



National American Indian and Alaska Native

MHTTC

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IN OUR NATIVE AMERICAN COMMUNITIES · VOL 1 ISSUE 3 SPRING 2020

Suicide,
Trauma,
and Finding
a Way to
Heal



DIRECTOR'S CORNER

Welcome to the latest issue of *Mental Health in our Native American Communities*, which will focus on suicide prevention and treatment. In recent months, representatives from our center have spent countless hours in different tribal communities in order to assist with serious suicide clusters. Closely connected to suicide is the presence of depression and hopelessness. Many factors and issues can contribute to someone committing suicide in Native communities, such as the long-term consequences of historical and generational trauma. However, in our eagerness to assist tribal and urban Indian community members in a crisis, we do not always focus our attention on the strengths in these communities, which is paramount to acknowledge and understand. These strengths are crucial in helping a community move forward and be able to heal.

We are fortunate to include an interview with Ray Daw, MA, Diné, a longtime collaborator of our ATTC and MHTTC. He shares with us his wealth of experiences and addresses the important role his mentors have played in his professional development. He also shares his public health perspective on understanding the development of depression and suicide in tribal communities.

Ray Daw has been a member of our team for many years and has been part of the team working with the tribal suicide epidemic. Our team has developed practices for handling a tribal suicide epidemic and we have decided to share how we approach a tribal community in crisis, how we support them through the crisis and in the aftermath of the immediate crisis. We will give you a glimpse of this in our last article in this newsletter. Later this fall we will start recruiting tribal and urban Indian communities to participate in our Crisis and Resiliency program.


Our National American Indian & Alaska Native MHTTC is initiating several projects this spring. We will pilot a program in San Diego in April, Project Enhancement and Implementation, focused on how to implement and sustain a new project in a tribal community. This pilot training event will be followed-up with virtual learning collaboratives and support for the implementation of the program.

We continue to offer our program for returning Native veterans: Healing the Returning Warrior, with a specific focus on PTSD. The kickoff for our Native LGBTQ/Two-Spirit program will feature a TOT in Seattle this March. Finally, I would like to highlight how important it is to integrate spirituality in the prevention and treatment of mental health disorders as we conduct our fifth Spirituality Roundtable discussion in Denver this March.

I am delighted that I can share all the interesting projects we are doing in our center and I hope some of these mentioned will peak your interests. We are concerned about the spread of the corona virus, and the events outlined above will be subject to how the epidemic is developing, in order to protect participants as well as presenters. Traveling is very important to our work, so we hope this will be managed well so we can continue to meet with our colleagues in all parts of the country.

Regards,

Anne Helene Skinstad, PhD



Suicidality in Native American and Alaska Native Communities

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KEN C. WINTERS, PhD
Contributions from **MARY K. WINTERS, MEd**

Background

Suicide rates vary across tribes and communities, but Native American and Alaska Native (NA/AN) people overall face a disproportionate burden of suicide. In 2017, the age-adjusted suicide rate was 51% (males) and 80% (females) higher compared to the general population.¹ Suicide rates are increasing for the United States in general, including among NA/AN males and females.¹ Research on suicidal ideation among Native people reveal findings that are common to other ethnic/racial groups: rates are higher among females than males, and risk factors most strongly correlated to suicidal ideation are depression, traumatic life events and substance abuse.^{2,3}

The problem of suicidal ideation and suicide is compounded in many tribal reservation settings because of significant mental health service issues, including lack of available professional services, long waiting periods, transportation and geography barriers, and poor cultural adaptation of therapy approaches.^{4,5,6,7,8}

Responding to the Problem of Suicidality

Suicide prevention is a high priority for Native American populations. As noted in the interview with Ray Daw in this issue, several exemplary programs and resources exist. The Center for American Indian and Alaska Native Health, IHS, and SAMHSA have developed an impressive suite of suicide prevention resources for NA/AN people and communities. They are summarized in the following paragraphs. (*Links are included in the heading for each program.*)

[Centers for American Indian and Alaska Native Health, Colorado School of Public Health](#)

There are two important contextual points that guided the Center's suicide prevention program. One is the need for suicide prevention research and programming for urban NA/AN adolescents and young adults. Most research has been limited to rural reservation settings, yet it is estimated that about 75% of NA/ANs reside in urban areas. Another context point was that most people who die by suicide had contact with a primary care provider in the prior year, and 45% were seen in the month before their death, yet getting quick and efficient access to primary care for many NA/ANs are met with many barriers.

