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Change and Recovery from Substance Misuse: Native American Perspectives

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CHANGE AND RECOVERY FROM SUBSTANCE MISUSE:

NATIVE AMERICAN PERSPECTIVES

by

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Recovery from Substance Misuse: Native American Perspectives

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This qualitative study investigated the constructs of change within the action and maintenance stages of the Transtheoretical Model of Change (TMC) and balance within the domains of the Medicine Wheel (MW). The guiding questions addressed: a) point of focus in sobriety and recovery phases within the domains of the MW, b) specific mechanisms at work, c) support systems, tools, temptations, motivating factors, maintenance, gains, losses, and personal reasons for change, d) spiritual component, e) connection between tribal culture and recovery, and f) distinction between sobriety and recovery.

Eight adult Native Americans in sobriety or recovery for a minimum of 3 years participated. Participants completed a demographic questionnaire and 3 quantitative measurement checks (Native American Acculturation Scale, Garret & Pichette, 2000 revised by Trahan, 2004; Decisional Balance Scale, Maddock, 1997; and the Self-Efficacy Scale, Maddock, 1997). A semi-structured interview format was utilized and interviews were audio-taped. A team of 6 multi-ethnic research assistants transcribed, checked the transcriptions for accuracy, and analyzed the interviews under the guidance of the lead researcher. The participants' responses were analyzed and coded using a Grounded Theory strategy. The scores/findings from the measurement checks were calculated; the majority of participants indicated bicultural behaviors and scored in the expected ranges within the maintenance stage of change.

Both models are applicable with this sample. The MW revealed the process of searching for balance and the TMC showed the process of utilizing the medicine within the MW in order to create change. Strategies that emerged were the utilization of medicine and shifting perspectives. Experiencing a spiritual moment, recollection of the reason one quit drinking alcohol, examination of self and others, and reinforcement were shifts in perspectives that required the utilization of medicine. These led to motivation, balance and new behaviors. A new theoretical model for change and recovery from alcohol misuse emerged; sobriety was described as an event and recovery as a process. When combining the conceptual frameworks of the Medicine Wheel and the TMC, specific mechanisms of change were revealed. The findings may offer clients and therapists a new conceptual framework to facilitate balance and change.

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CHAPTER I

INTRODUCTION

Alcohol is in the class of the depressant drugs because these drugs tend to reduce brain activity and promote calmness and relaxation (Lingford-Hughes & Nutt, 2001). "The brain is very stingy with its 'joy juice' – so sneaking out this potion with drugs now means having less of it later" (Volpicelli, 2000; p. 27). Alcohol was formerly thought to affect the brain nonspecifically by slowing down all of its processes (Volpicelli, 2000, 2000). While it does affect numerous brain systems, particularly at high doses, its primary sedative effects appear to be related to its impact on a neurotransmitter called GABA (gamma-aminobutyric acid). Alcohol's pleasurable effects are probably due to its impact on endorphins (Lingford-Hughes & Nutt, 2001).

To understand and recover from addiction, it is important to understand not only how drugs affect the brain in general, but also what is different between those individuals who try and fail in their efforts to stop and those who move into the recovery process (Volpicelli, 2000). Moreover, is there a cultural context to understanding these differences within the process of change and recovery? Many who studied addiction, in search of a way to quantify the problem, often missed much of its essence as a result. Initially, physical addiction (or "dependence," as it is properly called) was seen as more important than psychological addiction because it could be measured and was visible (Epstein, 2001). However, psychological aspects of addiction – the impaired ability to control the use of the drug, the craving, the depression as it wears off, the life consequences – are equally important as the physical withdrawal symptoms or how often the drug is actually used (Epstein, 2001). Modern definitions of drug problems try to take

all of this into account. The most widely used scheme for defining alcohol problems is found in the American Psychiatric Association's Diagnostic and Statistical Manual (Volpicelli, 2000). There are two levels of alcohol problems that can be diagnosed: dependence and abuse. See Figure 1 for the diagnostic criteria for substance dependence and substance abuse from the Diagnostic and Statistical Manual IV-TR (DSM-IV-TR; American Psychiatric Association, 2000).

