Suggested Readings:

Readers might find of interest the publication by The American Psychological Association's Division 45 (Society for the Psychological Study of Culture, Ethnicity, and Race). This piece discusses the need to avoid over-dependence on the medical model with respect to mental health and the importance of Indigenous and ancient traditions (The Warrior's Path; APA Division 45, 2020; *https://doi.org/10.26077/2en0-6610*.

Understanding Indigenous Perspectives: Visions, Dreams, and Hallucinations (2021). Gayle Skawen:nio Morse and Vicky Tsinnijinnie Lomay, 2021, San Diego, CA: Cognella Academic Publishing.

Protecting and Defending our People: Nakni tushka Anowa (A Warrior's Path); *https://digitalcommons.usu.edu/kicjir/vol9/iss2021/8/*.

Summary

The complicated task of classifying mental and behavioral disorders has evolved over decades to a more research-informed system, as evidenced by comparing the progress from the first formal attempt to develop a taxonomy of mental disorders, DSM-1, to the current one, DSM-5. Yet the dominant tradition of diagnosing within the medical model faces changes as other perspectives gain merit attention. This author sees four priorities that deserve integration into future iterations of any new diagnostic system: inclusion of Indigenous psychologist and psychiatrists on the DSM Task Force; a rating system that provides a consideration of the cultural context of mental health issues; a greater focus on dimensional rather than categorical perspectives of symptoms and resulting diagnoses; and the addition of a rating system regarding client assets and strengths.

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Always My L'il Girl

Though the days and nights seem longer, the memories quickly faded before my eyes.
I ponder upon the years that passed so quickly by.
Long ago it seems you came into this world and grew as youth quickly faded before my eyes.
I ponder upon the years that passed so quickly by.

Now you are so close yet seemingly so far away there is worry that these days will fade before my eyes.
Now I ponder upon the years that passed so quickly by.
You will be on your way once again to take that journey as the hours pass so quickly by.
I know I will ponder through the years that will fade before my eyes.

Yet, when we see one another later in time, there will be no worry of those days fading away.
I will no longer ponder upon these times that passed so quickly by but will cherish the time everlasting as we both see our eyes.

~ Sean A. Bear I, Meskwaki
BA, Co-Director

URBAN INDIAN ORGANIZATION SPOTLIGHT

Tell us about your organization and the services you provide.

The Gerald L. Ignace Indian Health Center, Inc. (GLIIHC) was established in 1999 as a non-profit 501(c)(3) Title V Urban Indian Health Center to serve Milwaukee's urban Native community. The mission of the GLIIHC is to improve the health, peace, and well-being of urban Indians in the Greater Milwaukee Area. The GLIIHC provides comprehensive primary care, behavioral health services, preventive/health screenings, women's health care, prenatal health care, pediatric services, and social services in a holistic and culturally responsive way. The most recent service additions to the Health Center, within the past three years, include a full dental clinic and a pharmacy on site. A major focus of the Health Center is ensuring access to comprehensive primary and behavioral health care services.

The All Nation's Wellness Center is home to the Department of Behavioral Health. Located on the second floor of the Health Center, the Department of Behavioral Health offers culturally responsive trauma-informed behavioral health services to meet the mental health and wellness needs of individuals, couples, families, and the community at large. The Department has grown considerably over the past five years to provide behavioral assessment and treatment services for co-occurring mental health and substance misuse, assessment and treatment of childhood developmental disorders, treatment for acute and complex trauma, psychiatric medication management, crisis support

The *Gerald L. Ignace Indian Health Center* (GLIIHC) grew out of an awareness in the 1970s of the poor health of Milwaukee's Native American community. Since its inception, GLIIHC has tripled in size and besides the medical clinic, houses a pharmacy, dental clinic, behavioral health center and a fitness center that is used by the center's physical therapist.

services, and culturally based prevention education to the Native community in the Greater Milwaukee Area. Currently the Department operates with a total of 20 employees that provide these clinical and community-based programming services to support and strengthen Native traditional approaches to health and wellness.

What role does culture play in the development and implementation of your program's initiatives?