In 2017, the federal government (the National Institute on Minority Health and Health Disparities, NIMHD) funded the center and its partners in Albuquerque (Urban Indian Health Organizations in the US First Nations Community Healthsource) and Seattle (Seattle Indian Health Board) to evaluate an adaptation of an existing Screening, Brief Intervention and Referral to Treatment (SBIRT) program for suicidality screening and intervention. Known as the Suicide Prevention for Urban Native Kids and Youth (SPUNKY), this program enhances the standard SBIRT components by including the sending of caring text messages which are adapted from empirically-based, effective interventions for suicide prevention. The text messages, which are sent over the course of several months, are intended to improve SBIRT retention and increase social and cultural connectedness, which are strong protective factors against suicidal ideation and suicide.

Interested in more about the use of the SBIRT model as a clinical tool to address behavioral problems?

See [Prevention in Our Native American Communities, Vol 1, Issue 1, Spring 2019.](#)

Indian Health Services (IHS) Suicide Prevention and Care Plan

A priority of IHS is to meet the standard that any NA/AN person who is experiencing suicidal ideation and has made a suicide gesture or is a family member of a suicide victim shall have access to suitable behavioral health services. IHS has authored the American Indian and Alaska Native National Suicide Prevention Strategic Plan, a national initiative to support collaborations across tribes on suicide prevention efforts. This plan is designed to provide resources to support these efforts, and to help communities and individuals understand and obtain services related to suicide. The plan consists of 7 components, each of which are summarized below.

1. How to Talk About Suicide

Guidelines and practice tips for how to start the conversation, the importance of asking the key question (e.g., "Are you thinking about ending your life?"), avoiding the wrong way to ask the question (e.g., "You're not thinking about killing yourself, are you?"), ways to validate the person's experience, and how to assist the person get help.

2. Warning Signs and Risk Factors

Whereas signs of suicidality may not be obvious, there are "red flag" behaviors that may indicate a person is at risk for suicide. If warning signs are noticed, this is a starting point for the conversation with the person. Common warning signs include social withdrawal, substance abuse, feeling hopelessness that has no way out, rage or anger, and expressing there is no reason to live.

3. Resources for Providers

The plan provides health care professionals with numerous resources to support community education efforts, and to enhance clinical services related to screening, intervention and post-intervention when faced with a suicidal person.

4. Resources for Patients, Friends and Family, Youth and the Community

A companion resource in the plan are descriptions of various options where a suicidal person or a significant other can find help, including the confidential, 24 hours a day, 7 days a week, National Suicide Prevention Lifeline at 1-800-273-8255 (TALK). Also included are training centers and tribal centers specializing in suicide prevention resources.

5. Media Campaigns

Several exemplary suicide prevention media campaigns are highlighted; each has downloadable resources. Campaigns summarized are the following:

Community is The Healer That Breaks the Silence (Thrive) Campaign; What a Difference a Friend Makes; and several suicide prevention videos.

6. NA/AN Community Crisis Response Guidelines

Various levels and types of response for suicide-related events are provided for tribes and tribal organizations. The role of IHS and area offices in assisting tribes are described.

7. Zero Suicide Initiative

The Zero Suicide model is described. This initiative is a comprehensive approach to suicide care that focuses on how health care systems can reduce the risk of suicide for all patients. The safety and support of clinical staff who treat and support suicidal patients are also addressed in the model.

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An example of broadening efforts to prevent suicide in all communities is the [Question, Persuade, and Refer \(QPR\) program](#). QPR aims to “save lives and reduce suicidal behaviors by providing innovative, practical, and proven suicide prevention training”. The program provides quality education in order to empower individuals of all backgrounds to learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

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SAMHSA's Suicide Prevention Resource Center (SPRC)

The SPRC provides a virtual learning lab aimed at supporting communities as they build and improve effective suicide prevention strategies. Details of the Center's resources aimed at NA/AN communities are provided below.

1. How Native Communities Can Take Action

The principle that suicide prevention needs to be culturally relevant is paramount. Elements of culturally relevant prevention programs include the use of culturally competent practices that increase protective factors and reduce risk, creating a shared vision of health and wellness by connecting the community's resources, and gathering insights from elders and community members about the issue of suicide and incorporating their knowledge into the community's prevention response ([see https://www.sprc.org/keys-success/culturally-competent](https://www.sprc.org/keys-success/culturally-competent)).

2. Tailoring Prevention

SPRC recently added additional guidance about the value of prevention tailoring as a way to enhance desired outcomes when resources are limited (<http://www.sprc.org/effective-suicide-prevention>). Tailoring is enhanced by:

- using a systematic, data-driven process to develop and shape the suicide prevention programs;
- organizing the prevention program around multiple coordinated and evidence-based prevention strategies; and
- selecting a prevention approach that optimally addresses the specific risk factors and contextual issues pertinent to the NA/AN community.

SPRC recommends that the tailoring model is best implemented by starting with a strategic planning process. Six steps of this planning process are recommended:

Step 1. Describe the problem and its context: use data and other sources to understand how suicide affects your community and to describe the problem and its context.

