COLVILLE TRIBAL MEMBERS' VIEWS OF MENTAL HEALTH

AND WELLNESS: A QUALITATIVE INVESTIGATION

By

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the dissertation of MARCELLA RAYANN PALMER find it satisfactory and recommended that it be accepted.

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I must begin by acknowledging the role my family, especially my parents, had played in my life and academic endeavors. Unknowingly, my parents instilled the drive to succeed as an individual, which is much more than accomplishing materialistic gains and receiving recognition. My definition of success means that I have the ability to give, live, love, and learn from others. I want to thank my father, who always said, "I'll give until it hurts, but it hurts to give." As a child, I thought the phrase meant that an individual chose not to give to others due to selfish beliefs. Now that I have matured, lived a portion of my life, and had a beautiful child, I view that statement in a new light. That statement now describes who I am as a person. I give all of who I am to others, which may leave me vulnerable to being hurt emotional or physically. However, given my nature I continue to give to others out of respect for the unconditional love I had received in life.

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COLVILLE TRIBAL MEMBERS' VIEWS OF MENTAL HEALTH

AND WELLNESS: A QUALITATIVE INVESTIGATION

ABSTRACT

By Marcella Rayann Palmer, Ph.D.
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The national trends in minority utilization of mental health services (i.e.,

counseling/psychotherapy) indicate that members of racial/ethnic minority groups including

American Indians tend to underutilize and prematurely terminate from available services relative

to the majority population (Chapleski, Gelfand, & Pugh, 1997; Choney, Berryhill-Paapke, &

Robbins, 1995; LaFromboise, Trimble, & Mohatt, 1990; Price & McNeill, 1992; Sue & Sue,

1999). However, researchers have provided a variety of explanations from a quantitative

approach for underutilization, including that "culture matters" in reference to one's

conceptualization of mental health or wellness, help-seeking behavior, coping styles, and

identifying support systems (Choney, Berryhill-Paapke, & Robbins, 1995; Garrett, 1999; Garrett

& Garrett, 1994; LaFromboise, 1988; U.S. Department of Health and Human Services, 2001;

Voss, Douville, Little Soldier, & White Hat 1999).

This study was a qualitative field study focusing on Colville tribal members' views of

mental health and wellness. There were three objectives to the study: describe in a

phenomenological sense how Colville tribal member's conceptualize mental health and wellness

in a culturally relevant manner, examine factors that contribute to help-seeking responses and

identify sources considered for assistance when an individual demonstrates help-seeking

behavior, and explore the types of community activities that the Colville tribal members identify that may promote mental health and wellness.

Volunteers (N=20) who are 18 years of age or older and enrolled Colville tribal members participated in a 45-minute interview in order to convey culture-based perceptions. This study included four groups of five tribal members according to chronological age (18-25, 26-40, 41-60, & 61 and older) in order to gather generational information about views and perceptions of mental health and wellness. Grounded theory was utilized to analyze the data.

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DEDICATION

This dissertation is dedicated to my mother and father who provided both emotional and financial support during my lifetime. I also dedicated this manuscript to my beloved husband and beautiful daughter as an inspiration for personal growth and encouragement for higher education. Life events can affect ones' sense of self and it is during those moments that emotional support is of utmost importance. Therefore, this dissertation is dedicated to a wonderful man, Rob Nelson, who provided encouragement, guidance, and reassurance at a pivotal point in my life.

CHAPTER ONE

Introduction

Introduction to the Study

The national trends in minority utilization of mental health services (i.e.,

counseling/psychotherapy), indicate that members of racial/ethnic minority groups including

American Indians tend to underutilize and prematurely terminate from available services relative

to the majority population (Chapleski, Gelfand, & Pugh, 1997; Choney, Berryhill-Paapke, &

Robbins, 1995; LaFromboise, Trimble, & Mohatt, 1990; Price & McNeill, 1992; Sue & Sue,

1999). In fact, Sue and Sue (1999) found that minority clients tend to terminate counseling at a

rate of more than 50% after only one contact with the therapist.

A variety of explanations have been provided to clarify the underutilization of mental

health services, which include issues such as the lack of awareness of availability; fear and

mistrust; power differentials within the counseling relationship; lack of culturally relevant

treatment programs; language differences, differing worldviews, beliefs, and values; and

reaching out to family, friends, elders, or spiritual healers versus participating in psychotherapy.

Therefore, researchers within the multicultural counseling field have suggested that

psychologists should move away from conventional counseling doctrine and move toward

incorporating culturally sensitive mental health approaches that maintain cultural values in order

to meet the needs of ethnic and racial minority populations (Atkinson, Thompson, & Grant,

1993; LaFromboise, Trimble, & Mohatt, 1990). For example, oftentimes American Indians view

the tribe and extended family as a necessity and important entity of self-identification versus the

Western concept of individuation. Therefore, the importance of the extended family would

influence counseling interventions and therapeutic progress.

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Culture-based perceptions and their effects is an area that remains poorly understood. In fact, a greater understanding is needed given that minority populations must either accept or reject interpretations of their emotional or psychological problems and the interventions implemented by practitioners within the mental health system (Cheung & Showden, 1990). Oftentimes, minority individuals have experiences that are incongruent with the conceptualization of psychological problems that are driven by Western psychological notions of mental health. Therefore, it would be beneficial to investigate patterns of help-seeking behavior in minority populations in order to identify and gain insight as to the paths that they take in order to reach the point of participating in mental health services. In addition, broadening our understanding of help-seeking behaviors can lead to incorporating culturally appropriate conceptualizations and interventions.

Researchers have indicated that "culture matters" in reference to influencing one's conceptualization of mental health or wellness, help-seeking behavior, utilization of services, various coping styles they embrace, and identifying their social support systems (Choney, Berryhill-Paapke, & Robbins, 1995; Garrett, 1999; Garrett & Garrett, 1994; LaFromboise, 1988; U.S. Department of Health and Human Services, 2001; Voss, Douville, Little Soldier, & White Hat, 1999).   For example, traditional healing practices and spirituality are components of an American Indian lifestyle that may influence conceptualization and help-seeking behavior. American Indians view mental health as being holistic and spiritual, which indicates that one must be in harmony and balance in order to have wellness.

A study conducted with American Indian high school students found that trustworthiness was an important factor in the therapeutic relationship (LaFromboise & Dixon, 1981). Additionally, the results indicated that ethnicity of the counselor may not be as important as

utilizing culturally appropriate communication and trustworthy interactions. More recent work by Price and McNeill (1992) documented that American Indian college students strongly committed to their tribal culture illustrated less favorable attitudes toward seeking counseling than the group of individuals who were weakly committed to the Anglo culture or to both cultures. Therefore, it is important that practitioners are culturally sensitive to minority populations in regards to embracing differing cultural views and beliefs in order to strengthen the therapeutic relationship and encourage minority populations to utilize services.

Culture influences the *meanings* that people convey to their illness and/or emotional distress (U.S. Department of Health and Human Services, 2001). These various meanings can compromise the ability of assessment tools that indicate symptomology of mental illness. For example, Indian people often do not consider themselves to be experiencing emotional distress such as anxiety or depression, even under conditions that generally precipitate these reactions in others (Swinomish Tribal Mental Health Project, 1991). In addition, not all languages have relevant definitions for mental health illnesses, such as descriptions of being depressed or anxious (U.S. Department of Health and Human Services, 2001). Manson, Walker, and Kivlahan (1987) indicated that American Indian people view relationships and the world around them differently than do members of the majority culture. For example, American Indian populations may experience and express psychological distress in ways that are unfamiliar to most mental health providers, such as "experiencing bad medicine" (i.e., family curse). Therefore, this differing worldview needs to be reflected in the process used to diagnose and the evaluation process involved in standardized diagnostic instruments in order to draw a more accurate conclusion of the person's mental status.

Past research has focused on the development of mental health services and the unique way of viewing mental health and wellness, typically using quantitative methods and analog studies. Most of the quantitative methods were comprised of individual variables (e.g., attitudes toward help-seeking behavior, level of acculturation/ethnic identity, beliefs, values, possible interventions, and utilization of traditional healers). Such research has identified factors such as acculturation level and the bicultural struggles of American Indians as important variables in regards to utilization of services or counselor preferences (Choney, Berryhill-Paapke, & Robbins, 1995; LaFromboise, Trimble, & Mohatt 1990; Price & McNeill, 1992; Thomason, 1991). However, this research has typically incorporated analog studies that used non-representative samples and focused primarily on attitudes and perceptions of the counseling relationship.

Other quantitative studies incorporated small community-based populations that focused on psychological diagnosis such as depression, anxiety, adjustment reactions, and psychoses (LaFromboise, Trimble, & Mohatt, 1990; Manson, Walker, & Kivlahan, 1987; Trimble, Padilla, & Bell, 1987). Most of the research on American Indian populations indicated that drugs and alcohol abuse are often associated with psychological disorders (Manson, Walker, & Kivlahan, 1987; Trimble, Padilla, & Bell, 1987). Another issue is that symptoms used in the research are based on traditional Western classification of mental health instead of utilizing the worldview of American Indians. Given the discrepancies in worldviews, the Western taxonomies may not incorporate differing worldviews appropriately which leads to misdiagnoses and inappropriate interventions.

One qualitative study evaluated the traditional philosophies of helping and healing the Lakota people. Voss, Douville, Little Soldier, and White Hat (1999) found that the traditional

values and beliefs greatly influenced help-seeking behavior and participation in services. The researchers noted that cultural differences could create a tension between expectations of practitioners and traditional practices. The researchers were evaluating this study from the viewpoint of social work intervention and services rather than from the clinical practitioner's view. However, the findings indicated that culture does matter in conceptualization and culturally appropriate interventions.

It is clear from the research conducted to date, that American Indians represent a population that underutilizes mental health services and maintain differing worldviews from the majority culture. Much of the past research surrounding American Indians has focused on values, beliefs, and worldviews from a quantitative design, which does not lend itself to gathering rich descriptive data in regards to one's perceptions. Therefore, the research surrounding American Indians' views of mental health and wellness from a naturalistic perspective is limited to non-existent. The absence of such literature in this area supports the need for this present study. Given this void, this study explores Colville tribal members' views of mental health and wellness.

Purpose and Implications

In response to the research problem, the primary purpose of this study was four-fold. First, the study was designed to examine in detail Colville tribal members' views of mental health and wellness. Second, the study investigated what factors contribute to help-seeking responses. Third, the study identified resources that were considered when an individual determined they needed assistance. The fourth purpose of this study was to examine the types of community activities that the Colville tribal members identified that would promote mental health and wellness.

To examine this phenomenon, the study utilized an in-depth qualitative interview in order to obtain a rich description of culturally relevant conceptualizations of mental health and wellness from Colville tribal members. There are numerous reasons why this topic warranted research. Foremost, there had not been any prior research on this particular area, which focused on obtaining operational definitions from persons within a given minority population. Utilizing a qualitative approach allowed the *participants* to define the relevant constructs and parameters of mental health and wellness. Mental health practitioners can utilize information gathered from this study in order to provide better services for Colville tribal members. Furthermore, gaining a better understanding of this populations' views will allow mental health practitioners the opportunity to incorporate culturally sensitive approaches while offering services to the minority community. Last, this study will enable mental health practitioners to better understand and utilize culturally relevant conceptualizations while working with the identified population in order to provide more culturally appropriate interventions that may increase utilization of mental health services.

Operational Definitions

American Indian

The term "American Indian" refers to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment (United States Census 2000).

The term American "Indian" means any person who is a member, or a one-forth degree or more blood quantum descendent of a member of any Indian tribe (Interior of Bureau of Indian Affairs, 1994, #25 CFR, p.51).

Colville Tribal Member

A tribal member is defined as all persons that possess at least one-fourth degree of the blood of the tribes and bands, which constitute the Tribes (Title 8 Enrollment, Referendums And Elections, Chapter 8-1 Membership, 1988).

<div align="center">Organization of the Remainder of the Study</div>

The report of this study is divided into five chapters. Chapter One, *Introduction to the Study*, presented an overview of the study. Chapter Two, *Review of Related Literature*, reviews relevant literature of the five components, *cultural barriers, acculturation, beliefs, values*, and *worldviews*, discusses the effects these components have on culturally relevant conceptualizations and underutilization of services and expresses the rationale for using qualitative methodology in the study. Chapter Three, *Research Methodology*, describes the research design and procedures employed for data collection and analysis in detail. Chapter Four, *Findings*, describes the participants' responses of mental health and wellness, circumstances that may negatively affect their wellness, methods they use to feel better including how those methods assist them, and what type of activities or resources within the community that could promote wellness. Chapter Five, *Discussion*, discusses major findings from the study and provides recommendations for future research.

CHAPTER TWO

Review of Related Literature

Introduction

The purpose of this chapter is two-fold. First, this chapter discusses the differing values, belief and worldviews of American Indians. Second, this chapter reviews the relevant literature of components such as possible explanations of underutilization and premature termination of mental health services by American Indians. Additionally, the later part of the chapter focuses on the review of the literature that identifies cultural barriers and acculturation issues, which influence help-seeking behavior and alternative resources that may promote wellness. Furthermore, this chapter explores the effects these components have on culturally relevant conceptualizations and underutilization of services.

Differing Values, Beliefs, and Worldviews

American Indians have differing values, beliefs, and worldviews than those held by the "majority" culture. However, it is important to recognize within group difference also. For example, it has been noted that each tribe also has its own language, religious beliefs, traditions, and way of life (Broken Nose, 1992). Therefore, one would make a huge mistake to assume that all Indian nations are the same and that interventions for one tribe would work perfectly for another tribe. Given these identified within group differences, gaining tribal specific knowledge when working with a given population would be of great benefit to any practitioner.

Researchers within the field of multicultural counseling have continued to gather important information about various minority groups, including American Indians. In fact, LaFromboise (1988) stated that American Indians who participate in psychotherapy often express concern about how conventional Western psychology superimposes biases onto

American Indian issues, which shapes the clients behavior in a direction that conflicts with Indian cultural life-style orientation and preferences. A primary difference between Western and American Indian perceptions of psychology focuses on the unique values within the two cultures. For example, Western values was based on saving, domination, competition and aggression, doing, individualism and the nuclear family, mastery over nature, future-time focused, scientific explanations, and winning means everything (Garrett, 1999). In contrast, the American Indian view of values incorporates placing importance on community contribution, sharing, cooperation, noninterference, being, community and extended family, harmony with nature, a time orientation toward living in the present, preference for explanation of natural phenomena according to the spiritual, and a deep respect for elders (Garrett, 1999). However, like any other cultural or ethnic group, there are both between-group differences and within-group differences among American Indian communities. Therefore, it is important to respect and gain knowledge about each individual community's values, beliefs, and traditional practices in order to provide appropriate services.

One of the most recent studies of American Indian value orientation (DuBray, 1985), used the Kluckhohn Value Schedule to examine the value orientation differences between 36 American Indian female social workers (who represented 28 different tribes) and 36 White American female social workers (as cited in Garrett, 1999). The findings indicated a significant overall difference between the American Indian and White American participants, where the American Indian preference for (a) being, (b) collateral relations, (c) present time, and (d) harmony with nature, contrasted with the White American preference for an orientation toward (a) being, (b) individualistic relations, (c) future time orientation, and (d) mastery over nature. However, DuBray (1985) attributed socialization into the social work profession as an

explanation for the reversal in the White American participants' preference for being orientation versus the doing orientation, given the professional training that incorporates a spontaneous expression of the self (Garrett, 1999). Generally, the results supported Kluckhohn and Strodtbeck's (1961) original findings for the traditional value orientation of the American Indian population.

Researchers advocate for professionals to gain cultural knowledge of differing worldviews in order to provide culturally relevant services (Atkinson, Thompson & Grant, 1993; Cheung & Showden, 1990; LaFromboise, Trimble, & Mohatt, 1990). One aspect is that American Indians not only have differing worldviews, but there are within-group differences that should be accounted for. It appears that differing values and beliefs may lead to interpersonal conflict in regards to struggling between two cultures, which can lead to an increase in emotional distress.

Explanation of Underutilization of Mental Health Services

American Indian communities continue to be challenged by many significant health problems, including psychological distress, but fail to utilize available services. Various explanations have been provided to explain the underutilization and premature termination of mental health services amongst the American Indian population. Dana (2000) suggests that Western taxonomies utilized for diagnosis and interventions have led to erroneous descriptions or pervasive pathology and underutilization of services among minority populations.

According to LaFromboise, Trimble, and Mohatt (1990), underutilization of mental health services by American Indians is associated with tension surrounding power differentials in counseling relationships and conflicting goals between the counselor and client which may be influenced by the level of acculturation. The authors have identified three types of psychological

interventions (social learning, behavioral and network therapy) as treatment modalities that may assist in overcoming utilization barriers. Social learning theory incorporates social skills training which is less culturally biased than other types of interventions. According to LaFromboise, Trimble, and Mohatt (1990), one positive aspect of social skills training is that the community is empowered to define the community-level target problems (i.e., substance abuse) to be solved and the type of behaviors appropriate for each situation (i.e., culturally appropriate assertiveness). Given that this method relies heavily on modeling and rehearsing activities, it is compatible with the American Indian culture in that role modeling is a major source of learning.

Behavioral therapy is another form of psychological intervention that is action-oriented and focuses on the present rather than on the past. The focus is consistent with American Indian worldviews and the interventions tend to lend themselves to paraprofessional implementation (LaFromboise, Trimble, & Mohatt, 1990). Network therapy lends itself to the American Indian worldview in that this approach utilizes the clan, group, or family members as a social force to assist in overcoming psychological issues. The role of the counselor is that of a "catalyst" where the social supports system is the entity that works with the crisis in order to help the person out of isolation (LaFromboise, Trimble, & Mohatt, 1990).

One issue that affects underutilization statistics is the lack of availability of services within an American Indian community. Access to health and mental health facilities is limited and in many cases may be unavailable to American Indian populations (Runion & Gregory, 1984). Even though progress has been made in regards to federally funded Indian Health Service programs, many American Indian communities have limited access to local and state programs, and local hospitals that participate in contracting with Indian Health Services. However, when a tribe lacks a treaty relationship to the federal government, no federal program services can be

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implemented. Therefore, the tribal community can only obtain state and local agency services, which many of the tribal members are often unaware of available state-level services as are the general population (Runion & Gregory, 1984).

Runion and Gregory (1984) found through field experience that the Louisiana mental health service personnel were unaware of the American Indian communities within their service areas and the state plan made no reference to this special population. For example, the authors stated that community services were totally unavailable to Native Americans. Additionally, the Louisiana mental health service personnel had no informational outreach capacity and services that were provided to the American Indian communities were scarce, if present at all. Given the lack of awareness of available services, the authors concluded that there was a need for a cultural brokerage system between American Indian communities and available mental health services. In addition, the authors supported the idea that program development should involve tribal community representatives who would be able to continue the educational process once the financial support of the grant was removed. Runion and Gregory (1984) indicated that through their observations and ongoing tribal dialogues they gained tribal cooperation and completed minimal training of tribal members to provide mental health services within the tribal community, which was considered a success.

Another issue that effects utilization is the lack of American Indian psychologists. In conjunction with the American Psychological Association (APA), Stapp, Tucker and VanderBos (1985) conducted an examination of psychological personnel and found that there were only 180 American Indians that held masters or doctoral degrees in psychology. Given this figure, there would be only one American Indian psychologist for every 8,333 Indian people, which compares

most unfavorably to the current availability rate of one psychologist for every 2,213 people in the general population (LaFromboise, 1988).

These statistics indicate that American Indians are underrepresented in the fields of applied psychology, a finding that remains a serious concern since the American Indian population experience high rates of mental health disorders associated with social stress. For example, according to the Indian Health Service Report (1997), American Indians were five times more likely to die of alcohol-related causes than are whites (as cited in U.S. Department of Health and human Services, 2001). Given the fact that there is a lack of American Indian psychologists, American Indians may be forced to see non-Indian psychologists and may develop negative attitudes toward non-Indian psychologists who are presumably insensitive to the cultural complexities of American Indian problems. Therefore, knowledge of and respect for an Indian worldview and value system are fundamental in creating a therapeutic relationship and assist in defining the counseling style or approach most appropriate for the client (LaFromboise, Trimble, & Mohatt, 1990).

According to Thomason (1991), the potential mismatch between the expectations of American Indian clients and non-American Indian counselors may explain the high premature termination rate among American Indian populations. Therefore, it has been suggested that the counselor must strive to make the first interview or contact with an American Indian client therapeutic rather than using the time for information gathering or making a clear diagnosis of the client's problem (Heinrich, Corbine, and Thomas, 1990). In fact, Heinrich, Corbine, and Thomas (1990) stated that American Indians resent the situation demand of self-disclosure and deem the counselor's probing as intrusive and inappropriate. In addition, orientating the client to accurate counseling expectations and instilling hope would be beneficial during the initial

session in order to get the client to return for a second session. Utilizing culturally relevant conceptualizations and interventions will assist American Indian and non-Indian psychologist in the therapeutic process while working with the American Indian population.

The literature concerned with utilization factors suggests that American Indians underutilize mental health services, which may be due to incorporating Western taxonomies, lack of American Indian psychologists, the need to educate American Indian clients to the therapeutic process, and promoting mental health services within the American Indian communities. Additionally, the evidence supports the notion that American Indian communities continue to be unaware of available services within the community, which compounds the issues related to underutilization of much needed mental health services.

Not only is there a need for a cultural brokerage between the American Indian communities and mental health providers, but there is also a need for a greater cultural understanding and awareness as to the unique issues that the American Indian communities face on a daily basis. It appears that educating the American Indian communities about the therapeutic process and expectations would decrease the likelihood of premature termination on the part of clients. Another way to encourage American Indians to participate in services is by gaining the support and involvement of tribal community representatives who would be able to implement and support culturally relevant interventions and educational materials. It is important that American Indians receive mental health services, given the high rate of emotional distress among the communities, therefore professionals should move away from the typical counseling doctrine and incorporate cultural sensitivity in order to meet the needs of a given population.

Cultural Barriers

Cultural barriers and lack of understanding have contributed to the limited mental health services for American Indians, given that the mental health delivery system focuses predominantly on the Western traditions (Runion & Gregory, 1984). According to Dana (2000), mental health providers continue to erode minority cultures by implementing mainstream diagnostic categories and interventions that are inconsistent with minority communities. It seems that utilization of the diagnostic categories was based on the mistaken assumption that mental health services had a universal application, instead of being aware that cultural differences may influence symptomology and behavioral expression. Another cultural factor, such as acculturation level, also appears to affect treatment effectiveness. Acculturation refers to the extent to which an individual has adopted the beliefs, values, customs, and institutions of the dominant culture (Atkinson, Thompson, & Grant, 1993).

