

# When clinical care lacks context: diagnostic reductionism and the development of culturally grounded prescribing and withdrawal policies in Native American communities

## Abstract

Understanding the adoption of Western psychiatric methods in Native American communities requires placing current clinical practices within the ongoing impacts of colonization, historical trauma, and systemic injustices that continue to characterize Indigenous experiences of distress. These factors deeply shape how mental health symptoms are perceived, diagnosed, and treated, often leading to the use of reductive biomedical models that ignore cultural, historical, and relational factors crucial to Native well-being. While psychiatric medications can provide stability during acute risks or severe symptoms, their wider use is problematic if implemented without proper cultural awareness or contextual understanding.

Despite these complexities, an estimated 15–20% of Native Americans use psychiatric medications, even as Indigenous participation in clinical trials remains disproportionately low. This underrepresentation reduces the relevance of psychopharmacologic research for Native populations and raises critical questions about safety, effectiveness, and the appropriateness of standard prescribing practices. Biological and lifestyle factors—including population specific variations in metabolic patterns, diet, substance use patterns, cultural beliefs, and the lasting psychological effects of historical trauma—further complicate medication adherence, metabolism, and treatment outcomes. These considerations highlight the importance of exploring culturally appropriate alternatives before starting pharmacologic treatment and ensuring that prescribing practices respect the sociocultural and historical realities and needs of Indigenous communities.

Addressing these disparities requires culturally informed research and clinical care, as well as creating dedicated, community driven, and culturally grounded spaces for psychiatric withdrawal, tapering, and psychosocial options. These spaces would enable Native individuals to safely reduce or stop medications within frameworks that respect both clinical needs and Indigenous knowledge systems. Moving these initiatives forward is vital to improving mental health equity, fostering culturally competent interventions, and ensuring Indigenous communities have access to care that maintains scientific rigor while supporting cultural sovereignty. Equally essential is the development of culturally grounded policy frameworks for psychiatric medication prescribing and withdrawal in Native American communities, which ensure that clinical decision making aligns with Indigenous sovereignty, community priorities, and the realities of lived experience.

**Keywords:** indigenous mental health, psychotropic medications withdrawal, diagnostic reductionism

Volume 17 Issue 2 - 2026

Norman Coeeyate,<sup>1</sup> Marcello Maviglia<sup>2</sup>

<sup>1</sup>Associate Director, Center for Native American Health - a Public Health Institute for Indigenous Knowledge and Development/Lecturer II, Department of Family & Community Medicine/University of New Mexico Health Sciences, USA  
<sup>2</sup>Clinical Professor, Family and Community Medicine/ Core Faculty Member at CNAH (Center for Native American Health)/University Of New Mexico, USA

**Correspondence:** Marcello Maviglia, MD, MPH, Clinical Professor, Family and Community Medicine/ Core Faculty Member at CNAH (Center for Native American Health)/ University Of New Mexico, Albuquerque, USA,  
Email [mmaviglia@salud.unm.edu](mailto:mmaviglia@salud.unm.edu)

**Received:** March 03, 2026 | **Published:** April 9, 2026

## Introduction

Native American populations continue to be diagnosed at high rates by mainstream mental health systems with conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD). Western psychiatry rarely interprets emotional distress within Indigenous historical and relational contexts; instead, it relies on its own diagnostic framework, often without regard for the circumstances that shape distress. In this process, culturally grounded experiences of grief, loss, and disruption are translated into individualized psychiatric disorders.<sup>1-3</sup> From an Indigenous standpoint, this diagnostic translation is profoundly decontextualizing: it separates Native psychological distress from the collective and intergenerational realities of colonization that give it meaning.<sup>1-5</sup>

Native scholars emphasize that what Western psychiatry labels as “mental disorders” is more accurately understood as the

psychological imprint of historical trauma—the ongoing impacts of land dispossession, cultural suppression, and population decline that continue to affect Native well-being.<sup>4-7</sup> These frameworks highlight that the high rate of psychiatric diagnoses in Native communities reflects not a collection of discrete biomedical illnesses, but the unhealed wounds caused by colonial disruption. By assigning simplistic diagnostic labels to psychosocial and historically rooted Indigenous distress, Western psychiatry risks concealing the cultural, relational, and political roots of suffering.<sup>7-9</sup>

While psychiatric medications can be useful during periods of acute risk or severe symptoms, their broader utilization outside these circumstances requires careful cultural and clinical consideration. In many Native American communities, these medications are commonly prescribed despite the absence of evidence grounded in the psychological needs of Indigenous populations. Research examining the safety, effectiveness, and long-term consequences of psychotropic

drugs in Native contexts remains limited, and Native individuals continue to be markedly underrepresented in clinical trials.<sup>10–12</sup> These factors restrict the relevance of standard psychopharmacologic findings and creates uncertainty about appropriate dosing, expected benefits, and potential harms over time.<sup>12–14</sup> These gaps exist alongside broader concerns about methodological limitations, publication bias, and the structural forces that shape the evidence base for psychiatric medications.<sup>15–19</sup>