Step 2. Choose long-term goals: identify a small set of realistic and achievable long-term goals (e.g., reduce the suicide rate among a particular group).

Step 3. Identify key risk and protective factors: prioritize the key risk and protective factors on which to focus your prevention efforts.

Step 4. Select or develop interventions: begin planning your approach by deciding which activity or combination of activities best address your key risk and protective factors.

Step 5. Plan the evaluation: develop an evaluation plan to track progress toward your long-term goals, show the value of your prevention efforts, and give you the information you need to refine, expand, or determine other next steps for your programming.

Step 6. Implement, evaluate, and improve: implement and evaluate your activities, and use your evaluation data to monitor implementation, solve problems, and enhance your prevention efforts.

Recommended Resources

To Live to See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults

This guide is designed to help Native communities and those who serve them develop effective, culturally appropriate suicide prevention plans. (<https://www.sprc.org/resources-programs/live-see-great-day-dawns-preventing-suicide-american-indian-and-alaska-native>).

Healthy Indian Country Initiative promising prevention practices resource guide

This guide highlights the work of the 14 Healthy Indian Country Initiative tribal grantee programs, including suicide prevention programs. (<https://www.sprc.org/resources-programs/healthy-indian-country-initiative-promising-prevention-practices-resource-guide>).

Suicide prevention: Resources for American Indian/ Alaska Native communities

This directory of resources is designed to assist AI/AN communities in developing their own suicide prevention programs. (<https://www.sprc.org/resources-programs/suicide-prevention-resources-american-indianalaska-native-communities>).

Adolescent Suicide Prevention Program Manual: A Public Health Model for Native American Communities

This manual describes the Adolescent Suicide Prevention Program conducted from 1989 to 2005. (<https://www.sprc.org/resources-programs/adolescent-suicide-prevention-program-manual>).

Working with Native Communities

Doreen Bird, MPH, SPRC Senior Tribal Prevention Specialist, explains why and how to involve the community when developing suicide prevention programs for American Indians and Alaska Natives. (<https://www.sprc.org/news/working-native-communities>).

Four Recommendations for Tribal Suicide Prevention

YouTube presentation by Dr. Melissa Walls of the Bois Forte and Couchiching First Nations Ojibwe discusses these keys to suicide prevention in NA/AN communities: assess structural influences on suicide, target early life course risk factors, identify cultural influences on prevention, and listen to indigenous voices. (<https://www.youtube.com/watch?v=Rf3WX9hKi1U>).

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently unveiled a free, new mobile app called *Suicide Safe* to help health care providers assist patients with suicidal ideation and behaviors. The *Suicide Safe* app is available for free download on Apple and Android mobile devices. [More information is available at this link.](#)

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A Career in Search of Healing: A Conversation with Raymond Daw

KEN C. WINTERS, PhD

Transcribed by Keely Driscoll and Elleh Driscoll

Our MHTTC team wanted to feature a major contributor to our work throughout the country in the areas of mental health, substance abuse, and prevention. We had the pleasure of interviewing our colleague, Mr. Raymond Daw, Navajo Nation, Diné, who has over 35 years of experience working with many non-profit agencies in the behavioral health field. His work has been heavily geared towards developing Native trauma-appropriate approaches that are healing and effective in tribal behavioral health prevention, intervention and treatment services. He also has extensive experience addressing suicide in Native communities.

KW: To start, could you please provide a brief overview of some of the contributions you've made to the field and some of the important models that you've organized your work around?

RD: I have a master's degree in counseling from the University of New Mexico (UNM) and I've worked as a counselor, prevention specialist, clinical supervisor, clinical director, executive director, and administrator over the course of my career. I have also had a fortunate career where I have gotten to know and work with many of the best people in the field. Mainly, Dr. William Miller from UNM, one of my mentors. I have gotten to know great leaders in the field of motivational interviewing fairly well through him, and I have gotten to meet people that he's worked with throughout his career.

Another colleague who I have put a lot of work in with is Dr. Maria Yellow Horse Brave Heart who designed and developed the circle trauma model. I also consider her a mentor.

KW: These are excellent pioneers that you've had as mentors. You are fortunate, and it means that you've been able to take that knowledge and spread it elsewhere.

RD: It's good for me to mention them because they have been a good influence on my work and how I frame my approach. They've been a major influence in that way.

KW: I see that culture and the role of historical trauma is weaved throughout your work. Have your mentors helped you shape some of that thinking?

RD: Right, they have. And I can't ignore Roger Dale Walker, Western Band Cherokee, out of Oregon, Dr. Clyde McCoy, Eastern Band Cherokee, from Miami, Dee Bigfoot, Caddo Nation of Oklahoma, Karina Walters and Bonnie Duran from Washington, Michael Water Horse from Washington, and colleagues at the University of Colorado.

