2017

Attitudes and Perceptions of Mental Health Treatment for Native American Clients

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Walden University
2017

Abstract

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By

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M.S.W., New York University, 1986

B.S., Brooklyn College, 1982

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

Walden University

November 2017

Abstract

The need for mental health service is increasing in American Indian/Alaska Native (AI/AN) communities. While research has examined the availability, access, and effectiveness of provided services to the AI/AN, very little is known about the influence of the attitude and perceptions of both clinicians and clients in their therapeutic relationship in the treatment process. Using the frameworks of liberation, oppression, and trauma theory, this qualitative phenomenological study explored mental health service delivery and utilization issues within an AI/AN community. Data were collected through semistructured interviews with 14 clinician and client participants. The data were sorted into themes and subthemes and analyzed using the NVivo 11 computer software. Intergenerational struggle represented the primary theme and other subthemes such as assimilation, acculturation, and communication were among some of the secondary themes gathered from the data. Analysis of the themes provided greater insights into the dynamics of the participant's lived experience in various organizational structures within the larger community as well as a better understanding of mental health service delivery and utilization in maintaining sobriety in their daily struggles. The results indicated that intergenerational struggle along with other environmental factors were the chief causes of their cyclical journey through the penal and other systems; thus reducing their ability in maintaining longer sobriety and in improving their mental health. The implications for positive social change in this study include the reduction of stigma associated with these health issues through the education of the community and in training clinicians in factor-specific issues impacting life altering critical events in AI/AN struggles.

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Dedication

This work is dedicated to the Native American population whose experiences for the past 500 years continue to represent an unending struggle to survive in a very foreign environment.

Acknowledgments

I would like to thank the participants for the honor of allowing me to enter into their worldview to share their experiences and tell their stories. Without the involvement of these individuals from two Southwestern mental health clinics, serving Native American and community members, this research would not have been realized. Your integrity and remarkable openness has allowed me to gain greater insight into the existing health and mental health compliance problems, along with the service delivery issues within the Native American population.

I offer special thanks to my chair, Dr. Nina Nabors, whose belief, understanding, guidance, feedback, and emotional support pulled me through when things were falling apart. To Dr. Coles, Dr. Lerman, and Dr. Verdinelli, whose assistance and invaluable comments were crucial when, I struggled with the structure and seemingly endless revisions to this manuscript. This would not be made possible without the help of so many others who have helped in so many ways directing me through the maze of local, state, and federal government policies; hospital administrators, and placing my name on the monthly board meeting agenda in response to agency policies and requirements. I would also like to thank the editors Dan Fleischhacker and Elizabeth Bahn who helped with the final editing.

To my mom, sisters, and especially my son, Raashid, without whose continuous support this dream would not have been realized. Thanks for your love and patience in those circumstances when I could not be there. Your prayers and the weekly calls to make sure that I was ok made the difference when my health was at its worst.

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Chapter 1: Introduction to the Study

The plight of the American Indian/Alaska Native (AI/AN) people's physical and mental health has long been a concern to the research community (Castor et al., 2006; Gone, 2007). Nonetheless, there have been very few studies conducted to address this problem and those that were completed proved less effective in the implementation of the needed change (Gone, 2008). Twenge and Crocker (2002) noted that other marginalized groups in the United States that experienced similar adverse conditions had been affected to a lesser degree than was evident in the AI/AN population. Yet, Twenge and Crocker indicated that like similarly-affected ethnic groups, there was the propensity for the group to underutilize the services that were available to treat the adverse conditions. For example, discontinuation of mental health and substance abuse treatment was greater than 50% after the initial visit in these Native American groups (Calabrese, 2008; LaFromboise, Trimble, & Mohatt, 1990; Sue & Sue, 2008).

Psychiatric disorders, especially mood disorders and substance use, were diagnosed at a particularly high level in AI/AN communities (LaFromboise, Albright, & Harris, 2010). However, it was hard for researchers to determine exact percentages due to the scarcity of research data specific to this population. The methodologies used in obtaining statistics about these health issues are also dated (Gone, 2004). In one study with a community mental health group of ANs, it was found that 85% of the men and 65% of the women were dually diagnosed, meaning there was more than one diagnosed condition occurring at the same time (U.S. Department of Health and Human Services, 2001). Jones, Dauphinais, Sack, and Somervell (1997) indicated that 61% of the children

in a Northern Plains tribe had experienced at least one incident of traumatization early in their lives. Another study conducted in 2006, found that Native American (NA) males between the ages of 15 and 24 had a suicide rate of 27%, a rate ten times higher than that of the U.S. population (Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Olson, & Wahab, 2006; Suicide Prevention Resource Center, 2013). Between the years 2003-2006 the suicide rate for Alaska Natives was 51.4% compared to 16.9 in the non-Native Alaska population (Suicide Prevention Resource Center, 2013). One study looked at interpersonal violence within the NA community and found that over 65% of the participants experienced some form of violent act, of which 28% recounted childhood physical abuse, 48% recounted rape, 40% recounted domestic violence, and 40% recounted multiple victimization experiences (Evans-Campbell et al., 2006). In addition to these factors it should be noted that 26% of AI/AN in comparison to 13% of the general population and 10% of the White Americans lived in abject poverty; this fact plays a major part in the general mental health condition for these groups (Gone, 2003; Willmon-Haque & Subia Bigfoot, 2008).

Frequent or long exposure to incidents of severe stress influenced by traumatic events has a direct effect on the brain and the immune system (Kiecolt-Glaser, McGuire, Robles, & Glaser 2002; Natelson, 2004). Such experiences create a vulnerability to infectious diseases, a greater chance of developing severe depression, and the likelihood of increased alcohol and drug usage, as is indeed evidenced in the AI/AN population (Duran, Firehammer, & Gonzalez, 2008). Broome and Broome (2007) attributed the majority of the illness and death of the AI/AN population directly to alcoholism,

depression, and suicide. Broome and Broome also acknowledged a wide range of other serious and life-threatening illnesses including heart diseases, cancers, diabetes, and gastrointestinal disorders as the leading cause of deaths. Their list also included forms of mental illness that had occurred as a result of traumatic dysregulation to the immune system. The physical ailments that were present, coupled with poverty, and poor living conditions still exist in AI/AN communities (Kendal-Tackett, 2009).

Exposure to new traumatic events, harsh environmental conditions, and existing discrimination has also been linked to excessive psychological pain and are also associated with numerous illnesses influencing the mental health of the AI/AN (Gone, 2007; Walters & Simoni, 2002). Researchers have shown that the Western methods of addressing the increasing mental health issues were ineffective and inadequate to meet the needs of the AI/AN people (Alcantara & Gone, 2007; Evans-Campbell, 2006; Gone, 2008). These conclusions were based on historical experiences involving lack of trust and insensitivity to cultural issues.

Consequently, the acculturation and assimilation practices of the majority system have been viewed as an additional method of oppressive and mind-altering practices in the mental health services (Adams, 1995; Gone 2003). Researchers, such as Hodge, Limb, and Cross (2009), were of the consensus that Western therapeutic practices did not only represent inconsistencies and contradictions with the NA cultures, but had, in fact, epitomized another form of colonization. This system of belief was seen in clients' behaviors such as less frequent visits to receive services, the likelihood of not returning to treatment, or not maintaining compliance with required Western-trained therapist

procedures (Adler, 2008; Hanson & Eisenbise, 1981). Factors such as frequent staff turnover, language barriers, insensitivity to cultural needs, and past experiences of mass sterilization in the Indian Health Service (IHS) hospitals still fostered a great level of distrust of the Western system of healing among NA communities (Walter & Simoni, 2002). Contributing to this dilemma was the clinicians' attitudes and perceptions of the majority culture's worldview of indigenous philosophies, which is presumed to be incongruous and inferior to the Western concept of healing (Fouad & Arredondo, 2007; Sue, 2003).

The development of a procedure to address cultural competency for phenomena, such as intergenerational trauma, was necessary in alleviating misperceptions, personal biases, insensitivity, and negative attitudes that continued to exist in the therapeutic relationship with the AI/AN clients (Duran, Duran, & Brave Heart, 1998; Gone, 2010; LaFromboise et al., 2010). This procedure promoted less fear or guilt for both client and clinician, enabling greater receptivity in the discussion of these issues during the treatment process (Gone, 2010). Consequently, the need still existed for further examination into culturally relevant healing practices that explored in totality the physical, spiritual, social, emotional, and environmental factors that were vital to the therapeutic well-being of the client (Broome & Broome, 2007; Hodge et al., 2009). It was noted that the AI/AN culture and belief system was based on a circular system of care (Duran, 2006), an important concept to keep in mind. From the NA's perspective, treatment was not necessarily just for the identified patient but for the whole family, the community, and generations to come, and this perspective is often a foreign concept to

Western thinking (Constantine, Myers, Kindaichi, & Moore, 2004; Oetzel et al., 2006). A person looking at the problem from outside of the clinician-client relationship would wonder whether confusion lay with the perception of the problem, the cultural competence of the therapists, the treatment methods, or was a combination of all these factors (Abrams, 1999).

The purpose of this investigative qualitative study was to examine the far-reaching implications of attitude and perception in treatment compliance, as it related to service delivery to NA clients. These attitudes and perceptions possibly resulted from the effects of intergenerational trauma passed down from one generation to the next and the struggles attributed to survival in the environment. Thus, understanding the dynamics of both positive and negative experiences as it pertained to relationships within the therapeutic approach will be important in addressing core issues of past trauma and the struggles of this and future generations.

Background of the Problem

AI/AN lives had been subjected to harsh physical, social, and emotional conditions, with increased exposure to traumatic events over the past 500 years (Manson, Beals, Klein, & Croy, 2005). Irrespective of formal treaties or official acknowledgment of the various Indian tribes, events in history that were unexpected had ushered in significant changes and the destruction of many lives through disbanding of tribal practices and the displacement of thousands of AI/AN families from their homelands (Broken Nose, 1992; Quinn, 1990; U.S. Bureau of Indian Affairs, 2001). Their way of life, cultural values, spiritual beliefs, custom of dress, child-rearing practices, and dietary

and healing needs were radically altered by enforced federal mandates; while these same governmental agencies, reneged time and time again on promises made in treaties to the AI/AN people (Gone, 2008; Hancock, 2009; Sutton & Broken Nose, 2005). With the passage of the Indian Removal Act by Congress on May 28, 1830 (The Library of Congress, 1830), the relocation, removal, and creation of reservation systems became the official form of acknowledgment by the federal government towards the AI/AN people (Adler, 2008; Danieli, 1998; Teicher, 2002).

More than a century has passed since these events, and yet, successive generations were still afflicted by generational trauma related to the oppression of their forefathers (DiNicola, 1997; Poupart, 2003). The literature in the field contains accounts of the longstanding problems between the indigenous people of America and the colonial powers that instituted systematic measures of enslavement and control under the guise of education and enlightenment (Hodge et al., 2009; Teicher et al., 2003). The recording of major battles, relocation procedures, fort incarceration, and deaths through diseases, broken treaties, loss of homelands, boarding school acculturation processes, and reservation displacement, represent the systematic and documented genocide of the people (Danieli, 1998; Evans-Campbell, 2006).

Conversely, there had been very little documentation or research about the effects of historical trauma (HT) as evident in subsequent generations of AI/AN populations. These historical effects included major fears of continued displacement, remedial health practices that did not address the extreme depressive symptoms associated with their losses, and the inherently oppressive education system offered in the AI/AN communities

(Duran et al., 2008; Teicher, 2002). However, researchers have validated a medical model that, in effect, examined the treatment of disease purely from a reductionist or one-dimensional perspective instead of in its entirety as seen in the healing practices of traditional healers (Broome & Broome, 2007).

The U.S. Census Bureau (2001) reported steady growth in the NA indigenous groups, now numbering over 1.4 million individuals. There were an additional 1.1 million people who self-identify as AI/AN, but who were not recognized as AI/AN by the federal government (U.S. Census Bureau 2002). According to the latest census (U.S. Census Bureau, 2010) there was an increase of 1.1 million live births in this population between the 2000 and 2010 census. This increase included individuals with one or a combination of more than one race, expanding the population size to 5.2 million people in the United States who identified themselves as being as AI/AN (Norris, Vines, & Hoeffel, 2012).

The projected increase of AI/AN population for 2050 is 8.6 million individuals, representing 2% of the total U.S. population (U.S. Census Bureau, 2010). This represents a major increase from the decline of AI/AN in the latter part of the 19th century, when only 250,000 Natives remained after the genocidal actions of the government (Hodge et al., 2009; Poupart, 2003). This population increase and the continuing effects of acculturation practices drew attention to the growing need for healing/mental health services to address all aspects of past generational traumas which underlay as causal or contributing factors to current problems, including poverty, unemployment, substance/alcoholism abuse, high teen suicide rates, and other prevalent environmental

conditions in the life of NA people residing on and off the reservations (Evans-Campbell, Walters, Pearson, & Campbell, 2012).

Problem Statement

AI/AN individuals tend to utilize mental health services more on a crisis basis or as a last resort (Gone, 2004; Manson, 2003; Novins, Beals, Croy, Manson, on behalf of The American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project [AI-SUPERPFP TEAM, 2008]). Consequently, AI/AN clients experiencing intergenerational trauma were at greater risk of exposure to severe depression, alcohol and substance abuse, internalized oppression, victimization, aggression, and violence (Oetzel et al., 2006). When these conditions were coupled with the systematic loss of cultural identity through acculturation and assimilation processes, an ineffective education system, poverty, and a land that had become inadequate for sustaining them, there was the tendency to regard mental health services as a method of coping with the lack of resources and opportunities in the AI/AN communities (Fox & Boerner, 2009; Manson et al., 2005; Walters & Simoni, 2002). These circumstances represent an even bleaker outlook that continued to fuel the seemingly unending frustration. From this perspective, the feeling of hopelessness persists and depression increases.

Western psychological healing methods were found to be ineffective and did not provide restorative healing to the NA client (Abrams, 1999). On the other hand, many of the traditional approaches collectively addressed the mind, body, and soul in the treatment of the client (Hodge et al., 2009). Examples of ineffective treatments for the

AI/ANs were seen in the Western psychoanalytic approaches and the 12-step substance abuse programs that were devoid of cultural applications in which NAs' worldview and experiences were not taken into consideration (Gone, 2008; Gone & Alcantara, 2007). In this respect, the perception and worldview of the clinician are antithetical to the traditional methods of healing, a method that limited the curative process from a much broader perspective (Portman & Garrett, 2006). This aspect of the treatment process continues to produce patient anxiety in the present therapeutic relationships, as it had in the past with previous interactions between the client and the clinician (Broome & Broome, 2007; Oetzel et al., 2006).

Purpose of the Study

The purpose of this phenomenological study was to examine the attitudes and perceptions of seven Western-trained clinicians and seven NA clients in their roles as deliverers and recipients of mental health services respectively. My examination included addressing the awareness and interaction in the relationship between the clinicians and the NA clients in the treatment process. This entailed the exploration of the participants' experiences and attitudes that could have contributed to the perpetuation and misunderstanding between the two groups and causing an even wider gap in service utilization for the AI/AN's. For the purpose of this study, attitude was defined as the longstanding views that influenced or guided behaviors (Colman, 2003). As the research evolved and a better understanding of the experiences of the phenomena unfolded in this study, the definition of attitude expanded to include a psychological construct, (Fishbein & Ajzen, 2010), which depicted the mental and emotional characteristics of the

individual's feelings and reactions. This was brought about by the direct or indirect exposure or experience with external influences, which became the predictor of behaviors that helped them cope with life circumstances (Fishbein & Ajzen, 1975, Perloff, 2010).

Nature of the Study

I used a qualitative approach with a constructivist perspective in examining social phenomenon in this study. I used the rigors of the phenomenological design as the process of collecting and making inquiry of the data. As such, this research method allowed me to understand and determine how each participant defined the human experience and to present their perceptions correctly in this study (Creswell, 2003; Glaser & Strauss, 1967). I employed this model in both observations and interviews to gather, integrate, and interpret the lived traumatic experiences of the participants. I examined how colonial practices of the past have affected the customs of the present through assimilation and acculturation practices.

The qualitative method of this study allowed me to examine the participants' relationship to Western treatment practices in two Southwestern mental health clinics. Using this method of research, I elicited the participants' responses through open-ended questions and observations in personal interviews in order to arrive at a more complete analysis of the presenting problems as demonstrated (see Creswell, 2003). Learning the views, challenges, and attitudes of both clinicians and clients in providing and receiving mental health services allowed for a significantly richer interchange in data collection (see Laureate, 2006).

Research Questions

1. How have clinicians' and clients' personal beliefs and worldview of Western treatment methods impacted the therapeutic relationship of the AI/AN clients?

2. What role does attitude and perception play in treatment noncompliance for AI/AN clients?

Conceptual Frameworks

I used several overlapping theoretical models in developing the conceptual framework of this study. The liberation and oppression theory as well as the historical and intergenerational trauma theory provided a way to examine the linkage and commonalities that existed as a result of a lifetime exposure to colonization. These phenomena represented the factors that affected the physical, mental, and emotional wellbeing of the AI/AN people.

Grounded Liberation Theory

The nature of an individual's existence and ultimate survival are the chief concerns of the liberation theory (Glass, 2001). This concept was committed to the established practices, which framed problems within the context of the oppressor and the oppressed (Freire, 1970; Montero & Sonn, 2009). The Freirean model addresses the philosophical ontology of oppression with its emphasis on the challenges of ethnic minorities or people of color around the world (Thomas, 2009). This framework provided the theoretical applications of liberation and oppression theory, which I used to address AI/AN issues in this study, such as the concepts of assimilation, acculturation, historical, and intergenerational trauma.

In its wake, colonization produced not only conflicts, but also contradictions in its indoctrinations (Glass, 2001; Macedo, 2000). Thomas (2009) called attention to the effects of colonization and its aftermath, referring to them as evoking a schizophrenic reality of having to be present in a society, yet not too visible. Thomas likened this to the indoctrination drilled into children only to be seen but not heard.

Oppression produced unrelenting physical and psychological trauma to its victims in an economic and ideological system that denied the ethnic minority group's dignity, justice, education, employment, and self-determination (Glass, 2001). Oppressive systems destroyed any hope or possibility of change for ethnic minority groups (Macedo, 2000; Thomas, 2009). This devastation was seen in the majority educational system that functions mainly to perpetuate the exploitation of marginalized groups within its control (Comas-Diaz, 2000; Thomas, 2009). Results of this study demonstrated the efficacy in application of the liberation model in examining the disparity between the majority culture and the marginalized groups within the United States. I placed special focus on the participants' views of the NAs still experiencing oppressive conditions left over from the throwback of colonialism (see Hill, 2006; Thomas, 2009).

Historical and Intergenerational Trauma

Whether it was the liberation from an exploitive colonial system or the release from spiritual bondages, Duran (2006) spoke of the need for deliverance from the ancestral and earth wounding of AI/AN people. This was the process through which a systematic extermination and the destructive practices of the natural environment had caused the phenomena of historical and intergenerational trauma for successive

generations (Yellow Horse Brave Heart, 2003). It has been proposed by other researchers that if psychology is to become relevant to the NA communities, changes germane to the treatment practices must be put in place to address the insensitivity of the cultural and ethical mishandling of cultural beliefs and practices (Solomon, & Wane, 2005; Swinomish Tribal Mental Health Project, 2002;Teicher, 2002; Walls, Johnson, Whitbeck, & Hoyt, 2006). These changes also pertain to addressing the internalized oppression that has taken place over the centuries (Duran et al., 2008). In this regard, Duran et al. (2008) posited that culture was an integral part of the wounding and healing system that must take place in the treatment process (Brave Heart, 1998, 2000). In other words, the clinicians' lack of knowledge of the NA client's culture has adverse effects upon the therapeutic process. I will explore the intergenerational concepts and research in greater depth in Chapter 2.

Definitions

Axiological or axiology: Study of the nature of values as it pertained to the types and criteria governing value judgments, especially dealing with ethical concerns. Consequently, axiological ethics represent moral judgment that depends solely on the philosophy of value (Findlay, 1970). It was through feelings and emotions that people determined the values of a culture or a race that was different from theirs. It also spoke to the degree through which human's distinguished value through thoughts, emotions, and feelings (Hartman, 1967).

Epiphenomenon: Intergenerational trauma represents one of the byproducts or side effects of the phenomenon of colonization (Jensen, 1994) Epiphenomenon is a

secondary phenomenon coming about as a result of the phenomenon (Megill, 2007; Robinson, 2012). For the NA people: poverty, health issues, substance use, lack of trust, etc. were a few of these adverse reactions (Taylor, 1963).

Historical trauma (HT): Brave Heart-Yellowhorse, (2003) defined HT as the cumulative emotional and psychological wounding experiences occurring over the lifespan and across generations that originated from group trauma of massive proportions. A pattern of maternal abandonment of a child at a young age might be seen across several generations is an example of historical or intergenerational trauma.

Historical unresolved grief: Grief that accompanies the trauma and accounts for the soul wounding effect in subsequent generations (Brave Heart, 1998, 2000).

Holism or holistic: This view maintained that the whole is greater than the sum of its parts (Colley & Diment, 2001). This concept was fundamental to NA communities and cultures. Their belief system of healing was rooted in the physical, mental, and spiritual aspects of the individual as well as the whole community. The important concept of taking all of the individual's conditions, and not just physical symptoms, into account in the treatment of illness represents the idea of addressing the totality of the individual's needs (Brave Heart, 2003; Calabrese, 2008; Colley & Diment, 2001; Constantine, et al., 2004).).

Intergenerational trauma: HT was an example of intergenerational trauma; it was the general idea of trauma experienced by an individual in an earlier generation that can have effects that reached into the lives of future generations (Brave Heart & DeBruyn, 1998).

Noncompliance: The failure or unwillingness of a client to work together with a clinician in carrying out the medical directives of healthcare providers (Awara & Fasey, 2008).

Sequelae: A negative aftereffect that arose as a result of a condition or abnormal condition such as an illness or a disease (Manson, Beals, Klein, Croy, & the AI-SUPERPFP, 2005).

Soul wounding: The physical, psychological, and spiritual wounding of the AI/AN people and to the destruction of the languages, cultures, and devastation of the lands (of which they were made guardians by the holy ones) as the cumulative internalized wounds that cut across generations (Abrams, 1999; Brave Heart, 1998). Duran (2006) referred to this sustained collective wounding as the spiritual and mental health phenomenon that has never been either grieved or healed.

Assumptions

I assumed that that no single element of inquiry, whether subjective or objective, adequately interprets or fully understands the epistemological factors of all of the participants' experiences. Nonetheless, this study was generalized only to two clinical settings, and as such, the findings can be subjected to other interpretations (see Creswell, 2003). I also assumed that through the observation process with structured interviews and the use of open-ended questions, the participants were honest and disclosed information that represented their true experiences. I thought a phenomenological methodology to be the model best suited to explore the essences of human events and understanding of these human experiences.

Limitations

Language was a possible barrier for me as a nonnative researcher who is not fluent in the native language. Language also presented as a potential problem for the clients, because the interviews were conducted in English without an interpreter. Confidentiality presented as another barrier for the participants, requiring interviews to be held at a separate location and in private rooms, which was not in the natural setting. This safeguarded the anonymity of the individual participant, but did not allow for the natural qualitative process (Creswell, 2003). Another limitation was the fact that the composition of the participants was not representational of all the NA tribes or all the clinicians working in mental health facilities across the United States.

A greater representational pool of participants might have produced more significant themes with mental health experiences that were more specific. However, my use of a sample of 14 participants was due to time constraints and convenience in recruitment. The smaller sample size did not represent the anticipated limitations because my use of the phenomenological model was to capture the lived experiences of each participant. All the components in dealing with oppression, trauma, and soul wounding would have been challenging to capture in a quantitative model of analysis.

Delimitations

The use of a central phenomenon narrowed the scope of the study. I confined this study to the interviewing process, particularly in the administration of selected open-ended questions for participants possibly witnessing and or experiencing intergenerational trauma and oppression. The client participants were persons 25 years of

age and older who had resided on or off the reservation. Since language, comprehension, and trust were barriers for some of the clients, these issues were addressed with them before and during the interviewing process. Likewise, a lack of understanding or appreciation of client culture and language presented a potential barrier for the clinicians. This was addressed in like manner as with the clinicians. However, this investigation was limited to the analysis of the participants' experiences. The age of the clinicians were 25 years and older whose experiences with attitudes and interactions impacted the compliance of the treatment and utilization of mental health service delivery to the AI/AN clients.

Significance

I did not find any long-term studies within the AI/AN population that validated or dispelled the negative worldview of the majority culture's belief about the NAs and AN people. Little had been done to authorize research to study the debilitating phenomenon of internalized oppression, historical, and intergenerational trauma, particularly as these phenomena related to the traumatization and soul wounding of the AI/AN people. Nor had studies been conducted on the service delivery and compliance issues addressed as vital components to the NA community's healthcare needs (Gone, 2004).