Along with these diagnostic and research limitations, there is a growing recognition of the need for structured, culturally sensitive policies and spaces dedicated to psychiatric withdrawal practices. It needs to be stressed that withdrawal, whether planned or unplanned, is not a peripheral clinical issue; when it is not properly recognized or supported, it becomes a major driver of clinical destabilization and mistrust in psychiatric care. Withdrawal from psychotropic medications can increase distress, destabilize recovery, and deepen mistrust in psychiatric care. Symptoms such as anxiety, agitation, insomnia, sensory disturbances, and mood instability may emerge during tapering and can be misinterpreted as relapse rather than withdrawal.<sup>20–23</sup>

When withdrawal is not properly recognized or supported, it becomes a major source of clinical destabilization and mistrust in psychiatric care. Peer-based approaches and community-defined practices have shown promise in helping individuals navigate withdrawal safely and with greater cultural alignment.<sup>22,23</sup> Symptoms such as anxiety, agitation, insomnia, sensory disturbances, and mood instability may emerge during tapering and can be misinterpreted as relapse rather than withdrawal.<sup>20–23</sup> This misinterpretation can lead to unnecessary reinstatement or escalation of medications, reinforcing long-term dependence and obscuring the need for culturally grounded withdrawal supports.<sup>23–25</sup> Indigenous perspectives on relational health, land-based practices, and community responsibility further underscore the importance of withdrawal frameworks that respect cultural meaning, autonomy, and the right to self-determined healing.<sup>24,25</sup>

Growing evidence shows that the biological narratives used to justify psychotropic prescribing—particularly the serotonin-imbalance model—lack empirical support and have been sustained largely through pharmaceutical marketing and professional repetition rather than scientific consensus.<sup>26,27</sup> These narratives have shaped public expectations, influenced clinical decision-making, and contributed to the widespread belief that emotional suffering reflects discrete neurochemical defects requiring pharmacologic correction.<sup>28,29</sup> Recent systematic reviews further demonstrate that the serotonin theory of depression does not withstand scientific scrutiny, raising questions about the biological assumptions that underlie much of contemporary psychopharmacology.<sup>30</sup> For Native communities, these reductionist explanations obscure the cultural, historical, and relational dimensions of distress and reinforce treatment approaches that prioritize medication over context, meaning, and community-based pathways of healing.

Historical experiences with exploitative research practices—including inadequate informed consent, lack of transparency, and inequitable benefit-sharing—have fostered deep mistrust toward biomedical research among many Native communities.<sup>31–33</sup> These legacies highlight the need for ethical reforms rooted in tribal sovereignty, data governance, and community-driven oversight. Collecting and using data from Native American individuals and tribes must involve tribal agreements, cultural respect, and protections against misuse or commodification.<sup>33–36</sup> Without strong safeguards, behavioral health and pharmacologic research risk replicating

extractive patterns that have long characterized Western engagement with Indigenous communities.<sup>36–38</sup>

Therefore, engaging Indigenous communities in research must extend beyond token participation. It requires forming partnerships grounded in respect and empowering tribal nations to develop and implement their own research governance policies, including protocols for informed consent, data ownership, and community oversight.<sup>39–41</sup> These frameworks should be rooted in Indigenous data sovereignty and aligned with tribal values, priorities, and long-term health objectives. Within this policy environment, psychiatric withdrawal practices must be explicitly addressed, ensuring that tapering and discontinuation occur within culturally grounded, community-guided spaces that integrate both medical and Indigenous knowledge.<sup>42</sup>

Beyond biological factors, the sociocultural context significantly influences mental health experiences and treatment outcomes. Cultural identity, community ties, traditional diets, lifestyle choices, and Indigenous healing practices are central to Native perceptions of wellness.<sup>43–45</sup> However, mainstream psychiatric care often overlooks these aspects, resulting in mistrust and reduced utilization of services. Integrating Indigenous knowledge with psychiatric treatment can produce more effective and culturally relevant interventions, particularly when combined with structured withdrawal supports and community-based approaches.<sup>39,46</sup>

Moving toward such an integrated model—including policies and community-guided venues for safe psychiatric withdrawal—offers a promising path for supporting healing and resilience within these populations. Importantly, policy development must also consider the lessons learned from existing federal treatment guidelines, such as those outlined in SAMHSA’s Treatment Improvement Protocols, which highlight the need for culturally informed, ethically grounded, and community-responsive approaches to medication use and discontinuation.<sup>47</sup>

**Terminology note:** In this article, “Native American” specifically refers to tribal nations within the United States, while “Indigenous” is used to address broader pan-Indigenous contexts and values.

