# INTRODUCTION

Jami Bartgis, PhD

It is with great pleasure that we release the first special issue on *Strength-based Approaches to Wellness in Indian Country* in the journal *American Indian and Alaska Native Mental Health Research*. This issue includes a wide range of articles that address how strength- and resilience-based approaches can support public health policy, research, and practice improvements broadly to better serve Indigenous peoples. It is my hope that this special issue inspires public health policy makers, researchers, and health care professionals to challenge the current paradigm for working with Indigenous populations and to support more strength-based and culturally congruent models. To do this, we must think outside the box and build on the inherent strengths that lie within Indigenous communities in a number of ways.

First, strength-based approaches to health and wellness in tribal communities are not new, but are embedded in diverse tribal best practices, established by systematic observation over centuries, that have been passed down orally from generation to generation. The oral transmission of tribal best practices results in increased supervision and fidelity through a one-on-one mentorship model in which training typically occurs over decades. Two articles published in this special issue identify tribal science as "Indigenous ways of knowing." Unlike randomized clinical trials used Western science, tribal science has collected knowledge of long-term effects of practices that are in tune to the role of the environment. For example, Brave Heart and colleagues address tribal best practices for healing from historical and intergenerational trauma, and Tingey and colleagues address the potential of entrepreneurship education to improve environmental conditions for the promotion of sobriety and life (i.e., prevention of substance abuse and suicide). I acknowledge these diverse tribal best practices and worldviews are an important foundation of *Strength-based Approaches to Wellness in Indian Country*.

Second, unlike Western health beliefs, tribal worldviews recognize the "whole" person within the context of the environment and implement tribal best practices that are holistic in approach, including the entire family and spirituality. In effect, health and spirituality are not separated, but integrated. You will learn more about the holistic model in the article by Rountree

and Smith that examines the literature from a relational worldview, identifying key resilience factors for Indigenous peoples. I acknowledge the importance of holistic medicine and healing practices as a strength-based approach passed down using Indigenous methods for serving tribal and urban Indian communities.

Third, inherent in many tribal worldviews is the concept that "energy follows thought." While the exact expressions, applications, and practices of this concept vary significantly from tribe to tribe, it has important implications for our collective work in public health. In many tribal cultures, the concept that energy follows thought is applied to day-to-day living in diverse ways. As examples, one should not cook food for the family when experiencing a negative mood or the food will taste bad; one should not speak ill of others, as doing so might make them sick; one should not predict a negative event happening in the future or one could make it happen; and one should not participate in dancing during a time of mourning, as doing so may pass that grief on to others. While outsiders may consider this concept and the various applications to be superstitions, tall tales, or myths, they actually have a basis in Western science, and the Indigenous ways of knowing may be much more advanced than current Western science.

The first Western scientific advancement in the field of behavioral health to support this *thought energy* concept is Cognitive Behavioral Therapy (CBT). CBT is the most commonly accepted intervention for a wide range of mental and behavioral health issues; it is based on the general idea that what a person thinks or says through self-talk will impact how that person feels, and how the person feels will then impact how that person interacts with the world. Hence, CBT teaches people to restructure thinking (i.e., thought) to be more positive and realistic so that it may impact their feelings and behaviors (i.e., energy). CBT also has important implications for family and other interpersonal relationships: if a person changes his/her behavior toward others, then they may change their response to the person.

The second Western scientific advancement to support the concept that energy follows thought is the self-fulfilling prophecy. In a hallmark study by Robert Rosenthal and Lenore Jacobson, teachers actually influenced the achievements of randomly selected students just by being led to believe that these students were "late bloomers" and were going to excel in the classroom. Hence, teacher expectations (i.e., thought) of students actually impacted the student performance (i.e., energy).

I propose that the energy we create in public health matters for addressing the health disparities of tribal peoples—both for those trying to recover from mental illness or behavioral conditions, and for the lives of all people through the expectations we set for them. You will see

this highlighted in this special issue. For example, Clark identifies how "out of balance" current clinical assessments are because they only assess deficits, and further hypothesizes that such assessments may pathologize individuals. This idea is backed up by Barraza and youth colleagues, who are publishing a youth-developed self-assessment tool; they identify that deficit-based assessments may decrease youth motivation to get help and could negatively impact their outlook on life. While I believe Western scientific advances have hardly begun to explore how our *thought energy* can impact us and the world around us, they do provide important ideas for us to consider about the energy we are creating in our professional lives and what impact that might have on Indigenous peoples.

