

Toward Indigenous Mental Health Systems: Integrating “Buen Vivir”, Mental Health, and Psychosocial Support*

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How to cite this paper: Prewitt Diaz, J. O. (2026). Toward Indigenous Mental Health Systems: Integrating “Buen Vivir”, Mental Health, and Psychosocial Support. *Psychology*, 17, 917-939.
<https://doi.org/10.4236/psych.2026.179046>

Received: July 3, 2026

Accepted: September 27, 2026

Published: September 30, 2026

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Abstract

Mental Health and Psychosocial Support (MHPSS) increasingly recognizes that well-being is shaped by cultural, social, historical, and environmental factors. This conceptual article proposes an integrated framework that combines Indigenous philosophies of **Buen Vivir** with community-based MHPSS to promote collective flourishing among Indigenous Peoples in Latin America and the Caribbean. Drawing upon interdisciplinary literature, international policy frameworks, and regional evidence, the article argues that culturally responsive mental health systems should integrate historical trauma, cultural continuity, traditional healing, ecological stewardship, community leadership, and human rights. The framework offers practical guidance for developing Indigenous-led mental health systems that strengthen resilience, self-determination, and sustainable well-being through intercultural collaboration.

Keywords

Indigenous Mental Health, Buen Vivir, Community-Based Mental Health and Psychosocial Support, MHPSS, Collective Flourishing, Cultural Continuity, Intercultural Care, Decolonizing Mental Health, Indigenous Knowledge Systems, Latin America and the Caribbean

1. Introduction

During the past two decades, international organizations have increasingly recognized that effective mental health systems must be culturally responsive, commu-

*Buen Vivir, to give it its Spanish name, describes a way of doing things that is community-centric, ecologically-balanced and culturally-sensitive. Gudynas, E. (2011) Buen Vivir: Germinando alternativas al Desarrollo. *América Latina en Movimiento*, 462, 1-20.

nity-centered, and grounded in the social determinants of health. The World Health Organization (WHO) has called for transforming mental health systems by addressing inequities, strengthening community participation, and recognizing the importance of human rights, while the Pan American Health Organization (PAHO) has emphasized intercultural approaches that respect Indigenous knowledge systems and traditional medicine. Similarly, the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support have established a layered framework that integrates basic services, community supports, focused psychosocial interventions, and specialized mental health care. Together, these developments represent a significant departure from models that define mental health primarily through diagnosis and treatment toward approaches that recognize the importance of culture, community, participation, and resilience.

Despite these advances, important conceptual gaps remain when these frameworks are applied to Indigenous Peoples in Latin America and the Caribbean. Existing models generally seek to improve cultural competence within established mental health systems rather than examining how Indigenous philosophies themselves might redefine the goals, organization, and evaluation of Mental Health and Psychosocial Support. As a result, Indigenous knowledge systems are frequently incorporated as culturally appropriate adaptations to existing services rather than being recognized as sources of theoretical and practical innovation capable of reshaping contemporary understandings of mental health. This distinction is particularly important because many Indigenous communities conceptualize well-being not as an individual psychological state but as the quality of relationships linking persons, families, communities, ancestors, territories, spiritual traditions, and the natural environment.

One of the most influential Indigenous perspectives contributing to this broader understanding of well-being is **Buen Vivir**, a term widely used in Latin America to describe a family of Indigenous philosophies that emphasize harmonious coexistence, reciprocity, collective responsibility, ecological stewardship, and cultural continuity. Although the Spanish expression **Buen Vivir** has become widely recognized in academic and policy discourse, it represents several distinct Indigenous concepts—including *Sumak Kawsay* among the Kichwa and Quechua, *Suma Qamaña* among the Aymara, *Tekó Porã* among the Guaraní, and *Lekil Kux-lejal* among the Tseltal Maya—that have developed within different historical and cultural contexts (Acosta, 2013; Gudynas, 2011). While these philosophies are not identical, they share an understanding that health and well-being emerge through balanced relationships among individuals, communities, nature, and the spiritual world. Rather than treating emotional suffering solely as an individual clinical problem, they invite a broader perspective in which healing involves restoring the social, cultural, ecological, and spiritual conditions that sustain collective life.

This relational understanding of well-being offers an important opportunity to advance contemporary Mental Health and Psychosocial Support. Rather than re-

placing existing clinical or humanitarian approaches, Indigenous philosophies can enrich them by expanding the goals of MHPSS beyond symptom reduction and functional recovery toward the promotion of collective flourishing. Such a perspective aligns closely with emerging international efforts to strengthen community participation, address structural inequities, protect cultural rights, and integrate traditional knowledge into health systems. It also supports the development of culturally grounded, rights-based, and ecologically informed models of care capable of responding to the complex realities facing Indigenous communities throughout Latin America and the Caribbean.

The article therefore argues that the future development of Indigenous Mental Health and Psychosocial Support should be guided not simply by adapting existing mental health services to Indigenous contexts, but by creating intercultural systems in which Indigenous philosophies, community leadership, traditional healing, and contemporary scientific knowledge function as complementary sources of understanding and practice. Through this approach, Mental Health and Psychosocial Support becomes an instrument for strengthening cultural continuity, social cohesion, ecological stewardship, and self-determination while supporting the long-term flourishing of Indigenous Peoples across the region.

Approach to the Conceptual Synthesis

This article uses an integrative conceptual-synthesis approach rather than a systematic review or meta-analysis. Sources were selected purposively to illuminate four linked bodies of knowledge: 1) Indigenous philosophies of relational well-being and **Buen Vivir**; 2) Indigenous mental health, historical trauma, cultural continuity, and intercultural psychiatry; 3) community-based MHPSS and implementation practice; and 4) international and regional standards on Indigenous rights, ethnicity, health, and participation. Priority was given to peer-reviewed studies and reviews concerning Indigenous Peoples in Latin America and the Caribbean, foundational conceptual works needed to define the framework, and authoritative guidance from the United Nations, WHO, PAHO, IASC, ILO, and regional truth or human-rights bodies. Recent regional research was added where it clarified service disparities, community meanings of distress and recovery, suicide risk, or co-designed implementation (Araujo et al., 2023; Garza et al., 2025; Moya-Salazar et al., 2023; Paniagua-Avila et al., 2026; Pieters et al., 2025).