Awareness about how these phenomena have impacted life experiences can contribute to a greater understanding of health and mental health dysfunction within this population (U.S. Census Bureau, 2000). Acknowledgment of the problems experienced by the NA client can bring about the necessary social changes within the communities and the people. These changes can also better address the huge disparity between high

levels of health and mental health illnesses/deaths for this underrepresented, understudied, and marginalized group of people.

Being cognizant about intergenerational trauma and internalized oppression could produce greater dialogue about the cause and effects on all levels and create a better basis for understanding this phenomenon and its impact. These efforts could help to validate the individual's pain in the treatment process. The results from this study will help in the process of acknowledging the fact that internalized oppression and intergenerational trauma was the offspring of HT. The most specific social change implication of this study was to bring about better understanding and increased communication between the systems, to provide greater sensitivity to cultural issues and appropriate healing methods, to increase utilization and compliance in treatment, and possibly, to help to reduce mental illness in this population.

Summary

The purpose of this study was to examine how attitudes and perceptions impacted the treatment process and the utilization and compliance of mental health services for the present generation of AI/AN living on and off the reservations, by exploring their lived experiences of intergenerational trauma and internalized oppression. In Chapter 2, I will review current literature, starting with the historical factors and the current research on historical and intergenerational trauma. My review of the research literature about internalized oppression, underutilization of mental health services, and prevailing mental health issues will also be presented. In Chapter 3, I will provide the method of inquiry that was used to gather the original data. While in Chapter 4 I will discuss the findings

gathered and the results obtained from the interview process, Chapter 5 will include the

limitations, implications for social change, and my recommendations to address the

struggles within this specialized population.

Chapter 2: Literature Review

Introduction

The term, AI/AN, refers to the indigenous peoples of North America. They represent 565 federally-recognized sovereign nations, with an additional 52 tribes yet to be recognized and more than 200 distinctive spoken and written languages currently in use (IHS, 1999; McLeigh, 2010). Although there are similarities and differences among these groups in cultural values, spiritual beliefs, kinship systems, and healing practices, exposure to the same traumatic events of colonization and present-day acculturation and assimilation practices conjoined them as one group (Manson & Trimble, 1982; Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002).

HT signified the phenomenon that has arrested the cognitive, emotional, and social development of individuals across generations (Duran, 2006; Gone, 2009). Researchers have pointed out that present trauma of the AI/AN people, labeled as HT, was a direct result of the physical and psychological trauma brought about by European colonization of this group of people (Evans-Campbell et al., 2012; Whitbeck, Adams, Hoyt, & Chen, 2004). Unresolved intergenerational trauma left survivors with deep emotional scars, fears, shame, and losses that had profound impact on their lives and the lives of their children (Calabrese, 2008; Whitbeck, 2006). Although clinicians struggled with treating patients experiencing HT and protracted traumatic events that span several generations for Native Americans (Fouad & Arredondo, 2007), Western treatment methods continued to ignore the extent of suffering, the magnitude of pain, and the consequences of emotional distress in the current generation (Calabrese, 2008;

Constantine et al., 2004). In this regard, effective healing practices would be invaluable in helping NAs cope with life's stressors as well as helping to resolve past traumatic events (Duran, 2006; Duran et al., 1998).

Though limited in scope, researchers in this area contended that these healing practices were largely inappropriate and ineffective for the specific needs of the AI/AN population (Awara & Fasey, 2008). Despite this acknowledgment, the mental health system and its providers have not remedied the gaps in services. Western healing practices do not address issues associated with HT or concepts, such as soul wounding, internalized oppression, and personal biases, while also displaying a lack of cultural sensitivity and cultural competency within the treatment process of NAs living on and off the reservations (Duran, 2006; Everett, Proctor, & Cartwell, 1983).

For this literature review, I searched scholarly databases through the Walden University Library, including Academic Search Complete, PsycINFO, PsycARTICLES, and Medline. I also searched for information online from relevant organizations such as the Smithsonian Institute and the Bureau of Indian Affairs. I also obtained other secondary sources such as books that dealt with issues of healing from Western and Native perspectives. Model dissertations were reviewed through Walden University's research center for research methods. Historical events and legal documents were retrieved from the University of New Mexico libraries, the U.S. Census Bureau, and various governmental agencies. All of these materials were read and summarized and the appropriate sources relating to historical and intergenerational trauma were selected. I used a range of keyword terms including *American Indian, Alaskan Native, Native*

American, Indigenous People, assimilation, acculturation, oppression, cultural competency, colonization, boarding school, perception, trauma, mental health, and *healing practices* in the search of the literature.

Theoretical Constructs

I used liberation, oppression, and trauma theory to study the perceptions of treatment, compliance, service delivery, and the underutilization of services within NA communities (see Creswell, 2003; Duran et al., 2008). Liberation theory frames problems within the context of oppressor and oppressed, and liberation theorists like Freire (1970) believed in the right of all people who struggle for their freedom (Montero & Sonn, 2009). While oppression theory speaks to the systematic and socially supported subjugation, pervasive mistreatment, exploitation, and invalidation of the AI/AN people (Comas-Diaz, 2000; Poupart, 2003).

According to Duran (2006) and Poupart (2003), the majority group perpetuated oppression on successive generations of the oppressed in the continued practices of acculturation and assimilation, and these practices allowed the majority to maintain control and compliance in reinforcing the dominant power structure. In so doing, these Westernized practices became internalized by the AI/AN people in ways similar to those of other marginalized groups who have taken on learned behaviors from the majority group whether they fit well into their overall cultural frameworks or not (Duran et al., 2008). Consequently, internalized oppression was seen as multifold and represented horizontal hostility and vertical violence, perpetrated mostly on family members, community groups, and themselves, while the rage or violence native people experienced

had very little or no effect on the majority group (Duran & Duran, 1995; Poupart, 2003). In turn, members of marginalized groups became oppressive to one another believing in and using similar methods of oppression within their community groups as their oppressor (Duran et al., 2008; Rapaport, 1977). This situation fueled the anger within and contributed to the cyclical behaviors of violence, aggression, abuse, and poverty.

Trauma theory indicates that psychological sequelae in the individual experiencing trauma often produces symptoms of dissociation, denial, repression, somatization, helplessness, and depression (Gorman, 2001). These indicators represent warning signs that the individual is experiencing estrangement or emotionally shutting down (Hill, 2006). In their research on two AI/AN reservations (southwest and northern plains tribes), Manson et al. (2005) established that experiences of trauma in any context gave greater rise to risk of future traumatic events should the capability or means of addressing those events effectively not be present. In addition, Manson et al. posited that continuous exposure to a poor social and physical environment accounts for the greater degree of violence perpetuated on loved ones that continued to be twice as high as the national average of the majority group. Manson et al. selected 16 types of trauma to explore in a structured interview that they gave to 3,084 participants from both tribes who ranged from 15 to 57 years of age. The goals of the team were to define the nature and duration of the trauma in these communities, to examine the demographic correlates of trauma exposure, and to make a comparison of the results with the National Comorbidity Survey, a psychiatric epidemiological survey of the U.S. population. The authors compared the rates of trauma incidences by gender across both tribes as well as with a

sample of the general population. Their results indicated that both male and female tribal members experienced a greater degree of trauma than members of the majority group. These traumas involved witnessing traumatic events, experiencing trauma perpetrated on love ones, or being victims of physical or emotional attack themselves.

Adverse environmental conditions, coupled with the HT experienced by the AI/AN people, were not only harmful for the current generation but for subsequent generations (Gone, 2004; Moodley, Sutherland, & Oulanova, 2008). Community-based studies have suggested that the prevalence of psychiatric disorders, especially mood and substance-use disorders were especially high in the AI/AN communities (Gone, 2009). The Senate Select Committee on Indian Affairs (U.S. Congress, Office of Technology Assessment, 1990) determined that NA adolescents were at a greater risk for psychological difficulty, such as clinical depression, substance abuse, and suicidal behaviors, when compared to the non-Indian adolescents. These social problems, in the areas of health and mental health issues, are indicative of past traumas and the current social, economic, and political conditions existing in the AI/AN communities (Gone & Alcantara, 2007; Gone, 2010).

Like oppression, intergenerational trauma was the cause of the soul wounding of the AI/AN people (Brave Heart-Yellowhorse, 2003; Duran, 2006). In turn, this phenomenon is related to the presence of environmental factors, such as poverty, unemployment, substance/alcohol abuse, and high suicide rates, especially among adolescents (Brave Heart, 2005; Duran et al., 2008). This type of trauma possibly accounts for other barriers found in treatment compliance and service delivery (Gone,

2009). Issues such as a clinician's competency in dealing with the cultural aspect of the AI/NA client, the clinicians' own personal biases, and their worldview also plays a role in treatment compliance and service delivery (Constantine et al., 2004; Weaver, 1998, 1999).

Unresolved Historical and Intergenerational Trauma

Traumatization had been identified as irreparably damaging to both the conscious and unconscious mind (Gone, 2009). Chronic and severe traumas had been linked to experiences of disempowerment and deprivation (Kendall-Tackett, 2009). Trauma is said to leave its victims with a feeling of helplessness, undermined beliefs, a diminished self-concept, and impaired personal development (Silove, 1996). In this respect, the psychological legacy of the AI/AN people seemed to follow the losses experienced through colonization, in which displacement, loss of cultural identity, lack of language acquisition, elimination of traditional healings or spiritual practices, and ultimately, soul wounding became the systematic birthright handed down from one generation to the next (Duran et al., 2008).

Theorists have based their work about the HT among AI/AN people on studies of Holocaust survivors and their descendants who recorded their symptoms and behaviors (Kestenberg, 1980; Nadler, Kav-Vaenaki, & Gleitman, 1985; Whitbeck et al., 2004). The symptoms those researchers uncovered were varied and included denial, depersonalization, isolation, somatization, memory loss, agitation, anxiety, guilt, depression, intrusive thoughts, nightmares, psychic numbing, and survivor guilt.

Researchers have designated these experiences as the survivor syndrome (Kestenberg,

1980; Neiderland, 1968, 1981; Stannard, 1992).

Whitbeck et al. (2004) used a qualitative methodology to conceptualize the

psychological distress existing on two AI reservations. In their study, 143 parents of

children aged 10 to12 were the participants and were evaluated on the prevalence of

thoughts concerning emotional distress and historical loss in their own children. The

researchers developed the Historical Loss Scale and the Historical Loss Associated

Symptoms Scale for assessing the frequency of thoughts and the perceptions of the

consequences of emotional distress as it is transmitted across generations. Their results

indicated that the internal reliability of both of these scales were very high, and it was

thought that the scales accurately depicted the frequency of negative thoughts and

feelings that pertained to the historical losses. The results also confirmed that the

participants' awareness of historical losses were not restricted only to the elders in the

community but that the historical losses had quite a significant impact on the minds of the

adults of the younger generation as well (Whitbeck et al., 2004).

There were many differences between the effects of historical losses on other war

survivors, especially the Jewish Holocaust survivors of the 1930s and 1940s, and the

AI/AN genocide survivors of today (Brave Heart & DeBruyn, 1998). The most

significant difference between the groups was represented by the duration of the trauma

in the Jewish experience, which was confined to a single period of time, while the AI/AN

experience had been ongoing for hundreds of years (Whitbeck et al., 2004). This

represents a factor to be considered in both the degree and extent of the losses over the

centuries (Brave Heart & DeBruyn, 1998). Thus, one can begin to see the enormity of the problem even with the limited studies that have only begun to partially address some of the concerns that were brought to light thus far. In this study, I did not address the proliferation of unresolved trauma, but I attempted to speak to the implication of unmet needs in the treatment process. It is believed that unresolved trauma contributed to the upsurge in health and mental issues in contemporary Native communities (Gone & Alcantara, 2007) and I used this assumption as the underlying basis for this study.

Acculturation and Assimilation

As a phenomenon, acculturation was first studied scientifically in 1918 (Abrams, 1999). Despite the fact that acculturation should require a two-way progression, when a minority and majority group made contact, the imposed learning and change occurs only with the minority group's culture being displaced (Abrams, 1999). In those instances, the dominant group usually accomplished this through forced acculturation and assimilation (LaFromboise, 2010).

Consequently, the systematic and strategic procedures employed in the colonization process became the impetus for the acculturation and assimilation of the AI/AN people (Gone, 2009). In an attempt to compensate for the events of the past, comprising disregard of treaties, loss of homelands, and destruction of spiritual and healing practices, healthcare and mental health programs were established within the IHS, a division of the Bureau of Indian Affairs (U.S. Bureau of Indian Affairs, 2001; U.S. Department of Health and Human Services [USDHHS], 2001). The attempt was made to address the rising healthcare and mental health needs and to establish the Western

medicinal practices because the traditional healing methods were forbidden (National Indian Health Board, 2002; Oetzel et al., 2006). Along with the establishment of these health systems, Congress enacted public laws to further support all other federal provisions of healthcare needs to the AI/AN population (Quinn, 1990). Of particular interest was Public Law 94-437 §3a, or the Indian Health Care Improvement Act, that established the continuation of the present system of care for the AI/AN population (Gone, 2004; Indian Health Services, 1999).

Despite those measures, the services provided had proven ineffective and inadequate in addressing the established health care needs of the AI/AN people (Quinn, 1990; Sue, 1980). Research had confirmed the disequilibrium in service delivery with the needs that arose in the AI/AN communities (Gone, 2004). Imbalance seen in areas of child maltreatment in the NA communities was one such reality of the presenting problems (USDHHS, Administration on Children, Youth, and Families, 2003). This had been evident in the loss of cultural values and parenting skills resulting from the separation from families and placement in the boarding school system, where traditional child-rearing skills were never taught, and could not be handed down to subsequent generations. As a result, child-rearing practices were based on learned behaviors that were punitively reinforced (Pinel, 2006; Subia-Bigfoot & Schmidt, 2010; Swinomish Tribal Mental Health Project, 2002). The Western culture's forced acculturation process had further endangered the mental health of NA children (Berlin, 1987; Schechter et al., 2006). This was seen in the practice where these children were removed from their homes and placed in the Child Welfare system. These formative years were spent with a series

of disruptions and continued traumatization to their development (Gone, 2004; Schechter, 2004). The removal of children from their homes for any reason weakens the community, the family, the health, and emotional well being of the child as well as of the parents (Evans-Campbell, 2006; Monture, 1989).

Berlin (1987) pointed to the fact that dislocation and change from the traditional ways of living, compounded by the forced assimilation for survival, often left devastation in its wake. This dislocation subsequently led to hopelessness and incalculable loss on the part of the AI/AN. Acculturation practices often occurred with children who conformed easily to the new ways (Neiderland, 1981). This occurred because their identities were more fluid and they had less cultural knowledge; these children quickly succumbed to the physical and psychological molding of the ways of the dominant culture (Evans-Campbell, 2006). However, children recognized the discord between the two worlds and got caught in a confused identity. These children also lacked the necessary knowledge to make corrections and lost their sense of personal power to change their destiny (LaFromboise et al., 2010). With the loss of identity coupled with situational losses, the children often acted out or shut down, became depressed, and/or resorted to alcohol or other forms of mind-altering substances as a means of coping (Calabrese, 2008).

Traditional parenting and the innate nurturing practices became an impossible task in any capacity and were out of the question for these parents. Neglect and abuse followed with the cycle repeating in the ensuing generations (Evans-Campbell, 2006). NA children often found themselves in the child welfare agencies, which created another

set of trauma for the developing child (Monture, 1989; USDHHS, Administration on Children, Youth, and Families, 2003).

Conceptual Framework of NA Health

Poverty is one of the overarching factors that drove the lack of success within most marginalized groups in society (Fox & Boerner, 2009). Poverty cuts across cultural divides, ethnicity, nationality, gender, sexual preferences, and age groups. Legacy represented the sum total of a previous generation's efforts and that generation's contribution to posterity. The losses within the NA community had more than just a negative impact on the development of the emotional health of the families (Adler, 2008); losses had come to represent the inheritance of the ancestors, an inheritance that had produced unresolved grief and devastated future generations of children (Evans-Campbell et al., 2012).

At the present time, there are an inordinate amount of problems within the NA communities, ranging from an ineffective education system that contributed to the greater concerns among the younger generations with disproportionate suicide rates, high school dropout rates, teenage pregnancy, and gang-related problems to a larger collective plight within the adult population that are experiencing a permanent state of cultural, social, and economic displacement within the majority system (Evans-Campbell, 2006; LaFromboise, 1988; Powell, 1880). These factors give rise to issues of poverty, unemployment, lack of transportation, water supply, indoor-plumbing, inadequate housing, and major healthcare issues (Gone, 2008; Hodge et al., 2009). The medical and mental health system cannot keep pace with the increase in health issues, such as

diabetes, cancer, mental health treatment, and drug and alcohol abuse, and the significant

rise of violent victimization and adolescent suicide that were epidemic in proportion

(Broome & Broome, 2007; Manson et al., 2005) and which represent some of the

obstacles that contributed to problems within the NA communities (Gone, 2004).

Thus, the AI/AN population represents one of the most diverse ethnic minority

groups with health and mental health problems in the United States (USDHHS, 2001).

This was noted in a health report provided by the Surgeon General office in which the

health perspective of this group was shown to be inclusive of the entire AI/AN population

(Walls, Johnson, Whitbeck, & Hoyt, 2006). In other words, it included not only the

individual, but also the members of the community, in addition to all branches of the

healthcare services (neurological, medical, psychological/psychiatry, traditional/cultural,

and social/environmental), reflecting a more holistic healing system (USDHHS, 2001).

However, there were preferences between traditional and Western methods or the

combination of both, for treatment in mental health practices and substance-use care;

where considerations were given to preferences for Traditional or Western mental health

and substance use care in healing practices (Walls et al., 2006). Awareness of the

historical context contributing to the physical and psychological traumas has remained

the single most devastating factor influencing mental health conditions in today's AI/AN

communities. This places AI/AN people at a much greater risk of exposure to new

traumatic experiences than the majority group or any other marginalized groups in the

United States (Manson et al., 2005). Consequently, lack of economic success, poverty,

and poor environmental conditions in the present add to the effects of historical trauma

and the constant exposure to violence. The feelings of helplessness develop into severe emotional problems and can perpetuate an unending cycle of depression from one generation to the next (Gone, 2006). As a result, dismissal or negation of concerns associated with these issues has invalidated the AI/AN experience. This produces ineffective treatment results and the healthcare conditions of the people remain unchanged. The indigenous healing practices germane to their cultural beliefs had been either forbidden or almost lost from lack of use over the centuries. The definition of indigenous healing referred to the specific helping, beliefs, and customs that developed explicitly to address individual and group needs arising in those cultures or communities (Sue & Sue, 2008).

Culture and Treatment

Patterson (1998) maintains that any system is the collection of its integrated parts and functions as a whole rather than as a collection of parts. Likewise, the essential ontological concept of holism holds that individuals are the elemental aspects of their environment whose interactions affected the changes in the world around them (Parse, 1998). In line with this view, analysis of the individual's behavior is culturally relevant in order to understand the person's perceived perceptions. Western research methods and systems of healing were not considered to be conducive to a holistic concept of treatment. Their methods do not support a systematic approach to treatment that addresses the whole mind, body, and soul/spirit (Duran, 2006). The body symbolizes only one aspect of the human being. The spiritual, physical, and emotional mechanisms are all interconnected and represent the whole person. Deterioration of any aspect of these components

undoubtedly affects the functioning of the others. Likewise, treatment of mental health conditions through ineffective healing practices that did not address intergenerational trauma possibly contributes to the damages of the patient's wellbeing (Duran, 2006).

Researchers have now recognized historical trauma as the foremost devastating phenomenon affecting the spiritual, health, and mental health of the AI/AN people (Adler, 2008). Ethnic obliteration and displacement of the AI/AN people remains the undisputed historical factors that continue to weigh heavily on the emotional, physical, and spiritual suffering of successive generations. These factors became apparent long before the 2001 U.S. Census acknowledged not only the steady increase in the AI/AN population, but also the rapid increase in healthcare and mental health needs and the dwindling funds appropriated to the 143 IHS service centers nation wide. These facilities were comprised of 34 hospitals, 59 healthcare centers, and 50 health stations on the reservations (Gone, 2004; National Indian Health Board, 2002). The available funds are miniscule in proportion to the escalating mental health service needs in one of the fastest growing marginalized groups in the United States (Everett et al., 1983; Gone, 2004).

The acknowledgment of the effects of historical trauma has provided the incentive to address the question about the effectiveness of Western healing practices as it related to the quality of presence in relationship with the patients' physical, psychological, and spiritual needs (Nebelkopf & Phillips, 2004; Sandner, 1977; Solomon & Wane, 2005). Practitioners like Corey (2005) and Duran (2006) assert that a genuine dialogue and interaction must be developed between the clients and clinicians. The experiences and opinions of both clients and clinicians undoubtedly affect subsequent therapeutic

interactions and interventions. It was clear that, if the clients and clinicians had preconceived opinions about each other, due in part to negative historical relationships, the whole interchange is affected. Gone's (2009) research looked at these issues using traditional healing methods experienced in the AI/AN healing sweat lodge activities. Gone interviewed nineteen staff members and clients about the therapeutic healing approach used to address the legacy of the NA historical trauma. The interview data produced the specific meanings of healing for both the clients and staffs. Four distinctive themes emerged. The first theme noted that adult dysfunction was a result of the pain carried by the clients, including substance abuse. The second theme addressed the harmful effects and the need for the acknowledgment and purging of the pain. The third theme focused on self-improvement, spiritual growth, and self- understanding. The fourth theme entailed the reclamation of their indigenous heritage, identity, and, spirituality that would act as a counterbalance to the effects of colonization (Gone, 2009). In this regard, Gone emphasized the fact that the NA inheritance at birth and early childhood had become a transfer of unhealthy or abnormal behaviors in adulthood, requiring confrontation and acknowledgment in order to bring about release from generational pain. He also pointed out that the sweat lodge participants saw the recovery of lost cultural heritage as a liberating expression in this healing process. However, Gone further explained that this procedure of interpreting the meaning of healing in this group did not resonate with many clinicians, especially when they found themselves in a defensive mode with the resurfacing of suppressed issues of bias beliefs or similar oppressive thoughts handed down from past generations (Calabrese, 2008; McCabe, 2007).

NA Mental Health

The phenomenon of the unmet need has become one of the permanent conditions often attributed to most marginalized groups (Awara & Fasey, 2008). Seen as a high priority, items such as healthcare needs are often addressed on healthcare agendas in healthcare facilities around the country. Yet, studies related to addressing the mental health needs within specific minority groups, such as AI/AN clients, are almost nonexistent (Duran, 2006; Gone, 2004; Hodge et al., 2009).

LaFromboise's (1988) review pointed out that other research has clearly demonstrated that all AI/AN clients' experiencing generational trauma had unmet needs as their central issues. However, it was not clear whether this occurred from the lack of cultural competency on the part of the clinician, the shared indifference by the majority group, the proportioned dwindling resources, or the more precise impact of acculturation and assimilation on the AI/AN people. The understanding and application of the treatment and research process had been ineffective in addressing the crucial elements of needs for these communities.

The AI/AN clients' perception of health and mental health wellness consist of those fundamental traditional ingredients that promoted soundness in the physical and emotional well being in their lives (Schiff & Moore, 2006). It represents walking the path of Good Medicine, in harmony and balance, which for the AI/AN means being in harmony with nature (Garrett, 1999; Garrett & Garrett, 1996). The AI/AN cultures emphasized the importance of balance or the interconnectedness between the spirit, mind, body, and their environment (Hodge et al., 2009). It was their belief that all four

components must be in harmony in order to experience optimum health. Trauma experienced as a result of encounter with European colonists and later contact with the various systems of the U.S. government had disturbed these balances and continued to be a destructive force even today (Gone, 2008; Oetzel et al., 2006).

Each individual and each group experiencing these disruptions would be affected differently as they each traveled a different path to the healing process (Duran, 2006; Gone, 2009; McCabe, 2007). As a result, the restorative function of the traditional ceremonies serve as a means of dealing with the devastations that were encountered until the official ban by the federal government occurred, which discontinued these healing and religious practices (Dufrene & Coleman, 1994). The decisive methods of acculturation and assimilation within the boarding schools and churches were instrumental and effective in the destruction of the cultural, spiritual, and healing practices used to maintain the physical, emotional, and spiritual health for the Native people (McCabe, 2007). The fundamental value of wellness for the AI/AN people varies based on the uniqueness of each tribal group.

The major concerns pertaining to cultural competency or insensitivity by the dominant culture stemmed from misperceptions about the individual and the collective misunderstanding of the Native issues. In viewing the dilemma, the attempt to treat the AI/AN clients through the Western mode of healing and disregarding the traditional methods represented a lack of understanding of the perspective of historical trauma and the unresolved issues accompanying them (Gone, 2008; Nebelkopf & Phillips, 2004).

The proposed healing practices did not represent the required changes to address the healing of the nations or the individual clients (Hodge et al., 2009).

