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Predictors of Mental Health Help-Seeking in Alaska Native Communities

Jorene Volkheimer
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Walden University

College of Social and Behavioral Sciences

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Jorene Volkheimer

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Walden University

2022

Abstract

Predictors of Mental Health Help-Seeking in Alaska Native Communities

by

Jorene Volkheimer

MS, University of Phoenix, 2011

BA, Gordon College, 1993

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

General Psychology Research

Walden University

May 2022

Abstract

American Indian/Alaska Native (AI/AN) persons have been identified as a group with greater risk for transgenerational trauma; furthermore, they experience environmental, systemic, and pragmatic barriers to treatment for mental and social issues. Researchers have called for more studies of groups like AI/AN to better understand the complex social, interpersonal, and intrapersonal problems involved in accessing and using mental health services. The purpose of this study was to examine the predictive relationships of demographics, transgenerational trauma, locus of control, and stigma on help-seeking and use of mental health services in the AI/AN population in a quantitative study. The developmentally based trauma framework was chosen as the conceptual framework and theory of planned behavior was chosen as the theoretical framework for this study. A correlational survey research design using a quota sampling strategy was employed. The predictors included demographics, transgenerational trauma, stigma, and locus of control. The criterion variables included attitude towards help-seeking, intention to seek help, and use of mental health services. A hierarchical multiple linear regression analysis plan was implemented. Findings were nonsignificant for all predictors except the measure of transgenerational trauma. Limitations regarding the challenges of working with the AI/AN population and conducting survey research during extraordinary external circumstances (the Covid 19 pandemic) are discussed. Although the findings were nonsignificant, the results point to research methods that are innovative and culturally relevant to support better response rates and integrate with positive social change for vulnerable populations like AI/AN.

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Dedication

I dedicate this dissertation to my parents Palmer and Leah Olorun who passed away on January 18, 1996, with my nephew Ethan Olorun. I also dedicate this dissertation to the late Nancy Kiokun (my grandma). I am named after her, and my Cup'ig name is Carr'er (meaning 'a little bit'). I also want to acknowledge my ancestors who I have had the opportunity and privilege to be able to stand on the shoulders of giants. I would also like to dedicate this dissertation to my tribe, which has supported my educational goals through scholarships in my masters and doctoral programs.

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I would like to acknowledge the following AI/AN scholarship organizations, Nunivak Island, Mekoryuk, Alaska, Calista Education and Culture, Inc, Association of Village Council Presidents, the Native Village of Mekoryuk, and Walden University's Positive Social Change Fellowship. I also wish to acknowledge my committee members: my Dissertation, Chair, Dr. Susan Marcus for her persistent, patient, and supportive demeanor and Dr. Jay Greiner, Committee Member for his keen eye on grammar and vast knowledge of work with the Lower 48 tribes. My family, my children, Nancy and Inde Volkheimer, I hope this work will help with the next generation and generations to come.

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Chapter 1: Introduction to the Study

The American Indian/Alaska Native (AI/AN) population is an underserved group that has struggled with psychological and social psychological problems that stem from long-standing discrimination and many obstacles in accessing appropriate mental health services (Brave Heart et al., 2011; Floersch, 2016; Hodge, 2012; Smith, 2013; Trimble et al., 2014). The intent of this study was to examine how some of these psychological and social psychological issues affect help-seeking, so that more appropriate and accessible services can be developed and made accessible to this ethnic group.

This dissertation study examined the predictive relationship of demographics, transgenerational trauma, locus of control, and stigma on mental health help-seeking of AI/AN individuals from Alaska. These variables have been studied extensively in mainstream populations and to some extent in minority populations, including the AI/AN population (Ayalon & Young, 2005; Bombay et al., 2013; Cheng et al., 2013; Freitas-Murrell & Swift, 2015; Heart et al., 2016; Kira et al., 2014; Komiya et al., 2000; Link & Phelan, 2001; Maxwell, 2014; Phipps & Degges-White, 2014; Thurman et al., 1990). However, the predictive combination of variables has not been studied.

The research may have several implications for positive social change. The results of this study can potentially be shared with policy makers to guide policy and program development in the tribal communities in Alaska. Findings on the role of transgenerational trauma could also be used to shape training for mental health personnel who work with AI/AN patients. Lastly, it is hoped that the results of the study will contribute to the literature on minority mental health access for help-seeking and provide

direction for stakeholders regarding research, education/prevention, evaluation, treatment, and policy.

In this chapter, the purpose, problem, and the general requirements for a quantitative approach are introduced. The chapter will include the conceptual framework, research questions, assumptions, hypothesis, delimitations, and significance of the study for the chosen population. The introduction of the theory and conceptual framework, methodology, and approach will provide the groundwork necessary for the reader to understand the rationalization for the choice of theoretical framework, conceptual framework, methodology, and significance of the study.

Background of the Study

Mental health and help-seeking in minority populations have been the subject of intense study since the early 1960s, when the community mental health movement, substance abuse, and care for the marginalized became central to political, economic, and social debate (Ayalon & Young, 2005; Felitti et al., 1998; Herrman et al., 2005; Hodge, 2012). Help-seeking in general has a long history of study, as in Gourash's (1978) meta-analysis that found which individuals seek out informal help first and young, attractive, verbal, independent, and single (YAVIS) women sought out mental health professionals more than any other demographic.

The current literature on minorities' help-seeking has focused on specific barriers, most notably structural barriers (e.g., lack of care providers, insufficient access to culturally specific resources) and individual differences (e.g., stigma, historical mistrust of providers, cultural/ethnic practices). For example, Gary (2005) discussed structural

barriers to mental health services, such as transportation and culturally competent care. Andrykowski and Burris (2010) discussed a general lack of mental health services in rural areas.

More recently, researchers have turned to examine the barriers to accessing treatment that have been linked to individual differences. For example, a need for evidence-based practices (Floersch, 2016), and locus of control as an individual difference (Cheng et al., 2013; Thurman et al., 1990), attitudes to help-seeking (Freitas-Murrell & Swift, 2015; Hammer & Spiker, 2018), and historical mistrust (David, 2010; Heart et al., 2016; Hodge, 2012) are also barriers to services. What has not been studied comprehensively is, how many of these variables influence help-seeking in this unique American ethnic population.

Problem Statement

A considerable number of studies, including literature reviews, meta-analyses, compendiums, and books have consistently indicated that minority populations lack adequate and appropriate access to professional, mental health services (Cheng et al., 2013; Clement et al., 2015; Ringel & Brandell, 2011). Nam et al. (2010) conducted a meta-analysis of 14 psychological services regarding help-seeking studies and found gender differences to be an important predictor variable (females are more favorable towards help-seeking) but also identified an interaction between gender and cultural background (e. g. White, Asian American). Other ethnic minorities (e.g., Latinx and African Americans) have been studied (Bruce & Thorton, 2004; Clement et al., 2015) but little attention has been given to AI/AN living in Alaska.

AI/AN persons have been identified as a group with greater risk for transgenerational trauma, that is, family trauma that is repeated through generations (Bombay et al., 2013; Brave Heart et al., 2011; Freitas-Murrell & Swift, 2015; Kira, 2014; Maxwell, 2014; Phipps & Degges-White, 2014). This makes the need for access to mental health services more acute and even more challenging to provide. Access to culturally sensitive services at all levels, from infrastructure to research to treatment (Floersch, 2016), have been indicated as needs for the AI/AN population.

Some of the barriers to treatment are external, for example, lack of availability (Clement et al., 2015; Maxwell, 2014) and lack of cultural competency (Cheung & Snowden 1990; Heart et al., 2016). However, some of the barriers to treatment may result from individual differences including demographics and intrapersonal characteristics (Ayalon & Young, 2005; Cheng et al., 2013). In addition to the Nam et al. (2010) findings of gender and cultural differences, Cheng et al. (2013) conducted a meta-analysis of collectivistic cultures examining locus of control and coping as control variables but did not explain variations in externality and anxiety and 30% in and above agentic goals. Acceptance was a common strategy for collectivist worldviews in stressful situations as opposed to action-oriented behaviors found in more individualistic orientations (Cheng et al., 2013).

Although locus of control has been a variable of interest in many studies of access to and use of mental health services (Kuo, 2013), and is a psychological and cultural construct (Bobb, 1990), there is little research that examines locus of control as another important predictor of help-seeking. Therefore, I investigated the cultural and

psychological construct in the AI/AN population as a collectivist predictor and possible interactive effects of the other predictors.

In sum, a review of the literature points to several key variables (I.e., Transgenerational trauma, locus of control, and stigma) that influence help-seeking, and calls for more studies that examine these factors in minority and underserved populations such as the AI/AN community. State- and national-level work has been done to improve attitudes about mental health issues (Schomerus et al., 2012) and quality of life for minority populations (Felitti et al., 1998). However, more psychosocial models are needed to help reduce stigmatization of mental health concerns as well as help-seeking intentions, attitudes, and service utilization in the AI/AN population.

Purpose of the Study

The purpose of this study was to examine the predictive relationships of demographics, transgenerational trauma, locus of control, and stigma on help-seeking and use of mental health services in the AI/AN population in a quantitative study, using the theory of planned behavior (TPB; Ajzen, 1991) and the developmentally based trauma framework (DBTF; Kira et al., 2013). The independent variables are demographics, transgenerational trauma, locus of control, and stigma, and the dependent variables are help-seeking; attitude; intent; and use.

The eleven predictors as stated earlier will include the measures using:

- Demographics (8), gender, age, socioeconomic status (SES), tribal affiliation, and IRS (Indian Residential School)-family member (A question about

whether a parent or grandparent attended boarding school to measure the transgenerational effect (Bombay et al., 2013)

- Cumulative Trauma Scale (Short Form) TQS-C-A (Kira et al., 2008)
- Rotter's (1966) I/E Locus of Control Scale (RIES)
- Stigma Scale for Receiving Psychological Help (SSRPH, Komiya et al., 2000)

The dependent variable will be measured with the following:

- Mental Help Seeking Attitude Scale (MHSAS, Hammer et al., 2018)
- Mental Help Seeking Intention Scale (MHSIS, Hammer & Spiker, 2018)
- An item asking how many times in the last 12 months have you sought professional help for psychological problems?

Hypothesis and Research Questions

As stated, the predictors (independent variables) are transgenerational trauma, locus of control, and stigma and will also include the stated demographics. The outcome/criterion variables (dependent variables) are help-seeking; attitude; intention; and use of mental health services. This quantitative study used existing, psychometrically valid measures to assess the predictive relationships between the predictors and criterion using hierarchical multiple linear regression (HMLR; see Tabachnick & Fidell, 2019).

Research Questions

Research Question 1: To what extent do demographics predict attitudes towards help-seeking (HS)?

H₀1: Demographic variables (age, gender, socioeconomic status, SES), tribal affiliation, and Indian Residential School (IRS-family member) do not predict mental health help-seeking attitude.

H_a1: Demographic variables (age, gender, socioeconomic status, SES), tribal affiliation, and Indian Residential School (IRS-family member) predict mental health help-seeking attitude.

Research Question 2: To what extent do locus of control (LOC), stigma, and transgenerational trauma (TT) predict attitudes towards HS beyond the contribution of demographics?

H₀2: LOC, stigma, and TT do not predict attitudes towards HS beyond the contribution of demographics.

H_a2: LOC, stigma, and TT predict attitudes towards HS beyond the contribution of demographics.

Research Question 3: To what extent do demographics predict intention to seek help?

H₀3: Demographic variables (age, gender, SES, tribal affiliation, and IRS-family member) do not predict intention to seek help.

H_a3: Demographic variables (age, gender, SES, tribal affiliation, and IRS-family member) predict intention to seek help.

Research Question 4: To what extent do LOC, stigma, and TT predict intention to seek help beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member)?

H₀4: LOC, stigma, and TT do not predict intention to seek help beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

H_a4: LOC, stigma, and TT predict intention to seek help beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

Research Question 5: To what extent do demographics predict number of help-seeking events?

H₀5: Demographics variables (age, gender, SES, tribal affiliation, and IRS-family member) do not predict the number of HS events.

H_a5: Demographics variables (age, gender, SES, tribal affiliation, and IRS-family member) predict the number of HS events.

Research Question 6: To what extent do LOC, stigma, and TT predict number of HS events beyond the contribution of demographics?

H₀6: LOC, stigma, and TT do not predict number of HS events beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

H_a6: LOC, stigma, and TT predict number of HS events beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

Conceptual Framework

For this paper, I used the DBTF (Kira et al., 2013) as the conceptual framework and the TPB (Ajzen, 1991) as the theoretical framework. The DBTF extrapolates its definition of trauma from the American Psychiatric Association's *Diagnostic Statistical Manual, 4th edition* and American Psychological Association's definitions of trauma and adds four types to eventually define traumatization as:

a process that can be triggered by stressors with different levels of intensities that range from chronic hassles to severe traumatic complex stressors, such as Hiroshima bombing and the Holocaust, and have potential to trigger posttrauma spectrum disorders, and/or posttrauma spectrum competencies and growth (Kira, et al., 2013, p.120).

The DBTF is an ecological model and accounts for physical, emotional, developmental, and sociological dynamics of individuals and groups (Kira et al., 2013). Kira et al. (2013) adds Type III traumas to the four tier dynamic, which includes traumas that account for collective identity, intergroup conflict, and annihilation anxiety. In his study, Kira et al. (2013) found that these traumas have a negative effect on Palestinian adolescents who experienced annihilation anxiety and mortality anxiety because of intergroup conflict in Palestine. Daily 'hassles' and macroaggressions experienced by this population also compounded the trauma experienced by the group.

The DBTF labels the comprehensive trauma as *cumulative trauma* (CT; Kira et al., 2013). The general hypothesis is that along with Type I traumas (e. g. single traumas like car accidents), Type II traumas (e. g. complex traumas or ongoing trauma caused by abuse; child abuse), Type III traumas (I. e. annihilation anxiety, collective identity, and discrimination) as well as Type VI traumas (e.g. CT) when combined together created an

experience to include all traumas and exacerbated daily hassles that affects coping appraisals, either positive or negative (Kira et al., 2013). Other transgenerational trauma work has been studied (i. e. historical trauma) but the wording in their measures target American Indians living in the continental United States or *Lower 48* (as labeled by AI/AN entities in Alaska). To test for transgenerational transmission of trauma, a question will be asked if a parent or grandparent attended residential school in Alaska or somewhere in the Lower 48 (Bombay et al., 2013).

The DBTF (Kira et al., 2013) considers the developmental life of individuals and communities. On the other hand, Adverse Childhood Experiences (ACEs) work in Felitti et al.'s (1998) research does not account for cumulative trauma, the collective experience of AI/AN groups, issues like collective identity, or annihilation anxiety, and discrimination. AI/AN were tested with the Cumulative Trauma Scale (CTS-S, Kira et al., 2013) and in some areas scored higher than Palestinians who were used as a comparison group. With the evidence given thus far, the most useful measure was to use Cumulative Trauma Scale (Short Form) TQS-C-A (Kira et al., 2008) as a measure for AI/AN living in and from Alaska. In sum, the DBTF is an ecological model and accounts for physical, emotional, developmental, and sociological dynamics of individuals and groups. The background knowledge of transgenerational trauma and CT was used to guide the selection of variables.

Theoretical Framework

In my methodology, I used Ajzen's (1991) TPB. Ajzen discussed intention and attitudes in general with his expectancy-value model formula. The utility of the model in

the current study was used to demonstrate its usefulness for the AI/AN community through the study and measures.

The theory has been applied in predicting behavior intentions in psychological help-seeking (Schomerus et al., 2009). Three subconstructs of intention include: (a) *behavioral beliefs*, consequences of the intended behavior originating in an individual's beliefs, (b) *normative beliefs*, the expectations of norms in others' resulting from their beliefs on norms, and (c) *control beliefs*, factors present that may positively or negatively affect the performance of one's behavior stemming from their own beliefs (Schomerus et al., 2009).

In their study of Europeans in Germany, Schomerus et al. (2009) found behavioral beliefs may provide positive or negative consequences because of and result in a negative or positive attitude about the behavior. The perception of pressure from social or subjective norms constitutes normative beliefs, and the perception of behavioral control from their perception in difficulty in performing a behavioral task constitutes the control belief an individual may adhere to and execute. In other words, they found that if an individual has difficulty executing a certain behavior, it may have an influence on volitional control, and the perception of behavioral control, which may have a direct impact on behavior. Though their study was limited to Europeans in Germany and may not be generalizable to the chosen population in the current study, this and prior research suggest that this theory can be useful in developing the hypotheses for studying help-seeking in the AI/AN ethnic population. Chapter 2 provides further details on both the conceptual and theoretical frameworks.

Nature of the Study

The research design of this dissertation study was a correlational quantitative study. A multivariate approach used demographics, the independent variables as predictors and dependent variables as criterion or outcome variables. A choice of web-based or paper-and-pencil data collection methods (Groves et al., 2009) were used to collect data and accommodate potential obstacles to participation. A convenience sample of 44 AI/AN participants from five regional tribal groups were sought and flyers in community centers, stores, common areas; stores, cafes near and around universities, and nonhealth related tribal organizations were an avenue to recruit participants.