The synthesis proceeded in three analytical steps. First, recurrent constructs were identified across the selected sources, including relationality, reciprocity, cultural continuity, territorial belonging, collective rights, community leadership, and plural systems of care. Second, these constructs were compared with the four-layer IASC model to identify areas of convergence and conceptual omission. Third, the resulting themes were organized into six mutually reinforcing principles and examined against regional examples for practical plausibility. Regional examples are illustrative rather than representative, and the framework is offered as a proposition for participatory testing, not as evidence of intervention effectiveness. This scope is important: the article seeks conceptual coherence and ap-

plied usefulness while recognizing that each Indigenous People must determine whether, and how, the framework fits its own knowledge, language, governance, and healing traditions.

2. From Biomedical Mental Health to Collective Flourishing

The evolution of Mental Health and Psychosocial Support (MHPSS) reflects one of the most significant paradigm shifts in contemporary global health and humanitarian practice. During much of the twentieth century, mental health services were largely organized around biomedical models that emphasized the diagnosis, classification, and treatment of psychiatric disorders. These approaches produced important advances in neuroscience, psychopharmacology, and clinical psychology and remain indispensable for individuals living with severe mental disorders. Nevertheless, they frequently conceptualized emotional distress primarily as an individual phenomenon, placing comparatively less emphasis on the broader social, cultural, historical, and environmental contexts in which psychological suffering develops. As a result, conventional mental health systems often proved insufficient for addressing the complex realities experienced by populations affected by armed conflict, forced displacement, disasters, chronic poverty, social exclusion, and the enduring consequences of colonization.

The emergence of Mental Health and Psychosocial Support represented an important response to these limitations. Rather than replacing clinical mental health services, MHPSS broadened the understanding of psychological well-being by integrating insights from public health, community psychology, anthropology, education, social work, humanitarian action, and human rights. The publication of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings in 2007 marked a turning point by establishing a layered framework in which specialized clinical care is situated within broader systems of family support, community participation, protection, education, and access to basic services (Inter-Agency Standing Committee [IASC], 2007). This ecological perspective recognizes that mental health is influenced not only by biological and psychological factors but also by the quality of relationships, institutions, livelihoods, safety, culture, and opportunities for meaningful participation in community life.

For Indigenous Peoples in Latin America and the Caribbean, this broader understanding represents an important advance but does not fully resolve the limitations of conventional mental health systems. Although community-based MHPSS recognizes the importance of culture and participation, many interventions continue to be designed within conceptual frameworks that originated outside Indigenous societies. Cultural adaptation often focuses on modifying existing services rather than questioning whether the underlying assumptions concerning health, illness, recovery, and well-being adequately reflect Indigenous worldviews. Consequently, Indigenous knowledge systems may be acknowledged without fundamentally influencing the conceptual foundations of MHPSS itself.

Indigenous philosophies associated with **Buen Vivir** offer an alternative perspective that broadens the very purpose of mental health and psychosocial support. Across the diverse Indigenous traditions of Latin America and the Caribbean, well-being is generally understood as emerging from balanced relationships among individuals, families, communities, ancestors, spiritual traditions, ancestral territories, and the natural environment. Although these philosophies differ across cultures, they share the understanding that human beings are fundamentally relational rather than isolated individuals. Emotional suffering is therefore often interpreted not simply as an internal psychological condition but as the manifestation of disrupted relationships involving family, community, culture, spirituality, governance, or the environment. Healing, correspondingly, becomes a process of restoring these relationships rather than focusing exclusively on symptom reduction.

This relational perspective complements contemporary developments in global mental health that increasingly emphasize the social determinants of health. The World Health Organization's World Mental Health Report recognizes that mental well-being is profoundly shaped by education, employment, housing, discrimination, violence, environmental conditions, and opportunities for social participation (World Health Organization, 2022). Indigenous philosophies extend this analysis by explicitly incorporating cultural continuity, spiritual life, ancestral territories, and reciprocal relationships with nature as essential determinants of well-being. From this perspective, mental health cannot be separated from the vitality of Indigenous languages, the transmission of traditional knowledge, the protection of sacred places, or the exercise of collective rights.

An important implication of this perspective concerns the definition of recovery itself. Conventional mental health systems frequently evaluate success through reductions in psychiatric symptoms, improvements in functioning, or increased resilience. These remain essential outcomes and should continue to guide clinical practice. However, for many Indigenous communities, recovery also involves restoring the cultural, social, and ecological conditions that enable communities to sustain meaningful lives across generations. Revitalizing Indigenous languages, strengthening traditional governance, protecting ancestral territories, rebuilding community trust, preserving ceremonial practices, and promoting intergenerational learning all contribute to well-being in ways that are not adequately captured by conventional clinical indicators. Consequently, community-based MHPSS should be evaluated not only by improvements in individual mental health but also by its contribution to the collective capacities that sustain healthy and resilient communities.

This broader orientation also expands the ethical foundation of Mental Health and Psychosocial Support. Rather than viewing Indigenous Peoples primarily as recipients of services, it recognizes them as active participants in defining the goals, methods, and evaluation of mental health systems. Such participation reflects internationally recognized principles of self-determination and free, prior,

and informed consent while strengthening the cultural legitimacy and long-term sustainability of MHPSS interventions. Indigenous leadership becomes a central component of effective mental health systems rather than an optional element of community consultation.