For twenty years, GLIIHC has been a trusted provider of culturally inclusive health care for the Native American and Alaska Native community in Milwaukee. The Health Center utilizes the teachings of the medicine wheel as the foundation for its holistic health and wellness programming. In the behavioral health setting at GLIIHC, those seeking services may choose to utilize an integrated approach to treatment that includes talk therapy with traditional healing practices or utilize groups and services that primarily focus on traditional healing practices and ways of life. Traditional healing practices that are regularly offered at the Health Center include talking circles, the White Bison Wellbriety approach to recovery, use of traditional medicines (i.e., sage, cedar, sweetgrass), the planting and harvesting of traditional medicines and foods, sweat lodge ceremonies, the incorporation of prayer, traditional arts groups, singing/drumming groups, community gatherings, storytelling, talking with elders, and prayer fires.

Please describe past and current behavioral health initiatives and success stories/outcomes from these initiatives.

The Department of Behavioral Health implements a range of behavioral health initiatives to meet the needs of the community. Current program initiatives include mental health and suicide prevention programming, substance abuse and recovery programming, and domestic violence, sexual assault, and human trafficking programming. The Department has experienced several successes as it has steadily grown in the past 5 years. In the past two years, the Department has been building the internal capacity to provide forensic healthcare services for the treatment of sexual assault in conjunction with the medical clinic. The forensic healthcare program is set to begin services in Fall 2022. The Department also received a behavioral health award of distinction from the National Committee of Quality Assurance for behavioral health integration into the Health Center's patient-centered medical home model.

However, the most important successes are those that involve the clients and community that are served. Individual client successes are often characterized by a positive gain as a result of seeking behavioral health care, such as in the instance of Taylor (name has been changed for client privacy). Taylor, a 16-year-old Ojibwe female, began weekly therapy in 2020 after disclosing a sexual assault to their family. While in therapy, they were also going through court with their perpetrator. During this time, Taylor was struggling with self-harm, frequent alcohol use, failing classes, depressive symptoms, flashbacks, nightmares, panic attacks, and suicidal ideation. While working together via telehealth, Taylor and their counselor were able to integrate art, music, and medicines into their care. Taylor would keep supplies for art nearby during sessions and use their medicines when they needed. In sessions, the pair would identify ways to integrate culture with interventions, such as using the format of a winter count when creating a trauma narrative.

Due to ongoing family stressors, Taylor had a suicide attempt that led to hospitalization and higher levels of care, but they continued to come back to the Health Center for community programs for youth and to continue outpatient treatment. During this time, they also began attending a youth group for LGBTQ2+ youth at the Center. Since then, Taylor has a newfound hopefulness in their life and has learned to manage their symptoms using an integrated dialectical behavioral therapy/cultural approach. They have come out to their family as non-binary and they're on track to graduate on time this June with an acceptance for college. They have also started working on advocacy around survivors of sexual violence, including plans to become an advocate professionally in the future. Through the integration of culture, Taylor has reconnected to their inner strength, and they feel more prepared as they transition into adulthood.

Please tell us about challenges/ barriers in the field and recommendations for overcoming these barriers.

Challenges present in this field of work all the time. Transportation and assistance accessing a higher level of inpatient or intensive outpatient care are frequent challenges our clients experience. To address these challenges, the Department established a care coordination program that provides intensive case management and coordination of wraparound care for clients and the community. The Care Coordination team works alongside clients and their behavioral health service providers to ensure their wraparound service needs are assisted while they are receiving behavioral health services. Care coordination needs may include warm hand-offs to higher levels of behavioral health care, providing bus tickets to assist with transportation barriers as well as assisting with setting up medical transport services for those who receive coverage through insurance carriers. Most important, the Department does not turn individuals away from services given the number of struggles and barriers that our community frequently encounters in accessing care. The Care Coordination team provides frequent wellness follow-up calls to individuals to check in on welfare, provide reminders about upcoming appointments, and to schedule needed appointments.