KW: Have your mentors done a lot of work with depression and suicide or have you learned more about this topic based on your own independent thinking and research?

RD: Well you know depression is probably the greatest mental health problem in Indian Country and the world. These people that I have mentioned have created an understanding around that particular disorder from their different perspectives. Depression does influence alcoholism, suicide, domestic violence, substance use disorders, medical health problems, incarceration rates, and it affects quality of life across the board. And for individuals, families, communities, and tribes it really does have a widespread impact. I have a friend, Pamela Jumper-Thurman, PhD, Western Cherokee from Colorado. She has done really good work with the community readiness model, which helps to assess readiness for action at a community level. It is an important tool that is available to understand how widespread of an impact problems like depression and trauma have had on Native communities. I have been really blessed to have a lot of colleagues become friends and a lot of colleagues become mentors to me over the years.



KW: Have you seen big differences in what contributes to suicide among young people versus adults in Native country? Or are there more similarities?

RD: I think generally there's not a lot of difference across age groups, especially today. But I think the problem of depression manifests itself differently between generations. We know in Indian country the death rates among our teenagers and young adults is higher than in any other ethnic group. That is due to unintentional injuries and deaths, including suicides, deaths related to alcoholism, deaths related to substance use disorders, and deaths related to violence. There are young people dying at a very high rate early on - 15-25 years of age; they are the most susceptible and the most vulnerable people. What I've seen demographically across Native Country and looking at census data is that from age 35 on these death rates, particularly among Native American men, begin to go down. Because by then, like I said, the ones who are most likely to die from depression and all these other problems have already died. We don't talk about that.

So when men make it past 30-35 years of age then they're a little more likely to live on into late adulthood. These are probably the people who have received really good family support and have benefited from culture, education, and career success. The ones who haven't been able to do that early on are the ones who are at risk for suicide or early death.

KW: Some of these trends are not just due to the suicide phenomenon, correct? It is factors associated with violence and other risk behaviors that are more prevalent among men than women?

RD: Yes, this is true. But also, after 35 or 40 years of age you begin to see problems related to long-standing healthy lifestyles. Chronic illnesses such as diabetes and hypertension. Some of this is because many men have a problem with alcohol. There is the impact of unintentional injuries, including head injuries, heart disease, and cancer. I have looked at mortality trends among particular communities that I have worked in and I have seen chronic illnesses begin to have a major impact on men after age 35.

KW: How is clinical-level depression playing a factor with suicide?

RD: I think we are seeing more of it today than a generation or two generations ago. We see among women increases in alcohol and substance use behaviors and suicide. I saw a report last month that said the death rate among women is increasing. I think a lot of that is social and cultural changes that are occurring, not only in the US, but worldwide.

KW: I know the rates of substance use and disorders among women have been on the rise for decades. How much is the historical trauma phenomenon an issue as a part of depression among Native Americans and Alaska Natives?

RD: That's a really good question. When I go to a community, any community whether it be Native American, African American, South African, or anywhere, and people begin to talk about their health conditions, economic conditions, social conditions, and political conditions, the question that always comes to my mind is how did things get this way? It almost always takes me back to looking at historical information. What happened to this community, county, tribe, this country - for quality of life conditions to be the way people are describing? This is when the historical trauma framework really is a useful perspective. We begin to talk to people about the problems in the community they will invariably go back historically and talk about things that they believe may have contributed to where they are today. That's the historical trauma framework in action.

We know through studies on adverse childhood experiences (ACEs) for example that trauma in and of itself has biological and emotional impacts over time, especially if they are repeated over a lifespan of an individual. I am always thinking, if traumatic experiences occur over time in a community, then how do those traumatic experiences that occur over the lifespan of any community begin to show up? Likely in biological, cultural, social, economic, and political ways.

"There are several things that I talk about with parents around suicidality. One is nutrition. Second is physical activity. Third is socialization - the importance of getting young people to socialize outside. Fourth is having a caring and respectful relationship with your adolescents, and fifth is being abstinent from alcohol and other substances. These are some of the things that I talk about."



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KW: It helps then to connect with communities and help them gain insight. To help community members describe and discuss their historical trauma, the model promotes communities and individuals to move forward towards a healthier path by understanding the roots of their despair.

RD: And understanding what traumas have led to that despair. The historical trauma model actually has four parts to it. The first part deals with confronting the trauma - which is what I was describing and talking to people about - what traumas have they experienced over their individual lives, lives of their family, and the lives of the community. That's the process of confronting the trauma. These are traumas that we have experienced and this is how we know them to exist. It is an assessment of trauma history.