The framework proposed in this article therefore advances the evolution of Mental Health and Psychosocial Support by positioning **collective flourishing** as its overarching objective. In this article, collective flourishing means the sustained capacity of a People to live with cultural continuity, reciprocal and trustworthy social relations, and meaningful authority over community life and territory. Its concrete components include: 1) the intergenerational vitality of language, identity, knowledge, and ceremony; 2) cohesive relationships and institutions capable of mutual care; and 3) collective agency to protect land, exercise rights, sustain livelihoods, and shape a desired future. The construct includes individual well-being but is not reducible to it. Well-being describes a valued condition of living; resilience denotes the capacity to adapt or persist under adversity; and recovery refers to movement after disruption toward restored or newly constructed functioning and meaning. Collective flourishing is broader and more explicitly political, cultural, relational, intergenerational, and ecological: it asks whether the conditions exist for persons and communities to thrive together over time. These conditions include cultural continuity, social cohesion, ecological stewardship, equitable access to resources, meaningful participation in community life, protection of human rights, and opportunities for future generations to maintain their identities, languages, and relationships with ancestral territories. Within this perspective, mental health is understood not merely as the absence of illness but as the presence of healthy, reciprocal, and sustainable relationships that support dignity, resilience, hope, and shared well-being.

This conceptual shift does not diminish the importance of specialized mental health care. Rather, it situates clinical services within a broader intercultural system in which biomedical knowledge and Indigenous philosophies function as complementary sources of understanding and practice. Such an approach reflects the growing recognition that sustainable improvements in mental health require interventions that are simultaneously clinically sound, culturally grounded, socially just, and ecologically responsible. The following section examines how the historical experiences of Indigenous Peoples in Latin America and the Caribbean have shaped contemporary mental health realities and why these histories must inform the future development of culturally responsive Mental Health and Psychosocial Support systems.

3. Historical Trauma and Contemporary Indigenous Mental Health in Latin America and the Caribbean

Contemporary mental health among Indigenous Peoples in Latin America and the Caribbean cannot be understood apart from the historical processes that have shaped their societies over more than five centuries. Colonization, forced dis-

placement, enslavement, epidemics, cultural suppression, territorial dispossession, and structural discrimination have produced forms of collective suffering that extend beyond individual experiences and continue to influence community well-being today. These historical processes disrupted social institutions, weakened traditional governance systems, interrupted the transmission of languages and cultural knowledge, and altered relationships between Indigenous communities and their ancestral territories. Consequently, many of the psychosocial challenges experienced by Indigenous Peoples today are embedded within historical, political, cultural, and ecological contexts rather than arising solely from individual vulnerability or biological predisposition.

The concept of historical trauma provides an important framework for understanding these realities. Historical trauma refers to the cumulative emotional, psychological, cultural, and social consequences of massive collective adversity that are transmitted across generations through families, institutions, and communities (Brave Heart et al., 2011). Unlike conventional trauma models, which primarily examine discrete events affecting individuals, historical trauma recognizes that entire populations may experience enduring disruptions to identity, social organization, and collective memory. For Indigenous Peoples, these disruptions often include the loss of land, language, spirituality, governance systems, and cultural continuity. Understanding these historical dimensions is essential for developing Mental Health and Psychosocial Support (MHPSS) interventions that address the root causes of distress rather than focusing exclusively on contemporary symptoms.

Throughout Latin America and the Caribbean, historical trauma has assumed diverse forms. In the Andean region, the internal armed conflict in Peru disproportionately affected Quechua-speaking communities, exposing thousands of Indigenous families to violence, forced displacement, disappearances, and social fragmentation. The Peruvian Truth and Reconciliation Commission documented that the majority of those killed during the conflict were Indigenous rural residents whose communities subsequently experienced profound disruptions in social cohesion, trust, and cultural continuity. Recovery has therefore required far more than individual psychological treatment. Community rebuilding, cultural revitalization, recognition of historical injustices, and participatory reconciliation have become essential components of psychosocial recovery (Comisión de la Verdad y Reconciliación, 2003).

Comparable experiences have been documented among Maya communities in Guatemala, where decades of armed conflict and state violence produced widespread displacement, loss of life, and destruction of traditional social structures. Community-based healing initiatives have demonstrated that collective ceremonies, remembrance practices, spiritual traditions, and local leadership can strengthen psychosocial recovery while complementing clinical mental health services. These experiences illustrate that collective memory, rather than representing a barrier to recovery, may function as a source of resilience by reaffirming identity, dignity,

and continuity across generations.

Historical trauma also intersects with continuing structural inequities. Indigenous Peoples throughout Latin America and the Caribbean remain disproportionately affected by poverty, limited educational opportunities, inadequate health services, political exclusion, environmental degradation, and discrimination. These conditions contribute to elevated risks for depression, anxiety, substance misuse, suicide, interpersonal violence, and chronic psychological stress. Importantly, however, these disparities should not be interpreted as characteristics of Indigenous cultures themselves. Rather, they reflect the continuing consequences of unequal social, economic, and political systems that constrain opportunities for healthy development and collective well-being.

Recent regional evidence further underscores these challenges. The Pan American Health Organization (PAHO) has identified Indigenous Peoples as experiencing persistent barriers to equitable health care, including shortages of culturally appropriate mental health services, language barriers, geographic isolation, and insufficient recognition of traditional healing systems. PAHO has therefore advocated intercultural health policies that strengthen Indigenous participation, integrate traditional medicine, and address the social determinants of health through coordinated action across health, education, environmental protection, and community development sectors (Pan American Health Organization [PAHO], 2017, 2019). Such recommendations align closely with the framework proposed in this article, which views MHPSS as an integral component of broader efforts to promote cultural continuity, social justice, and community resilience.

Environmental change represents another increasingly significant determinant of Indigenous mental health. Throughout the Amazon Basin, Indigenous communities confront deforestation, illegal mining, water contamination, biodiversity loss, and climate change, all of which threaten traditional livelihoods and relationships with ancestral territories. These processes have contributed to what has been described as ecological grief—the emotional distress associated with the loss of ecosystems, culturally significant landscapes, and traditional ways of life. For many Indigenous Peoples, environmental degradation is simultaneously an ecological, cultural, spiritual, and psychological crisis because land is inseparable from identity, history, and collective memory. Protecting ancestral territories therefore contributes not only to environmental sustainability but also to psychosocial well-being and cultural survival (Cunsolo Willox & Ellis, 2018).