Western Treatment Methods

Over the years, Western healing had operated from several assumptions. One of these states that reality contained discrete entities of what can be observed and measured through the senses. Yet another stated that science functions from universal principles and these universal principles were unrestricted by culture (Highlen, 1966). As a result, Western medicine recognized its healing methods to be more highly advanced and technically grounded than those of other cultures (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002; Sue & Sue, 2008).

The Western concept of treatment is predicated primarily on a diseased or pathological system through which diagnosis and treatment deal with the isolation of known causal factors (Gone, 2010; Pinel, 2006, Sue & Sue, 2008). Mental health practice in the United States tends to be based on the medical model (Blankaart, 1693; Garrett, 1999; Gone, 2004; Manson, 2003). This model focuses exclusively on the eradication of the disease while ignoring other aspects of the individual's health that possibly provided contributing influences. Consequently, the Western model implicitly rejected the interconnectedness of systems such as the mind, body, and soul in its attempt to find the root cause of illnesses (Rapaport, 1977). Psychology and its allied mental health fields had followed suit in their eagerness to eradicate pathological conditions of the mind in a similar manner by disregarding the spiritual aspect of the person (Colley & Diment, 2001; David. 1992).

Blankaart (1693) defined and initially used the term *psychology* as the treatment of the soul while anatomy was the treatment of the body. Psychology's intent was to bring into focus the effects of the soul and its interaction with the physical as well as the emotional and mental wellbeing of the individual (Colley & Diment, 2001; Colman, 2003). Hatfield and Hatfield (1992) defined wellness as the process by which one strived to develop balance by taking the initiative to rethink previously held beliefs and integrating them into one's life. The AI community viewed health and wellness not only from the physical, but also from the emotional and spiritual perspective (Garrett, 1999; Voss, Douville, Little Soldier, & White Hat, 1999). Spirituality was the connectedness one has with all aspects of life in the universe (Garrett & Garrett, 1994). However, it was the contention of many of these researchers that the Western practice takes a less comprehensive approach to healing.

An approach that separates those vital components of the patient's core values did not allow for complete healing and only expressed dissatisfaction in the manner and outcome of care (Awara & Fasey, 2008; David, 1992). McCormick (2005) asserted that Western healing has encouraged passivity of the patient's role in the process and often devalued the contribution of feelings or insight presented to the clinician. In this respect, Western healing reduces patient participation, and denies autonomy, responsibility, and control for their healthcare (Awara & Fasey, 2008; Gone, 2009; Laureate Education, Inc., 2007).

Effectiveness of Current Treatment Practices

Attempts to identify the effectiveness of Western therapeutic treatment of NA clients struggling with various forms of mental illness had been a difficult task for a number of reasons. According to Gone & Alcantara (2007), obstacles in the treatment process were often compounded by the lack of culturally sensitive providers or by providers with values and personal worldviews that were different from AI/AN clients. Such values and worldviews represented a hindrance for compliance with service utilization (Duran et al., 1998; Heinrich, Corbine, & Thomas, 1990; Oetzel et al. 2006). The cultural perspectives of these clients were often ignored and this lack of understanding impeded the treatment process (Garrett, 1999; Gone, 2006; Oetzel et al., 2006). Trust factors and the acculturation process of the AI/AN descendants were not properly addressed (Gone & Alcantara, 2010). Too few empirically supported studies that were culturally specific and relevant to the AI/AN experiences of psychological distress had been done (Gone, 2008; Gone & Alcantara, 2007).

Consequently, the researchers embarked upon an electronic and manual search of the literature, producing 3,500 studies that were later reduced to 56 articles and chapters dealing with mental health interventions of NA clients (Gone & Alcantara, 2007). The greater percentage of this group of studies was not totally concerned with the methods or procedures that affected the mental health needs of this population (Gone, 2004). A process of elimination further reduced the numbers to nine studies that actually provided evidence of programs or treatments offered to this identified group. Additional eliminations were made and only two studies remained that had controlled conditions,

suitable sample sizes, and significant results in terms of the relationship between evidence-based practice which, aspired to identify effective therapeutic treatment, methodological rigor, and demonstrated therapeutic outcome in mental health treatment to this population; while the randomized clinical trials did not offer a clear explanation of cause and effect in treatment or represent convincing therapeutic outcome in mental health treatment of this population (Gone & Alcantara, 2007). The studies by Manson and Brenneman (1995), LaFromboise and Howard-Pitney (1995) presented treatment approaches in a randomized and controlled setting that looked at the development of coping skills in the treatment of depression, dealing with traumatic events, and the provision and delivery of effective mental health services. These were categorized based on subheadings such as randomized or controlled outcome, nonrandomized or uncontrolled outcomes, intervention descriptions, summary intervention overview, clinical case studies, and intervention approaches (Gone, 2003;Gone & Alcantara, 2007).

Manson and Brenneman (1995) investigated prior interventions used with older NA's in the Pacific Northwest experiencing depressive symptoms along with severe health problems. The intervention included 16 weeks of 2-hour sessions. These sessions introduced skills training in the area of relaxation, positive thinking, development of increased social skills, and involvement in enjoyable activities. These sessions were offered at a tribal college in the community in order to increase participation rates and reduce the stigma often associated with mental health involvement (Gone & Alcantara, 2007). Tuition was reduced for the participant's attendance. Assessments were done with the health-screening course, Coping With Depression (Lewinsohn, Hoberman, & Clarke,

1989), containing indicators such as health status, life satisfaction, and depressive symptoms (Gone & Alcantara, 2010). Twenty-two participants who were experiencing depressive symptoms, coronary heart disease, diabetes, and arthritis were randomly selected and placed into the treatment group. A second control group with 26 other participants was placed on a waiting list. This represented a quasi-experimental design, because of the recruitment process for the participants (Manson & Brenneman, 1995). The results showed that there was a decrease in the depressive symptoms and unpleasant events in the participants' lives and an increase in enjoyable experiences. However, the life satisfaction for these participants did not increase. This was unlike the group on the waiting list who experienced improvement in each of the areas (Manson & Brenneman, 1995).

LaFromboise and Howard-Pitney (1995) established the Life Skills Development Curriculum to address high school students who were high risk for suicide in a New Mexico pueblo. The program length of 100 sessions, given three times per week, covered the entire school year. The skills training component of the program focused on areas such as identification of emotions; self-esteem building; problem solving through increased communication; discarding self-destructive behaviors; participating in suicide intervention training and goal setting for future plans (Gone & Alcantara, 2007). The project was developed in partnership with community members to help guarantee the cultural relevance of the training. Four classes were selected to participate in the program and 69 students were placed in the treatment group while another 59 students went to the none treatment control group (Gone & Alcantara, 2007). Classes and students were not

randomly assigned to achieve group similarity as required in pretreatment matching,

because of an institutional restriction; as a result the depression variable had to be

removed as an outcome variable in this quasi-experimental design (LaFromboise &

Howard-Pitney, 1995).

A self-assessment survey was completed by all the participants, with indicators

such as suicidal tendencies and depressive experiences, before and after the curriculum

ended. The results indicated that the participants in the treatment group were less

suicidal, developed more hope, and had become more skillful with methods of

intervention and problem-solving techniques; yet belief in their ability to influence their

thinking and change their circumstances had not been altered (Gone & Alcantara, 2007).

This was unlike the control group, whose size was reduced considerably by the end of the

school year, producing difficulty in the interpretation of the results. Neither study

accomplished the thoroughness of a procedural randomized clinical trial (Gone &

Alcantara, 2007). However, they represented the only two studies in over 30 years to use

a quasi-experimental format to provide evidence of effective treatment in the NA

communities (Diken & Rutherford, 2005; Gone & Alcantara, 2007).

Conclusion

Clinicians brought knowledge, a specific skill set, as well as a new perspective

from which symptoms of the client were assessed (Garrett, 1999). Through a variety of

approaches as seen in cognitive-behavioral, psychodynamic, client-centered, and gestalt

theories, they were able to provide appropriate treatment and made appropriate

diagnoses, (Cervantes & Parham, 2005). Treatment of clients varied from individual,

family or marriage counseling, and group methods (Awara & Fasey, 2008). However, in these treatment methods, the AI/AN clients were not seen as experts able to present an accurate account of their experiences (Gone & Alcantara, 2010). LaFromboise (1988) pointed out that Western approaches to psychological intervention represented cultural limitations that did not include procedures that promoted the wellbeing of the Native client. LaFromboise (2010) referred to the fact that treatment tools rarely integrated practical features of this or any other minorities' coping methods that had been effectively used over the centuries. In addition to developing appropriate instruments of measurement, Western clinicians had been told to familiarize themselves with traditional cultural values and traditions in order to effectively diagnose and treat Native clients (Lazarus, 1982). Nevertheless, the Western method represented a new perspective in treatment for the AI/AN, whose concept of healing was not segmented but whole.

Summary

The purpose of this study was to examine how attitude and perception impacted the treatment process and the utilization and compliance of mental health services for the present generation living on and off the reservation, by exploring the lived experiences of AI/AN survivors of intergenerational trauma and internalized oppression. This chapter was a review of the literature related to service need, service delivery, and compliance issues as they pertained to the personal viewpoint and worldview of the participants. This was an attempt to understand specific issues such as personal biases, cultural sensitivity, cultural competency, soul wounding, oppression, and internalized oppression, while it allowed me to speak to the Western as well as the traditional healing practices in the

AI/AN communities (see Duran, 2006). In Chapter 3, I will explain the method that I

used to gather and interpret the original data.

Chapter 3: Research Method

Introduction

The focus of this study was specifically on the AI/AN client's utilization of mental health services. However, the general perception of how attitude impacted mental health workers and clients on issues, such as treatment compliance and service delivery, were unknown. Thus, it was important for me to examine the influence of the clinician and client's worldviews as well as their personal experiences contributing to behaviors while in the treatment process.

In this chapter, I will present the research methodology used in establishing factors attributing to the increase in mental health issues in the NA population. This will include a discussion of issues on negotiating entry, participant's selection, role maintenance, and the complex ethical issues arising in research studies (see Marshall & Rossman, 2006). The phenomenological research design I used examined how the participants' attitudes impinged upon aspects of historical and intergenerational trauma within the NA communities.

Research Design

It had been the experience of many researchers that traditional research did not give voice to the oppressed and marginalized groups in society as traditional research methods are thought to be involved with issues of control and further contribute to a negative effect within these groups (Rossman & Rallis, 2003; Sue, 1978). Qualitative methodology is known for its relative strength in capturing the humanistic perspective or the lived experiences of the participants (Creswell, 2003, 2006). This method provided

me with a richer comprehensive approach and a wider context from which to study social

phenomena.

Role of the Researcher

Within the construction of the qualitative method, I assumed the unique position

of identifying as the instrument of analysis in the perceptions and attitudes of the

participants (see Marshall & Rossman, 2006). I had to demonstrate competence in

carrying out the procedural steps and effectiveness and skills in the research process.

Required skills included listening, observing, and forming an empathic alliance with the

participants (see Rudestam & Newton, 2007). My roles were determined by the degree of

participation, ranging from engaging in full social contact, as occurred in the one-on-one

personal interviews, to being a detached observer without any direct interaction, as

occurred in the strict process of observing behaviors and events and also seen in my

analysis of documents and other gathered materials (see Marshall & Rossman, 2006).

Per the instructions of Patton (2002), I listed the determination of ethical issues,

such as disclosing the intent and benefits of the study and the known effect the study will

have on the participants and community groups. I conducted both formal and informal

negotiation for entry into the location and eventually had access to the participants within

two mental health clinics in the southwest. Part of this process required letters and

meetings with the gatekeepers within the agencies and later letters of Informed Consent

signed by the participants who took part in the study. In addition to the recruitment and

selection of the participants from the mental health clinics, I interviewed, collected, and

interpreted the data. Setting boundaries for the study, collecting information through

unstructured observation, and creating documentation using visual materials were all functions that I performed in carrying out this study.

One of my most vital functions as the researcher/instrument was building trust with the participants. This factor was crucial because I am not of NA descent and cannot fluently speak the language of the particular group I was working with. However, I had lived and worked on one of the southwest reservations for the past 18 years. My work with families and children in nine of the 18 schools throughout the district had allowed me greater familiarity with many of the community leaders, elders, and their loved ones. Participation in community events had also provided acceptance from my NA colleagues and community members. This represents an important aspect of the trust that was required for conducting interviews with the selected participants. Nonetheless, the issue of trust was still present when I attempted to collect data from the clinicians and clients in both clinics.

In this study, I was also required to conduct individual interviews and document or compile views and experiences expressed by the participants It was my role as the researcher to develop explicit, open-ended questions that gleaned the specific mindset and worldview of the participants' learned experiences and attitudes. This pivotal role required me to bracket particular biases or prejudgment of collected or changing data (see Creswell, 2003). It also required me to set aside personal assumptions and engage in the interpretative process, thus being able to examine new development and understanding through the participants' eyes (see Flinders 2003). I was required to be sensitive to participants' personal biases, experiences, and cultural values. As the interviewing

process unfolded, new data and the procedure evolved, which required the filtering of this new data through my personal lens. Through this lens, I recognized my personal growth in this process.

At the time of this study, I had conducted interviews and worked as a psychotherapist in both private and institutional settings for more than 38 years. However, it was important for me to acknowledge that a nonbiased state was not easily attained (see Creswell, 2006; Flinders, 2003). It was therefore necessary to be conscious of being overly subjective in the process of analysis. For example, preconceived ideas and beliefs that were founded on my own experiences could introduce bias into the analysis process and affect the results of the study. An example of this would be having a negative experience with a NA (one individual) and then let that experience dictate what I believed or how I felt about all members of the group, which would be an injustice to the whole population. As a result, I paid greater attention at all times to my value judgments and own personal perspective during the interviewing, interpretation, and writing process (see Marshall & Rossman, 2006).

Research Questions

1. How had clinicians' and clients' personal beliefs and worldviews of Western treatment methods impacted the therapeutic relationship with the AI/AN clients?

2. What role did attitude and perception play in treatment noncompliance for AI/AN clients?

I designed supportive questions to allow for a deeper exploration into the understanding and personal experiences of these issues and asked them of each participant in the interview process. Specific questions were selected for the clinicians as well as the clients. With these questions, I attempted to elicit the subjective experience of the mental health clinicians and NA clients working together in the treatment process.

Clinicians' Interview Questions

1. Did your educational training prepared you to work with NA clients, and if so, in what way did they prepare you?

2. How did your educational and professional training impact the therapeutic relationship with NA clients?

3. Based on your personal experiences, what did you think were the primary reasons NA clients seek services? Follow-up probe (FUP): What did you think were the main causes for their distress? (What brought them to therapy/counseling?)

4. How did you respond when your clients did not follow the recommended treatment? FUP: What did you think the "noncompliance" was related to? 2nd FUP: Did you assume/think the reason for the noncompliance was different for NA clients?

5. In general, was there anything else about treatment that I have not asked that you would like to share?

Clients' Interview Questions

1. What had it been like receiving treatment with a therapist as a NA client?

2. Had the fact that you are NA come up in therapy?

3. If it had, did your therapist understand what it meant, and how being a NA affected who you are?

4. Did you think that the way NAs had been treated over the past 500 years affected how they function (are doing) today?

   a. How did you think your cultural and spiritual identity related to what was happening to you?

5. How did you respond when your therapist recommended treatment? (FUP): What did you do when you did not agree with what the therapists recommended?

6. In general, was there anything else that you would like to share about treatment that I have not asked?

Context

My focus in this study was on the service providers and clients at these southwest mental health clinics. These clinics represented the only two care providers in the area that offered comprehensive services incorporating mental health treatment with a matrix model for substance abuse treatment and the 12-step model for substance abuse recovery. These service sites for the AI/AN were made available to clients with the use of private or Medicaid insurance. Consequently, these southwest healthcare clinics were the setting I deemed appropriate in conducting this study. I drafted flyers advertising the recruitment

in English and placed them in all the areas that the clients frequented (waiting area, bulletin boards, restrooms, lunchrooms, washrooms, group rooms, and therapists' rooms) which provided the NA candidates with access to learn about and potentially participate in the study. A copy of the recruitment flyer can be found in Appendix A.

A letter of intent from the administrators at the two southwest mental health clinics provided me with the necessary cooperation in recruiting participants. I conducted interviews with the selected participants at the designated locations in private rooms located at the clinic and the public library. In the event that further clarification was necessary, the participant was contacted by phone to review the information and make necessary corrections.

Selection of Participants

I considered interviewing14 participants would be sufficient in which the process of observation to gather other forms of data would be necessary in conducting a qualitative phenomenological study such as this one (see Creswell, 2003, 2006; Marshall & Rossman, 2006; Moustakas, 1994). The participant sample consisting of 14 volunteers included seven clinicians and seven clients. Each volunteer completed a demographic sheet. For this study, I made participant selection from a convenience sample of adults aged 25 years and older in order to facilitate the level of experiences relevant to the study. The age criterion of 25 and older was used in the selection of all the participants to ensure greater exposure in the field of counseling as well as in the lived experiences. All the participants who called in were prescreened over the phone and were accepted if they met the eligibility criteria. Clients had to be AI/AN, 25 and older, and in attendance

in the treatment program. The level of the clients' experiences in counseling was also a consideration. Their educational level ranged from no formal education to college graduates. To be considered for the study, clinician credentials were to be licensed mental health counselors with educational levels of masters and postmasters schooling. The length of treatment for the clients was from the initial referral up to 2 years of service time that might have been interrupted by reincarceration. A total of 17 individuals expressed interest in the study. Of this number, 14 met the eligibility criteria and three individuals did not.

I initiated the interviewing and observation process to elicit the participants' perspectives on the problem under study. The same interviewing process was used to obtain their subjective views. The interviews and measures were the means by which I established the data collection, analysis, development, and further exploration of the research questions.

It was also my intention that this study was to create awareness with the clinicians of their overt interactions that influenced the clients' compliance with treatment. It was my hope that the problems identified in this study would benefit the participants as well as the community. In this regard, the development of trust, along with greater client participation, could address the needed treatment concerns and disband further marginalization of this client population (see Creswell, 2006).

Protection of Participants

Each participant received and signed a consent form in order to officially agree to be a volunteer. The development of the consent form took into consideration the usage of

language and its context. A thorough review of the consent form was done to determine a

better understanding of the language of the document as well as the research purpose. I

explained the study, reviewed the expectation of each participant, and the ethical

guidelines under which the study was to be conducted. Full disclosure of risk factors, and

the kind of interaction with the participants and the community was included in the

consent agreement.

This was done in order to protect the human participants and safeguard the

individuals from unnecessary harm by explaining the option of withdrawal if the need

arose (Creswell, 2003; Marshall & Rossman, 2006). A debriefing at the end of the

interview also allowed each participant to ask any final questions that they might have

about the purpose of the study.

Approval from the Institutional Review Board and the Walden University

Research Reviewer was obtained in order to conduct the study (Copies of the approvals

can be found in Appendix E). The approval from both of these administrative bodies

served as further protection for the participant's cultural beliefs and values within their

represented groups. Thus, the protection of the participants and their respective group

identity throughout and after the research process was also very important. Information

that might endanger the individual or group's identity was not disclosed to ensure

confidentiality (Creswell, 2006; Marshall & Rossman). Names of the participants were

not be used. Pseudonyms and a study number for identification were assigned to each

participant. This included the officially assigned Institutional Review Board number

given to conduct the study. Data were obtained and stored on paper, audio, and electronic

media in a secured locked cabinet and on a password-protected computer in my office. I was the only one with access to the material during the collection of the data. In addition, I handled all the documents during the transfer, analysis, and archiving of the materials. As stated above this data is locked in a secured cabinet and password protected on my personal computer. The raw data will be shredded and destroyed 5 years after the completion of the study. The electronic data will also be deleted after 5 years.

Data Collection

The participants were identified as Group A ($n = 7$) representing the clinicians and Group B ($n = 7$) representing the clients with a total of $N = 14$ participants. Participants were asked to engage in a 60-minute interview in which open-ended questions were used to direct the participants towards the research objectives. Data collected for analysis included demographic information, observational and interview protocols, field notes (useful in verifying patterns that emerged in observation and interviews), unstructured open-ended interview questions, audiotapes, and transcribed interviews (Marshall & Rossman, 2006). Pseudonyms were selected for each participant and assigned for identification in the study. The data collected were obtained within the confines of the mental health clinics and the private interview rooms at the public library. In each interview, open-ended questions that were developed in preparation for the meeting were asked. The participants were encouraged to describe the lived experiences of receiving and providing mental health services that did not acknowledge the effects of historical trauma in the treatment of their present life circumstances.

Data Analysis

An in-depth interview using open-ended questions were used to gain greater understanding of each participant's lived experiences of the presenting problem on a daily basis. The process of analysis began after the interviews ended and transcriptions were completed. Earlier consent was arranged for the taping and verbatim transcribing of the materials.

The steps taken in analyzing the data included the preparation and transcribing of the materials. This was followed by reading and deciphering the general sense of the collected information, while reflecting on the overall tone in the meaning. However, this did not represent the earliest stages of data analysis. According to Creswell (2006) and Rossman and Rallis (2003), the process involved the building of a foundation by developing a greater understanding of the data. This was done through reflective thinking, re-reading, and asking analytic questions of the raw data. This included conducting various analyses of the data by using selective coding to analyze themes of significant statements generated by the participants (Patton, 2002). This involved the use of the NVivo for Mac/version 11 computer software program to quickly locate multiple perspectives on a category or theme in the participant's response from the text and other collected materials. Themes were developed, analyzed, and coded from the individual context as well as from the overall theoretical framework of the study.

Issues of Trustworthiness

According to Smith and Deemer (2000), qualitative investigations are based upon multiple factors that are centered upon our existing knowledge, understandings, and experiences. Patton (2002) also noted that the credibility of the qualitative study is contingent upon the necessary rigors in the exploration process, the reliability of the researcher, the appreciation of the naturalistic inquiry, use of inductive analysis to support conclusions, more focused sampling and holistic thinking.

In this regard, due diligence is required by me to safeguard the credibility of the findings in the study (Marshal & Rossman, 2006). Thus, to ensure the trustworthiness of the results of this inquiry, greater attention was paid to the data collection procedures. This involved crosschecking the audio recording and the transcriptions process for accuracy with the participants. It also entailed maintaining consistency in the coding practices involved in identifying and sorting the themes that sustained the inquiry for further analysis. In addition, Lincoln and Guba's (1985), concept of confirmability had to be adhered to for maintaining trustworthiness and objectivity in the research process. In order to achieve this during the data collection, I kept a running journal during and after the interviews in which I paraphrased the responses and asked the participants to confirm my understanding of their statements in order to reduce personal bias and maintain objectivity. These corrections were made through future contact by phone calls to the participants. This also helped in allowing the participants to know that they were being heard and their views and experiences were understood and validated. From this process, key themes were developed and verified across the content of all the participants

dialogue. In addition to these methods of verification, the strategy of triangulating multiple sources of data (which is the act of bringing more than one source of data to bear on a single issue) was enlisted to ensure that the materials gathered from these participants were in line with and validated the experiences in the literatures research about the lived experiences of the AI/AN population (Lincoln & Guba, 1985).

Clarification of my personal biases and limitations were accomplished by responding to the questions and concerns about my wanting to work with the NA population. Sharing my story of the years of working and living in their community showed them that I had been exposed to some of the hardship and struggles that they experienced. This work had allowed me to see and learn from the perspective of those individuals who have or don't have access for one reason or another the use of community resources that are available. Both structured and open-ended questions were helpful in probing further and through active listening allowed each participant the opportunity to be heard. This issue of being heard and not listened to ranks very high in the themes among the clients. On the other hand, compliance and following directives were major themes for the clinicians.

Summary

In this chapter I addressed the method and the mechanics of this study. This represented the collaborative efforts and the collective procedures used in obtaining and analyzing relevant data, to answer the research questions of how the personal belief system of the clinician and clients had impacted the therapeutic relationships of the mental health issues in the AI/AN communities. Special considerations were taken to

safeguard the participants and the population of study. Some of these elements were addressed in this chapter, especially in the selection of a qualitative research design, which provided a richer platform in dealing with the social contexts. A qualitative methodology using open-ended interview questions was instrumental in eliciting lived experiences of both the clinicians and client's responses. The recruitment, selection, and protection of the participants throughout and after the data collection process, confidentiality and storage of data, as well as the issues of trustworthiness were also addressed in this chapter. In addition, all aspects of the roles of the researcher, such as obtaining the community partners, selecting the participants, and the analysis of the collected data were presented. Whereas, the next chapter will provide the results obtained from the thorough examination of the data, which included the demographic information of the participants as well as the identified themes derived from their dialogue as a cause of the present and past struggles within the majority cultures communities.

Chapter 4: Results

Introduction

In this chapter, I will present the findings obtained from the data I collected to explore the impact that attitude and perception had on mental health treatment compliance and service delivery to the AI/AN population. The implications of service provision and service utilization by the NA population experiencing forms of mental illness, substance abuse, and other health issues were examined from a phenomenological perspective. This perspective provided me with a distinctive lens through which I gained a better understanding of the essence of the narrative themes in the process of unraveling the participants' lived experiences.