Correlational studies have been found to be a cost-effective approach for collecting large quantities of data from individuals efficiently and reliably (Buckingham and Saunders, 2004). However, I had no control over how the participants took the survey and manipulation of variables was minimal.

As a member of the AI/AN population, I had to balance between the known resistance to research and inquiry (as research is considered intrusive and not welcomed, see Hodge, 2012; Smith, 2013) and the importance of understanding the influence of these factors of help-seeking in this population. Therefore, I chose the culturally appropriate paradigm of DBTF and selected variables based on a knowledge of the AI/AN communities. I also consulted with tribal members, colleagues, as well as with Walden University and sought approval from institutional research review boards with Alaska Area Institutional Review Board and Walden University to successfully conduct this study, which is detailed in Chapter 3.

Demographic variables, (gender, age, SES, tribal affiliation, and Indian Residential School (IRS-family member), followed by transgenerational trauma, stigma, and locus of control were identified as potential predictors using hierarchical multiple linear regression (HMLR) to test the hypotheses for the dependent variables of attitude to seek help, intention to seek help, and the number of actual help-seeking behavior. Appropriate univariate and bivariate assessments of the data were conducted first to determine if the regression assumptions were met and are detailed in depth in Chapter 4.

Definitions

American Indian/Alaska Native (AI/AN): National Congress of American Indians (NCAI, 2018), defined a person of AI/AN heritage as “persons belonging to the Indigenous tribes of the continental United States (American Indians) and the Indigenous tribes and villages of Alaska (Alaska Natives) (National Congress of American, Indian, NCAI, 2018, p. 9).” Tribes are recognized by the federal government on a government-to-government relationship (NCAI, 2018). The number of tribes in the U. S. is 571 tribes and 231 are in Alaska. The AI/AN population has been steadily growing (Census, 2010).

Demographics: demographics include the ability to read and write English (Knight et al., 2009), have a general understanding of the purpose of the study, the variables being studied, the expectations for completing the study, gender, socioeconomic status (SES, education level and level of income), tribal affiliation, and if they had a parent or grandparent who attended residential school (Bombay et al., 2014). The demographic questions were asked using the Census Bureau’s guidelines and Census Population Survey (CPS, Census, 2019).

Socioeconomic status (SES): this was a key variable that determined attitude, intention, and use of mental health help-seeking (Hammer et al., 2018; Knight et al., 2009) and was a question in this survey. Household incomes used Census Bureau guidelines as well as a question for education level found in the CPS (Census, 2019).

Group, tribe, and community: Five main ethnic groups are common in Alaska. The groups are Aleut/Alutiiq, Athabascan, Southeast (Tlingit, Haida, and Tsimpsian), Inupiat/Inupiaq, and Yupik/Cupik/Cup'ig. Additionally, groups are designated as tribes. These designations were used interchangeably in descriptions and discussions of the main variables and demographics. Another common use of the AI/AN entities is village in Alaska, as in federal recognition of tribes as, for example the 'Native Village of Eyak.'

Regional: Groups of AI/AN are also designated in a regional area, regional and tribal corporations were used interchangeably. Tribal corporations in a regional area are specific to tribes and/or communities, and regional tribal corporation is also used among AI/AN entities as a designation.

Tribes and tribal corporations: tribes and tribal corporations are considered a legal entity and are defined as:

Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688; 43 U.S.C. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their special status as Indians (US Code, 2019).

Tribes and tribal corporations can also be labelled as nonprofit or 501c3s and each may have a regional health, nonprofit, and for profit arm as well as social services organizations.

Trauma: Using the DBTF, Kira et al. (2013) define trauma from an ecological and developmental standpoint to include: a single trauma occurrence to collective identity trauma designated as, annihilation anxiety to discrimination experienced by a group (or continuous or ongoing trauma) and is encompassed in Kira et al.'s taxonomy of trauma.

They define trauma as:

a process that can be triggered by stressors with different level of intensities that range from chronic hassles to severe traumatic complex stressors, such as Hiroshima bombing and the Holocaust, and have potential to trigger posttrauma spectrum disorders, and/or posttrauma spectrum competencies and growth. (p. 120).

Help-seeking: Gourash, in an early review (1978) defined help-seeking as individuals who sought help from professionals and not friends, family, or neighbors. However, a more current definition from Clement et al. (2015) defines help-seeking as the process of seeking out help from primary (and secondary/tertiary services) mental health services, and talking therapies, in all stages from initiation to engagement of care.

Attitude: an individual's "overall evaluation (i.e., good versus bad) of the act of seeking help from a mental health professional (Hammer et al., 2018)."

Intention: "motivation to exert effort to perform a behavior (Ajzen, 2006)" as in seeking treatment.

Locus of control: how an individual takes responsibility, both, or how control is attributed to self or elements out of themselves (Anderson et al., 2016; Bobb, 2000).

Stigma: a process "involving labeling, separation, stereotype awareness, stereotype endorsement, prejudice and discrimination in a context in which social,

economic or political power is exercised to the detriment of members of a social group” (Link & Phelan, 2001).

Assumptions

Regarding survey research and the measures used to collect the data, the assumption was that the measures were reliable and valid and provided accurate data for the variables and population of interest (Buckingham & Saunders, 2004). All the measures were checked for reliability, validity, and utility for the chosen population, checked for internal consistency of the measures as well as construct validity. More information of the measures is elucidated in Chapter 3.

As typical with survey research, it was assumed that the respondents would answer in an honest and reliable way so that inferences from the analyses would be accurate and relevant to the population of interest (Buckingham & Saunders, 2004). The assumption of anonymity was ensured by direct access to the SurveyMonkey website and the storage of de-identified data in Excel™ and SPSS. The assumption of noncoercion was implemented by informing participants their right to leave the study at any time without consequence.

I am an AI/AN and I believe that this provided me with insights regarding the choice of variables and theories while considering AI/AN worldview. However, I am also aware that this may make the research susceptible to researcher bias. Steps were taken to minimize my bias including restrictions in my participation in data collection, review by the doctoral committee, institutional review board feedback, and following conventional methodological procedures in this study (see Field, 2013).

Scope and Delimitations

The population of choice was the AI/AN group living in and from Alaska. As stated before, the DBTF was chosen because of the ecological and developmental approach used in the framework, as well as cumulative and continuous effects of trauma.

Trauma was the first variable to research and after learning of the multidimensional aspects of the variable, help-seeking was researched. The advancements in each variable proved robust and substantial. Initially, all the variables seemed to be confounding, they could have been this or that, but what could change in situations the most was attitude. Locus of control was a variable of interest for me for decades and within the last 10 years studied more closely and was considered to predict outcomes.

The population of choice is considered a vulnerable population. Protocols to curtail breaches of ethics and obtaining the required information to conduct the study were observed. Informed consent and qualifications for the study were posted on flyers, informed consents on the SurveyMonkey website, and paper surveys for interested individuals to participate. Every effort to address any bias were followed. For example, I took ethics courses and tests to ensure ethical procedures were followed.

As mentioned earlier, researcher bias was a concern in this study because I am AN and bias is a concern for researchers of the same race. Researcher bias was avoided by following protocol and procedures outlined by research ethics implemented by the American Psychological Association (APA, 2018) and approval boards. Every effort to

minimize researcher bias was followed. The survey nature of the study allowed participants to provide objective and nonbiased answers.

Respondent bias was also a concern. Respondents were directed to a SurveyMonkey website to complete the questionnaires to minimize bias. To decrease the biases, I followed survey research methodologies (Buckingham & Saunders, 2004; Tabachnick & Fidell, 2019) to maintain research integrity of the discipline and field.

Limitations

Correlational studies are inferential in nature and do not provide causal data of the variables (Field, 2013). Consequently, cross-cultural research may be conducted considering each variable in post studies or postdoctoral activities. Predictive validity for the measures were new for the chosen population and provided data for more research. The study was not a random or stratified random sample and the results of the study may not be generalizable (Buckingham & Saunders, 2004). Survey research is a common research design and the predictor variables were not controlled by me. Inferential data was interpreted with caution. Additionally, the response bias was a concern as participants self-select to take part in the survey. The data collection setting was not in my control and the participants were asked to find a quiet, safe place to complete the surveys.

Significance

Issues of cultural competency and historical mistrust (David, 2010, Hodge, 2012) have had negative effects for AI/AN to seek professional help for life or trauma induced events. Therefore, the challenge to assist in finding solutions and preliminary data were

required. The contributions to the discipline and cross disciplines include comparativeness to other groups, indications of transgenerational trauma, locus of control, and stigma on help-seeking for both intentional and attitudinal paradigms as well as actual help-seeking behavior. Preliminary information for the chosen population to assist in future studies, such as, program evaluation, cultural sensitivity training, or for other groups to replicate may be provided.

The recommendations provided from this study may influence policy for equitable access to mental and behavioral health services. The information provided by this study may provide policy makers information to determine how and why the results of the study can affect implementation and recommendations from disciplines; such as, program evaluation, cultural sensitivity, and the information from this study may help to assist practitioners to use more culturally appropriate approaches to the treatment of psychological issues, if not worldview acknowledgement, as well as outreach and prevention in help-seeking behavior for the population of choice.

The preliminary information may allow better outreach and services implementation for the chosen group and to help to heal from the cumulative trauma, transgenerational trauma, stigma, and identify how locus of control is expressed in the AI/AN group. Methodology was provided by this dissertation study and recommendations for culturally competent designs for the chosen population and other minority groups. With the results of this study, stakeholders, practitioners, researchers, policymakers, and respondents have robust, reliable, and valid data to make

appropriate decisions for providing good mental health and health services for AI/AN groups.

Summary

Chapter 1 has introduced the topic of the study, purpose, background, nature, definitions, assumptions, questions, scope, and delimitations as well as reliability and validity issues for a quantitative approach. Limitations and how they were addressed were identified, as well as any biases that could jeopardize the study. The issues of external validity were also addressed. The significance and potential contributions were discussed as well. Chapter 1 also provided the foundations for the study. Issues of methodology and cultural competency were addressed. The protocol for research in a vulnerable population was reached using an indigenous lens, discussions with professionals in the field, across disciplines, and feedback from colleagues to determine the most culturally competent and sensitive approach to obtaining the required information from AI/AN groups from Alaska was implemented using culturally sensitive approaches and observations. In Chapter 2, the literature review and implications for the study are discussed. Chapter 3 is the methodology and methods of data collection and analysis. Chapter 4 is data collection and analysis. Chapter 5 is the interpretations of results, recommendations, and implications for the field and society in general.

Chapter 2: Literature Review

While research on the help-seeking for mental health services for minority, ethnic, and racial groups continues to grow, the AI/AN population has not been well-studied (Brave Heart et al., 2011; Schomerus et al., 2009). This group is important to study, however, as researchers have found that the AI/AN population experience unique challenges that are relevant to mental health help-seeking and ability to cope (Kira et al., 2014). These challenges include substantive evidence of transgenerational trauma suffered because of minority status, reservation living, impoverishment, and substance addiction (Brave Heart et al., 2011; Sotero, 2006). Furthermore, help-seeking research has identified sociodemographic and individual difference indicators that may also influence the likelihood of asking for help. These indicators include socioeconomic status (SES), perceived cultural stigma associated with help-seeking, and locus of control. Mental health help-seeking and the TPB has been studied by Schomerus et al. (2009), who found that the willingness to seek mental health services are related to attitudes (Hammer et al., 2018) which effects beliefs about that behavior.

The purpose of this dissertation study was to examine the predictive relationship of selected sociodemographic variables, transgenerational trauma, stigma, and locus of control on help-seeking attitudes, intentions, and use of mental health services in the AI/AN population.

The review of the literature begins with a broad discussion of research on mental health help-seeking (access and availability), then narrows to focus on studies of minority groups to clarify a contemporary understanding of the research problem. The discussion

then turns its focus on AI/AN research on the predictors and necessity of the study of them, and the dynamics regarding the context of the study.

The next part of this chapter focuses on the unique mental health issues (Cheng et al., 2013; Rogler, 1983) and treatment challenges experienced by the AI/AN community in or from Alaska. A discussion of the conceptual and theoretical frameworks supporting the variables of transgenerational trauma, locus of control, and stigma on help-seeking behavior are presented to demonstrate how they were relevant to the chosen methodology and philosophy of the dissertation study. Assumptions, research questions, and definitions are also discussed considering the requirements of the literature search.

Literature Search Strategy

I used Walden University's library, Ebscohost, PsycARTICLES, Tests and measures link, and dissertations to search for information as well as measures or psychometrics. Key terms I used to search included *locus of control*, *externality*, *external locus of control*, *transgenerational*, *generational*, and *historical trauma*, *historical intergenerational trauma*, and *generational posttraumatic stress disorder*, as well as *formal and informal help-seeking*. Other help-seeking terms searched included, *support groups*, *individual and group therapy* as well as the term *treatment* to replace therapy. Google scholar was also used to research the literature of the constructs under study. Some articles were not accessible through Google scholar and other forums were used. Help-seeking and mental health articles were obtained using search criteria including limiting publications to 2010 or newer for more up-to-date information. Additionally, as more information about AI/AN's was needed the Alaska Statewide Electronic Doorway

website was used to search for the chosen population and transgenerational trauma, as well as expert authors in the field.

My local university was also used to do literature searches on the subjects. Subsequent searches using the three main variables and topics in the dissertation process included assumptions and theories in books and articles. The term string *history of help-seeking behavior* was searched with the local university's search engine to learn more about the history of help-seeking to provide preliminary information and origins for this study. The American Psychological Association's (APA, 2018) website was also searched for information on, transgenerational trauma, formal and informal help-seeking, and locus of control. Further searches were required in subsequent chapters and sections.

Help-seeking Behavior in Mental Health Services

Help-seeking for mental health services has been studied extensively since the 1950s. Gourash, in an early review (1978) defined help-seeking as individuals who sought help from professionals and not friends, family, or neighbors. Individuals communicated about distressing events to obtain direction and support. Individuals communicated with friends or family as informal forms of help-seeking.

Some of the first studies (Gurin et al., 1960; Hollingshead & Redlich, 1958; Lowenthal et al., 1975) examined the epidemiology of help-seeking. These studies examined sociodemographic patterns in help-seeking, that is, who seeks help and reasons for help-seeking, mentioning demographics and culture (Gurin et al., 1960), ethnicity and social class (Lowenthal et al., 1975), as well as on family of origin (Hollingshead & Redlich, 1958). These and other original studies identified in Gourash's (1978) review

identified a common set of characteristics among seekers. The young, white, educated, middle-class, and female model. The YAVIS model (young, attractive, verbal, intelligent, and successful) was soon engineered to streamline and create a more cost-effective system for how clients were treated for mental health issues (Austad & Hoyt, 1992; Gulliver et al., 2010), and if they were successful.

The impetus for studying help-seeking and resulting therapeutic benefit increased as mental health help-seeking became more acceptable by some demographics after World War II (Hollingshead & Redlich, 1958). Managed care and insurance companies began to reimburse professionals for services (Austad & Hoyt, 1992). This substantively affected help-seeking behavior, use of mental health services, and public policy decisions, which in turn affected reimbursements and coverage (Strupp, 1986). The demand for mental health services has grown to 18.1 million individuals suffering from depression in 2000, with substantial costs to productivity, disability, and life (Birnbaum et al., 2010). The cost of depression had reached \$83 billion by 2000. Trauma survivors in military and mainstream populations sought mental health services where they had control for treatment options, less waiting for appointments, experienced a more community-based feel, provided convenience, resulted in nonthreatening treatment, and the opportunity to access female therapists (Kantor et al., 2017).

In addition to demographics, current reviews, and meta-analyses on mental health help-seeking, researchers have focused on the barriers experienced by specific ethnic populations (Gulliver et al., 2010). As early as 1983, Rogler presented an alternative resource and barrier theory, where obstacles to pursuing and committing to mental health

care in Hispanics were explored. The comprehensive study found that immigrants who enter this country at the “very bottom of the urban stratification heap” (Rogler, 1983, p. 10) suffer economically and psychologically (i.e., anxiety and depression), and lack the resources and knowledge to access help. More recent research has shown that individuals with lower income and lower education have more barriers to access mental health help. Barriers may include structural obstacles (e.g., insufficient public transportation), and stigma influenced cultural issues (Clement et al., 2015; Gary, 2005; Roh et al., 2017).

The Study of Mental Health Help-Seeking for Minority Populations

The World Health Organization proposed mental health as an individual being able to cope with life, work productively, and the ability to contribute to their community (Herrman et al., 2005). Mental illness can be considered a disability and has deleterious effects on an individual’s life and community (Brave Heart et al., 2011).

Economic inequality and corresponding disparities in access to mental health services led to the advent of the Community Mental Health Center Act of 1978 (Cheung & Snowden, 1980). However, minority groups persisted in not using mental health services. Asian groups were least likely to use mental health services, whereas blacks, in the 1980s used services more (Cheung & Snowden, 1980). It has only been in the last 15 years that studies of mental health help-seeking and use of services in minority populations have produced findings that clearly distinguish the economic and cultural barriers these groups face. In their 1991 systematic review of research on ethnic minorities and mental health, Vega and Rumbaut asserted that the lack of representation

of people of color in the clinics and in research positions conspired to make this population's needs invisible, until recently.