The Caribbean and Caribbean coastal regions of Central America illustrate additional dimensions of Indigenous mental health. Garífuna and Miskito communities experience recurrent hurricanes, coastal erosion, migration, economic marginalization, and limited access to culturally appropriate health services. These cumulative stressors affect family cohesion, community organization, and opportunities for cultural transmission while increasing exposure to chronic uncertainty and displacement. Community-based MHPSS initiatives that strengthen local leadership, traditional knowledge, multilingual communication, and disaster pre-

paredness have demonstrated the importance of integrating psychosocial support with broader community resilience strategies.

Despite these challenges, an exclusive emphasis on adversity risks overlooking one of the most important characteristics of Indigenous societies: their remarkable resilience. Across Latin America and the Caribbean, Indigenous Peoples have preserved languages, governance systems, spiritual traditions, ecological knowledge, and collective identities despite centuries of external pressures. These strengths constitute protective factors that should form the foundation of culturally responsive MHPSS. Evidence across Indigenous settings suggests that cultural continuity, participation in traditional practices, and effective local governance can operate as protective resources, although their forms and effects are context-specific and should not be presumed without community-defined evidence (Chandler & Lalonde, 1998; Gone, 2013; Kirmayer et al., 2011). Recent regional reviews also show that the evidence base remains geographically uneven and often gives inadequate attention to Indigenous definitions of health, underscoring the need for community-led research and data governance (Garza et al., 2025; Moya-Salazar et al., 2023). Consequently, Indigenous knowledge systems should be regarded not merely as cultural resources but as essential components of sustainable mental health systems.

Recognizing both historical trauma and cultural resilience fundamentally changes the objectives of Mental Health and Psychosocial Support. Rather than viewing Indigenous communities primarily through narratives of vulnerability, culturally responsive MHPSS seeks to strengthen existing capacities while addressing structural inequities that continue to undermine well-being. Healing is understood not as returning to a previous state but as creating conditions in which Indigenous Peoples can exercise self-determination, preserve cultural continuity, strengthen community relationships, and sustain healthy interactions with their ancestral territories and the natural environment.

Indigenous Peoples in Urban and Peri-Urban Settings

The framework must also apply to Indigenous people living in cities and peri-urban settlements. Urban residence does not extinguish Indigenous identity, yet migration, displacement, discrimination, insecure work, and housing precarity may fragment everyday access to territory, language, elders, ceremonial life, and community institutions. At the same time, urban Indigenous associations, migrant networks, cultural centers, faith communities, digital networks, and periodic return to ancestral communities may sustain belonging in forms that differ from rural territorial organization. An intercultural mental health system should therefore avoid treating urban Indigenous people as culturally assimilated or as deficient versions of territory-based communities.

In practice, urban and peri-urban implementation requires flexible affiliation rather than residence-based assumptions. Services can support language access, mobile or tele-mental-health links with trusted community providers, urban healing and cultural spaces, peer navigation, documentation of self-identified com-

munity ties, and referral agreements connecting city clinics with Indigenous authorities and healers when the person requests such involvement. Territory should be understood both as a material relationship to ancestral lands and as a network of memory, obligation, identity, and practice that may continue across distance. Evaluation should ask whether people can maintain or rebuild meaningful cultural and social connections, not merely whether they live within a formally recognized territory. Digital care may improve reach, but it must be co-designed around language, connectivity, privacy, accessibility, and community control rather than introduced as a culturally neutral substitute for relationships.

This perspective provides the foundation for the integrated framework proposed in the following section. By combining Indigenous philosophies of **Buen Vivir**, contemporary community-based MHPSS, intercultural health, and human rights principles, the framework seeks to move beyond culturally adapted mental health services toward Indigenous mental health systems capable of promoting collective flourishing across Latin America and the Caribbean.

4. An Integrated Framework for Indigenous Mental Health and Psychosocial Support

Building upon the historical experiences, cultural strengths, and contemporary challenges discussed in the preceding sections, this article proposes an integrated framework for Mental Health and Psychosocial Support (MHPSS) that is specifically designed for Indigenous Peoples in Latin America and the Caribbean. The framework does not seek to replace existing mental health systems, nor does it advocate the substitution of biomedical practice with traditional healing. Rather, it proposes an intercultural model in which Indigenous knowledge systems, community institutions, humanitarian MHPSS, public health, and specialized mental health services function as complementary components of a coordinated system of care. The framework recognizes that sustainable improvements in mental health depend upon strengthening the relationships that sustain individuals, families, communities, cultures, and ecosystems.

Unlike many existing approaches that begin with psychiatric diagnosis or service delivery, this framework begins with the recognition that Indigenous communities possess longstanding systems of knowledge concerning health, healing, governance, spirituality, and collective well-being. These systems have evolved over centuries within specific ecological and cultural contexts and continue to provide important sources of resilience despite the profound effects of colonization and social change. Consequently, culturally responsive MHPSS should build upon these existing strengths rather than introducing externally designed interventions with minimal community participation.

The proposed framework is organized around six mutually reinforcing principles that together create an Indigenous system of Mental Health and Psychosocial Support. Although each principle is presented separately for analytical purposes, they function as an interconnected system in practice.

Principle 1: Community Leadership and Self-Determination

The first principle recognizes Indigenous leadership as the foundation of effective Mental Health and Psychosocial Support. International human rights instruments, including the United Nations Declaration on the Rights of Indigenous Peoples and International Labour Organization Convention No. 169, affirm the right of Indigenous Peoples to participate fully in decisions affecting their health, education, culture, and development ([International Labour Organization, 1989](#); [United Nations, 2007](#)). Consistent with these principles, MHPSS initiatives should be designed, implemented, and evaluated in partnership with Indigenous authorities, elders, women, youth, traditional healers, and community organizations.