Consequently, in this chapter, I will provide an overview of the evidence of trustworthiness in the manner in which this study was specifically attuned to this population. In this chapter, I will also explain the data collection process; identify the instrument of analysis; and describe the methods used in interviewing, gathering, analyzing, and reporting the themes that developed from interviewing the participants. Self-reported demographic details from the interviews along with a brief description of each participant will also be presented. I will also discuss the patterns and themes that emerged as a result of the participants and the participants' responses to the interview questions used in the coding and analysis process. The chapter will conclude with the assumptions of the study and a summary.

Participants Demographic Profile

I used the demographic data, collected after the signing of the consent forms, to obtain pertinent information from the interviewed participants. Two separate demographic forms were developed: One for the clinicians and one for the clients group. Items such as gender, language, household income, number of years practicing, service delivery experience, diagnosis, number of years receiving services, treatment experiences, number of visits per week, and education level were some of the information requested on the forms.

I obtained volunteers from two clinic sites located in a bordering town to one of the reservations in the area. Sixteen individuals volunteered to participate in this study; however, two of those individuals were excluded due to concerns related to scheduling, recording, and transportation. A total of six clinicians and three clients were interviewed from the first clinic. One client participant was dropped due to recording problems and rescheduling was not possible. A total of five clients and one clinician volunteered from the second clinic site. The 14 participants that completed the interview process consisted of seven clinicians and seven clients.

The clinicians consisted of three men and four women, five with master's degrees, one with a bachelor's degree, and one traditional (AI/AN) female with only GED training. (It should be noted that this is common practice, due to the high dropout rates of NA's in the educational system, which is another contributing factor to their dilemma). The gender and ethnic breakdown of the clinicians were two NA women, three Caucasians (two men and one woman), and two Hispanics (a man and a woman). The

ages of the clinicians ranged from 39 to 62 years, with the average age being 50 years old.

The client makeup consisted of one woman and six men who identified as NAs and were diagnosed with symptoms of depression, alcohol, and substance abuse. The ages of the clients ranged between 27 and 60 years, with the average age being 43 years old. All seven clients had a high school diploma, while four had additional certificates. One client was currently in an automotive program, and another would be graduating in the summer; the study took place from a local college.

The first clinic used more of the Western approach in treating mental illness and substance use. This clinic utilized various substance abuse programs; among them is the 12-step program, such as the Narcotic Anonymous and Alcoholic Anonymous, in combination with individual or group psychotherapy to address the addiction and mental health component. The second clinic also used the Western treatment methods in their treatment approach; however, they had incorporated more of the traditional healing methods in their treatment process to accommodate those clients (called relatives) who would be more comfortable with its use. For example, this clinic used the traditional talking circles, drumming, and sweat lodge in the traditional methods of healing. Tables 1A and 1B summarizes the demographic information for the clinician and the client participants.

Table 1A

Participants Demographic Information (Clinicians)

Clinicians	Pseudonyms	Age	Gender	Education	Clinic	Ethnicity
P1	Lando	53	M	Masters	1	Hispanic
P2	Nancy	62	F	GED	2	NA
P3	Penny	50	F	Masters	1	Caucasian
P4	Saul	57	M	Masters	1	Caucasian
P5	Suzie	40	F	Masters	1	NA
P6	Tiamara	39	F	Masters	1	Hispanic
P7	Vance	50	M	Bachelors	1	Caucasian

Note. Andy, a NA male clinician was dropped due to inability to make scheduled appointments. Clinicians P2 and P7 did not have a master's level licensing, but had years of experience. Clinic 1 and Clinic 2: NA = Native American.

Table 1B

Participants Demographic Information (Clients)

Clients	Pseudonyms	Age	Gender	Diagnosis	Clinic	Education	Ethnicity
P1	Cecilia	50	F	D/A	2	HS	NA
P2	Hue	29	M	D/A	1	HS+	NA
P3	Kaz	31	M	D/A	2	HS+	NA
P4	Todd	52	M	D/A	2	HS	NA
P5	Trent	46	M	D/A	1	HS+	NA
P6	Wesley	27	M	D/A	2	HS+	NA
P7	Mitch	62	M	D/A	2	HS	NA

Note. Libby, a NA female client was dropped due to transportation and childcare issues. Clinic 1 and Clinic 2: NA = Native American; HS+ = College or skills training beyond high school.

Analyzing the Data

I used the NVivo 11 for Mac analysis program for sorting and compiling the rich data of the participants' experiences. After the completion of the interviews, the audio recordings were uploaded into my desktop computer and transcribed. During the transcription process, notations were added to my personal journal that commented on behavioral observations, in areas such as body language, voice intonation, or responses that were deemed inconsistent with the context of the discussion. Items such as nervous laughter when discussing rage or anger were examined. The emotional contents indicating anxiety, discomfort, or fear were explored during the interviewing process and recorded in my journal. In addition the extent of the distress was also assessed in order to address and allay those negative feelings as they were presented in the discussions. Consequently, the data used in the analysis process included coded information derived from the observations and the narratives to form the identified themes developed during the interviewing process.

I primarily used the NVivo program in the coding and classification process. The program functioned as an organizational tool that helped with the storing and structuring of the themes and subthemes obtained from the narratives. I then used the Nvivo program to create parent and child subheadings under which the themes and subthemes were placed. The parent themes served as the primary topics under which secondary themes of the same subject matter were filed for later analysis of the specific area of focus. This method of categorization also allowed me to use the themes to make queries of the

information, while exploring the data for similarities or differences in the analysis of the

lived experiences.

Settings of Data Collection and Analysis Procedures

I used two sites in the data collection process. Permission was obtained from the

director and board members of the first site to post flyers (see Appendix A) in various

locations of this clinic in the southwestern part of the country. Interested participants

were provided with an appointment time and place to meet when they met the study

criteria. I interviewed the eight participants from the first clinic (six clinicians and two

clients) in a reserved room at the local public library. Pseudonyms were created to protect

the participants' identities, and I coded them as such throughout the collection and write-

up process. Clinician and client consent forms were thoroughly gone over and completed

by the participants before starting the process. Separate open-ended questionnaires were

developed for the client and the clinician participants (see Appendix B).

After reviewing the demographic information, I found that two clinicians did not

meet the minimum academic criteria of a master's degree (see Appendix C). One

individual had worked for 25 years in the field but held only a bachelor's degree, and

another individual from the second site, held only a GED with 15 years training as a

traditional counselor. Due to their length of time working with this population, I included

their responses; nevertheless, this demonstrates the wide range of educational levels of

clinicians working with this population. There were two other participants from this first

site who were interested in participating; however, the interviewing of these participants

did not materialize due to scheduling problems. One was a clinician who broke four

scheduled appointments and then decided he could not make it. The other was a client

who showed up for the appointment with her two young children (ages 4 and 5) who sat

in the room, while I conducted the interview. Major portions of the interview were

unrecorded, due to several disruptions from the children. Regrettably, her responses had

to be eliminated because she did not want to reschedule. She had no childcare and

transportation was also an issue. She was given a ride to the interview site and had no

means of returning a second time.

After several weeks of trying different suggestions to generate new volunteers for

the study at the first site with no success, I decided to move to a second site in order to

generate additional participants. The same recruitment procedure was followed as at the

first site. After receiving official approval from the director, board members, and legal

department at the second site, I posted flyers at designated areas of the second clinic (see

Appendix A). The clinician and clients (also called relatives at this site) thoroughly

reviewed the consent and the demographic information forms (see Appendix C). Each

participant also completed the interview process in order to begin the interview process

(Appendix B).

The recording of the interviews allowed me to capture the participants' lived

experiences in receiving and providing health services to this specialized population with

greater accuracy. I recorded the interviews on an Integrated Circuit Digital Recorder. The

recordings were later imported to my home computer and transcribed verbatim into a

Microsoft Word document. Following Colaizzi's (1978) methods of identifying

qualitative themes, the interviews were read several times to obtain the essence of the

contents; then key items central to the phenomenon were extracted. After review, these themes were later imported to the QSR NVivo for Mac 11 instrument and downloaded to my desktop where meanings were framed and themes identified for coding and analysis. If clarification was necessary to any areas of the audio recording, participants were called to get the correct understanding or meaning of the contents.

<div align="center">**Response to Research Questions and Themes**</div>

Each individual's life experiences vary based on the intensity and degree of the physical, mental, and emotional challenges they encounter in coping with environmental stressors. These challenges were no less true of the participants in this study, whose experiences were quite distinctive from each other. Nevertheless, the similarities in experience, whether positive or negative, colored the beliefs and attitudes in their response in each circumstance.

The first research question was: How have clinicians' and clients' personal beliefs and worldview of Western treatment methods impacted the therapeutic relationship of the AI/AN clients? The second research question was: What role does attitude and perception play in treatment noncompliance for AI/AN clients? With these questions, I attempted to elicit the cognitive processing of each individual's influence on the issue of noncompliance in the treatment procedure. The interview questions asked of both groups helped to establish the context of the participants' views in their understanding of the therapeutic relationship, whereas the broader perspective of these questions explored the individuals' awareness based on the environmental influences as well as other internal and external stimuli impacting the relationships in connection with the healthcare

providers and the clients in the treatment process. In turn, this affected both the compliance and service delivery needed in alleviating the ongoing health struggles of the AI/AN population. The clinicians and clients openly expressed their feelings about their personal beliefs and worldview on issues dealing with the treatment process in the healthcare system as well as the other systems through which AI/AN clients are funneled through in the rehabilitation process. The court represented both the legal and penal system through which programs are provided for the reentry into the community. Programs such as the Probation Department or Halfway Houses provided the monitoring of activities and progress in the treatment recovery process. However, beside the few treatment programs that exist in the larger community and those arms of the legal system that provide the monitoring, there are very few resources that follow the client back into their own communities to make the difference in bringing about the degree of change that is needed. These important factors listed in this section need to be ever present in our understanding of the level of disparity; not only of the socioeconomic factors within the environment, but also in the physical, emotional, and spiritual disconnectedness within this population who have not been able to heal and move beyond the depth of anguish and pain in their very existence.

What follows highlight the themes obtained from the interview questions of each participant group experience. Even though some of the questions asked of the clients and the therapists were somewhat different in content, (e.g. "What has it been like receiving treatment with a therapist as a NA client? Do you believe that your educational training prepared you to work with NA clients?) Yet, the context of the questions converged in

the substantive meaning identified in the presented themes. The clinicians spoke to the same treatment factors addressed in the clients' questions, and the themes were based on exact responses to their questions. Forty other minor themes were developed from the narratives; however, they were subsumed under the primary umbrella of intergenerational struggle and other sub headings such as: assimilation, acculturation, and communication; survival experiences and struggles; confusion, grief, and loss; depression, alcoholism, and substance abuse; participant's personal beliefs and worldview; therapeutic relationship; cultural & spiritual identity; maladaptive and adaptive coping; defensive and ambivalent behaviors; family system dysfunction; western & traditional treatment practices; attitude and perception of treatment noncompliance; shame and embarrassment; emotional reactions; abandonment issues; anger, depression, and stages of recovery. These minor themes will be explored further in the theme summaries, which will indicate the specific themes pertaining to one or both groups as they are presented in the tables. Likewise, tables were not developed for all the themes, even though these themes represented various forms of struggles over the centuries. Some may represent more recent physical, psychological, and environmental issues that might not have been present for past generations over the years. For example, the struggle with the "therapeutic relationship or issues of treatment compliance," presented as a problem only after counseling services were made available and the AI/AN population accepted these services as a form of treatment. Therefore, whether it was the western or the traditional treatment methods used in the latter half of this century, when more AI/AN were acculturated to these practices and became more trusting of the methods of western medicine, these issues

were not present for the duration of the AI/AN struggles. Consequently, the development of the tables were selected based on both the past and present relationships, to the extent of the length of the struggles; the degree of the severity, and the level of suffering, as well as the cost to the individuals and to the AI/AN population as a whole.

Many of the parent themes such as grief and loss, survival experiences, or maladaptive and adoptive coping could be easily recognized as overarching themes; nonetheless, they could not be easily carried across in all of the topic and subtopics as was clearly evident with the struggles that were consistent in all aspects of the lives of the AI/AN people and across consecutive generations. Consequently, *intergenerational struggles* as the primary themes was observed to extend to all subject areas in the narratives as well as in the literature, and was selected as the overarching theme for all the themes of inquiries. The client's struggles surfaced in all the themes and the subthemes developed in response to the research questions and the interview materials used in the process of analysis. These struggles were considered as an essential component that linked all of the clients lived experiences as well as the clinicians' service delivery in their exposure to dealing with the factors of noncompliance within the treatment process. In this regard, I have identified *intergenerational struggles* as the predominant factor generated from the narratives, and it will be addressed along with some of the other themes and sub-themes in this Study.

Table 2

Theme 1: Intergenerational Struggles

Subtheme	Key participant insight	Significant meanings
Assimilation practices	For the longest time I was confused and lost between the two cultures (client).	The feelings of confusion & not belonging to either group produce more uncertainties in their lives.
Acculturation practices	Feeling pressed down on by the Whiteman's teachings …we need counselors to teach more on our traditions and culture (client)	Feeling the need to learn the traditional ways to express the innate cultural ties that have been lost or lacking in their lives.
Alcoholism/substance abuse	There is a high sense of desperation... looking for understanding and changes in their lives (clinician)	New ways of educating community to the increasing numbers of NA in the system, while alerting them to the dangers that requires urgent attention to needed change
Depression	Knowing that I am not alone (client)	No longer feeling isolated, with experiences of loss and feelings of hopelessness.
	Mental health exacerbated by the substance use (clinician).	Coping methods include numbing the feelings which comes w/a higher price of self destructive behaviors
Stigma associated with the diseases	The mistakes you made are going to define you…(client)	These health Issues especially mental illness & alcoholism are frowned upon by society, but not seen as diseases to contend with.
Communication	Clients do not ask when there is uncertainty or confusion (clinician)	They blame themselves for the lack of understanding & fear that they would be found out and further labeled as unintelligent.
	Receiving & giving mixed messages (clinician)	You don't know how to raise & take care of your children

Intergenerational Struggles: Clinicians' and Clients' Perspective

Intergenerational struggles refer to the relationship between the different

generations in a group of people from different socioeconomic backgrounds within a

geographic location. In this instance, we are examining intergenerational struggles among

the AI/AN clients and their experiences in the healing process. We are also exploring the

clinicians' perceptions of the impact these struggles have had on the lives of the clients in treatment.

The clinicians discussed their experiences of clients' struggles from the perspective of situational trauma, occurring as a result of severely distressing events in their lives. Thus, incidences derived from social, emotional or environmental factors can be situational events that clients grappled with as the historical legacies of intergenerational trauma. Two participants pointed out what they had observed or experienced as struggles within the treatment setting. They referred to the struggles as becoming an act of desperation handed down from succeeding generations, with no abatement in sight. Another mentioned that in this century alone, the progression was seen generationally with the grandparents, parents, and now the teenage children experiencing similar if not worst internal and environmental struggles. The clinicians also spoke to the struggles in the rise of co-occurring diseases in the addiction cycle with mental illness and other physical illnesses such as cirrhosis of the liver, diabetes, and other related illnesses as a major cause of these struggles. Other traumatic experiences such as sexual and physical abuse; suicidal and homicidal behaviors were common themes addressed in the treatment process. Nonetheless, issues such as poverty, deficiency of skills, past traumatic incidents, along with the lack of family and community support, were noted to be the mechanisms driving the clients cyclical journey.

Their journey takes them through the legal and healthcare systems, back into the community, where they resort to similar behaviors taking them back through the same systems over and over again in the same cycle. One client referred to his journey through

the systems from early adolescence when he would find himself in this particular cyclical movement between counseling services and the prison system for about four to five months in jail, getting out, spending a few weeks or months out, and then the cycle starts over when he would find himself back in the system once again. The clinicians have also noted these movements over the years, which is a major part of the noncompliance issue. These repeated behaviors have become the norm, from one generation to the next, for which the clinicians pointed out that the interactions have provided only temporary relief to the client's life circumstances, with no permanent change in the ongoing struggles.

In discussing their struggles, the clients identified systems insensitivity to their needs and discriminatory practices within and outside of the legal and penal systems. As did the clinicians, they pointed to the client's personal struggles in dealing with their addictions, as they try to cope with other conditions that have resulted from co-occurring illnesses, while trying to maintain sobriety. The ever-present environmental issues, economic hardship within the communities, lack of finances for childcare, and the inadequate housing for themselves and their loved ones continued to influence their attempts to become successful and have a better quality of life. The lack of healthy competition in the job market is partially due to the higher dropout rate in the higher education programs. This and other factors accounted for the lower skill levels that are incompatible in competing with individuals in the majority group, in a very tight economic market. These issues are key contributors to the struggles they faced. The clients addressed transportation as a major issue in compliance with treatment, an issue that becomes paramount in later finding and maintaining a job. They shared some of the

losses incurred, through the assimilation and acculturation process, through the boarding schools system. They also addressed the sustained damages of unresolved trauma in their individual circumstances and the consequence this had on their lives and the NA community. These clinicians and clients are in agreement on some of the issues and shared insight into their experiences and the struggles they faced.

The excerpts below are examples of the clinicians' and the clients' responses about some of the struggles that were either witnessed (clinicians) or experienced (clients). The references made here are based on modern day struggles experienced as a result of psychological, physical, and other day-to-day traumatic events in their environment. The issue of poverty along with the socioeconomic conditions has not improved over the years in several generations. This includes situations such as housing issues, transportation, childcare, educational training, poor health care, substance abuse, and systems integration and indoctrination. These are representational of the larger environmental struggles that come under the intergenerational heading. The following excerpts from narratives represent some of the struggles identified as areas of concerns by the participants.

> Often times I see repeat clients, people that I've worked with years ago… they made an attempt, but it's kind of tough when you have…because the unemployment rate in the Native community is high, ok…you are going to have one dwelling, with three or four cousins or brothers and sisters and their wives and children all sharing a home and it is due to economics…(Lando/clinician)

So that's one of the quandaries that we face, are the conditions there. They are going back to that environment… as much as they want what we have to offer here it is pretty tough when they are the lone ranger in that home, when everything else is going on and at some point they often succumb to it and that is why we see them back (Lando/clinician)

They are being pressured… maybe if they are on probation they have to check in and they are not following their court order. They are unemployed, with health problems, and a lack of education, umm… So the support isn't there. Maybe the ride/transportation is an issue; they may feel abandoned at a very young age. A lot of them don't even have parents and extended families any more and its alcohol related, always alcohol related (Nancy/clinician)

The majority of clients who come in with either significant mental health or substance abuse problems; have a history of trauma, sexual abuse, physical abuse, or addiction in their own families. The NA gets "Fee for Service Medicaid", but they don't have those coordinators of services. So everybody else gets the luxury of …kind of having a little case manager that kind of help coordinate and organizes, and these guys don't… I believe, they don't provide care coordinators for the "Fee for Service" individuals, because there is a push for them (NA's) to use Indian Health Services (IHS). However, they don't want to go to IHS, because everybody knows everybody, and they feel like their information doesn't get held confidentially (Penny/clinician)

A large percentage of the NA people have moved away from their traditional roots and have assimilated into the western way of life. Yet, the places where they seek services are more culturally oriented in order to comply with federal and state regulations. When the clinician attempting to use the more culturally based tactics, the client is kind of not able to connect. They see that as the clinicians trying to enforce their culture on them… when they are really not wanting to. They are thinking their problems are just the symptoms they are having and its not based on their culture. So there is that kind of miscommunication of us… so they assume all therapists are going to do the same thing since they are NA's. I think one of the bigger pieces to that are how some clients live in rural populations on the reservations. Transportation becomes an issue with different things such as childcare, which is another issue. A lot of time it's not that they are intentionally trying to miss group, its maybe reasons of not having the resources they need as far as childcare. That's one of the bigger things I see, which is the economic issues they face (Suzie/clinician)

I have gone to people's homes and seen where they live and what their living environment is like and I think that is an important thing to get a mental picture, so you will have a context. If I am saying, take your children out to play, and there is nothing but dirt and wind, where are they going to play? You know they are going to stay inside their homes… however cramped it might be, because it's cold and they have no place they can go or they don't have any toys… or it's

muddy and snowing. A lot of these people come from 30 or 40 miles to the paved highway… (Saul/clinician)

Well…the first time they send me back to treatment, which was the 30-days treatment for about a month and then I got back out and start counseling again. I was good for four, five months then I drank and went back. Another three months went back… another six weeks…no about four months, went back. And this time I was suppose to sit back in jail until February, but they let me out on an ankle bracelet. So, that one detects when you are drinking. But, I mean… for me to be out here you know, it's… I guess it's worth it. I'm paying for myself…paying for my freedom (ha, ha). So, I gotta pay like $70 per week in order to stay out (Kaz/client)

I see them still in pain. I want to say something to them, but I feel I am not in the right to say something, cause… I am still in the healing process. I come from a family that's alcoholic and drug users. I thought that was a family…I thought that was um… normal. I started to use marijuana & alcohol when I was 9 years old. In high school it was full blown, there was no reaching me and at twenty-one I was gone…27 or… no twenty-four I went to prison for three years… I got out when I was 27, when I came back from prison… man the things I saw in there, I didn't want to go back (Hue/client)

But like I have been saying the transportation problem, makes it kind of hard to get to treatment some times. Coming down here, the transport that I use …they give us a hard time bringing us down here and picking us up. Sometimes

we just have to hitch hike down here. I think that it does affect us people, you know, but…umm, I…ah… I try not to think about it. Stuff like racial issues, it comes with the territory. The cops here in Fullerton, they mostly pick on the NA's…if you do nothing, meaning you are just walking down the sidewalk, they come around and scope you out and come around another corner again and then back, looking for something… for something that they can find or do something wrong that they can take you to jail for (Todd/client)

There is no job, no transportation. There is nothing out there. All I have to do is just stay home in the house. I can't live like that…because I finish my high school and I was going to NTC (Northeast Technical College) in Power Point. So my older brother and me got into an argument, he couldn't take me to the bus stop where I can catch the bus to school. So I just left it… but it came to a point where I started drinking…I got so depressed I just left (Cecilia/client)

My father was abusive. He was a dry-drunk when he quit…stops cold turkey, but all the emotions and everything went into being mean, abusive, and structure and all this and that …yea, he took it out on us. My mother told him, if you want to be with me, no more drinking…so he stopped cold turkey. I was 10 or 11 when I started drinking and smoking. I was 43 when I got in trouble with the law. I am 46 now that's what I mean…(Trent/client)

Yeah! Personally my dad was introduced around the time when boarding school first started, my mom her side too; they both were doing the boarding school. They were both raised traditionally when they were taken away to

boarding schools. So I think a lot of their teachings, traditional teachings did kina get pushed aside and they were reformed into…assimilated into the Western culture (Wesley/client)

I haven't been sober! Oh man! When I was about five years old. I don't know where I picked up those…alcohol abuse is a part of me…it just became a part of me. I couldn't kick it, but I would sure like to get it out of my system, you know…like you said, change your mind, I am slowly doing that. I start riding bull when I was five years old and my dad used to give me shots of whiskey (Mitch/client, 2016).

Assimilation and Acculturation

Social behaviors and norms is an embodiment of our cultural beliefs and symbolize the building blocks for all civilizations. It and represents the most distinctive and complex component of who we are as a person or as a group of individuals. These participants discussed the extent of their involvement in their native culture, and the degree to which they have been assimilated into the majority culture. This has proven to be both negative and positive which is representational of their dilemma. The acculturation process is tantamount in importance to the survival of the AI/AN people. Nonetheless, it maybe argued that the losses that have occurred and the costs are equally important, if not more devastating. However, some of these individuals still hold fast to the cultural aspects of who they are as an AI/AN and what this represents to them. They referred to the lack of understanding in communication as well as the confusion that

comes with the melding of cultures and people's way of life. These narratives expressed

some of the clients' discussion about the topic:

> Culturally …I am proud to be NA... a female NA, but umm…I was never brought
>
> up in the Native tradition, like going to ceremonies and have anything done for
>
> me… or I never been… I went, but I don't understand that…I still don't
>
> understand that…even in prayers I don't understand it too. So spiritually, I know
>
> there is God, I believe in it …I understand that more, so it's more like
>
> spiritually…umm, I get more help and I am comfortable with that (Cecilia/client).

> I still hold onto the values that come with our culture, … that does play a
>
> major role in my life today, especially when, especially when um… I am going
>
> through sobriety. I wish that more young adults would follow my…not follow
>
> you know, but lead with cultural and spiritual beliefs in their path. I surround
>
> myself with culture…know the other way of living, which is the Whiteman's way
>
> of living… balancing both of them, so I have the knowledge of both worlds, so I
>
> can pass it on to someone who wants it just like me (Hue/client).

> My spirituality ah…when I was using alcohol, I lost my spirituality, didn't
>
> care and all that stuff, but coming here I'm making more progress and more
>
> contact with my spirituality. And my culture is coming back to me too
>
> (Todd/client).