Culture effects beliefs, values, expectations, social interactions, and help-seeking behavior in various ways. For example, Cheung and Snowden (1990) indicated that mental health is a culturally embedded notion due to the fact that diagnosis and treatment modalities rely significantly on language. Given cultural differences, it would not be uncommon for an individual to have imbedded beliefs about the nature of mental health problems and possible alternative solutions to overcoming the distress in comparison with mental health providers who may lack cultural understanding and knowledge. Additionally, Cheung and Snowden (1990) reviewed empirical literature of national trends in minority utilization of mental health services and concluded that patterns of social interactions was affected by culture in that minority members may turn to family, friends, co-workers, community leaders, or tribal chiefs for guidance, interpretation, and possible solutions rather than a mental health provider. However,

the authors stated that the nature and extent of the use of folk healers is a matter of controversy within the literature. For example, some research has described a decrease in seeking out traditional healers, while other research has indicated that traditional healers have adjusted their role within the community in order to meet the needs of community members and encourage utilization of traditional healers (Cheung & Snowden, 1990).

Given the historical events of deceit by past governmental policies regarding the American Indian population, many American Indians tend to mistrust government services or care provided by white practitioners (U.S. Department of Health and Human Services, 2001). The fear and mistrust among minority populations greatly influences help-seeking behavior and utilization rates, including the possibility of premature termination. In fact, many clients have various expectations of the counseling process and preconceived notions as to quality of care, which may influence a mistrusting attitude toward practitioners. According to Cheung and Snowden (1990), some minority communities avoid utilizing mental health programs because of the low quality of care that is provided, possibly due to organizational structure and operating procedures. Additionally, many ethnic minorities have financial constraints that inhibit their ability to utilize available services, provided that there are available services within the area or even contemplate seeking assistance for their psychological problem.

LaFromboise and Dixon (1981) examined perceptions of trustworthiness by conducting an analogue study with 48 American Indian high school students. The students rated the effectiveness of two counselors (one American Indian and one non-Indian) in two-role played counseling segments. The trustworthy role plays portrayed a counselor who was attentive and responsive to the client, provided structure and direction to the session, and displayed respect for the cultural identity of the client. The non-trustworthy role play illustrated behavior of

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inattentiveness and cultural insensitivity, limited eye contact, slouching, and fidgeting. LaFromboise and Dixon found that the perceived trustworthiness of the counselor was far more important than ethnic similarity between the client and the counselor.

Oftentimes, cultural factors can influence whether or not American Indians believe that their needs are met by Western medicine. Dana (2000) stated that historically, mental health services have failed to exhibit sincere concern for multicultural populations. For example, Western medicine fails to incorporate diverse beliefs and values other than those of the dominant culture. Therefore, minorities are expected to adapt to the Western philosophies in order to receive necessary services. Coulehan (1980) presented three case reports from his experiences as a medical practitioner among the residents of a Navajo reservation in Arizona. He indicated that integration of traditional healing practices into Western medicine resulted in a more efficacious treatment of the American Indian patients. Coulehan (1980) stated that traditional ceremonies met the unique needs of the American Indian population in order to obtain wellness, which seem to be unattended to by Western medical practices. Therefore, he suggests that American Indians may benefit better from the incorporation of traditional healers and medical practitioners.

Marbella, Harris, Diehr, Ignace, and Ignace (1998) conducted a study that included semi-structured interviews to examine the prevalence, utilization patterns, and practice implications of the use of American Indian healers in conjunction with the use of physicians. One hundred-fifty participants from an urban Indian Health Service clinic in Milwaukee, Wisconsin completed surveys and a semi-structured interview, in order to measure the number of patients seeing healers, types of ceremonies used for healing, reasons for seeing healers, and whether patients informed physicians of their use of healers. The authors found that most patients reported seeing a healer for spiritual reasons and visited herbalists, spiritual healers, medicine men, and

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participated in sweat lodge ceremonies the most often. However, many of the patients indicated that they had an interest in obtaining care from both a physician and alternative healers. It seems that expanding the therapeutic realm to include traditional ceremonies would be beneficial to American Indians in order to meet their unique needs.

American Indians develop a cultural bond with their homelands through ceremonies, beliefs, and traditions. Therefore, American Indians may face emotional distress when they leave their homeland to pursue educational and professional endeavors (Griffin-Pierce, 1997). However, given that many American Indians strive to maintain harmony in their life, being relocated off the reservation may instill feelings of loneliness, hopeless, despair, culture shock, and homesickness. It would not be unusual for one to experience increased emotional reactivity, which may manifest itself into symptomology of anxiety. One aspect that Griffin-Pierce (1997) indicated was the fact that it is not uncommon for American Indian students to want to return to their homelands for traditional ceremonies in order to regain harmony. Therefore, it is important to recognize the unique need of traditional American Indian people who find themselves wanting to return to their homelands in order to regain the state of wellness, which differs greatly from the dominate culture.

Another aspect of cultural barriers includes non-verbal behavior based on traditional upbringing. Non-verbal behavior can greatly affect the therapeutic relationship between an American Indian client and non-Indian counselor. For example, anecdotally it has been noted that non-Indian counselors avoid intense direct eye-contact, due to the fact that it could be construed as being disrespectful (Sue & Sue, 1999; Thomason, 1991). Based on personal observations, Garrett and Garrett (1994) suggested that American Indian people learn through patience and observations, hence may not be as verbal as non-Indian clients. Oftentimes,

American Indian clients speak softly and use time to reflect prior to responding as a communication style. Unfortunately, the American Indian communication style may be labeled as slow, passive, withdrawn, uncooperative, or unassertive by members of the mainstream society (Garrett & Garrett, 1994). Silence is a sign of respect within the American Indian culture. In fact, theoretically there is no word for "excuse me" in the Lakota language because there is no polite way to interrupt a conversation (Broken Nose, 1992). Instead, one is expected to wait for the other person to finish speaking. Therefore, this type of communication interaction may be described as being passive by the dominant culture, when in actuality it is a way of showing respect for another.

The literature exploring cultural barriers provides theoretical and anecdotal ideas that are based on observations of practitioners and empirical investigators that may explain how various cultural barriers effect utilization of services due to cultural uniqueness of a given population. For example, American Indians tend to be fearful and mistrustful of governmental services due to a horrific historical past that involved great deception and misrepresentation. This type of deception was compounded by the fact that American Indians received inadequate medical and mental health care. American Indians not only have to overcome barriers such as mistrust and fear, they are also faced with differing terminology, beliefs, and social interaction patterns than the dominant culture. One important aspect is that American Indians tend to incorporate traditional healing practices along with Western medicine in order to achieve wellness. Therefore, it appears that professionals should acknowledge cultural differences in order to incorporate culturally relevant interventions that may decrease emotional distress amongst the American Indian communities.

Influences of Acculturation Level

Historically, American Indians have been displaced off their own land and characterized as "aliens" for the past 100 years (LaFromboise, 1988). For example, once the European settlers *discovered* and *colonized* North America, the American Indian communities have been greatly influenced by European settlers and policies of the U.S. Government in regards to adopting the majority cultural values and beliefs (U.S. Department of Health and Human Services, 2001). In fact, Choney, Berryhill-Paapke, and Robbins (1995) identified acculturation as the degree to which an individual accepts and adheres to both majority and tribal cultural values. Unfortunately, many American Indians were forced to acculturate to urban living, which may increase the individuals' vulnerability for developing psychological problems due to heightened stress related to adaptation to the dominant culture. For example, Garrett and Garrett (1994) stated that many American Indians experience conflict when they try to internalize unfamiliar values of the dominant culture or when they attempt to practice traditional roles necessary for the preservation of their self-concept.

Garrett (1999) identified that among the earliest studies of American Indian communities, a cooperative venture took place in 1941 between the University of Chicago and the United States Office of Indian Affairs to evaluate the development of American Indian children under the impact of mainstream American society. The researchers provided detail findings of traditional values and culture among the Hopi, Sioux, Papago, Zuni, and Navajo Nations. Among the findings was a statement made by DuBray (1983, p. 25) that "a program of administration which was oriented primarily to assimilate the Indians into the general American population was highly detrimental to the welfare of Indian communities and Indian personality" (as cited in Garrett, 1999, p. 88).

Many American Indians reside off-reservation and within the dominant culture in order to look for stable employment. This transition may be a very difficult task, especially for young people moving to high-density urban areas (Heinrich, Corbine, & Thomas, 1990). Feelings of loneliness, insecurity, and alienation would not be uncommon for those who relocated off the reservation. However, it is important to recognize that there are cultural differences in how American Indians may express or report their emotional distress, which may be perceived as a psychological problem rather than a transitional adjustment stage. Cheung and Snowden (1990) stated that given the lack of attention in symptom expression and biased diagnosis of American Indians, there is the potential for diagnostic error within the American Indian population; overdiagnosis in some categories and underdiagnosis in other categories based on cultural characteristics. However, the authors failed to provide specific examples that may have grave consequences for the delivery of appropriate services to this specified population.

Trimble, et al. (as cited in Pedersen et al., 1984) indicated that American Indian beliefs about etiology of psychiatric disorders, personal control, the ability to change life events, perceptions of stress-inducing situations, and social expectations about help-seeking and help-providing behavior often differs from the majority culture. These differences are essential in making treatment decisions, identifying appropriate interventions, format for delivery of services, roles of participants, and therapeutic objectives (Manson, Walker, & Kivlahan, 1987).

Spindler and Spindler (1958) conducted a classic study among the Menomini of Wisconsin population and identified five categories of "Indianness," using the degree of acculturation as a reference (as cited in LaFromboise, Trimble, & Mohatt, 1990). The five categories included Native-oriented, peyote cult, transitional, lower status, acculturated, and the elite acculturate. Later in 1982, Loye and Robert Ryan modified the Spindler categories as follows:

1. *Traditional* – These individuals generally speak and think in their native language and know little English. They observe "old-time" traditions and values.

2. *Transitional* – These individuals generally speak both English and the Native language in the home. They question basic traditionalism and religion, yet cannot fully accept dominant culture and values.

3. *Marginal* – These people may be defensively Indian, but are unable either to live the cultural heritage of their tribal group or to identify with the dominant society. This group tends to have the most difficulty in coping with social problems due to their ethnicity.

4. *Assimilate* – Within this group are the people who, for the most part, have been accepted by the dominant society. They generally have embraced dominant culture and values.

5. *Bicultural* – (referred to in Ryan and Ryan, 1982) as transcendental) – Within this group are those who are, for the most part, accepted by the dominant society. Yet they also know and accept their tribal traditions and culture. They can thus move in either direction, from traditional society to dominant society, with ease. [(p.6-7) as cited in LaFromboise, Trimble, & Mohatt, 1990].

In 1990, Sue and Sue developed another model of acculturation, the Racial/Cultural Identity Development Model (R/CID). The R/CID model provided a conceptual framework to aid therapists in understanding the attitudes and behaviors of clients who were culturally different (Sue & Sue, 1999). The model defines five stages of development, which include conformity, dissonance, resistance and immergence, introspection, and integrative awareness. Additionally, at each level of identity there are four corresponding beliefs and attitudes that correspond to the person's identity and are manifest in how they view (a) the self, (b) others of

the same minority, (c) others of another minority, and (d) majority individuals (Sue & Sue, 1999).

The models of acculturation have encouraged researchers to document the role of acculturation and the effects upon the counseling process and treatment outcomes (Atkinson, Thompson, & Grant, 1993). For example, LaFromboise (1988) noted that through personal communication with university personnel, she found that there are an increasing number of American Indian university students who are seeking psychological services during their academic career, especially if there are American Indian psychologists available. Typically the university environment promotes formal methods of seeking help. However, many of the university students who resided in their home environment indicated that they would seek help from family members before seeking mental health services elsewhere (LaFromboise, 1988).

Price and McNeill (1992) conducted another study that focused on the relationship of American Indian college students' cultural commitment and pre-counseling attitudes. The 80 American Indian students who participated in the study represented 46 tribes. Each participant completed the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS), which reflected the students' attitudes toward seeking psychological assistance. In addition, the participants were also assessed for the degree of cultural commitment by responding to a four level identity scale. The authors found that American Indian college students who were strongly committed to their tribal culture indicated significantly less favorable overall attitudes toward seeking psychological services than the students who were weakly committed to their tribal culture. Additionally, the strongly committed group of students had less favorable attitudes in terms of recognizing the personal need for counseling, confidence in mental health professionals, and interpersonal openness regarding personal issues than those students who were committed to

the Anglo culture or committed to both cultures (Anglo and Tribal). Overall, women tend to be more inclined to participate in seeking mental health services than men.

Another study, conducted by Johnson and Lashley (1989), indicated that cultural commitment might affect treatment outcomes or expectations. This quantitative study examined American Indians college students' preferences for an ethnically similar counselor and attitudes toward counseling. The study utilized the Expectations About Counseling Questionnaire (EAC) to assess areas of personal commitment, facilitative conditions, counselor expertise, and nurturance. Overall, 90 assessment instruments were completed, but six were incomplete, leaving a total of 84 assessments. The results revealed that American Indian's degree of cultural commitment significantly affects preferences for counselor ethnicity. For example, participants with a strong commitment to the American Indian culture expressed a greater preference for an ethnically similar counselor. Additionally, participants who had a stronger cultural commitment also had a greater expectation for nurturance, facilitative conditions, and counselor expertise than the respondents with a weaker cultural commitment to the American Indian culture. Therefore, the authors suggest that acculturation or degree or cultural commitment may be more important as a determinant of preference for counselor characteristics than ethnicity.

In a review of the literature by LaFromboise, Trimble, and Mohatt (1990), they noted a difference in help-seeking behavior between American Indian and non-Indian populations, based on the type of client problem. For example, female American Indian students preferred a female counselor if they were to seek help for a personal problem rather than an education or vocational concern. Additionally, American Indian students who attended boarding schools tend to have issues related to depression more frequently than American Indian students in rural or metropolitan areas. According to the U.S. Congress (1990), American Indian college students

reported personal pressure for academic achievement, fear of failure, financial concerns, difficulties in receiving financial aid, pressure to succeed, and fear of failure to meet family expectations as the most common stressful events (as cited in LaFromboise, Trimble, & Mohatt, 1990). One possible explanation for the increased stress levels may be due to feeling caught between two cultures; the dominant culture and the traditional culture.

Acculturation levels within the American Indian communities may vary according to generations. For example, the values of children will be related to the degree of their acculturation to the mainstream of Western society, meaning that the more the Indian children acculturate, the more they tend to incorporate Western values. Additionally, the process of value assimilation may detrimentally affect the American Indian child's self-concept (Lazarus, 1982).

Acculturation level appears to effect American Indians beliefs and perceptions in regards to wellness and help-seeking behaviors. The literature suggests that forced acculturation and conflicting beliefs could cause an increase in emotional distress amongst the American Indian communities. However, American Indians may express their emotional distress in a manner that is nonconductive to Western taxonomies, which may lead to overdiagnosis and underdiagnosis. Therefore, it is important to take into consideration one's values, beliefs, and worldview in relation to views of psychological or mental health practices in order to provide appropriate services.

View of Mental Health

According to Hatfield and Hatfield (1992), wellness is proactive and is the "process that involves the striving for balance and integration in one's life, adding and refining skills, rethinking previous beliefs and stances toward issues as appropriate" (p.164).

As for the American Indian cultural terminology, this means "walking the path of Good Medicine" (living a good way of life) "in harmony and balance" (maintaining a harmonious interaction between the mind, body, spirit, and natural environment) "with all our relations" (being connected with all living beings; Garrett & Garrett, 1996, 1999). Basically, for many American Indians the term of wellness means being in harmonious relationship with nature.

Many American Indian communities view the concept of health and wellness as not only a physical state but a spiritual one as well (Garrett, 1999). Spiritual practices tend to be an integral part of everyday life and are a necessity to maintaining balance and harmony among the American Indian population. American Indian people tend to look at all things as having life or a spiritual energy, which is of importance to remaining in harmony. Spirituality focuses on the harmony that comes from the connectedness one has with all parts of the universe (Garrett & Garrett, 1994). Therefore, from a traditional perspective, the term *mental health* is a misnomer, given that American Indians view a persons' well being as holistic rather than separating one's mental aspect from the rest of the person.

Locust (1988) identified a number of basic American Indian traditional beliefs regarding wellness and unwellness:

1. American Indians believe in a Supreme Creator. In this belief system there are lesser beings also.

2. Human beings are threefold beings made up of a spirit, mind, and body.

3. Plants, animals, like humans, are part of the spirit world. The spirit world exists side by side with, and intermingles with, the physical world.

4. The spirit existed before it came into a physical body and will exist after the body dies.

5. Illness affects the mind and spirit as well as the body.

6. Wellness is harmony in spirit, mind, and body.

7. Unwellness is disharmony in spirit, mind, and body.

8. Natural unwellness is caused by the violation of a sacred or tribal taboo.

9. Unnatural wellness is caused by witchcraft.

10. Each is responsible for his or her own wellness. (p. 317-318)

Additionally, Locust (1985) described the American Indian view of unwellness as follows:

> American Indians believe that each individual chooses to make himself well or to make himself unwell. If one stays in harmony, keeps all the tribal laws and all the sacred laws, one's spirit will be so strong that negativity will be unable to affect it. If one chooses to let anger or jealousy or self-pity control him, he has created disharmony for himself. Being in control of one's emotional response is necessary if one is to remain in harmony. Once harmony is broken, however, the spiritual self is weakened and one becomes vulnerable to physical illness, mental and/or emotional upsets, and the disharmony projected by others. (p. 14)

American Indian communities tend to function within strong group cohesion and utilize the extended family or entire tribe as a support network. Therefore, American Indians are quite concerned about Western psychological concepts like *mental health*, *personality*, and *self* because of the absence of naturalistic or holistic concepts in the design and implementation of the therapeutic process (LaFromboise, 1988). Not only do American Indian communities view mental health as a holistic concept, there are language barriers that include translations that represent a completely different concept. For example, in the Lakota (Sioux) language, the term mental health *(ta-un)* means being in a state of well-being (LaFromboise, 1988). Additionally, a

Hopi person who is in the state of well being is peaceful and exudes strength through self-control and adherence to the universal American Indian values of wisdom, intelligence, responsibility, poise, cooperation, kindness, unselfishness, and protectiveness toward all life forms (Trimble, 1981).

According to LaFromboise (1988), many American Indians believe that mental illness is a justifiable outcome of human weakness or the result of avoiding the discipline necessary for the maintenance of cultural values and community respect, such as being in harmony with one's environment. For example, LaFromboise (1988) stated that one way of having disharmony was by utilizing Coyote stories that contain a theme of danger that is associated with excessive individual behavior (e.g., greed, envy, or trickery). The American Indian communities use individualization as means for achieving community solidarity rather than as personal achievement. American Indian communities emphasize unity through seeking harmony and balance both inwardly and outwardly (Garrett, 1999). Therefore, it is important that one maintains cultural values as means for controlling their preoccupation with themselves versus focusing on the tribal community. For example, when problems arise in Indian communities, they become not only problems of the individual but also problems of the community (LaFromboise, 1988).

American Indian communities often utilize traditional healers as means to regain harmony within their life. The traditional healer embraces a holistic view that incorporates the interwoven aspects of being; including the spirit, nature, body, and mind. The traditional healer is viewed as an individual who operates in a multifaceted capacity, being a physician, counselor, spiritual advisor, and historian. Additionally, a healer is viewed as a safekeeper of ancient legends, which are maintained through the oral tradition of storytelling (LaFromboise, 1988).

According to Powers (1982), the traditional healer utilizes the wisdom of spiritual legends for insight into human behavior and to explain emotional and behavioral distress (as cited in LaFromboise, 1988). In fact, Thomason (1991) stated that the traditional healer makes a diagnosis without asking personal questions of the client or expecting the client to self-disclose intimate details.

American Indian communities utilize social networks such as the extended family, entire tribe, and elders within the tribe as resources for emotional support. According to Garrett and Garrett (1994), the extended family (often times includes at least three generations) and the tribal community take precedence over all else. American Indian people tend to see themselves as a part of a greater whole (the tribe) rather than as an individual. Therefore, many American Indians will judge themselves by their actions as to whether or not they are benefiting the tribe in regards to maintaining harmony within the universe. It is not unusual for American Indian communities to honor and respect the elders due to their lifetime worth of wisdom that they have acquired through life experiences. Therefore, elders tend to play a vital role in the continuance of tribal community by functioning as parent, teacher, community leader, and spiritual guide (Garrett & Garrett, 1994).

Given that traditional philosophies of helping and healing appear to be so important to American Indians, Voss, Douville, Little Soldier, and White Hat (1999) conducted a qualitative study utilizing elders, educators, leaders, and mental health providers who worked among the Lakota population. The researchers found distinctive approaches used to ensure social health and well-being, which were interwoven into the *natural law* and to ceremonial life of the tribe, such as the use of healing ceremonies by "medicine men/women" and having family members actively participate in a ceremonial life which promotes wellness. The findings also suggest that

there is a revitalization of traditional healing practices among the Lakota population, which may have implications for practitioners regarding implementation of culturally relevant interventions. All 32 participants indicated that the Lakota people tend to utilize alternative approaches in the helping and healing process. For example, they identified the Purification Ceremony (sweat lodge), Sun Dance, vision quest, utilizing a medicine man or woman, and use of herbal remedies as means towards obtaining wellness. Another factor that was pointed out was the importance of the family, who also participated in the ceremonial life toward wellness. Health care was identified as being primarily an extended family matter.

Voss, Douville, Little Soldier, and White Hat (1999) obtained the Lakota peoples' views of mental and physical health by utilizing an exploratory method, which included an audiotaped, structured interview. According to the participants, mental health and physical health are viewed as inseparable from spiritual and moral health. It was important for one to be in harmony with the *Wo'ope* or natural law of creation. In contrast with the Western psychiatric thinking, the traditional Lakota people believed that an individual consisted of four dimensions of self; *nagi* or one's individual soul, *nagi la*, the divine spirit immanent in each human being, *niya* or the vital breath; and the *sicun* or intellect. The Lakota people believe that an individual has the power within himself or herself to overcome life's obstacles, and therefore they turn to their *nagi la* for assistance rather than seek external assistance from a practitioner.