Vega and Rumbaut (1991) also identified specific concerns for the four main groups that mirrored the findings of the earlier review by Cheung and Snowden (1980). The SES of all four minority groups was considerably lower than mainstream American incomes and educational levels (Stevens, et al., 2015; Vega & Rumbaut, 1991). While all the groups suffered high rates of poverty, specific groups in all four groups dominated lower income rates than average American citizens. The lowest among SES were second waves of Asian and African Americans, specifically groups of Laotian, Haitian, and Ethiopian ancestry. Intuitively, many researchers have observed that with lower SES, more social and individual problems or issues occur at higher rates in all areas of life (Vega & Rumbaut, 1991).

Blacks had higher rates of distress and lower well-being scores than non-Hispanic Whites in the second epidemiological survey for the National Center for Health Statistics in 1971-75 (Vega & Rumbaut, 1991). From 1972 to 1978, a 5% jump in minorities' use of mental health services (from 15 to 20%) was correlated with the growth of these groups at that time (Cheung & Snowden, 1980). The Hispanic population was difficult to study because of population idiosyncrasies and lack of access to participants.

In the 80s, minority groups tended to seek out more mental health services, including hospitalization, as it was around that time, almost 6 million Asian and Latinx Americans migrated to the United States to seek a better life for individual and family wellbeing. The Immigration and Reform Act of 1986 assisted in the naturalization of 3

million Asian and Latinx Americans (Vega & Rumbaut, 1991). The increased demand led to disruption of services and financial strain on both help-seekers and providers (Cheung & Snowden, 1980). Issues of cultural competency were identified as one of the major structural barriers to services for all four minority groups (Black, Hispanic, Asian, and Native American).

Since the early 2000s, several reviews have been conducted and revealed that ethnic minorities who were restricted in access by SES and cultural bias were more likely not to use mental health services and had poor mental and physical health outcomes (Paradies et al., 2015). These studies were primarily focused on U.S. African American adult populations (Paradies et al., 2015; Williams & Williams-Morris, 2000) and the Latinx/Hispanic community (Bruce & Thorton, 2004; Clement et al., 2015), but scant attention has been relegated to AI/AN living in and from Alaska.

Factors that Influence Mental Health Help-Seeking in Minority Populations

Help-seeking is defined as a person's recognition of the need for professional assistance, stigma tolerance in seeking professional help, openness to dealing with an individual's problems, and confidence in the ability of the professional to be of assistance (Nam et al., 2010). A variety of factors have been examined to better understand what influences help-seeking, and the barriers that limit or prevent minority persons in need from receiving timely, adequate services.

Demographics

Many demographics have been studied, but the ones of greatest relevance to this effort include gender, age, SES, and ethnicity. Gender has been shown to be a strong

predictor of who uses mental health services, that is, women more than men (Nam et al., 2010). For example, Nam et al. (2010) conducted a meta-analysis of 14 psychological services for help-seeking and found gender differences to be an important predictor (females are more favorable towards help-seeking) among college students. The author also identified an interaction between gender and cultural background (comparing White and Asian American participants). Extrapolating that, White students reported being more favorable towards help-seeking than their minority classmates.

Economics have been used as a key variable in the study of help-seeking in minority populations (Knight et al., 2009). However, despite having higher socioeconomic status, individuals from Asian backgrounds occupy low rates of mental health help-seeking behavior at one-third ratio of use (David, 2010). The author goes on to mention having insurance and higher rates of acculturation as indicators of the use of mental health services. On the other hand, Asian Americans with English as a second language, more ties to cultural traditions, and individuals' factors like emotional restraint found in their traditional culture were less likely to seeking mental health services (David, 2010).

Geographic location and infrastructure have also been studied as important predictors of mental health help-seeking and use of services (Andrykowski & Burris, 2010). Environmental, external, systematic, or pragmatic barriers like transportation or a lack of services or funds for treatment exist for individuals in rural areas (Andrykowski & Burris, 2010). AI/AN groups include general help-seeking behavior and seeking help for substance abuse (Heart et al., 2016; Venner et al., 2012) as well as cultural competency

among mental health providers as a barrier. Social network barriers or availability of treatment sources in rural areas are also concerns.

Age has been studied (Bobb, 2000; Cheung & Snowden, 1980) and several studies have demonstrated that help-seeking, both formal and informal, differ across age groups (Mackenzie et al., 2006). Aging (Cheng et al., 2013) may mediate locus of control and help-seeking attitudes and behaviors, which may influence intention, self-control, and taking responsibility. In all studies, older adults (Mackenzie et al., 2006) were more open to help-seeking, self-control, and taking responsibility.

As described in the earlier section, SES has been shown to be a strong predictor of help-seeking and use of mental health services. Ethnic minorities who were impoverished have more barriers and less resources to access mental health services than the comparative White population (Cheng et al., 2013; Paradies, et al., 2015; Williams & Williams-Morris, 2000). Additionally, resources and access are a determinant of help-seeking for those individuals who wished to follow-through with a desired action (Ajzen, 1991).

Race and ethnicity have long played a role in access to and use of mental health services. As discussed in mental health help-seeking scenarios, cultural dissonance, SES, and gender have played a role in not seeking services. SES as discussed by Vega and Rumbaut (1991), cultural competency (Brave Heart et al., 2011; David, 2010), and structural or pragmatic issues (Andrykowski & Burris, 2010) have been identified as deterrents for minorities from seeking out mental health services.

Historical mistrust because of the history of discrimination and oppression, collectively experienced by AI/AN groups was also identified as barriers to procuring formal help in mental health fields (Gary, 2005; Hodge, 2012). The United Nation's Convention Relating the Status of Refugees identifies the rights to freedom from discrimination along with other barriers as obstructions to the right to mental health and were regarded as a vulnerable population (Herrman et al., 2005). However, more positive outcomes regarding help-seeking were affiliated with more supportive people in an individual's life (Venner et al., 2012).

Substance Abuse as a Primary or Co-Occurring Problem

Going back to studies as early as the 1980s, both the research and professional literature have recognized that mental health treatment, help-seeking, and diagnosis is often complicated by the co-occurrence of substance abuse disorders. For example, the National Comorbidity Survey (Kessler et al., 1996) revealed that co-occurrence was prevalent in the general population, but less than half of those with co-occurring disorders sought treatment. More recently, Preister et al. (2016) published an integrative review of 36 articles rigorously selected for quality and examined both data and text for commonalities and differences and found that personal barriers (vulnerabilities and beliefs), and structural barriers like those identified in the earlier literature also limit help-seeking and access to treatment.

Additionally, common co-occurring disorders include mood disorders, antisocial personality disorder, and anxiety disorders, predict these disorders that may occur at a younger age (adolescence) than substance abuse (Kessler et al., 1996). The prevalence of

help-seeking occurs more often in comorbid diagnoses when individuals are alcohol dependent rather than abuse. However, Kessler's study was not aggregated by race. Chronicity and severity of comorbidities were also a concern. Environmental factors may add to the onset of the mental disorder. The likelihood of receiving treatment included both disorders (substance abuse and mental health disorders; Kessler et al., 1996).

Priester et al. (2016) asserted that the chronic, more severe mental illness have a more resistant therapeutic history. Low treatment entry and structural challenges require more prevention/education activities to encourage access to treatment for those who enter treatment with dependence and co-occurrence. Priester et al. (2016) also recommends more culturally competent services for minority populations. Service availability and provider training to include inclusive, developmental, and community based dynamics are recommendations by Priester et al. (2016) for appropriate service accessibility for minority populations. Different races were not aggregated in Priester et al.'s (2016) study either.

Seeking help for substance abuse is a concern for the AI/AN population as research has indicated that it is up to six times the national average of mortality rates in the AI/AN population (Venner et al., 2012). Epidemiological studies indicated that substance abuse in this population has not diminished, and help-seeking is constrained by sociodemographic, cultural, and psychological factors (Hilton et al., 2018). Nonetheless, because of its symptomatic nature and co-occurrence with posttraumatic stress disorder, as well as the highly stigmatized nature of the disorder in AI/AN populations, and to

lessen nonresponse from participants, substance abuse will not be added to the inferential nature of this study.

Conceptual Framework: Developmentally Based Trauma Framework

The DBTF labels the comprehensive traumas as cumulative trauma (CT, Kira et al., 2013). The general hypothesis is that along with Type I traumas (single traumas), Type II traumas (complex traumas or ongoing trauma caused by abuse), Type III traumas (annihilation anxiety, collective identity, and discrimination) as well as Type VI traumas (cumulative) when combined altogether created an experience to include all traumas, and amplify exacerbated daily hassles that affects coping appraisals, either positive or negative (Kira et al., 2013). Other transgenerational trauma work has been studied (i. e. historical trauma), but the verbiage in their measures target AI living in the continental U. S., or Lower 48 (as labeled by AI/AN entities in Alaska). To test for transgenerational transmission of trauma, a question was asked if a parent or grandparent attended residential school in Alaska or somewhere in the Lower 48 (Bombay et al., 2013).

Transgenerational trauma has been studied extensively in different world cultures, as well as, in examinations of generations who have been affected by natural and man-made disasters (Kira et al., 2013). There are many models and conceptualizations that are broadly applicable (e.g., Ringel & Brandell, 2011; Sotero, 2006) and recent models that are specific to Native Americans (Brave Heart et al., 2011). Professionals in health and social services have also described these phenomena using terms like *historical trauma theory*, *generational Post-Traumatic Stress Disorder*, or *generational trauma*. Recently, the term *intergenerational trauma* has been used by AI/AN and mainstream cohorts

addressing the issue. Smith's (2013) book on decolonizing methodologies explained how to conduct research on the indigenous experience, where high rates of social maladies are experienced.

For the purposes of this study, Kira et al.'s (2013) model of the DBTF was used.

This model defines traumatization as:

a process that can be triggered by stressors with different levels of intensities that range from chronic hassles to severe traumatic complex stressors, such as Hiroshima bombing and the Holocaust, and have potential to trigger posttrauma spectrum disorders, and/or posttrauma spectrum competencies and growth. (p.120).

The DBTF is an ecological model and accounts for physical, emotional, developmental, and sociological dynamics of individuals and groups (Kira et al., 2013). They add Type III traumas to the dynamic, which includes traumas that account for collective identity, intergroup conflict, and annihilation anxiety. In their study, Kira et al. (2013) found that these traumas have a negative effect on Palestinian adolescents who experience annihilation anxiety and mortality anxiety because of intergroup conflict in Palestine. Daily 'hassles' and macroaggressions experienced by this population also compounded the trauma experienced by the group.

The DBTF considers the developmental life of individuals and communities. Concurrently, adverse childhood experiences (ACEs) work in Felitti et al.'s (1998) research does not account for cumulative trauma, the collective experience of AI/AN groups, issues like collective identity or annihilation anxiety, or discrimination. AI/AN were tested with the CTS-S (Kira et al., 2013) and in some areas scored higher than Palestinians who were used as a comparison group. With the evidence given thus far, the

most useful measure was to use the TQS-C-A (Kira et al., 2008) as a measure in AI/AN living in and from Alaska.

The background and framework for the DBTF was generated in 2010 by Kira et al., where the etiology of post cumulative stress was explored in different cultures like in the Iraqi people. Kira et al.'s (2010) work with identity trauma and the general enmeshment with culture, hierarchy of nested identity, allostatic load, and index traumas helped to form the theory. Social identity theory was explored as well as, internalized identity, social roles, and personal identities. Identity hierarchy like collective identity, and annihilation anxiety are part of the first level of identity, the second includes personal, and autonomy based identities (as found in Type II traumas), the third is role identity (the connection between individual and society), and includes issues of fear of self-actualization failure, and finally the fourth as physical identity as manifested in mortality salience in collective identity like the September 11 attacks (Kira et al., 2010).

Other Models of Trauma

As mentioned earlier in this section, there are many other worthwhile models. These include Sotero (2006), who was one of the first to articulate a conceptual model of what was then called "historical trauma" (Sotero, 2006, p. 93). This construct bridges the relationship between an individual's current mental health and their socio/political history. Sotero chronicled the mass trauma experience of AI/AN or indigenous peoples affected by colonial conquest of their lands, lives, and rights. The primary generation is the generation who experienced reservations and Indian Residential Schools (IRSs), as well as loss of rights to property and the ability to participate in government decisions.

The intrapersonal and interpersonal social and psychological consequences were passed down to the next generation through exposure, socialization, and stories, which had a negative effect on health and well-being (Sotero, 2006).

The authors Ringel and Brandell (2011) discuss trauma in clinical terms and use the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR*) to diagnose posttraumatic stress disorder (PTSD) like symptoms, PTSD, complex traumas, and ‘disorders of extreme stress not otherwise specified’ (DESNOS), which may at some point be later diagnosed as a personality disorder. Besides PTSD, the disorder diagnoses provide little direction and at times fragmented treatment that may never address the underlying trauma. In Ringel and Brandell’s (2011) model of historical trauma, recognized disparities in health at the group level, collective events, and correlations of PTSD with other health disparities. The ‘mass trauma’ experienced by one generation affects the cultural roles of the next, as well as protective processes. The sequential collection of these cultural traumas, which causes disintegration in culture because of momentum is passed down to the next generation and is destructive for the child and their generation. Systemic and structural policies aimed to dismantle the culture and identity are enforced and add to the dynamic. Ringel and Brandell (2011) describe the next generation as adversely affected because of the dynamic and at some point, developmentally compromised, and later traumas in life due to the sociopolitical climate compounds the traumatic condition. Nonetheless, discrimination is not used as a diagnostic criterion in the *DSM-IV-TR*.

The dynamic of the historical nature of generational trauma causes a loss of cultural resiliency (Ringel & Brandell, 2011), which is protective in nature. The trauma process works in perpetuity and interwoven into the culture. A lack of resources to support healing intensifies maladaptive response resulting in collective physical and mental health disparities. Ringel and Brandell (2011) also recognize trauma theory that affects AI/AN is in the theoretical construction stage and the next steps as intervention research.

Brave Heart et al. (2011) developed a Native American specific model which observes the phenomenon of historical trauma from a public health perspective. The author identifies socio, ecological, cultural, and political dynamics of AI/AN and collective trauma exposure. Brave Heart et al. (2011) defines trauma as; “cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma” (p. 283). The term *historical trauma* was first used in 1995. The term helps to reduce stigma experienced by AI/AN because of collective experiences of loss through disease and lands. Brave Heart et al. (2011) also uses *Historical Trauma Response (HTR)* and *historical unresolved grief* because of prohibitive acts against ceremonies (in the last century) AI/AN performed on the recently departed.

Brave Heart et al. (2011) also identified intensities of traumas and regional differences in their occurrences. The authors also recognize the need for research in HTR and interventions currently being used. The high morbidity and mortality and life expectancy because of historical trauma is not supported by the scant literature on *historical unresolved grief*, PTSD, and depression for the AI/AN population who

experience them at a higher rate. Brave Heart et al. (2011) advocates for supports that enhance the path of the tribal culture for healing and restoration. Boarding schools and the disruption of the attachment cycle is another unresolved area to study. The reframing to stigma reduction and contextualizing to transgenerational trauma effect is the intent of Brave Heart et al.'s (2011) model.

There are many other models and theories of transgenerational trauma (e.g., Freitas-Murrell & Swift, 2015; Maxwell, 2014; Phipps & Degges-White, 2014). In summary, it can be said that all the above modern models incorporate historical antecedents, biological, sociological, cultural (e.g., race, ethnicity), and psychological factors that influence the generational transmission of emotional distress, mental illness, and reduced quality of life.

Current Research Findings in Transgenerational Trauma

The improvement of research techniques and access to indigenous cultures has allowed for an increased study of transgenerational trauma. For example, Waretini-Karena (2013) studied the Maori people using a qualitative approach to explore how *historical intergenerational trauma* and colonization affected their development. He used the Purakua Theory of the Maori lifespan as explanation of trauma. He demonstrated the distinct Maori experience of *historical intergenerational trauma* and how the Doctrine of Discovery, and other assimilation tactics were used against the Maori for lands and resources. The political environment was also examined to provide interventions that are culturally appropriate for the Maori (Waretini-Karena, 2013). Waretini-Karena noted that

this work demonstrated how common the suffering of indigenous peoples is at the current time.

In another study, Furey Maratita (2017) interviewed 10 adults in the Pacific islands for post traumatic growth using semi structured interviewing. She qualitatively coded and analyzed the findings using thematic analysis, using elders for stories and accounts being told to school aged children. Positive engagement was demonstrated through engagement and increased values. Post-traumatic growth was enhanced through positive relationships, burgeoning interests, and spiritual growth.

A final example is a study by Robinson (2016), the author explored the relationship of transgenerational trauma and cortisol levels for children. The study wished to demonstrate maternal exposure to trauma and resultant cortisol levels, and anxiety in children. The approach was a longitudinal study and hoped to find intervention and prevention strategies to decrease transgenerational trauma. Robinson (2016) assessed maternal history of trauma and secondary caregiver reports for child anxiety. Her hypotheses of maternal exposure but not cortisol reactivity to child anxiety were supported. Cumulative trauma (CT), timing, and cortisol reactivity were all related, differentially to child anxiety.