There are theoretical models that have been developed in order to understand the decisional process going on within the patterns of alcohol dependence and alcohol abuse. This study will refer to alcohol dependence and alcohol abuse as alcohol misuse. One of the most widely used models concerning the decision making process and the process to change patterns is the transtheoretical model of change (TMC; Prochaska & DiClemente, 1984). This model posits that individuals are at varying levels of motivation, or readiness, to change. It involves stages of change, mechanisms of change, levels of self-efficacy and temptations, and the weighing of pros and cons to change. Another model addressing the process of change and how patterns of substance misuse create imbalance is the Medicine Wheel. It is a pan-Indian model that represents existence, and through existence there are: (a) a continuous process of change, (b) a continuous process of adapting and healing from change, (c) the understanding that change is natural, and (d) through change, there is always a struggle for balance and harmony. The Medicine Wheel is considered to be sacred to some Native American cultures (Garrett, 1994). It is a way to understand substance dependence and substance abuse within a cultural context concerning the varying levels of motivation and the mechanisms of change that may be occurring specifically within Native American populations.

Figure 1. DSM-IV-TR Criteria for Substance Dependence and Substance Abuse

Diagnostic Criteria for Substance Dependence and Substance Abuse

Substance Dependence

A. A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period:

(1) tolerance, as defined by either of the following:

(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect

(b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:

(a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)

(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire for unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period.

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated abstinence or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school, neglect of children or household)

(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

From the American Psychiatric Association, Diagnostic Statistical Manual IV-TR (2000).

The purpose of the present study was to explore the applicability of the constructs of the Medicine Wheel and the Transtheoretical Model of Change to understanding the self-change process in Native Americans as they proceed within the recovery phases of alcohol misuse. This research was designed to develop a deeper understanding of the process of change and recovery from alcohol misuse within a cultural context. Previous

research suggests that there are cultural differences in the process of change regarding motivating factors that involve spirituality, identity, and cultural displacement.

To pursue this exploration, this study begins with an overview of the general population description and the prevalence of Native American alcohol misuse. The complexities of cultural affiliation within alcohol misuse recovery will also be discussed. This includes research emphasizing Native American perspectives on alcohol and their views of sobriety and recovery. Furthermore, the Medicine Wheel and the Transtheoretical Model will be discussed by understanding their theoretical frameworks and their applicability to Native Americans. Through these discussions, the present study of understanding the process of change and recovery from alcohol misuse from Native American perspectives was proposed. Methods that discover and analyze the process of change and recovery through the data will be used in order to understand the applicability of the Medicine Wheel and the Transtheoretical Model. Developing theory from the data may further research in addictions regarding the process of change. An increased understanding of how the process of change and adaptation to change from alcohol misuse in Native Americans may assist professional helpers to design interventions tailored to the unique degree of readiness to change within this population.

General Population Description

Native Americans form a highly heterogenous group composed of over 562 federally recognized tribes and over 200 state recognized tribes with over 200 languages (Young, Joe, Hassin, & St. Clair, 2001). There are approximately 4.3 million people, or 1.5 percent of the total United States population, who reported that they were Native American or Alaska Native (United States Census, 2000). The population is young,

ranging from 26 to 39 percent under 18 years of age as compared to 29 percent of the total United States population (SAMSHA, 2004). Female-headed households represent 27 percent of families versus 17 percent of the United States average (Sue & Sue, 2003). There are over 60 percent of Native Americans with mixed heritage, having Black, White, and Hispanic backgrounds (Sue & Sue, 2003). Furthermore, Native Americans differ in degree of acculturation (Trimble, Fleming, Beauvais, & Jumper-Thurman, 1996). The majority of Native Americans do not live on reservations, in part because of the lack of economic opportunities (Johnson, et al., 1995). In 2000, the United States Census showed approximately 34 percent of Native Americans living in tribal areas. Tribes may differ from one another in customs and values, but they all share the history of having lost their ancestral lands, forced education in boarding schools, attempts to eradicate their language and religion, and restrictions on their traditional means of obtaining a livelihood (Norton & Manson, 1996).