Other forms of alternative approaches that American Indian communities implement to obtaining wellness have been identified. In a review of the literature, Heinrich, Corbine, and Thomas (1990) provided anecdotal narratives of four traditional activities that American Indians may participate in as means to become in harmony with the universe; the vision quests, sweat lodge, four circles, and the talking circle. The vision quest is a "rite to passage to a personal

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crisis of meaning" that consists of three phases; severance, threshold, and reincorporation. The individual is on a quest that provides them separation from the context of everyday life and everyday meaning, allows the person to enter the unknown and receive new knowledge and power through a direct experience of transition, and then allows the person to return to the everyday world with community support in order to live out externally their internal changes that occurred during the vision quest (Heinrich, Corbine, & Thomas, 1990).

The sweat lodge is a physical and spiritual self-purification ritual, which emphasizes the relationship of the human being to all of creation. A medicine man or elder will assist the individual in prayer in order to provide spiritual guidance. The four circles are used for self-understanding by visualizing the significant relationships in one's life and consist of circles of relationships between the client and Creator, spouse, nuclear family, and extended family. The talking circle is a forum for expressing thoughts and feelings in an environment that provides total acceptance and no time constraints. Oftentimes, sacred objects such as eagle feathers or stones may be used in conjunction with the sacred pipe and prayer (Heinrich, Corbine, & Thomas, 1990). Being familiar with traditional healing practices can assist with developing the therapeutic relationship and implementation of culturally appropriate interventions in order to work towards wellness.

LaFromboise (1988) stated that most psychological interventions have been culturally limited and have not accepted assumptions or procedures that may benefit the Indian client. She also noted that often times the treatment plans rarely incorporate functional aspects of American Indian problems or acknowledge the efficacy of coping mechanisms that have been utilized for centuries. According to Lazarus (1982), it is important for the counselor to become familiar with the American Indian cultures, traditions, and value systems in order to become a more effective

helper. In addition, Garrett (1999) stated that it is essential to understand the client's cultural values as expressed through their value orientation and utilizing appropriate counseling interventions and modes of communication as means for promoting wellness with the client.

In summary, on American Indian views of mental health the literature supports the expansion of Western taxonomies in order to include culturally different conceptualizations and interventions. Given that American Indians tend to have differing values, beliefs and worldviews, it is essential that professionals incorporate culturally relevant treatment interventions and modalities that assist in the therapeutic process (Garrett, 1999; LaFromboise, 1988; Voss, Douville, Little Soldier, & White Hat, 1999). However, the literature continues to provide a global understanding from the Western view of mental health versus utilization of ethnic minority viewpoints. Underutilization is a serious issue that has been evaluated and explained by researchers using western terminology and assessments. Additionally, theoretical research has identified possible reason for underutilization but the literature is lacking in the area of culture-based perceptions as to explain the phenomenon of underutilization. If fact, the study by Voss, Douville, Little Soldier, and White Hat (1999) appears to be the only qualitative research that focused primarily on culture-based perceptions. Unfortunately, many psychological interventions lack culturally sensitivity and fail to incorporate procedures that may benefit the Indian client, which leads to underdiagnosis, overdiagnosis, premature dropout rate, and underutilization of services. Therefore, it is essential to gain knowledge from an identified population in regards to their culture-based perceptions in order to provide services that meet their specific needs.

According to Cheung and Snowden (1990), one area of research that remains poorly understood concerns culture-based perceptions and their effects. The authors suggested that

empirical accounts of indigenous beliefs must take place in order to gain a better understanding

of such beliefs, interpretations, and interventions that may be more beneficial to minority

populations. Additionally, Price and McNeill (1992) suggested that additional research is needed

to determine how conventional services and the descriptions of services may be modified to be

more appealing to American Indian clients who identify with the traditional tribal culture.

Gaining a cultural perspective from within would be beneficial, in that, assumptions would not

be made from a Western perspective. Instead, utilization of tribal members as consultants to

define parameters of operational definitions and expectations would be more culturally

appropriate than inflicting Western views onto a unique population (Broken Nose, 1992).

Therefore, the methods of this study will incorporate both aspects of identifying functional

coping mechanisms within the American Indian community and provide possible culturally

relevant interventions that may be beneficial for treatment planning with the Colville tribal

members.

The literature is limited in qualitative work that utilizes community members to define

the parameter of a working definition of mental health. For the most part, researchers tend to

utilize Western taxonomies as the defining parameters even though minority groups have

differing worldviews and perceptions of mental health. Therefore, this research will focus on

obtaining an operational definition of mental health and wellness from the specific community of

Colville tribal members, in order to gain a better understanding of their worldviews and

perceptions.

Rationale for a Qualitative Investigation

Qualitative methods are utilized to uncover and gain insight about the nature of a

phenomenon and allows for the development of new concepts or theoretical perspectives about

the particular phenomenon. Additionally, the purpose of grounded theory method is to build theory and explain the area under study (Strauss & Corbin, 1990). Therefore, a qualitative method is deemed appropriate for investigating and analyzing the aspects of Colville tribal members' views of mental health and wellness.

There are numerous advantages for using qualitative research for this particular study. Qualitative research allows the participants to provide a rich description of the identified phenomena. Conducting research in a naturalistic environment promotes flexibility and allows the participants to remain in a familiar atmosphere versus a control environment. Additionally, qualitative research employs data collection in a holistic, multifaceted manner of the phenomenon under study rather than identifying isolated characteristics to analyze.

Another benefit to using qualitative research is that the findings may be used to clarify and illustrate quantitative findings, guide practitioner's practices, and assist in the development of basic knowledge (Strauss & Corbin, 1990). Qualitative research provides the opportunity to evaluate multiple perspectives of the same phenomenon, which provides the researcher with the ability to make some generalizations about the phenomenon from the perspective of the identified population. Finally, qualitative research procedures allow for data collection utilizing traditional oral communication which would lead to more efficacious results.

As was stated in Chapter Two, the review of the literature indicates that limited qualitative research has been conducted on investigating specific ethnic minority members' views of mental health and wellness. In fact, the literature supports the expansion of Western approaches to mental health in order to incorporate more culturally appropriate conceptualizations and interventions (Atkinson, Thompson & Grant, 1993; Cheung & Showden, 1990; Choney, Berryhill-Paapke, & Robbins, 1995; Garrett, 1999; Garrett & Garrett, 1994;

LaFromboise, 1988; LaFromboise, Trimble, & Mohatt, 1990; U.S. Department of Health and Human Services, 2001; Voss, Douville, Little Soldier, & White Hat 1999).

This study was designed to investigate Colville tribal members' views of mental health and wellness, help-seeking behavior, resources that may be utilized to relieve emotional distress, and identify community activities that may promote mental health and wellness. Therefore, an important purpose of this study was to gain a better understanding of Colville tribal members' views of mental health and wellness in a way that may assist in culturally relevant conceptualizations and interventions.

CHAPTER THREE

Research Methodology

Participants

The focus of this study was on a specific tribal community, the Colville Confederated

Tribes in Washington State. Therefore, advertisements for volunteers was placed in the Colville

Tribal Tribune (which is disburse to enrolled tribal members and those who subscribe), as well as

on hard copy message boards within the tribal community and throughout the surrounding

residential community. The sample consisted of 20 volunteers from the Colville Reservation or

surrounding area who were 18 years of age or older. The 20 volunteers were separated into four

identified age groups (18-25, 26-40, 41-60, and 61 and older) and each age group contained five

participants.   All volunteers were enrolled Colville tribal members who reside on or near the

Colville Reservation and who were involved or uninvolved in the mental health services within

the community setting.

Procedures

Volunteers contacted the primary researcher via telephone, e-mail, or in person in order

to arrange for an individual interview. Upon initial contact, participants were screened to

establish chronological age and enrollment criteria as prerequisites to participate in the study.

The meeting time and place was established during the initial contact and the primary researcher

traveled to the participant's geographical location in order to overcome transportation barriers

that exist due to the size of the Colville Reservation.

Prior to beginning the one-on-one interview, the researcher asked the participant to sign a

human subjects consent form approved by the Washington State University Institutional Review

Board, which satisfied all components of the research project (see Appendix B). The in-depth

interview began with the primary researcher completing the demographic form in cooperation with the participant in order to build rapport. All participants were interviewed within the community setting and interviews continued until there were five participants in each previously identified age groups. All participants who completed the one-on-one interview process were entered into a drawing for a variety of prizes (e.g., Pendleton blankets, microwave, flannel sheet set, rug set, handmade goods, and towel sets).

Data Collection

Volunteers who meet the criteria for being an enrolled Colville tribal member and age requirements were asked to participate in a 45-minute interview. Data collection was completed in community settings within the boundaries of the Colville Confederated Tribes Reservation. Each interview consisted of previously developed open-ended interview questions that direct participants toward the research objectives. The interviews were primarily open-ended but also allowed for the researcher to gather information from the participants that taps into the constructs of conceptualization of mental health and wellness, circumstances in which help-seeking responses occurred, sources of assistance considered in order to relieve emotional distress, and activities within the community that may promote mental health and wellness. All interviews were audio-recorded for accuracy and later transcribed verbatim. (See Appendix C for sample interview questions).

Data Analysis

There are numerous methods available for analyzing data but, given the focus of this study, grounded theory was utilized. According to Strauss and Corbin (1990), grounded theory involves a verbatim transcription of the interviews, an examination of the transcribed data to identify themes or meaning units contained in the participant's responses, creating a data matrix

scheme from the identified themes or meaning units, followed by an independent review of the data by trained coders that result in a final categorization of all collected data into the matrix scheme. Reliability of categories and accuracy of sorting the data are ensured by employing independent coders or by using appropriate computer software.

Coding or identifying themes represents the operation in which the collected data are broken down, conceptualized, and put back together in a new form (Strauss & Corbin, 1990). This coding process allows the researcher to pull out themes from a larger body of information in order to create categories of similarly related data. The categories allow for patterns to emerge, which then can be analyzed. By analyzing the categories and properties, the researcher inductively formed explanatory relationships that provide a better understanding to the phenomenon being studied.

In summary, the data analysis process was as follows: Field data were collected from enrolled Colville tribal members. The data were analyzed, reviewed, coded, and placed into specific categories based on emerging themes and patterns. Additional properties emerged from within the categories as they were analyzed and reviewed. Explanations of the relationships between categories emerged inductively, which provided a better understanding of Colville tribal members' views of mental health and wellness.

CHAPTER FOUR

Findings

Introduction

Chapter Four details the results from the present study. First, the results of the

demographic questionnaire are reported, including a section describing the quantitative features

of each chronological age groups' responses. Qualitative results are then reported by question

across the age groups. Given the richness of the raw data, the analysis includes a consolidated

form of the participant's responses to each question. In addition, the matrices, domains, and

properties defining *mental health and wellness* and the factors that contribute to mental health

and wellness are presented in both written illustrations and charts. The last section of this

chapter focuses on answering each of the research questions according to the raw data.

Analysis Format

The present study was analyzed by grounded theory, which involved a microanalysis of

verbatim transcription of the twenty interviews. A detailed line-by-line analysis was

implemented at the beginning of the analysis process to generate initial categories, including

properties and dimensions. Each transcribed interview provided a wealth of rich data that

produced a variety of views on mental health and wellness.

The microanalysis process allowed the researcher to discover new concepts, evaluate all

possible meanings of the concepts, and then return to the transcribed document to look for

incidents or words that elaborated on the meaning of the concepts. During the open coding

process, theoretical comparisons were conducted to reveal possible properties and dimensions of

a concept. For example, the researcher completed a systematic comparison of the definition of

mental health from the participants' views and from the literature in order to identify properties

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and dimensions in the data that may have been overlooked. Systematic comparison was an

essential process since the properties are characteristics of a category that give it meaning and

the dimensions illustrate the range of general properties that vary among a given category.

Overall, during open coding, data are broken down into discrete parts, closely analyzed, and

compared for similarities and differences.

The data were grouped into similar events, happenings, and objects under a common

heading or classification. Each classified element had recognizable properties that formed

patterns that aligned themselves along various dimensions. Finally, data were conceptualize

through the process of grouping similar items according to defined properties and giving each

item a name that stood for the common link.

The axial coding process reassembled the data that were broken down during open

coding. Explanations about the phenomena of mental health and wellness developed through

relating the categories to their subcategories along the lines of their properties and dimensions.

The analysis utilized the actual words used by participants and the conceptualization of those

words that explained a variety of conditions, actions, interactions, and consequences associated

with the phenomena.   The repeated patterns of conditions, actions, and interactions explained

the phenomena of mental health and wellness.

Finally, the data were integrated to refine categories that supported the theory of mental

health and wellness among the Colville tribal members. Refinement of the theory involves

reviewing the scheme for internal consistency and for gaps in logic, filling in poorly developed

categories and trimming excess ones, and validating the scheme (Strauss & Corbin, 1990).

Description of the Participant Sample

Participants were asked to describe themselves in terms of gender, age, ethnicity (self-identified), whether or not they were an enrolled Colville tribal member, country of birth, time in the United States, employment status, occupation, income level, number of dependents, marital status, primary language spoken in the home, the length of time they had lived in their community, and described the ethnic or racial composition of their community. Additionally, each participant identified their degree of commitment to cultural values (i.e., strong commitment to both Anglo and Tribal cultures, strong commitment to Tribal culture and weak commitment to Anglo culture, strong commitment to Anglo culture and weak commitment to Tribal culture, or weak commitment to both Anglo and Tribal cultures).

The results of the written demographic questionnaire completed by participants indicated that of the 20 participants, three were men and seventeen were women. All participants identified as enrolled tribal members who resided on or near the Colville Tribes Reservation. Table 1 illustrates the parameters of each descriptor.

Table 1

Demographic Characteristics of Participants (N=20)

Characteristic	N	%
Gender		
Male	3	15
Female	17	85
Ethnicity (Self-identified)		
Native American	8	40
Indian	4	20
Colville Tribal Member	2	10
American Indian	1	5
North American Native	1	5
Caucasian	1	5
Bi-racial/Other	3	15

Table 1 (continued)

Demographic Characteristics of Participants (N=20)

Characteristic	N	%
Employment Status		
Full-Time	12	60
Part-Time	0	0
Unemployed	4	20
Retired	4	20
Annual Income ($)		
0 - 5,000	1	5
5,001-10,000	2	10
10,001-15,000	5	25
15,001 - 20,000	3	15
20,001 - 25,000	2	10
25,001 - 30,000	1	5
30,001 - 35,000	1	5
35,001 - 40,000	2	10
40,001 - 45,000	2	10
45,001 - 50,000	0	0
50,001 +	1	5
Number of Dependents		
0	8	40
1	6	30
2	4	20
3	1	5
4	0	0
5	1	5
Marital Status		
Married	8	40
Single	6	30
Widowed	2	10
Partnered	2	10
Divorced	2	10

Table 1 (continued)

Demographic Characteristics of Participants (N=20)

Characteristic	N	%
Occupation		
Admin. Assistant/Clerical	3	15
Business	1	5
Education	2	10
Homemaker	1	5
Laborer	2	10
Managerial	1	5
Retired	4	20
Service Worker	1	5
Student	2	10
Technician	3	15
Highest Education Level Completed		
No GED	0	0
GED	1	5
High School Graduate	2	10
1 Yr. of College	9	45
2 Yrs. of College	5	25
Bachelor Degree	3	15
Master Degree	0	0
Doctorate Degree	0	0
Ethnicity/Racial Composition of Community		
Native American/Indian	7	35
Native American/Caucasian	5	25
Native American/Hispanic	4	20
Mixed (NA and 2 other groups)	3	15
Caucasian	1	5
Degree of Cultural Commitment		
Strong Anglo and Tribal	7	35
Strong Tribal/Weak Anglo	9	45
Strong Anglo/Weak Tribal	1	5
Weak Anglo and Tribal	3	15

Ethnicity of Participants

Sixteen of the participants in this study self-identified themselves as Native American (i.e., Native American, Indian, Colville tribal member, American Indian and North American Native). Three participants identified themselves as bi-racial, while one participant self-identified as Caucasian.

Ethnicity or Racial Composition of the Community

Participants were asked to identify the ethnic or racial composition of the community where they resided. Seven participants reported that their community consisted of individuals who were Native American or Indian. Five participants noted that their community was comprised of predominately Native Americans and some Caucasians. Four participants noted their community as being predominately Native American with some Hispanic individuals. Additionally, three participants stated that their community was "mixed," consisting of Native Americans and at least two other ethnic groups. However, one participant described her community as being predominately Caucasian.

Cultural Commitment

Each participant was asked to identify the degree of commitment to cultural values, utilizing four categories: strong commitment to both Anglo and Tribal cultures; strong commitment to Tribal culture and weak commitment to Anglo culture; strong commitment to Anglo culture and weak commitment to Tribal culture; or weak commitment to both Anglo and Tribal cultures. Seven participants reported being strongly committed to both Anglo and Tribal cultures. Nine participants stated they had a strong commitment to Tribal culture and weak commitment to Anglo culture. One individual noted having a strong commitment to Anglo

culture and a weak commitment to Tribal culture. Finally, three participants reported having a weak commitment to both Anglo and Tribal cultures.

Economic Status of Participants

Twelve of the participants reported being employed full-time, while four participants stated they were unemployed. Additionally, four participants identified as being retired. Annual income ranged from $5,000 up to $55,000, with the mean income of $23,800. There were multiple modes of annual income which were $15,000 and $45,000. The participant who made $5,000 a year was a college student while the participant that made $55,000 a year was a college graduate (4-year degree). There were 17 of the 20 participants (85%) who had received either a General Education Degree (GED) or a high school diploma and completed at least one year of college. Occupations varied from Administrative Assistant to Managerial positions. Participant's level of education ranged from receiving a GED to obtaining a bachelor degree. Although, one participant reported they had received two bachelor degrees.

Age of Participants

Each of the four age groups (i.e., 18-25; 26-40; 41-60; 61 and older) consisted of five participants. Participant's chronological age ranged from 19 to 80 years old, with the mean age of 44.8 years old. Chronological age had multiple modes, which consisted of 19, 38 and 53 years old.

Time in the Community

The participant's time within the community ranged from 2 to 60 years, with the mean of 26.4 years. As Table 2 illustrates there were multiple modes that existed within this category, which consisted of 2, 12, 29, and 50 years.

Table 2

Descriptive Characteristics of Participants (N=20)

Characteristic	Mean	Mode	Median
Age (at time of survey)	44.8	19	45
Actual Income ($ in thousands)	23.8	15/45*	19
Time in the Community (years)	26.4	2/12/29/50*	28.5

* Multiple Modes exist

Quantitative Features of the Group Responses

While this study was designed to investigate Colville tribal members' views of mental health and wellness, help-seeking behavior, resources that may be utilized to relieve emotional distress, and identify community activities that may promote mental health and wellness, the design lends itself to evaluating the participant's responses as a whole and across generations. Given that the raw data include four specific age groups (i.e., 18-25; 26-40; 41-60; and 61 and older), the qualitative analysis includes within group differences and between group differences. Therefore, each research question has been analyzed as a whole, but also discusses within group differences according to beliefs, values, worldviews, and life experiences.

Question One: "What Does it Mean to You to Be Mentally Healthy or Achieve Wellness?"

Question One resulted in qualitative similarities and differences between the groups, as illustrated in Table 3. Participant responses varied as they described multiple aspects of being mentally healthy or achieving wellness. Total responses from each age group to the first interview question ranged from 14 to 21. Group One, age 18 to 25, generated the fewest number of responses to the identified categories of mental health and wellness. Each group generated responses categorized as elements of mental health and wellness, which consisted of a mental, spiritual, emotional, sense of self or physical self, and an environmental self. All groups spoke

to the importance of maintaining a balance between at least three elements of wellness (i.e., physical, emotional, and the spiritual self or mental, physical, and emotional self). Only one person, who was within the age group of 41 to 60, spoke to the importance of maintaining a balance between the physical, mental, spiritual and emotional self.

While a majority of the inter-group differences were slight, some were more apparent. For example, only one individual in Group Two gave a response to the importance of having a spiritual self as an element of wellness, while four individuals within Groups Three and Four generated responses that spoke to the importance of a spiritual self. Groups Three and Four also offered four responses each to the importance of an environmental self, while Group One only had two individuals speak to that issue. Given that all five members of Groups Two, Three, and Four generated responses that spoke to the importance of maintaining a sense of self or physical self, it appears that this element may be a core aspect of wellness. Additionally, all five members of Groups Two and Four spoke to the importance of an emotional self, while four members of Groups One and Three endorsed this element as well. Taken as a whole, the participants generated responses that spoke to the importance of maintaining a sense of self or physical self, an emotional self, an environmental self, a mental self, and a spiritual self respectively.

Table 3

Quantitative Results in Response to Question One: "What Does it Mean to You to Be Mentally

Healthy or Achieve Wellness?"

	Groups				TOTALS
Category/Code	1	2	3	4	
Mental Self	2	4	3	3	12
Spiritual Self	2	1	4	4	11
Emotional Self	4	5	4	5	18
Sense of Self/Physical Self	4	5	5	5	19
Environmental	2	3	4	4	13
TOTALS	14	18	20	21	73

Question Two: "What Do You Consider to Be Circumstances or Situations That Can Negatively

Affect a Person's Mental Health or Well-being?"

Question Two generated qualitative results that had similarities and differences between

the groups, as illustrated in Table 4. Participant responses slightly varied as they described

specific life events that would negatively affect one's mental health. The range of total

responses from each age group was from 17 to 25. Although, Group Four, age 61 and older,

generated the fewest number of responses. Three groups generated responses categorized as life

events that effect ones' mental, spiritual, emotional, and sense of self or physical self along with

environmental stability. Group Two was the only group who did not produce responses that

indicated negative life circumstances would affect one's spiritual well-being. Additionally,

Group Three was the only group that had all five participants who formulated ideas for each of

the five categories.

Again, a majority of the inter-group differences were slight, while others were more

evident. For instance, only one individual in group One and two participants in Group Four gave

a response suggesting that the spiritual self would be affected by life events, while all five

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individuals within Group Three generated responses that spoke to the impact upon the spiritual self. Given that all five members of Groups One, Two, and Three and four members of Group Four indicated that the emotional self was affected by negative life situations, it is clear that external forces have the greatest impact on the emotional self. Also, all members of Groups Two and Three and four members of Groups One and Four noted that life events would impact the physical self or sense of self and one's environmental stability. A total of seventeen participants noted that the mental self would be affected by life circumstances. Essentially, the participants produced responses that spoke to how four of the five identified categories (i.e., emotional self, physical self or sense of self, mental self, and environmental stability) would be effected by negative events, such as the loss of a family member, divorce, alcohol use, traumatic experiences, and environmental changes.