Like the Maori experience, transgenerational trauma is a prominent issue among AI/AN groups (Freitas-Murrell & Swift, 2015) and may be a contributing factor affecting help-seeking behavior. Particularly when private, as well as for profit institutions wish to demonstrate accountability regarding federal, state, and local regulations (Felittli et al., 1998), as well as to demonstrate program effectiveness. This makes the need for access to

mental health services more imperative, and even more challenging to provide. However, issues of historical mistrust may compound the dynamics of help-seeking in the AI/AN community (Hodge, 2012).

In Freudian interpretations of group identity, an individual claims identity as the entity that is consistent within oneself and sharing a characteristic(s) with others (Volkan, 2001). An individual's identity with the large group regardless of their socioeconomic status, provides the 'sameness' and protection needed for an individual's identity in belonging to a group an important construct. When the large group experiences turmoil, the psychodynamics of regressed groups emerges. According to Volkan (2001), transgenerational trauma occurs when trauma is 'deposited' into the next generation through behaviors, as well as thoughts and Kira et al. (2010) recognizes this phenomenon as well.

The 'unpacked' (Waretini-Karena, 2013) trauma is deposited into the next and future generations and kept for future resolution until a generation can resolve the 'traumas' passed from one generation to another. The process fulfills the Native American prophecy of the healing to take Seven generations. The initial generations' shame and guilt prevents it from acknowledging and resolving the trauma of what occurred (Volkan, 2001), and the initial survivors' subsequent survivors' guilt is eventually demonstrated by criticism in oneself and those around him or her (mostly loved ones, Brave Heart et al., 2011). Hence, the process of intergenerational transmission of trauma is initiated, processed, and transmitted to the next generation. A similar concept is the Alaska Native practice of 'namesake' in order to 'allow' the new

child to take on the essence of the elder, who they are named after, provides comfort to relatives who will experience loss and grief, but to a lesser extent of the process (but a healthier adaptation) of transgenerational trauma.

In Western psychological perspectives and approaches, a representative trauma is 'chosen' to allow the group to achieve cohesiveness. In AI/AN groups, a holistic or in psychological terms, a developmental approach is utilized, is dependent on regional location and different processes regarding the transgenerational effect. For example, the boarding school experiences for many AI/AN groups, or Wounded Knee for the Lakota in the Lower 48 (Mohatt et al., 2014). The recycling of trauma will be implemented until a generation is able to deal with the trauma. The phenomenon is also true for victimizers of traumatized groups in human history (Volkan, 2001). Currently, we do not know the trauma load of AI/AN in Alaska, at the regional or individual level.

Stressors or 'hassles' (Kira et al., 2010) may cause a *time collapse*, where past traumas are associated with a present threat (Volkan, 2001). The enemy will be renewed, and the victim will have a renewed sense of entitlement to resolve the trauma. However, most AI/AN view healing as nonviolent and use ceremony to assist in healing. Groups may then use violent or nonviolent means to try to resolve the trauma, and may regress, making the group unable to heal from the trauma. Transgenerational trauma may be a barrier for groups and individuals in that group to seek out help. Tribal communities are at a conceptual stage of understanding of transgenerational trauma, however, because of all the barriers provided thus far, many are considering culturally sensitive approaches to healing and considering how they want to heal.

Stigma

The construct of stigma has been defined as a process “involving labeling, separation, stereotype awareness, stereotype endorsement, prejudice and discrimination in a context in which social, economic or political power is exercised to the detriment of members of a social group” (Gary, 2005). Clement et al. (2015) reviewed 144 studies ($n=90,189$) and found a significant negative correlation ($d = -.27$) between the experience of stigma and propensity to seek help, and the most reported stigma barrier was disclosure. Ethnic minorities were identified as one of the groups as disproportionately deterred by the experience of stigma. Other groups included males, youth, military personnel, and health professionals (Clement et al., 2015). Stigma, discrimination, misdiagnosis, and mistrust in the system by minorities can act together to create an atmosphere where minority groups may be more hesitant to seek mental health services (Clement et al., 2015; Freitas-Murrell & Swift, 2015). These variables have been shown to contribute to interrupted treatment, recidivism, and higher rates of mortality and morbidity among minority groups (Baron et al., 2007; Gary, 2005).

AI/AN Cultural Experience of Stigma

Like the American Indian in the Lower 48, the culture of help-seeking in AI/AN has been negatively influenced by the lack of access to services, the omission of culturally relevant providers and services, and the reticence to seek care outside of local or culturally consistent circles (Hodge, 2012; Trimble et al., 2014). For example, Venner et al. (2012) conducted a mixed methods study of 56 Alaskan Natives with alcohol dependency problems. The results indicated that, as in previous studies, economic

barriers (few facilities, need for childcare) reduced the likelihood of help-seekers to reach out. Interestingly, this study found that cultural barriers (lack of cultural matching, lack of regard for native healing), social barriers (community opinion), and personal barriers (denial of problem) were most important (Venner et al., 2012).

Freitas-Murrell and Swift (2015) collected quantitative survey data from 126 Alaska Native college students and found that stigma was a very important predictor of help-seeking, and the addition of a variable measuring how strongly students identified with white culture was extremely significant, that is, AN participants who identified more closely with the mainstream culture were more comfortable seeking professional assistance (Freitas-Murrell & Swift, 2015). Cultural differences in help-seeking behavior have been identified by Cross and Day (2015). AI/AN who live on reservation are 25% of the population and 18% in rural areas. There are also spiritual beliefs in help-seeking as the authors noted. Acculturation also plays a role. It has been my observation that the worldview differences of help-seeking have been blurred and how indigenous individuals seek help. The use of the term transgenerational trauma will help in stigma reduction (Brave Heart et al., 2011) and help in misdiagnosis (Ringel & Brandell, 2011), along with how tribes' wishes on how to heal.

Additionally, tribes have grown in the last 10 years (Gone & Trimble, 2012) from 1.4 to 2 million. More urbanization has occurred as well to support their families and selves, yet suffer high rates of PTSD, substance abuse, and suicide. Other studies also focused on the AI/AN culture (Gone & Alcantara, 2007; Manson, 2000) and are seeking out evidenced based practices for appropriate treatments to the mental health disparities

and conceptions of psychopathology. Infrastructure for mental health systems for the AI/AN are in evaluation stages and the efficacy of such care are still under review.

Locus of Control

Locus of control has been a well and long studied variable in minority and indigenous cultures (Cheng et al., 2013). Bobb (2000) used a quasi-experimental design and cross-cultural research methodology to study locus of control, assimilation, and epistemologies among the Newe Tribe in Nevada. Locus of control was recognized as a cultural variable; and the results indicated older, trust (or government/reservation) dwellers had higher allocentrism scores. Allocentrism is the individualistic trait that identifies with collectivism. The allocentric group exhibited higher externalism scores as well as older males holding more cultural identity scores (Bobb, 2000). Younger males also had a more fate control ideology. Younger females had lower scores in powerful others while younger males had higher scores. However, internality scores among middle aged men living in urban areas were significant.

Bobb (2010) noted that there is a lack of a theoretical link between cultural orientation and locus of control, especially among AI/AN tribes. Theoretical frameworks regarding locus of control and cultural variations may have flaws or weak correlations to support AI/AN groups in terms of control variations as evidenced by a lack of significance across the board in her study. Additionally, the operationalization of culture is limited, and research with locus of control, a psychological and cultural variable, and trauma (both individual and community norms) is limited. It should be noted that the Newe tribe is not representative of the rest of the AI/AN groups (Bobb, 2000).

Measures of Locus of Control

Much of the research for locus of control has originated in the 1960s with the advent of *Rotter's (1966) Internal/External locus of control Scale* (Cheng et al., 2013), and tapered off in the early to mid 1990s, with one current study on locus of control and help-seeking (Magaard et al., 2017). Locus of control is defined by how an individual takes responsibility, both or how control is attributed to self or elements out of themselves (Anderson et al., 2016; Bobb, 2000). Since then, other locus of control scales have emerged, such as, the *Health Locus of Control Scale*. Other studies that focused on locus of control included issues like substance abuse or depression across other cultures (Cheng et al., 2013). However, many studies recommend more studies on minorities, and some allude to the use of an external locus of control scale by and for minorities (Cheng et al., 2013). The locus of control variable was assessed by Rotter's (1966) Internal/External locus of control scale, to determine a correlation between the predictor and criterion variables.

LOC and Mental Health Help-seeking

Cheng et al. (2013) did a meta-analysis of collectivistic cultures regarding locus of control and coping. Acceptance was a common strategy in stressful situations as opposed to action oriented behaviors found in more individualistic orientations. Additionally, the authors suggested that proxy control in collectivist cultures places control of an individual in lieu of themselves to powerful others, which may cause depressive symptom due to foregoing control to others (Cheng et al., 2013). The authors also recognized the idea of self-construal's (how one defines oneself as independent of,

interdependent with, or dependent on) and how they may affect psychological well-being (Cheng et al., 2013). Locus of control has been a variable of interest in many studies of access to and use of mental health services (Kuo, 2013).

As a potential mediating variable between demographics, trauma, and behaviors of help-seeking, this variable has been helpful for examining within group differences as well as differences across groups and may determine treatment outcomes (Thurman et al., 1990). Instruments and measures used to determine locus of control also use more individualized than collective terms. However, intensive study of this personality variable in AI/AN individuals and the other mentioned variables has not yet been thoroughly conducted. Very little research has focused on help-seeking and internality and externality. Additionally, Locus of control was considered a cultural variable in cross-cultural research (Bobb, 2000).

Cheng et al., (2013) discussed cultural differences among minorities in 18 different countries. Major minority groups did not include AI/ANs' and the authors recommended more studies with locus of control in terms of externality. The authors provided seminal work regarding locus of control in their meta-analysis with minority groups. The authors studied 152 studies and found that externality had a weak correlation to anxiety; however, as in the discussion of trauma, cultural differences may or may not provide a negative connotation to a term and may view a phenomenon in a very different light.

As mentioned earlier, a lack of research regarding transgenerational trauma, evidence-based practices, interventions, psychopathology, and the interaction of these

variables with locus of control, and stigma are limited. Concurrently, the AI/AN population is still growing, and infrastructures are in evaluation phases. Behavioral health is 50 years behind medicine and is making strides to close the gap; however, advances in each area are increasing, as multidisciplinary, multimodal, and multimethods are being tested in all minority groups.

Theory of Planned Behavior

The TPB was originally developed by Ajzen (1991). Ajzen (1991) discussed intention and attitudes in general with his expectancy-value model formula. The utility of the model in the current dissertation study was used to demonstrate its usefulness for the AI/AN community through the study and measures.

This theory has been applied in predicting behavioral intentions in psychological help-seeking (Schomerus et al., 2009). Three subconstructs of intention include: (a) *behavioral beliefs* consequences of the intended behavior originating in an individual's beliefs, (b) *normative beliefs*, the expectations of norms in others' resulting from their beliefs on norms, and (c) *control beliefs* factors present that may positively or negatively affect the performance of one's behavior stemming from their own beliefs (Schomerus et al., 2009).

The results of behavioral beliefs may provide positive or negative consequences because of and result in a negative or positive attitude about the behavior (Schomerus et al., 2009). The perception of pressure from social or subjective norms constitutes normative beliefs, and the perception of behavioral control from their perception in difficulty in performing a behavioral task, constitutes the control belief an individual may

adhere to and execute. If an individual has difficulty executing a certain behavior it may have an influence on volitional control, and the perception of behavioral control, which may have a direct impact on behavior (Schomerus et al., 2009). The study was limited to Europeans in Germany and may not be generalizable to the chosen population in the current study.

The TPB has been studied in women, youth, and Native American youth and eating behavior (Fila & Smith, 2006). In their study, correlations were found in healthy eating behavior and barriers, subjective norms, attitude, and perceived behavioral control. Taste and availability of food were also highly correlated. Intention may have higher correlations with healthy eating, and a gender difference was found (Fila & Smith, 2006).

Summary

The reliance on others to assist in the assistance process from the inception of incident to seek help for older or more culturally involved individuals may require more research, such as proxy control issues (Cheng et al., 2013). A comprehensive evaluation of current cultural models being used may be required to determine what models are working and what models may need modifications. Intention and attitudes about help-seeking in AI/AN are needed and using the TPB model provided some inferential data necessary to make recommendations on direction for prevention and treatment of Type III traumas and cumulative trauma (CT) found in the DBTF. The results helped to provide some preliminary information for the AI/AN group and a general model for minorities to follow.

Behavioral health is 50 years behind medicine and is making strides to close the gap; multidisciplinary, multimodal, and multimethods are being tested in all minority groups. Even though many collectivist cultures may gravitate to their worldview, concerted efforts to find culturally competent approaches to evidence-based practices, interventions, psychopathology, and the interaction of these variables with locus of control and stigma in help-seeking behavior are needed for the growing AI/AN population. Concurrently, AI/AN communities are closing the behavioral health and medical model gap with pragmatic, intervention research to advanced theoretical framework research as well as tribally managed institutional review boards.

Chapter 3: Research Method

The purpose of this dissertation study was to examine the predictive influence of selected demographic characteristics and individual difference variables on measures of mental health help-seeking in AI/AN people living in and from Alaska. Ajzen's (1991) TPB was proposed as the guide to the selection of variables for the study. Kira et al.'s (2013) DBTF model of transgenerational trauma was proposed as the conceptual framework to justify the inclusion of the assessment of trauma. Chapter 3 presents the research design including, rationale, the variables, sampling and sample size, recruitment, data collection, instrumentation, analysis, validity, ethics, and finally the summary of the overall methodology prior to data collection.

Research Design and Rationale

Variables

The independent variables (IV) were demographics, transgenerational trauma, locus of control, and stigma. The dependent variables (DV) were help-seeking; attitude; intent; and use. The intent of this study was to use the models presented to predict help-seeking using eight demographics variables, a variable for measuring transgenerational trauma, a variable measuring stigma, and finally one to measure locus of control. Help-seeking, intent, attitude, and use of professional psychological services were the dependent variables. The 11 predictor variables are presented in Table 1.

Table 1*Variables Proposed for the Present Study*

Predictor Variables	Source
Demographics	
Gender	
Socioeconomic Status (SES)	
Age	
5 Tribal affiliations (Inupiat/Inupiaq, Athabaskan, Yupik/Cupik/Cup'ig, Aleut/Alutiiq, Tsimshian/Haida/Tlingit), coded as 4 dummy variables	Field (2013)
Immediate family member (parent or grandparent) who was at a residential school Bombay et al. (2014)	Bombay et al. (2014)
Individual Difference Measures	
Internal/External LOC Scale	Rotter (1966)
Cumulative Trauma Scale (Short Form) (TQS-C-A)	Kira et al. (2008)
Stigma Scale for Receiving Psychological Help (SSRPH)	Komiya et al. (2000)
Criterion Variables	
Mental Help Seeking Attitude Scale (MHSAS)	Hammer and Spiker (2018)
Mental Help Seeking Intention Scale (MHSIS)	Hammer et al. (2018)
How many times in the last 12 months have you sought professional help for psychological problems?	

Research Design

The research design was a nonexperimental, cross-sectional study using five psychometrically valid measures (see Buckingham & Saunders, 2004; Field, 2013). A hierarchical linear multiple regression approach for the analyses was identified, using two groups of variables (demographics; then the variables of interest; see Pallant, 2013). This

type of design is commonly utilized in quantitative approaches to examining the influence of multiple factors on mental health help-seeking (Gulliver et al., 2010).

There were several advantages of this type of design. Multiple methods of data collection allowed me the flexibility to seek out hard-to-locate participants. The efficiency for collecting many data on many variables in a short period of time was another advantage; it was also cost-effective. The disadvantages of this type of design include the inability to test causal relationships in a substantive way (e.g., quasi-experimental design or longitudinal studies); the limitations of collecting data using questionnaires which are at risk for bias, error, and under- and overreporting; and the challenges of creating a representative sample using nonprobability methods (Buckingham & Saunders, 2004; Field, 2013).

Methodology

Population

According to National Congress of American Indians (NCAI, 2018), the definition of AI/AN is “persons belonging to the Indigenous tribes of the continental United States (American Indians) and the Indigenous tribes and villages of Alaska (Alaska Natives)” (p. 9). Tribes are recognized by the federal government on a government-to-government relationship (NCAI, 2018). There are 571 tribes in the United State and 231 of those tribes are in Alaska. At the time of writing this chapter, the total AI/AN population of all regions in Alaska was 119,241 (Alaska Native Health Board, 2018), a 15,000 difference from the 2010 Census Bureau count (Census, 2010). I was

able to calculate the estimated population from all the corporations' websites at approximately 130,649 enrolled shareholders.

In 1971, a congressional act created 12 regional corporations associated with five specific regional ethnic groups and an additional corporation for individuals who chose not to identify with one of the other 12 regional corporations. The corporations are split into health and social services branches. The health branches are responsible for the institutional review board operations. The five main groups in Alaska are: Aleut/Alutiiq, Athabascan, Southeast (Tlingit, Haida, and Tsimpsian), Inupiat/Inupiaq, and Yupik/Cupik/Cup'ig.

Sampling and Sampling Procedure

The inclusion criteria consisted of individuals of AI/AN descent aged 18 years of age or older, all gender preferences were asked to participate, tribal identification, and have a general understanding of the purpose of the study, the variables being studied and the expectations for completing the study.