Prevalence

Native Americans, as a group, continue to show increased rates of alcohol abuse. It is important to note that the actual rates of alcohol and substance abuse vary inter-tribally and by age group, with some tribes and age groups having rates lower than those of the U.S. general population (Young, Joe, Hassin, & St. Clair, 2001). Compared to the general population, Native Americans as a group show mortality rates 8 times greater for ages 25-34 and 6.5 times greater for ages 35-44 (Indian Health Service, 1998). Most reported drinking behavior occurs among Native Americans between ages 15-44 (Indian Health Service, 1998). As far as the variability of alcohol abuse among tribes, studies show higher rates in the northern and western plains areas (Abbot, 1998, Young et.al.,

2001), noting that the research describing a complete epidemiology of adult drinking are limited (May, 1995).

The age adjusted alcoholism death rate in the Indian Health Service in 1992-1994 was 7 times higher than the United States All Races rate. There were 39.4 to 45.5 deaths per 100,000 in the Native American population, whereas there were 6.7 deaths per 100,000 in the United States All Races population (Indian Health Service, 1997). Native American males compared to Native American females have higher death rates from alcoholism (Indian Health Service, 1997). Although Native American females show higher death rates from alcoholism (20.1 to 87.6 per 100,000) compared to United States female population (<10 per 100,000).

Reports by SAMSHA (2005) stated that admissions to treatment facilities among Native Americans for alcohol showed it was the primary substance of abuse compared to admissions of other ethnic groups (63 versus 42 percent). Percentages of admissions of Native Americans entering treatment for illicit drugs increased from 23.6 percent in 1994 to 37.1 percent in 2002 (SAMSHA, 2005). Furthermore, SAMSHA reports have shown that Native American female admissions to treatment facilities have increased compared to other ethnic groups (36 versus 30 percent). The average age of admissions among Native Americans is around 34 years, similar to the national average (SAMSHA, 2003). Age of first use appears to be at an earlier age compared with other ethnic groups, reporting substance use initially at age 14 or younger. Thirty-nine percent of Native Americans report unemployment at treatment entry. Moreover, 40 percent were more likely to be referred by the criminal justice system (SAMSHA, 2005).

Native American populations vary considerably in substance use patterns (Abbot, 1998). Generally, there appears to be large groups of individuals who abstain; but those who do abuse substances abuse excessively and have more serious problems (Kunitz & Levy, 1994). Abbot (1998) reported that there is a significant minority that drink alcohol heavily and experience the majority of the problems. Furthermore, many of the abstinent drinkers are over the age of 40 and were former "heavy" drinkers. A major concern is the fact that drinkers and their drinking patterns generate a large and disproportionate toll in terms of morbidity and mortality (Young, Joe, Hassin, & St. Clair, 2001). Those who do drink tend to ingest excessive amounts over a short period of time leading to drinking patterns that produce serious alcohol-related problems such as accidents, suicides, homicides, arrests, mental health co-morbidity, and fetal alcohol syndrome (Indian Health Service, 1997; May, 1995). These alcohol-related problems affect Native communities as a whole, leading for a need to examine patterns throughout the life course in order to obtain adequate information on which to base theories and from which to plan programs of targeted prevention to address alcohol-related problems (May & Moran, 1995).