The second part of the model then, is probably the most difficult part. Many communities have had to work around understanding the impact of that trauma.

The third part of the historical trauma model is about releasing the trauma. The fourth part of the model is when you transcend the pain. You create a life that is healthier. Transcending the pain of trauma.

Those are the four key parts to the historical trauma model, which really resonate with me. When people begin to go through that process of walking themselves through, confronting the trauma, understanding the trauma, releasing the pain of trauma, and transcending the pain of trauma - then it begins to make sense how we take a healthier road for ourselves individually, but also for families, communities, and tribes.

KW: Since you earlier talked about your work with William Miller and motivational interviewing, I assume when you are teaching communities about the model, you are using motivational enhancement techniques (MET) to talk about not staying stuck in the trauma but moving forward to the destination point of transcending it.

RD: One of the blessings in my life is that I have worked with probably the foremost Native American motivational interviewing trainer in the country, Kamilla Venner, PhD, member of the Athabascan tribe, from the University of New Mexico. I consider her another one of my mentors.

An MI approach to discussing issues is the way, historically, Native people communicated with each other: in a caring, nonconfrontational, nonjudgmental way. We have Native words that describe being nonjudgmental, having care, and having affection. It's not necessarily saying that it's MI but it's going back to traditional beliefs and culture and teachings.

KW: Have you talked to parents or parent groups about the problem of youth suicide or suicidality, and if so what kind of themes do you emphasize?

RD: There are several things that I talk about with parents around suicidality. One is nutrition. Second is physical activity. Third is socialization - the importance of getting young people to socialize outside. Fourth is having a caring and respectful relationship with your adolescents, and fifth is being abstinent from alcohol and other substances. These are some of the things that I talk about.

I think a phenomenon that's happening with young people is that after high school, there is absence of social support. When you go to high school, you have a really strong support system. But when graduation happens, that support system deteriorates. People in one's support system move on - they'll go to college, join the military, get married, have children. The support system from high school is pretty much gone.

If you can't create your own because you're isolated and going through some form of depression, it really ends up being a problem of despair. I think this happens across cultures. I think it contributes to the kind of problems we are seeing with young adults having problems with violence, substance dependence.



I don't think we do good work across the country with identifying and intervening with moderate to severe mental illnesses. We are starting to learn about it (early intervention). I am hoping we are on the front end of the learning curve in addressing it.

KW: Do you have any success stories from your work that you want to share with us?

RD: Well, I reviewed some basic approaches that I apply in my work and my thinking that influences what others and I have been able to do in Alaska, Montana, South Dakota, Minnesota, and Arizona. But I would like to note that I am a lifelong learner and so I am always learning as I go. I have been able to build a career on that. I also make it important for me to teach others. One of my daughters told me about 8 years ago: "Dad, you're trying to change the way people think and the way people behave and you're not doing a good job at it because you lost touch with how to do it. What you want to do is get into Facebook and figure a way to teach through that because that's where all the young people are. That's where all the people who are having problems are, especially family."

That really resonated to me. Today, I admit that I am on Facebook a lot. So, these days although I'm not working a job of sorts, I have been able to put more of my time into these different pages and groups that I am involved in. But also finding colleagues to help along the way so that I'm not the only one carrying the load. I think a lot of people in my generation discount that as an effective way of communicating, teaching, and reaching out. I think that's really unfortunate.

The other thing I want to mention is that in my career I've worked at transforming programs to be more effective and efficient - with Native programs in particular. Getting them to become more efficient and incorporating tribal values, cultures, and messages into their prevention and treatment practices, and understanding ways to implement best practices. I've been blessed to have worked at creating model programs like the community detox program. It is the only program today of this type that incorporates traditional Navajo practices into a residential program. That program has been able to achieve a graduation rate of about 90%. None of the providers in that unit are certified or credentialed behavioral health service providers. Rather, they are healers and medicine people and create healing in our own way.

KW: Ray, it's been a pleasure. I'd like to thank you for your willingness to give us so many insights. This has been an extremely informative discussion.



CULTURALLY MINDFUL IN SUICIDE CRISIS: Overcoming obstacles that hinder wholeness and togetherness in the tribe

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Introduction

Suicide epidemics in Native communities are heart-wrenching to watch and make us all very concerned. During these times, we become very interested in assisting these tribes. Our centers have been involved in providing support during several suicide epidemics. A crisis in any community makes us all want to jump in to help. But in our eagerness, we must also consider that the community may feel overwhelmed by the planning, adjustments, and influx of others.

In order to show respect to the communities we work with, we have adopted the practice that we must be invited first. Once this occurs, we speak to the leadership, professional workforce, spiritual leadership, and the community members themselves to gain a better understanding of what they think their challenges are. We do not want to overwhelm the community, so we prefer to do this in a good way.