Participants were asked to indicate their ethnicity to qualify to participate in the sample, if an individual was $\frac{1}{4}$ AI/AN blood quantum, they may participate in the study, have a general understanding of the purpose of the study, the variables being studied and the expectations for completing the study. The determination of AI/AN blood quantum was based on lineal descendency by tribes (Langdon, 2016) and the use of $\frac{1}{4}$ quantum blood was a requirement from the Marine Mammal Protection Act to hunt and fish and use marine mammals.

Power Analysis

The GPower 3.1.9.2 program (Faul et al., 2007) was used to determine an initial estimate for sampling using the F test, linear multiple regression, fixed model, with R^2 increase and 11 predictors. The *a priori* estimate was calculated for 11 predictors, alpha = .05, an effect size of .10 (small effect size) and power = .80, resulting in an estimate of $n = 179$. In addition, the “rule of thumb recommendations” (Hair et al., 2014; Siddiqui, 2013) suggested 15 to 20 cases per predictor, and recommended more for step-wise procedures. For this study, this meant a maximum of 220 cases (i.e., for the 11 predictors). To analyze the data using multiple regression, with tribal affiliation as one of the predictors (the five ethnicities entered using four dummy codes), a target of 44 cases from each tribal ethnicity was attempted.

Sampling Plan

A nonprobability, quota sampling strategy was proposed, as the intent is to have representation from all five ethnic groups, without the ability to randomly select participants. This strategy is convenient and cost-effective, yet, generalizing results from the sample to the population was done with caution (Buckingham & Saunders, 2004).

Concerted efforts for outreach from each regional location were key to obtaining the appropriate number of cases for each ethnic group, following the recruitment plan described below as well as asking for permission from the tribal and regional locations to hang flyers in community centers, stores, common areas; stores and cafes near or around universities, and non-health related tribal organizations were an avenue to recruit participants.

If an ethnic group was low in count, I attempted to request more participants via a certain community center, store(s), common area, or cafes near, or around a university, and non-health related tribal organizations via the point of contact individual for each tribal and regional location and repost on social media pages to call for more participants. Every effort was taken to obtain the required number of participants in the first round of call for participants requested at meetings and presentations.

Table 2

Alaska AI/AN Ethnic Groups

Ethnic Group	Freq.
Inupiat/ Inupiaq	44
Athabascan	44
Yupik/Cupik/Cup'ig	44
Aleut/Alutiiq	44
Tsimshian/Haida/Tlingit	44
Total	220

Procedures for Recruitment and Data Collection

Recruitment

The recruitment strategy began with presenting the study at the quarterly telephonic meeting of the Tribal State Collaboration Group (Oct 2020), researching times for the Bureau of Indian Affairs Rural Service Providers conference, and the Alaska Native Women's Resource Center. The conferences were contacted to reach tribal members from all the five ethnic groups. In between conferences, 20 tribal councils a week, from the 231 tribes in Alaska (see listing of the list of tribes found on the National

Congress of American Indian website) were contacted for a face-to-face or telephone meeting to determine their Tribal Institutional Review Board (IRB) status and to determine if approvals can be obtained to post flyers to recruit participants. If approvals were needed for tribal IRBs, I followed tribal protocol to obtain approvals. No tribal IRBs were pursued because of the short period of time allotted for data collection.

Plans to present a summary of my research proposal and distribute flyers to the directors, program managers, tribal administrators, and incumbents at each meeting, conference, and tribal council to ask to post and distribute the invitation electronically (via LinkedIn and other social media), and to post them at community centers, stores, common areas; cafes and stores near and around universities, and non-health related tribal organizations to recruit participants were followed through. Providers were informed of the requirements for collecting data and that approvals from tribal health corporations are not needed if recruitment is not being sought in health clinics and sub regional clinics.

I was able to determine that no letters of cooperation's are needed if recruitment is not occurring in clinics or sub regional clinics. Researchers familiar with the process were sought and because the research does not need regional health corporation approvals to recruit participants, I moved forward using the recruitment process delineated above and IRB approval from Walden and the Alaska Area Institutional Review Board having been completed.

A point of contact (POC) person was obtained from the participating agencies. The POC or their office was asked to distribute and hang flyers in community centers,

stores, common areas; cafes and stores near and around universities, and non-health related tribal organizations. The POC was contacted again if there were low numbers in a region or ethnic group indicated in Table 2. A goal of outreach to 20 tribal councils a week or until the quotas were full was attempted, along with presentations at the meetings and conferences. Once participants viewed the flyer, they were directed to the SurveyMonkey website on the flyer to read about the study, consent form, and instructions on how to complete the survey. Participants acknowledged consent by clicking a tab on the web survey and paper-and-pencil survey takers acknowledged consent by doing the survey and simply submitting it to me, which involved implied consent, and to keep the consent form for their records. The consent form for the web survey appeared on the first page. At the end of the survey the participant was thanked (via web-based survey or printed form) for their time and told how to request a summary of the study. Participants who did the web survey were encouraged to print a copy of the consent form for their future reference. Participants were informed that if they quit the study prior to completing the whole survey their information will only be used to determine any flaws in the system or survey.

Social media recruitment included creating a page on Facebook and LinkedIn and asked participants to like the page and share it. The page contained the SurveyMonkey website where the participant had access to the web survey or was able to print out the survey, consent form, and instructions to complete it out by hand. The participant was asked to contact me to submit the survey to my PO Box address or made arrangements to pick up and drop off the survey if requested. If participants needed a survey printed, they

were encouraged to contact me. I sent out the consent form and instructions on how to take the survey on the day the participant requests the survey. The survey was sent out to the participant the next day to protect their identity and to keep their information confidential (this procedure was not needed, as two people filled out the survey by hand).

Data Collection

Web-based and paper-and-pencil based versions of the questionnaires were available to participants. The reason for the multiple methods of data collection was that participants may not have the time, language skills, or an appropriate space to complete the survey. It was hoped that most participants would use the link to the SurveyMonkey website, which was the case. While this data collection method ensured the anonymity of the participants, I did anticipate that others may need a paper version if an internet connection was not available in their area or if a paper survey was easier than working on a computer for some individuals. The anonymity of the surveys was ensured to the participants and was informed that their information will be stored in a locked computer for web or cabinet for paper-and-pencil surveys.

When presentations were at meetings or conferences, participants were informed of the invitation, which described the “opt-in” process for participation, navigation to the SurveyMonkey website or contacting me to access a paper-and-pencil version. The informed consent described the focus of the research and the confidential steps taken to protect the participants. If individuals who requested the paper-and-pencil surveys, the individual was asked to contact me at my cell phone number or email address. As described above, I sent out the consent form and instructions on how to take the survey

on the day the participant requests the survey. The survey was sent out to the participant the next day to protect their identity. At the conferences and meetings, I had intended to have information on how to get a copy of the survey if any participants wished to use paper-and-pencil forms, the consent form, and instructions on how and when to submit the survey was accessible (which was not done because meetings and conferences were cancelled due to the pandemic).

If participants requested a paper-and-pencil survey on the social media websites, I requested a mailing address from the participant and asked to send it back to me at my PO Box. A self-addressed stamped envelope with my address on both returning and sending addresses were provided along with a copy of the surveys sent to the participant, to increase participation from the chosen population. The participant was informed of the length of the survey and where they should find a quiet area without distractions to fill out the survey. The participant was encouraged to take their time while taking the survey and/or to do chunks of the survey at a time or day. A form letter provided instructions on Informed Consent, completing the survey, directions on how and when to send the completed surveys, and who to contact for the results of the study for paper-and-pencil surveys. Procedures for ethics were followed, if the participant knew me or vice versa in paper-and-pencil surveys, procedures to ensure anonymity were followed and informed to the participant (this process was also not needed as surveys were dropped off and picked up with the participants consent).

Exit and Debriefing

For debriefing at the conclusion of the data collection, electronic participants were directed to the last page as a thank you page, the informed consent had information with instructions of how to contact me for a summary of the results; paper-and-pencil participants received this in the instructions letter. Participants were provided my phone number, email, or PO Box to request an electronic or paper summary of the survey, if the participants wished to have a copy of the completed study in summary form. Participants were provided several referrals if they needed to debrief in the referrals in the consent form. Participants were encouraged to print or save the consent form for the web survey and keep the consent form for the paper-and-pencil survey.

Instrumentation and Operationalization of Constructs

Demographic variables (gender, SES, age, and Tribal affiliation, were measured using US Census based scales (U.S. Department of Commerce, 2016) as well as AI/AN ¼ blood quantum commonly used by Alaska Native corporations to receive services. AI/AN blood quantum is based on lineal descendency by tribes (Langdon, 2016) and the use of ¼ quantum blood is a requirement from the Marine Mammal Protection Act (Langdon, 2016).

A question to determine if a parent or grandparent attended boarding school to measure the transgenerational effect (Bombay et al., 2014). In Bombay et al.'s (2014) study the effect of transgenerational trauma was measured by asking if one or more parents as well as grandparents attended Indian Residential School (IRS) or none. Participants were not asked to disclose their attendance of IRS to determine the

transgenerational impact of psychological stress levels on the individual to test for the transgenerational effect. Multiple generations reported more stress levels than individuals who had only one generation who attended IRS (Bombay et al., 2014).

For the predictors, the measures included Kira et al.'s (2008) Cumulative Trauma Scale (Short Form-TQS-C-A), Rotter's (1966) Internal/External Locus of Control Scale (RIES, Rotter, 1966), and the Stigma Scale for Receiving Psychological Help (SSRPH, Komiya et al., 2000). The criterion measures included the Mental Help Seeking Attitude Scale (MHSAS, Hammer et al., 2018), the Mental Help Seeking Intention Scale (MHSIS, Hammer & Spiker, 2018), and a question asking how many times a participant sought psychological help. Chapter One has the definitions of the variables.

Rotter's Internal/External Locus of Control Scale (RIES, Rotter, 1966)

Rotter's (1966) Internal/External Locus of Control Scale is a 29-item scale that measures internal or external locus of control (Cheng et al., 2013), with strong relationships with depression and anxiety and external locus of control at 30%, 95% *CI*, .27 and .32 and 30%, 95 % *CI* and .27 and .32, respectively. The measure was appropriate because it measures perceived control as well as links the psychological construct to cultural attachments (Bobb, 2000) and links to strict role identification. Individualism is perceived by taking responsibility for oneself and as not to burden others, in collectivist societies. Proxy control is also a widespread practice in collectivistic societies (Cheng et al., 2013).

Reliability for across samples have been validated and was appropriate for the sample in this study. Some studies have been done with Native American samples,

however, a paucity of research for AI/AN in or from Alaska exists. The predictive nature of locus of control on help-seeking was tested in this study.

Cumulative Trauma Scale (Short Form) TQS-C-A (Kira, et al., 2008)

The TQS-C-A Kira et al. (2008) is a 32-item measure which has 12 trauma subscales for four trauma types ranging from Trauma Type I to Trauma Type IV. Kira et al. (2014) used Palestinian and American Indian samples to determine cumulative trauma (CT). It appeared to be appropriate for AI/AN in Alaska, with good internal consistency at .85 for adults in general and reliability at .85 -.92 with nontraditional samples. Kira wished for me to provide appropriate citations of the measure if used, in an email informing him of the study and wish to use the TQS-C-A in March 2018. Formal authorization to use the measure was obtained in October of 2019, final authorization for the TQS-C-A in August 2020.

Stigma Scale for Receiving Psychological Help (SSRPH, Komiya et al., 2000)

The SSRPH (Komiya et al., 2000) has five items. College students were tested using a five point Likert scale and higher scores indicated stigma at receiving psychological help (Komiya, et al., 2000). The coefficient alpha was at .72 in Komiya's college sample, an acceptable level. Construct validity was determined with the Attitudes Toward Seeking Professional Psychological Help and the SSRPH (Komiya et al., 2000) was determined to be adequate for a negative association with stigma, which indicated seeking professional help with less social stigma, allowed an individual to seek professional help (Komiya et al., 2000).

The study of this factor in AI/AN individuals' appeared to be viable. Women scored lower in Komiya et al.'s (2000) study, consistent in the literature. Negative correlations were also found in emotional openness and level of psychological distress. The permission to use the scale was received by Good, G. E., in Sept 2019.

Mental Help Seeking Attitude Scale (MHSAS, Hammer et al., 2018)

Hammer et al. (2018) tested the Mental Help Seeking Attitude Scale (MHSAS) against the Attitudes Towards Seeking Psychological Professional Help (ATSPPH; Fischer & Turner, 1970) and the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS; Makenzie et al., 2004) in their 2018 study with college students. The measure seemed appropriate for this study as it uses the Theory of Planned Behavior (Ajzen, 1991) and does well in measurement equivalence/invariance with the two former measures, as the Attitudes Towards Seeking Psychological Professional Help (Fischer & Turner, 1970) follows no theoretical model and the Inventory of Attitudes Toward Seeking Mental Health Services (Makenzie et al., 2004) does not measure multiple constructs within a construct such as psychological openness (Hammer et al., 2018), which may cause confusion among researchers and professionals in the mental health field. Permission to use the Mental Help Seeking Attitude Scale was sought May 2018 on the author's website. The measure also demonstrated cross-cultural utility while comparing it to the two older measures.

Reliability was demonstrated (Hammer et al., 2018) with internal consistency at exploratory ($\alpha = .93$) and confirmatory ($\alpha = .94$). The MHSAS demonstrated construct validity at or surpassing the IASMHS and the ATSPPH using hierarchical linear

regression, explaining 9% above and beyond the two measures (Hammer et al., 2018), demonstrating its validity and inclusion as a measure in this dissertation research. The goodness of fit within the items in the MHSAS measure was at 8.5 for the 9-item version. Content validity was obtained via metric equivalence or invariance for men and women per the $\Delta CFI < .01$ and $\Delta RMSEA < .015$ rules. Reliability of the MHSAS was garnered among practitioners in the field.

Mental Help Seeking Intention Scale (MHSIS, Hammer & Spiker, 2018)

The Mental Help Seeking Intention Scale (MHSIS, Hammer & Spiker, 2018) measured intention, a higher-level construct of attitude to determine the definitiveness of help-seeking in individuals who seek professional psychological help. Like the MHSAS (Hammer et al., 2018) the MHSIS (Hammer & Spiker, 2018) seemed to have good internal consistency and compatibility with the chosen measures. The MHSIS (Hammer & Spiker, 2018) seemed to demonstrate cross-cultural utility in the AI/AN community. Permission for use of the MHSIS (Hammer & Spiker, 2018) was also sought in May 2018.

Behavior was asked by how many times a participant sought professional psychological help for their mental health status in the last 12 months. Internal consistency was sought with the use of the survey battery proposed thus far.

Analysis Plan

SPSS was used to analyze the data from the survey research data collected from the AI/AN participants to answer the following research questions:

Research Question 1: To what extent do demographics predict attitudes towards help-seeking?

H₀1: Demographic variables (age, gender, socioeconomic status, SES), tribal affiliation, and Indian Residential School (IRS-family member) do not predict mental health help-seeking attitude.

H_a1: Demographic variables (age, gender, socioeconomic status, SES), tribal affiliation, and Indian Residential School (IRS-family member) predict mental health help-seeking attitude.

Research Question 2: To what extent do locus of control, stigma, and transgenerational trauma predict attitudes towards help-seeking beyond the contribution of demographics?

H₀2: LOC, stigma, and TT do not predict attitudes towards HS beyond the contribution of demographics.

H_a2: LOC, stigma, and TT predict attitudes towards HS beyond the contribution of demographics.

Research Question 3: To what extent do demographics predict intention to seek help?

H₀3: Demographic variables (age, gender, SES, tribal affiliation, and IRS-family member) do not predict intention to seek help.

H_a3: Demographic variables (age, gender, SES, tribal affiliation, and IRS-family member) predict intention to seek help.

Research Question 4: To what extent do LOC, stigma, and TT predict intention to seek help beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member)?

H₀4: LOC, stigma, and TT do not predict intention to seek help beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

H_a4: LOC, stigma, and TT predict intention to seek help beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

Research Question 5: To what extent do demographics predict number of help-seeking events?

H₀5: Demographics variables (age, gender, SES, tribal affiliation, and IRS-family member) do not predict the number of HS events.

H_a5: Demographics variables (age, gender, SES, tribal affiliation, and IRS-family member) predict the number of HS events.

Research Question 6: To what extent do LOC, stigma, and TT predict number of HS events beyond the contribution of demographics?

H₀6: LOC, stigma, and TT do not predict number of HS events beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

H_{a6}: LOC, stigma, and TT predict number of HS events beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

First, tests of assumptions of linearity, normality, multicollinearity, independence of residuals, singularity as well as homoscedasticity of residuals (Pallant, 2013; Tabachnik & Fidell, 2019) were conducted to ensure that the data meet the assumptions for multiple hierarchical regression. Outliers were checked for and deleted if detected as not to breach the assumption in the model (Pallant, 2013).