Complexities of Cultural Affiliation and Substance Misuse Recovery

Culture can be considered as "a way a group answers the questions they face on a daily basis, gives a sense of place in the world, and provides a worldview appropriate to that structure" (Stone, Whitbeck, Chen, Johnson, & Olson, 2006, p. 243). Acculturation is a concept referring to "the degree to which the individual (in this case, the American Indian person) accepts and adheres to both majority (White/Euro-American) and tribal cultural values" (Choney, Berryhill-Paapke & Robbins, 1995, p. 76); it can affect their

process of daily exploration and feeling a sense of place in the world (Marin & Gamba, 2002). Acculturation involves understanding change and the response to change (Choney, Berryhill-Paapke & Robbins, 1995). Attitudes, behaviors, and values are part of the change process (Chun, Organista & Marin, 2002). This process of change is continuous on individual, developmental and generational levels (Phinney, 2002). When considering these levels, it is important to consider acculturation as an ever-evolving process. This form of cultural adaptation can affect mental health adjustment (Organista, Organista & Marin, 2002). Individuals who experience high degrees of changing their attitudes, behaviors, and values accordingly, can become vulnerable to differing degrees of acculturative stress (Chun, Organista & Marin, 2002). Studies have found acculturative stress to be a risk factor for developing psychological problems (Chun, Oranista & Marin, 2002). The lives of many Native Americans continue to be characterized by experiencing high degrees of acculturative stress (Choney, Berryhill-Paapke & Robbins, 1995). Consequently, higher risk for social, physical, and mental health problems can occur because of this form of adaptation (Chun, Organista & Marin, 2002). Placing alcohol misuse within a cultural context among Native American people may provide important information into understanding the process of change. How Native cultures define the problem of alcohol misuse and how they respond to the problem creates a sense of meaning and purpose for this diverse population (Cauce, 2002) and may possibly lessen the degree of acculturative stress.

The idea of enculturation – the degree an individual is embedded in his or her cultural traditions as evidenced by traditional practices, traditional language, traditional spirituality, and cultural identity (Whitbeck, Chen, Hoyt, & Adams, 2004) – can serve as

a protective and curative factor in alcohol misuse (Gray & Nye, 2001; Herman-Stahl, Spencer, & Duncan, 2003). Stone et al. (2005) found that individual components of enculturation such as participation in traditional activities and traditional spirituality, had significant effects on alcohol cessation. Moreover, some studies have found no significant association between cultural identity and alcohol cessation, stating that practices and spirituality may be better measures of understanding enculturation than cultural identity (Beauviais, 1998; Stone et al, 2006). When considering enculturation, it is important to understand: (a) the degree of cultural commitment; (b) whether the individual comes from a reservation, rural, or urban setting; and (c) the tribal structure, customs, and beliefs that are relevant to the situation (Garrett, 1994). Spindler and Spindler (1958) identified degrees of acculturation and Loye and Robert Ryan (1982) modified Spindler and Spindler's degrees of acculturation in the following five ways (LaFromboise, Trimble, & Mohatt, 1990; p. 638):

1. Traditional – these individuals generally speak and think in their native language; and know little English. They observe "old time" traditions and values.
2. Transitional – these individuals generally speak both English and the native language in the home. They question basic traditionalism and religion, yet cannot fully accept dominant culture and values.
3. Marginal – these people may be defensively Indian, but are unable either to live the cultural heritage of their tribal group or to identify with the dominant society. This group tends to have the most difficulty in coping with social problems due to their ethnicity.

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

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

Herman-Stahl et al. (2003) reported that Native Americans with a low orientation toward traditional culture were more than 4.4 times as likely to be heavy drinkers, compared with more culturally oriented adults. Bicultural individuals were almost three times as likely to drink heavily and 2.3 times as likely to have an alcohol-use disorder, compared with individuals with a Native American traditional orientation. Although evidence is accumulating that traditional culture plays an important role in alcohol cessation and maintenance of sobriety, we do not fully understand the specific mechanisms through which it works (Hazel & Mohatt, 2001; Miller, 1998).