## Psychotropic medications utilization and risks

Long-term exposure to psychotropic medications introduces a layer of complexity that is often underestimated in both clinical practice and policy discussions. Over time, these agents can produce a constellation of psychological, cognitive, neurological, and metabolic effects that are not merely “side effects” in the narrow pharmacological sense but cumulative disruptions that shape daily functioning, relational life, and community participation.<sup>48–51</sup> In Native American contexts—where distress is frequently intertwined with historical trauma, chronic stressors, and structural inequities—these long-term effects may carry particularly negative consequences.<sup>48–50</sup>

Psychologically, chronic use may blunt emotional range, diminish initiative, and erode the capacity for sustained engagement in family, cultural, and community roles. What begins as subtle dampening of in relational capacity, over years, may become a pervasive pattern that undermines relational reciprocity.<sup>51–53</sup> For many Native adults, whose well-being is closely tied to kinship networks, ceremonial participation, and land-based practices, these changes interfere with core dimensions of identity and belonging.<sup>48–50</sup>

Cognitively, prolonged exposure can slow processing speed, impair attention, and disrupt executive functioning. These effects may be misread as symptoms of an underlying disorder rather than consequences of the medication itself, particularly in systems

that rely heavily on symptom checklists rather than longitudinal, context-sensitive assessment.<sup>51–53</sup> In communities where educational and vocational opportunities are already constrained by structural barriers, even modest cognitive slowing can have substantial consequences for autonomy, employment, and the ability to navigate bureaucratic systems.<sup>48–50</sup>

Neurological effects often emerge gradually and may fluctuate with dose adjustments or attempts to taper.<sup>52,53</sup> Because these symptoms can mimic anxiety, relapse, or behavioral dysregulation, they are frequently misinterpreted, leading to dose escalation or the addition of new medications.<sup>52,53</sup> This pattern is especially concerning in Native communities where access to consistent follow-up care is limited and where mistrust of medical institutions is historically grounded, including in relation to prior coercive and harmful practices.<sup>54</sup>

Metabolic effects accumulate in ways that intersect directly with the broader determinants of health in Native communities. Weight changes and metabolic instability do not occur in isolation; they interact with food insecurity, disrupted traditional food systems, and the high prevalence of metabolic conditions shaped by colonization and environmental dispossession.<sup>56</sup> In these contexts, long-term psychotropic exposure can accelerate health trajectories that are already burdened by structural inequities, further contributing to rates of morbidity and mortality.<sup>48–50,56</sup>

For children and adolescents, the stakes are even higher. Youth exposed to long-term psychotropics may experience sedation, disorganization, hyperactivation, social withdrawal, and paradoxical reactions that interfere with developmental tasks and relational learning.<sup>52,53</sup> These effects are magnified in children with neurodevelopmental vulnerabilities, including those with Fetal Alcohol Spectrum Disorder, whose neurobiological profiles often produce unstable or amplified responses to medication.<sup>52,53</sup> Yet these reactions are rarely recognized as iatrogenic; instead, they are interpreted as evidence of worsening pathology, prompting additional cycles of medications and of medicalization.<sup>51–53</sup> In Native communities—where youth development is embedded in extended family systems, cultural and community participation—these side effects may interfere with the function of these traditional networks.<sup>48–50</sup>

Taken together, the long-term effects of psychotropic medications raise concerns that are not merely clinical but structural, cultural, and ethical. They intersect with histories of coercive medical practices, with the ongoing marginalization of Indigenous knowledge systems, and with the profound mismatch between standardized psychiatric protocols and the lived realities of Native individuals and families.<sup>48–50,54–56</sup> These concerns underscore the need for prescribing practices that are not only evidence-informed but culturally grounded, historically aware, and attentive to the cumulative, long-horizon consequences of chronic psychotropic exposure.<sup>48–50,55,56</sup>

### Diagnostic reductionism

A central challenge in primary care is distinguishing contextual distress from psychiatric disorder. The DSM framework, while intended to provide diagnostic clarity, often collapses this distinction by defining disorders through symptom clusters that are largely context-blind.<sup>57</sup> A patient grieving a spouse, a young adult facing eviction, or a caregiver overwhelmed by chronic stress may all meet criteria for major depressive disorder, despite the fundamentally relational and situational nature of their suffering.<sup>57–60</sup> In Indigenous communities, where distress is deeply embedded in historical

trauma and collective experience, such context-blind criteria risk misrepresenting culturally grounded expressions of suffering.<sup>60</sup>

This diagnostic compression is not a minor technical issue. It is one of the primary mechanisms through which ordinary distress becomes medicalized.<sup>66</sup> Symptom-count approaches ignore the social, economic, and interpersonal conditions that give rise to suffering. When context is removed, distress is reinterpreted as disease, and the clinical encounter becomes oriented toward pharmacologic solutions.<sup>61,62</sup> This dynamic also contributes to the misinterpretation of withdrawal symptoms—such as anxiety, agitation, or insomnia—as relapse rather than medication-related phenomena, a pattern well-documented in withdrawal research.<sup>58,59</sup>

A substantial body of critical scholarship argues that psychiatric diagnoses do not function like diagnoses in the rest of medicine. They do not identify underlying pathology; they describe patterns of experience.<sup>63</sup> Unlike other medical diagnoses, DSM categories lack biomarkers, laboratory tests, imaging correlates, and genetic signatures.<sup>63,64</sup> Thus, when clinicians assign a diagnosis such as major depressive disorder, they are not uncovering a biological process. They are applying a culturally constructed label to a set of experiences that may have multiple meanings.<sup>63,64</sup>

This distinction is crucial. If the diagnosis does not explain the distress, medication cannot be assumed to be the appropriate response.<sup>65</sup> The risk is that the label becomes the justification for treatment rather than a tool for understanding.<sup>65,66</sup> Diagnostic reductionism therefore contributes to overprescribing, misinterpretation of withdrawal symptoms, and the long-term medicalization of psychosocial distress—patterns that disproportionately affect Indigenous communities whose suffering is deeply rooted in historical, cultural, and structural contexts.<sup>60–66</sup>