Community participation extends beyond consultation. Indigenous communities should define priorities, identify culturally meaningful indicators of success, determine appropriate methods of intervention, and participate actively in monitoring and evaluation. External organizations—including governments, universities, humanitarian agencies, and international organizations—should serve as technical partners that strengthen local capacity rather than replace community leadership. Such collaboration promotes cultural legitimacy, strengthens trust, and contributes to the long-term sustainability of mental health systems.

Principle 2: Cultural Continuity as a Protective Factor

The second principle recognizes cultural continuity as one of the most powerful determinants of Indigenous mental health. Research conducted in diverse Indigenous settings has demonstrated that communities maintaining strong cultural identities often experience greater resilience despite significant social and economic adversity. Languages, ceremonies, oral traditions, traditional ecological knowledge, artistic expression, and intergenerational learning all contribute to psychological well-being by strengthening identity, belonging, and collective purpose ([Chandler & Lalonde, 1998](#); [McIvor et al., 2009](#)).

Accordingly, culturally responsive MHPSS should actively support language revitalization, community education, cultural celebrations, storytelling, traditional arts, and opportunities for elders to transmit knowledge to younger generations. These activities should not be regarded merely as cultural preservation but as essential psychosocial interventions that strengthen protective factors while promoting dignity and hope. Mental health services become considerably more effective when they reinforce rather than compete with Indigenous cultural institutions.

Principle 3: Complementarity Between Traditional and Biomedical Systems

A third principle concerns the relationship between traditional Indigenous healing systems and contemporary mental health services. Historically, these systems have often functioned independently or, in some cases, in opposition to one another. Such separation has contributed to mistrust, reduced accessibility, and missed opportunities for collaboration. Contemporary intercultural health increasingly recognizes that traditional and biomedical approaches frequently address different dimensions of suffering and therefore need not be viewed as com-

peting systems.

Within the proposed framework, psychologists, psychiatrists, primary health-care providers, community health workers, and traditional healers collaborate through mutual respect and clearly defined roles. Severe mental disorders requiring specialized psychiatric care continue to receive evidence-based clinical treatment, while traditional healing contributes to cultural meaning, spiritual well-being, family participation, and community reconciliation. Referral systems, joint consultations, intercultural training, and collaborative care planning strengthen continuity of care while respecting the integrity of Indigenous knowledge systems. Such complementarity improves both accessibility and cultural safety.

Managing Disagreement, Safety, and Ethical Responsibility

Complementarity does not mean that every practice is automatically compatible or that professional and traditional authority become indistinguishable. Programs should establish a locally negotiated protocol before crises occur. The protocol should specify who may participate in care planning; how informed consent is obtained in the person's preferred language; what information may be shared; how confidentiality applies to family, communal, ceremonial, and clinical settings; and which conditions require urgent clinical assessment or protective action. Consent must remain voluntary and revisable. A person should be able to accept traditional, biomedical, combined, or sequential forms of care without coercion, retaliation, or loss of access to essential services.

When disagreement arises, the first response should be respectful consultation focused on the person's stated goals and safety rather than an abstract contest over which knowledge system is superior. Traditional healers and clinicians should clarify their interpretations, anticipated benefits, possible harms, and limits of competence. Immediate risks—including suicidal intent, severe self-neglect, violence, delirium, intoxication or withdrawal, and acute psychosis with impaired capacity—require prompt assessment through an agreed referral pathway and the least restrictive safe response available. Biomedical teams must not use risk language to dismiss Indigenous explanations, and traditional authority must not override a competent person's refusal or expose confidential information without permission. For children, adolescents, or adults with impaired decision-making capacity, procedures should integrate applicable law, the person's evolving preferences, family or community supports chosen by the person, and culturally legitimate safeguarding.

Programs should designate an intercultural liaison or small ethics group composed of Indigenous and clinical representatives to review recurring disagreements, adverse events, and referral failures. Documentation should distinguish shared facts from differing interpretations and record the consent governing information exchange. This arrangement makes complementarity accountable: collaboration is sustained through negotiated boundaries, bidirectional referral, and transparent review rather than assumed goodwill alone.

Principle 4: Community-Based Mental Health and Psychosocial Support

The fourth principle builds directly upon the Inter-Agency Standing Committee Guidelines by recognizing communities as the primary setting for Mental Health and Psychosocial Support. Indigenous societies have traditionally relied upon extended families, reciprocal social networks, communal labor, traditional authorities, and spiritual leaders as the principal sources of support during periods of adversity. Contemporary MHPSS should strengthen rather than replace these community capacities.

Teachers, community health workers, peer supporters, women's organizations, youth groups, local governments, and Indigenous organizations all contribute to the early identification of emotional distress, promotion of psychosocial well-being, disaster preparedness, violence prevention, and community resilience. Community-based interventions—including healing circles, collective ceremonies, participatory education, traditional conflict resolution, and mutual support groups—reinforce social cohesion while reducing reliance upon specialized clinical services that may be geographically or economically inaccessible. Such approaches also facilitate continuity between everyday community life and formal health systems.

Principle 5: Ecological Stewardship and Territorial Well-Being

Perhaps the most distinctive feature of the proposed framework is its explicit recognition that environmental well-being constitutes an essential determinant of mental health. Indigenous philosophies associated with **Buen Vivir** consistently emphasize that relationships with ancestral territories, forests, rivers, mountains, and ecosystems are fundamental components of collective well-being. Environmental degradation therefore represents not only an ecological crisis but also a psychosocial, cultural, and spiritual challenge.

Mental Health and Psychosocial Support should therefore incorporate activities that strengthen environmental stewardship, traditional ecological knowledge, community conservation initiatives, sustainable livelihoods, and disaster risk reduction. Land-based healing, traditional agriculture, restoration of sacred places, and community responses to climate change simultaneously strengthen cultural identity, social cohesion, and emotional well-being. Such initiatives also align with increasing international recognition of the relationship between climate change, ecological loss, and mental health (Cunsolo Willox & Ellis, 2018).