Table 4

Quantitative Results in Response to Question Two: "What Do You Consider to Be Circumstances or Situations That Can Negatively Affect a Person's Mental Health or Well-being?"

Category/Code	Groups				TOTALS
	1	2	3	4	
Mental Self	4	5	5	3	17
Spiritual Self	1	0	5	2	8
Emotional Self	5	5	5	4	19
Sense of Self/Physical Self	4	5	5	4	18
Environmental Stability	4	5	5	4	18
TOTALS	18	20	25	17	80

Question Three: "If You Found Yourself in (an identified situation) and Were Looking For Help or a Way to Feel Better, What Would You Do?"

Question Three responses generated qualitative parallels and diversity between the groups, as illustrated in Table 5. Total responses from each age group ranged from 13 to 23. Group One, age 18 to 25, generated the fewest number of responses as to resources they utilized while in distress. Each group generated responses that were categorized, but none of the groups produced responses for all identified categories. Given the variety of responses, categories emerged but contain subcategories. For example, the "Kin/Family" category included all persons identified as "relatives," whether or not they were biologically related. The "Uninvolved People" domain contained individuals who had no vested interest in providing advice to the individual (i.e., acquaintances). "Organizations" included Tribal Police Department, Tribal Council, workshops, Al-Anon, Alcohol Anonymous meetings, conferences, and the community. The "Traditional" category included activities such as sweats, meditation, talking circles, and vision quests. "Church/Prayer" included the Cursillo, prayer, Long House, talking to the priest, and the Catholic, Christian, Seven Drum, and Shaker religions.

Question Three generated substantial inter-group difference. For instance, Group One did not utilize four identified resources, which were self-help methods, organizations, traditional methods, and spiritual guidance through prayer or a religious entity. Group Two failed to endorse two categories; uninvolved people and family treatment. Both Groups Three and Four did not identify one category, uninvolved people and family treatment respectively. Seventeen participants, including all members of Groups One and Three, identified the kin or family category. Church or prayer was the next category that was identified, with all five members of Groups Two and Four noted the importance of this category. Only one member of Groups One

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and Three indicated that family treatment was utilized. Half of the participants stated they turn

to friends for support; while nine participants identified they internalize their problems versus

reaching out to others. Seven participants identified both turning to a counselor and utilizing

traditional methods. Interestingly, of the seven individuals who identified utilization of a

counselor, four of them identified their degree of cultural commitment as strong to Tribal

traditions and week to Anglo culture, while two of them identified their degree of cultural

commitment as strong to both Anglo and Tribal cultures, and one noted they were weakly

committed to both Anglo and Tribal cultures. In summary, participants indicated that kin or

family and church or prayer were their main resource for the relief of distress. The categories of

friends and internalizing issues closely followed. The participants equally endorsed utilization of

a counselor and traditional means.

Table 5

Quantitative Results in Response to Question Three: "If You Found Yourself in (an identified

situation) and Were Looking For Help or a Way to Feel Better, What Would You Do?"

	Groups				TOTALS
Category/Code	1	2	3	4	
Kin	5	4	5	3	17
Friends	2	2	2	4	10
Uninvolved People	1	0	0	1	2
Internalize (Self)	2	1	4	2	9
Family Treatment	1	0	1	0	2
Counselor	2	2	2	1	7
Self-Help Methods	0	2	2	2	6
Organizations/Groups	0	2	2	2	6
Traditional Methods	0	2	2	3	7
Church/Prayer	0	5	2	5	12
TOTALS	13	20	22	23	78

Question Four: "How Would Doing (the activity they describe) Help You to Feel Better?"

Question Four generated qualitative parallels and some slight variations amongst the groups, as illustrated in Table 6. Each group offered a number of total responses that ranged from 16 to 22. Again, Group One, age 18 to 25, generated the fewest number of responses as to how specific resources improved their mental health. The responses generated five specific types of improvement within the individual, which consisted of emotional support, mental wellness, sense of self, physical wellness, and spiritual enhancement.

While a majority of the inter-group differences were slight, some were more noticeable. For instance, only one individual in Group One gave a response that described how their spirituality had improved, while all five members of Group Four provided responses that indicated spiritual growth. Additionally, two members of Group Two and four members of Group Three were able to identify how turning to outside resources for assistance while in distress had enhanced their spiritual self. Noticeably, all five members of Groups One and Three generated responses that discussed how their emotionality was enhanced by seeking help from external resources. If fact, emotional improvement was the category identified as being more likely to have growth during a distressful time. However, nineteen and eighteen participants identified emotional and mental development as the top two categories respectively. Interestingly, fifteen participants indicated that both their sense of self and physical well being had been improved by reaching out to external resources during a negative life situation. Taken as a whole, the participants generated responses that identified four personal growth areas that had improved by seeking help from others or activities. Those categories included the emotional, mental and physical self, along with an enhanced sense of self.

Table 6

Quantitative Results in Response to Question Four: "How Would Doing (the activity they

 describe) Help You to Feel Better?"

Category/Code	Groups				TOTALS
	1	2	3	4	
Emotional Support	5	5	5	4	19
Mental Wellness	5	5	4	4	18
Sense of Self	3	5	4	3	15
Physical Wellness	2	5	4	4	15
Spirituality	1	2	4	5	12
TOTALS	16	22	21	20	79

Question Five: "What Activities/Opportunities/Resources Might Serve to Promote Mental Health

and Well-being For You and People in Your Community?"

Question Five generated qualitative similarities and differences amongst the groups, as

illustrated in Table 7. Participants provided a range of total responses from 15 to 19. Group

Four, age 61 and older, produced the fewest number of responses that identified community

activities and resources available to the tribal community. The responses generated eight

specific resources or activities and a category that noted the community lacked resources. The

eight resource categories are as follows: (a) volunteering, (b) family time, (c) physical activities,

(d) conferences or training, (e) traditional activities, (f) counselor or groups, (g) elders, and (h)

spiritual activities.

Most of the inter-group differences were minimal. For example, sixteen of the

participants spoke to having access to physical activities within the community. Additionally,

fourteen responses indicated the community consisted of traditional activities that would

promote wellness. Socializing with family members or friends was identified by nine of the

participants, with three members of Groups Two and Four noting family time as a resource for

wellness. Interestingly, one member of each group identified having access to a mental health

provider or support groups.

The more obvious inter-group differences focused on categories that were not identified

as a resource by any of the participants. For example, Groups One and Three did not identify

volunteering as an activity within the community. Additionally, no members of Group Four

indicated that conferences or trainings within the community would promote wellness. Group

Two had all five members identify traditional activities, while only two participants of Group

Four acknowledged the presence of traditional activities within the community. Overall,

responses suggested the community had a variety of resources that were available, but the value

that each resource had varied according to self-perceptions. Physical and traditional activities

were noted as being accessible, followed by spending time socializing with family or friends.

Table 7

Quantitative Results in Response to Question Five: "What Activities/Opportunities/Resources

Might Serve to Promote Mental Health and Well-being For You and People in Your

Community?"

Category/Code	Groups				TOTALS
	1	2	3	4	
Volunteering	0	1	0	2	3
Family Time	2	3	1	3	9
Physical Activities	4	4	5	3	16
Conferences/Training	1	1	2	0	4
Traditional Activities	3	5	4	2	14
Counselor/Groups	1	1	1	1	4
Elders	2	2	1	2	7
Spiritual Activities	2	1	1	1	5
Nothing Available	2	1	1	1	5
TOTALS	17	19	16	15	67

Degree of Cultural Commitment and Utilization of Traditional Methods

Quantitative results of the degree of cultural commitment are illustrated in Table 8, while results of utilization of traditional interventions are illustrated in Table 9. Responses indicated some quantitative similarities and difference amongst the groups. For instance, Group Two, Three, and Four had at least one member identify the importance of utilization of tribal traditions as means for improving wellness. Even though three members of Group One, age 18 to 25, indicated they had a strong commitment to Tribal culture and weak commitment to Anglo culture, no one identified traditional interventions as a method they implemented to promote wellness. Group Two, age 26 to 40, had one participant who had a strong commitment to Tribal culture and weak commitment to Anglo culture and one participant who had a weak commitment to both Anglo and Tribal cultures identify traditional methods as being useful in promoting wellness. Group Three, age 41 to 60, had two participants who identified as having a strong commitment to Tribal culture and weak commitment to Anglo culture who had utilized traditional interventions to improve their mental health. Group Four, age 61 and older, had one participant who had a strong commitment to Tribal culture and weak commitment to Anglo culture and two participants who identified as having a strong commitment to both Anglo and Tribal cultures who noted that traditional methods were a part of their regime to become mentally healthy. Table 8 illustrates the degree of cultural commitment among all participants.

Table 8

Degree of Cultural Commitment of All Participants

	Groups				TOTALS
Degree of Cultural Commitment	1	2	3	4	
Strong Tribal/Weak Anglo	3	1	4	1	9
Strong Anglo/Weak Tribal	0	0	0	1	1
Strong Anglo and Tribal	1	3	0	3	7
Weak Anglo and Tribal	1	1	1	0	3
TOTALS	5	5	5	5	20

Table 9

Quantitative Results of Degree of Cultural Commitment and Utilization of Traditional Methods

	Groups				TOTALS
Degree of Cultural Commitment	1	2	3	4	
Strong Tribal/Weak Anglo	0	1	2	1	4
Strong Anglo/Weak Tribal	0	0	0	0	0
Strong Anglo and Tribal	0	0	0	2	2
Weak Anglo and Tribal	0	1	0	0	1
TOTALS	0	2	2	3	7

Participants' Responses to Question One:

"What Does it Mean to You to Be Mentally Healthy or Achieve Wellness?"

Participants provided a variety of responses to the question, "What does it mean to you to be mentally healthy or achieve wellness?" Table 10 illustrates responses each group provided for Question One. Given the importance of each groups' responses to the categorical analyses, the consolidation of the responses for each group are included verbatim in Table 10.

Table 10

Question One Consolidation Responses of Each Group

Group One: (Age 18-25)	
Category	Description
Resiliency	able to handle stress (accept and deal with it appropriately); financial stress; function in daily life
Inner strength/balance	having it together; having strong faith in God; turning to Him for everything and depending on Him; something inside of them drives them
Relationships	talk openly; get together and have dinner (with family); have somebody to love and talk to; bond with others; need a companion and a friend
Identity	having pride in who I am; still trying to be Indian; take care of yourself; be happy with myself; independent, strong willed person, motivated, self-reliant
Substance free	be drug and alcohol free
Personal success	having financial stability; having a good home life; having good family time; be happy; be able to achieve my goals; feeling of accomplishment

Group Two: (Age 26-40)	
Category	Description
Resiliency	no worries; tackling the problems that you have surrounding you; fear and stress is gone out of my life
Inner strength/balance	ups and downs are balanced out; having it together; being in control of my life (and to change it); inner peace; empowerment; think clearly
Relationships	family connection; being with someone who makes you feel loved; love others
Identity	feel fair/good about myself; confident, determination; finding out who you are; tell the truth
Substance free	abstaining from alcohol use; don't have drugs or alcohol in their life
Personal success	feel happy; confident about my job; being successful with life, family, friends, and their job; loving home life

Table 10 (continued)

Question One Consolidation Responses of Each Group

Group Three: (Age 41-60)	
Category	Description
Resiliency	well adjusted; make rational decisions; having the strength to deal with what life gives you
Inner strength/balance	no major traumas going on in life; emotional, spiritual, physical and mental balance; spirituality is my core; wellness comes from within me; able to think clearly; be at peace with yourself and surroundings
Relationships	having family close to me
Identity	knowing myself; reflected in your physical being; self-aware; confident; comfortable with self; caring; understanding of others; reliable; physically well; independence
Substance free	being alcohol and drug free
Personal success	reflected in your environment; satisfied with life; economically fine; don't have a violent home; be grateful for what you have

Group Four: (61 and older)	
Category	Description
Resiliency	don't let too many outside things bother or get you down
Inner strength/balance	stable; go with your heart; pray everyday; joy to get up in the morning; feeling of serenity; strong basis of religion, family, and neighborhood; spiritual wellness
Relationships	need friendship and companionship; being treated well as a child; being respected and loved; positive relationships; feel connected to others
Identity	exercise; sense of security; being proud of myself; high self-esteem
Substance free	don't get mixed up with drugs and alcohol; don't abuse medication
Personal success	approval from others; taught to be self-reliant; function in their livelihood, take care of family and help in their community; satisfaction with what you've done

The Factor Domains That Define Mental Health and Wellness

The consolidation of each participant's responses to Question One served to provide

initial categories for open coding. Axial and selective coding proceeded and characteristics of

mental health and wellness clustered into several categories: (a) mental self, (b) spiritual self, (c)

emotional self, (d) sense of self or physical self, and (e) environmental stability. Responses also

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clustered into various categories of domains that defined attributions of being mentally healthy

and achieving wellness. The identified domains were: (a) relationship to the internal self, (b)

relationship to the external self, (c) relationship to others, and (d) relationship to power. A

relationship between the attributes emerged within each domain. The attributes illustrated

properties that could be conceptualized along continua of movement toward wellness, with some

describing active processes, some being descriptive of states of being, and some describing

reactive processes to external events. This process is illustrated in Table 11.

Table 11

Continua of Wellness

Wellness			
A movement in relationship to:			
Internal Self	**External Self**	**Others**	**Power**
Self-esteem	Praise	Connection	Self control
Desire change	Desire Change	Encouragement	Empowerment
Balance between positive sense of self and self-criticism; serenity, inner peace	Physically well	Feeling connection, family, love, having a supportive environment	Balance between change and stability
Motivation	Be active	Getting support from others	Capable of doing what you want
Independence	Optimist	Being respected	Determination
Feeling good about your life	Productive	Generate a supportive environment	Willingness
Not self-defeating	Interactive	Not isolated	Giving

Mental health is defined by one's relationship to oneself.

Participant responses clearly indicated that being mentally healthy is defined by the relationship one has with themselves, with others, and a sense of stability.   In fact, groups spoke of "having pride in who one is" and having a "sense of connectedness to others" as important facets to achieving wellness. Groups mentioned that, "wellness comes from within" the person. Another participant stated that, "wellness is found through living and experiencing the good and bad … finding out who you are." It was made apparent that "self-awareness" was one aspect to gaining knowledge about who you are as a person. "Knowing [yourself], values, boundaries, and goals" were examples used by participants to describe elements of being mentally healthy. However, it was important to learn to balance your own needs and desires with those needs and desires of others. Some participants spoke of how difficult it was for them to implement self-care since they were taught the needs of others were more important than their own. In fact one participant identified a mentally healthy person as someone who was "very comfortable with themselves, caring about other people, understanding other people, and are very reliable."

Groups elaborated on characteristics of a mentally healthy person, which included being "independent," being "physically well" by "hard work and exercise," and having a "high self-esteem." Another participant noted there are different components to being mentally healthy, such as "feeling good about yourself, tackling problems that you have surrounding you, and being determined to succeed" in life. One participant stated she needed to "think that [she] was important so that [she] would have a sense of self." Another participant spoke to the same phenomena talking about "what makes us survive is somebody thinking we are wonderful" and having "somebody else who thinks you are somebody."

Numerous participants spoke to the importance of "being drug and alcohol free" in order to maintain wellness. In fact, one group member mentioned they were now "well adjusted" meaning, "I am not an alcoholic, I don't smoke, I don't do drugs, and I don't have a violent home." However, the participant responses clearly indicated that being alcohol and drug free consisted of physical implications along with emotional and environmental stability.

The participant identified another element to wellness as a mental aspect, meaning that one must "be able to handle stress" (i.e., accept and deal with stress appropriately), such as financial issues. Others spoke to the fact that being mentally healthy means, "being able to think clearly, make rational decisions, and having the strength to deal with what life gives you. For instance, one participant stated that, "when you are stable … you don't let too many outside things bother or get you down; don't allow any outside influence like drugs and alcohol."

In summary, being mentally healthy or achieving wellness is characterized as an active process that indicates movement, growth, and self-awareness. The overall process of gaining a sense of self includes being independent but also being connected to your surroundings. The growth process includes implementation of coping skills to handle the stressful moments of life, while allowing the self to live and learn from life experiences.

Mental health is defined by one's relationship to others.

All of the groups indicated that an element of mental health was the development of "positive relationships," whether that was with a family member, significant other, or role model. One participant stated that wellness included, "being happy and confident" about my job and life, such as having "successful relationships with family and friends." Another participant stated that part of her wellness was that "no major traumas were going on in [her] life," which included relationship difficulties with others. However, another participant stated that a mentally healthy

"person has to function in areas like their livelihood, to take care of their family, to help in their

community, to do a job, to socialize but don't over indulge … and to have their family" to love.

Responses also spoke to how "wellness is reflected in your physical being and in your

environment," such as in your home, work, yard, or reservation. In fact, many participants stated

that wellness "always comes back to the home." Two groups mentioned that wellness begins in

childhood and "it is the people in the world that take time out for theses young people" that will

make a difference. Another participant stated, "what happens in the home" is important, "like

telling the children that you love them, showing them you care, and knowing when to give your

kids a hug." One woman stated, "I feel that people who don't talk … hold back their feelings ...

and don't show emotion, don't express anything … can have a negative impact on their life."

She noted the importance of building relationships within the home and the positive impact those

relationships have on achieving wellness.

One woman spoke of how she looked up to her grandmother since her grandmother "was

a strong believer in God… she had it together, meaning she had a strong faith in God." In fact,

this individual indicated that striving to be like God was one way of achieving wellness. Other

participants noted that, "the spiritual side" of wellness is always being "grateful for what you do

have." At least one member of each group indicated, "spiritual wellness was the foundation" for

obtaining "good mental health." Responses also spoke to the importance of being "at peace with

yourself and your surroundings."

In summary, wellness incorporates various facets such as building and maintaining

positive relationships with others, being able to function in stressful situations, and having a

stable environment from childhood. Expression of emotions (or lack of) can have an influence

on an individual's sense of self and emotional connection to others. Spirituality appears to be an important element of wellness, given the sense of serenity and connection to a Higher Power.

Mental health is defined by one's relationship to power.

All groups spoke to the importance of having "control" of their lives. One participant stated that, part of "being mentally healthy" meant "being in control of my life" and "what I chose to do." Others indicated that, "you have control to change your life," meaning that wellness is obtained through empowering yourself. However, participants mentioned the importance of having a balance between change and stability. As one participant discussed how people move toward wellness she noted that, people "are only going to become well when they want to, not when people tell them to."   She continued to describe how people must be willing to change and accept that they have the ability to change.

Participants also spoke to being empowered by being "satisfied with what you had done in life," such as personal accomplishments. Many responses spoke to the financial difficulties within the community. Three groups spoke of "having financial stability", which led to being satisfied with their life as an element that was necessary for wellness. According to the participants, financial stability was a measure for personal success.

In summary, movement toward wellness incorporates a sense of control and the ability to empower ones self, which may include self-awareness in order to obtain personal growth. However, personal growth can only occur when the individual is willing and motivated to address issues that hinder their wellness. Additionally, acknowledgement of personal accomplishments and obtaining financial stability were identified as important elements that contributed to becoming mentally healthy.

"What Do You Consider to Be Circumstances or Situations That Can Negatively Affect a

Person's Mental Health or Well-being?"

After identifying the qualities and characteristics that contribute to being mentally

healthy in Question One, each participant generated ideas as to what types of circumstances or

situations would have a negative impact upon someone's wellness. Participants identified

numerous contributing factor responses as to specific events that may occur in one's life. Given

the importance of categorical analysis, Table 12 includes the verbatim consolidated responses

each group generated.

Table 12

Question Two Consolidation Responses of Each Group

Group One: (Age 18-25)	
Category	Description
Relationships	death in the family; family problems; divorce
Substance use	alcohol; drugs
Environment	neglectful home; none of your needs being met; parents using substances; lack of emotional support; no positive role models; parents are not around; low income/money problems
Trauma	physical abuse; going to prison

Group Two: (Age 26-40)	
Category	Description
Relationships	family conflict; harassment; name calling; death of a family member; divorce; [family member] tried committing suicide; [sibling] sent to prison; end of a relationship
Substance use	alcohol use in the family; own use of drugs and alcohol
Environment	domestic violence; married to an abusive husband; others drain me
Trauma	verbal abuse; emotional abuse; physical abuse; sexual abuse; not wanted by parents

Table 12 (continued)

Question Two Consolidation Responses of Each Group

Group Three: (Age 41-60)	
Category	Description
Relationships	divorce; death in the family; mixed marriage; seeing your own children struggling; not liking yourself
Substance use	alcohol use; being an alcoholic
Environment	neglected as a child; boarding schools; European ways; unemployment; welfare; not fitting in; culture clash; politics; living in an alcoholic home; domestic violence; married an alcoholic; moving from the mission to the public school
Trauma	physical abuse; sexual abuse; emotional abuse; first haircut (at boarding school)
Personal changes	medical problems; being raised a Catholic and switching religions; teen pregnancy

Group Four: (61 and older)	
Category	Description
Relationships	death; relationships with people that you deal with on a daily basis; being treated with little respect; being selfish; being dishonored; not able to accomplish good for other people
Substance use	going to the bar to escape; drinking; drugs; use of alcohol or drugs
Environment	violent home; the way you are treated as a child; basic needs are not met; domestic violence; no religion
Trauma	being sent to boarding school; childhood abuse; sexual abuse
Personal Changes	poor physical health; physical illness; low self-esteem

The Factor Domains That Define Negative Circumstances

The consolidated responses of participants were used in the analyses and emergence of

categories that identified three main factors that negatively affect wellness. Factors that effect

wellness were clustered into several categories: an impact on the (a) mental self, (b) spiritual

self, (c) emotional self, (d) sense of self or physical self, and (e) environmental stability. Various

categories of domains that defined factors that negatively effect wellness emerged though the

responses. The factors of each domain were related to: (a) the self, (b) others, and (c) the

environment. The properties of each of these domains are illustrated in Table 13.

Table 13

Negative Circumstances

Life Events
Factors affecting wellness:

Self	Others	Environment
Feeling of no control	Loss of connectedness	Disconnected
Self medication	React to behavior	Violence; neglectful
Disempowered	Substance abuse	Violence; neglectful
Lack of self-esteem; feeling unwanted	Disrespectful; influential	Uncontrollable

Life events affect upon the self.