Culture as Prevention to Cultivate Health and Wellness in Our Daily Lives

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Program Manager

A Child's First Laugh

"Laughter is medicine" is a common phrase one can hear across our Native communities. Being able to laugh can be considered a way to cope with issues and promote healing and unity. American Indian/ Alaska Native communities envision youth to have full and healthy lives, equality in all facets of life, and become grounded in culture and tradition. When our first grandson was born, we were residing in Diné Bikéyah (Navajoland). He was born to Coahuiltecan and Navajo Nations. He has been immersed in both cultures so that he is grounded in knowing who he is and where he comes from to guide him to a positive future. During his first few months of life, his parents, grandparents, and other family members each tried to our best to get the first laugh. When one of his aunties coddled and tickled him to finally get him to burst out with laughter, we all knew it was time for a party to be held in his honor. It was a time for the families to come together and celebrate his journey from the spiritual world to be unified with his earthly family. It was a sacred time and one we will never forget. To continue his path in a positive direction, it has taken guidance from the family and consistent opportunities to support his young life. It has not always been an easy path, but together we have chosen to help him have a strong mind, body, and spirit.

Mental Health and Wellness Across Indian Country

Mental health and wellness can look and be addressed differently among diverse cultural communities because it affects everyone differently. The health and well-being of our AI/AN youth is seriously impacted on a greater scale from other ethnic populations due to intergenerational trauma and adverse childhood experiences. According to the Centers for Disease Control, Native/Indigenous people in America report experiencing serious psychological distress 2.5 times more than the general population over a month's time.[1] Often, AI/AN people struggle with explaining their feelings of distress, anxiety, and other mental health issues, as there are not Native language terms to describe the feelings.[2] For our AI/AN youth to be mentally healthy, we strive to help them reach developmental goals and learn healthy social and emotional skills for coping when issues arise. Today's youth face stressors that can be overwhelming, and they may be filled with uncertainty of how to address them.

Mental health disorders in our youth are seen as profound changes in the way children behave, learn, and/or address their emotions with consequences of their actions causing distress and problems. When a child is engaging in unhealthy behaviors that interfere with home/school life, a practitioner uses instruments and literature to assist with a possible diagnosis of a mental disorder.

The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) was created to help mental health professionals diagnose mental disorders that differ from those that are easily identifiable. The DSM-5 includes revisions directed at including the experiences and symptoms youth face on the continuum of their life span, including the disorder's manifestation. Although it is understood that symptoms may begin during childhood, some mental health disorders may arise in adolescence. The onset and diagnosis can be observed and made within a school setting from those who work directly with children, such as educators and other professionals in an academic setting.

Some students may have more than one diagnosis for a mental health disorder, while others' diagnosis may change with age. Moreover, not all mental health disorders first experienced during one's youth continue into adulthood, and not all mental health disorders are first experienced before adulthood. However, disorders can be progressively more problematic as one ages. Natives have higher rates of substance use disorders (SUDs), posttraumatic stress disorder (PTSD), suicide, and attachment disorders, which have been linked to the intergenerational historical trauma forced upon them, such as removal from their

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The most common diagnosed mental health disorders in children ages 3-17 are attention-deficit/ hyperactivity disorder (ADHD), anxiety problems, behavior problems, and depression.[3]

lands and the use of government-operated boarding schools, which separated AI/AN children from their parents, spiritual practices, and culture.[4] The DSM-5 lists disorders structured to recognize age-related aspects. It also has a chronological listing of diagnoses from infancy and childhood and those that are more common to adolescence, as well as diagnoses that relate to young adulthood and the later stages of one's life.

What Does Native Treatment Look Like?

Research demonstrates that mental disorders can be treated and managed with youth when mental health professionals utilize various treatment options. For those working in AI/AN communities, it is imperative to use culturally informed, evidence-based, and experience-based programs and services to support Native students' holistic well-being. It is most beneficial for parents and mental health professionals to work collaboratively with educators, administrators, support staff, coaches, and other family members involved in the child's treatment, using culturally responsive methods for the best outcomes.

When disorders are diagnosed early, services for children and their families usually are effective in the lives of children with mental health disorders.[5] Often in tribal communities, belief systems regarding mental health disorders and contributing factors differ among AI/AN populations. The standard diagnostics are not easily applicable to Native communities. However, there are some culture-bound syndromes which have been found to occur only in Native populations. Culture-bound syndromes are patterns of abnormal behavior that are only found in specific cultures or sub-cultures.[6] To offer high-quality services and access such as screenings, referrals, and culturally responsive treatment, families and schools need to seek providers that will partner with tribal communities. When the services are provided in collaboration with the Indian Health Service, school communities, and sovereign tribal entities that know the value of including cultural methodologies as best practices, there is hope in addressing the mental health and well-being for AI/AN children and their families.