Then, hierarchical multiple linear regression (HLMR) was used to determine if the predictors (transgenerational trauma, locus of control, and stigma) significantly explained the variance in the criteria (help-seeking attitudes, intentions, and behaviors) above and beyond the variance explained by the demographics. All the variables followed theoretical foundations and are deemed qualifiers for testing hypotheses (Tabachnick & Fidell, 2019). In case of the need to choose which variable to remove because of the nature of outliers, I kept transgenerational trauma over locus of control and stigma.

The Durbin-Watson test was not used to measure autocorrelation, to avoid Type 1 errors (Tabachnick & Fidell, 2019) because the insignificance of the variables. The hierarchical nature required the input of variables regarding the importance of the predictors to the study and design as well as the participants. General ANOVA procedures were followed, the last step in sequential regression provided the necessary output files to assess the significance of the model (Tabachnick & Fidell, 2019).

Threats to Validity

Regarding external validity, I made every effort to successfully execute the quota sampling strategy to get proportional representation from each of the five ethnic groups via the regional locations. This also decreased stigmatization in regional areas of Alaska. However, because this was not a random or stratified random sample, the results of this study were generalized with caution (Buckingham & Saunders, 2004). Regarding internal validity, survey research was limited, as the predictor variables of interest are not manipulated or controlled by me. Therefore, the results were interpreted with caution. Additionally, the responses of the participants may be influenced by response bias. The participants were asked to respond as honestly and individually as possible, but the data collection setting was not under enough control to minimize this. Construct validity was maximized, as the research utilized well-studied and psychometrically evaluated measures.

Ethical Procedures

The data was provided to the two institutional review boards (IRBs) for review. After, Walden University IRB, the Alaska Area IRB approval process was sought. Approval numbers are 11-13-19-0476694 for Walden University and (1430255-3) for AAIRB. The approval process for tribal council IRB processes may be different or may not be in operation, I followed tribal protocol to obtain approvals. The tribal council level IRB approval processes appeared to be in evaluation and research stages to implement tribal IRB processes; therefore, it was my assumption that an exceedingly small percentage of tribal IRB approval processes was correctly anticipated. If approvals were

needed for tribal IRBs, I followed tribal protocol to obtain approval from the tribal council. Tribes were informed of IRB approvals once recruitment commenced and provided a short presentation and flyer of the study if requested.

The stakeholders and participants were informed of the quota sampling procedure and required number from each tribal ethnicity. The participants were informed of their right to terminate the survey if they wished with no consequences. The participants were informed of taking their time. The participants were reinforced of the sensitive nature of the study and provided resources to debrief if they required. Participants were provided referrals for counselling for further debriefing, several referrals (Bersoff, 2009) were provided in the consent form.

Participants were informed that the data will be stored in a locked computer and behind a locked door. A locked container provided safe storage of the anonymous information, for paper and pencil surveys. The individual was identified by numbers or general tribal information (i.e., Aleut1) or what they were assigned by the SurveyMonkey website and participants were informed of the procedure as well as anonymity regarding the sensitive topic of the study. The individual was informed that their data will be protected, and only regional, aggregate data will be shared in the results of the study. Participants were informed that paper data will be destroyed after five years, as well as electronic data secured on storages devices and mailing addresses or identifying information destroyed upon receipt by me.

Summary

Chapter 3 was the method and methodology of the study. A multivariate regression analysis was used to determine the predictive relationship of the variables using and potentially testing paradigm models. The DBTF model proved to be somewhat of a valid and reliable model for AI/AN members (Kira et al., 2014) as well as applications of the TPB for an AI/AN population (Fila & Smith, 2006). More on the efficacy of these models will be discussed in Chapter 5. The results of this study demonstrated the viability of the design, methodology, and method of inquiry to obtain needed information from a vulnerable population.

The framework for the study and approvals to move forward from two institutional review boards was sought. The details to provide a culturally sensitive research design using a quantitative approach has been conducted and in Chapter 4 the results of the data collection will document and report their efficacy. Results and recommendations will be provided in Chapter 5. The results will add to the literature for this vulnerable populations, for future researchers to use as a reference, and minorities to use as a model.

Chapter 4: Results

The purpose of this study was to examine the predictive relationships of demographics, transgenerational trauma, locus of control, and stigma on help-seeking use of mental health services in the AI/AN population from Alaska, using the TPB and the DBTF. The independent (predictor) variables were demographics, transgenerational trauma, locus of control, and stigma, and the dependent (criterion) variables were mental health help-seeking; attitude; intent; and use.

The research questions were:

Research Question 1: To what extent do demographics predict attitudes towards help-seeking (HS)?

H₀1: Demographic variables (age, gender, socioeconomic status, SES), tribal affiliation, and Indian Residential School (IRS-family member) do not predict mental health help-seeking attitude, intention, and use.

H_a1: Demographic variables (age, gender, socioeconomic status), tribal affiliation, and Indian Residential School (IRS-family member) predict mental health help-seeking attitude, intention, and use.

Research Question 2: To what extent do locus of control, stigma, and transgenerational trauma predict attitudes towards HS beyond the contribution of demographics?

H₀2: LOC, stigma, and TT do not predict attitudes towards HS beyond the contribution of demographics.

H_{a2}: LOC, stigma, and TT predict attitudes towards HS beyond the contribution of demographics.

Research Question 3: To what extent do demographics predict intention to seek help?

H₀₃: Demographic variables (age, gender, SES, tribal affiliation, and IRS-family member) do not predict intention to seek help.

H_{a3}: Demographic variables (age, gender, SES, tribal affiliation, and IRS-family member) predict intention to seek help.

Research Question 4: To what extent do LOC, stigma, and TT predict intention to seek help beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member)?

H₀₄: LOC, stigma, and TT do not predict intention to seek help beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

H_{a4}: LOC, stigma, and TT predict intention to seek help beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

Research Question 5: To what extent do demographics predict number of help-seeking events?

H₀₅: Demographics variables (age, gender, SES, tribal affiliation, and IRS-family member) do not predict the number of HS events.

H_{a5}: Demographics variables (age, gender, SES, tribal affiliation, and IRS-family member) predict the number of HS events.

Research Question 6: To what extent do LOC, stigma, and TT predict number of HS events beyond the contribution of demographics?

H₀₆: LOC, stigma, and TT do not predict number of HS events beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

H_{a6}: LOC, stigma, and TT predict number of HS events beyond the contribution of demographics variables (age, gender, SES, tribal affiliation, and IRS-family member).

Chapter 4 consists of data collection, the time frame, actual recruitment activities, and response rates. The preliminary descriptive statistics for the demographics characteristics of the chosen population are discussed. A discussion of external validity, basic univariate analyses, evaluation of statistical assumptions, results of the survey, descriptive statistics idiosyncratic to the chosen population, and results are delineated. Findings found in the statistical analyses using associated probability values, confidence intervals, effect sizes associated with the statistics, and results from the post hoc tests were performed. The answers to research questions are summarized at the end of the chapter to include general findings and inferential data to make appropriate recommendations as a connection to Chapter 5.

Data Collection

The data collection began in late October 2020 and went to early January 2021. Eighty-six participants took the survey and 59 completed all the items, a 68% response rate. The discrepancies from the actual data collected from the plan presented in Chapter 3 were significant. Additionally, not being able to present at conferences where many Alaska Native people congregate were stalled because of the pandemic and the need to join teleconference calls with entities like the Tribal/State Collaboration Group were used as a backup plan. The Institutional Review Board (IRB) process to collect data from a vulnerable population like the AI/AN living in and from Alaska was affected by the pandemic as well as the requirements to demonstrate adequate progress in the dissertation process at Walden University.

A total of 190 tribes out of the 231 tribes were contacted and the contacts were garnered from the Bureau of Indian Affairs Indian Child Welfare Act, Tribal Directory list. Tribal contacts who were not able to receive email or able to do the survey online were sent a flyer via postal mail to help recruit from their tribal communities. The initial projected 220 participants sought was reduced to 61 participants because of the difficulties encountered above, to provide a general descriptive statistic and multiple linear regression analysis regarding the variables in the AI/AN population from Alaska. The post hoc power analysis results are in the following section.

Results

Description of the Sample

Demographics

Six demographic (predictor) variables were collected. The variables were gender, age, a parent or grandparent who attended Indian Residential School (IRS), tribal identity, education, and income level (SES). I assessed the demographics using the IBM SPSS Statistics 27 analysis program. A summary of the demographic characteristics is presented in Table 3.

Table 3*Summary of Demographic Characteristics*

Variable Name	Values	Frequency	Percent	Valid Percent
Gender	Male	9	14.8	15
	Female	51	83.6	85
	Total	60	98.4	100.0
	Missing	1	1.6	
Age	19 to 24 years	4	6.6	6.7
	25 to 34 years	14	23.0	23.3
	35 to 44 years	13	21.3	21.7
	45 to 54 years	14	23.0	23.3
	55 to 64 years	11	18	18.3
	65 or more years	4	6.6	6.7
	Total	60	98.6	100.0
	Missing	1	1.6	
IRS	Parent or grandparent did not attend	21	34.4	35
	Parent or grandparent attended	39	63.9	65
	Total	60	98.4	100.0
	Missing	1	1.6	
Tribal Affiliation	Inupiat/Inupiaq	10	16.4	16.4
	Yupik/Cupik/Cup'ig	25	41.0	41.0
	Aleut/Alutiiq	9	14.8	14.8
	Tsimpsonian/Haida/Tlingit	4	6.6	6.6
	Athabascan	6	9.8	9.8
	Other (2 or 3 mixes of the 5 main tribes)	7	11.5	11.5
	Total	61	100.0	100.0
Education	9th to 11th grade	1	1.6	1.7
	Graduated HS or technical institute	14	23.0	23.7
	1 year college or technical school	10	16.4	16.9
	2 to 3 years of college	11	18.0	18.6
	Graduated college	11	18.0	18.6
	Some graduate school	4	6.6	6.8
	Graduated graduate school	8	13.1	13.6
	Total	59	96.7	100.0
	Missing	1	1.6	
Income level	Less than \$20,000	4	6.6	8.5
	\$20 to \$34,999	4	6.6	8.5
	\$35 to 49,999	13	21.3	27.7
	\$50 to 74,999	6	9.8	12.8
	\$75 to \$99,999	9	14.8	19.1
	\$100 to \$149,999	3	4.9	6.4
	\$150 to \$199,999	1	1.6	2.1
	\$200,000 or more	1	1.6	2.1
	Prefer not to answer	6	9.8	12.8
	Total	47	77.0	100.0
	Missing	1	1.4	
	System missing	13	21.3	
	Total	14	23	
Total		61	100.0	

Most of the respondents were female (85%) and between the ages of 25 – 54 (68.3%). Sixty-five percent of respondents had a parent or grandparent who attended IRS and 41% identified as Yupik/Cupik/Cup'ig as their tribal affiliation. Many respondents graduated high school (23.7%), attended 1 (16.9%) year or 2 (18.6%) years of technical school or college (total 35.5%), or graduated from college with a Bachelor of Arts degree (18.6%, totaling 77.8% of the total sample). The main income base was \$35,000 – 49,999 (27.7%) and another spike at \$75,000 – 99,000 (19.1%). This second income spike suggests that the participants had gainful employment, which is a trend in Alaska because of the North Slope oil field job opportunities or mining opportunities found in Alaska.

Missing Data Analysis

I observed in the data that the variables after the demographics appeared more susceptible to missing data; in particular, 12 cases were identified. I ran a cross-tabular analyses to examine the differences between the 12 versus 61 cases. The only significant difference was on the Indian Residential School (IRS) variable (a parent/grandparent did/did not attend), Chi-Square = 6.58(1), $p=.01$. This suggests that those who did not have a parent or grandparent attend IRS may not have identified completing the survey as beneficial because it may have not felt applicable to their situation. If this is the case, the generalizability of the findings could be limited because the design is inferential. Cases with missing data were removed from subsequent analyses.

Criterion Variables

Three criterion (dependent) variables were studied: mental health help-seeking; attitude; intention to seek help; and number of times help was sought (Sought). The descriptive statistics are presented in Table 4.

Table 4

Descriptive Statistics for the Criterion Variables

		MHSAS	MHSIS	Sought Help
N	Valid	59	61	61
	Missing	2	0	0
Mean		3.87	4.63	1.84
Median		3.78	5.00	.00
Std. Deviation		.29	2.37	4.31
Skewness		-.19	-.25	3.15
Std. Error of Skewness		.31	.31	.31
Kurtosis		2.88	-1.19	9.96
Std. Error of Kurtosis		.61	.60	.60
Minimum		2.78	1.00	0
Maximum		4.56	9.00	20
Sum		228.33	282.33	112

The frequency distributions for mental health help-seeking (MHHS) for attitude and MHHS for intention were normal. However, for Sought, 60% of the sample had not sought help. To explore the relationship among criterion (help-seeking) variables, a correlation matrix was calculated (Table 5) and the results indicated that attitudes towards help seeking were significantly negatively correlated with intention and actual help-

seeking. The discrepancy between attitude and intention to seek help and the actual number of help-seeking behaviors will be discussed further in Chapter 5.

Table 5

Correlations Among the Criterion Variables

	MHSAS	MHSIS
MHSAS		
MHSIS	-0.64*	
MHHS Sought	-0.24	0.36*

Note. * $p < 0.01$ level (2-tailed).

To examine differences between tribal groups on the criterion variables, a series of One-way Analysis of Variance (ANOVA) were calculated. All ANOVAs met the assumption for homogeneity of variance, $p > .05$ (Table 7), despite the substantive differences in group size. The results of all ANOVA's were nonsignificant, suggesting no differences between tribes on intention, attitudes, and actual help-seeking (Table 8). It is noteworthy that the Tsimpian/Haida/Tlingit group had the highest mean for intention to seek help but the lowest mean for number of times help was sought (Table 6).

Table 6*Descriptive Statistics for Tribal Differences on Criterion Variables*

	Intention to Seek Help			Attitudes Towards Help-Seeking			No. Times Sought Help		
	<i>N</i>	Mean	<i>SD</i>	<i>N</i>	Mean	<i>SD</i>	<i>N</i>	Mean	<i>SD</i>
Inupiat/Inupiaq	10	4.40	2.80	9	3.96	.35	10	2.70	4.21
Yupik/Cupik/Cup'ig	25	4.63	2.31	25	3.85	.21	25	2.04	5.47
Aleut/Alutiiq	9	4.62	2.10	8	3.97	.35	9	2.33	4.69
Tsimpsian/Haida/Tlingit	4	6.08*	1.26	4	3.81	.14	4	.50	.58
Athabaskan	6	5.50	1.38	6	3.63	.44	6	1.00	1.55
Other (2 or 3 mixes of the 5 main tribes)	7	3.38	2.13	7	3.94	.22	7	.71	1.50
Total	61	4.62	2.37	59	3.87	.29	61	1.84	4.31

Table 7*Tests of Homogeneity of Variances*

Criterion		Levene Statistic	<i>df1</i>	<i>df2</i>	Sig.
MHHS	Based on Mean	1.05	5	55	.40
Sought	Based on Median	.26	5	55	.93
	Based on Median w/adjusted <i>df</i>	.26	5	40.55	.93
	Based on trimmed mean	.69	5	55	.63
MHHS	Based on Mean	2.00	5	53	.09
Attitude	Based on Median	1.41	5	53	.23
	Based on Median w/adjusted <i>df</i>	1.41	5	33.60	.24
	Based on trimmed mean	1.80	5	53	.13
MHHS	Based on Mean	2.20	5	55	.07
Intention	Based on Median	1.90	5	55	.11
	Based on Median w/adjusted <i>df</i>	1.90	5	44.10	.11
	Based on trimmed mean	2.23	5	55	.06

Table 8*One-way ANOVA MHHS Sought for Attitude and Intention by Tribes*

		Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	Sig.
Sought	Between Groups	30.87	5	6.17	.31	.90
	Within Groups	1081.49	55	19.66		
	Total	1112.36	60			
MHSAS	Between Groups	.56	5	.11	1.41	.24
	Within Groups	4.23	53	.08		
	Total	4.79	58			
MHSIS	Between Groups	24.44	5	4.89	.86	.51
	Within Groups	312.25	55	5.68		
	Total	336.69	60			

Research Question 1: Do demographics predict attitudes towards help-seeking?

The Mental Help Seeking Attitude Scale (MHSAS, Hammer & Spiker, 2018) items were scored by adding up the sum of the answers and dividing by nine.

Examination of the relationships among the independent (predictor) variables revealed that most of the demographics were not correlated with each other. The only two significant relationships were between gender and income ($r = .32, p = .02$); and educational level and income ($r = -.26, p = .04$). No significant correlations between demographics and attitudes towards mental health help-seeking were demonstrated, and the regression analysis could not be performed.

Table 9*Attitude Towards Help-Seeking and Demographics*

		MHSAS	Gender	Age	IRS	Educ. Level	Income
Pearson Correlation	MHSAS	1.00					
	Gender	-.10	1.00				
	Age	-.08	-.20	1.00			
	IRS	.01	-.16	.10	1.00		
	Educ. Level	-.05	.13	.20	-.12	1.00	
	Income	-.02	.32*	-.15	-.07	-.26*	1.00

Note. N=59; * $p < .05$

Research Question 2: Do locus of control, stigma, and transgenerational trauma (TT) predict attitudes towards help-seeking?