Spicer (2001) discusses some interesting dynamics related to cultural factors and alcohol misuse in Native communities. The idea that higher cultural affiliation in Native American individuals may show improvement throughout the course of change but once they reach the stage of sobriety, they begin to distance themselves from other Native American drinking associates while also feeling isolated from non-Indian society. This, in turn, leads to a moving away from ethnic affiliation to some extent during the first year or two after becoming abstinent. Perhaps there are higher chances of relapse during this

time based on temporary loss of cultural affiliation and feelings of intense isolation. Nevertheless, Spicer (2001) noted that research shows most individuals who maintained their sobriety after 2 years increased their activities in the Native community.

Hints of cultural processes involved when Native Americans change their drinking behavior are broad. For example, researchers emphasize the "maturing out" process (abstaining from misuse as they get older), changes in social relations, spirituality/religion, and health concerns (Kunitz & Levy, 1994; Quintero, 2000; Spicer, 2001; Westermeyer & Nieder, 1985). Clearly, there appears to be something at work in the lives of Native American people that leads them to change their drinking behavior as they get older, as relationships change, as stronger connections develop with spiritual/religious experiences, and as their health changes. To make sense of substance misuse, it is important to understand how Native Americans ascribe meanings to illness. Moreover, the motivation to change has strong ties to the cultural meaning of the illness (Miller & Rollnick, 2002). Motivation can be explored through understanding how a culture copes with the symptoms, how supportive the families and communities are, and where they seek help (Johnson & Cameron, 2001, Quintero, 2000). Attitudes and beliefs can capture the key signs of motivation, recognizing strengths and perhaps the specific mechanisms through which the maintenance of sobriety works (Christensen, 2001; Johnson & Cameron, 2001). In order to develop some level of understanding of motivations within a culture, it is important to allow individuals from that culture to provide their perspectives. Acknowledgement of perspectives within a cultural context can provide further understanding on the complexities of alcohol misuse and the process of change.

Native American Perspectives on Alcohol

"Origin stories provide a powerfully effective social vehicle that facilitates and structures this process of integration. Origin stories provide accounts of the complex webs of relationships that must be established and maintained in order to insure harmony" (Quintero, 2000; p. 1041). To understand an origin or creation story of a tribe is to understand their meaning of relationships, connectedness, and balance (Quintero, 2000). In studying narratives, it can be argued that we ultimately can never know if the stories accurately describe what really happened and why. Nonetheless, they point to the motivations these individuals acknowledge and emphasize in accounting for changes in behavior (Spicer, 1998). Changes in the life course can be universal, but the explanations of these events are more culturally specific (Struthers & Eschiti, 2004). Native American people may frame changes in their drinking behaviors with culturally important modes of meaning (Watts & Gutierres, 1997). By framing these changes in such a way, Native Americans make sense of their experience in a way that is culturally salient to both them and their listeners (Wing & Thompson, 1995).

Qualitative studies on Native American substance abusers and their view of alcohol misuse show some re-occurring themes throughout the narratives. These themes involve morals, identity, point of focus in the decision to quit, purpose, transformation, and relationships with the world (Hazel & Mohatt, 2001; Quintero, 2000; Spicer, 1998; Watts & Gutierres, 1997; Wing & Thompson, 1995;). From a moral perspective, how did some of these individuals perceive non-Indian's view of Native Americans abusing alcohol? Some described it as Whites feeling it is an imposition to the White world, that it is corrupt to their society (Spicer, 1998). As far as the moral stance Native Americans

take upon themselves, they believe alcohol misuse is incompatible with their ideals as Native people (Quintero, 2000). Although there is a personal degradation they feel from White society, they also discuss the cultural degradation felt through the consequences suffered from unmet obligations towards their family and community (Hazel & Mohatt, 2001). The inability to care for oneself struck moral issues for some Native American individuals who misused alcohol, stating that they were unable to avoid sickness, poverty, and feelings of inferiority (Hazel & Mohatt, 2001; Wing & Thompson, 1995).

