

Developing a Culturally Sensitive Curriculum: Teaching Native American Children About Psychological and Behavioral Health*

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The SEPA (Science Education Partnership Award) is a NIH (National Institutes of Health) program to provide science education to children K-12. In 2009, the NIH provided a supplement to develop a curriculum to inform students about factors that affect the mental health of native Americans. The goal of the current project was to develop a behavioral health curriculum sensitive to native American values and present these materials in a four-day workshop to educators of native youth. A multi-month effort was required to: (1) develop a needs assessment from local tribal representatives; (2) obtain relevant cultural research; and (3) enlist tribal representatives to deliver portions of the curriculum. The adapted curriculum addressed content sensitive to American Indian cultural issues. These issues and others were addressed within the context of a four-day professional development workshop held on the campus of the University of Nebraska Medical Center, Omaha, N.E.. The workshop focused on two primary content areas: (1) factors related to the development and expression of maladaptive behaviors and mental illness; and (2) factors related to the development of healthy and adaptive behaviors.

Keywords: American Indian, native American, education, mental illness

Background

The SEPA (Science Education Partnership Award) is a NIH (National Institutes of Health) program to provide science education to children K-12 and the general public. In 2005, Maurice Godfrey, Ph.D., University of Nebraska Medical Center, was the recipient of a SEPA grant (“Breaking Barriers: Health Science Education in Native American Communities”) to provide science curricula to teachers and students in 16 schools located on six Indian reservations in Nebraska and South Dakota. In 2009, the NIH provided a supplement to develop a curriculum to inform students about factors that affect the mental health of native Americans. The goal of the current project was to develop a behavioral health curriculum sensitive to American Indian values and present these materials in a four-day workshop to educators of native youth.

Project Goal

Native Americans are among the most underserved populations (Ocampo, 2010), yet, indigenous

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Americans seek mental health services at very low rates (Lewis, Woods, Zuniga, & David, 2010). This incongruous finding is related to the disconnect between Western approaches to behavioral health services and the traditional needs of the native American community which comprised of hundreds of tribes, languages and variations in traditions and beliefs. Melding native American beliefs with current scientific understanding of factors that contribute to adaptive behavior was the challenge in developing a curriculum for American Indian students.

Practical Considerations

There were a host of practical considerations in offering a four-day workshop, not the least of which was scheduling at a time when school staffs were likely to attend. Recruitment for the workshop took place through the UNMC (University of Nebraska Medical Center) SEPA (Website, <http://www.unmc.edu/sepa>), at semi-annual community advisory board meetings, and through visits by project staff at reservation schools. Teachers, counselors and administrators of the SEPA partner school districts were invited to participate. Housing, meals and travel reimbursement to and from the workshop site were provided. Participants also received a stipend. In addition, the curriculum was Web-based, requiring the availability of an on-line computer terminal for each of the participants.

Curriculum Development

A multi-month effort was required to: (1) develop a need assessment from local tribal representatives; (2) obtain relevant cultural research; and (3) enlist tribal representatives to deliver portions of the curriculum. The foundation curricula, entitled “The Science of Mental Illness” (BSCS (Biological Sciences Curriculum Study), 2005) and “The Science of Healthy Behaviors” (BSCS, 2006) were not focused on the native American community. Rather, they were focused on the science of “mental illness” in general. The adapted curriculum was an expanded version of the above and addressed content sensitive to native American cultural issues, such as suicide, substance abuse and depression (CDC (Centers for Disease Control and Prevention), 2009; Gone, 2004; IHS (Indian Health Service), 2010; SAMHSA (Substance Abuse and Mental Health Services Administration), 2010). These topics were important to address considering that native Americans are at a higher risk for a number of behavioral health problems, including suicide, which occurs at rates that are 70% higher for American Indians and Alaska natives, particularly among young men and boys (Ocampo, 2010). These issues and others were addressed within the context of a four-day professional development workshop held on the campus of the University of Nebraska Medical Center, Omaha, N.E.. The workshop focused on two primary content areas: (1) factors related to the development and expression of maladaptive behaviors and mental illness; and (2) factors related to the development of healthy and adaptive behaviors.

Needs Assessment

Eighty-five administrators and teachers in seven schools throughout Nebraska and South Dakota responded to inquiries related to mental health issues as addressed by their current curriculum (see Table 1). Staff concerns included potential areas of conflict with tribal values and current mental health practices in tribal schools. Among the participants were members of the following tribes: Santee, Yankton, Wichita, Ponca, Rosebud, Blackfeet, Winnebago, Sioux, Cheyenne, Prairie Band Potawatomi, Omaha and Sisseton-Wahpeton.