Responses indicated that numerous life events could have a negative impact upon one's well-being. Examples that were generated included all developmental stages, beginning at birth and lasting through one's lifetime. One woman said, wellness "stems from the very beginning … as an infant." She noted, "how you are treated and raised, and the things that happen in your life when you are young" is what shapes your sense of self and mental well-being. Another participant said, "I think that is why a lot of [adults] have mental problems because they couldn't deal with what was brought to them when they were young." It was stated that since people were hurt as children, one could "hardly expect them to grow up to be well loved, well mannered, well physically and mentally" because they are defensive given their past experiences.

A person's sense of self and physical well-being was another theme that was identified by numerous participants. For example, one person stated that nutrition was an important element and now she recognized that she could have taken better care of her dietary needs. Others spoke to the importance of having a positive self-image and noted there were times in their lives when they "did not like" themselves very much. Some individuals spoke of poor decision-making

skills and the inability to value their own worth as reasons for why they did not like who they were as individuals. In fact, one woman said, "if you end up thinking only of yourself, you are being cheated of the biggest thing in life … making somebody else happy." Another participant indicated they "went to prison" and "felt trapped … everything was out of control." They noted their "spirit" was broken and they became vulnerable to others, which left them feeling powerless. Another individual indicated being pregnant at a young age had impacted her life in numerous ways, including her sense of self.

Numerous participants spoke to the loss of a family member as being an event that had a huge effect on their wellness. One individual stated that "the most threatening situation that has happened in my life was the time of losing my mother." Others mentioned they never allowed themselves to become "angry" about their loss, but felt "sadness and loss." Death of a close family member had even triggered other family members to attempt suicide and behaviorally act out to the point where they became incarcerated. Another person stated when a "family member dies, you think that nobody wants to be around you" … so you "go out and drink to try to take your mind off of it."

The theme of dealing with a negative life event focused on turning to alcohol or substances as a way of coping. For instance, numerous individuals stated that people "get down" and "go to the bar" to "escape" from their issues. Others spoke of how alcohol or drugs had affected their behavior, such as "running around" and "not taking care of [their] children." Responses indicated that participants felt like "failures" in life and turned to drinking as a way to avoid the emotional pain. However, some participants discussed how being "addicted to drugs and alcohol" can "control how you live your life." One participant indicated that given her history of substance abuse, she was always concerned "the law would take [her] kids away." It

was clearly stated that alcohol and drug use affect a person's environment, such as not being able to "keep a job" and "showing up late for work … not being efficient at work … or arguing and fighting with friends and family." One participant stated she had tried to let others know how substance use was "affecting them because they could not see it" for themselves.

Overall, responses indicated that a variety of life circumstances could affect how one perceives themselves, which may lead to utilizing coping skills that cause additional distress. For example, many participants discussed how emotionally they were affected by life decisions, death of a loved one, and childhood trauma, which led to substance use. Others spoke to the issue of abusing substances, which led to family conflicts and environmental consequences, such as loss of employment or being unproductive.

Others affect wellness.

Again, responses indicated that others actions (or lack of) can affect one's sense of being mentally healthy from childhood. For example, children who didn't get "the care they needed as a child, such as being "loved … touched … and told they were smart, pretty, or talented" would have a lower self-esteem. One woman stated while "growing up, my mom didn't tell me she loves me … she never hugged me … or told me anything like I am beautiful." She later added that even to this day, she had not received the physical or emotional caring from her mother, which had an impact on her sense of self.

Responses indicated that "relationships with people that you deal with on a daily basis" could affect your wellness. For instance, when you are disrespected by other, like being "harassed, called names, and receiving dirty looks" can make you "feel real uncomfortable" and "excluded." Additionally, participants spoke of being verbally abused by others. One

participant stated at times "my ex-boyfriend said mean things to me … that made me feel bad about myself."

Violent or abusive relationships were identified as an element that affected one's mental and emotional well-being. One woman stated, " guys I was with they just beat me up so it probably just made me feel more worse … it made me not even care anymore" about who I was as a person. She noted she had to deal with their "over protective" behavior, "jealousy," and "cheating." Another women discussed a past abusive relationship and said, at the "time my ex-boyfriend left me … I was effected mentally … because I thought I couldn't find anybody else."

Again, alcohol and substance use was a theme throughout conversations. Participants indicated when others drink "they act differently, think differently, say things differently" and "it impacts everybody around them, especially loved ones." One woman who was married to an "alcoholic" stated they "relied on the alcohol first" before they focused on their "real priorities – the family." Others noted alcohol and substances "controlled" their partners, which led to verbal abuse and physical abuse. One woman said that "if there is a lot of drinking and drug in the family" or children were "sexually molested" then it would "negatively affect a person." She continued by saying "when they are older they just can't function like they would have been able to if things hadn't happen to them."

One interesting topic that emerged from discussions with participants was how the "mentally ill" were treated within the community. One participant stated, all people "need friendships and companionship" and had noticed that the "mentally ill" were treated with disrespect. Even brothers and sisters of "mentally ill" individuals do not "have compassion for them." She indicated she was disturbed at the fact that "the other siblings treated the person with little respect."

In sum, the responses indicated that others' behavior and actions could impact one's wellness. Some of the themes that were discussed included being disrespected by others, need for companionship, traumatic childhood experiences, abusive relationships, and substance use. Participants spoke to how negative life events can impact someone's sense of self and ability to function later in life.

Environment factors that affect wellness.

One theme that emerged from the responses indicated that a home environment was one element that affects one's mental health. Such as a "neglectful home" that consists of "no emotional support" given that "parents are not around." Or, "when there is a big family and the father drinks, beats the mother, and the kids don't have enough to eat" the individual will then "either follow that pattern or they do a complete change." However, for a change to occur one must have a "positive role model" to influence behavior and learn how to respect others. One participant said, "I didn't like watching my mom drink" because growing up in a home with parents who used alcohol "was rather emotionally stressful at times." Additionally another woman stated that "living in an alcoholic home" was extremely difficult for her because she saw her "mother being beaten" by her father, while he was under the influence. Interestingly, one participant stated it was difficult for children to seek help since children are "unaware of services within the community" and "as a young child, they don't know where to turn. They have no help." She indicated that often times children may realize help is needed but have no where to turn to. Her solution to the issue was that "maybe they can get help by someone (an adult) that may be aware" of the family issues and that person could intervene.

Domestic violence was also noted as being a factor that could influence the home environment. "Living in a domestic violent relationship with verbal, physical, and mental abuse"

can affect one's sense of self and mental well-being. One woman revealed that her domestic

violent relationship included a cycle of her partner giving "empty promises" and continually

saying "I'm sorry, I need you" or "you are the only good thing that I have in my life." However,

this woman took responsibility for allowing the cycle to continue and said, "I drug it on and

caused it … I would do all these things to become better … well … whole, and then I would get

back with that person." She indicated once she returned to the relationship "it was like [she]

could feel him draining [her] back down."

Again, financial hardship, such as being from a "low income" family, was identified as

an environmental element that impacted one's wellness. Other factors that contributed to

financial hardship were "unemployment and medical problems" since those issues "could be

stressful" on all family members. However, one woman stated that her sense of self worth was

affected by financial status. She noted "you see people that are succeeding financially better

than you are when you are young" which caused me "to wonder if [my] husband loved [me] as

much as the couple next door."

Numerous participants discussed how the history of boarding schools and the poor

treatment of students affected wellness among tribal members. One woman stated, "what used to

make me sad was that people would send their kids away to a boarding school or a mission and

have them raise them." Another participant indicated boarding schools "pretty much wiped out

any wellness at that time" because students "got in trouble from the nuns for talking the Indian

language," and "peers made fun of you when you tried to use the tools that the Europeans used to

be well." One woman stated that as a young school girl she was told by peers that "you're trying

to be White" because her "Native culture was taken away" from her. She reported that she was

"left with nothing." In fact, "so many people have tried to fill that nothing with booze and with

drugs" since they had "no positive role models" to look up to for guidance. The boarding school situation was also difficult on one's mental health because "being separated from family during that time" and having your "hair cut was really traumatic." Although, some participants spoke to how they "felt inadequate" because "moving from the mission to the public school" system was very difficult for them. Others noted they had been raised Catholic and then "switched religions" and converted to being a "Christian."

Some responses indicated that "cultural conflict" was an issue that affected their sense of self. The cultural conflict included being in a "mixed marriage" meaning marrying a non-Indian and dealing with "environmental differences." Others spoke to how agencies impacted the "Indian way of life." For example, one participant felt the state system "takes your freedoms away from you and they stuff pills down your throat" to control your sense of wellness. One woman stated "it seems that the mental health process seems to be control; if they can't control you one way they will control you another." For instance, in the past "the White man took over Indian property and started moving in and putting up fences and telling us we couldn't move off this little square. And you must conform and be under our control. Stay on your reservation, don't move off."

In summary, it is clear that the participants identified a variety of environmental factors that affect mental health and wellness. Responses included financial hardship, home environment, boarding school experiences, cultural and religious conflicts, being controlled by outside entities, and lack of knowledge about available services.

Participants' Responses to Questions Three and Four:

"If You Found Yourself In (an identified situation) and Were Looking For Help or a Way to Feel

Better, What Would You Do? How Would Doing (the activity they describe) Help You to Feel

Better?"

Given that Questions Three and Four are directly related, the responses have been

combined to allow the richness of the data to emerge. Each participant generated specific

resources they tend to utilize when faced with negative life circumstances. Additionally, they

provided information as to how turning to specific resources had an impact on themselves.

Table 14 illustrates a combination of responses each group provided for Questions Three and

Four and given the importance of each groups' responses to the categorical analyses, the

consolidation of the responses for each group are included verbatim in Table 14.

Table 14

Consolidated Responses of Each Group for Questions Three and Four

Group One: (Age 18-25)	
Category	Description
Emotional connection	relate to what I was going through; she has always been there; there is that bond between us; bring up good memories; talk to a whole bunch of people
Problem solving	show me which way I should go if I am confused; give advice; talk out my problems; get a third party insight to the situation; rather have suggestions than tell me what to do; willing to be open
Self-analysis	I wouldn't really talk to anyone about it I kept it to myself; just shrug it off; crying just helps me release anger

Table 14 (continued)

Consolidated Responses of Each Group for Questions Three and Four

Group Two: (Age 26-40)	
Category	Description
Emotional connection	she understands because it happen to her too; they supported me; knowing somebody cares about you; my auntie makes me feel secure; Al-Anon provided confidentiality
Problem solving	vent; meetings with family members to help us through it; thinking about the problem and figuring it out instead of turning to alcohol or drugs
Self-analysis	it is up to me to take care of it; realized what I was doing wrong and figured out how to get back on track
Physical activities	you just feel different; like a weight has been lifted off of you; feel free; helped keep me focused
Faith	feel a little bit more positive; the priest just made me feel better; knowing that God was helping me; inner peace
Normalize	realized that other people were experiencing and had experienced the same pains; I am normal; felt better about life experiences; justify [her] own pain

Group Three: (Age 41-60)	
Category	Description
Emotional connection	get real understanding from others; bond with others; took care of each other; you are not isolated; just feel free to cry and be angry; knowing it was a safe environment; trust others; supportive; didn't feel threatened; comfort and healing
Problem solving	got some ideas about things; nice to have someone else who is objective; gain a wider perspective; get some of the skills so that we are able to do it for ourselves
Self-analysis	going through some exercises (self-help); help me understand my dad
Physical activities	emotional growth; spiritual growth; sense of belonging; don't focus on what you don't have; feel healthy; inner strength
Faith	helps me believe in a higher power that I am not doing everything all alone; you can communicate with the Creator either verbally or in your thoughts; connected and there is a kind of peaceful feeling; non-judgmental, support
Normalize	knowing the way it happens to other people, it is within the normal range of what happens; hearing other people who have had the same kind of experience

Table 14 (continued)

Consolidated Responses of Each Group for Questions Three and Four

Group Four: (Age 61 and older)	
Category	Description
Emotional connection	help support each other; talk to someone who cares; provide unconditional love; sense of connection; understanding
Problem solving	get advice
Self-analysis	having something to be responsible for
Physical activities	get in touch with the spirit; help physical health; peaceful
Faith	ask for health and mind; let go of fear; put it in His hands; trust in a Higher Power; cleansing
Socialize	makes me happy; social interaction with others in the same boat
Model behavior	look up to others and build positive relationships
Normalize	others had similar experiences

The Factors of Improving Wellness

The consolidation of each participant's response to Questions Three and Four served to supply initial categories for open coding. Axial and selective coding resumed and characteristics of the enhancement of mental health and wellness clustered into several categories: (a) emotional, (b) mental, (c) sense of self, (d) physical well-being, and (e) spiritual improvements within the individual. Responses also clustered into various categories of domains that defined attributions that affected wellness. The factors of each domain were related to: (a) the self and (b) others. The properties of each of these domains are illustrated in Table 15.

Table 15

Improving Wellness

	Resources
	Factors affecting wellness:

Self	**Others**
Emote	Provide support, comfort and understanding
Feel proud	Encouragement
Centered/balanced	Emotional connection
Trust	Objectivity, advice, safe environment and confidentiality
Vulnerability	Unconditional love

Help-seeking behavior that enhances the self.

Participants identified a variety of resources and reasons why those resources assisted in the wellness process. Spiritual growth included participating in prayer, talking with the priest, vision quests, attending the Long House, meditation, and going to a Cursillo. One participant stated when she was faced with emotional distress, she turns to her "Higher Power" so she can "tell Him [her] problems and put it in his hands." She also stated she turns to her Higher Power because "you know you are in good hands." Another individual noted she received strength from her Higher Power because she knew she was "not doing everything all alone" since "God was helping" her.

Both meditation and prayer allowed for the participant's to feel like they "were doing something" and allowed time for everything "just to work itself out." Others indicated talking to a priest was helpful because the priest made them "feel a little bit more positive" and "we could tell him anything and he wouldn't judge us." It was also mentioned that the priest was dependable and continued to be available for consultation as needed. Some even referred to the priest as providing "a lot of strength" for others.

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Attending Long House services was helpful by allowing others the opportunity to speak about what is "bothering" the person. Also, "hearing the songs" and "going out onto the floor," which is a sacred place, provided a sense of "connection and peace." Vision quests allowed for "spiritual and emotional growth" because an individual could "find their spirit that will guide them" since the spirit takes a shape or form of something tangible (i.e., a deer, eagle, or a fawn). Once a person has identified their guiding spirit then they can "call upon the spirit" to provide inner strength. One woman stated the Cursillo helped her "to open up" and "see a new way." Responses indicated "everything that is good is spiritual" and many participant's stated that spirituality was their "center."

Participant responses suggested that attending a range of activities provided encouragement and helped with the process towards wellness. In fact, some mentioned they "get more self-centered" with self-help exercises and noted that participating in activities kept them "occupied and enjoying life." One woman stated she enjoys "going hunting and fishing" because it allows for alone time and she "feels free." Others made reference to taking long walks in the woods because being out in nature and having silence was "like a cathedral."

Some participants spoke to the importance of attending conferences, workshops, and group meetings, such as Alcohol Anonymous and Al-Anon. It was clear these environments provided "confidentiality" and helped "justify emotions" that individuals were feeling. One woman stated she continued to attend workshops because they "helped keep [her] focused" on maintaining her wellness. Others discussed the opportunity to normalize their life experiences and being in a "safe" environment so they could talk and emote about their own personal issues. The environment provided "support," connection to others, and "helped with mental blocks."

Some of the cultural activities that were identified included attending pow-wows, sweats, wakes, Indian medicine, and participating in talking circles. Again, having life experiences normalized and feeling connected to others was a primary element of the environment. One woman spoke of her experience with talking circles and she stated what was helpful was "hearing others who had the same experiences" as she had and feeling a "connection" to the group members. The impact that pow-wows had on wellness include "feeling happy" by participating in a ceremony and enjoying the "music" or having the opportunity to "listen to what the elders have to say." One participant stated sweats helped her because she felt "like weight had been lifted off" of her shoulders. Wakes were noted for the importance in "letting go of the loss" and were a way that friends and family could "bid farewell" to the deceased. Another aspect was that a wake brought "everyone together" and provided a supportive environment that "helped with the grief period." One individual provided a story about how she turned to Indian medicine, the elders, and her auntie for assistance when her family was being negatively affected by "bad medicine." She said, the elders instructed her to "go sweat" and then they "told her what [she] needed to do" to have the bad medicine lifted. She was told to have her daughter drink "wild rose water … put wild rose water throughout her house … and smudge with cedar" to ward off the bad spirits.

Friends and family members are another important element that contributes to one's well-being. For instance, one woman stated, "I confide in a very close friend" because the friend "supports me." Another woman indicated she had a friend to whom she went with a variety of problems because she knew that they had "similar experiences" and were able to relate to her emotional pain. Others spoke of their closeness with grandparents or parents. A number of participants stated they turn to their mother because "she could relate" and "she has always been

there" for emotional support. Responses spoke to the importance of the bond between family members and friends. One woman indicated she turns to her auntie for support because she "feels secure" with her auntie, not to mention that her auntie told her she was "a strong person." Another participant spoke about the "comfort and healing" she received just by her grandmother's presence. Basically, the participant's all spoke to the safety, security, bond, and consistency the family unit provided. Some individuals spoke to getting "advice" from family members because they trusted them and had utilized elders to "give them direction."

Responses indicated that attending counseling was helpful for a variety of reasons. For example, one participant stated counseling helped her "realize what [she] was doing" and helped her get on the "right track," such as developing the "right thinking" in her mind. Others noted that having someone who was "objective" and able to provide "suggestions" was helpful. Some participants stated they "gained a wider perspective" from counseling and enjoyed being able to talk with someone about their issues. Counselors provided "acknowledgement, encouragement, and reassurance" at times. One woman spoke to how counseling made her face reality by having to "hear what you don't want to hear" but noted, "you just have to be able to take it." Another participant noted that counseling allowed her to hear "hey you know what to do just go do it," which provided her the support and encouragement to face her issues.

One individual identified "feeling safe … loved … part of the community … and being able to contribute something" to others as the most important aspect of her wellness. Her wellness is achieved by utilizing self-reflection and self-help. Another participant said they tackled their issues head on because she "felt like it was up to [her] to take care of it" since she controlled her destiny. Responses indicated that taking "care of the problem" made others "feel better" and gave them a sense of empowerment. One individual stated they now "think about the

problem and figure out what to do instead of turning to alcohol or drugs." It was clear that by empowering one's self, the individual feels proud they are being proactive and providing self-care.

Overall, responses spoke to the variety of methods participant's endured to obtain wellness. It was evident that safety, emotional connection, support, objectivity, confidentiality, and presence of unconditional love were important elements necessary for personal growth. Participants utilized a variety of methods to improve their mental wellness, emotional connectedness, physical well-being, spiritual self, and sense of self.

Participants' Responses to Question Five:

"What Activities/Opportunities/Resources Might Serve to Promote Mental Health and Well-being For You and People in Your Community?"

Each participant generated a variety of ideas as to what types of activities and resources within the tribal community promoted wellness. Table 16 illustrates responses each group provided for Question Five. Given the importance of each groups' responses to the categorical analyses, the consolidation of the responses for each group are included verbatim in Table 16.

Table 16

Question Five Consolidation Responses of Each Group

Group One: (Age 18-25)	
Category	Description
Tribal involvement	root feast; Indian songs; berry picking; root digging; grave cleaning; weepy ceremony; pow-wows; sweats; Chinook dances
Socializing	get together and have dinner; family gatherings; BBQ's
Education	school; trainings; listening to elders
Programs	people that try to do things for the community; meetings; work; AA; help groups; counselors
Religious activities	go to church; Shaker church; Seven Drums
Recreation	music; fishing; basketball; baseball; football; swimming; skiing; snowboard

Table 16 (continued)

Question Five Consolidation Responses of Each Group

Group Two: (Age 26-40)	
Category	Description
Tribal involvement	pow-wows; sweats; beading; learning the language; winter dances; Chinook dances; get support from Tribe
Socializing	socializing with others; family time together; dinners; BBQ's; pizza night; parties with families; leisure time together to socialize; community members getting out and participating
Education	going to school; get elders to teach the kids; being a role model for children; bring people from the outside to talk about wellness
Programs	Karaoke night; alcohol relay; Alcohol Awareness conference; counseling program at mental health
Religious activities	prayer; Shaker religion; Seven Drums
Recreation	sports; shows; hunting; arcades; football; school dances; music; concerts; movies; swimming; camping; hiking

Group Three: (Age 41-60)	
Category	Description
Tribal involvement	hearing the language; naming ceremonies; vision quests; stick games; pow-wows; sweats; pipe ceremonies; talking circles; stick games
Socializing	visiting with others; time with children
Education	martial arts; schools do more cultural things; culture clubs; youth conferences; health fairs
Programs	alcohol relay; Alcohol Awareness conference; culture camp; pride drive
Religious activities	prayer; Shaker religion
Recreation	community centers have youth activities coordinators; swimming; camping; working in yard or garden; go to the zoo; museums; attend school functions; sports; crafts; rodeos

Table 16 (continued)

Question Five Consolidation Responses of Each Group

Group Four: (61 and older)	
Category	Description
Tribal involvement	clan lifestyle; pow-wows
Socializing	socialize at bingo; get together with family; friends in the community who are positive; extended family help raise children; role models; playing cards with family
Education	elders spend time at schools; being responsible for something
Programs	teen center; working together as a community; Operation Santa Clause; Food Bank
Religious activities	wakes; positive relationship with a spiritual self; Long House; Pilgrimages; Church; Cursillos; Altrayas
Recreation	school sports; veteran activities; school functions; fairs

The Factor Domains That Define Activities and Resources

The consolidated responses of participants were used in the analyses and emergence of categories identified eight community resources, in addition to the category representing the lack of resources with the community. Activities and resources that promote wellness clustered into several categories: (a) volunteering, (b) family time, (c) physical activities, (d) conferences or training, (e) traditional activities, (f) counselor or groups, (g) elders, and (h) spiritual activities. Various categories of domains that defined factors of community activities and resources emerged through the responses. The factors of each domain were related to the self and the environment. The properties of each of these domains are illustrated in Table 17.

Table 17

Promoting Wellness

Activities and Resources	
Factors affecting wellness:	
Self	**Environment**
Emotional connection	Physical activities
Giving to others	Supportive
Identity	Tribal traditions

Activities and resources within the tribal community that promote wellness.

