

intervention can take place. Those who do not receive prompt treatment often experience unremitting impairment at a cost to the individual, to his or her family, and to society as a whole (Rand Corporation, 2008). Accurate diagnosis and availability of mental health treatment are factors in the secondary prevention of long-term mental health problems among veterans. Increased and long-term funding for mental health care is essential, as is increased public awareness of the War's impact on its veterans' mental health and well-being. Many veterans who are experiencing mental health problems are not assessed as meeting requisite disability ratings criteria to enable them to receive disability benefits for their mental health. Access to the health care veterans often need immediately—to give them the best chance at stable mental health and well-being—is inadequate. Many still face long wait times to see a mental health professional and establish treatment (Wynn, 2007). The VA system must continue to increase its efforts to move quickly in assessing OIF and OEF veterans and in processing their benefits claims. To err in favor of immediate treatment for veterans seems preferable and less costly in the long run than to err in the opposite direction and later approve benefits for a veteran whose quality of life and ability to contribute to society may have deteriorated in the interim.

AN AMERICAN INDIAN ILLUSTRATION OF PRIMARY PREVENTION

Joseph P. Gone

Given the urgent need to address prevalent mental health problems, it is easy to overlook cultural diversity in the perceived characteristics, causes, courses, and cures for disabling emotional distress. I was reminded of this when I explored depression and drinking on the Fort Belknap Indian reservation in Montana (Gone, 2007, 2008). There I met a middle-aged cultural traditionalist named Traveling Thunder who explained to me why many community members struggled with substance abuse and associated distress. In his view, the primary problem was that, "We never was happy living like a Whiteman." As it turned out, this simple observation captured an entire rationale about reservation mental health that reappears everywhere I go in Indian country.

Traveling Thunder outlined four historical epochs in recounting his community's past. In the era of Pre-Colonial Paradise, he described indigenous North America as a utopia in which "there was no alcohol, no drugs" because people lived according to strict aboriginal custom. Once the Whiteman arrived in the era of Colonial Incursion, Euro-American domination changed everything, decimating the customs

that had suited Native life for millennia. This Euro-American suppression of cultural practices led to an era of postcolonial anomie in which community members could no longer make sense of who they were and of what their futures might be.

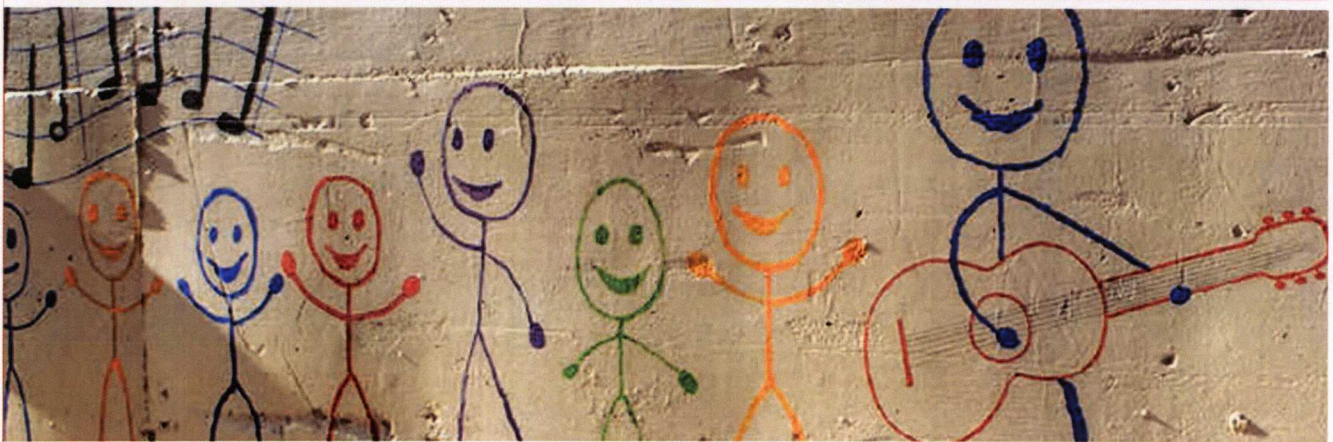
Here Traveling Thunder explicitly referenced mental health problems: "If people ain't proud of who they are, then they're . . . doing alcohol, drugs. Once you're into alcohol and drugs, you're gonna probably get into a depression. . . . And you're gonna want to kill yourself." Fortunately, Traveling Thunder also recognized a fourth epoch, the contemporary era of Post-Colonial Revitalization. He specifically credited the return to ceremonial practice starting in the 1970s with the potential to restore "an alcohol- and drug-free mind" to distressed tribal members. Thus, in contrast to consulting psychiatrists who threaten to "brainwash me forever so I can be like a Whiteman," Traveling Thunder recommended "putting up" a ceremony for people contending with serious emotional distress.

Attention to this *discourse of distress* offers important lessons for the cross-cultural prevention of mental health problems. First, such discourses make plain that "mental health" might be experienced and expressed quite differently in diverse cultural settings. For example, Traveling Thunder's emphasis on history, identity, and spirituality contrast markedly with the professional emphasis on broken brains or unexpressed emotions. Second, such discourses implicate broad-based antecedent conditions (Ferner & Ferner, 1989) rather than classic disease analogies in tracing the developmental trajectories of emotional distress. For example, Traveling Thunder's post-colonial anomie sets the stage for any number of maladaptive conditions—including substance abuse, educational failure, and interpersonal violence—such that prevention of any one outcome is likely also to forestall others.

Third, such discourses reveal the promise of preventive interventions that originate locally and achieve their effects because they "make sense" within local frames of meaning. For example, Traveling Thunder's prescription of ceremonial practice as the most appropriate mode of intervention for mental health problems requires little from outside professionals and instead privileges the expertise of reservation ritual leaders in meeting the needs of their own communities. Finally, this recognition of effective local resources for addressing emotional distress helps to redefine the role of outside professionals who desire to help. For example, instead of reproducing the expert-client relationship with its inherent power asymmetry, knowledgeable preventionists might enter instead into collaborative and empowering partnerships with tribal communities in which successful prevention projects fundamentally depend on the proportionate contributions of everyone involved. In this reworking of the colonial encounter, such prevention partnerships might actually generate therapeutic benefits in their own right.

S E C O N D E D I T I O N

PREVENTION IS PRIMARY



Strategies for Community Well-Being

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