> I think for the longest time I was confused, umm… jumping between
>
> Western (Christianity) and then into the spiritual you know… NA traditional
>
> beliefs, because on my dad's side is Christian and my mom's side is NA

traditional. So I think I was caught up in the middle trying to figure out where I was going. So sometimes on Sundays we would go to church and then some weekends we would go out to my mom's parent's house in the neighboring state and do their traditional ceremonies. I think I was lost for a long time and I didn't have any structure with that and …umm, that might have played a part into my substance abuse… no stern don't do this. Because in the Christian way you can sin and you can repent and you're forgiven for that…umm, traditionally it's just a taboo, so it's kina like I was spiritually and culturally lost for a little bit (Wesley/client, participants, 2016).

Participants' Experiences, Survivals, and Struggles

The participants' struggle represents those challenges in dealing with compliance in providing and utilizing healthcare services within this population. Both groups expressed sadness in what they saw around them. The clinicians spoke of a sense of feeling despondent about the dilemma of the client returnees who have experienced some degree of success, as well as those who have not been successful in the treatment process due to other environmental factors that have hindered them in the past and in the current circumstances. Consequently, their return back into the community without the needed support, where they are faced with the same issues that placed them into the various systems only worsened the problems and perpetuates the cycles of struggles within the systems. The clients reported feeling overwhelmed with events such as their substance abuse and eventual incarceration in the prison system, which left them feeling powerless and feeling somewhat limited in their ability to change their circumstances. Some of the

participants shared their experiences within the community systems about pursuing and providing treatment, while others shared information about the cycle of imprisonment, homelessness, death of loved ones, and abandonment by family and community members. The positive features shared of maintaining sobriety through the treatment programs are often short lived due to the frequent relapses upon reentry into the community with little or no skill set or tools to resolve problems when they occurred. Consequently, those lingering environmental issues that prevent them from maintaining sobriety, becoming gainfully employed, or gaining the educational skills to provide financial support for their love ones, has become the impetus to re-entry into the prison system. Thus, the seemingly unending cycle of dependency on the same systems they are trying to correct or escape produces the feeling of being trapped with no means of escape. At times, the disappointments they felt in their individual circumstances far outweighed the abuse of power used by those in charge in maintaining the status quo. This was especially true of the police officers, and those individuals in the support systems that provided the help they needed. Table 3 gives a snapshot of a few of the areas of struggles inside the structured systems as well as in their return to the communities. While the participants' narratives shared some of the systematic hardship in dealing with the treatment of mental illness, homelessness, alcoholism, and substance abuse and other medical problems prevalent with the struggles in this group, they are not representational of all the struggles within this population.

Table 3

Lived Experiences/Survival and Struggles

Subtheme	Key participant insight	Significant meanings
Desperation/Alcoholism/substance use	The sustained dysfunction created further alienation & chaos in families four generations or more who are in greater turmoil today (clinician)	The acculturation process promoted intergenerational addiction & contributed to the failure to function normally in a family system or in the community
Labeled defensive w/ambivalent behaviors	Historical & intergenerational trauma have created a climate that is cautious & none trusting (clinician/client)	Past negative experience accompanied by the continued acculturation & assimilation processes produces such behaviors.
Neglect/abandonment	Learned social behaviors negated their innate parental and or social responsibility (clinician). Parental binge drinking (client)	Generations of children forcible taken from their homes & placed in boarding schools and the shelter systems (foster homes) created the generations of parents who neglects & abandon their children
Domestic violence on loved ones	Perception of the threat level or seriousness of situations with no other way of expressing feelings or outlet of the frustration (clinician)	Experiences of violence became the normal encounter in managing the individual's behaviors in coping with the environment
Systems contradictions	Operations of the legal & penal organizations in the communities (clinician /client)	Same system that legalizes alcohol is the same which punishes offenders
Transportation & childcare	Noncompliance may not be intentional, but the resources are not available (clinician/client)	Economic stability, resources, and or support system are important in complying with court-mandated treatment.
Overwhelmed by systems requirements	Simplified way of life … recommendations and referrals without the means or support to accomplish them (client)	Complexities of the layers of bureaucracy & hurdles within each system, without problem solving skills can add to the struggles

Excerpts from clients' responses related to this follow:

I had girlfriend issues, work issues, family issues, and my issues. They were all

boiling up and one day I just said, "fuck it". I did the worst possible thing for

about 4 days straight. I just took that as a blessing, I guess. If it weren't for me

doing that, I probably would not be here answering these questions (Hue/client)

I started to use marijuana & alcohol when I was 9 years old. But

criminalization, getting in trouble, going to jail in and out, you know… I went to

jail got out, did my thing. Then when I tried to do good, tried to get right, I'd go

ask them for help… but they just thought of me that basically I would go drink.

So I kina had a lot of animosity… I don't know if that is the right word, hatred,

anger, and said, fuck you guys… That's the part where I ended up on the streets

(homeless). I'd hitched hike to different cities here and there… (Kaz/client).

He (police) just pulled me in and took me straight to Power Point jail.

They never take me to court or nothing. I just stayed in there for three weeks.

Then they said, I should have been taken to court a couple of days after you got

arrested…so they just released me and put me on probation. Right now I am still

on probation and I have four months to go on it. Umm…just out there getting no

help, kina heavily frustrates me…the umm… like right now its cold and I try to

ask for assistance for fire wood or coal, you know… I just gotta do what I gotta

do (Todd/client).

I was age ten or eleven, something like that when I started using. My older

brother was the one that was using. He used to party and drink, that's where I

picked it up. I didn't for the longest time think it was bad, because it was an

everyday thing. And then it started affecting what I did, how I lived and

everything. I finally got in trouble and that's when I discovered that it was a

problem. I did not know what I was doing. I used to scrape money together to get alcohol, weed or whatever; it doesn't bother me because, I have been to the point where you strip down… you are grabbing your sack and everything. I have no angst about it anymore (Trent/client).

Right now I am calm…I understand you know…but if I go into Fullerton and I see a cop…oh! Oh! No good. You see them…you see them, sometimes you see them throwing people around, you know. They are not nice…but you can't do nothing about it. They give you tickets for jay walking …well, this guy goes to us, "hey, there is a lot of food in that trash can. So we seen this jar…full jar of peanut butter, we went over there and was looking at it, when this cop comes by…he gave us a…what do you call…he gave us a ticket for scavenging (Mitch/client).

…What I am seeing is also more of the negative reasons… meaning the parents are on a drinking binge, and they are out of the home for weeks at a time and then they return and the child have to cope with everything… the changes in the family, the stress of the environment, domestic violence, (that is a trend that we are seeing also) and a lot of grandparents raising their kids. Kids are getting shuffled around from different homes, aunts, and other family members. That is one thing that I am seeing a lot more of… unfortunately (Suzie/clinician).

So when somebody comes to a place like this and they start to respond to treatment, but they are going back… so we say wow! They are going back to that environment… as much as they want what we have to offer here it is pretty touch when they are the lone ranger in that home… when everything else is going on

and at some point they often succumb to it and that is why we see them back. It is

just a way of coping. It is traumatic, they feel rejected and no one wants to be

isolated, you see that a lot (Lando/clinician, 2016).

Issues of Grief and Loss

Equally important to the treatment process is the understanding and

acknowledgment of behaviors such as anger, fear, isolation, despondency, hopelessness

and the inability to trust that accompanies grief and loss. The losses endured by the

AI/AN population over the centuries resulted in the loss of lives, land, culture, language,

and way of life, just to name a few. Consequently, these losses have since manifested into

historical and intergenerational trauma, producing symptoms such as depression, anxiety,

posttraumatic stress disorders and other co-occurring diseases. From the clinicians'

perceptive grief and loss are seen as two of the essential elements contributing to the lack

of change in the treatment process for the AI/AN population. From the client's

perceptive, their experience with issues of grief and loss are aspects of a relentless cycle

of unending pain in their life circumstances. Table 4 and the narratives below indicated

some of the areas of concerns that were identified.

Table 4

Participant's Response to Grief and Loss

Subtheme	Key participant insight	Significant meanings
Self-blaming	Experiencing feeling of shame (client)	Taking ownership of the drinking behavior or giving up
Healing practices	Acknowledging that counseling is not easy… (client)	Culture does not promote sharing problems, feelings, and emotions
Identity loss	Loss of identity deprive ownership of one self in the context of the community and the world around them (clinician)	Youths today and adults of the past generations are lost from the lack of knowledge of themselves and their past as a people
Land and Cultural losses	Language/Spirituality are core losses to identity (client/clinician)	No longer speak, read, or understand written forms of languages & the arts of healing. Homelands are no longer sacred
Rescuing	Third and fourth generation attempting change using the same methods with the same results (clinician)	Destruction of the family system over the generations have produced greater dysfunction for the AI/ANs

Excerpts from clients' responses related to this follow:

When you have a wounded culture such as the NA, because of the historical…

westward expansion and the horrendous things they suffered as a people; those

wounds, even though we are generations removed, those wounds are still fresh…

you have people in crisis, not necessarily in immediate crisis, but prolong crisis…

A lot of time you get people in a high sense of desperation and the last thing they

need is condemnation (Lando/clinician)

I'll give you an example of lets say grief, when you talk about grief and

loss. For certain Natives it is part of the culture not to talk about death and dying

and that can be an issue for some clients. But what I've found is, if I respect that

and take it at their pace, most time they are able to or eventually can get to that

point where they can disclose a lot of that and talk about it (Suzie/clinician)

Well I think…that's how they destroyed us. Destroyed the culture…that's how they grabbed the land from us people. Alright… All right here …alright, they started from the Atlantic Ocean, when that Christopher Columbus came in…he was trespassing first…look at all these signs around here that says no trespassing…what in the world is that. We should have put a sign over there for him. He was the first one to bring in the whiskey or alcohol, all right and it spread like this (Mitch/client)

We talk a lot about our substance abuse issues as a NA and what it is going to lead to. For instance, for me it led to loosing control with my drinking to the point where I lost everything: my job, my family, and I ended up being incarcerated (Todd/Client)

Yeah! It is stressful… I am the only one. It's just me…I have a dad… …my father… he's been in and out of prison all his life too, so I don't really…I talk to him, but it's not really a father and son connection, you know. He was always in prison when I was growing up, but I don't talk to my family. When I was growing up my parents drank ok…my mom passed away, but throughout my teenage years I fucked around…(Kaz/Client/Participants, 2016).

Depression, Alcoholism, and Substance Abuse

A physical or psychological condition arising from another illness is known as the sequelae of the original illness. Thus, emotional or medical illnesses such as depression, alcohol, and substance addiction can produce abnormal conditions resulting from these

diseases. In the case of anxiety and depression, in their severity can be the sequelae of substance abuse or vice versa, while cirrhosis of the liver is the sequelae of alcohol abuse (Silver Wolf, Duran, Dulmus, & Manning, 2014). Consequently, mental illness and substance abuse are often accompanied by a variety of health issues such as diabetes, cancer, strokes, kidney failure, and heart disease, which has become some of the major causes for the NA struggling with health issues (Baan et al., 2007; National Center for Health Statistics, 2007). Two participants addressed issues of self-medicating as a result of the feeling of hopelessness in dealing with the irretrievable losses coupled with the struggles with their illnesses.

From my experience here, I see some clients where I knew that the grief was a major part of the self-medication… and since that area was not fully explored, those clients tended to struggle more with the substance use. And for that reason eventually getting to the point of decompensating and eventually dropping out of the program. There are a lot of co-occurring disorders that we work with… a lot with this population. However, depression is the underlying cause why NA seeks mental health services (Suzie/Clinician)

I noticed that there is a lot of clients beside myself that are going through the same thing…depression, anxiety, and stressing out…and knowing that I am not the only one going through… that gives me a better feeling… at the end of the day after my counseling, I feel better about myself. Umm… I got so frustrated with it… I tried to do what I can to make it right, or to hang in there, to be patient and maybe thinking that it'll turn out better, but I just gave up. It came to

depression and I just lived with that …umm I noticed that I started drinking more

… umm, my mom's house (Cecilia/Client, 2016).

Personal Beliefs and Worldview

All the participants expressed their understanding of the positive and negative

aspects of their beliefs, worldview, and their personal experiences. Six participants

examined their knowledge of community involvement in the treatment of AI/AN clients

and the difficulties with compliance, as a result of miscommunication and other

environmental factors that are often times beyond their control. Both clinic sites have a

representation of Caucasians, Hispanics, and Native Americans male and females

clinician's with varying perspectives on their beliefs. The client participants represented a

mixture of individuals who were traditionalist and non-traditionalist, as well as those who

were middle of the road in their beliefs and worldview on issues pertaining to their

beliefs and feelings. Consequently, the clients' responses reflected the questions asked,

which asked about their feelings based on their understandings, exposure, and receptivity

to the cultures; or, the assimilation and acculturation process they have experienced.

These are samples of their personal beliefs as it pertains to the ability to effectuate needed

change in the AI/AN life circumstances.

Table 5

Beliefs and Views

Subtheme	Key participant insight	Significant meanings
Clients Personal Belief and Worldview	We should not be playing the victim card…use internet & social media to educate one another (client)	Needing motivation to bring about the needed changes in their circumstances & in the greater communities
Clinicians Personal Belief and Worldview	Treatment relationship is huge ...you cannot do the work if you don't have the person to work with (clinician).	Understanding the importance of the therapeutic relationship is vital to the treatment process. It must be nurtured.
Coping	The use of traditional healing, Western treatment, as well as the use of substances to seek relief of the pain is not always successful (client).	The intensity of environmental and internal struggles can become overwhelming & relief offered may not be effective.
Book knowledge verses actual experience	They haven't experienced alcoholism/addiction, homeless, & being in jail (client)	The understandings gained from the written sources are often times not the true representation of what actually occurred.
Privileges of the majority group	Being able to afford an attorney in the court hearing make the difference of going to jail or not (clinician).	Role of economics in the equation of life experiences are vital survival.

Excerpts related to these issues follow:

They are looking for understanding. They are looking for somebody not so much

to provide answers, but maybe to instill a sense of hope, and when your empathy

is not genuine, intuitively, they pick up on it. Basically it is appeasement.

Maintaining that client, clinician relationship is an on going thing and the more

you can reinforce that the more trusting they become and that is where the good

work begins (Lando/clinician)

The majority of clients who come in with either significant mental health

or substance abuse problems; have a history of trauma, sexual abuse, physical

abuse, or addiction in their own families. There is a cultural belief that things

should be handled in another way and so… if I am seeking out services and my family knows about it and I am NA, my family might shame me for going against the culture, which is… we don't handle our stuff that way. (Penny/clinician)

I think it depend upon each individual experience that walks in the door. Some people are very trusting or willing to trust easily and can do that… other people have been so damaged that they won't trust anybody ever…and they are just trying to get through waking up and breathing (surviving) yea!

I think the loss of culture has a big piece to do with it …and I think the kids need some type of identity, in order to feel proud of themselves, because there is a lot of the juvenile clients that I meet with… they need a sense of identity to know that they are a part of something bigger that could also promote positive changes. (Suzie/clinician)

The majority of providers like myself are non-native American. This was based on my experience of living and working on the reservation, in the department of Behavioral Health. All the clinicians were "quote unquote", White People...who came in from somewhere else. They travelled in to work everyday and came in and basically said, "you don't know how to take care of your kids," or "you need help, or you can't take care of yourself". And that was their interpretation of it. I think …the NA population might be a little more cautious… based on the past history. (Tiamara/clinician)

To some they still hold that grudge. They still blame the white people. Yea, they blame…like if it weren't for them, we wouldn't be in this situation.

We'd have more or you know… we'd still, be able to hold onto our culture and our traditions. But not all NA's, follow that path, and having to be in counseling and being a NA, it's more like we are being pressed down on the Whiteman's teaching and we need, um… more NA counselors that would teach the tradition or culture… (Hue/client)

The younger generation… umm… I would say about 80% of them don't know what it's like to have gone through that. But the rest, you know, still speak the language, still chop wood, and still ride, still live that way... like the elders, yeah! I am pretty sure it has. Because now it kina hurt them to see the younger generation, kina going away from their heritage, you know. Seeing all the stuff on TV, trying to be something they're not, so… Yeah! I am proud of where I came from and I know my family (Kaz/client)

On the reservation… everything out there has like a stigma attach to it. Alcoholic Anonymous (AA) out there… to me is more built into religion. They want to God this; God that… out there it's more like you are evil, or you are bad, whatever. You are not forgiven for any of that stuff. Even though I have done the time and everything, that's the first thing people remember. Here, it is more about your alcoholism your feelings and how you deal with those. A lot of time you are there you are sad and no one wants to know, they don't want to hear it. (Trent/client)

It was my observation that if you had a good attorney, umm… you can get out of the DWI facility and a lot of the NA's unfortunately are not in that position

and they would go into court and plead guilty and immediately get put in jail. I would say 80 plus percent of clients in the DWI facility are NA (Vance/clinician, 2016).

Therapeutic Relationship

The two groups of participants had different experiences with the Western treatment process and how it impacts the therapeutic relationship. For the clinicians, this was based on their levels of clinical and cultural competency, especially the degree of exposure with specialized groups such as the NA population. For the client participants, there was no bonding occurring due to the lack of sensitivity that tended to aggravate the situation promoting hostility. However, both shared aspects of positive and negative experiences with the treatment system. They pointed to the fact that the treatment system in its existing approach does not always produce a positive therapeutic relationship experience. This is due in part to internal and external factors such as reaction to personal norms and biases, continued assimilation practices, language barriers, and culture specific training needs in clinical sensitivity. One clinician and one client expressed their own experiences as such:

> When I saw the flyer on relationship, I was actually really excited…because, I think that the relationship piece is huge. You cannot do the work, if you don't have the person to do the work with …that's my main thing. So, I think the relationship and the clinicians understanding their own biases, and the type of persons that they can and can't work with…knowing that we can't work with everybody is crucial in treatment (Tiamara/clinician)

I had this white counselor and I could not get through to him, with

everything I have to say… there was always something that he said that would

discourage me. Like a back and forth battle. He listened, but the

question…material didn't really stick. He just kept going forward, forward,

forward… When I had that male counselor, which was white I felt like he was

throwing all this at me using his education, big words, his um… character like

um… yes, I am sitting behind this desk, I got this coffee in my hand, I got this

watch on my wrist, I got this expensive computer in front of me. We were just

different that's it (Hue/client, 2016).

Cultural and Spiritual Identity

The questions about clients' cultural and spiritual identity had different reactions

from the clinicians and the clients. Both groups pointed out that not all AI/AN people

identify with their cultural and spiritual heritage. This lack of identification is especially

true for those individuals who have been fully immersed into the majority cultural group

practices, while others are more traditional and want very little to do with the Western

ways. Nonetheless, it was pointed out that there are some individuals who identify with

both cultures. They feel quite comfortable going back and forth between the cultures

without any major difficulty. These are examples of their experiences.

Oh! Cultural …I am proud to be NA... a female, but umm…I was never brought

up in the Native tradition like going to ceremonial and have anything done for

me… or I never been… I went, but I don't understand that…I still don't

understand that…even in prayers I don't understand it too. So spiritually, I know there is God, I believe in it …I understand that more, so it's more like spiritually…umm, I get more help and I am comfortable with that (Cecilia/client)

We'd still, be able to hold our culture and our traditions, but not ceremonies and stuff like that. Like I go to the sweat lodge… and with the bible baptism. I try to go once every week to the sweats. But no … I feel that we got to adapt and adjust, cause everything going to change. It's not always going to be same. You know, it's scary to change… scary to see change, but you gotta adapt and you gotta surround yourself with your culture and don't loose it…Yea! It still has me thinking to this day, who am I? Who am I? (Hue/client)

A lot of the clients I meet with…the culture is diminishing. They don't have any knowledge of their identity, they don't know of their cultural practices, client systems…they don't even have any knowledge of it. They have no idea of historical trauma or how that can play a role…so that's something of what I am seeing a lot more of, that's increasing. I think the loss of culture has a big piece to do with it … (Suzie/clinician)

One of the curious things that you will see is the blending of Native traditions with the Western philosophy: For instance, you'll see somebody says, I went to the Medicine man a month ago, but now I want to come here…I want to get some help form you guys. So you will see a blending of the two cultures, which I find interesting (Lando/clinician, 2016).

Maladaptive and Adaptive Coping Styles

Overwhelming life events, usually precedes maladaptive coping styles when there are seemingly no alternatives outcomes. While the adaptive coping occurs when support systems and skills are in place to problem solve other means of dealing with the stress that comes with these life experiences. The use of substances such as alcohol and other illicit drugs are learned behaviors used in coping with the physical, emotional, and psychological losses that have occurred over the centuries and in the day-to-day struggles. Physical violence, blaming, and other negative activities also acted as a form of distraction from the realities of the pain and the feelings of hopelessness experienced under these situations. These behaviors help to numb the pain, temporarily decrease the symptoms, and provide some relief when life events and the environment becomes too overwhelming with no clear resolution to the difficulties at hand. This method of coping does not change the root cause of the problems encountered. It only provides short term or momentary fixes that can cause other conditions or create permanent damages to an already volatile situation. This in turn produces more stress and pain that became the accepted custom in handling daily struggles.

The adaptive coping method produced more positive alternatives in handling those stressful life circumstances. It also provided a higher level of functioning that contributed to greater problem solving skills, with the ability to tap into a larger network of support when experiencing life's stressors. Individuals who have gained these skills can exert greater control over their situations, which if not addressed, can render them powerless as they try to cope with all the environmental factors surrounding them.

Each participant narrative varied based on their experiences with the different methods of coping. In the first three scenarios, clients used more of the maladaptive methods of coping, until they learned new skills and acquire the tools to turn the negative into positive ways of handling the challenges of an everyday life situation. The last two scenarios, demonstrated how self-acceptance and the discovery of a more intrinsic means of coping helped to produce more productive coping skills, through the awakening of the mind and educating one another about their purpose. They shared incidents when maladaptive and adaptive methods of coping were used to address the overwhelming problems in their lives and the struggles they encountered in doing so.

Table 6

Incidents in Coping

Subtheme	Key participant insight	Significant meanings
Alcohol/Substance abuse	Self-Medication (clinician/client)	The numbs of the pain and desensitizing the feeling…help in not deal with the grieving
Homelessness (prior to time in prison)	Loss of family and support systems (client)	The struggle with substance use & feeling hopeless to stop the downward spiraling.
Incarceration	Harshness of the prison system (client)	Teaches more violence and maladaptive coping as a means of survival within the systems.
Homelessness (after prison and half-way-house)	Retuning to the same environment that created the problems (clinician)	Probation without treatment or other environmental changes cannot produce positive behavior changes
Relapse and eventual Death	Decompensating and eventually dropping out of the program, return to prison or death (clinician)	Noncompliance can contribute to more prison time or death from the substance or the harsh physical environment.

Excerpts related to these issues follow:

I have done alcohol and drugs in the past. But this time, I had girlfriend

issues, work issues, family issues, and my issues (substance use). They

were all boiling up and one day I just said, "fuck" it. I started smoking

"MET." I did the worst possible thing to do for about 4 days straight. To

me having to do that I don't regret it. I just took that as a blessing, I guess.

If it weren't for me doing that, I probably would not be here answering

these questions (Hue/client)

People were complaining about this and that…government

screwed me, cops screwed me…nobody else did that… you did that… I

did it myself. So I use my time good…I learned from my counseling and

learn to talk to people (Trent/client)

Yes! He just came with more (I don't know the word) response

like um…well, like he would push my buttons. I wanted to do something I

guess, but I held back… I was just sitting there like another person. He did

not see me as a NA person who needed help, wanted help… He did not

see or understand my background. He just saw me as just another guy,

another client who will not complete… will or will not say no… no more.

That's why I kept coming back… saying something; to let him referred me

to another counselor. That is why I kept coming back, coming back, and

speaking my mind. I see them as seeing natives as a waste of time or

another statistic (Hue/client)

I can't change what I did in my past…I did my time, I did everything, but it's behind me. So, I can't express enough, you know… I woke up I found *my higher power*. Thing is, I was given tools from people I've met to make the choice, you know… I've seen people get out of prison and spend like three days at the halfway house and they drink, they party and they get sent back to prison. It's just a choice of what I want…but the thing is, I didn't have those tools to make that choice then… I didn't have counselors (Trent/client)

I do believe…yeah! There is some stuff that's going on that we need to be educating one another instead of playing the victim card right now. Oh man! This process is a tough one…it seemed kind of hard and impossible in the beginning and you kind of have that self-doubt about who you are. The mistakes you made are going to define you… but as for myself that's one of the reasons why I continue to push on with school and work at the same time. Finishing school and not let that define me is what has really helped through the Discovery program along with the counselors (Wesley/client, 2016).

Defensive and Ambivalent Behaviors

As an example of this theme, one clinician pointed to the fact that labeling serves as a deterrent to a positive treatment process. She noted that there is no one fit for NAs acculturated into the practices of the majority culture. While one client might adhere strictly to the traditional and another to the western practices; there are those who feel

more comfortable in taking part equally in the western as well as the traditional healing

practices, or using alternative practices as appropriate to their needs. Therefore, those

individuals who wish to maintain their traditional beliefs should not be penalized with

labels or receive inadequate treatment when beliefs clash with treatment practices. This

clinician elaborated on defensiveness and ambivalence.