I planned to include the measure of stigma as a predictor for this question; however, only 14 participants completed this part of the survey, so this variable could not be included. Correlations among the predictors and criterion were examined (Table 10) and no significant correlations were found between any of the predictors and the criterion. Therefore, the regression analysis was not computed.

Table 10*Correlations of Criterion Variables*

		MHSAS	LOC	TT
Pearson Correlation	MHSAS	1.00		
	LOC	-.07	1.00	
	TT	.09	-.03	1.00

Note. N= 58.

Research Question 3: Do Demographics Predict Intention to Seek Help?

Standard Hierarchical Multiple Linear Regression (HMLR) was performed to analyze the predictive relationship between intention to seek help and demographics (Table 11). No significant correlations between demographics and intention to seek mental health help was demonstrated and the regression analysis could not be performed.

Table 11

Correlations Between Demographics and Intention to Seek Help

		MHSIS	Gender	Age	IRS	Educ. Level	Income
Pearson Correlation	MHSIS	1.00					
	Gender	.11	1.00				
	Age	.06	-.20	1.00			
	IRS	-.07	-.16	.10	1.00		
	Educ. Level	-.10	.13	.20	-.12	1.00	
	Income	.16	.32*	-.15	-.07	-.26*	1.00

Note. N=45.

Research Question 4: Do LOC, stigma, and TT predict intention to seek help beyond the contribution of demographic variables?

Table 12 presents the correlation table for this research question. Except for some intercorrelations in demographics, as seen in RQ1 and 3, the demographics, locus of control, and transgenerational trauma demonstrate no strong associations or correlations with intention to seek out mental health help. The regression analysis could not be performed for RQ4.

Table 12*Correlation Between Intention to Seek Help, LOC, and TT*

		MHSIS	Locus of Control	TT
Pearson Correlation	MHSIS	1.00		
	Locus of Control	.11	1.00	
	TT	-.04	-.03	1.00

*Note. N=58.***Research Question 5: Do demographics predict number of help-seeking events?**

Table 13 presents the correlations among the demographics and number of help-seeking events. Age was the only statistically significant variable which demonstrated near but negative correlation with actual help sought ($r = -.28, p = .03$), and Indian Residential School (IRS) negative correlation approached significance ($r = -.23, p = .06$), so the regression analysis was calculated. Results indicated $R^2 = .101, F = 1.47, p = .219$. The IRS produced the largest standardized coefficient, although it was not statistically significant, $\beta = -.223, t = -1.689, p = .097$. It should be noted that of the 11 participants that were removed from the survey, 36% ($n = 4$) indicated “yes” on the IRS. This will be discussed further in Chapter 5.

Table 13*Correlation Between Demographics and MHHS Sought*

		MHH Sought	Gender	Age	IRS	Educ. Level	Income
Pearson Correlation	MHH Sought	1.00					
	Gender	.15	1.00				
	Age	-.28*	-.20	1.00			
	IRS	-.23	-.16	.10	1.00		
	Educational Level	-.17	.13	.20	-.12	1.00	
	Income	-.07	.32*	-.15	-.07	-.26*	1.00

*Note. N=58.***Table 14***Results of the Regression of Age, Gender, and IRS on Number of Times Sought Help*

Model	Coefficients ^a				
	Unstandardized Coefficients		Standardized Coefficients		Sig.
	B	Std. Error	Beta	t	
(Constant)	5.182	2.993		1.731	.089
Gender	1.239	1.607	.103	.771	.444
Age	-.400	.407	-.133	-.983	.330
IRS	-1.951	1.155	-.223	-1.689	.097
Educational Level	-.309	.325	-.127	-.949	.347

Note. R²=.101, F=1.47, p=.219.

Research Question 6: Does LOC, stigma, and TT predict number of help-seeking events beyond the contribution of demographics?

Table 15 presents the correlation table for this research question. Except for some intercorrelations in demographics, as seen in RQ1 and RQ3, the demographics, locus of

control, and transgenerational trauma demonstrate no strong associations or correlations with seeking mental health services. The regression analysis could not be performed for RQ6.

Table 15

Correlations of MHHS Sought, LOC, and TT

		MHH Sought	Locus of Control	TT
Pearson Correlation	MHH Sought	1.00		
	Locus of Control	.06	1.00	
	TT	-.19	-.03	1.00

Summary

Results for all the research questions except RQ5 had insignificant correlations among the criterion with the demographics and key predictors. For RQ5, Indian Residential School (IRS) was near significantly correlated and produced the largest standardized coefficient. The primary reason for the absence of significant relationships could be insufficient power (small sample size) and nonnormal distributions of some of the key variables (e.g., tribal group).

Type II error may have occurred as well, to obtain a true representation of the population. More recruitment may have been needed from conferences in person or face-to-face meetings with tribes. It was thought that the participants also demonstrated research fatigue, as by the end of the survey only 14 individuals completed the stigma section of the survey and 45 on the MHSIS, and MHSAS sections of the survey. The remaining data may have provided an inaccurate representation of the population.

Chapter 5 will provide an in-depth discussion of the method and methodology of the research paradigm, hierarchical multiple linear regression, its generalizability, and the challenges encountered, and the advantages and disadvantages of quantitative research for tribes in Alaska. Appropriate recommendations will be discussed to determine culturally sensitive approaches to research with Indigenous populations. The implications of research will be discussed as well as from an indigenous lens to determine culturally sensitive approaches for the AI/AN group from Alaska for future research and outcomes.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to examine the predictive relationships of demographics, transgenerational trauma, locus of control, and stigma on help-seeking and use of mental health services in the AI/AN population in a quantitative study, using the TPB and the DBTF as theoretical and conceptual frameworks, respectively. The independent variables were demographics, transgenerational trauma, locus of control, and stigma, and the dependent variables were help-seeking; attitude; intent; and use.

The intent of this study was to provide recommendations that can influence policy for equitable access to mental and behavioral health services in the AI/AN community. The results may inform policy makers, stakeholders, and practitioners so that they can apply more culturally appropriate approaches to the treatment of psychological issues in the AI/AN community living in Alaska. The findings are summarized here in terms of demographics and results of the research questions.

It should be noted that the sample was created using a convenience and snowball sampling procedure, and because of the pandemic, recruitment could not proceed as planned. This resulted in a smaller sample size ($n=61$). A post hoc G-Power analysis (Faul et al., 2007) with effect size $f^2 = .15$, alpha = .05, 8 predictors, and 5 tested predictors resulted in a power estimate of $(1-\beta) = .58$, which was not sufficient to detect average effect sizes. This limitation is discussed below.

Several interesting findings are noted here regarding the characteristics of the sample. The participants in this study were mainly female (84%) between the ages of 25 and 54. As discussed in Chapter 2, more women than men seek out mental health help

when experiencing a crisis or situation that causes stress (Nam et al., 2010), and more recent studies have demonstrated this (e.g., Liddon et al., 2018). In this study, gender differences on all the criterion variables were nonsignificant, suggesting that men and women engaged in help-seeking equally. Following IRB protocol, participants were volunteers and were able to leave the survey at any time, which may have affected the study of intention to seek mental health help-seeking.

Literature in recent years (and in the last few decades) have suggested that suicide rates have increased in the AI/AN male population in Alaska; this is a concern that the males in this group did not report statistically significant help-seeking. Concurrently, with the onset of the pandemic, COVID deaths have surpassed suicide deaths for AI/AN males from Alaska (Ahmad et al., 2020), yet men in general are less likely to seek out professional, psychological help (Liddon et al., 2018).

The greatest tribal representation came from the southwest region (41%), the Yupik/Cupik/Cup'ig region or tribe. As such, they will be the main group of focus in subsequent discussion. At the time of this dissertation, there were 119,241 AI/AN people from Alaska from 231 tribes, villages, or towns (Alaska Native Health Board, 2018). In comparison, the state estimates 19% of the AI/AN population to be from the Yupik/Cupik/Cup'ig region. Because the sample was nonrandomly drawn, it is not possible to make statements comparing the distribution or generalizations of tribal regions in the sample to the population of Alaska.

These results also indicated no significant differences between tribal regions on any of the criterion variables. The Yupik/Cupik/Cup'ig tribe had comparable rates of

attitude and intention to seek out mental health help to the other tribes but was the third lowest of all the tribes in reporting actual help-seeking behavior. There are no comparable statistics in the published literature that compare help-seeking differences across tribes.

Most participants had graduated from high school, attended technical school, or earned a bachelor's degree. Most participants earned at least \$35,000 to \$75,000 or an average of \$68,000 a year. Income was a primary variable regarding help-seeking studies, as minority populations tend to occupy lower SES categories. In a recent study for first generation college students, minority college students who also experience lower SES tend to view cultural dissonance in their college environment and their cultural background and how those cultural views may prevent him or her from seeking out help (Chang et al., 2020). That study emphasized self-reliance as a barrier for both white and minority students and how wishing to not be a burden and relational pressures may prevent the minority group from seeking out help. Chang et al. (2020) also described how these soft (self-expression) and hard independence issues as well as self-expressions in class systems (high, middle, and lower) may affect help-seeking for these college students.

The current survey in this dissertation did not ask whether participants received insurance through their employer or not. However, the Indian Health Services covers about 1/3 of the cost of health services (O'Keefe et al., 2021). SES is a strong predictor of help-seeking and use of mental health services. Barrier and resource theory (i.e., lacking

the resources and knowledge to access help, Rogler, 1983) may be an influencer on help-seeking for the AI/AN group in and from Alaska.

The age range of most of the help-seekers were from 25–54, and 60% of the majority in this group (Yupik/Cupik/Cup'ig) occupied this category. This age range is slightly older, with an average age at 39 years of age, in contrast with Caucasian groups who sought out help at 35 years old as well as ages for 'other' ethnic groups in the 35 years of age category in Liddon et al.'s (2018) study. However, it appears that the age range has lowered in the last decade from the late 30's to the mid 30's regarding the Liddon et al. (2018) study. For the Indian Residential School (IRS) variable, 39 of 60 (65%) participants had a parent or grandparent attend residential school.

To test the research questions, I used a hierarchical regression approach, first testing the demographic variables as predictors of the three help-seeking measures, and then second testing for the addition of the key predictors (Locus of control, transgenerational trauma, and stigma) for their predictive value. As stated in Chapter 4, the stigma variable had more than 77% missing data, and was insufficient to run descriptive and subsequent hierarchical linear multiple regression (HLMR) tests.

The hypothesis testing results of RQ's 1 through 4 and 6 were not significant. The demographics did not influence attitudes towards help-seeking, intention to seek help, or number of times help was sought. In RQ5, however, the Indian Residential School (IRS) variable was the closest to reaching significance having the highest correlation with the criterion variable of actual help sought ($r=-.23$, $p=.06$), and 64% of respondents from the Yupik/Cupik/Cup'ig group responded 'yes' to this question. The IRS produced the

largest standardized coefficient ($\beta=-.223, t = -1.69, p=.097$), although it was not statistically significant. The premise of the dissertation was based on the idea that IRS represented transgenerational trauma for IRS attendees and their children. The largest group (Yupik/Cupik/Cup'ig) had the highest number of parent or grandparent who attended residential school, at 64%. This finding is discussed below in the interpretation of findings and discussion of theory and is revisited in the recommendations for future research.

Interpretation of the Findings

Research Findings

There have been studies looking at AI/AN populations regarding the criterion and predictor variables but have not addressed all these variables in one study, so what follows are comparisons with prior studies on selected variables. First, the main group that emerged from this dissertation research were the Yupik/Cupik/Cup'ig who appear to be at, or above the same age as most mainstream or other minority help-seekers. The group is also mostly female, which is common in the literature on help-seeking. The group appears to be working class (Chang et al., 2020) to middle class in education level.

As noted above, most participants in this group (64%) reported that a family member attended an Indian Residential School (IRS, Bombay et al., 2014). While just a single indicator, the high frequency of IRS in the Yupik/Cupik/Cup'ig group may suggest that transgenerational trauma may be an issue for the Yupik/Cupik/Cup'ig group. As described in Chapter 2, the more generations that attended IRS experienced higher rates of social maladies (Bombay et al., 2014).

Locus of control was selected to measure perceived locus of control, cultural attachment (Bobb, 2000), and role identification (Cheng et al., 2013). This measure as a predictor was not significant in all the regression analyses. While the AI/AN view of well-being is nuanced towards collectivism rather than individualism (Cheng et al., 2013), and the secondary intent of the study was to determine collectivism versus individualism from a psychological and indigenous lens, this measure may not have been sufficient to detect these differences.

Theoretical Framework

Theory of Planned Behavior

The TBP by Ajzen (1991) was chosen to guide the choice of variables for the hypothesis testing but the proposed hypotheses were not supported. The TPB was created using mainstream populations and may not have been applicable to the AI/AN population. It is suggested that more theory building research is needed with minority groups. Strong theories are required for logistic regression models (Tabachnik & Fidell, 2019).

A more appropriate theory may be the explanatory models of illness theory (EMOIT) by Kleinman (1980), or the social ecology model (SEM; Mohatt, 2021) currently used by the Centers for Disease Control grantees. The EMOIT endeavors to weave care from the medical model, traditional healers, and the patient's worldview to provide solutions using expertise in these fields and perceived illness. This requires interaction of the fields to provide satisfaction and access to care (Akol et al., 2018).

Akol et al. (2018) explored the similar dilemma AI/AN face regarding mental health help-seeking and traditional ways of knowing and healing. Using some tenets of each of these models may be useful for tribes in exploratory research where spiritual and modern uses of mental health may be reached via collaborative efforts and mutual respect of knowledge bearers and healers in AI/AN communities for theory building and research in general.

Conceptual Framework

Developmentally Based Trauma Framework

The developmental and ecological nature of the DBTF is holistic and pertinent to the AI/AN population in and from Alaska. The cumulative nature of the taxonomy of trauma provided a solid foundation regarding collective identity, annihilation anxiety, and perceived discrimination experienced by the AI/AN group. The approach appeared culturally competent for this research. In the preliminary test of the hierarchical multiple linear regression (HMLR) the outcome data for transgenerational trauma did not reach significance and no further testing was possible. The measurement sensitivity for the CTQ-S-A regarding transgenerational trauma for the AI/AN may have been too weak to demonstrate any significant findings in the data collected.

While annihilation anxiety, discrimination, and collective identity were subconstructs to research for transgenerational trauma, the preliminary results of the HMLR did not provide enough evidence to provide further testing. In the inverse relationship, shame and guilt (Volkan, 2013) may have been better to study to determine

the correlations of the predictors on the criterion in the AI/AN, which may be related to each other in a more consistent manner.

Cultural differences in measurement of traumas may also have influenced providing significance, as the preliminary measure was used on AI/AN in the Lower 48 and not tailored for AI/AN use in Alaska. Theoretical and conceptual development using the DBTF (Kira et al., 2013) as well as measurement efficacy was not performed on the AI/AN in Alaska as well. Transgenerational Trauma is multifaceted and has a complex history for each group and is context specific for AI/AN.

Limitations of the Study

There were several methodological issues that constrained the validity of the findings. These are discussed here in terms of measurement, internal validity, and external validity.

Measurement Validity

As described in Chapter 3, the measures were selected based on their sound psychometric profiles, and/or consistency with reported literature. However, several factors could have influenced measurement reliability. First, the survey had a total of 160 questions from the 5 questionnaires. Attrition of participants as they completed the survey, as 86 started, and 61 ended up with complete survey responses (excluding the stigma scale).

The survey used the locus of control measure to indirectly assess cultural identification on the locus of control variable. The original intent of the use of the locus of control measures was to determine if it influenced the help-seeking behavior in the

AI/AN community but because it did not detect an effect, further tests were not possible. From a measurement perspective, the choice of locus of control scale was insufficient for capturing this cultural issue, other measures and approaches may be better. Acculturation may have a negative connotation for the AI/AN population and measures of enculturation may be more appropriate. The Multidimensional Health Locus of Control Scale (Wallston, 2005) could be an alternative to determine self-efficacy, health locus of control, and well-being. Further recommendations are discussed below.

Challenges with the Measure of Transgenerational Trauma

The concept of transgenerational trauma regarding Indian Residential School (IRS) has been identified and studied as early as 2001, as in Gray and Nye's article on AI/AN and comorbidity and substance abuse. This question was chosen from Bombay et al.'s (2014) work with AI/AN groups in the Lower 48. The survey was only one question yet provided near significant results for the AI/AN groups in Alaska. However, only one question was not multidimensional to determining the transgenerational effect of a parent *or* grandparent who attended IRS. Bombay et al. (2014) used two more questions about parents or grandparents who attended IRS

...who had one or more parents and grandparent who attended IRS (two previous generations attended), those who had a parent or grandparent who attended (one previous generation attended), and those who did not have any parents or grandparents who attended (non-IRS comparison group). (p. 330)

The IRS variable does not determine causality for transgenerational trauma and hierarchical linear multiple regression (HLMR) is inferential in nature for the AI/AN group. Bombay et al. (2014) described the methodological difficulty in standardizing the question for AI/AN, indigenous, and tribal groups and the questions are new in

determining the effects of transgenerational trauma on Indian Residential School attendance, yet the transgenerational trauma scale did not reach significance.