### Cultural determinants of psychotropic response

Patterns of response to psychotropic medications vary widely across individuals and communities, shaped not only by biological factors but also by the broader social, cultural, and political environments in which treatment occurs.<sup>67,68</sup> In many Indigenous contexts, the experience of medication effects cannot be separated from histories of colonial disruption, structural inequities, and the relational ecologies that shape health and illness.<sup>69</sup> These eco social conditions influence how medications are understood, tolerated, and incorporated into daily life, often in ways that differ markedly from the assumptions embedded in mainstream psychiatric practice.<sup>70</sup>

Because most psychopharmacologic research has been conducted with populations of European ancestry and within Western institutional settings, the applicability of standard dosing guidelines to Native communities remains uncertain.<sup>70,71</sup> The absence of Indigenous representation in clinical trials limits the ability to anticipate differential responses, side-effect profiles, or patterns of adherence that emerge within distinct cultural and community contexts.<sup>71</sup> This gap in knowledge has direct clinical implications: clinicians may misinterpret medication-related symptoms, overlook culturally mediated expressions of distress, or attribute adverse effects to psychiatric relapse rather than to the complex interplay of biological, social, and historical factors.<sup>72,73</sup>

Addressing these challenges requires integrating culturally grounded understandings of wellness into prescribing and withdrawal practices.<sup>73</sup> Such integration involves not only attention to individual variability but also a commitment to research and clinical frameworks that respect tribal authority, community priorities, and the relational ecosystems that shape Indigenous health.<sup>73</sup>

## Data sovereignty, ethics, and research governance

Historical experiences with extractive and unethical research practices—including inadequate consent, lack of transparency, and misuse of biological samples—continue to shape Indigenous communities' relationship with biomedical and behavioral health research.<sup>70,71</sup> These legacies are not abstract historical grievances; they directly influence present-day decisions about participation in genomic studies, clinical trials, and psychiatric research.

The Havasupai case remains a defining example of how data collected for one purpose was later used for unrelated research without tribal consent, reinforcing fears of loss of control and misuse.<sup>71</sup> More than 400 tribal members provided blood samples for what they understood to be a diabetes study, a condition of urgent concern within their community. Years later, they learned that their DNA had been used in multiple unrelated projects—including research on schizophrenia, inbreeding, and population migration—topics that were culturally sensitive, irrelevant to their consent, and in some cases in conflict with core Havasupai beliefs. They also discovered that researchers had accessed certain medical records without proper authorization. These actions led to a lawsuit and ultimately a settlement in which the tribe received compensation and, critically, the return of their blood samples, which hold deep cultural and spiritual significance.

In response to such violations, Indigenous scholars and tribal nations have articulated sovereignty-based frameworks for research governance. These frameworks assert that tribes hold inherent authority over all data derived from their citizens, lands, and cultures.<sup>70,71</sup> Indigenous data sovereignty emphasizes that data is not merely informational but relational—tied to identity, governance, and collective well-being.<sup>70</sup>

For pharmacogenomic and psychiatric research, sovereignty-based governance is essential. Without tribal oversight, data can be misinterpreted, commercialized, or used in ways that conflict with community values.<sup>71–73</sup> Ethical research therefore requires that data collection, storage, interpretation, and secondary use occur under tribal authority, with clear agreements regarding ownership, access, and benefit-sharing.<sup>73</sup>

These principles are equally important when research involves psychotropic medication histories, including withdrawal experiences—domains that are deeply personal, clinically sensitive, and culturally significant.

## Structural inequities & social determinants of distress

Structural inequities shape the behavioral health landscape in Native communities long before any clinical encounter occurs. Chronic underfunding of tribal health systems, limited access to specialty care, geographic isolation, and the cumulative effects of historical trauma create conditions in which distress is both predictable and rational.<sup>58,59</sup> These structural pressures are not background variables; they are primary determinants of psychological distress. When such distress enters the clinical setting, however, it is often reframed as an individual psychiatric disorder rather than a response to systemic conditions.<sup>60,61</sup>

Economic instability, housing insecurity, food scarcity, and exposure to chronic stressors further compound vulnerability.<sup>59,60</sup> These social determinants shape not only the onset of distress but also the likelihood of receiving psychotropic medications. In many rural and reservation settings, psychotropic prescribing becomes a default response to structural problems that remain unaddressed.<sup>61,62</sup> The result is a pattern in which medications substitute for the structural

supports—stable housing, safe environments, culturally grounded care—that are necessary for long-term well-being.

Diagnostic frameworks that ignore context exacerbate these inequities. As previously noted, DSM categories are largely context-blind and can pathologize responses to structural adversity.<sup>57,58</sup> When distress rooted in poverty, discrimination, or historical trauma is interpreted as a discrete psychiatric disorder, the clinical response shifts toward medication rather than structural intervention.<sup>60–62</sup> This dynamic contributes to overprescribing and reinforces the medicalization of social suffering.