> Whereas, my conversation with coworkers who are non-native, they tend to say
> there is some defensiveness, there is some kind of ambivalence about talking
> about the grief. I find that I have to educate co-workers at some point.
> A person who may be ambivalent to attending therapy is possible due to past
> negative experiences. However, this is not true of all NA's. It is almost as if there
> is an inability to want to go into their culture. And so with those clients, I find it is
> sometimes easier to go with just the Western approach rather than the cultural.
> And so I have to try to find a balance where it is most comfortable for them. The
> more Western oriented client's open up more freely. And the NA's who are more
> culturally inclined, I have to do a lot more work with them. From my
> understanding with talking with them (non-native clinicians), they may want to
> respect it… but their idea of respect is by not even going there, other wise they
> feel they may offend the client. So that piece never gets covered… in not knowing
> what approach to take or how to actually pursue that area of the client's needs. I
> think those clients that are more guarded… the mentality were to just shut down.
> Then that prevents the clinician from exploring other aspects of that type of
> behavior (Suzie/clinician, 2016).

Family and Systems Dysfunction

The conflicts and the unhealthy interactions that arise among family members interfere with the family's functioning in a productive healthy manner. These learnt behaviors have become a mainstay in the NA community and was addressed by both the clinicians and the clients as they have dealt with these types of dysfunction in the treatment process.

I think to a large degree there is just a lot of desperation. It is intergenerational, and you see this handed down. It is kind of sad to see, the grandparents did it, the parents did it, and now the clients are doing it, and they have teenage children who are now doing it. So in an instance, you see four generations is having this negative impact. And I think, just seeking a sense of normalcy…you know the level of dysfunction in the NA community because of alcoholism primarily, but now, what seems to be on the rise, is drug abuse or the addiction… just basically the chaos in the families and people seeking… I guess, refuge from the storm (Lando/clinician)

Well, they grow up …a lot of times without very much and a lot of times the people that we are meeting don't have a lot of basic life skills dealing with problems that come along… and then a lot of times, where people come from, their solutions have been dysfunctional for generations… other people have been so damaged that they won't trust anybody ever…and they are just trying to get through waking up and breathing (surviving) yea! (Saul/clinician)

What I am seeing is more of the negative reasons… meaning the parents are on a drinking binge, and they are out of the home for weeks at a time and then they return and the child have to cope with everything… the changes in the family, the stress of the environment, domestic violence that is a trend that we are seeing also and a lot of grandparents raising their kids (Suzie/clinician)

I was ten/eleven, something like that… my older brother was the one that was using. He was Mr. "basketball star". He used to party and drink, that's where I picked it up…I didn't for the longest time; think it was bad, because it was an everyday thing. And then it started affecting what I did, how I lived and everything. I finally got in trouble and that's when I discovered that it was a problem … my father was also abusive. He was a dry-drunk. He quit…stops cold turkey, but all the emotions and everything went into being mean, abusive, and structure and all this and that … (Trent/client, 2016).

Attitude and Perception of Treatment Noncompliance

The history of the NA people gave evidence of the current attitude held in the rescinding of false promises in land purchases in the past, to the provision of healthcare service needs in todays environment. The lack of trust developed as a part of their lived experiences is very much a part of the AI/AN people's psyche today as it was centuries ago, with some moderation due to the acculturation process. These participants viewed treatment recommendations and noncompliance issues from the position of having deep-seated life experiences that has affected their current circumstances in making choices that are hard to change without the supports of the larger community systems. Poor

communication skills and the lack of accountability were some of the behaviors

highlighted in the interviews that when improved, could generate needed changes in the

life circumstances of the AI/AN population.

> I think one of the biggest things that I see in terms of that is …the whole thing is
>
> with accountability and responsibility. Somebody who has a problem with
>
> substances, the accountability and the responsibility is lacking. So they become
>
> very resistant to any thing that involves, I say truth… They become very
>
> protective over their drug of choice, because that's their medicine, their best
>
> friend. And they come in and you are telling them they have to give up their
>
> buddy, for what. So you see, I think a lot of it is just normal human nature. I think
>
> at the very core, it's all just basic normal human behavior (Lando/clinician)

> If they are not compliant, we try communicating with them to see what is
>
> going on… is there something going on … do they have an issue with the
>
> clinician…if so, maybe we could try a different clinician and see if that is a better
>
> fit. We try to do as much to try to accommodate them. If it's scheduling, we try to
>
> say maybe there is a different route you can try, or maybe if you can't afford
>
> payment, we can work on payment arrangements, or look for services that can
>
> help or refer them to a different place that could provide better services for their
>
> financial needs…so we try to accommodate them as best we can (Suzie/clinician)

> I think it is a number of contributing factors. I think um… sometimes it
>
> get to be recommendations for this, recommendations for that, come to this
>
> appointment, come to this UA, (urinary analysis), come to this group… it can get

very overwhelming. That means, they are taking off work three or more times per week to get in for appointments… or having to find sitters for x amount of time during the week, when they normally wouldn't, um… so those are some of the factors why there maybe noncompliant with services (Tiamara/clinician)

From the time I started drinking…started smoking till now, everything I've done was my choice and here I am a felon… prison and all this and that…So if a counselor or somebody was going to tell me to do this, I'd listen. Because ever since I start going to counseling …I start seeing somebody, everything has been good. So my choices compared to them recommending this or that, has been way better. I have the positive reinforcement from listening to other people; because all these years I've been listening to myself has been bad…(Trent/client, 2016).

Confusion, Shame, and Embarrassment

Mandatory assimilation practices of the past have produced confusion at all age levels and such confusion remains true today. This confusion exists not only about their identity as members of the NA population, but also about the identity of their spiritual and cultural beliefs of who they are as a people. References were made with regards to the feeling of betrayal when the dominant culture and its forced religious dogmas were often chosen over the traditional and the NA spiritual way of life; this still has a major impact today on the enculturation process and the religions convictions. In some respect, there was also confusion with the systems that are in place, which represented a major

part of the problem, through which the people must navigate them, in order to survive in the world of the majority culture.

The clinician and client participants spoke to the confusions they have observed and experienced. Some of the clients addressed their understanding of the embarrassment or shame they felt as NAs who continue to experience the losses, while not having the means of regaining the missing pieces of their cultural identity. They also touched on the feeling of powerlessness and the lack of hope in not being able to help themselves in desperate times.

> Well the Ridge Nation is a dry reservation and Fullerton is not. So that's what a lot of coming to buy alcohol… coming to buy that sort of stuff. So, there is a lot of NA that live quite a long distance from here that are involved in the legal system that eventually trickles down and we are saying come here three or four times a week for services…while this is the system that does the incarceration or dispense the punishment for the use when they mess up (Tiamara/clinician)

> I think for the longest time I was confused, umm… jumping between the Western and then spiritual you know… traditional NA beliefs; because one side my dad's side is Christian and my mom's side is NA traditional. So I think I was caught up in the middle trying to figure out where I was going, so sometimes on Sundays we would go to church and then some weekends we would go out to my mom's parent's house in the neighboring state and do their traditional ceremonies. I think I was lost

for a long time and I didn't have any structure with that and …umm, that might have played a part into my substance abuse …no stern don't do this. Because in the Christian way you can sin and you can repent and you're forgiven for that…umm (Wesley/client)

There would be parties at the house most of the time and I would see everyone laughing, hugging, crying, talking, and I thought wow… I thought that was a family…I thought that was um… normal. I use to stay with my cousins and older sister and I guess I saw one of them do it, so I ask to try it (Hue/client)

There is a cultural belief that things should be handled in another way and so… if I am seeking out services and my family knows about it and I am NA, my family might shame me for going against the culture, which is… we don't handle our stuff that way. So I don't know if that has a lot to do with it…but in doing counseling with some people it seems that they are conflicted about whether they should or shouldn't…and they will say, my family is like that but, I am not that way (Penny/Clinician)

I think it is because of shame I guess… shame that some of us lost this culture and spirituality… or that this won't work for them. But the Whiteman's way would work for them and that's shame too. Or shame that they are poor and need help… or shame that someone comes around that's non-Native and see them the way they live…you know they…we feel shame. I guess its shame. No, and I was embarrassed to not be able to

answer that question just like that, of who am I. It still has me thinking to

this day, who am I? Who am I? Yea, that was me back then…shame,

everything I said, it's me (Hue/Client, 2016).

Emotional Reactions

All the participants in one form or another experienced a variety of emotions in

dealing with or reacting to the emotional and physical changes in their everyday

circumstances whether this resulted from the spiraling effects of the addiction disease or

the emotional roller coaster effects from mental illness: When combined with alcohol and

other illegal substances, or the environmental conditions they must endure, their struggles

became less manageable because of all the uncertainties around them. One client

participant was able to share some of his reactions of anger experienced in an abusive

situation, and in hindsight what could have been if the resources were available in the

community to help his family members to prevent the addiction and incarceration.

My father was abusive and a dry-drunk. All the emotions and everything went

into being mean, abusive, and structure and all that… Yea, he took it out on us. I

used to have some angry issues about that but, like I said, I can't say enough

about counseling and AA; because all the things that hurt and all the things that

used to bother me, it all came out…it's gone. Counseling up here or in the city is

different. You tell them how you feel and they hear it. For me I think, if…when I

was… from elementary, Junior High all that …if I had somebody come in and

just talk you know, or sit you around a table and talk to you. I never got that…

when I was in elementary; when I was in Jr. High nobody talked to me about

those stuffs. I think it takes just one person to say, hey! How are you feeling? I

talk to my nephews and nieces now. I talk to them and play with them and I see a

difference now. So, for me if somebody asks me that… cause that's one thing that

I see in the NA environment, is they don't share emotions and feelings

(Trent/client, 2016).

Abandonment Issues

Changes associated with the forced assimilation or acculturation process requires

the unearthing of ingrained values and ideals germane to the individual's belief system.

Whether it is the desertion of children, family members, one's culture, language, way of

life, or community, the abandonment of these intrinsic identity markers speaks volumes

to the level of pain associated with these losses.

I think some of them they feel abandoned at a very young age. A lot of them don't

even have parents any more and when you say what happened, oh! Its alcohol

related, always alcohol related. As I said earlier, you know if it's in the home… if

that's what they grew up with, they think that a normal behavior and they don't

know how to change it. They just continue to live with that (Nancy/clinician)

I think what you see happening is the Native people are leaving the

reservation in higher numbers. They are living in the outlying communities,

which mean that they are becoming acculturated to the standard or norm of the

community, which sorts of blurs the traditional ways. And you can see the sort of

resentment from the elders, who feel that the younger generation is discarding

their traditional heritage for ... it is almost…you'd hate to use the words… what

they consider sell-out, but is what they are implying… It is traumatic, they feel

rejected and no one wants to be isolated, you see that a lot (Lando/clinician)

Kids are getting shuffled around from different homes to aunts and other

family members. That is one thing that I am seeing a lot more of… unfortunately

(Suzie/clinician)

I could say when I was growing up my parents drank, ok…my mom

passed away, He… (My father) was always in prison when I was growing up. So

throughout my teenage years I fucked around…But the older…like the elders…

yeah I am pretty sure it has, because now it kina hurt them to see the younger

generation, kina going away from their heritage, you know…seeing all the stuff

on TV, trying to be something they're not (Kaz/client, 2017).

Feelings of Anger and Depression

One client discussed his feelings of frustration and anger he felt in his observation

of his physical environment and the hopelessness he associates with the people in the

community. Another client expressed her feeling of anger, isolation, and depression she

experienced before coming to treatment.

I don't think shits gonna change in Flatrock. Cause you know, some people they

ask the tough questions and some people don't have the answer to it. And so now

we have all these other races come onto the reservation to do the work for us,

which you know, we should be doing ourselves… and you know that's shame too

that we can't do it ourselves. I like man, it's real sad. You see these people

walking around…you see these broken down buildings, you see kids walking on

the road and I don't know where they're going to…young kids walking. You can see the…sadness on their face. The alcohol and drug… gangs…its real bad down there now. I mean …people like, ah… I'd say working class people in Flatrock they don't see none of that…they don't see the cruelty…to that side of Flatrock, they don't see that. But people like me… younger people you know, we do see that, because we are experiencing that…and that's why we are so much …I wouldn't say more involved … trying to better the community, you know… have these little changes…get the younger kids involved in something else rather than picking up the lighter or outing the bottle you don't have to…(Hue/client)

Umm…going to therapy or counseling has really helped me deal with my depression and stress. There is a lot of resentment and anger I went through with my own family; because they have been judging the way I make my choices. I got so frustrated with it…what I went through… I tried to do what I can to make it right, or to hang in there to be patient and maybe thinking that it'll turn out better, but I just gave up. Sometimes it last a long, long time. I couldn't take it any more so I just gave up and that really got to me. It came to depression and I just lived with that …umm I noticed that I started drinking more often, when I left my mom…umm, my mom's house. There is no job, no transportation. There is nothing out there. All I have to do is just stay home in the house (Cecilia/client, 2016).

Recovery: Adaptive Stages

It should be noted that recovery begins when the client takes the first step to seek

help from a professional counselor and begins the process. All of the client participants

have taken that steps toward sobriety, either from a voluntarily standpoint or to be in

compliance with the legal mandates of their parole requirement. Each of the clients were

at different levels on the path to recovery. Some clients had years of maintaining sobriety,

while some had several relapses, and still others were at the beginning stage of a long

journey to recovery. Yet, they have all initiated the changes they hope will achieve

abstinence from substance use. These clients explained aspects of their journey.

> I am still in the healing process. It's been a while since I have done alcohol and
>
> drugs, but I still feel I am not in the right to share whatever experience I have.
>
> Because I may say the wrong thing and they go out and start drinking again. So,
>
> counseling man it's tough, and um… not too many people get through with it. I
>
> don't know why is that…(Hue/client)

> I am going on six years sober now…so, it took a long time for me to
>
> understand everything and for me I had to get out of the reservation, the native
>
> environment, and get put in a halfway house and that's when I woke up. That's
>
> when I found my higher power and discovered that my happiness lies within
>
> everything I do and everything that… the choices I make, the habits I
>
> make…that's what makes my destiny you know (Trent/client)

> I haven't been sober! Aha! I realize I have to do this, I have to start you
>
> know…I got two girls that are you know… so I have to look at that. But, right

now alcohol is really affecting my body now…like I can't swallow real good…

Yeah! It burned out the…they are going to put a video camera in my stomach on

the 23rd…they are going to really check me out to see what I am really…how

damage is my body, you know (Mitch/client, 2016)

Conclusion/Results

The research questions examined how the personal beliefs and worldview of the

clinicians and clients impacted the therapeutic relationship of the AI/AN clients and what

role attitude and perception played in treatment noncompliance. This study revealed that

even though beliefs and worldview, along with attitude and perception of both the

clinicians and clients, had quite a significant impact on developing a positive alliance in

the therapeutic bonding process, these factors were shown to be secondary to the

prevailing causes for noncompliance. The analysis of the data demonstrated that all the

themes and subthemes under the umbrella of intergenerational struggles had the most

profound impact on treatment noncompliance and the effect of the health and mental

health of this client population. These themes represented the AI/AN's experiences in the

assimilation and acculturation process in the context of survival in the larger world

community. Consequently, intergenerational struggle and its secondary causes

represented the predominant factors that contributed and perpetuated the negative lived

experiences for this client population. The results suggested that some issues were more

impactful than others, but nonetheless they all contributed to the client's experiences in

the treatment process and eventually to their quality of life.

There were some satisfactions in the life changing experiences for the participants in their involvement with both the western and the traditional treatment approaches. Both the clients and clinicians were in favor of the overall counseling practices in treating mental health issues, along with alcohol and substance abuse treatment. Although there were clear preferences among the clients between the stalk western methods, and the incorporation of traditional and the western practices; client's preferences remained personalized based on the level of acculturation and assimilation, as well as their own knowledge and experiences with each practices.

Summary

In this chapter I offered an extensive assortment of participants lived experiences in their attempt to cope with the effects of dealing with alcohol and substance abuse addiction and mental health issues in two southwestern clinics. The narrative responses taken from the participants' interviews were used to address the specific themes that were identified as area of concerns for the AI/AN population. Intergenerational struggles emerged as the most significant theme supporting the importance in addressing not only the quality of life during and after the treatment process, but also in tackling the larger social and environmental problems contributing to the increase of mental illness and substance abuse in this population.

The participants shared that along with historical trauma, poor economic conditions, lack of education and job opportunities; the AI/AN population falls prey to intergenerational struggles, which had been evident in their communities in the past and will continue into the future, if not addressed on these and other levels. For example, the

clients shared that abstinence and depression recovery continues to be a major hurdle in

maintaining sobriety after their ordeal with these illnesses. These concerns along with the

interpretation of the results, the limitations of the research, the suggestions for further

studies, and the recommendations for social changes will be discussed in Chapter 5.

Chapter 5: Summary, Conclusions, and Recommendations

Introduction

NA clients experiencing depression, alcohol, and substance abuse illnesses are symbolic of the legacy of both historical and intergenerational trauma whose residue is not only psychological and developmental, but also social and physical in nature. In this study, I explored some of the experiences gleaned from both a personal as well as from a systems perspective, involving different lenses through which a person can understand the context and the complexities of behaviors in the individual's environment. In this phenomenological research study, I examined the attitudes, perceptions, and the lived experiences of 14 participants (seven clinicians and seven clients) and their impact on the therapeutic relationships, the issues of noncompliance in the treatment process, and the ability to cope with these illnesses.

I used the qualitative method of observation and open-ended interview questions to examine the social phenomenon in addressing the research questions and throughout the data collection and analysis process. Subsequently, the theme of intergenerational struggles was deemed the all-inclusive influence impacting all other aspects of the AI/AN lives and was recognized as the most relevant factor transcending time, culture, and generational boundaries and producing untold suffering and continued losses in the NA communities. All other themes were subsumed under this topic. Those subthemes were: assimilation, acculturation, and communication; survival experiences and struggles; grief and loss; depression, alcoholism, and substance abuse; participant's personal beliefs and worldview; therapeutic relationship; cultural and spiritual identity; maladaptive and

adaptive coping; defensive and ambivalent behaviors; family and system dysfunction; Western and traditional treatment practices; attitude and perception of treatment noncompliance; confusion, shame, and embarrassment; emotional reactions; abandonment issues; and anger, depression, and stages of recovery.

Interpretation of Findings

In this qualitative phenomenological study, I examined the lived experiences of the attitudes and perceptions of 14 participants from two counseling agencies servicing AI/AN clients dealing with mental health, alcohol, and substance abuse problems. In this study, I also assessed the degree of impact on the therapeutic relationships of dealing with issues of noncompliance in the treatment process, while coping with these illnesses. Through extensive interviews, I explored these participants' feelings, thoughts, and experiences in their respective roles as clinicians and clients in the treatment process. The collected data were of significant value not only in highlighting the state of health in the population, but also recognizing the amount of disparity and gaps in their economic circumstances brought about as a result of intergenerational struggles that have confounded their lives for centuries (see Evans-Campbell et al., 2012). Intergenerational struggles have had overwhelming consequence on the coping abilities in the lives of the AI/AN population, since their acculturation and assimilation by their colonial captors (Evans-Campbell et al., 2012). Consequently, in this study I examined the causes and effects of their struggles from a wider perspective to take into account all the dynamics impacting their traumatic involvements in the majority culture's way of life and the consequences that resulted.

Due to the complexities of the AI/AN experiences, no one theoretical framework was applicable in this study. Therefore, I used a combination of theories to examine the causality of the past and current dilemmas in the AI/AN communities. Grounded liberation and oppression theory as well as historical and intergenerational trauma theory were deemed appropriate for helping to explore the far-reaching effects from a wider human perspective. These concepts helped me examine the individuals' existence within the framework of forced assimilation and acculturation processes, in line with the continued destructive practices that have occurred due to the suppression of the human spirit and the endowed potential of the AI/AN people (see Duran, 2006; Freire, 1970; Montero & Sonn, 2009; Yellow Horse Brave Heart, 2003). In this respect, I used the grounded theory to examine the context and content of the individuals' experiences as well as the interpretations and social structures in which they were derived (see Moustakas, 1994). Therefore, in this investigative approach, the use of grounded theory enabled the untangling of the elements of the lived experiences within this population (see Moustakas, 1994). In so doing, it allowed for a closer analysis of the gaps in the data over the centuries of internalized generational traumas, along with the unrelenting effects of the present-day environmental struggles, which had not been addressed from this perspective.

Using these theories, I looked at the continued oppressiveness within the modern day organizations such as the legal, court, probation department, penal, and religious systems which have continued to dominate all aspects of the AI/AN lives, once individuals are caught within these and other establishments. It was pointed out by one

clinician that being cautious for the client is coming in with their guard up, which trickles

down to the treatment, because of having to deal with all the above systems that are at

play in the clients' lives. Representing once again the destructive forces of these

ideological structures, whose policies and procedures tended to deprive and dampen the

individual's spirit of the possibility of changing those survival behaviors learned within

these systems (see Macedo, 2000; Thomas, 2009). This possibility of learned behaviors is

especially true in circumstances pertaining to traumatic events in which alcohol and

substance use became the means of coping with life's stressful situations and the health

implications arising from them.

 The participants' narratives gave testimony to the untold story of the devastations

within the corrections system, while confirming what I found in the literature. For many

AI/AN's, today's corporal punishment represented yet another punitive approach as seen

in past actions of forced incarcerations into forts and the development of reservation

systems as containments. Responses to the past and present control factors over the

centuries have subsequently morphed into the harsh effects from the losses and the

psychological pain experienced as generational struggles.

Intergenerational Struggles and Survival Experiences

 Strauss and Howe (1991, 1997) defined generation as the collective of a group of

people born over a period of about 20 years or approximately the interval of one phase of

life, namely childhood, youth, adulthood, midlife, or old age. In their work, they

examined how generational disparities shaped attitudes, behaviors, and the course of

history. Thus, the results I gathered from the themes in this study were discussed from the

perspective and the lived experiences of the participants. For instance, a clinician

participant in this study referred to the struggles of their clients as becoming acts of

desperation handed down from succeeding generations with no long-lasting changes

available for the dilemmas they face. Another clinician commented on the fact that, this

century alone, the progression was seen generationally with the grandparents, parents,

and now the teenage children experiencing similar if not worst internal and

environmental struggles as have been pointed out in the literature (see Gone, 2004;

Moodley et al., 2008). The clinician participants pointed out that what was quite

noticeable in the past was the fact that only one generation would go through the

treatment process. More recently, this has changed to two or even three generations

seeking help or going through the prison system and treatment simultaneously or at

different times over their lifetime. Several of the client participants noted that they have

gone through the penal and treatment system along with parents, siblings, or other

relatives, and other members of the community. Consequently, there are greater numbers

of returnees through the various systems with the individuals and families affected by the

same struggles of alcohol or substance abuse. Other client participants pointed to the

struggles they have observed and experienced in the treatment process, years later when

they were reentering treatment. This was due to relapse from the failure to maintain

sobriety, a positive mental health status, and a permanent job that would allow them to be

economically stable within the community.

The increased movement seen through the systems begs the question of whether it

is the result of greater trust within the AI/AN population that was not evident in the past

that has created this new help seeking behavior. Some researchers are of the belief that the increase could be attributed to the acceptance of the treatment process, whether western or traditional; others believe that there could be a better system for early detection of signs of addiction at a younger age. Still others are of the consensus that the legal systems approach in handling the problem has not been relevant in terms of identifying the causes of the existing problems. This was made clear with the increase that is taking place in the clinics as well as the predicted increase noted by the 2010 census. The projected rise in the AI/AN population is from 5.2 million to 8.6 million by 2050 (U. S. Census Bureau, 2010). This will likely produce an even greater number of individuals with similar illnesses instead of the decrease that is needed. Represent an increase of 3.4 million AI/AN individuals with the possibility of developing these health, mental health, substance, and alcohol abuse problems in the community's environment; this has not changed over the centuries.

Clinician participants in this study have seen not only the rise in the number of AI/AN clients within the systems, but also that the age ranges of the clients have been decreasing with younger children entering the systems. These clinicians spoke to what has now become evident in the clinic setting as a shift in the numbers from a steady flow of AI/AN clients, which represented about 50% of the clinic population at the first site, having surged to an additional 20% increase over the past 5 to 7 years. They pointed out that this current trend has brought with it at least a 5% increase in the juvenile clientele (ages 12–18) who are experiencing diminished cultural identity, an inability to identify with their ethnicity, and are not fully able to fit into the majority culture.