Principle 6: Human Rights and Social Justice

The final principle recognizes that sustainable mental health cannot be separated from broader questions of social justice. Persistent inequities in education, health care, housing, employment, political participation, and environmental protection continue to shape mental health outcomes among Indigenous Peoples throughout Latin America and the Caribbean. Consequently, MHPSS should function within a broader rights-based framework that seeks not only to alleviate psychological distress but also to strengthen the social conditions necessary for healthy communities.

Governments, humanitarian organizations, Indigenous institutions, and civil

society all share responsibility for reducing structural barriers that undermine well-being. Policies supporting bilingual education, culturally appropriate health services, territorial protection, community development, environmental justice, and Indigenous participation in decision-making contribute directly to Mental Health and Psychosocial Support by strengthening the social foundations of collective well-being.

5. From Principles to Practice: An Implementation Sequence

The six principles become operational through a staged, iterative sequence. The sequence is not a rigid external blueprint; each stage is governed jointly and may be revisited as relationships, risks, and community priorities change.

Stage 1: Establish Indigenous Governance and Ethical Authority

The initiating government or organization should begin by identifying the Indigenous authorities and community constituencies whose consent and leadership are required. A governance group should include, as locally appropriate, elders, women, youth, people with lived experience, traditional healers, disability representatives, community health workers, and clinical personnel. Before needs assessment or data collection, partners should agree on decision rules, compensation, ownership and permitted use of knowledge, free, prior, and informed consent, mechanisms for complaint, and Indigenous data governance. The first deliverable is therefore not a clinical program but a legitimate partnership with explicit authority and accountability.

Stage 2: Develop a Community-Defined Situational and Resource Map

Assessment should document distress and disorder without reducing need to diagnostic prevalence. Participatory mapping should identify local concepts of well-being and suffering; existing family, cultural, spiritual, environmental, and livelihood supports; barriers to care; high-risk groups; current clinical capacity; and trusted or mistrusted institutions. Separate attention is needed for people living away from ancestral territories and for those whose language or community ties have been disrupted. The resulting map should connect the six principles to priorities selected by the community and to the four IASC layers. This stage should also establish a baseline using both conventional indicators, where useful, and community-defined markers of collective flourishing.

Stage 3: Co-Design the Service Model and Care Pathways

Partners should translate priorities into a locally coherent package rather than import a stand-alone intervention. Co-design specifies what will occur at household, community, primary-care, and specialist levels; which activities are cultural or ceremonial; which require clinical competence; and how individuals move between them. A written pathway should cover routine referral, urgent risk, follow-up after hospitalization, substance-related crises, violence and safeguarding, disaster displacement, and continuity of traditional support. The co-creation of mental health strategies with Maya community partners in Guatemala illustrates the value of beginning with local knowledge and systems relationships rather than treating cul-

ture as a late-stage adaptation (Paniagua-Avila et al., 2026; Pieters et al., 2025).

Stage 4: Prepare and Support an Intercultural Workforce

Workforce preparation should be bidirectional. Clinicians and managers require training in local history, language access, cultural humility, anti-racism, Indigenous rights, community engagement, and the ethical protocol for collaboration. Traditional healers, peer supporters, teachers, and community health workers who choose defined service roles need training appropriate to those roles in psychological first aid, recognition of urgent risk, confidentiality, documentation, and referral. Training alone is insufficient: supervision, case consultation, fair compensation, protection from overload, and continuing dialogue are required. Competence should be assessed through observed practice and community feedback, not attendance certificates alone.

Stage 5: Launch Through a Demonstration Phase and Strengthen Referral Pathways

Implementation should begin at a scale that permits learning. A demonstration phase can test language access, consent procedures, waiting times, cultural safety, joint consultation, transportation, telehealth, medication continuity, and return referral to community supports. Each referral should have a named receiving person or service, a method for confirming arrival, and a feedback process authorized by the service user. Programs should track failed referrals and adverse events, because the existence of a directory does not constitute a functioning pathway. Early findings should be reviewed by the governance group and used to modify the model before expansion.

Stage 6: Evaluate Through Community-Defined and Clinical Outcomes

Evaluation should combine individual, relational, cultural, service, and structural indicators. Conventional outcomes may include symptom burden, functioning, safety, quality of life, service access, continuity, and satisfaction. Community-defined outcomes may include trust, mutual assistance, participation, cultural and language continuity, access to elders or healers, perceived collective efficacy, continuity of meaningful roles, territorial or ecological stewardship, and confidence in the future. Measures should be selected or developed with the community, translated and cognitively tested where necessary, and interpreted with Indigenous partners. Data access, secondary use, authorship, and dissemination should follow the governance agreement. Improvement is demonstrated not only when symptoms decline, but when the system strengthens the relationships and collective capacities it was designed to support.

Stage 7: Institutionalize, Finance, and Adapt

Sustainability requires formal mandates, recurring budgets, workforce positions, referral agreements, and accountability mechanisms across health, education, social protection, environment, emergency management, and Indigenous governance. Scale-up should preserve local authority; it should not standardize away the very differences that make the model legitimate. Periodic review should examine whether the program has shifted decision-making power, reduced barriers

ers, protected confidentiality and consent, supported cultural institutions, and produced equitable access to specialized care. The implementation cycle then returns to co-design, allowing the system to adapt to urbanization, climate hazards, demographic change, technology, and evolving community aspirations.

6. The Original Contribution of the Framework

The growing literature on intercultural mental health, Indigenous psychology, community psychology, and Mental Health and Psychosocial Support (MHPSS) has significantly advanced understanding of the relationship between culture and psychological well-being. Intercultural psychiatry has improved recognition of culturally specific expressions of distress and promoted culturally sensitive assessment and treatment. Community-based MHPSS has demonstrated the importance of strengthening families, social networks, and local institutions, particularly in humanitarian emergencies. Indigenous psychology has further emphasized that health and healing must be understood within culturally grounded systems of meaning rather than exclusively through Western psychological theories. Together, these fields have contributed to a more comprehensive understanding of mental health that extends beyond individual diagnosis and treatment.