Native Medicine

Culture as a prevention tool is paramount for mental health practices among AI/AN youth so they will continue to be grounded. Traditional healing systems are just as important to the restoration to good mental health as the Western-based methods found in the DSM-5 and other helpful tools. Native youth and their families who meet the criteria for mental health disorders such as depression, anxiety, and substance abuse disorders are much more likely to seek help from a spiritual and/or traditional healer rather than from specialty or other medical sources.[7] Often this approach may take precedence because of high poverty rates that many AI/AN communities face and other barriers that prevent them from receiving Western-based treatment.

The traditional practitioner provides services with a focus on mind, body, and spirit that holds a connection to cultural and traditional teachings. These connections are considered cultural protective factors. These are concepts that are key to the "cultural context, identity, adaptability, and perseverance" of AI/ANs.[8] Cultural protective factors include holistic healing methods and the promotion of well-being for one's community. Culture is seen as a strength and primary protective factor within AI/AN communities.

The MHTTC School Mental Health K-12 Program impacts Indigenous positive mental health and well-being in a crucial way by supporting positive protective factors in our students' identities. Our history, stories, and traditions have carried Native families in times of adversity and celebration. To help our AI/AN youth develop healthy coping strategies, we are called to look at culture as prevention to cultivate health and wellness in our daily lives. Using 'laughter as medicine' is an integral part of Native culture that helps one heal. It can be used and interpreted in many ways but is seen as a key component to address mental health and wellness for the mind, body, and spirit. It is our role as educators, administrators, mental health professionals, and support staff to provide culturally responsive methods as the best practices to sustain resiliency. It is in our youth's DNA to find strength through culture and tradition.

Cultural protective factors can include:

- ***strong culture***
- ***family***
- ***enduring spirit (stubborn, hard to accept change)***
- ***connection with the past***
- ***traditional health practices (ceremonies)***
- ***adaptability***
- ***wisdom of elders.[8,9]***

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ACTIVITIES & EVENTS

For all of our upcoming events, publications, and announcements, *please visit our website.*

Date	Event
Alaska (*register*): Wednesday, June 29 **Idaho** (*register*): Thursday, June 30 **Oregon** (*register*): Tuesday, July 12 **Washington (state):** TBA	***Listening Sessions for Native Communities in Region 10*** In collaboration with Northwest MHTTC (HHS Region 10) The Northwest Mental Health Technology Transfer Center humbly seeks to develop a deeper understanding and connection with the numerous Native communities, leaders and governments in Region 10. We are collaborating with the National American Indian and Alaska Native MHTTC in holding listening sessions for each of the 4 states in Region 10, including partnering with Native consultants who have offered to host these events. Through these listening sessions, we hope to: • Establish and/or deepen connections with Native communities, governments, agencies and leaders in our Region. • Understand Native-identified topics and priorities for mental health workforce training and technical assistance (TA). • Generate collaborations in Aug '22-Sept '23, honoring the strengths & priorities determined by Native communities.
Tuesday, June 28	***Safe Zone Training*** We will be hosting our final Safe Zone virtual training with the Gila River Health Center in Chandler, AZ, to help behavioral health staff provide a safe space and opportunities to discuss the unique challenges for Native LGBTQ/Two-Spirited individuals about accessing behavioral health services. The training is conducted by Matt Ignacio, Ph.D. Tohono O'odham. Staff will identify training needs to engage Native LGBTQ/Two-Spirit people in affirming, supportive, and culturally responsive behavioral health care. *Register*
Coming in July	***Native Medicine: Cultivating Mental Health Resilience and Deep-Rooted Vitality for AI/AN Youth*** Join us to activate (y)our full presence, power, and resilience. We will be guided by Gera Marin, a Traditional Healing Arts Practitioner, Sacred Runner (Chaski), urban farmer, and coach in a 6-class journey where he will share techniques to generate emotional stability amidst the storms. Whether you are an educator, parent, organizer, or tribal leader, this series will support you with physical and mental fitness tools to assist you in sustaining your highest potentials in service of AI/AN youth communities.

National American Indian & Alaska Native MHTTC Mental Health Technology Transfer Center Network
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