It was also pointed out that this lack of identity and the inability to identify with their native culture was representational of many of the participants' age of acculturation and the process of assimilation, as well as the devices used to bring about these changes. One client participant reported that he was only 5 years old when he was exposed to alcohol and the correctional facility way of life. Other client participants reported their first contact was in fifth or sixth grade. In the past and more so today, generations of children were born with fetal alcohol syndrome. However, the more recent years have seen an increase in the use of *methamphetamine* (also referred to as meth), which is also an addictive substance, and a drug of choice for substance users. Individuals' having children born meth positive may increase their chances of being genetically predisposed to alcohol abuse and other substances and having a higher risk of addiction (Warne & Bane Frizzell, 2015). These children are removed from their homes and placed into the foster care system when one or both of the parents are absent from their lives for indefinite periods of time, such as in instances of incarceration, illnesses, or death from substance use. One client shared their experience with the death of his mother from substance abuse, while his father was incarcerated. When he got older and had the same substance problem, he was going through the prison system at the same time with his father. Abandonment, neglect, and death of the parents from these diseases are the primary issues that the new generation must contend with (Lowe, Liang, Riggs, & Henson, 2012).

The second site has also seen an increase in the number of clients because of their specialization in more of the traditional healing methods, but juveniles were not apart of

this increase, because it also specializes only in adults. Their client population was an 80/20 ratio (80% NA, 20% Caucasian and Hispanic). They had two new buildings constructed in order to expand the development of two new programs to house and accommodate the treatment needs that were required. A further increase was noted in the first clinic site where they had to move locations on two occasions to accommodate the client increase. A third move required the splitting of the agency to two different sites to contain the increased number of referrals from the probation and court systems. All of the participants pointed to the struggles that emerged through the acculturation processes in which the blending or total wiping out of the traditional aspects of the AI/AN culture created a blurred perspective of their sense of being and helped to produce other major consequences that impacted each generation's survival abilities (see Warne & Bane Frizzell, 2014; Yellow Horse Brave Heart, 2003). This caused irreparable damages that are not only psychological and physical in nature, but also social with economic consequences to the individuals as well as to the collective body of people (Evans-Campbell et al., 2012).

Assimilation, Acculturation, and Communication Issues

Views on assimilation, acculturation, and communication issues varied within the two groups of participants. Some clinician and client participants were more aware than others of the influence and some less so of the consequences these processes have had on the lives of the AI/AN populations. However, it was evident in all the discussions that there was a clear lack of understanding by all of the participants of the larger impact that the assimilation and acculturation processes have had on this population. This problem

was quite apparent within the majority of the interviews, in which both groups seemed to have no lack of personal experiences by which they were affected, but had very little or no concept of the larger problems that were presented. There was a scarcity in the knowledge of the historical factors pertaining to the causes of intergenerational struggles within the AI/AN population.

Both the clinician and client participants addressed the need for cultural training, which would require training during their academic tenure for new clinicians coming to the field, and those who are already working with clients to attend seminars to learn more on the aspects of acculturation and assimilation of the AI/AN client. My observation revealed that both groups' personal experiences tended to impact each other based on preconceived personal biases in their interaction, because of the lack of knowledge and past negative exposure within the larger communities.

On a more direct level of communication with the groups, the clinician participants spoke to the issues regarding interaction in which language and cultural differences present as a major problem even though the majority of the client spoke and understood English. They explained that there were subtle nuances in every language that cannot be deciphered or expressed in another language. They further pointed out that in these and other instances when there was a lack of the clients understanding, they would not ask for clarification and would leave without knowing what was being asked of them. However, the finding that was consistent with the literature indicated that many AI/AN peoples exercise caution in personal communication with outsiders (Human Resource Services Administration, 2003a; Swinomish Tribal Mental Health Project, 2002), due to

long standing issues of distrust. And, on the other hand, some of the client participants referred to this as not feeling comfortable in asking in fear of seeming unintelligent, which was also consistent with the literature findings (Sue, 1978; Sutton & Broken Nose, 2005; Twenge & Crocker, 2002).

Grief and Loss

The theme of unresolved issue of grief and the countless losses represented some of the client participants' major causes for self-medication. This has been one of the leading struggles causing decompensation with the end result of dropping-out of treatment. It has been indicated in the literature that Western treatment methods were lacking in understanding the extent of the AI/AN pain and tended to ignore the consequences of the emotional distress within the generations (Duran, 2006). This issue was addressed by the participants in this study in terms of the clinicians' inability to speak to the client's cultural beliefs by making them relevant to the presenting situations. As such, client participants' response to the acculturation process was one in which Christian's views of heaven and hell created confusion and fear of damnation when they embrace their cultural and spiritual beliefs. Thus, in trying to understand the complexity of their grief and loss, it was necessary to understand the emotional and spiritual aspects of their daily lives. The literature also pointed out that the losses within the AI/AN communities had more than a negative impact on the development of the emotional health of the families (LaFromboise et al., 2010; Warne & Bane Frizzell, 2014). The losses represented the inheritance of the ancestors while producing unresolved grief in the devastation for countless generations of the past as well as generations in the future

(Evans-Campbell et al., 2012). These researchers believed that the AI/AN culture symbolized one of the most devastating losses impacting the levels of struggles experienced in the current generation and those to come in the future.

Depression, Alcoholism, and Substance Abuse

The major theme throughout the participants' responses implied that the struggles seen in the generations had indeed become the pivotal influence or fulcrum around which all other events in NA lives revolved. Whether they are environmental issues such as transportation, childcare or housing shortages on and off the reservations, these represented factors contributing to struggles with mental health and substance issues. Hence, the longstanding issue of distrust of the majority cultures genocidal attempts has also influenced areas such as academic success, lack of skilled jobs, and the use of those healthcare programs that were available. Therefore, these factors along with the inadequate systems responses to the population's needs represented some of the significant causes influencing the poverty that have existed within the AI/AN population.

Consequently, all of these conditions discussed by the participants have a major impact on the individual's ability to function in work activities to maintain the care of them-selves and love ones (Manson et al. 2005). In the interviews, the client participants addressed their struggles with the diseases and the battle in maintaining sobriety. However, they also shared the struggles they experienced in coming to term with the treatment and finding it difficult relating to some of the clinicians who they felt were not understanding the dilemma of being AI/AN in the larger community. They shared struggles with those who used religious teaching to condemn their behaviors, bringing

about more guilt or anger and driving them back to using substances. They are aware of the vicious cycle and becoming more hopeless and feeling trapped by the devastating health consequences that often occur from long-term experiences with mental illness and substance abuse without the proper treatment (Silver Wolf, Duran, Dulmus, & Manning, 2014). On the other hand the clinician participants acknowledged the huge increase in AI/AN's whose cyclical rotation through the system prevents the maintenance and stability in the community due to the disrepair of the environmental problems that have not been addressed. They emphasized the development of chronic diseases related to the abuse of alcohol and other substance use linked to illnesses such as cirrhosis of the liver, colon, breast, and throat cancers (Baan et al., 2007), as well as pancreatitis (Chick & Kemppainen, 2007). Depression and other forms of mental illness, such as bipolar disorders, denial, agitation, guilt, anxiety, nightmares, stress, and other physically related illnesses, are also indicators that were observed within this group (Duran et al., 2008).

Participants' Personal Beliefs and Worldviews

Personal experiences represent the lessons learned about our world and the coping strategies gained from survival skills needed to navigate each new circumstance in whatever was presented in the environment. They provide the context of what we believe; which allowed for better decisions practices, healthier interaction, and the ability to make more suitable choices in dealing with those around us. Thus, our personal beliefs and worldviews can be the sum total of the day-to-day events of our past and present experiences. Negative experiences abound in our lives, especially when we come from the position of learned personal biases we use to separate ourselves from people who are

unlike us. This creates barriers in dividing our world into "them and us". These are the experiences that marginalized groups have contended with in the majority society.

The personal beliefs and worldviews of the participants in this study are associated with their perception and knowledge of historical and intergenerational trauma over the past 500 years. This is a combination with the experiences of new environmental struggles derived from both internal and external forces that are still creating major difficulties for the AI/AN population. Some of the clinician participants believe that there is a sense of desperation in the clients' effort to bring about changes to their circumstances. This feeling of despondency often compels the individuals to try anything; be it the western or the traditional means that they believe would disperse the pain. Yet, the client participants also acknowledge the struggles of feeling pressed down with the majority cultures teachings that does not support embracing their own cultural and traditional needs. Even though many AI/AN have been acculturated, there is still the feeling that they should be given the opportunity to select remnants from the past and be able to embrace their own heritage as a part of their identity. Many of the participants (both clinicians and clients) believed that this has a central role in maintaining the status quo in the thinking that does not provide solutions to the AI/AN populations problem, but triggers new wounding to the already fragile spirit and scarred emotions of succeeding generations (Evans-Campbell et al., 2012).

Therapeutic Relationship

Personal experiences were given in the interview narrative examples in the previous chapter, in which several participants attributed personal biases from past

negative experiences within the majority culture to be a deep-rooted problem in maintaining a therapeutic relationship for individuals in this population. One client participant shared the obstacles he encountered in working with non-native clinicians from whom he felt discouragement and was not able to find the bonding that the therapeutic relationship offered (Saltzman, Luctgert, Roth, Creaser, & Howard, 1976). Other participants pointed to the issue of trust or the lack thereof, when the centuries of negative interactions as well as the historical factors were examined. Both clinician and client participants noted that the trust had eroded over the centuries and required new evidence of healing that would be carried over into the treatment process.

The therapeutic relationship or the therapeutic alliance is considered one of the primary catalytic ingredients desired in bringing about the needed changes within the treatment process (Awara, & Fasey, 2008; Bartle-Haring, Shannon, Bowers, & Holowacz, 2016). When this was achieved, it provided an essential linkage between the healthcare professional and the client in developing a strong foundation used to achieve the treatment goals and objectives (Bartle-Haring et al., 2016). However, as discussed by the participants and supported by the literature, not all therapists could easily achieve this relationship with their clients. Some of the client reported that this was very hard, because of the longstanding distrust in their relationships. Thus, maintaining the emotional contact necessary to function in a self-differentiated capacity as proposed by Bowen's system theory (Bartle-Haring et al., 2016; Ferrera, 2014) required both clinician and client to develop a bond that closely resembled a family unit that nurtures change and development in a supportive manner (Bartle-Haring et al., 2016).

This was especially true in respect to treatment of the AI/AN clients. In this regard, some of the clinician participants acknowledged that treatment conducted with the AI/NA population required clinicians to have healthy attitudes in this leadership role, in understanding the population's needs, while recognizing their own personal biases, and limitations in their scope of treatment. They recognized that this would allow more productive interchange and would be instrumental in producing greater positive outcome in the treatment process.

However, contrary to the literature findings, clinicians and the clients were often contrasting traditional native belief concepts with the methods of healing practices, limiting the curative process from that perspective (Portman & Garrett, 2006). Thus, both clinician and client participants expressed apprehension concerning the frailty of the therapeutic relationship, which was very rarely achieved in their treatment practices, yet, remained synonymous to the therapeutic relationship. This created a great deal of misunderstanding and prevented the development of the alliance necessary in promoting the essential linkage for healing (Broome & Broome, 2007). The misunderstanding and fears of the past still lingers in the behaviors of the present generations experiencing similar feelings were also evident in the subsequent generations as described by the participants of this study.

Cultural and Spiritual Identity

One's cultural identity is the feeling of belonging to a particular group of people where beliefs, customs, language, foods, and way of life are a celebration endemic to this population. Likewise, spiritual identity symbolizes belonging to a particular spiritual

group in their ways of worship, as seen around the world in the various religious sects or faith practices (Calabrese, 2008). It represents the individual's self-conception, self-perception, and combined knowledge of who they are in their existence in the world around them, and how this has impacted their lives

These values remain vital in identifying who they are as individuals and as a people. When these spiritual and cultural values were stamped out and lost, based on federal proclamations, AI/AN's lost the essence of who they are as individuals and as a people (Duran, 2006; Gone, 2009; McCabe, 2007). One client recalled that when asked the question "who are you?" He was unable to respond, because he did not having an answer to the question. Others expressed confusion that has occurred as a result of the uncertainties that have existed by not belonging or feel accepted to either the majority culture and not having enough knowledge of their own to gain assurances of who they are in the majority world. The clinicians have also looked at the steady increase of AI/AN clients in the system and attributed this to the diminished cultural and spiritual loss that has occurred. Likewise, the increase in both genders within the treatment process, as well as the lowering of ages as seen with the emerging juvenile population, is attributed to the direct result of the loss of their identity in all the generations.

Maladaptive and Adaptive Coping

This theme addresses the AI/AN struggles for survival within an inhospitable environment. Maladaptive behaviors are often associated with the inability to cope with everyday life circumstances, due to excessive stress, anxiety, and fears caused by environmental factors. This includes health issues related to internal and external stimuli,

which tended to complicate the drive towards poorly thought-out solution that would remedy the problems, but exacerbate it further. For example, the client experiencing depression due to health issues derived from substance abuse will continue to self-medicate as a means of coping with the emotional and physical pain they feel. Thus, exposure to maladaptive behaviors has often prevented these individuals from learning positive coping strategies to deal with life's situations in making adjustment by choosing more appropriate methods in handling life stressors.

Many of the clinician and client participants expressed their views on how these maladaptive behaviors have influenced either the progress or the hindrance of the treatment process. Giving examples of how situations were handled with maladaptive measures, until tools were given to cope with the stresses and anxieties that arose in the everyday environment was helpful in relieving fears and helped in making better choices with fewer negative consequences. The clinicians referred to the negative aspect of learned behaviors that some clients engaged in as a coping mechanism for survival; it seemed to numb the relentless pain they were experiencing. The client participants spoke about their methods of coping with life struggles and of the addiction cycle that added to the overwhelming system battles they must face within the larger community. One client explained that the use of substances was the lesser of the two evils in the coping process. This client participant further alluded to the fact that the use of Meth for a number of days was a process of dealing with the pain, which provided the opportunity to be here today to talk about that journey.

However, adaptive behaviors allowed individuals to change a non-constructive or disruptive behavior from causing further negative consequences, while producing more positive personal and social behavior outcomes. Some of the client participants referred to these coping experiences as a form of transcendence on a journey from the darkness into the light, or finding their "higher powers" when they acknowledged their inner strength. This allowed them to use the tools they were given in treatment to change their method of coping; thus, changing their lives in a more positive manner. They spoke about the positive feelings they experienced as being small but powerful accomplishments. In this regard, adaptive behaviors are used to adjust another type of behavior in any given situations that would be more appropriate; such as exercising or as one client stated finding money to buy gas to go to counseling or an AA meeting, instead of buying alcohol or drugs (Warne & Bane Frizzell, 2015).

Defensive and Ambivalent Behaviors

This theme represented the participants' own biases, cultural values, their knowledge base, and level of familiarity with the AI/AN culture, as well as the norms and mores of working with this client population. Both groups of participants addressed the misuse of psychological jargons to label clients who were either unwilling to discuss issues such as death and dying in grief counseling. The clients discussed the stigma experienced when they associated with their traditional identity, due to the cultural taboo it conjured up that was quite prevalent in the treatment of the AI/AN population. Some clients were also not comfortable to discuss their feelings with non-native clinicians, based on their perception, experience, and feeling that an outsider (none-native) would

not understand them. Several participants explained that their reactions were highly individualized based on their individual level of acculturation and the belief systems that were in practice. Some AI/AN are fully immersed in what little cultural practices have remained. Yet, there are individuals who are at the opposite spectrum in their observance, and still others who use both traditional and western practice in order to survive in a foreign environment. Nonetheless, there are client participants who are quick to point out that "we are feeling pressed down by the Whiteman's teaching" and are not trusting of their own systems. Hence, this could account for part of the ambivalence that was noted in the earlier discussions.

However, those clients not wanting to address issues that are culturally sensitive like death and dying; should not be perceived as being defensive, but understood as a cultural practice to be respected and valued. The terms defensive and ambivalent used as a nonproductive labeling tactic was seen as blaming the victims for a poor outcome having to do with the clinician's treatment experiences and limitations of an inadequate skillset for working with this particular population. This was noted by one AI/AN clinician, who reportedly had to educate non-Native clinicians about the cultural practices in defense of the clients.

Finding other ways of addressing these sensitive issues in the treatment process requires specific skills of the clinician as well as the need to go beyond their biases in dealing with the client. Becoming defensive would further hurt the therapeutic relationship and prevent healing for the client. Calabrese (2008) and McCabe (2007) alluded to the defensive mode clinicians find themselves in when suppressed issues

handed down from past generations resurface in the treatment process as repressed biases.

Family and System Dysfunction

This theme of the dysfunctions or what was considered the lack of normalcy within the AI/AN family systems were addressed from both the clinicians' and the clients' personal perspectives. They all recognized that dysfunction resulted from the increased use of alcohol and substances abuse as well as the more frequent contacts with the court and penal systems. Nonetheless, some of the participants also attributed these system dysfunctions to the unresolved issues of grief that had become one of the foremost struggles for the AI/AN communities. The participants recognized that whether the struggles were with substances or grief, the issues were always interrelated: causing the loss of hope, decompensating, dropping-out of treatment, and having the client end up in the prison system, once again in a vicious cycle that take them away from their families and causing them to abandon their children.

Many of the participants indicated that for some families, the issues like substance use, abandonment, loss of identity, or giving up, were learnt behaviors handed down from one generation to the next. These learned behaviors occurred over the centuries of oppressive teachings that did not invite cultural way of life, which took responsibility for the growth, development, and wellbeing of its people. Some also felt that the lack of exposure to anything other than what existed in the past, were the manner in which problems were solved. Several of the client participants shared the information that parents, grandparents, siblings, and extended family members for generations have been

alcoholics and substance abusers, who were involved in the penal system simultaneously or one after the other. Consequently, the clinician participants' experiences were also that of working with the accumulation of consecutive generations having gone through the treatment process together and/or in cycles of entry and exits from the prison system and into treatment. The clinician participants acknowledge these cyclical behaviors not only as mandated act by the courts, but also represented acts of desperation on the part of the AI/AN clients. They recognized that clients were losing hope and wanted to try anything that would bring about the changes necessary for survival. This is in wake of all the uncertainties in their lives, which might indirectly address the immediate environmental problems that they have yet to deal with upon reentry into the larger community that has yet to change.

Dysfunction has resulted in situations when parents are locked up in jail or on drinking binges outside of the home: the losses or disruption that occurred with both parents and children are innumerable in such situations. The clinician participants discussed events in which children were taken from the home due to neglect and sent to placement where other types of abuse occurred. Some of the client participants discussed those instances when parents were incarcerated, and they as children were sent to correctional facilities due to conduct behaviors, or placed into the Foster Care system. They felt that this had a major impact on their developing more deviant behaviors, and worsening the problems. They were often shuffled from one foster home to the next, deepening the issues of abandonment and fears for the child who is experiencing

displacement and added to a greater feeling of powerlessness about their being able to change their circumstances then and later on in life.

Studies conducted on the AI/AN population have indicated that when removals occurred, it became evident that the spiritual and cultural values learned by young children as well as the parenting skills they later imitate in their interaction with the adults are usually lost (Evans-Campbell, 2006). Other studies indicated that the learning difficulties of children born to parents with alcohol and substance abuse issues, and who are in the educational system were presented with major delays in the early elementary years, producing very high dropout rates in later academic settings (McLeigh, 2010; Monture, 1989). In their research, LaFromboise (1988) and Powell (1880) spoke to other areas of struggles that were evident in the elementary schools. This includes children who struggled with learning from the majorities' culture's concept which often goes against the traditional methods of teaching. The literature pointed out that these struggles goes hand in hand with the lack of success they experienced, which placed them on the road for early experimentation with alcohol and other substances, developing later into teenage pregnancy, gang related problems, later incarceration, and health issues (Carter, 2011). In his study of the problems, Berlin (1987) referred to these factors as the disruption or displacement from the traditional ways of living, which when compounded by forced assimilation for survival, often led to feelings of hopelessness within the AI/AN population (Neiderland, 1981). All of these issues of the family and system dysfunctions were supported by the participants' personal experiences in course of removal or displacement within these organizations; these are consistent with the unresolved grief

that represents, some of the major causes for self-medication and the systemic cycles seen in the AI/AN population.

Western and Traditional Treatment Practices

This theme addressed the participants' views about Western and Traditional healing practices and some of the struggles within the systems contributing to the problems with service delivery. From the clinicians' perspective, the western methods represented both the medical and educational values through which they have attained their training, knowledge, use of clinical skills, and experiences. In their discussions the clinician participants shared some of the difficulties in providing services to AI/AN population. They alluded to the power position in the medical model, which tended to place the clients on a different level or in an inferior position from the professionals. The clinicians felt that they had to remain vigilant and work constantly to eliminate this aspect of their work.

Alternatively, the traditional model represented centuries of knowledge in the healing arts from a natural and holistic perspective that addressed the health needs of the AI/AN people. Some of the participants discussed the fact that western and the traditional concepts of healing were not always in alignment and often times clashes or ineffective in meeting the patient's needs; as seen in the struggles to treat the culturally diversed individuals with mental health, physical health, and substance abuse healthcare issues (Awara & Fasey, 2008; Calabrese, 2008).

The AI/AN population favored the traditional methods of healing, not only because of the cultural significance, the familiarity with its' outcomes, and trust issues

with the majority culture; but also due to the fact the cultural healing practices were

slowly eroding away and needed to be preserved. However, over the centuries of the

acculturation and assimilation process, the majority of the AI/AN population had moved

closer to the western healing practices and has since embraced more of the western

method of treatment. From this perspective, both the western and traditional practices had

become two viable means of treatment options. Consequently, the probation system had

two choices to make referrals: one strictly to the Western or to the treatment programs

that offers both. Providing an alternative to those clients who still hold onto the cultural

values of their healing practices is important to be considered. Yet, the participants'

spoke to the fact that many clients use was based on a number of factors like: cost,

availability, or appropriateness in terms of emergency situations. It even depended on

whether they thought the traditional or Western medicine were or were not working, they

were inclined to use, based on their needs. Thus, from the client participant's perspectives

both the western and traditional practices have become viable means of treating illnesses.

Nonetheless, there were mixed feelings among the client participants who reported that,

even though they had incorporated the traditional and western medicine into their service

use, they still held fast to the cultural and traditional values that the traditional treatment

offered. The service usage depicted above in the two clinics was corroborated by the

literature (David, 1992; Gone & Alcantara, 2007).

The Issue of Treatment Noncompliance

This theme focused on the participants' attitude and perception in handling

aspects of treatment noncompliance. The individuals' personal experiences colored the

pallet and play a major role in their perception of the world around them. Both the clinician and client participants experienced negative feedback about the concern of noncompliance. The clinician participants spoke to the issue of communication as a major factor for noncompliance in this population and this issue was attributed to the AI/AN client's perception of the larger community. However, some clinician participants also pointed to areas such as economic or financial problems that existed, childcare and transportation issues, or even weather conditions that are uncontrollable factors to contend with, especially when they live in isolated areas.

Thus, when compared to the traditional model, the Western treatment model is often criticized for providing segmented treatment that was noninclusive of the patients' families as well as the community's need. This send the wrong message to the people many of the clients reacted by retreating from services. On the other hand the client participants reported that treatment noncompliance hinged not only on communication and treatment factors but also on a multitude of dynamics such as cultural sensitivity to their needs and the responsiveness to their requests; health and trust issues, feelings and perception of the clinicians and the larger communities view towards the AI/AN population. The negative experiences of the past that has not been dealt with, coupled with the added stress to conform and comply with required systems pressure to maintain sobriety can be overwhelming (Duran, 2006; Lowe, Liang, Riggs, & Henson, 2012).

Confusion, Shame, and Embarrassment

The themes derived from the participants' responses described the mindset of some of the AI/AN people as a result of the past 500 years. This mindset represents the

emotional feelings such as feeling of failure, mingled with anger, over the continued oppressive systems of the majority group. Some of the client participants were able to express the confusion, shame, and embarrassment they felt in trying to deal with the stigma associated to their own personal losses of not being able to identify with the cultural aspects of who they are as Natives; losses of family members and friends to the diseases within the community and the greater shame of the losses of their cultural and spiritual identity of being AI/AN. Thus, the sense of confusion, shame, and embarrassment have led to a feeling of hopelessness in which they express the sentiment of feeling trapped with no real solutions to make the needed changes to their current circumstances.

Clinician participants struggled with the need to recognize the effects of intergenerational trauma and the enormity of their clients' pain can empathize, but feel limited in their attempt to change the situations that are outside of the treatment room, having to deal more with larger environmental issues. In this regard, the literature has shown that the western treatment approaches have done very little to address the pains of the emotional emasculation these experiences have presented for the AI/AN people (Duran, 2006; Fouad & Arredondo, 2007). As a result of these feelings, many of the researchers have acknowledged that the AI/AN population has developed very deep emotional scarring in trying to deal with unresolved trauma of the past and the profound consequence this has on future generations (Calabrese, 2008; Whitbeck, 2006).