Each group identified numerous community activities and resources that promote mental

health and wellness. The activities and resources clustered into several categories: (a)

volunteering, (b) family time, (c) physical activities, (d) conferences or training, (e) traditional

activities, (f) counselor or groups, (g) elders, and (h) spiritual activities. Each category of

activities and resources had identified sub-categories, which contribute to wellness in a variety of

ways.

Volunteer work within the community allowed others to "be responsible for something."

One member noted she enjoyed "working together as a community" in order to help others.

There were two volunteer programs that were identified: (a) Operation Santa Clause and (b) the

Food Bank. Participants stated helping others "makes you feel better" and the environment is a

"social place."

Numerous participants spoke to the importance of spending time with family and friends.

Some noted how "socializing" and spending time together allowed them to focus on good

memories, which improved their mood. The clan lifestyle was described as an environment

where "people come together to help others" who are in emotional distress. Family activities

were identified as a part of wellness because "they did it together." Participating in family

functions, such as shopping and having dinners, was identified as helpful due to the fact that you are around loved ones and "feel safe." Others noted the importance in allowing the "extended family members" to help raise the children, since it provided guidance and encouragement.

Physical activities were the most identified tools for wellness. Some of the identified activities included the following: bingo, teen center, sports, veteran activities, playing cards, concerts, BBQ's, fairs, fishing, hunting, pizza nights, skiing, snowboarding, school functions, movies, arcades, martial arts, hiking, camping, swimming, school dances, alcohol relay, pride drive, culture camp, crafts, karaoke, zoo, museum, clubs, community center, rodeos, school work, working in the yard, and going to work. One participant stated it was important for people to do "something constructive to avoid negative thoughts, which may be triggered by boredom." Others indicated getting an education was a way to improve your sense of self and made you more likely to be employed in the future. One woman said, "I love school, it is a good feeling" to know that I am accomplishing my goals.

Conferences and trainings provided awareness. Some of the conferences and trainings that were identified included the Alcohol Awareness conference, Tribal Health Fair, and youth conferences. Some participants spoke to the importance of having presenters come to the reservation to "discuss issues on faith and provide acts of strength" like the "Men of Royalty from Hawaii" did. It was noted that the presentation helped those participants to "be a better person." One participant stated she was thankful for the support she received from the Tribe to attend conferences, trainings and meetings. She noted getting "Tribal support," which could be financial or the acknowledgment of the importance of attending functions would be extremely important in helping others achieve wellness.

Responses identified a variety of traditional activities that promoted wellness. Some participants spoke to the relationship between the "spiritual growth" they receive from traditional activities and their feeling of being "in balanced." Traditional methods include wakes, pow-wows, sweats, beading, stick games, naming ceremonies, Indian language, winter dances, Chinook dances, vision quests, talking circles, pipe ceremonies, root feast, singing Indian songs, berry picking, root digging, grave cleaning, and weepy ceremonies. One individual noted he felt an emotional connection to his community when he participated in pow-wows, sweats, and wakes. Others noted feeling better because sweats initiates a "cleansing process," like weight is lifted off of your shoulders. "Stress reduction" was related to beading, sweats, and pow-wows, while others noted a decrease in cognitive ruminations. One elder indicated being involved with traditional ways allows "people to be at peace with the environment." It was obvious the participants agreed that traditional activities were "a time for families to come together," which improves one's sense of self, emotional connectedness, and productivity. One participant noted how weepy ceremonies encourages the individual to get "in touch with the spiritual side," which enhances mental health. Additionally, winter dances improved wellness by helping "family and friends to have a better year," meaning people dance in honor of a family and ask for the family to receive wellness. Talking circles were identified by a few participants as being helpful because "they get you strong" due to having "a sense of belonging to this earth" and encourage "spiritual growth."

Participants acknowledge the benefits of counseling and group therapy. One woman stated, "there are counselors and people in the community that you can talk to and who are willing to listen," which was an outlet she utilized in the past. Another woman stated just by "talking and doing self-help exercises" she was able to work through her issues and "gained a

wider perspective." Others spoke to how therapy provided "a change in feelings," allowed them

to "come up with different options," and gave them "reassurance." Another participant indicated

they gained "encouragement and acknowledgment" from therapy, which increased their self-

esteem. One participant identified objectivity and "learning skills to maintain wellness" as

qualities of therapy. One woman who had a very traumatic childhood, noted she needed a safe

place to "process" her emotions and was grateful for having her feelings "normalized" by the

therapist. Support groups, such as AA and groups for mothers, were identified as being helpful.

One woman stated "if you go to the mental health office there are help groups," you just have to

be willing to face your issues.

One elder stated "having someone in the community to look up to as a role model" was

essential to wellness. Responses supported that statement by acknowledging the importance of

elders within the community. For instance, one woman stated elders give a person "spiritual

guidance and direction," which gives you peace. Another woman described her relationship with

her grandmother and the great respect she had for her grandmother. The grandmother was

identified as "the rock in the family" because she provided guidance, "oral traditions" and a

sense of emotional connectedness. It was evident that the loss of this woman's grandmother

greatly affected her wellness by leaving a huge void in her self identify. A few participants

indicated elders could make an impact within the school systems by teaching cultural education

and providing guidance.

Participants identified various spiritual activities that impact one's wellness. For

example, prayer, the Shaker religion, Seven Drums, Cursillos, Altrayas, Pilgrimages, Long

House, and Catholic Church were identified as available resources. Responses noted the positive

impact that the Shaker religion, Seven Drums, and Indian songs had on wellness. The element of

spirituality was a way one could feel "at peace" and provided a "connection" to the Higher Power. Spiritual ceremonies were identified as an event "where families could come together." Wakes were described as helpful because it was a way to "bid the deceased farewell" and also helped others to "let go of their loss."

In sum, the Tribal community has numerous resources and activities that promote wellness. However, the benefits from the variety of activities can vary. The common elements that all resources possess, is the sense of connectedness, personal identity and desire for support.

Summary of All Responses to Interview Questions

This section provides a summary of all the generated responses to the questions that were investigated by this study. The summary for each question is presented independently.

Summary of Results of Question One: "What Does it Mean to You to Be Mentally Healthy or Achieve Wellness?"

Mental health is defined by five specific attributions: the (a) mental self, (b) spiritual self, (c) emotional self, (d) sense of self or physical self, and (e) environmental self. Wellness is characterized as a process that can be conceptualized along continua of movement that incorporates active processes, states of being, and reactive process to external events. The continua of wellness tend to incorporate four specific relationships: (a) relationship to the internal self, (b) relationship to the external self, (c) relationship to others, and (d) relationship to power.

A relationship with the internal self involves a positive self-esteem, a desire to change, a balance between a positive sense of self and self-criticism, motivation, independence, feeling good about your life, and avoiding self-defeating behaviors. The external self accepts praise, has a desire to change, becomes physically well, and is active, optimistic, productive, and interactive.

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The active relationship with others involves connection, encouragement, having support, being respected, and loved. Power has relationships to self-control, empowerment, balance between change and stability, ability of doing what you want, determination, willingness, and to give to others.

Wellness is defined as maintaining "a balance of emotional, physical, spiritual, and mental" aspects, but "there is always one area that maybe is not as strong as the other." Further, maintaining environmental stability was identified as an aspect of wellness. Therefore, the continua of wellness relies upon one maintaining a balance between the mental, spiritual, emotional, sense of self or physical self, and environmental stability.
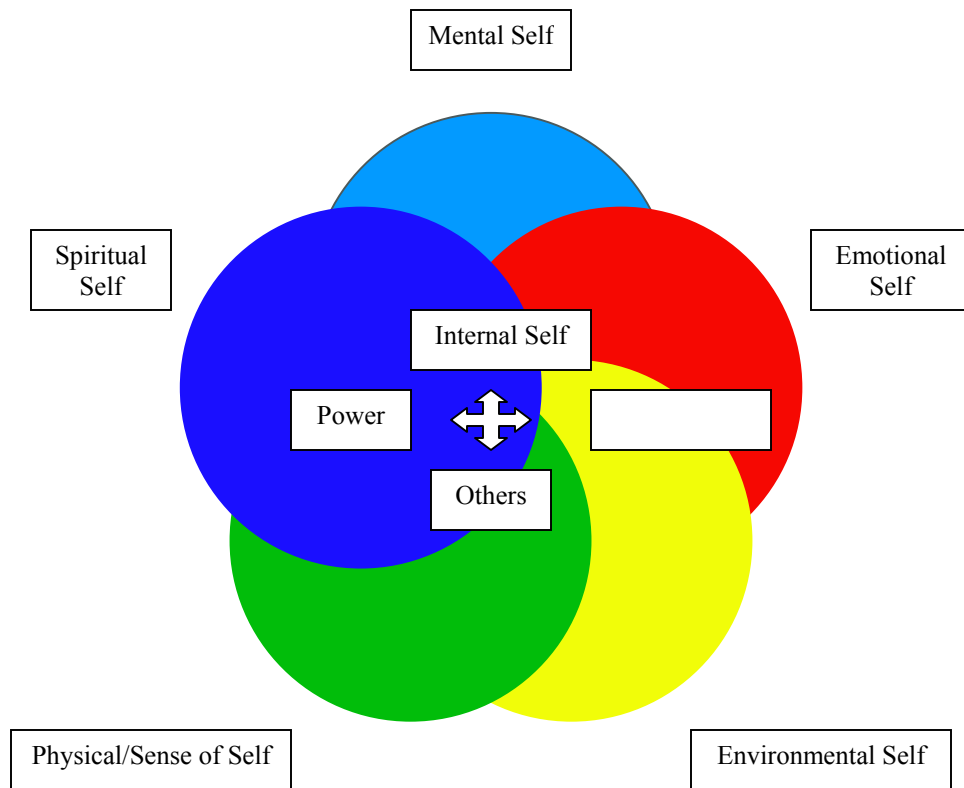
Figure 1. Colville tribal members' holistic model of wellness. The active process, state of being, and reactive process to external events that are conceptualized along continua of movement are depicted as the elements which are essential for personal growth.

Summary of Results of Question Two: "What Do You Consider to Be Circumstances or Situations That Can Negatively Affect a Person's Mental Health or Well-being?"

Responses indicated there were five core variables that can negatively affect a person's mental health. Participants believed that negative life events impact the mental self, spiritual self, emotional self, sense of self or physical self, and the stability of one's environment. Responses identified a variety of negative life events that affected wellness, which include the

following: complications with physical health, poor decision-making, loss of a family member, substance use, lack of emotional and physical attention, being disrespected by others, violent and abusive relationships, mental illness, neglectful home environment, domestic violence, financial difficulties, boarding school experiences, and cultural conflicts.

Negative life events affect the self, others and environment when a person is faced with emotional distress. It was clear that the sense of self was impacted by experiencing a feeling of no control, participating in self-destructive behaviors, being disempowered, and having a low self-esteem. The relationship with others would change in that others would be disconnected, reactive, and disrespectful. However, it was apparent that an individual's wellness was greatly impacted when others within the environment abused substances. Therefore, participants believed environmental resources were affected by life situations and the decisions and actions of others. Responses about the environmental resources tend to identify properties such as disconnection, violence, neglect, and being out of control.

Participants acknowledge the importance of developmental stages and indicated wellness begins at birth and last through one's lifetime. Responses affirmed the impact of negative life circumstances and illustrated possible complications from the devastating impact upon one's wellness. It was clear that wellness could be affected by one's self-perception of the event, impacted by how others react to the event, and the environmental conditions that are present during a life-changing episode.
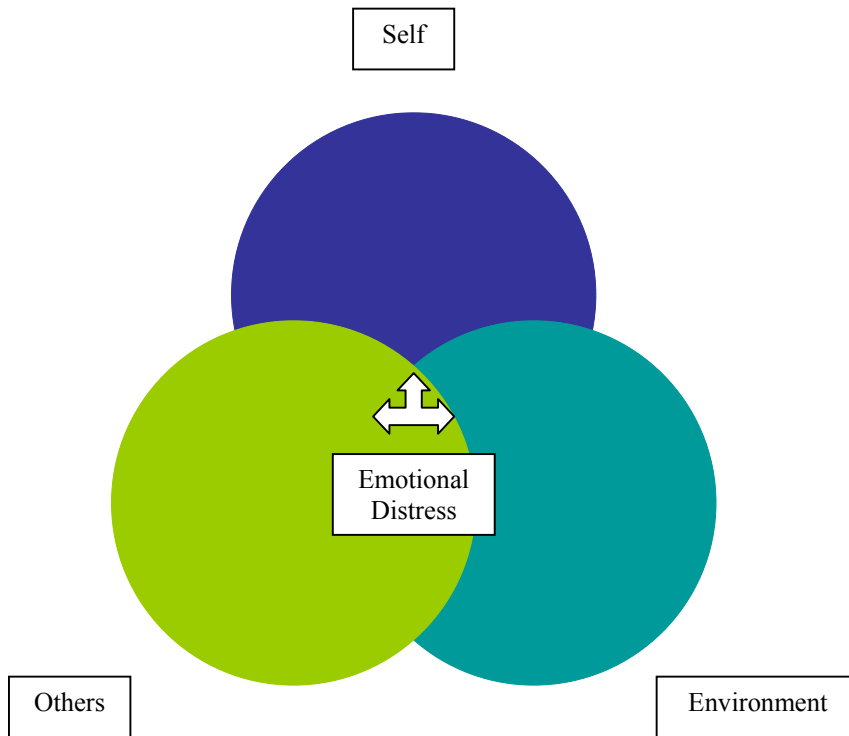
Figure 2. Negative life events. The item depicted indicates the impact of negative life events upon one's sense of wellness. Emotional distress brought on from relationship difficulties, substance use, trauma, and personal experiences impacts the self, others, and environment.

Summary of Results of Question Three and Four: "If You Found Yourself in (an identified situation) and Were Looking For Help or a Way to Feel Better, What Would You Do? How Would Doing (the activity they describe) Help You to Feel Better?"

In summary, participant responses indicated they saw five essential variables that contributed to maintaining wellness. Participants believed help-seeking behavior must incorporate improving the emotional self, mental self, sense of self, physical well-being, and

spirituality. Responses identified properties of improving wellness that focused on the self and others. Individuals discussed utilizing spiritual outlets, self-help exercises, attending conferences and workshops, participating in cultural activities, attend counseling with a professional, and self-reflection as means for obtaining wellness.

Responses supported the notion that help-seeking behavior enhanced the self by allowing one to emote, feel proud, become balanced, instill trust, and experience a sense of vulnerability. On the other hand, participants received support, comfort, understanding, encouragement, emotional connection, objectivity, advice, safety, confidentiality, and unconditional love from others.

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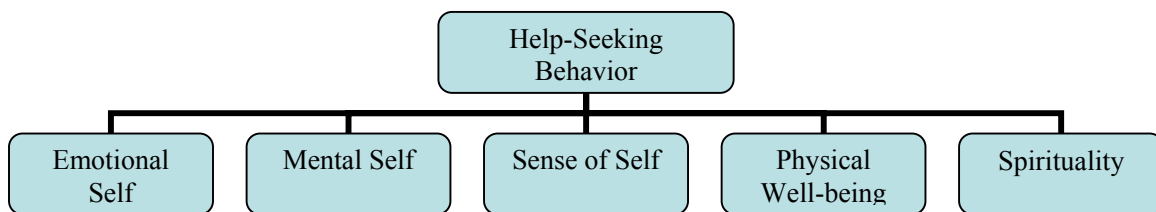
Figure 3. Help-seeking behavior. Elements of wellness that are impacted by seeking help.

Summary of Results of Question Five: "What Activities/Opportunities/Resources Might Serve to Promote Mental Health and Well-being For You and People in Your Community?"

Again, participants identified numerous activities and resources within the tribal community. Participants believed that volunteer work, family time, physical activities, conferences and trainings, traditional activities, counselors and groups, elders, and spiritual activities enhanced wellness. Responses indicated that such resources affect the self and the environment. Participants spoke to the importance of maintaining an emotional connection, self-identity, and giving nature. It was clear that the environment provided support, physical involvement, and elements of the Tribal culture.

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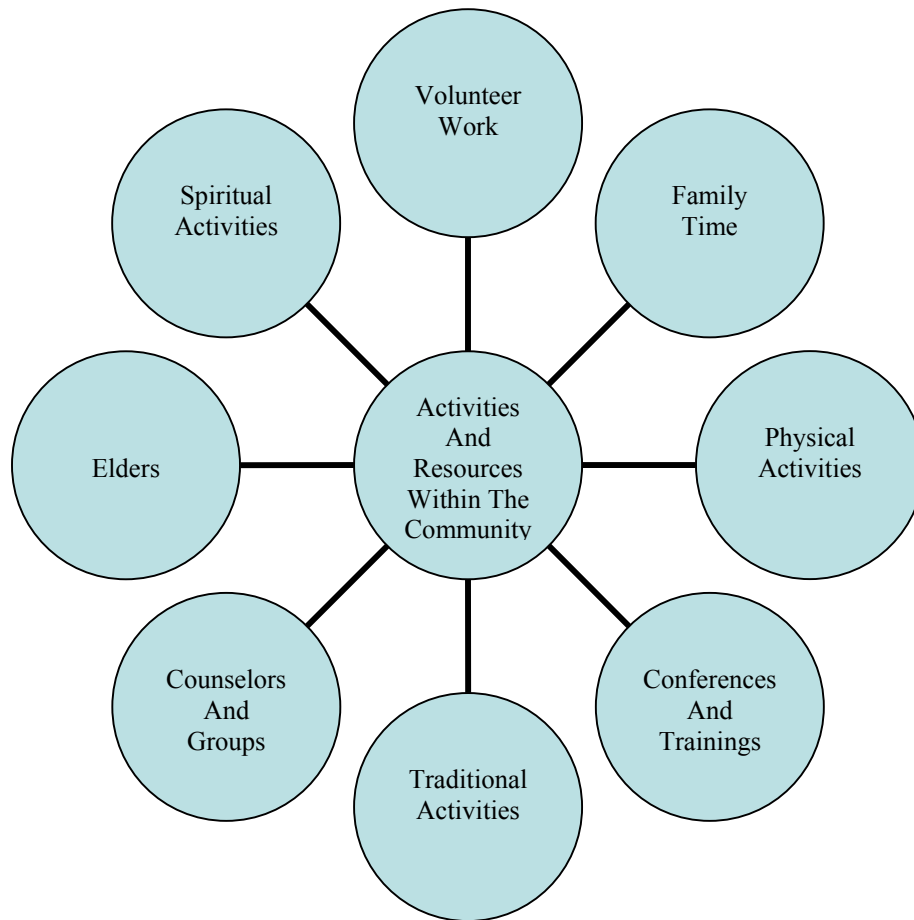
Figure 4. Activities and resources within the Tribal community. The illustration represents activities and resources that were identified by Colville tribal members as methods utilized within the Tribal community that promote mental health and wellness.

Summary of Degree of Cultural Commitment and Utilization of Traditional Methods

Nine of the twenty participants identified as having a strong degree of cultural commitment to Tribal culture and weak commitment to Anglo culture. One participant identified as having a strong degree of cultural commitment to Anglo culture and weak commitment to

Tribal culture. Further, seven participants identified as having a strong degree of cultural commitment to both Anglo and Tribal cultures. Finally, three participants noted having a weak degree of cultural commitment to both Anglo and Tribal cultures.

Of the nine participants in the strongly committed to Tribal cultural group, only four individuals indicated they utilized traditional methods to enhance their wellness. The one individual who identified with a strong commitment to Anglo culture did not utilize traditional interventions, but two participants who identified as having a strong commitment to both Anglo and Tribal cultures supported the use of traditional methods to improve their mental health. Further, one participant who identified as being weakly committed to both Anglo and Tribal cultures indicated they used traditional interventions to obtain wellness.

Overall, utilization of traditional methods was implemented by those who identified as either strongly committed to Tribal culture, strongly committed to both Anglo and Tribal cultures, or weakly committed to both Anglo and Tribal cultures. The strongly committed to Anglo culture was the only group that did not utilize traditional interventions. In conclusion, the responses indicated that four of the nine participants within the strongly committed to Tribal culture were apt to utilize traditional means, where as the other five members of the strongly committed to Tribal culture group did not utilize traditional interventions to achieve wellness. Therefore, the degree of cultural commitment was not a strong indicator of whether or not an individual would utilize traditional interventions to enhance their wellness. In fact, only thirty-five percent of all participants utilized traditional methods, regardless of their degree of cultural commitment.

CHAPTER FIVE

Discussion

Introduction

The present research was performed to meet numerous objectives. The study was designed to begin investigation of the mental health and wellness phenomena, from the perspective of Colville tribal members. Specifically, the investigation was intended to inductively generate or discover what factors contribute to help-seeking responses, and in turn, what identified resources are considered when an individual determined that they needed assistance. The research was intended to allow Colville tribal members to identify the types of community activities that would promote mental health and wellness. Finally, this investigation was proposed to stimulate interests for future research about tribal specific views of mental health and wellness based on the findings.

Chapter Five discusses the findings of this investigation of *Colville Tribal Members' Views of Mental Health and Wellness* in relation to the proposed objectives of the examination, the implications of the results, and the methodological limitations of the study. The chapter begins with a summary of the methodological limitations in the present investigation. The next section provides a summary of the grounded theories of mental health and wellness in this study. Then, the findings are discussed, comparing the present results to previous research with similar focus and contrasting the current results with existing theories. The implications of the current findings are also assessed relative to several hypotheses and of the unique variations the study represents. Finally, suggestions are made about direction for future research related to views of mental health and wellness.

Methodological Limitations in the Study

This section evaluates the methodological limitations of the present investigation. The limitations of the study include: (a) limitations of the sample size, (b) format variables, and (c) analysis limitations.

Sample Size

The sample consisted of 20 volunteers from the Colville Reservation or surrounding area who are 18 years of age or older. The 20 volunteers were separated into four identified age groups (i.e., 18-25, 26-40, 41-60, and 61 and older) and each age group contained five participants. The sample sizes of most descriptive and qualitative studies are small. In fact, purposeful sampling would include five to twenty-five participants (Leedy & Ormrod, 2001). Generalization of results is difficult given the small sample size. Therefore, qualitative studies are not intended for generalized findings, but rather for rich, descriptive illustrations of phenomena (Strauss & Corbin, 1998).

The present investigation utilized a small sample of Colville tribal members to identify grounded theories about the defining and contributing attributions of mental health and wellness. Additionally, the study was intended to identify help seeking behaviors, and available resources and methods that were utilized to obtain wellness. Twenty Colville tribal members participated in this study.