Despite these advances, important conceptual limitations remain. Much of the existing literature focuses on adapting conventional mental health services to Indigenous populations rather than asking whether Indigenous philosophies themselves might redefine the goals and organization of mental health systems. Cultural adaptation often occurs after the basic assumptions of mental health care have already been established. As a result, Indigenous knowledge is frequently incorporated as an adjunct to existing services rather than serving as a foundation for designing systems of care. This distinction is particularly important because many Indigenous societies conceptualize health as a characteristic of relationships among people, communities, territories, spiritual traditions, and ecosystems rather than as an attribute of isolated individuals.

The framework proposed in this article differs from existing models in four important respects.

First, it redefines the primary objective of Mental Health and Psychosocial Support. Conventional systems generally evaluate success through reductions in psychiatric symptoms, improvements in psychological functioning, or increased resilience. While these outcomes remain important, they do not fully capture Indigenous understandings of well-being. The framework presented here proposes collective flourishing as the overarching objective of MHPSS. Collective flourishing encompasses emotional well-being but extends further to include cultural continuity, community cohesion, ecological sustainability, self-determination, social justice, and the preservation of Indigenous identities across generations. In this perspective, mental health becomes inseparable from the conditions that allow communities to sustain meaningful lives.

Second, the framework positions Indigenous philosophies of **Buen Vivir** as

conceptual foundations rather than cultural adaptations. Existing intercultural models commonly adapt Western approaches to Indigenous contexts by incorporating language interpretation, cultural consultation, or traditional healing into service delivery. Although these innovations have improved cultural responsiveness, they often leave the underlying assumptions of mental health systems unchanged. The present framework instead begins with Indigenous understandings of reciprocity, relationality, harmony, and collective responsibility, allowing these principles to shape the organization, implementation, and evaluation of Mental Health and Psychosocial Support. Biomedical knowledge and Indigenous knowledge are therefore understood as complementary rather than hierarchical systems.

Third, the framework integrates domains that are frequently treated separately within policy and practice. Mental health, cultural preservation, environmental stewardship, disaster risk reduction, Indigenous governance, education, and human rights are commonly managed by different institutions using different conceptual models. Indigenous communities, however, often experience these domains as inseparable aspects of everyday life. Environmental degradation affects cultural identity; language loss influences psychological well-being; governance influences social cohesion; and historical injustice continues to shape community trust. By integrating these dimensions into a single conceptual framework, the proposed strategy encourages coordinated action across multiple sectors while recognizing the interconnected nature of Indigenous well-being.

Finally, the framework expands the practical application of community-based MHPSS beyond humanitarian emergencies. Since the publication of the IASC Guidelines, community-based Mental Health and Psychosocial Support has become an essential component of disaster response, conflict recovery, and humanitarian programming. The present framework argues that these principles should also inform long-term Indigenous mental health systems. Community participation, local leadership, cultural continuity, traditional healing, ecological stewardship, and rights-based governance should not be viewed as emergency interventions alone but as permanent features of sustainable mental health systems. This perspective shifts MHPSS from a temporary humanitarian response toward an enduring model of community development and public health.

7. Applying the Framework through the IASC Model

The Inter-Agency Standing Committee (IASC) Guidelines provide an internationally recognized framework for organizing Mental Health and Psychosocial Support through four complementary layers of intervention. Although originally developed for humanitarian emergencies, the framework offers a useful structure for Indigenous mental health systems when interpreted through the philosophy of **Buen Vivir**.

At the foundation of the IASC model are **basic services and security**. Within Indigenous contexts, this layer extends beyond access to food, shelter, health care,

and physical safety to include protection of ancestral territories, culturally appropriate services, environmental security, and recognition of Indigenous rights. Community well-being depends not only on material resources but also on the preservation of relationships with land, language, and cultural institutions.

The second layer emphasizes **community and family supports**, an area in which Indigenous societies possess longstanding strengths. Extended families, traditional authorities, elders, ceremonial life, reciprocal social networks, and community organizations constitute essential sources of psychosocial protection. Strengthening these existing institutions often provides more sustainable benefits than creating parallel systems of care.

The third layer consists of **focused, non-specialized supports** delivered by trained personnel who are not mental health specialists. Within Indigenous communities, these interventions may be provided by teachers, community health workers, peer supporters, traditional healers, faith leaders where appropriate, and local organizations working collaboratively with professional mental health services. Training should emphasize cultural humility, Psychological First Aid, trauma-informed practice, community engagement, and referral pathways while respecting Indigenous knowledge systems.

The fourth layer includes **specialized mental health services** for individuals experiencing severe psychological distress or mental disorders. Psychologists, psychiatrists, psychiatric nurses, and other specialists remain indispensable components of Indigenous mental health systems. However, their work should be integrated within broader community structures and conducted in partnership with Indigenous authorities and traditional healing systems whenever appropriate. Specialized care thus becomes one component of a comprehensive intercultural system rather than the defining feature of mental health services.

Viewed through the philosophy of **Buen Vivir**, the IASC framework evolves from a hierarchy of services into a network of reciprocal relationships. Each layer reinforces the others, creating an integrated system in which specialized clinical care, community participation, cultural continuity, environmental stewardship, and social justice collectively support mental well-being. In this way, the framework proposed in this article builds upon existing MHPSS guidance while extending its application to the long-term development of Indigenous mental health systems throughout Latin America and the Caribbean.

8. Limitations

The framework presented in this article is intended as a conceptual model for strengthening Mental Health and Psychosocial Support (MHPSS) among Indigenous Peoples in Latin America and the Caribbean. Although it integrates evidence from Indigenous studies, humanitarian psychology, public health, intercultural psychiatry, community psychology, and international human rights, several limitations should be acknowledged.