Emotional Reactions

This theme dealt with the negative consequences that resulted from the traumatic events that produced physical, emotional, and or psychological sequelae in the lives of the individual's experiencing these events. The participants of both groups discussed those events that produced the aftereffects of their illnesses such as mood swings, depression, and anxiety. The participants acknowledged that these psychological symptoms are often warning signs that are ignored or medicated with alcohol and other substances to dull the pain or diminished other indicators that may be present. The clinician participants also noted that the clients' self-concepts, or perception of how they evaluate themselves are usually quite reduced along with impairment in their personal development (Silove, 1996). It was also recognized that individuals subjected to trauma experience numerous symptoms not limited to dissociation, fear, repression, somatization, helplessness, and depression (Gorman, 2001). In their research study, Duran et al., (2008) determined that due to the early onset of traumatic events in combination with the self-medication process, AI/AN individual are often seen as emotionally stunted. The literature also confirmed the findings that chronic or severe trauma caused individuals to experience powerlessness about being able to change their life circumstances (Kendall-Tackett, 2009).

Abandonment Issues

This theme discussed some of the developed childrearing practices in the AI/AN communities since the boarding school era. The participants examined the practice then, and the ones used today, of placing AI/AN children in the foster care system, along with

the misperception and confusion that might have caused in the lives of the children and their families. Some of the client participants reported that their parents and grandparents were victims of both the boarding school and the foster care systems. The clinician participants also pointed to the role that alcohol and substance use played in the issue of abandonment of the children and the families. Parents leave home to binge drink or when they are imprisoned for months or years at a time, abandoning their children. Both participant groups struggled and some were even angered by what this behavior represented for the affected children, themselves, and the weakening of an already depleted community. What began as the forced acculturation process, which removed the children from their homes and traditional communities; placing them in shelter systems, where their language, culture, and way of life were strategically stripped away through various forms of punishment, later developed into a nightmare of abandonment practices for many of the families in later years (Pinel, 2006; Subia-Bigfoot, & Schmidt, 2010; Swinomish Tribal Mental Health Project, 2002; Warne & Bane Frizzell, 2015).

Anger, Depression, and Stages of Recovery

The participants in this study expressed in their own way different feelings and concerns that were discussed or dealt with in the treatment process and within their own groups. Feelings of anger, disappointment, desperation, frustration, helplessness, anxiety, and depression were some of the terms that frequently occurred the discussions. These feelings were also symbolic of this population's take on the climate of the AI/AN communities across the country. All of the client participants connected intergenerational struggles to the very harsh realities that have surrounded the lives of the AI/AN people.

Likewise, the clinician participants acknowledged the presences of the client's struggles within the treatment process and those that were associated with external conditions in the communities. Similarly, the client participants described some of the personal experiences they had in dealing with the everyday struggles to exist within the various systems they must navigate to survive in the majority culture. Community-based studies have suggested that the prevalence of psychiatric disorders, especially mood and substance use disorders are especially high in the AI/AN communities (Duran et al., 2008; Gone, 2004; Rapaport, 1977).

Nonetheless, there were some glimmers of hope embedded within the harsh realities that were presented. There have been significant changes occurring as a result of the treatment procedures that were in place. Though few in numbers, these changes represent some of the positive movement in a very small segment of the AI/AN population. Their individual efforts to make changes in their life circumstances have resulted in maintaining sobriety longer (i.e., five and twelve years), though not always permanently, again due to the ever-present environmental factors that produced undue stress in coping with their circumstances. Yet, changes are occurring in very small pockets of the client populations. These changes are reportedly coming about as a result of the shift in the client's mindset of the events happening around them. However, abstinence can only be continued when the presenting environmental influences are in accord with the disease state of the mind and the body.

Limitations of the Study

The goal of this phenomenological study was to understand how attitude and personal beliefs of both clients and clinicians have affected the therapeutic relationship and the impact this had on the compliance process in treating this population. It is important to note that one of the many positive aspects of the qualitative study is that the research takes place within a natural setting as seen in the home or clinic environment. This placement in a natural setting would have allowed the researcher, through observation and discussions, to build rapport while obtaining relevant information about the participants' behavior and lived experiences with the least amount of interruptions to the setting (Creswell, 2003). However, this was not possible due to issues of confidentiality. The interviews of the participants took place in a private room at the local library, which was not the natural setting for these individuals. This allowed the participants to remain anonymous to the other staff members as well as the total client population. These aspects of the process presented a further restriction over which I had no control.

The use of participants from only two distinctive clinic settings in this southwestern community was also nonrepresentational of the Native American tribes and the clinicians across the United States. This was partially due to the lack of resources and time constraints in completing this study. Therefore, this factor presented as a limitation in the interpretation and drawing of conclusions in the impact and its application to all treatment situations that may exist across the country. The purposive testing method also decreased the generalizability of the findings to all AI/AN mental health and substance

abuse treatment situations; consequently, the findings could be subjected to other interpretations than those presented here (Castetter & Heisler, 1977; Creswell, 2003). Nonetheless, the findings maybe transferable to other health treatment issues, as well as to other geographic location and minority groups across the country (Marshal & Rossman, 2006). The findings maybe useful to other situations that presents with similar research questions having to do with other marginalized groups experiencing similar conditions arising from similar struggles.

Social Change Implications

Many marginalized groups have experienced similar struggles throughout history in their fight for survival in a seemingly harsh socioeconomic climate, when successes in the majority culture's systems are measured by the combination of education, income and occupation. Even with these advantages, fairness, justice, and humanity are afforded only to some and those who are ill prepared experience major struggles in their existence. In addressing issues specific to the AI/AN dilemma, I have taken a look at the AI/AN individuals' struggle with intergenerational trauma and their use of maladaptive and adaptive measures to address those problems. In addition, I have examined the clients' struggles with substance use, their interaction with the penal system, the losses experienced, and the individual as well as the collective pains they have struggled with over the centuries. I have also looked at the developments of the negative impact and the impending increase in the numbers of AI/AN that will be in the system by 2050, if changes are not made (U.S. Census Bureau, 2010).

The positive social change implications from this study would be the reduction of the stigma associated with mental health and substance abuse issues in this population. This would include the education of the general public, health care providers, and training the health communities; in the specifics of the AI/AN needs, which represents a necessary component for social change. More education is needed in the larger legal and health systems as well as the governmental bodies in order to enact environmental changes that are vital to this process. Changes brought about through the education of the public, community members, and families, could help with the reduction in the number of AI/AN individuals who continue to struggle with these diseases across the generations. For the individual, this would also reduce the negative impact associated with the feeling of isolation caused by these illnesses and would help to engage the controlling systems that provide not only the consequences for their actions, but also the rehabilitation and health care services for change. It would help to empower individuals and provide the current family members a greater chance to change the course of their own health histories now and in future generations. This would include a larger number of AI/AN individuals who can maintain a greater degree of success in their experiences with sobriety and eliminating other health related sequelae.

The experiences within the penal and court systems have also added to the struggles with alcohol and substance use, which in turn have increased the number of negative contact to the already strained relationship within the majority group's culture. However, these issues are multifaceted and issues such as the existence of poverty and other forms of social inequality, environmental issues such as housing shortages,

transportation issues, lack of job training, and jobs to support economic viability within the majority community; represented larger issues that were not fully explored or briefly touched upon throughout this study. They need to be tackled simultaneously with the issues of treatment and sobriety; due to the major impacted they have on the AI/AN communities and the changes that will make the greatest difference.

The knowledge gathered from this study could provide developing clinicians still in the academic settings as well as those clinicians already in the field a wider foundation of the struggles that affects the AI/AN population. Those clinicians already in the field experiencing difficulty in developing the therapeutic bond with this population could cultivate a trusting relationship with the client in the development of a greater degree of empathy or sensitivity to the AI/AN cultural thinking. This could help in dealing with the cultural taboos, through the use of cultural or psychoanalytic tools in the treatment process, while addressing the addiction and the other mental health issues. Consequently, greater consideration could be given to skillsets such as listening and hearing the immediacy of the client's needs and concerns.

While the overall therapeutic goals for the clinician and the client may present as being similar, they may have differences in order of urgency for both of them. For example, the generalized goal for both the clinician and the client, maybe to decrease the issues of depression and substance use. However, the clinician's timetable may not be aligned with the client's because of factors that may be outside of the clients control, such as going back into the same home environment, which was the cause of the problem and has not changed. Therefore, the client would be back inside the court system in a matter

of weeks, not giving the treatment process a chance to take hold and thus, represented a major cause for the cyclical movement in the system.

Information gained from this dissertation could also inform training for clinicians and other staff members on the importance of developing a wider knowledge base, experiences, and greater proficiency in working with acculturation and assimilation issues in the AI/AN population. Clinicians cognizant of other aspects of their client's struggles, in dealing with systems and other environmental factors, could offer support to clients preferring the traditional verses the western healing methods. Cultural identity issues seen with both the younger and older generations could be addressed in the therapeutic process to tackle the confusion and shame that abounds. The understanding gained from this study could also inform and assist in the struggles within the treatment relationship, building on the trust issues, and bring about the healing within the AI/AN and the larger community perception of each other. The insight and significant gains that were achieved through the two Southwestern clinics were strong indicators that other changes, could be forthcoming and could have a major impact on the outcome of future generations.

The implication of this study is also the realization that changes starts with us and can make the difference in how we live our lives, which has a major impact on our families and the communities in which we live. Agents of change represent very powerful tools in our systems. They symbolize an important step in the direction of societal growth towards equitable treatment to all segments of society, because of the interconnectedness in our technologically advanced society. In that regard, our communities are viewed as

the macrocosm of the human societal system in which survival is paramount for each group of individuals as a whole in the existence of the human family. When any segment of society ceases to function in a healthy viable manner, this affects the survival of the entire system. Struggles within the AI/AN population in the U.S. represents just such a system that produces a debilitating effect that left untreated will lead to our demise.

In her study on personal power, Stratman (1990) indicated that personal power has both an individual and societal implications in the area of human development in bringing about necessary changes. Stratman pointed to the fact that all life experiences are colored by our personal powers, which enables us to initiate and implement changes in our given circumstances that helps us to take charge of our own lives. Clients within the treatment programs are on their way to regaining their personal powers, through a better understanding of how the self-medication process have impacted their lives in an attempt to alleviate the emotional pain. The clients have experienced not only the negative effects of substance use, but have now obtained skills to practice and achieve sobriety even though short lived at times, due to personal and system wide struggles. These struggles could once again produce intermittent jail time, job loss, or support systems that are added to the mix of events in their lives. In this respect disseminating the results of this study in presentations to the clients, family members, and to other community members would help to empower each group to be apart of the needed change. These findings will also be published and other presentation made upon request.

Recommendations for Action

All behaviors good or bad are learned. Therefore, behaviors like self-medication, fear, or violence can be understood as part of an arsenal of survival mechanisms in a seemingly hostile environment (Rife, 2009). This study as well as other researches has shown that the majority of individuals using or abusing substances in the AI/AN communities have encountered similar events in their lives in which they use substances as a method of coping with the pain they experience, as a result of their emotional and physical circumstances. It was also revealed that the developmental years are the most vulnerable stages, when young children learn by watching family members, peers, and other individuals in the community participating in these negative behaviors and later practice them. Therefore, different methods of addressing the issues of substance use are needed to tackle the problems in the communities as well as in the individual's home. Thus, presentations in various settings and age appropriate levels would be important in disseminating this information to the communities.

Consequently, clinicians and clients could develop a better understanding of the role they play in the delivery and utilization of services in order to have more productive outcomes. It is therefore paramount to have prevention that is not only holistic in nature, but also sensitive to the AI/AN history in their cultural interactions, while dealing with the majority culture's concerns and their issues with alcohol and substance abuse. In addition, these other dynamics of the treatment process are not only vital to these procedures, but also required as a means for survival, despite all the limitations that has being presented. Though this may seem to be a monumental task for both, yet it is not

impossible because all the barriers and issues that have hindered progress can be dealt with in an open forum. Bringing about restoration and development that is needed to move forward in the larger communities. The first course of action would be to engage in community education, perhaps even using the media to publicize the problem, taking away the stigma that is attached to the issue. Have an open community forum as a means of further informing individuals, families, agencies, and other community support systems of how they see the problem and how best it could be addressed that best serve the collective. Next step is to set up a meeting time where various governmental agencies such as the courts, prisons, probation, tribal officers of the various groups, chapter house leaders, the police, and sheriff departments as well as representatives of the client population, various organizations like shelters, and treatment facilities; to be invited to participate in the discussions. To accomplish this goal and bring about the necessary changes, most if not all the players must be a part of the discussion by inviting all the players of the community together at the same table

Recommendations for Future Study

Further investigation through a phenomenological lens should be carried out to determine whether the increase in numbers seen in two Southwestern clinics of AI/AN is a factor occurring in other parts of the country. It is not clear whether the rise seen in the adolescent population in one of the two clinics is occurring in other communities. It is also not clear whether the rise in this population is due to proactive measures of early detection or because of the impending population increase noted in the 2010 U.S. Census. The clinician participants of both clinics in this study noted the sharp increase in numbers

in the AI/AN adult population. This was illustrated in the clinicians' discussions that two

years ago the makeup of the total clinic population was 50/50 (50% AI/AN and 50%

other), which has now risen to 70/30 (70% AI/AN and 30% other); a 20% increase in the

NA client population. One clinic in question has moved twice for lack of space and is in

the process of moving a third time. The second clinic constructed two additional

buildings to accommodate and house clients in additional types of treatment methods that

were required. It would be important to examine these changes state wide as well as

nationwide to study the effectiveness of the current treatment and systems interventions.

This state and national focus can include the effectiveness of the western treatment

programs, the combination of the western and traditional, and the purely traditional

approaches based on the individual's assimilation, acculturation, and their personal

beliefs and preferences in the different communities across the country.

In addition, it would be important to examine areas of this study that were outside

the purview of this investigation that were of major concern for all the participants. These

issues have influenced the changes throughout the generational struggles and

traumatization of the AI/AN population. These areas of concerns were:

- Family and System Dysfunctions: The loss of the caregiving responsibilities

  of children left behind in the adoption and foster care system, or left behind

  with family members. The rise in teenage substance use while parents are

  incarcerated at the same time that they or other family members were also

  going through these systems; would also provide some answers to the

  intergenerational problems that still needs to be addressed.

- Confusion, Shame, Embarrassment, and Anger: The indiscriminate assignment of the governing bodies in the assimilation and acculturation practices to religious groups have had a major impact on the current state of being for the AI/AN population.

- Issues of Abandonment and Loss: These issues are viewed from the perspective of the younger and older generations who have difficulty identifying with either the traditional or majority cultures views or both.

Because mental illness, alcohol, and substance abuse are common community issues nation wide, contact with organizations within the AI/AN communities to complete the interviews questions online would provide a larger participant pool and give a different perspective on the specific issues for the geographic areas. These proposed research studies would require more direct contact with personnel in these organizations in order to provide the volunteers computer access to a website that would provide detailed questionnaires from the various communities.

The Researcher's Experience

As a novice researcher, I lacked the experience of conducting a qualitative study. However, having worked with specialized populations my entire professional career as a therapist gave me some exposure to the interviewing process and the ethical issues that were presented in working with the AI/AN population. Therefore, I took precautionary measures throughout the entire process to safeguard the participants during the data gathering process, as well as following the ethical guidelines in maintaining confidentiality throughout the development of the dissertation procedure. To ensure that

my personal biases were not integrated into the process, I bracketed my own experiences and focused solely on the topic, the questions, the presented problems, and the participant's responses (Moustakas, 1994); by paying greater attention to ensure that the process was not affected. When asked by the participants why I was doing the study, I was very candid in my responses. My explanation addressed my personal experiences working and living in the community and the concerns that were evident. I then asked if it presented a problem and was told no; they only wished more was being done to help.

Throughout the procedures, I made the concerted effort of observing very closely each participant's body language, verbal, and nonverbal cues, in order to be mindful of their emotional state and the impact that the process might have on them. The use of the open-ended question format, allowed me greater active participation in this segment of the interview process, which required the reviewing of the consent forms and demographic questionnaire, and answering any additional questions of each individuals in the respective groups (Postholm & Madsen, 2006). Even though the interviews were recorded, I took notes on what I observed, after the interview and during the transcription process to ensure that I did not forget nonverbal cues that could not be captured on the recorder. I also made notations on how I was impacted by the participant's response as well as my understanding of their stated concerns. There were differences in each of the participants' responses. Those who were accustomed to talking in public had much to say about their experiences. However, those individuals for whom it was their first time and were not accustomed to this format needed prompting or further probing until they forgot about the recorder and spoke freely of their experiences.

Due to the length of the interviews and the very large amount of data that I obtained, the transcription phase was very long and tiresome. I had to rewind the recording to make sure I understood a great deal of the recording and later confirming by phone, because the confidentiality issues precluded the home addresses of the participants. Therefore, I had to listen to what was said when the audio was not quite clear and get clarification by phone. However, I was fortunate to have only one recording that was not quite clear, but was also able to clarify its meaning by the phone calls.

As a non-Native individual, I have lived and worked for the past 20 years on one of the reservations in the southwestern area of the country as a mental health therapist. And even though I have interacted with many of the AI/AN in the community, I am still considered as an outsider. As a Black female of West Indian heritage, I have been stripped of my own cultural identity and can identify with many aspects of the AI/AN cultural experiences. I have not actually experienced the same type of confinement endured over the centuries as the AI/ANs or have been subjected to some of the horrors that untold generations have faced. However, I have experienced some of the same colonial practices of assimilation and acculturation that is very much a part of the AI/AN culture. Consequently, this research has offered me the opportunity to learn more of the AI/AN struggle in righting their circumstances in history, by strengthening the weaker links in the chain of lives lost to despair and the hemorrhaging of young souls that have succumbed to the relentless system where fear triumph.

Conclusion

This study has shown that intergenerational struggle has a major influence on the quality of life for the AI/AN population. There were conclusive indicators that the health and mental health issues, including the past and current economic crises within the AI/AN communities, were brought about as a result of the colonialization process. In order to adapt to healthier behaviors and reduce stressful situations due to environmental conditions, changes must be foremost in the future plans for this population. However, there are relatively few studies that have addressed the phenomenon of intergenerational struggles that pertained to perception and attitude of the health concerns in the AI/AN population, which makes this study fairly unique in its objectives.

While other studies have revealed that intergenerational struggles existed in various forms in the AI/AN communities, this study attempted to corroborate those findings by examining the roles of the individual stake holders to the extent of how the systems that are in place attempts to maintain the status quo, without bringing about any substantial changes in its wake. This investigation also suggested that the educational treatment programs must provide better tools for clinicians in working with minority population, and greater care should be taken to educate and prepare more NA clinicians who are culturally sensitive to those individuals in need of care. Competent individuals, taking care of their own were the emphasis in the discussions. It was evident that even though there are many positives achieved on the road to recovery: Such as increased self-confidence, living substance free for months and even years; movement from homelessness into temporary and permanent living accommodations; and even

graduating from college programs; it still remains that there was much more to be done to help in effectuating and maintaining these positive changes; because the numbers that achieve these positive movements and cheat death are fewer than the countless individuals who remain incarcerated and die prematurely each year. One such glaring evidence can be seen in the return from incarceration and treatment to the same environmental conditions that perpetuate conditions such as poverty, poor educational experiences, and the lack of success in obtaining skilled jobs to improve their economic circumstances.

It was also demonstrated that treatment and counseling services are invaluable in the prevention and the retardation of these illnesses, and are making inroad with the healing processes. Nonetheless, it is not enough to spend millions of dollars to treat and send those individuals back into the environment and life circumstances, which was the cause of their illnesses. Many of the problems that existed would require all systems, including the larger governmental bodies within the majority culture to support the changes that are necessary. This would include organizations such as the healthcare system, court, legal, and law enforcement bodies, penal, drug, and alcohol facilities that are all part of the legal administrative procedures, and the treatment process in order to bring about the needed changes.

Healthy minds and bodies can be a source of revenue for any community. Learning coping strategies will provide the tools to deal with stressful events in any environment within a leveled playing field. In this respect the plight of future generations of the AI/AN's health and mental health consequences can be reduced substantially and

hopefully eliminated. The insights gained as a result of this study have an enormous

impact on the application of intergenerational struggle in the mix of service provision and

utilization from both the personal, professional, and on the societal level (Moustakas,

1994).

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YOU ARE INVITED TO JOIN IN A RESEARCH STUDY

FOR

NATIVE AMERICAN CLIENTS AND THERAPISTS

IN

The Counseling Relationship

Purpose: To look at the beliefs and thoughts of clients and therapists who receive and provide mental health services

Participants: Counselors must be 25 or older, providing mental health services and clients must be 25 or older, receiving mental health or substance counseling, living on or off the reservation.

If interested, please call and we can set up a time to meet to do the interview.

Beverly Johnson

Gift Card

YOUR HELP IS GREATLY NEEDED AND APPRECIATED!

Appendix B: Interview Questions

Clinicians

The questions asked of the Clinicians are:

1. Do you believe that your educational training prepared you to work with Native American (NA) clients and if so, in what way did they prepare you?

2. How have your educational and professional training impacted the therapeutic relationship with NA clients?

3. Based on your personal experiences, what do you think is the primary reasons NA clients seek services, (follow up probe, FUP) and what do you think are the main causes for their distress? (What brings them to therapy/counseling?)

4. How do you respond when your client's don't follow the recommend treatment? FUP: What do you think "non compliance" is related to? 2nd probe: Do you assume/think the reason for the non-compliance is different for Native American clients?

5. In general, is there anything else about treatment that I have not asked that you would like to share?

Appendix B: Interview Questions

Clients

The questions asked of the clients are:

1. What has it been like receiving treatment with a therapist as a Native American (NA) client?

2. Has the fact that you are NA come up in therapy? (Follow up probe, FUP) If it has, does your therapist understand what it means and how being a NA affects who you are?

3. Do you think that the way NA's have been treated over the past 500 years affects how they function (are doing) today?

3a. How do you think your cultural and spiritual identity relates to what is happening to you?

4. How do you respond when your therapist recommends treatment? (FUP): What do you do when you don't agree with what the therapists recommends?

5. In general, is there anything else that you would like to share about treatment that I have not asked?

Appendix C

<u>CLINICIAN DEMOGRAPHIC QUESTIONNAIRE</u>

Thank you for taking the time to participate in this study. Please answer each question honestly and to the best of your ability. Please fill in the appropriate responses where necessary and circle or check off the answer that fits best.

1.   Gender:

- Male
- Female

2.   What is your age? _____

3.   Circle or mark the race/ethnicity you identify with.

- American Indian/Alaskan Native
- Black/African American
- Hispanic/Latino
- White/Caucasian
- Other (specify) _____

4.   Do you speak English and Navajo?

- English Only
- Both English and Navajo
- Other languages (Specify) _____

5.   Highest level of education:

- GED
- High school
- Some college
- College graduate
- Post graduate studies (Masters)
- Post graduate degree (Doctorate)

6.   Household income:

- Less than 10,000
- 10,000-30,000
- 31,000-50,000
- 51,000-70,000
- 71-000-100,000
- Greater than 100,000

7.   How long have you been a mental health clinician? _____ Years

8.   How long have you worked at this clinic? _____

9.   What is your clinical function with the patients?
_____

10.   Circle or check off the best response that represents your Service Delivery Experience

- Clients attend regular scheduled mental health & substance use appointments
- Clients rarely attend mental health & substance use appointments
- Clients attend mental health & substance use service appointments mainly on a crisis basis.
- Other service experiences (Specify)_____

Appendix C

<u>CLIENT DEMOGRAPHIC QUESTIONNAIRE</u>

Thank you for taking time to participate in this study. Please answer each question honestly and to the best of your ability. Please fill in the appropriate responses where necessary and circle or check off the answer that fits best.

1. Gender:

   - Male
   - Female

2. What is your age? _____

3. Circle or mark the race/ethnicity you identify with.

   - American Indian/Alaskan Native
   - Black/African American
   - Hispanic/Latino
   - White/Caucasian
   - Other (specify) _____

4. Do you speak English and Navajo?

   - Navajo Only
   - English Only
   - Both English and Navajo
   - Other languages (specify)_____

5. Highest level of education:

   - GED
   - High school
   - Some college
   - College graduate
   - Post graduate studies
   - Post graduate degree

6.   Household income:

- Less than 10,000
- 10,000-30,000
- 31,000-50,000
- 51,000-70,000
- 71-000-100,000
- Greater than 100,000

7.   How long have you been a patient receiving mental health services from this clinic or other facilities_____?

8.   Circle or check off the best response that represents your Treatment Experience

- I attend regular scheduled mental health counseling/treatment
- I seldom attend scheduled mental health counseling
- I have never attended or received mental health counseling before this
- Other treatment experiences (Specify)_____

9.   Number of visits (sessions attended) to the mental health clinic? _____

10. What is your mental illness or substance use diagnosis and are you dually diagnosed? (More than one diagnosis) _____

Appendix F: NIH Research Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Beverly Johnson** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 04/07/2012

Certification Number: 898572

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Beverly Johnson** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 01/15/2017

Certification Number: 2265329

Appendix G: IRB Approval

Walden University's approval number for this study is 05-01-15-0108264 and it expires

on April 30, 2016