Each of the four groups contained five participants. Review of the quantitative data illustrates that Group One, age 18 to 25, generated the least amount of responses to interview Question One, Three, and Four. However, Group One participants were at least as productive in the quality of content as the other groups. Thus, developmental factors, such as life experiences, tend to differentiate between the chronological age groups.

Review of the transcripts indicated some differences existed quantitatively or qualitatively between the chronological age groups, but no significant differences appeared within the total sample size. Future research on mental health and wellness among ethnic diverse populations should utilize research designs that would emphasis total sample size as a variable in order to further establish the impact group size may have on the quality and quantity of content of the findings.

Sample Demographics

The sample of Colville tribal members in this investigation included seventeen women and three men. The researcher acknowledges the need to include additional men in future studies in search of grounded theories about mental health and wellness. All volunteers were enrolled Colville tribal members who resided on or near the Colville Reservation and who were involved or uninvolved in the mental health services within the community setting.

The researcher made a concerted effort to include a gender diverse target population as a total. However, given that the screening process began when volunteers contacted the primary researcher via telephone, e-mail, or in person in order to arrange for an individual interview, the researcher accepted all volunteers who met the specified requirements, until all five positions within the identified age groups were filled. However, two of the three men were assigned to the 18 to 25 age group, while one man was assigned to the 61 and older age group. One male participant stated he was hesitant to participant because "men don't usually talk about personal issues."

The sample of Colville tribal members did not include participants who self-identified as disabled or differently-abled. Therefore, the researcher recognizes the need to include physical and mental disabled men and women in future studies. This self-identified group could provide a

different view of mental health and wellness, especially given the personal challenges they may have faced.

In summary, future research could benefit from continued efforts to include an equal proportion of male and female participants and individuals with a variety of ability found in the Colville tribal population. This expansion of inclusion would provide the fullest opportunity for tribal members to voice their perspective on mental health and wellness.

Format Variables

The forty-five minute interview format of this investigation may have posed some limitations. Given the oral traditions of the Native American population, forty-five minutes seemed to be a short time to allow some participants to describe their perceptions, life experiences, and wisdom related to the five interview questions. Future efforts could benefit from a format using either one of two questions with a set time limit, pose all five research questions with unlimited time, or utilize focus groups that address three or four interview questions.

Given that data were collected from all participants versus analyzing data after each interview, the research was unable to gain additional clarification of some topics which were identified during the analysis stage. Future efforts could benefit from a format that encourages analyses of data after each interview in order to increase awareness of common themes that begin to emerge. Another format that may be beneficial would include a follow-up interview with the participants to gain further clarification if needed.

This study only utilized individual interview format. Implementing a focus group of each chronological age group may offer additional richness, complexity, and depth to the meaning of mental health and wellness. Themes that emerge from the focus groups could be compared to

the individual themes that describe wellness, negative life events that affect wellness, and resources that are available to promote wellness within the tribal community.

Utilizing different questions in individual interview, a focus group or survey format may also expand our understanding of the phenomena of wellness. For example, using the question, "What does it mean to you to have balance?" may generate alternative descriptions of wellness. Asking about tribal members' life changing events may tap into the process one goes through when faced with adverse events. For instance, questions like "Can you remember a personal life event that challenged your wellness?" or "Can you recall any changes in you sense of balance, during your lifetime?" or "Describe how cultural elements or activities may promote your mental health." Each of these alternative questions may generate additional richness in the data and help clarify previous findings regarding distinct themes of wellness. Utilizing a survey format may not provide the same quality of richness, but would allow for a larger data set of participant responses.

Analysis Limitations

This study was limited to the implementation of grounded theory induction and thematic analyses. The analyses generated the intended rich, descriptive data and grounded theories about the definition of mental health and wellness, processes of obtaining and maintaining wellness, and the available resources within the tribal community that promote wellness. Other observation suggested that additional analyses could make valuable contributions in other fields of study.

For example, conversation analysis of the transcripts could further clarify our understanding of the dynamics of the communication style and process differences among generations. Additionally, such analysis may enhance contributions to the general study of

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Colville tribal members' orientation for expression of family secrets and traditional healing methods. Therefore, a design that encourages more spontaneous and unlimited time conversation could strengthen the theory resulting from the present study, by evaluating the cognitive processes used in developing the schematic content related to wellness.

Summary of Methodological Limitations and Recommendations

In summary, future research procedures could benefit by implementing methods to address several limitations and possible expansions identified in the current study. Varying the sample size for both the total sample of participants and recruiting for more proportionate inclusion of men, women, and self-identified disabled or differently-abled individuals, would serve the purpose of enhancing the results. Additionally, format changes could enhance the oral traditions and provide researchers with an expanded view of themes, not to mention strengthen the validity of the theories generated by the present study.

The present investigation suggests conversation analysis of the data may generate a significant contribution to the fields of communication, cultural studies, and cognitive and social psychology. Overall, such a contribution would provide a deeper understanding of Colville tribal interactions, communications, and schemas.

Findings of the Present Study

In spite of the identified limitations, the present investigation succeeded in inductively generating theories about the defining and contributing factors of mental health and wellness, identified specific negative life events or circumstances that affect wellness, identified where tribal members turn to when in a difficult situation, described how they felt better by turning to someone or something, and identified activities and resources within the tribal community that

promote wellness. Additional, the theories which emerged are grounded in the experiences of twenty Colville Confederated Tribes members who resided on or near the Colville Reservation.

The Grounded Theories of Mental Health and Wellness

Findings of this investigation suggest that mental health is comprised of five elements: (a) mental self, (b) spiritual self, (c) emotional self, (d) sense of self or physical self, and (e) environmental stability. However, the importance of each element may fluctuate according to external influences, such as negative and positive life circumstances. The core aspect to wellness is directly related to the importance of maintaining a sense of self or physical self. A sense of self was thought as having numerous domains, such as having pride in who you are and knowing yourself and culture. Others domains included being motivated, self-reliant, independent, strong-willed, confident, determined, honest, self-aware, understanding of others, reliable, respected, loved by others, caring, having a high self-esteem, and maintaining an emotional connection to those around you. On the other hand, the physical self was thought of as being alcohol and drug free and taking care of your physical being by diet and exercise. Maintaining an emotional self was also identified as an important facet of wellness. The emotional self was illustrated as feeling connected or bonded to others, being loved and appreciated, and continuing to build positive relationships with others.

Wellness is not a linear process, rather a developmental process which could be conceptualized along continua of active processes, a state of being, and reactive processes to external events. The movement toward wellness includes dimensions of a relationship with the internal self, external self, others, and with a sense of power. These parameters are not mutually exclusive. For instance, an individual's relationship to others is thought to be a part and parcel

of their relationship to themselves and vice versa. Additionally, one's relationship to themselves includes a relationship to their sense of power.

Mental health as a process also subsumed other processes like resiliency, inner strength or balance, positive relationships with others, self-identity, maintaining a substance free lifestyle, and achieving personal success. Therefore, the movements toward wellness were thought to be products of one's internal resources, the resources drawn from others, and resources within the environment. All boundaries of the internal and external resources were thought of as fluid. For instance, an individual may draw strength from the support and encouragement from others or gain confidence from their own personal success, but the strength and confidence could become internal resources from which they could draw upon at another time. This provides a beautiful model for how coping skills are learned within the active process of interacting with others or reacting to an external event.

As was mentioned in Chapter One, American Indians view mental health as being holistic and spiritual, which suggested that one must be in balance or harmony to obtain wellness. Participants spoke of the importance of maintaining a balance between at least three of the five elements of wellness. For example, it was important that balance of the physical, emotional and spiritual self or of the mental, physical and emotional self was maintained. Although, maintaining a balance between the physical, mental, spiritual, and emotional self could also be thought of as harmony.

Environmental stability was an additional element of mental health that was identified. The stable environment was thought of containing financial stability so basic needs could be met and stress levels were controllable, having a good home life and family time, and not being exposed to violence within the home. It was apparent that environmental stability tapped into

emotions, such as feeling connected to others, being respected and supported by others, being able to function in stressful situations, and having a stable environment from childhood.

One participant made a profound statement describing wellness. She said, wellness "is a sequence of growth and if you don't get what you need at the right sequence, you may be able to compensate for it later, but you are never going to have the product that you would have had if everything had been there at the right time and at the right place." It was clear that wellness was an active process that included basic needs, such as food, clothing, shelter, love, approval, success, achievement, and stability.

The sense of power or control is thought to develop through determination, willingness to achieve or change, and empowering one's self. Participants indicated that recognition of control may be displayed as self-respect and having an openness to self-monitor your behavior. The findings support the notion that change can only occur when someone is open to the process. However, one's relationship to power incorporates a balance between change and stability.

Many characteristics of wellness were thought to exist in balance. Wellness is often seen as the balance of particular characteristics or as a state of being, which in itself is a balance of energy. The findings of this study add to the growing body of research that suggests wellness is a balance of specific elements. However, the results suggested that environmental stability is as important as maintaining a mental, emotional, physical, and spiritual self.

Circumstances That Can Negatively Affect a Person's Mental Health or Well-being

Results of this investigation indicated that a negative life situation could affect one's mental, spiritual, emotional, and sense of self or physical self. Further, one's environmental stability may be compromised as well. External forces had the greatest impact on the emotional self, closely followed by the sense of self or physical self and environmental stability. External

forces or key contributing factors were identified as a death in the family, divorce, a neglectful home environment, family conflicts, family member's abuse of substances, domestic violence, sexual abuse or traumatic experiences, boarding school experiences, and unemployment or being on welfare. In fact, these identified factors were so powerful they affected ones' sense of self, played an instrumental role in how others' behavior and actions could affect an individual, and illustrated how a negative or neglectful environment could influence wellness.

Again, the parameters of negative life events are not mutually exclusive. For example, the death of a loved one is thought to impact the mental, spiritual, emotional and sense of self. Additionally, the death may also contribute to a change in the environment or living situation, which could add stress to a situation that may have already decreased ones' coping skills. It was clear that when a negative life event occurs, the coping skills of the individual are challenged. In fact, alcohol or substance use and abuse was thought of as a prime example for self-medicating behavior when an individual became overwhelmed with life circumstances.

The process of one's response to a negative circumstance is described as fluid and lacks boundaries. So while an individual is under distress and their coping skills are being challenged, they may feel disempowered and be disconnected from others and the environment. Therefore, an initial response to an event could not be individually categorized; rather the event affected multiple elements of wellness. In fact, early traumatic events were thought of as being the catalyst for emotional and relational difficulties given the cyclic nature of emotional distress. Hence, wellness could be achieved through learning how to process and overcome distress, which may involve the self, relationships with others, and environmental stability.

Relationships and emotional connectedness with others was thought of as essential components of wellness. Violent behavior and abuse were defined as factors that challenged

ones' sense of self, emotional well-being, mental capacity, spiritual connection with the Creator, and the stability of the living environment. Relationships incorporated the cyclic nature of wellness in that ones' senses of self could be impacted by others and the environment and vice versa. It was clear that obtaining love, respect, and encouragement as a child was essential to the development of a health self. In fact, a neglectful home life, which included abuse, neglect, and excessive alcohol or drug use by the parents, was identified as impacting a child's emotional, mental, sense of self and physical self, and the stability of the environment. Given that children learned behaviors, values, and beliefs through observational experiences, the spiritual self would not be able to grow and develop if a role model was not available. The lack of growth of a spiritual self may impact other elements of wellness as well.

The impact a home environment could have on wellness was discussed along a continua, beginning at childhood and including adulthood. Domestic violence was identified as an event that impacted ones' mental, emotional, physical, spiritual, and physical self. It was clear that the victims' sense of self was damaged by the verbal, physical, and mental abuse. Given this hostile environment, the stability of the environment had been compromised as well.

Environmental factors such as financial hardship and boarding school experiences impacted self worth and identity. Individuals who struggled with financial stability felt worthless and like a failure since they were unable to provide adequate housing or met the basic needs of the family. On the other hand, boarding school experiences contributed to the loss of a sense of self, identify, self-respect, and a feeling of adequacy. Participants identified having their beautiful hair cut off, not being able to speak the Indian language, being relocated from their family for long periods of time, and losing their identities as factors that contributed to their loss of self, identity, self-respect, and connection to the Indian community.

Help-Seeking Behavior and the Impact Upon Wellness

Findings of this study indicated that Colville tribal members utilize a variety of resources when faced with negative life circumstances. Additionally, participants identified how turning to specific resources improved their wellness. The enhancement of mental health and wellness occurred within five categories: (a) emotional, (b) mental, (c) sense of self, (d) physical well-being, and (e) spiritual improvements within the individual.

Tribal members identified ten resources that they utilized when faced with adversity. Those resources include sub categories which are defined as follows: the "Kin/Family" category includes all persons identified as "relatives," whether or not they were biologically related; the "Uninvolved People" domain contained individuals who had no vested interest in providing advice to the individual (i.e., acquaintances); "Internalize" involved self-reflection and process; "Family Treatment" included family therapy; "Counselor" were trained professionals within the mental health profession; "Self-Help Methods" were bibliotherapy, worksheet or activities for self-exploration; "Organizations/Groups" included Tribal Police Department, Tribal Council, workshops, Al-Anon, Alcohol Anonymous meetings, conferences, and the community; the "Traditional" category included activities such as sweats, meditation, talking circles, and vision quests; and finally, the "Church/Prayer" category included the Cursillo, prayer, Long House, talking to the priest, and the Catholic, Christian, Seven Drum, and Shaker religions.

Use of kin or the extended family was the primary resources utilized by participants. Followed by, utilizing prayer, organized religion, or spiritual activities. The next outlet that was utilized encompassed turning to friends for support, encouragement, and advice. The two least resources utilized included turning to uninvolved people and implementation of family treatment. However, it is important to point out that talking circles, which can be a form of family therapy,

were a sub-category of "Traditional Methods." It is common for families to utilize talking circles as a method for resolving issues, which is the purpose of family therapy as well. It appeared that participants identified family therapy as therapy the family received from a trained professional within the mental health field.

Personal growth during a distressful time was a process that affects primarily the emotional and mental development of the self. However, utilizing external resources could impact the sense of self and physical well being given that others within the community would provide support, guidance, encouragement, and genuine feedback.

Wellness could be improved by two identified attributions, the process ones' self goes through and how others within the environment can impact the individual. The self must be allowed to emote, trust others, be vulnerable to change and the possible outcomes, have a sense of pride, and become balanced or centered. However, this process may incorporate receiving support, encouragement, understanding, unconditional love, and emotional connectedness from others within the environment. Additionally, one must feel safe and trust others, which may rely on others providing objectivity, safety, and confidentiality.

As individuals utilize the identified resources or activities, they subject themselves to an environment that provides emotional connection, support, encouragement, and understanding. Further, the individual feels empowered by learning how to problem solve, self-analyze their issues, increase their faith, have their issues normalized by others, be physically active, and have the opportunity to be social. This active process of achieving wellness affects the emotional and mental self, along with improving the physical self and sense of self, and allows the spiritual self to be enhanced.

Activities and Resources Within the Community That Promote Wellness

Results of the present investigation suggest that the Colville Reservation has a variety of resources and activities within the tribal community that promote mental health and wellness. The categories of resources that emerged include volunteering, family time, physical activities, conferences or training, traditional activities, mental health providers or treatment groups, elders, and activities that promote spiritual growth. On the other hand, there were perceptions that indicated a lack of resources within the community that would promote wellness. However, further discussion revealed that these individuals had heard of activities or resources others used, but had not personally utilized the identified resources.

It was evident that physical activities, such as fishing, sports, games, music, school dances, and recreational involvement were identified the most as contributing factors to wellness. Closely following was the involvement in traditional activities, which consisted of Indian language, beading, winter dances, pow-wows, sweats, weepy ceremonies, Chinook dances, pipe ceremonies, talking circles, stick games, vision quests, naming ceremonies, root feast, berry picking, root digging, and living among a clan lifestyle. Further, gaining the support of the Colville Tribe (meaning Tribal Council) was an important element that encouraged tribal members to participate in wellness activities. Socializing with others and enjoying family time provided positive interpersonal interactions, a sense of connectedness, personal identity, and opportunity to be a role model. Mental health providers and support groups were recognized by each group of participants, but the participation level would be considered underutilized.

All identified activities and resources incorporated factors that influenced the self and the environment. Tribal involvement, socialization with others, cultural and educational growth, structured programs, spiritual activities, and recreational activities were of utmost importance to

the tribal members. Participation in such activities provided emotional connection with others and with themselves, allowed for opportunities to give to others, and contributed to the development of personal and cultural identity. On the other hand, the environment was affected by incorporating tribal traditions, provided support towards wellness, and encouraged involvement in physical activities.

Overall, resources and activities that promote wellness improve mood, decrease emotional stress, and provide support, which enhances ones' mental health. The identified activities provide a sense of connectedness, support, encouragement, guidance, and direction. The traditional activities in particular, are a "cleansing process" and assist in the grieving process when faced with the loss of a loved one. It was evident that participation in activities decreased cognitive rumination and improved personal identity, emotional connectedness, spirituality, and productivity while utilizing oral traditions.

Mental Health and Previous Findings

Participant responses in the present investigation illustrated that both the terms and process of mental health and wellness virtually encompasses all of the findings of previous research. Responses also specified distinct and unique differences from previous research. Similarities and differences are considered in the following section.

Previous research findings can be grouped into categories of harmony or balance of mind, body, spirit and natural environment. Further, previous research suggested alternative methods to obtain wellness. Responses in the present investigation could also be put into personal variables, stress variables, and relationship variables. Furthermore, a majority of the specific responses of this study can be found in previous research.

Both previous research and the present investigation demonstrated that wellness is a process that involves striving for harmony and balance (Hatfield & Hatfield, 1992; Garrett & Garrett, 1996, 1999). The concept of wellness incorporated a physical state as well as a spiritual state (Garrett, 1999). However, responses indicated that mental health encompassed a mental self, emotional self, sense of self or physical self, spiritual self, as well as an environmental component.

Studies (e.g., Garrett & Garrett, 1994, 1996, 1999; Hatfield & Hatfield, 1992; Locust, 1988) pointed out that wellness is a process of balancing the physical, mental, and spiritual elements and learning how to integrate the harmony into one's life. Locus (1988) identified a number of basic American Indian traditional beliefs regarding wellness and unwellness. Overall, American Indians have a strong belief in a "Supreme Creator" and wellness is harmony in spirit, mind, and body (Locus, 1988). Additionally, Locus (1985) stated that American Indians believe that each individual chooses to make himself well or to make himself unwell. Responses to the present investigation support the notion of self-preservation, given that the individual can change only when they choose to make a change. Self empowerment is an important element that contributes to wellness.

American Indian populations tend to integrate spiritual practices into everyday life, given that spirituality is a necessity to maintaining balance and harmony. Garrett and Garrett (1994) indicated that spirituality focuses on the harmony that comes from the connectedness one has with all parts of the universe. Responses indicated that the traditional perspective of wellness encompassed a holistic view rather than separating each element into a distinct concept. LaFromboise (1988) indicated American Indians were concerned about Western psychological concepts like mental health due to the absence of holistic concepts in the design and

implementation of the therapeutic process. Therefore, wellness contains specific categories, but each category is not mutually exclusive. Responses suggest the category's boundaries are fluid and inter-twined, very holistic in nature. Further, mental and physical health is viewed by American Indians as inseparable form the spiritual and moral health (Voss, et. al., 1999).

LaFromboise (1988) reiterated that American Indians believe mental illness is brought about by a human weakness or the result of avoiding the discipline necessary for the maintenance of cultural values and community respect, such as being in harmony with the environment. If one stays in harmony with the tribal laws and sacred laws, then their spirit would be strong enough that negativity would be unable to affect the spirit (Locus, 1985). Additionally, American Indian communities encourage unity through seeking harmony and balance both inwardly and outwardly (Garrett, 1999). The Lakota people believe that an individual has the power within themselves to overcome life's obstacles and when in distress they turn to their *nagi la*, one's individual soul, for guidance (Voss, et. al., 1999).   Responses of this study identified spirituality as an important element of wellness, especially since spirituality provided a sense of serenity and connection to a Higher Power.

A variety of methods that promote wellness in American Indian communities have been discussed in the literature. Utilization of traditional healers allows an individual to regain harmony within their life. Traditional healers approach wellness through a holistic view that incorporates the spirit, nature, body, and mind. The traditional healer is a safe keeper of ancient legends and utilizes the wisdom of spiritual legends to explain emotional and behavioral distress (LaFromboise, 1988; Powers, 1982). Further, traditional healers avoid asking personal questions and do not expect individuals to self-disclose intimate details, which provided a sense of security, trust and confidentiality for the individual (Thomason, 1991). Findings of the present

investigation support the utilization of traditional healers and concerns related to trust issues, such as self-disclosure of intimate details and upholding confidentiality.

American Indian communities utilize social networks, such as the extended family, entire tribe, and elders for emotional connection and support. Extended families may include at least three generations and the extended family and tribal community take precedence over all else (Garrett & Garrett, 1994). American Indian communities value and honor the elders given their lifetime of wisdom and life experiences. Elders function as teachers, parents, community leaders, and spiritual guides (Garrett & Garrett, 1994). The responses to this study supported the importance of elders' wisdom, roles within the community, and ability to provide guidance and spiritual growth for others. Voss, et. al. (1999), found wellness can be obtained by having family members actively participate in a ceremonial life and family was an important factor for wellness.

Heinrich, Corbine, and Thomas (1990), reviewed the literature and found that vision quests, sweats lodges, four circles, and talking circles were utilized by tribal members to obtain harmony within the universe. Additionally, sacred objects such as eagle feathers or stones may be used in conjunction with the sacred pipe and prayer (Heinrich, Corbine, & Thomas, 1990). Findings of this current study indicated that traditional ceremonies are essential for wellness, given the spiritual and personal growth that could be obtained from the process. For example, the sweat lodge is a physical and spiritual self-purification ritual that emphasizes the relationship of the human being to all of creation.

Models of acculturation have influenced the documentation of the role of acculturation and the affects upon the counseling process and treatment outcomes (Atkinson, Thompson, & Grant, 1993). According to LaFromboise (1988), American Indian university students are

seeking psychological services during their academic career, especially if there are American Indian psychologists available. However, a majority of students who resided in their home environment indicated they would seek help from family members before utilizing a mental health provider. Further, Price and McNeill (1992) found that American Indian college students who were strongly committed to Tribal culture tend to utilize traditional interventions and methods more often than students who were committed to the Anglo culture or committed to both Anglo and Tribal cultures. Additionally, students who were committed to the Anglo culture or committed to both Anglo and Tribal cultures were more likely to recognize the personal need for counseling and had more confidence in mental health professional than the strongly committed to Tribal culture group of students.