By including trauma-informed care practices, and our understanding of historic and intergenerational trauma, we are better able to build relationships with communities. We avoid adopting stereotypical behaviors of those outside the communities, who have mishandled scientific data, and participated in "helicopter research." We realize and understand the suspicion and mistrust that many tribal communities have of state, federal, and other government agencies or outside institutions. We also understand that this may contribute to the vulnerabilities of these communities and subject them to long-term consequences.

Respect the community's boundaries

Communities will be more responsive and much more interested in receiving assistance from those who allow them the opportunity to have control over the process. Our approach is based on community-based participatory program/research (CBPP/R) or tribally-driven participatory research (TDPR).

It is important to work on developing a relationship and building trust with the community, including tribal council, elders, and leaders in the community, while respecting tribal sovereignty.

We need to study the strengths of the people, and the challenges that the community is faced with. Understand the financial situation of the community, health related issues, organization of health care, educational strengths and challenges, and transportation issues. Infrastructure in general, and tribal traditional and spiritual beliefs and practices.

We prefer to have Native experts play a role (preferably Native professionals) who understand and respect the tribal beliefs and practices. If our experts are non-Native, it is important that they understand and have cultural humility for the community.

Assessment

The goals with the assessment process is to get a better understanding of the issues in the community and the family survivors of the victims. Assessments should always be built upon community involvement, outreach, and CBPP/R. Meet with tribal council members, elders, health care professionals, school representatives, children and adolescents; engage with medicine peoples, tribal healers, and/or spiritual leaders. Be self-cognizant, self-aware, and respect tribal sovereignty and their beliefs and practices.

Think of the assessment as the beginning of healing; community members get to talk about their concerns and their experiences by face-to-face assessment.

Make sure to understand the traditional, bi-cultural, and acculturated people within the community. It is important to take into consideration historical and religious institutions, boarding schools, and the traumas associated with these institutions, such as child/female sexual assaults by these institutions.

The adolescent community: Are young people using social media to discuss how to develop a suicide pact? Speak to the youth face-to-face, as they will understand much more than people realize. Respect what they say, as many times, the youth are further ahead with underlying information than the professionals and adults of the community.

Intervention

Offer suggestions based on the assessment discussed with the community, and make sure the conclusions are congruent with the community's perception.

Base the suggestions on change, strengths, and the resources in the community. Utilize cultural humility and culturally-informed suggestions.

Crisis and resiliency program: assist the community in developing a crisis plan, but do not attempt to sound like the expert on their communities. Suggestions are fine, but should come from a place of respect.

Follow-up and the long term

Do not consider this an isolated crisis event, but rather shows a need for support for the long haul. Follow-up is very important. Offer suggestions, assist the community with keeping track of their data, offer suggestions for new ideas, look for grant applications, etc.

Support first responders and people working with the victims' family members as to prevent secondary trauma or burnout. Get involved in cultural events and ceremonies, but remember, you are being "observed." Be very self-aware and cognizant of your words, behaviors, and micro-behaviors (this includes any facial, eye, or physical remarks). The awareness of others who show disrespect can be very upsetting.

Be aware of how crisis events are portrayed in local media and if possible, on social media. Any negative portrayal or discussions about the community as it relates to the crisis is not helpful and can make matters worse. If possible, when discussing response strategies with all team members, counter negative portrayals with strengths-based messaging.

Report writing

Report writing should take place in collaboration with the community. The report should be shown to tribal council before it is published outside of the community.

Our National AI & AN ATTC, MHTTC, and PTTC have established the national Suicide Prevention Taskforce, where community members and professionals can regularly participate in virtual meetings over an extended period of time (Intensive TA) after crises. These virtual meetings have been very helpful to many communities that have experienced suicide epidemics, and have provided support to the professionals working in the community. Compassion fatigue and burn-out among professionals working in Native communities with constant crisis results in high rates of turn-over in staff at a time when the community needs stability.

The Boy Who Learned Courage

I have worked with youth for quite a while, both professionally and culturally. There is one who comes to mind in my life. He came to me to ask if there was something wrong with him, as he was not able to cry for his recently passed sister. He had recently turned 17 but shared that he had not cried once in the last 9 years. As a child, he had grown up with a father and uncles who had driven into him that big boys or men don't cry. He had said he was so sensitive back then and would cry easily. Not from pain, but from teasing or people putting him down. Since he was about 5 years old, he and his brother were not allowed to cry, even in their new community where bullies had bothered both.