Like Bombay et al. (2014), Kaspar (2014) used similar questions for IRS as an independent variable. The author surveyed individuals who were 35 years of age to 54, and 3 ranges (35-44, 45-54, and 55 and older) to detect this variable. She also had this in the Indigenous Canadian languages and had more time to collect data. Kaspar (2014) collected data from 13,922 indigenous, Canadian respondents to detect the predictability and provided power (α) of how the IRS question influences low SES outcome and later negative health outcomes.

Challenges with the Measurement of Stigma

Only 14 of the 86 respondents answered all the five questions in the measure of stigma in this dissertation research. These questions were placed near the end of the survey, which may have caused research fatigue and later attrition in the participants. Other researchers have noted difficulty in studying variables like stigma (e.g., stereotyping and discrimination) given the power dynamics in society (Link & Phelan, 2001).

Stigma research has been studied intensely since the 80s (Link & Phelan, 2001). Recent authors have suggested that this construct as being too vague in definition and idiosyncratic for participants to elucidate yet can affect all areas of life for individuals affected by it (Shaw, 2021). Challenges in executing research on stigma is that it may be defined differently by different researchers and used in ways that do not capture the true nature of what participants experience. Other issues include standardization of the

measure by western groups, fears regarding how particular signals may ‘label’ an individual and may be inherent in them, how it creates division for more vulnerable populations to be seen in a negative light (Link & Phelan, 2001), and which can be more stigmatizing for AI/AN (Shaw, 2021). However, the use of the word *transgenerational trauma* had a less stigmatizing effect on research and the effect that AI/AN were more able to follow through with research (Brave Heart et al., 2011; Bombay et al., 2014).

Internal Validity

As elucidated in Chapter 3, survey research is convenient and economical but is weak in internal validity relative to more rigorous designs (Buckingham & Saunder, 2004). Type I error was not a concern, as all testable hypotheses reported null results. Type II error was considered very possible, as the small sample size, weak measures, and low power may have precluded detecting significant relationships (Tabachnick & Fidell, 2019). IRS could have been a potentially strong predictor if a better measure was obtained. I did not have control of the environment of the respondents who completed the survey, and the predictor variables were not manipulated or controlled by me. Response bias may have been a concern, as I am from the Yupik/Cupik/*Cup'ig* tribe. The participants were asked to respond as honestly as possible.

External Validity

External validity is the degree to which the findings from this sample can be generalizable (Buckingham & Saunders, 2004). I attempted to obtain significant numbers of respondents from each tribe by using a quota sampling strategy to obtain proportional representation or variation of each tribe and to help to decrease stigmatization of the

nature of the dissertation research but was not successful, which will be covered in the next section. The heterogeneity of tribes in the U. S. is diverse. Currently there are 531 different tribes in the U. S. and 231 of those tribes in Alaska. These tribes also have different experiences with colonialism and mental health systems. The research strategy was mainly reliant on convenience and snowball sampling during the pandemic, which was not sufficient to obtain a good representation of the variations in tribal membership.

Other Constraints

The pandemic made it near impossible to reach out to tribes to present the survey to tribal administrators and to send the flyer out to seek out participants. As discussed in Chapter 4 tribal offices were closed; however, telephone calls were made to present the material and to ask the tribal administrator, office administrator, or tribal family/youth services worker for an email to send the information of the survey to and where to find it. The Alaska Federation of Natives conference (which happens every year in October) where all the tribes congregate to discuss issues that may affect tribes was cancelled and I was not able to present the survey there. They also informed me that it was not the place to present the study at except at a booth. The Bureau of Indian Affairs Rural Provider's Conference was also cancelled, which may have been a more appropriate venue.

The pandemic stalled Alaska Area Institutional Review Board (AAIRB) approval, subsequent data collection, and outreach to tribes to find the appropriate numbers for reliable and valid data. The AAIRB required all research, including dissertation research to be approved by them. The AAIRB requires a rigorous standard for data collection protocols for vulnerable populations (45, CFR). For example, the consent form was

reviewed to ensure readability concerning the chosen population; and the review of the proposal by the AAIRB, and coordination of the approval by volunteers who provided approval for research during the pandemic, substantively slowed the approval process.

The IRB approval was received from Walden University, then AAIRB, and then again by Walden after changes were made from feedback from the AAIRB. Changes to the consent form and proposal were submitted to the Walden IRB and the process of data collection was then approved.

Challenges with COVID were also encountered during the data collection process, as conferences and tribal offices were closed during the pandemic. I contacted tribes directly through telephonic presentation, verbal presentation of the dissertation research, and requesting an email address to send the contact person of where to find and take the survey, and a flyer containing a social media page (Alaska Native Research) to download the survey, or to go directly to the survey via SurveyMonkey. I also contacted a native social service nonprofit entity who had monthly teleconference meetings to present on the topic, discussed with the group, and requested them to take the survey, and to share with coworkers, friends, and family. I also contacted friends and family to share and like the social media page containing the link to the survey, tribes with social media pages were also contacted. Some tribes were unreachable and only had fax services and no email services.

Recommendations

AI/AN view well-being in nuances of collectivism versus individualism (Cheng et al., 2013). Chang et al. (2020) studied mental health help-seeking, with soft and hard

independence and how differing classes operate, may prove to be useful for future research with AI/AN college student and/or populations, may provide clarity on help-seeking, mental health utilization from AI/AN communities for AI/AN communities.

AI/AN perspective regarding areas of life essence (philosophy of existence, Wilson, 2008) to shared responsibility (Beans et al., 2019) to shared history, and a wish for shared healing as well as shared power is the collective perspective for the AI/AN group. The politics and tribal ways of knowing is beyond the scope of this dissertation, but more research is recommended in all areas of study, including indigenous relevant measures of health and wellness; and indigenous ways of knowing to conduct culturally competent research in all areas of concern. The findings in this dissertation for the Yupik/Cupik/Cup'ig group imply the need for more research exploring culturally relevant approaches regarding interventions and outreach to the AI/AN group living in and from Alaska (Brave Heart et al., 2011).

The current methodology of choice among AI/AN participants/coresearchers, researchers, and practitioners has been recently written about in the last few years to using research methods, such as, Community Based Participatory Research (CBPR, Beans et al., 2019). CBPR is community action research as well as empowerment evaluation, where researchers and community members are coresearchers (Collins et al., 2018; Faridi, et al., 2007). The community is involved in all phases of the research project for effective change. CBPR uses the strengths of each party to identify issues from the onset of research to the finished product using power sharing and decision

making of the parties involved, which requires an iterative process with researchers and coresearchers (Collins et al., 2018; Faridi et al., 2007).

At the onset of this dissertation, CBPR was in its infancy and was not thought of as a research approach regarding quantitative research with AI/AN groups in Alaska. The need to use this process requires a researcher to use the paradigm from initiation of the project to the completion of it with the diverse communities of the AI/AN population. This recommendation focuses on the use of CBPR approaches, such that the target population may be more amenable to participating in research, thus providing more reliable, valid data, and reducing study attrition.

Studies may require the use of the CBPR in the prospectus stage of dissertation studies. CBPR approaches are nonexperimental (Faridi et al., 2007) and theory building may be the first step to build more culturally relevant designs appropriate for the AI/AN population. For example, dissertation studies at the University of Fairbanks (UAF) use CBPR or are required to take a course in Community Based Research Methods as a research paradigm for PhD students in Indigenous Studies writing their dissertations but the choice of methodology is up to the student (UAF, 2021). UAF had a community psychology PhD program but unfortunately discontinued the program recently.

A second recommendation is to approach this inquiry using qualitative methods to provide rich, substantive narratives about the AI/AN help-seeking experience. While quantitative research methods require large sample sizes to provide detection of effects (Tabachnik & Fidell, 2020) qualitative approaches uses exploratory research to help direct more focused research. Kasper (2014) recommended more research in theoretical

development to determine the negative health status of Indigenous Canadians. For example, using some tenets of the TPB and EMOIT may be useful for tribes in exploratory research, a qualitative approach, where the experiences of spiritual and modern uses of mental health may be obtained. Research in all areas from qualitative theory building to community engagement using CBPR may garner meaningful data to direct subsequent quantitative research regarding the chosen population. The use of the CBPR may alleviate issues encountered in measurement, validity, and Type II errors, using tribal members as coresearchers to provide direction in all facets of the research activities.

A third recommendation points to the use of more culturally relevant measures. For example, the measurement of transgenerational trauma was conducted using a single yes/no question (the IRS measure). It is recommended that this construct be ‘unpacked’ as attending an Indian Residential School has many implications for the measurement of social determinants of health. This includes educational choices (technical fields versus professional fields), access to employment opportunities, and connection to cultural identification.

The locus of control measure (Bobb, 2000; Cheng et al., 2013) was chosen for its role identity, collective versus individualistic cultural psychological values. What may be more important for future research is the phenomenon of acculturation i.e., if participants felt like they acculturated to the mainstream society, as acculturation is an indicator of seeking out mental health services (David, 2010). It should be noted that acculturation

has a negative connotation among the AI/AN community. Enculturation (thriving in both worlds) may be more relevant to explore in future studies.

Wolsko et al. (2007) addressed enculturation with the Yupik from a wellness perspective and recommended enculturation as an approach to research focusing on resiliencies versus deficiencies. Enculturation is the process of identification with an individual's cultural roots versus acceptance of both mainstream and their cultural roots inherent in acculturation (Winterowd, et al., 2008) or socialization to the mainstream culture (Yoon, et al., 2020). There are meta-analyses on enculturation and acculturation for mainstream and minority populations but none or very little that were specific to AI/AN. Yoon et al. (2020) observed a downward trend in acculturation research and that these constructs (both acculturation and enculturation) are context specific; however, the bilinearity nature of the constructs hindered the growth of bilinear measures and later bilinear research designs. The constructs are independent of each other but also may affect each other. These constructs are ecological and developmental, but acculturation may demonstrate conflict in two cultures versus being able to coexist in two cultures or being bicultural. The authors recommended more research on acculturation and enculturation to include dimension specific behaviors (Yoon et al., 2020) while researching each independently of each other.

The authors suggested short and long term research for longitudinal studies regarding acculturation, enculturation for immigrants, and over generations as well as systems and subsystems. Winterowd et al. (2008) recommended scale development as well as enculturation theory development to assisting the provider in guiding presenting

issues with the help-seeker. For AI/AN, the authors discuss the American Indian Enculturation Scale for AI//AN in Oklahoma (accounted for 2% of the study) who sought help for mental health issues. A question on ‘use of Indian medicine’ and ‘attending Indian church’ garnered insignificant outcomes. While not quite the new YAVIS (young, attractive, verbal, independent, and single) the Yupik/Cupik/Cup’ig are a microcosm in a macrocosm regarding cultural resiliency in location and group identity, where Yoon et al. (2020) recommended reporting on acculturation status or context as well as enculturation contexts to assist in advocacy in policy making to include other minority groups as well.

The assessment of stigma is a difficult variable to research, and this dissertation was not successful in data collection. Yoshioka et al.’s (2014) measure of perceived and personal stigma has been identified as a measure that may be less of a threat regarding mental health and help-seeking as well as psychological trauma. In a study by Zhu et al. (2019) of perceived stigma of depression in Chinese cancer patients, the authors found that stigma related to a ‘sign of weakness’ and that these individuals are discriminated against but not in confirmatory factor analysis. The average age was 50 in this study but perceived depression for the group was comparative to Western groups. Personal weaknesses in this group appear to be more in their control. Self report for depressive symptoms may also cause a higher rate of depressive symptoms, clinical diagnostics to measure depressive symptoms and stigma are recommended (Zhu et al., 2019).

Implications

Positive Social Change

Methodologically, the process and challenges of data collection during this dissertation research provided a case study of obstacles. There was considerable learning from this experience, in terms of how to proceed with more appropriate, socially, and culturally relevant methods.

CBPR, in addition to being a research recommendation, is also recommended as an avenue for social change. The originations for CBPR derive from the psychology field (Collins et al., 2018) and psychologists have yet to answer the call for more studies regarding the subjects of this paper. The complexity of the constructs requires translational research (Haring et al., 2021) as well as community action to affect policy. CBPR research garners valid, reliable data communities assist in cocreating (Collins et al., 2018) from initiation of the project and to project summary when it is completed.

Changes in policy may assist AI/AN communities to address the deleterious effects of historical mistrust, racism, and discrimination experienced by the AI/AN community and to find interventions AI/AN may use to reduce and prevent future abuse in the home, community, and society at large. The recommendations provided by culturally determined research practices may influence policy for equitable access to mental and behavioral health services. When AI/AN communities are included as coresearchers, then they are empowered to identify culturally appropriate responses to the egregious events that occurred in AI/AN communities and to help them heal. Information from this kind of study may help to assist practitioners to use more culturally appropriate

approaches to the treatment of psychological issues, as well as to acknowledge worldview differences.

It is hoped that future researchers will improve activities regarding methodology, theory building, and lessons learned to use CBPR activities in the AI/AN community to find ways of healing tailored to their experience and ways of knowing. To utilize this approach in research and social change; more research and application funding sources will be needed.

Conclusion

As more research and public knowledge of the consequences of AI/AN colonization and mistrust have emerged; the seriousness of the psychological and transgenerational barriers to mental health help-seeking has been acknowledged. More research and support for studying cultural and relational barriers with culturally competent research designs may help to elicit culturally competent interventions and counseling resources. The process of acculturation for the indigenous peoples of Alaska required the use of fragmented approaches to well-being, including mental health. This approach is the diametrically opposite to holistic approaches to healthy living which may deter mental health help-seeking for this population and may be a foreign idea for many AI/AN in general.

Culturally competent research and mainstream psychology, sociology, and health psychology must meet the population of interest where they are. This requires collaboration in formulating research designs, theory selection, and data collection to implement safe and effective avenues to generate meaningful data and actionable results.

If not implemented using an approach that results in sufficient representation of these underserved constituents, it is recursive and places the population at risk for more stigma and does not allow progress to occur. Properly ‘unpacking’ (Waretini-Karena, 2013) or deconstructing the issues with culturally competent research designs and re‘packing’ to determine a process reflecting an indigenous process and what is achievable is a long but worthwhile journey entailing ethical approaches for indigenous researchers, communities, and society at large. In this fashion researchers can contribute to the greater good of this community.

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Appendix A: Instructions for Paper-and-Pencil Survey

Dear;

Please find attached the consent form, the surveys, and this form letter which contains instructions on how to complete the surveys. Agree to participate by acknowledging consent by simply taking the survey and submitting it to the researcher will provide implied consent, please keep the consent form for your records. You do not need to sign the survey, completing and submitting the survey will provide implied consent. Fill out the hard copy survey and return it to the researcher. It will take about 45 minutes to complete. This is a onetime session to complete the study, you do not need to take a second study to participate. Find a quiet place to complete it and take your time, take breaks, or do it in chunks of time.

Send the completed survey to the researcher in the self-addressed envelope, please do not use identifying information like names or PO Box numbers, the researcher's address will be written on the envelope.

Keep the consent form for your records.

Directions for taking the surveys.

Demographics, please indicate your gender, either male or female, socioeconomic status, education, income level, age, ethnicity, and whether or not a parent or grandparent attended Indian Residential School.

The Rotter's Internal/External Locus of Control Scale (1966). This is a standard measure that identifies how people are affected by events and issues within their control as well as events and issues beyond their control.

For each question, check the statement that is the most true for you.

The Cumulative Trauma Scale, the questions will ask you about some specific events; please indicate how many times it happened if happened and how much it affected you negatively or positively on the provided scale.

Mental Health Attitude and Intention Scales (Hammer and Spiker, 2018) are scales that uses opposites. For example, on the usefulness or nonusefulness on mental health help seeking, please check all that apply. For the purposes of this survey, “mental health professionals” include psychologists, psychiatrists, clinical social workers, and counselors. “Mental health concerns” include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression). Please mark the box that best represents your opinion.

Stigma Scale for Receiving Psychological Help, the 5 questions are rated from 0 (strongly disagree) to 3 (strongly agree), with higher scores indicating greater perception of feelings of disapproval associated with receiving psychological treatment.

Thank you very much for your participation in my survey, please contact me if you would like the results of the survey. The estimated time to input, analyze and summarize the data may take up to 6 months to a year.

Sincerely,

Jorene Olrún-Volkheimer

Appendix B: Demographic Instrument

- Is ¼ AI/AN descent (Y/N)
- Ethnic group
 - Inupiat/Inupiaq
 - Yupik/Cupik/Cup'ig
 - Aleut/Alutiiq
 - Tsimpsian/Haida/Tlingit
 - Athabascan
- Gender (M/F/Other)
- Immediate family member parent or grandparent who was at a residential school (Y/N)
- Typical yearly household income
 - Less than \$20,000
 - \$20,000 to \$34,999
 - \$35,000 to \$49,999
 - \$50,000 to \$74,999
 - \$75,000 to \$99,999
 - \$100,000 to \$149,999
 - \$150,000 to \$199,999
 - \$200,000 or more
 - Prefer not to answer
- Highest level of education completed
 - Did not attend school
 - Grades 1 – 8
 - Grades 9 - 11
 - Graduated from high school/technical school
 - 1 year of college/technical college
 - 2 – 3 years college
 - Graduated from college
 - Some graduate school
 - Completed graduate school