These inequities also shape withdrawal experiences. Individuals living in unstable housing, experiencing food insecurity, or lacking consistent social support face greater challenges during tapering.<sup>52,53</sup> Withdrawal symptoms may be intensified by chronic stress, misinterpreted as relapse, or exacerbated by limited access to follow-up care.<sup>53–55</sup> Without structural supports, even well-designed tapering plans can fail, leading to reinstatement of medications and perpetuation of long-term dependence.

Addressing psychotropic use and withdrawal in Native communities therefore requires more than clinical expertise. It requires acknowledging that distress is often a rational response to structural conditions, and that sustainable healing depends on strengthening the social, cultural, and economic foundations that support community well-being.<sup>58,59</sup>

## Policy implications

Policy reform in Native behavioral health must begin with acknowledging that current systems were not designed with Indigenous worldviews, histories, or community priorities in mind. Structural underfunding of tribal health systems, limited access to culturally grounded services, and reliance on diagnostic frameworks that decontextualize distress all contribute to patterns of overprescribing and long-term psychotropic use.<sup>58–62</sup> These patterns are not the result of individual clinical decisions alone; they reflect policy environments that prioritize biomedical interventions over community-driven, culturally anchored approaches.

A central policy challenge is the absence of structured, culturally responsive withdrawal process supports. As noted earlier, withdrawal symptoms are frequently misinterpreted as relapse, leading to unnecessary reinstatement or escalation of medications.<sup>52,53</sup> Without policy frameworks that recognize withdrawal as a legitimate clinical process requiring specialized support, Native patients remain vulnerable to cycles of dependence, misdiagnosis and long-term side effects.<sup>53–55</sup> Policies must therefore mandate training for clinicians in distinguishing withdrawal from relapse, support the development of tapering protocols tailored to community contexts, and ensure that withdrawal services are accessible within tribal health systems.

Policy reform must also address the diagnostic reductionism embedded in mainstream psychiatric practice. DSM categories, which lack biomarkers and often ignore sociocultural context, can pathologize responses to structural adversity.<sup>57–64</sup> Policies that require contextual assessment—incorporating historical trauma, social determinants, and community narratives—would reduce inappropriate diagnoses and shift clinical responses away from medication-first approaches.<sup>60–62</sup>

As previously stressed, pharmacogenetic considerations are paramount. They further underscore the need for policy change. Native communities remain underrepresented in pharmacologic research, limiting the applicability of standard dosing guidelines.<sup>70,71</sup>

Yet this domain is particularly delicate, as much of contemporary pharmacologic research does not naturally align with Indigenous principles of care, relational accountability, or community-defined priorities. Policies must therefore ensure that any research involving Indigenous peoples adheres to tribal governance frameworks, respects data sovereignty, and avoids extractive practices.<sup>71–73</sup> If such research is undertaken, it must occur only with strong safeguards in place—requiring tribal approval, establishing clear data-sharing agreements, and ensuring that benefits flow back to communities rather than outward to external institutions.

Finally, policy must support the expansion of culturally grounded, community-based behavioral health services. Investments in traditional healing, community support networks, and Indigenous models of wellness are essential for reducing reliance on psychotropic medications and supporting safe withdrawal.<sup>58,59</sup> Policies that prioritize these approaches would align behavioral health systems with Indigenous values and promote long-term, community-driven healing.

### Integrated model for indigenous behavioral health

An Indigenous behavioral health model must begin with the recognition that distress is not solely an individual phenomenon but a relational, historical, and structural experience.<sup>58,59</sup> Western psychiatric frameworks, which emphasize symptom clusters and decontextualized diagnoses, often fail to capture the collective dimensions of suffering rooted in colonization, land dispossession, cultural suppression, and intergenerational trauma.<sup>57–60</sup> An integrated model must therefore move beyond diagnostic reductionism and incorporate Indigenous epistemologies that understand wellness as relational, interconnected, and grounded in community.

At the clinical level, the model requires a shift from medication-first approaches to relational assessment. This includes distinguishing withdrawal from relapse, recognizing the role of metabolic variability, and understanding how long-term psychotropic use interacts with structural inequities.<sup>52–55,67–73</sup> This shift begins with a reflection on the very questions clinicians are trained to ask. Too often, clinical encounters start with an effort to assign a diagnostic category to distress rather than to understand the person's life experience. Instead of beginning with the question "What disorder does this person have?", the clinician reframes the encounter by orienting their assessment around "What has happened, what is happening, and what supports are needed?" This orientation aligns with Indigenous worldviews that situate distress within relationships, responsibilities, and lived experience.

At the cultural level, the model centers Indigenous knowledge systems. These systems emphasize balance, relational accountability, and the interconnectedness of mind, body, land, and community. They reject the fragmentation inherent in biomedical frameworks and instead view healing as a process of restoring relationships—with family, community, ancestors, and land. Integrating these principles requires that clinical practice defer to tribal knowledge holders, cultural practitioners, and community-defined pathways of healing.

At the ethical level, the model incorporates data sovereignty and governance principles that protect Indigenous communities from extractive research practices.<sup>70–73</sup> Biological data, clinical histories, and withdrawal experiences must be governed by tribal authority, with clear agreements regarding ownership, access, and benefit-sharing. Ethical practice is not an add-on; it is a structural requirement for rebuilding trust and ensuring that research and clinical care align with community priorities.