Anyway, life has a way of teaching us things. Despite his sensitivity to teasing from family or relatives, he wouldn't cry against bullies, even as they hit him. His father was strict about this at first. He also shared that his older brother tormented him at home until he learned not to react to his brother and walked away. He had tried telling his mom and stepfather that his older brother was teasing him or hitting him, but being the hero, his brother could do no wrong. He eventually learned this, but remembered his dad's words that he had a right to defend myself, but I must never throw the first punch, and that is what he did. He said that there came a time that he could not bear to have others see him cry again. He said he would bite his lip, pinch himself, or hit something to cover up how he felt. Eventually he would not cry, nor did it feel as though he needed to. After this, many things came where he would have cried before. He had shared that he had lost relatives, loved ones, and friends, but he felt no need to cry, as if those feelings were turned off. In our cultural practices, we are not allowed to cry after a certain amount of time after a death but can right away if needed. After minutes or a few hours, we cannot cry for this person again. I had told him this, but he said that he felt no need to but wondered why his family would do so. It had been nine years since he had cried, but had recently lost his little sister to an accident. He looked so puzzled and concerned. I shared with him about teachings that holding his pain in can actually block feelings by backing up, much like a water hose if the hose is folded.

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He said that he felt that people would look at him as if they were wondering, “Why does this not bother him, why doesn’t he cry?” “Does he not care?” He said that he had thought about this and knew he felt the loss and really did care, but was not able to cry. He said he wanted to so badly and would envision them playing together and how would not see her like that again. He paused. I wanted to give him a hug, but decided to let him think a bit. It’s not always good to say, “I understand.” He then continued by saying that he tried for a few days to no avail. He had seen his family hurting, especially his father and sister. He then asked, “Is something wrong with me?” I know he was concerned.

I asked him how it felt when he tried to cry. He said that it was as if his tear glands were dried up and that he could not cry. Not only that, but when he started to feel something, it felt like those feelings would shut down. He was so concerned and afraid that people might think he didn’t care when he was actually struggling to feel it. He knew that crying would help him release the pain he did feel.

I told him how my father had not let me cry either, but also that I had caught him crying. Not only him, but other men. I had to sneak away very quietly as not to interfere with them. I saw how my mother, aunt, sister, and other women cried together and how comforted they felt. I told a story, a teaching, of a boy in much the same situation long ago. In the story, this boy was so hurt that he did not want to feel it anymore, so he had asked many spirits and animals how to not feel. Eventually one was able to tell him, as he had a very hard task of helping those who have passed away, so the Creator gave him a gift to help him. The boy was told not to keep those feelings out forever or there would be a greater pain when he once again used them.

Instead of telling him the rest, I asked him, “Shall we try what he did in order to cry once again?” He said, “Yes! I want this.” I told him that once he cries, that he should not try to fight it, but let it flow and feel all that comes. I said that he may cry much longer, but not to attach his mind or thoughts on what comes, but let them pass through. He agreed, smiling for the first time while we spoke.