Issues of identity did not involve referring to themselves as "alcoholics." Some studies show Native Americans' lack of concern with alcohol and disinterest in labeling the self as an alcoholic (Hazel & Mohatt, 2001; Watts & Gutierres, 1997). Researchers pointed out that this did not indicate "denial," as they were not reluctant to discuss their drinking and its consequences. Rather, it may reveal a different way of making sense of the self and the experience of alcohol (Watts & Gutierres, 1997). The decision to quit was not a significant factor of change – but more specifically a deliberate and self-conscious effort to refashion their lives (Hazel & Mohatt, 2001). The focus was on how they followed through once they made the decision to quit and they appeared to be less concerned about the events that happened to them when they made the decision to quit drinking (Quintero, 2000). Efforts to construct a sober life often involved a quest to reclaim spirituality and determine purpose in life (Watts & Gutierres, 1997). Understanding themselves as Native people and surviving the contemporary Native experience after quitting drinking was a significant part of the transformation process (Quintero, 2000).

Before discussing the re-occurring theme of Native American substance abusers and their relationships with the world, an explanation of a theoretical viewpoint of the work of Bateson (1972) as described by Spicer (2001) is in order. Spicer (2001) described relationships with the world and the experience with alcohol as competitive relationships versus cooperative relationships (understanding it from Bateson's theory). He noted that the Native American narratives he studied held a positive view towards a cooperative relationship with the world, which is, in brief explanation, not imposing force upon relationships and creating a sense of harmony. But as Native American "alcoholics," they tended to think and relate in a more competitive fashion; that is, controlling relationships within their world such as experiencing the struggles to control drinking and believing that one can master alcohol misuse through sheer force of will. The only release from this offset of beliefs about relationships is to engage in a cooperative relationship with alcohol. This cooperative relationship may lead to discussions about the positive values of drinking in their lives, making it difficult for these individuals to imagine life without alcohol. A solution to this struggle is recognizing the "thinking error" and developing an alternative to drinking. Studies show that most Native Americans who maintained sobriety found alternatives to how they relate to alcohol such as providing service to others suffering from substance misuse (French, 2004; White, 2000, 2004). This, perhaps, could be understood through the competitive/cooperative relationship with alcohol and the development of a healthier relationship with it.

In conclusion, these studies focusing on narratives are important since they offer a piece of the puzzle to understanding the process of change and recovery from a Native

American perspective. Perhaps, more importantly, these narratives also provide a tool for Native Americans to construct and present themselves in a culturally appropriate way. Understanding through a cultural context can shed light on the reported motivations underlying behavior change within an individual. The re-occurring themes that the qualitative studies presented lead to an exploration of Native American history in regards to sobriety and recovery. Within a Native historical context, how did this population understand addictions and overcoming them? The next section discusses the idea of sobriety and recovery awareness throughout history and the important factors involved in this process.

Native American Sobriety and Recovery

The History of Native American Sobriety and Recovery

Native Americans show the first documented stories of sobriety and recovery in North America. As early as the 1770's, there is documentation that Native American leaders played a prominent role in educating their tribes about the connection between alcohol and the growing imbalance within their societies (White, 2000). See Figure 2 for a brief historical description of Native American experiences with alcohol addiction and recovery. Alongside this description is the non-Native North American experience of alcohol addiction and recovery around the same time. Keep in mind that this information provides a brief snapshot of the history of North American alcohol addiction and recovery. Therefore, some specific information, persons and events may be excluded but are considered equally important.