First, the extraordinary diversity of Indigenous Peoples across Latin America

and the Caribbean necessarily limits the extent to which any single conceptual framework can represent the region as a whole. More than 800 Indigenous Peoples inhabit the region, speaking hundreds of languages and maintaining diverse governance systems, spiritual traditions, ecological relationships, healing practices, and historical experiences (Economic Commission for Latin America and the Caribbean [ECLAC], 2014). The framework proposed here should therefore be understood as a regional conceptual guide rather than a universal model. Effective implementation requires adaptation to the unique cultural, linguistic, historical, and ecological realities of each Indigenous community through meaningful participation and shared decision-making.

Second, the article employs **Buen Vivir** as an umbrella concept that encompasses several Indigenous philosophies, including *Sumak Kawsay*, *Suma Qamaña*, *Tekó Porã*, *Lekil Kuxlejal*, and related traditions. While these philosophies share important ethical principles—including reciprocity, relationality, collective responsibility, harmony with nature, and cultural continuity—they are neither identical nor interchangeable. Each emerges from a distinct historical and cultural context and should be interpreted within the worldview of the Indigenous People from which it originates. The use of **Buen Vivir** throughout this article is therefore intended to facilitate interdisciplinary dialogue rather than to suggest the existence of a single Indigenous philosophy applicable throughout Latin America and the Caribbean.

Third, this article is a conceptual synthesis rather than an empirical investigation or systematic review. Its purposive selection of scholarship, policy, and illustrative regional examples may omit relevant Indigenous-language, locally published, oral, or community-controlled knowledge that is not indexed in conventional databases. The synthesis should therefore not be interpreted as exhaustive, and the cited examples cannot establish regional representativeness or causal effectiveness. The proposed framework does not evaluate the effectiveness of specific interventions or present original field data. Consequently, many of the recommendations advanced here require further validation through participatory action research, implementation science, longitudinal evaluation, and community-based studies conducted in partnership with Indigenous Peoples. Such research should examine not only clinical outcomes but also culturally meaningful indicators of collective well-being, including language revitalization, cultural participation, community cohesion, ecological stewardship, trust in local institutions, and intergenerational knowledge transmission.

Finally, Indigenous societies are dynamic and continually adapting to changing social, political, environmental, and economic conditions. Migration, urbanization, climate change, technological transformation, demographic shifts, and evolving relationships with national institutions continue to reshape Indigenous communities throughout the region. Accordingly, culturally responsive MHPSS should remain flexible and adaptive rather than assuming static cultural identities or fixed models of community organization. The framework proposed

in this article should therefore be viewed as an evolving guide whose continued refinement depends upon sustained collaboration among Indigenous leaders, traditional healers, community organizations, researchers, governments, humanitarian agencies, and international organizations. Such partnerships are essential for ensuring that Indigenous mental health systems remain culturally grounded, scientifically informed, and responsive to the aspirations of the communities they serve.

9. Conclusion

Mental Health and Psychosocial Support has undergone a profound transformation during the past three decades, evolving from a predominantly clinical orientation toward ecological, community-based, and rights-based approaches that recognize the importance of culture, social relationships, and structural determinants of health. This evolution has significantly strengthened humanitarian practice and public mental health. Nevertheless, the experience of Indigenous Peoples in Latin America and the Caribbean demonstrates that further conceptual development is necessary if mental health systems are to respond effectively to the historical, cultural, ecological, and political realities that continue to shape Indigenous well-being.

This article has argued that Indigenous philosophies associated with **Buen Vivir** offer an important opportunity to advance the conceptual foundations of Mental Health and Psychosocial Support. Rather than treating Indigenous knowledge systems as cultural adaptations to existing mental health services, the proposed framework positions them as complementary sources of knowledge capable of informing the goals, organization, implementation, and evaluation of Indigenous mental health systems. In doing so, the framework extends contemporary MHPSS beyond the treatment of psychological distress toward the broader objective of collective flourishing, understood as the restoration and strengthening of relationships among individuals, families, communities, cultures, spiritual traditions, ancestral territories, and the natural environment.

A central contribution of this article is the integration of Indigenous philosophies, community-based MHPSS, intercultural psychiatry, historical trauma theory, humanitarian psychology, and international human rights into a single conceptual framework. Rather than presenting these fields as separate domains, the article demonstrates their complementarity and argues that effective Indigenous mental health systems require coordinated action across health, education, environmental protection, social development, humanitarian assistance, and Indigenous governance. Such integration reflects both the interconnected nature of Indigenous well-being and the growing international recognition that mental health cannot be separated from the broader social, cultural, and ecological conditions in which people live.

The framework also contributes to the ongoing decolonization of global mental health. It challenges approaches that position Indigenous Peoples primarily as re-

cipients of culturally adapted services and instead recognizes Indigenous communities as producers of knowledge, partners in research, and leaders in the design and governance of mental health systems. This shift from cultural adaptation to epistemological partnership represents an important step toward more equitable, culturally grounded, and sustainable models of care.

The implications of this framework extend beyond Latin America and the Caribbean. As countries increasingly seek to develop community-based and culturally responsive mental health systems, the principles of reciprocity, collective responsibility, ecological stewardship, cultural continuity, and self-determination embodied in Indigenous philosophies offer valuable insights for strengthening mental health policy and practice more broadly. Although developed within the context of Indigenous Peoples in Latin America and the Caribbean, many of these principles are relevant to other culturally diverse settings where communities seek to balance scientific knowledge with local traditions, strengthen community resilience, and promote social justice.

Ultimately, the future of Indigenous Mental Health and Psychosocial Support depends not only upon expanding access to clinical services but also upon strengthening the cultural, social, environmental, and political conditions that enable Indigenous Peoples to thrive. Community leadership, traditional knowledge, intercultural collaboration, protection of ancestral territories, and respect for collective rights should be recognized as essential components of sustainable mental health systems rather than peripheral considerations. By integrating these principles within contemporary MHPSS, governments, humanitarian organizations, universities, and Indigenous institutions can contribute to mental health systems that are not only clinically effective but also culturally legitimate, socially just, and capable of supporting the collective flourishing of Indigenous Peoples throughout Latin America and the Caribbean.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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