Table 1

Categories and Dimensions Used for Assessing the Curriculum Needs of AI (American Indian) Students

Categories	Categories
Learning more about a specific topic	Learning more about a specific topic
	Mental illnesses
	Current treatment and research
	Classroom strategies
Sensitivity to issues related to mental health	Contributing factors
	Contributing factors
	Animal research
	Statistics related to AI population
Topics students have shown an interest in	Specific diagnoses
	How to help friends with a mental illness
	Treatment options or support
	How to have a healthier lifestyle
	Prevalence of mental illness
Steps to include in school protocol to address mental illness	Do nothing if there are only subtle signs
	Attend sessions with a school counselor
	Contact parents
	Provide information on local resources
	Seek assistance from tribal resources

Note. *Participants responded to items using a 6-point Likert rating scale: from 1 “Strongly disagree” to 6 “Strongly agree”.

Tribal respondents reported that they were more likely to seek assistance and support from tribal resources than from Western-oriented ones in the case of a mental illness crisis. According to the U.S. Department of Health and Human Services (2001), many American Indians and Alaskan natives continue to employ traditional healers rather than Western therapies when faced with a mental health crisis.

Nevertheless, respondents identified a strong interest in obtaining more information related to developmental disabilities, depression, ADHD (attention-deficit/hyperactivity disorder) and drug/alcohol abuse. This illustrates the two epistemologies relevant to the behavioral health care of native Americans, namely, that of traditional native American healers and Western behavioral health providers.

Reconciling American Indian beliefs about mental illness with commonly accepted scientific understanding of mental illness is a major task. Professionals who work with native Americans must recognize customs and beliefs that are intrinsic to native culture (Wallerstein & Duran, 2006). By working with tribal members and respecting cultural practices, health care providers build trust and facilitate increased community awareness of mental health resources. Feedback from tribal representatives was obtained for initial drafts of the curriculum and a review of relevant cultural prohibitions for each module was undertaken with emphasis on the tribes whose members were most likely to attend the workshop.

Obtaining Native Presenters

A key concern of tribal members was providing native presenters to address important issues of concern to the native communities. In particular, issues related to historical trauma and addiction are best presented by members of the native American community and we recruited a native presenter to address this content. Our workshop also contained very specific science contents, such as pharmacology and neuroanatomy that did not

require specific cultural sensitivity. We also provided a field trip to an open campus residential facility for youth, where workshop attendees visited a group home specifically for male American Indian adolescents. This therapeutic environment included structured opportunities for residents to participate in traditional native American activities, such as dance, chanting and drums. The house parent, himself an American Indian, met with attendees and described the therapeutic environment of the home, after which, attendees met with residents who assisted in a tour of the group home.

Review of the Literature Pertaining to Behavioral Health and Native American Values and Beliefs

The workshop curriculum was sensitive to native American perceptions of mental illness, including etiologies and interventions. One of the foremost of these is appreciation of historical trauma as an etiology for behavioral dysfunction. American Indian history is replete with examples of betrayed trust and broken promises at the hands of representatives of the dominant culture. Experiences ranging from the trail of tears to Indian boarding schools have left an indelible mark on the American Indian heritage, and for many, historical trauma affects daily functioning (Yellow Horse Brave Heart & DeBruyn, 1998; Noriega, 1992). Indeed, the daily experience of many Native Americans includes elements of history, ancestry and spirituality. For many, the link between spirituality, physical health and healing requires living in harmony with all of nature (Sanchez, Plawecki, & Plawecki, 1996), a view not reflected in Western behavioral health care. Introducing a curriculum that is sensitive to these issues, while providing a science-based understanding of mental illness, might contribute to students' understanding of the many factors that contribute to mental illness and the variety of treatment approaches to address these illnesses.

The Curriculum

The curriculum needed to address factors contributing to health disparities in the native American population while acknowledging traditional native practices and customs. The curriculum presented information sensitive to tribal history and the many traditional belief systems surrounding mental illness (Christopher, Watts, McCormick, & Young, 2008; Okozi, Nael, & Cruza-Guet, 2010) and was cognizant of the pressures native American youth have in retaining cultural beliefs and values amidst the dominant culture.

The curriculum was designed to be interactive and the many Web-based activities not only engaged participants, but also permitted the use of more sophisticated materials than might be found in the typical classroom. This was consistent with recent pedagogical trends that not only focus on curriculum content, but also on how that content is most effectively delivered to students. However, effective content and engaging delivery does not determine a successful curriculum. One also must have acceptability. Participants indicated that the NIH curriculum modules would be implemented, at least in part, in the classroom with their students.