Figure 2. History of Alcohol Recovery

Non-Native American History on Alcohol	Year	Native American History on Alcohol
	1770	1772: Samsom Occom (Mohegan). *Mr. Occom's address to his Indian brethren* depicted how alcohol was the destruction of Native people.
	1780	
1790-1830's: Alcohol-related problems grew in American, *The Discovery of Addiction.*	1790	
	1800	1800: Handsome Lake (Seneca). Orally transmitted teachings equivalent to the AA's Twelve Steps and the *Big Book,* Six Nations Temperance League--sobriety based cultural and religious movement.
	1810	1805-1811: Tenskwatawa or Lalawethika (Shawnee). Known as a prophet and started a spiritual revitalization movement.
	1820	1819-1831: Kenekuk (Kickapoo). Blended Native customs and elements of Christianity
1830's: Black temperance groups.	1830	1829: William Apess (Ojibway): Autobiography of recovery from addiction, first account of alcohol recovery in American literature, *Son of the Forest.*
1840-1880's: Alcoholics, sharing own experiences, speeches, consultation, and advice-giving.	1840	1847: Kah-ge-ga-gah-bowh (Ojibway). Autobiography and biography on his and father's addiction, *The Devil's Spittle.*
	1850	
	1860	
1870's: "Reformed men" as professional counselors	1870	
	1880	1880's: John Slocum (Squaxin): The Indian Shaker Church, a religious movement group addressing alcohol and social stressors.

Figure 2. History of Alcohol Recovery (continued).

Non-Native American History on Alcohol	Year	American Indian History on Alcohol
	1890	
	1900	Quanah Parker (Comanche). Native American Church (peyotism).
	1910	
	1920	
1930's: AA began (anonymous founder: Bill Wilson)	1930	
	1940	
	1950	Mixture of past recovery movement occurring.
	1960	
1970's: Treatment Centers, Integrating the recovered counselor.	1970	1970's-1980's: Involvement with non-Native recovery movements
1980's: Family Recovery Movement	1980	
1990's: Cultural considerations	1990	Late 1990's: Don Coyhis (Mohican): Wellbriety movement, addresses balance and harmony within the self, the family, and the tribe.
2000's: "Holism" perspective	**2000**	Cultural healing, integration of Native and non-Native treatment with emphasis on Native cultural background (emic/etic approaches, level of acculturation).
	2010	

From White, W. L. (2000a, 2000b) and White Bison (2002).

Within a Native historical context, broad movements beginning with education and awareness, to storytelling of personal experiences, to the development of support systems, to the seeking of balance and harmony within the process of change has provided hints of the specific mechanisms through which sobriety and recovery continues to grow stronger (White, 2000). In other words, understanding the history of Native

Americans and their cultural rebirth from alcohol addiction transcends into the individual process of Native Americans and their path to sobriety and recovery (White Bison, 2002). Numerous studies show that North American Euro-centric approaches have not worked well in Native American communities (Garrett & Carroll, 2000; Nebelkopf & Phillips, 2004; Stone, Whitbeck, Chen, Johnson, & Olson, 2005). Perhaps one subliminal barrier to this acceptance is that the Native American understanding of addiction and recovery may not be treated as equally important as compared to the North American Euro-centric understanding of addiction and recovery. The need for Native Americans to provide their stories and experiences of the process of change and recovery is important because it provides clues for effectively addressing the more general devastation of substance misuse among indigenous ethnic minority populations (Garrett & Carroll, 2000). Looking at the history of Native Americans, it shows that they have become "seasoned professionals" in adapting to the process of change and recovery.

Sobriety and Recovery Awareness

Through the process of alcohol addiction and change, it is important to understand the distinction between sobriety and recovery. Alcoholics Anonymous's (AA) cofounder Bill Wilson touched upon this topic by asking, "Is sobriety all that we are to expect of a spiritual awakening? No, sobriety is only a bare beginning; it is only the first gift of the first awakening. If more gifts are to be received, our awakening has to go on" (AA World Services, 1973, p. 39). The recovery process goes beyond just being abstinent from using alcohol, it is a change in the physical, intellectual, emotional, and spiritual realms of one's life (White Bison, 2002). During an informal conversation, three Native Americans from three different tribes (i.e., Blackfoot, Crow, and Northern Cheyenne) in the

sobriety/recovery phases were asked the question, "What's the difference between sobriety and recovery?" All described it similarly. One individual's response depicted the main point of what was said in the group, and to some extent, showed a common understanding compared to Wilson's (1973) description noted above. The description this Native American individual provided was:

> Sobriety and recovery? Hmm . . . I think sobriety means to maintain an effort to abstain from the chemicals that causes our addictions, and recovery is . . . I think, a healing process in which we try to find a certain serenity and peace in the chaos we caused in our lives and the lives of others. Recovery is a lot harder I believe 'cause we have to face all the bad things in our lives and find some level of acceptance (personal communication, anonymous, July, 2006).