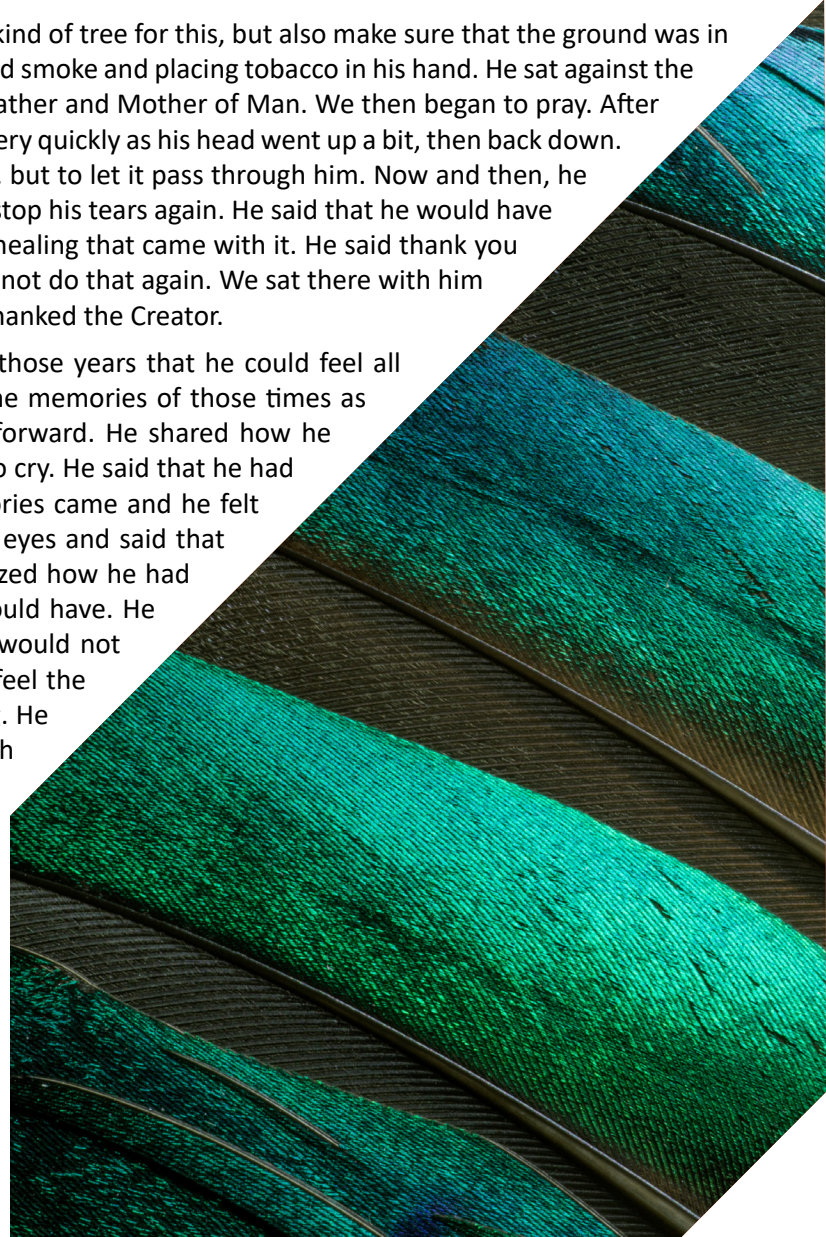
We walked outside and to the tree line. I had to find the right kind of tree for this, but also make sure that the ground was in the right way. I then prepared by lighting some herbs that would smoke and placing tobacco in his hand. He sat against the tree as I had instructed. I told him a story of the Great Grandfather and Mother of Man. We then began to pray. After about five to ten minutes, I heard him take a repeated breath very quickly as his head went up a bit, then back down. He began to cry uncontrollably, as I reminded him not to stop, but to let it pass through him. Now and then, he said he was so sorry. That he was wrong and would not try to stop his tears again. He said that he would have courage to cry and that he would welcome the tears and the healing that came with it. He said thank you again and again, but was also saying he was wrong and would not do that again. We sat there with him crying for about an hour. We then made another prayer and thanked the Creator.

We sat there for a bit and he shared with me that from all those years that he could feel all the hurt that he would have felt, but also remembered all the memories of those times as if they were passing through his mind like a movie on fast forward. He shared how he remembered how he had prayed to the Creator for help not to cry. He said that he had forgotten about that all those years ago, but then the memories came and he felt the hurt leaving as he cried. He smiled, still with tears in his eyes and said that he was wrong to have tried to stop those tears, how he realized how he had actually hurt himself by not feeling to the capacity as he should have. He said he was saying he was sorry to the Creator and that he would not do that again, but thanked the Creator so much as he could feel the happiness and sadness so much more than he had for so long. He realized as I nodded to him, that many times men do not teach boys the right way and that it takes so much more courage to cry in front of others. He then said that he now understood and would have the courage to Cry for now on. “Yes!” I said.

To this day, when ever I see this young man, his smile shines as we both smile and nod.

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

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RECENT ACTIVITIES & UPCOMING EVENTS

Date	Event	Location
02/2-6	Community Anti-Drug Coalitions of America National Leadership Forum - <i>staff attended this conference</i>	Black River Falls, WI
02/12	Healing the Returning Warrior Modules 3-4 webinar	View the recording
02/21-23	Spiritual Gathering of Healers	Black River Falls, WI
02/23-25	Telehealth TA trip	Ohkay Owingeh Pueblo, NM
02/26-28	Leadership Academy Enhancement Session	Albuquerque, NM
03/11	Healing the Returning Warrior Module 5 webinar	Online - register
03/12-13	Healing the Returning Warrior training	Jemez Pueblo, NM
03/17-19	National Indian Health Board's National Tribal Health Conference - <i>staff will present at this conference</i>	Omaha, NE
03/20	Native LGBTQ and Two Spirit curriculum Training of Trainers	Seattle, WA
03/30-31	Southwest Veterans Tribal Healing to Wellness Court training	Santa Ana, NM
04/08	Healing the Returning Warrior Module 2 webinar	Online - register
04/14-15	Project Enhancement and Implementation training	San Diego, CA
04/TBD	Historical Trauma Training of Trainers	Montana
04/TBD	Healing to Wellness training	Bernalillo, NM
05/TBD	MHTTC Advisory Council meeting	Iowa City, IA
05/27-29	Native American Curriculum adaptation consensus panel	Iowa City, IA

For additional events in our Prevention and Addiction programs, please visit their websites:

PTTC: pttcnetwork.org/native; ATTC: attcnetwork.org/native



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MHTTC

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