At the structural level, the model acknowledges that healing cannot occur in isolation from the conditions that produce distress. Poverty, discrimination, underfunded health systems, and limited access to culturally grounded services shape both the onset of distress and the trajectory of withdrawal.<sup>58–62</sup>

An integrated approach therefore requires addressing the social determinants of health and the historical conditions that shape suffering—factors that extend far beyond symptoms and into the structural realities of daily life. At the narrative level, this framework also reshapes how distress and healing are understood. Instead of viewing individuals as disordered or deficient, it recognizes resilience, relational strength, and the capacity for healing embedded within Indigenous communities. This narrative shift is essential for countering the pathologizing tendencies of Western psychiatry and for supporting community-driven, culturally grounded recovery.

Taken together, these clinical, cultural, ethical, structural, and narrative components form an integrated Indigenous behavioral health model—one that resists reductionism, honors sovereignty, and supports healing grounded in community, culture, and relational accountability.

### Conclusion

The mental health of Native communities cannot be understood through frameworks that separate individuals from history, land, and collective experience. Biomedical psychiatry, with its emphasis on symptom clusters, diagnostic reductionism, and pharmacological intervention, offers only a partial view of Indigenous distress.<sup>57–62</sup>

When these narrow models are applied without attention to historical trauma, cultural disruption, and structural inequities, they risk pathologizing Indigenous lives rather than supporting healing.<sup>58–60</sup>

Psychotropic medications may provide relief for some individuals, but their long-term use must be understood within the broader context of chronic side effects, structural adversity, underfunded health systems, and limited access to culturally grounded services.<sup>58–62</sup> Withdrawal experiences further reveal the limitations of biomedical approaches: symptoms are often misinterpreted as relapse, differences in how medications are processed and tolerated are overlooked, and individuals are left without culturally informed supports.<sup>52–55,67–73</sup>

Without structured, community-based withdrawal pathways, Native patients face unnecessary cycles of reinstatement and long-term dependence.

Transforming behavioral health systems in Native communities requires a shift from reductionist models to Indigenous frameworks of wellness that emphasize relationality, balance, and community accountability. This includes integrating cultural knowledge into clinical practice, strengthening tribal authority over data and research, and addressing the structural determinants of distress.<sup>70–73</sup> Policies must support culturally grounded services, invest in community-defined healing practices, and ensure that clinical and biological data are governed by tribal sovereignty.

Ultimately, healing emerges from the restoration of relationships—within individuals, families, communities, and with land and culture. By moving beyond diagnostic labels and embracing Indigenous models of wellness, behavioral health systems can support pathways of healing that honor identity, strengthen cultural continuity, and uphold the inherent sovereignty of tribal nations. This shift is not only clinically necessary but ethically imperative, offering a foundation

for behavioral health care that reflects the resilience, knowledge, and lived experiences of Indigenous peoples.

## Acknowledgments

We extend our gratitude to the tribal communities, Elders, and cultural leaders whose knowledge, guidance, and lived experiences continue to shape our understanding of Indigenous mental health. Their commitment to cultural continuity, relational strength, and community wellness provides the foundation for this work. We also acknowledge the clinicians, researchers, and community advocates who strive to create mental health systems that honor sovereignty, respect Indigenous knowledge, and support long term healing. Any insights offered in this article are grounded in the collective wisdom and resilience of Indigenous peoples, and we remain deeply grateful for their trust and collaboration.

## Funding

None.

## Conflicts of interest

The author declares there is no conflict of interest.