The majority of the curriculum was derived from BSCS materials as found in "The science of mental illness" and "The science of healthy behaviors". This was expanded upon to include content of relevance to the American Indian community. Each topic had specific objectives and tasks, many of which had a Web-interactive component. Several modules lent themselves to adaptation in keeping with the cultural traditions of the target audience. Among the curriculum modules were the following: defining mental illness; neurology and neuroanatomy; genetics; attention deficit hyperactivity disorder; depressive disorders and suicide; psychopharmacology; schizophrenia and other psychotic disorders; TBI (traumatic brain injury);

causes of mental illness and risk factors; introduction to treating mental illness; overview of developmental disabilities and severe behavior disorders; and addiction. In addition, modules that addressed healthy and adaptive behaviors were included such as: what is behavior; influences on behavior; and effective medical and behavioral treatments. Two modules (i.e., defining mental illness and depressive disorders and suicide) are provided as examples of the curriculum and its structure.

Defining Mental Illness

Teachers will be able to discuss the following areas:

- (1) Defining mental illness;
- (2) Mental illness in the population;
- (3) Warning signs for mental illness;
- (4) Diagnosing a mental illness.

Teachers will be able to implement the following activity:

Activity—“What do I know about mental illness”: This activity will provide teachers with information about what their students already know about mental illness and can be used to evaluate how much students have learned at the end of the course.

Depressive Disorders and Suicide

Teachers will be able to discuss the following areas:

- (1) Types of depressive disorders;
- (2) Symptoms of depression;
- (3) Dysthymia and bipolar disorder;
- (4) The cause of depression;
- (5) Treatment for depression;
- (6) Recent statistics and research on suicide;
- (7) Populations at risk for suicide.

Teachers will be able to implement the following activities:

(1) Activity—“Observing the depressed brain”: Students will have the opportunity to discuss how scientists study what happens in the brain during depression. Students will also review how doctors diagnose depression as well as observe and describe images from PET (positron emission tomography) scans.

(2) Activity—“Defining illness”: Students will review the health problems of the cases previously analyzed while teachers have an opportunity to lead discussions that encourage students to think of other words for “health problems”. Students will also be able to compare and contrast depression and sadness to have a better understanding of symptoms mental health practitioners investigate.

Evaluation and Outcomes

Participants completed a pre-workshop survey that included questions about maladaptive and adaptive behaviors. Participants used 6-point Likert scales to provide session by session daily feedback regarding timing and pace of presentations, quality of the presenters, the relevance of the content, if the topic was covered in sufficient detail and the usefulness of the information. They were also provided open-ended questions, such as: “Was there anything in particular about the presentations (or the settings) that helped or hindered the sessions today?”; “What questions do you still have about the topics covered?”; and “How do you think your students

would react to the materials that were covered today?'. Participants considered ADHD, depressive disorders and suicide as the most relevant modules.

Throughout, the focus was on science and education, not challenging or changing beliefs and practices. However, the curriculum was intended, in part, to reduce stigma attached to mental illness and our participants indicated a new awareness of mental illness and how these issues affect the school and home culture of native American students. Participants reported that the workshop increased their understanding of mental illness and they expressed a desire to share the information that they learned in the workshop with their colleagues.

Future Directions

The native American community is comprised of a vast array of traditions, beliefs and unique needs, ensuring that the contents of the workshop were appropriate and useful for all participants required consideration of that diversity. The curriculum needed to present information sensitive to tribal history and the traditional belief systems surrounding mental illness (Christopher, Watts, McCormick, & Young, 2008; Okozi et al., 2010). Furthermore, this program was intended as a curriculum piece for teachers to use with students, not as a way to help school personnel learn how to intervene with mentally ill students. Many of the participants were interested in learning specific strategies to address behavioral problems in the classroom, such as disruptive and non-compliant behaviors and inattention. However, due to the unique individual characteristics of each student and contingency management strategies of each classroom, this was not appropriate content for this workshop. Indeed, it was inevitable that participants asked questions about students, family and community members who experience mental health difficulties. Those issues illustrate the needs of the participating communities and of the current participants. Professionals must recognize that to develop, implement and sustain an effective intervention or curricula within this community, they must acknowledge traditional practices and customs as well as teach native Americans how to combine the use of Western and tribal practices to effectively reach individuals at risk.

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