Responses in the current investigation indicated that seven of the twenty participants (35%) indicated they utilized psychological services when faced with emotional distress. Of the seven individuals four identified their degree of cultural commitment as strongly committed to Tribal cultural and weakly committed to the Anglo culture, two indicated being strongly committed to both Anglo and Tribal cultures, and one noted being weakly committed to both Anglo and Tribal cultures. The present investigation indicated that the strongly committed to Tribal culture group of participants had more favorable attitudes in terms of recognizing the personal need for counseling. Additionally, thirty-five percent of the participants sought traditional interventions when in emotional distress. However, four participants were strongly committed to Tribal culture, two were strongly committed to both Anglo and Tribal cultures, and one was weakly committed to both Anglo and Tribal cultures.

Some of the differences found in the present study are unique and important contributions to the field. Participant responses in this investigation suggest that wellness is comprised of five

specific attributions versus the mind, body, and spirit phenomena. Colville members viewed

wellness in a holistic manner, but were able to describe attributions of wellness in a way that

allowed for the emergence of five categories: (a) mental self, (b) spiritual self, (c) emotional self,

(d) sense of self or physical self, and (e) environmental self or stability. However, the

boundaries and domains of each category are fluid and not mutually exclusive, which allows an

individual to react to a negative life event in a manner that could maintain their wellness or

threaten their mental health.

Summary of Comparisons with Previous Research Findings

The Colville tribal members involved in the present investigation generated most of the

defining and contributing factors found through previous studies. The findings of this

investigation demonstrated some differences from previous research. For example, while

stressors themselves have been thought to play a crucial role in wellness, previous findings have

addressed the importance of maintaining balance of harmony of the mind, body, spirit, and

natural environment. The participants in the current study broaden the perspective to include

emotional and environmental stability. Further, responses indicated that each element of

wellness (e.g., mental, emotional, spiritual, and physical self, and environmental stability) could

be affected by a negative life event, meaning that the active process of wellness could be

conceptualized on a continuum.

Development and maintenance of relationships, whether that was with the self, others,

environment, or the Creator, were considered factors that impacted wellness. However, this

investigation indicated that the qualitative nature of those relationships is considered crucial.

Responses indicated the nature of numerous relationships and the relationship matrices define

and contribute to mental health. For instance, a pivotal factor is being able to draw support from relationships during a time of distress.

Focus on self-preservation was expanded in the current study. Previous findings indicated that an individual had the power to choose wellness, as a way to better the tribal community versus individual accomplishment. Responses from the current investigation suggested that the individual recognized the power they possess and could implement self empowerment to make a change in order to achieve personal wellness.

Researchers have evaluated the impact acculturation may have upon the counseling process and treatment outcomes (Atkinson, Thompson, & Grant, 1993; LaFromboise, 1988; Price & McNeill, 1992). It has been documented that American Indian college students are more willing to seek psychological services, especial from an American Indian psychologist (LaFromboise, 1988). Although, American Indian college students who were strongly committed to Tribal culture indicated they were less likely to seek psychological services than the students who were weakly committed to Tribal culture (Price & McNeill, 1992). Additionally, the strongly committed group of students was less likely to recognize the personal need for counseling and had less confidence in mental health professions than the students who were committed to the Anglo culture or committed to both Anglo and Tribal cultures.

Responses in the current investigation indicated that four of the seven individuals who utilized psychological services identified their degree of cultural commitment as strongly committed to Tribal cultural and weak to the Anglo culture, two indicated being strongly committed to both Anglo and Tribal cultures, and one noted being weakly committed to both Anglo and Tribal cultures. Further, the present investigation indicated that the strongly committed to Tribal culture group of participants had more favorable attitudes in terms of

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recognizing the personal need for counseling. Overall, the degree of cultural commitment was

not indicative of who would utilize traditional methods or seek out psychological services. In

fact, an equal number of participants who were strongly committed to Tribal culture sought out

psychological services and participated in traditional activities to obtain wellness.

Hypotheses Generated From the Findings and Implication of the Grounded Theory of Mental

Health and Wellness

A variety of hypotheses grow directly or indirectly from the findings of the present

investigation. One hypothesis involves the continua of movement or energy of wellness. Based

on current findings, it may be hypothesized that as the energy of wellness increases, the

movement of self-growth increases toward personal satisfaction. Conversely, as the movement

of wellness decrease, as in a time of emotional distress, there may be an increase focus on self-

deprecating behavior.

Responses in the present inquiry appear to support a hypothesis that movement toward

wellness includes balance and harmony, which may include adversity as a necessary prerequisite

for personal growth. On the other hand, over indulgence of a focus on the self or continually

being faced with traumatic events would inhibit personal growth. The sense of maintaining a

self within a collectivist society may prove to be consistent with observations that a certain

amount of freedom and identity are necessary to operate within the American Indian value

orientation (DuBray, 1985; Garrett, 1999).

Participants clearly identified traumatic events as pivotal moments that challenge

wellness. Additionally, findings of the present study indicated the quality of relationships

determines the level of support one receives. Based on this knowledge, it can by hypothesized

that the quality of support systems, self-awareness of power and adequate coping skills directly

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relate to an individuals' ability to maintain wellness versus becoming unwell and possibly self-destructive.

The findings generated in this investigation may lead to the discovery of different process of cultural identity development for American Indians. Spindler and Spindler's (1958) definition of "Indianness" and Sue and Sue's (1990) Racial/Cultural Identity Development Model, posses many similarities to the descriptors used in defining and describing cultural identity. However, their models suggest linear movement toward cultural identity that the participants in this study would not subscribe to. The theories developed in this investigation would suggest not only concurrent but cyclic development of movement in relationship to self, others, power, and the environment. Therefore, it can be hypothesized that cultural identity is a concurrent development process rather than linear, and may be influenced by the degree of wellness one posses.

The present research suggests that wellness may best be measured as developmental phenomena, requiring various measurements at different times through a life span. Mental health may also require different measures for different aspects of one's life. Given the continua of development, wellness may be better measured in relative, rather than absolute terms. In addition, gender-specific measurements may also be required given various perspective of wellness. Additionally, given the fluid and cyclical nature of wellness, wellness and cultural identity could be measured at various times within a lifespan, and it is hypothesized that a positive correlation would exist between cultural identity and degree of wellness.

Wellness as a term is clearly indicative of a movement that subsumes and surpasses other terminology. This finding has distinct implications for the study of wellness within American Indian populations, especially given that wellness can be conceptualized along continua of active

process, some being descriptive of states of being, and some describing reactive processes to external events. The results of the present study demonstrate support for general theories that mental health incorporates the mind, body, and spirit (e.g., Garrett & Garrett, 1994, 1996, 1999; Hatfield & Hatfield, 1992; LaFromboise, 1988; Locust, 1988). However, the findings clearly suggest that wellness subsumes these elements and is augmented by different defining and contributing elements, such as the emotional self and environmental stability.

Implication for Counseling Practices

National trends suggest minorities, including American Indians, tend to underutilize and prematurely terminate psychotherapy in comparison to the majority population (Chapleski, Gelfand, & Pugh, 1997; Berryhill-Paapke, & Robbins, 1995; LaFromboise, Trimble, & Mohatt, 1990; Price & McNeill, 1992; Sue & Sue, 1999). Various explanations have been provided to clarify the underutilization of mental health services, which include issues such as the lack of awareness of availability; fear and mistrust; power differentials within the counseling relationship; lack of culturally relevant treatment programs, language differences, differing worldviews, beliefs, and values; and reaching out to family, friends, elders, or spiritual healers versus participating in psychotherapy.

The findings of the current investigation support previous explanations for underutilization and premature termination. However, the findings indicate that wellness is not just the mind, body, and spirit, but includes an emotional self and environmental stability. Responses suggest that wellness is a developmental process which could be conceptualized along continua of movement, which is active, a state of being, and reactive process to external events. Therefore, understanding the relationship the client has with their internal self, external self,

others, and a sense of power, would broaden the conceptualization of the individual's present problems, coping strategies, and support system.

The presenting problem may be described as not being in harmony or balanced. The notion of harmony and balance refer to being at peace with the self, others, and the environment. Therefore, utilization of alternative interventions may include turning to family, kin, friends, traditional methods, spiritual outlets, and internalization of the problem. Given the broad range of one's identified support system, treatment plans would be more productive if they included all aspects of the individuals' support system, worldviews, values, beliefs, and holistic view of wellness.

The development of an emotional self was identified as a core element of wellness. However, many participants struggled with obtaining a strong sense of self that supported the emotional self, while honoring the tradition of giving to the community versus ones' self. Therefore, part of the struggle was learning to balance personal success and individual happiness with the needs of the community. According to the participants, one had to find a balance between the mental, spiritual, emotional, sense of self, and physical self, along with maintaining environmental stability. It was important that one did not overindulge themselves in any aspect of their life or that would be seen as inappropriate and unacceptable behavior. This speaks to the importance that mental health providers understand the personal struggle of obtaining a balance of ones' self and the interest of the community.

The theme of environmental stability was discussed on various levels. For example, participants spoke of how others substance use within the home would negatively impact wellness. Other topics included their own substance use, domestic violent relationships, financial hardship, the loss of a loved one, and divorce. The common theme focused on the

importance of stabilization of the home environment in order to address mental health issues. Therefore, providers would benefit from exploring the home environment in order to evaluate whether the individual was in a place where they could focus on personal growth or if the environment was unstable which would hinder personal growth. Acknowledging and discussing environmental influences with the client may allow for exploration of expectations and address realistic treatment goals.

Given the social networks within the tribal community, treatment plans would benefit from including traditional interventions, psycho-educational groups or training, family or tribal involvement, and psychotherapy. It was evident that one's degree of cultural commitment was not indicative of their willingness to incorporate traditional interventions. Therefore, a practitioner who develops a holistic treatment plan would incorporate all available services and entities that would promote wellness. Finally, as mentioned in previous research, building a supportive, nurturing relationship which encompasses trust is essential, especially to ethnically diverse populations. Part of developing a trusting relationship includes honoring the client's worldview, beliefs, and values, along with maintaining confidentiality.

Suggestions for Future Research

Numerous future directions are implicated in the findings of this investigation. These implications include addressing some of the methodological limitations, expanding the study in order to contribute to other fields, replication of the study within other American Indian communities, and developing and testing new hypotheses. Varying sample size for both the total sample of participants, including implementation of focus groups may serve to enhance the findings of the present study. Recruiting for more proportionate inclusion of men, women, and self-identified disabled or differently-abled individuals would deepen the understanding of

wellness. Supplementing the study with additional measures of reliability and validity, such as experimenting with format changes and implementation of additional culturally appropriate terminology, may serve to enhance the findings themselves as well as the validity of the grounded theory of wellness discovered in the present study and may add depth and richness to the meanings participants hold about wellness.

Conversation analysis of the present investigation would verify the differences in verbal communication between generations of tribal members, tribal interactions, and schemas in the present study. It would be important for future studies to utilize designs in a way as to maximize the voice of tribal members in reference to the process of wellness.

The findings of the current investigation indicated that the quality of relationships contributed to wellness. A closer examination of the relational contexts and matrices of relational and emotional connectedness and how those elements affect wellness will offer direct input about these connections, contexts, and matrices. It would also further our understanding of mental health and wellness. Moreover, it may contribute to the general understanding of the importance of emotional connectedness and quality of relationships in a broader contextual manner of how those elements interplay with the development of wellness.

Closing Remarks

In this study of mental health and wellness, the research began by drawing from personal and professional observation. The investigation drew from the context of current literature and was further defined as being situated in a cultural context. The current study asked Colville tribal members to define the nature and process of wellness. By doing so, the participants in this investigation have informed and enriched the study of wellness, as well as contribute to my own knowledge of tribal views.

The process of this investigation generated more rich data than was anticipated. For instance, the participants spoke of negative experiences with mental health providers and identified resources they would build within the community if they had no financial restrains. This additional information broadens the depth of my understanding for underutilization of services by Colville tribal member. On the other hand, Colville tribal members described specific resources that could be implemented within the community to promote wellness.

Participants indicated the services they received at Tribal Mental Health were less than satisfying. For example, one individual disclosed they sought help for alcohol addiction, but due to the lack of "competent care" they ended up adding other addiction problems to the original presenting problem. This individual suggested that follow-up care and appropriate consultation were not implemented in the treatment plan. The individual went to a physician for another medical issue, where the physician immediately implemented an appropriate treatment plan that addressed their medical and psychological concerns.

Another situation involved a counselor discounting a client's concerns and worldview. In fact, the counselor instructed the client to belittle himself or herself by "catering" to another person, so the relational problem would dissolve. Another participant stated they went to counseling for grief issues related to the loss of their mother, but after three or four sessions the counselor left the reservation, causing the individual to relive abandonment issues. This participant became so upset and did not want to start all over with another counselor they chose not to return for needed services. Another participant indicated they received counseling and therapy was going well up until the point when the counselor said, "Wow, if I wasn't your counselor I would probably ask you out on a date." This individual felt violated by the counselor

due to the fact they shared their intimate thoughts and pains with this counselor who then violated professional ethics.

Sadly, the participants revealed they have never regained trust in the providers of Tribal Mental Health. Therefore, Tribal members who were frustrated and disappointed with services rendered at Tribal Mental Health opted to prematurely terminate therapy. Luckily, some were financial able to pay a private provider within the community. However, other participants went to a private mental health provider three or four times but had to discontinue needed services due to the high out-of-pocket expense. These scenarios illustrated the lack of trust clients had for providers and the importance of the therapeutic relationship.

Participants clearly stated that the therapeutic relationship and trust were of the utmost importance, but they also noted the importance of the level of comfort they felt within the environment. For example, mental health offices must have comfortable and relaxing waiting rooms and offices, not to mention friendly, supportive staff. It was evident that the comfort of the environment encouraged people to discuss intimate issues. In fact, one participant indicated they were much more willing to share personal information when they felt comfortable with the therapist and the environment.

Participants identified numerous resources they would incorporate into the tribal community to promote wellness. The ideas could be categorized as development of programs or educational programs, cultural education and traditions, development of facilities, and parental involvement.

Given the rural environment and unique needs of the reservation, some participants indicated they would develop a 24-hour crisis line to assist with emotional distress. Developing a crisis team that could respond to traumatic events, such as car accidents, house fires, loss of a

loved one, etc., would be helpful for the tribal membership. The crisis team would respond quickly so the family and children would have professionals to debrief with and have the emotional support needed at that time.

Additionally, the development and implementation of a Big Brother/Big Sister program was discussed since the program would provide mentors and encourage children to build positive relationships with others. Further, support groups and training within the community, such as patenting classes, were noted as important elements for wellness. Some participants indicated that educating community members about accepting and working with the "mentally ill" would be helpful because the "mentally ill" would feel part of the community versus being outcasts.

On the other hand, one participant discussed the importance of building a "team approach" to address developmental issues. They suggested that a team of professionals from the Women, Infant, Child program (WIC), Head Start, schools, medical personnel, and the court system could unify to provide "wrap around" services for families in need. Others discussed the development of a forum for tribal members to come together to discuss problems and work together as a community to overcome the adversity. However, it would be important to advertise the forums to encourage participation.

Others discussed the possibility of removing all the alcohol and drugs from the reservation, so people could focus on living healthier lives and learn to take care of themselves and family members. One participant suggested developing a program that increased community involvement like building a house or a garden for someone. The community could be informed about the programs and activities through community presentations, advertisements in the newspaper and flyers being posted throughout the reservation.

Cultural education in the schools and community were identified as a necessary element for wellness. Some ideas for topics included teaching about plants, animals, respect for life, connectedness, language, creative arts, hide tanning, beadwork, story telling, and spirituality in order to make the individual well rounded. Additionally, participants wanted more pow-wow's not just having pow-wow's on holidays. Another interesting idea focused on re-implementing the "old ways." Meaning that the community raised a child and when the child was out of line, a community member would correct that child and let them know that their parents would be notified of their inappropriate behavior.

As far as facilities, two specific topics were discussed; an amusement park and wellness center. It was noted that an amusement park would create fun and laughter, but it needed to be in a good area so everyone could have access to it. The other facility that was mentioned by numerous participants was a wellness center to address tribal members' needs. Participants provided specific ideas for the wellness center. For example, the wellness center would incorporate clinical treatment for the entire family, not just the individual. However, the treatment modality would incorporate traditional activities so people would gain a stronger sense of being Indian and gain a personal identity. The center would also have retreats for tribal members to improve their own wellness. The facility would be non-denominational and provide acceptance for all tribal members.

The wellness center would need to be built in a place with mountains, trees, water, and away from others. The center would include a fitness area so people could work on their physical well-being as well as their mental health. Some participants wanted the wellness center to have numerous swimming pools, including one with an elevated chair for the physically

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challenged. Other thoughts included having exercise equipment, free weights, saunas, and hot tubs.

The wellness center would be a safe place without television or radios so members could focus on wellness and become grounded. Confidentiality would be of utmost importance so members could feel safe. Given the issues that may be presented, age separation may be beneficial given the various developmental levels of individuals. One participant spoke to incorporating "alternative medicine" as a treatment modality for alcoholism. It was evident that tribal members longed for a wellness center that incorporated traditional and Western treatment modalities. However, the most importance factor was that the treatment modality was focused on the family unit rather than the individual.

Parental involvement was mentioned numerous times. Participants spoke to the importance of having parental involvement in school activities and with extracurricular activities that involved the children. It was noted that increasing parental involvement would reduce boredom, gang participation, and substance use. Additionally, responses suggested that having continual youth activities, whether at a community center or school, would provide the children with healthy activities and promote positive relationships.

In closing, the information provided by Colville tribal members was enlightening and broaden our understanding of wellness, including resources that could be developed within the tribal community. Further, participants addressed their concerns of confidentiality, comfort, and changes that could be made within the tribal system that would promote utilization of services.

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APPENDIXES

Appendix A: Demographic Information Form

DEMOGRAPHIC INFORMATION FORM

Gender: Male _____   Female _____

Age: _____

Ethnicity: _____

Enrolled Colville Tribal Member: Yes _____   No _____

Country of Birth: _____

Length of Time in U.S.:   _____

Are you currently employed?: Yes, full-time _____ Yes, part-time _____ No _____

Occupation: _____

Income Level:_____

Number of Dependents: _____

Marital Status:_____

Primary Language: _____

How long have you lived in your community?:   _____

What is the ethnicity/racial composition of your community?:   _____

Check the response that *best* represents the degree of your commitment to cultural values:

_____ a. Strong commitment to both Anglo and Tribal cultures.

_____ b. Strong commitment to Tribal culture, weak commitment to Anglo culture.

_____ c. Strong commitment to Anglo culture; weak commitment to Tribal culture.

_____ d. Weak commitment to both Anglo and Tribal cultures.

Appendix B: Consent Form

CONSENT FORM

My name is Marcella Palmer. I am an enrolled member of the Colville Tribe and a graduate student with the Department of Educational Leadership & Counseling Psychology at Washington State University. My advisor is Dr. Brian McNeill, who is a licensed psychologist. As a part of my doctoral degree program, I will be completing a research study. The purpose of this study is to investigate Colville tribal members' views of mental health and wellness; discover what factors contribute to help-seeking responses; identify sources that are considered when assistance is needed; and examine activities within the community that may promote mental health and wellness.

Copies of the completed study will be made available to the participating subjects, the Colville Tribe, and other researchers involved in studying culture specific perceptions of mental health and wellness. Potentially, this study will promote use of the culturally relevant conceptualizations and interventions, leading to more efficacious treatment modalities within the Colville tribal community.

Participating in the study is voluntary and you are free to withdraw at any time without penalty. You will be asked to participate in one 45-minute individual interview. Your name will not be identified to the information gathered or given to outside resources.

To ensure that details of interviews are recorded accurately, your interview will be audiotaped. Selected excerpts will be included in the written research report in association with chronological age. The audiotapes will be kept in a locked cabinet and will only be accessible to myself, Marcella Palmer, and to 3 faculty research advisors. The audiotapes will be destroyed upon completion of the research and presentation to the dissertation committee.

Potential risks to you are minimal. Risks might include embarrassment regarding audio recordings. You may ask that specific parts be deleted or that your comments may be withdraw from the study at any time without penalty. I would be pleased to provide you with a copy of the study's results upon its completion. If you have any questions not addressed by this consent form, please do not hesitate to ask. You will receive a copy of this form, which you should retain for your records.

Thank you for your time.

Marcella Palmer
Graduate Student
Department of Educational
Leadership & Counseling Psychology
(509) 332-1217

I have read the preceding comments and agree to participate in this study. I give my permission to be audiotaped under the conditions outlined above. I understand that if I have any questions

or concerns about the study, I can contact the researcher at the above location or the Washington State University Institutional Review Board at (509) 335-9661. I have received a copy of this form.

_____   _____
Participant's Signature   Date

Appendix C: Interview Questions

Interview Questions:

Introduction/Instructions: Today I would like to spend some time talking to you about what some people refer to as mental health issues. Other people call this same idea psychological well-being or emotional wellness. Are you familiar with this idea? Over the course of most peoples' lifetimes, we experience good times and bad times. There are times when we feel at our best psychologically, mentally, or emotionally, and other times when we feel that our mental health is suffering in some way. I want you to think about yourself and how you understand the terms mental health or psychological wellness.

1. What does it mean to you to be mentally healthy or achieve wellness?

    Probe: What are the traits/characteristics of a mentally healthy person?

2. What do you considered to be circumstances (situations) that can negatively affect a person's mental health or well-being?

    Probe: What could happen to you (internally or externally) that would threaten your psychological well-being?

3. If you found yourself in this type of a situation (i.e., you were experiencing _____) and were looking for help or a way to feel better (or get back to normal), what would you do?

    Probe: Would there ever be a time when you would go to someone or something other than yourself to feel better? Who or what would that be? Are there other options you would consider?

4. How would doing _____ help you to feel better?

    Probe: What would that do to restore your well-being?

5. As you think about the things that threaten people's well –being, consider also what types of things could actually promote well-being and good mental health. Some of these things you may have experienced (or may already exist) while other things might be available in an ideal situation (they might be things you wish existed). What activities/opportunities/resources etc. might serve to promote mental health and well-being for you and people in your community? Probe: How would _____ help to promote well-being? Are there other things you can think of that would really benefit

people in this way? Are there things in place in the community already which benefit people in this way? What are those things and how do they help?

Appendix D: Colville Confederated Tribes Resolution 1991-431