## References

1. Gone JP. Redressing First Nations' historical trauma: theorizing mechanisms for Indigenous culture as mental health treatment. *Transcult Psychiatry*. 2013;50(5):683–706.
2. Leichsenring F, Steinert C, Ioannidis JPA, et al. The efficacy of psychotherapies and pharmacotherapies for mental disorders in adults: an umbrella review. *World Psychiatry*. 2022;21(1):133–145.
3. McGuire TG, Miranda J. New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Aff (Millwood)*. 2008;27(2):393–403.
4. Brave Heart MYH, Chase J, Elkins J, et al. Historical trauma among Indigenous peoples of the Americas: concepts, research, and clinical considerations. *J Psychoactive Drugs*. 2011;43(4):282–290.
5. Kirmayer LJ, Gone JP, Moses J. Rethinking historical trauma. *Transcult Psychiatry*. 2014;51(3):299–319.
6. Brave Heart MY, DeBruyn LM. The American Indian Holocaust: healing historical unresolved grief. *Am Indian Alsk Native Ment Health Res*. 1998;8(2):56–78.
7. Waitzkin H. *The second sickness: contradictions of capitalist health care*. 2nd ed. Lanham, MD: Rowman & Littlefield; 2000.
8. Gone JP, Kirmayer LJ. Advancing Indigenous mental health research: Ethical, conceptual and methodological challenges. *Transcult Psychiatry*. 2020;57(2):235–249.
9. Henderson L, Claw K, Woodahl E, et al. P450 pharmacogenetics in Indigenous North American populations. *J Pers Med*. 2018;8(1):9.
10. Lee RS, Brown HK, Salih S, et al. Systematic review of Indigenous involvement and content in mental health interventions and their effectiveness for Indigenous populations. *Aust N Z J Psychiatry*. 2022;56(10):1230–1251.
11. Gone JP, Trimble JE. American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annu Rev Clin Psychol*. 2012;8:131–160.
12. de Vries YA, Roest AM, de Jonge P, et al. The cumulative effect of reporting and citation biases on the apparent efficacy of treatments: the case of depression. *Psychol Med*. 2018;48(15):2453–2455.
13. Maviglia M, Coeoyate NJ. Implementing psychiatric drug withdrawal practices: challenges with individuals with multiple comorbid behavioral and health problems. *J Psychol Clin Psychiatry*. 2024;15(2):79–85.
14. Johnstone L, Boyle M. *The power threat meaning framework*. Leicester, UK: British Psychological Society; 2018.
15. Claw K, Anderson M, Begay R, et al. A framework for enhancing ethical genomic research with Indigenous communities. *Nat Commun*. 2018;9(1):2957.
16. Tone-Pah-Hote T, Redvers N. The commercialization of biospecimens from Indigenous Peoples: a scoping review of benefit-sharing. *Front Med*. 2022;9:978826.
17. Carroll SR, Rodriguez-Lonebear D, Martinez A. Indigenous data governance: strategies from United States Native Nations. *Data Sci J*. 2019;18:31.
18. Crouch MC, Kim SM, Asquith-Heinz Z, et al. Indigenous Elder-centered methodology: research that decolonizes and indigenizes. *AlterNative*. 2023;19(2):447–456.
19. Walter M, Suina M. Indigenous data, indigenous methodologies and data sovereignty. *Int J Soc Res Methodol*. 2019;22(3):233–243.
20. Hudson M, Carroll SR, Anderson J, et al. Indigenous Peoples' rights in data: a contribution toward Indigenous research sovereignty. *Front Res Metr Anal*. 2023;8:1173805.
21. Rainie SC, Rodriguez-Lonebear D, Martinez A. *Indigenous data sovereignty in the United States*. Tucson, AZ: Native Nations Institute; 2017.
22. Maviglia M, Hume D, Coeoyate NJ. Peer support's role in helping individuals withdraw from psychiatric medications. *J Psychol Clin Psychiatry*. 2023;14(6):157–162.
23. Huang CY, Zane N. Cultural influences in mental health treatment. *Curr Opin Psychol*. 2016;8:131–136.
24. LaDuke W. *All our relations: native struggles for land and life*. Cambridge, MA: South End Press; 1999.
25. Substance Abuse and Mental Health Services Administration. *Medications for opioid use disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP21-02-01-002. Substance Abuse and Mental Health Services Administration; 2021
26. Pies RW. Debunking the two chemical imbalance myths (again). *Psychiatr Times*. 2019;36(8).
27. Mintzes B. Advertising of prescription-only medicines to the public. *Annu Rev Public Health*. 2012;33:259–277.
28. Lebowitz MS, Ahn WK. Effects of biological explanations for mental disorders on clinicians' empathy. *Proc Natl Acad Sci U S A*. 2014;111(50):17786–17790.
29. Lacasse JR, Leo J. Serotonin and depression: a disconnect between the advertisements and the scientific literature. *PLoS Med*. 2005;2(12):e392.
30. Moncrieff J, Cooper RE, Stockmann T, et al. The serotonin theory of depression: a systematic umbrella review of the evidence. *Mol Psychiatry*. 2023;28(8):3243–3256.
31. Levine BE. *Resisting illegitimate authority*. Oakland, CA: AK Press; 2018.
32. Hall W. *Harm reduction guide to coming off psychiatric drugs and withdrawal*. The Icarus Project and Freedom Center, 2012.
33. Fernando S. *Mental health worldwide: culture, globalization and development*. London, UK: Palgrave Macmillan; 2014.
34. Kirmayer LJ. Beyond the "new cross-cultural psychiatry": Cultural biology, discursive psychology and the ironies of globalization. *Transcult Psychiatry*. 2006;43(1):126–144.