**At the policy level**, federally funded grant programs typically create silos by requiring an often exclusive focus on an illness, disease, or problem. Clark refers to this as the "stranglehold that silos and categorical financing have wrought on [Indigenous] communities." Grants often require the measurement of a disease or illness and, more often, require the use of evidence-based practices that have not been created or tested for diverse tribal peoples. As policy makers we must ask ourselves: What energy are we creating when we silo a person's health by requiring exclusive focus on substance abuse within federal grant programs for Indian Country, without attending to the underlying current and historical trauma driving many addictions? What energy are we creating when we require measurement of negative experiences exclusively? How did we get to the place where we would impose practices on a community for whom the evidence base does not exist?

**At the research level**, we develop standardized screenings, assessment tools, and research methods that tend to be similar. While there are many measures of depression and hopelessness, it is much more difficult to find measures of happiness and hopefulness. How did it happen that, in our expert research opinions, we thought it was more valid and meaningful to measure the worst side of life than the best? What energy might that create for a behavioral health patient on a first visit filling out the assessment packet, in a profession where a significant number of patients drop out after the first session?

**At the practice level**, we implement evidence-based interventions that are normed on a few populations. We make a diagnosis and develop a treatment plan that is focused on addressing the problem/illness/condition. Unless a system of care is being implemented, the treatment and interventions are distinctly separate and there is generally a failure to include spirituality as a part of holistic health. Rarely do practitioners attend to the whole person within

their environment through the coordination of comprehensive services. What kind of energy do our intake processes and treatment interventions bring to patients? Does this energy impact people's willingness to seek care? Does this energy impact the outcomes patients achieve?

While the U.S. public health model has given some attention to the importance of strength-based approaches like those inherent within Indigenous worldviews, the current initiatives being rolled out to Indian Country continue to be focused primarily on problems, illness, and disease and to emphasize these as "real outcomes" over health promotion and well-being. Because the current federal initiatives separate physical health, mental health, and substance abuse, and create other silos based on a linear worldview, they are often in opposition to the worldviews of local tribal communities and may be contributing to ongoing health disparities. As an example, tribal communities have been experiencing youth suicide disparities for over 40 years and have continually struggled to be allowed to use tribal best practices as an intervention for a number of reasons (e.g., historical prohibition of tribal religious health practices, requirements to use evidence-based practices, lack of acceptance of Indigenous ways of knowing in Western science).

As we work to implement culturally appropriate models of care, it is critical that policy, practice, and research consistently support tribes and urban Indian organizations to implement strength-based strategies that are grounded in local community beliefs about health and well-being if we are ever to improve health disparities. Brave Heart and colleagues call on us to stop "pathologizing explanations for disparities." We believe that this special issue will allow us to raise the visibility of strength-based wellness approaches in Indian Country and highlight the great work that is already being done in policy, research, and practice. We also believe that this special issue will begin to raise challenges of the current public health approach toward Indigenous communities and to generate solutions that will better fit diverse tribal worldviews while improving the health and well-being of tribal populations.

I am very thankful for the dedication and commitment of the Journal Manager at *American Indian and Alaska Native Mental Health Research* who worked tirelessly to publish this special issue. Without her this special issue would not have been possible. I am also thankful to Dr. Spero M. Manson, Editor in Chief, for the commitment to publishing an online peer-reviewed journal to support access and learning for Indigenous communities. Most importantly, I am thankful for all of the incredible scholars who submitted and are publishing articles in this issue as they are leading the way in improving the conditions of tribal populations.

I hope that you enjoy this special issue on strength-based approaches and that it advances your thinking about the energy you create in the role you serve to address health disparities for Indigenous peoples.

Wado (Thank you),
Jami Bartgis, PhD

## REFERENCE

Rosenthal, R., &. Jacobson, L. (1963). Teachers' expectancies: Determinants of pupils' IQ gains. *Psychological Reports, 19*, 115-118. http://dx.doi.org/10.2466/pr0.1966.19.1.115

## AUTHOR INFORMATION

Dr. Bartgis is with One Fire Associates, LLC and the University of Oklahoma Health Sciences Center.