35. Kirmayer LJ, Dandeneau S, Marshall E, et al. Rethinking resilience from Indigenous perspectives. *Can J Psychiatry*. 2011;56(2):84–91.
36. Redvers N, Platt J, Green M. The land is a healer: perspectives on land-based healing from Indigenous practitioners in northern Canada. *Int J Environ Res Public Health*. 2020;17(12):4633.
37. Duran E, Duran B. *Native American postcolonial psychology*. Albany, NY: SUNY Press; 1995.
38. Gone JP. A community-based treatment for Native American historical trauma: prospects for evidence-based practice. *J Consult Clin Psychol*. 2009;77(4):751–762.
39. Smith LT. *Decolonizing methodologies*. London, UK: Zed Books; 1999.
40. Mohawk J. *Thinking in Indian: A John Mohawk reader*. Golden, CO: Fulcrum Publishing; 2010.
41. Wallerstein NB, Duran B. Using community-based participatory research to address health disparities. *Health Promot Pract*. 2006;7(3):312–323.
42. Kleinman A. *Rethinking psychiatry: from cultural category to personal experience*. New York, NY: Free Press; 1988.
43. Ang B, Horowitz M, Moncrieff J. Is the chemical imbalance an ‘Urban Legend’? An exploration of the status of the serotonin theory of depression in the scientific literature. *SSM - Mental Health*. 2022;2:100098.
44. Gopalkrishnan N. Cultural diversity and mental health: considerations for policy and practice. *Front Public Health*. 2018;6:179.
45. Stone D, Trinh E, Zhou H, et al. Suicides among American Indian or Alaska Native Persons - national violent death reporting system, United States, 2015-2020. *MMWR Morb Mortal Wkly Rep*. 2022;71(37):1161–1168.
46. Espey DK, Jim MA, Cobb N, et al. Leading causes of death and all-cause mortality in American Indians and Alaska Natives. *Am J Public Health*. 2014;104(suppl 3):S303–S311.
47. Whitaker R. *Anatomy of an epidemic*. New York, NY: Crown; 2010.
48. Permoda-Osip A, Abramowicz M, Kraszewska A, et al. Kidney, thyroid and other organ functions after 40 years or more of lithium therapy: a case series of five patients. *Ther Adv Psychopharmacol*. 2016;6(4):277–282.
49. Walker DE. *Coyote’s swing: a memoir and critique of mental hygiene in Native America*. Pullman, WA: Washington State University Press; 2022.
50. Hetrick SE, McKenzie JE, Cox GR, et al. Newer generation antidepressants for depressive disorders in children and adolescents. *Cochrane Database Syst Rev*. 2012;11(11):CD004851.
51. Ferner RE, Aronson JK. Clarification of terminology in medication errors: definitions and classification. *Drug Saf*. 2006;29(11):1011–1022.
52. American Psychiatric Association. *Indigenous populations face unique barriers to accessing mental health help*. 2022.
53. Ehlers CL, Gizer IR, Gilder DA, et al. Measuring historical trauma in an American Indian community sample: contributions of substance dependence, affective disorder, conduct disorder and PTSD. *Drug Alcohol Depend*. 2013;133(1):180–187.
54. Lawrence J. The Indian Health Service and sterilization of Native American women. *Am Indian Q*. 2000;24(3):400–419.
55. Zhou SF, Liu JP, Chowbay B. Polymorphism of cytochrome P450 enzymes and its clinical impact. *Drug Metab Rev*. 2009;41(2):89–295.
56. Kuhnlein HV, Receveur O. Dietary change and traditional food systems of Indigenous peoples. *Annu Rev Nutr*. 1996;16:417–442.
57. Horwitz AV, Wakefield JC. *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*. Oxford University Press; 2007.
58. Moncrieff J. Does antipsychotic withdrawal provoke psychosis? *Acta Psychiatr Scand*. 2006;114(1):3–13.
59. Maviglia M, Hume D, Coeoyate NJ, et al. Kindling in psychopharmacology: Unveiling an overlooked clinical challenge with significant implications. *J Psychol Clin Psychiatry*. 2024;15(5):282–290.
60. Wexler L. Looking across three generations of Alaska Natives to explore how culture fosters indigenous resilience. *Transcult Psychiatry*. 2014;51(1):73–92.
61. World Health Organization. *Guidance on community mental health services: promoting person-centred and rights-based approaches*. World Health Organization; 2021.
62. Beauchamp TL, Childress JF. *Principles of biomedical ethics*. 8th ed. Oxford University Press, 2019.
63. LaDuke W. *Recovering the sacred: the power of naming and claiming*. Cambridge, MA. South End Press; 2005.
64. Substance Abuse and Mental Health Services Administration. *SAMHSA’s concept of trauma and guidance for a trauma-informed approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014. HHS Publication SMA 14-4884.
65. Deegan PE. Recovery as a journey of the heart. *Psychiatr Rehabil J*. 1996;19(3):91–97.
66. Waitzkin H. *Medicine and public health at the end of empire*. Boulder, CO: Paradigm Publishers; 2011.
67. Waitzkin H. A Marxist view of medical care. *Ann Intern Med*. 1978;89(2):264–278.
68. White RG, Jain S, Orr DMR, editors, et al. *The Palgrave handbook of sociocultural perspectives on global mental health*. London, UK: Palgrave Macmillan; 2017.
69. Whelshula M, Hill M, Galaitsi SE, et al. Native populations and the opioid crisis: forging a path to recovery. *Environ Syst Decis*. 2021;41(3):334–340.
70. Kleinman A. *Rethinking psychiatry: from cultural category to personal experience*. New York: Free Press; 1988.
71. Kirmayer LJ, Brass GM, Tait CL. The mental health of aboriginal peoples: transformations of identity and community. *Can J Psychiatry*. 2000;45(7):607–616.
72. Kirmayer LJ, Pedersen D. Toward a new architecture for global mental health. *Transcult Psychiatry*. 2014;51(6):759–776.
73. Gómez Carrillo A, Kirmayer LJ. A cultural ecosocial systems view for psychiatry. *Front Psychiatry*. 2023;14:1031390.