This quote implies a transitional process happening between sobriety and recovery. Considering the complexities of this process, cultural meaning should be applied in order to explore the motivation, strengths, and maintenance through the transition from sobriety to recovery. Moreover, the distinction between sobriety and recovery is important in light of a history in which individuals with only a fragile hold on their own sobriety have been recruited to work as professional helpers, leaving them increasingly vulnerable to relapse (McGovern, 1992; White, 2000). The notion that people who have faced and overcome adversity might have special sensitivities and skills in helping others experiencing the same adversity – has deep historical roots (McGovern, 1992). The history of educating and healing through sharing personal experiences in regards to alcohol misuse within Native American tribes spans back to the 18th century and continues today to be a major part of the recovery process (White, 2000). Therefore, in order to become an effective

educator or healer, it is important to understand the distinction between sobriety and recovery.

Spirituality and Identity

"What you are speaks so loudly to me that I cannot hear what you are saying" (Smith & Grob, 2004, p.128). Spirituality and a strong sense of identity appear to be catalysts in the sobriety and recovery phases. These powerful agents of change emerge through, and are strongly connected to one's culture. The constructs of spirituality and identity can become quite complex when considering value systems and motivations within a cultural context (Bartocci & Dein, 2005). Native American cultural values have struggled for survival within a dominant society. Cultural displacement, a form of sociocultural disintegration through changing norms and cultural identity, can present itself through acculturative stress, minority stress, socioeconomic stress, and traumatic stress (Miller & Weisner, 2002). Moreover, the link between cultural displacement and substance abuse is strong (Miller & Weisner, 2002). With this in mind, cultural displacement can become a major obstacle in the development of healthy spiritual growth and a strong sense of identity formation.

The term "spirituality" derives from the Latin "spiritus", meaning breath and is used in the literature in three main and often overlapping ways: as a relationship with a higher power, as a search for meaning through this relatedness, and as the vital principle in persons (Dien, 2005). Hindu philosophy describes the spirit as "the self in every one and in all" (Dien, 2005, p.529) and spirituality as "infinite being, infinite awareness, and infinite bliss" (Smith, 2004; p. 126). Other definitions in the literature regarding spirituality have included the meaning and purpose in life, intrinsic values, transcendent

beliefs or experiences, relationships with self and others, balance, belief in the sacredness of life, idealism, respect for all living things, and harmonious interconnectedness (Hazel & Mohatt, 2001; Miller, 1998; Westgate, 1996).

Spirituality is culturally constructed (Dien, 2005; Smith, 2004). It is central to the worldviews of Native Americans (Hazel & Mohatt, 2001). Beliefs about spirituality that span across tribal communities involve a sense of harmony and balance within the self, the family, the community, and the environment (Garrett, 1994). There is a spirit world that exists side by side and intermingles with the physical world (Bensley, 1991). Native American conceptualizations lean toward a belief that humans are made up of spirit as well as the mind and body (Westgate, 1996). The spirit existed before it came into the physical body and will continue to exist after the body dies (Westgate, 1996). A fundamental belief is that all things are connected and that we have a sacred relationship with the universe that should be honored (Vick, Smith & Herrera, 1998). Spirituality involves seeking our place in the universe and that everything else will follow in good time (Herring, 1994).

Obtaining harmony, balance, and connectedness involves a process of transcendence (Vick, Smith, & Herrera, 1998). This operationalization of spirituality has been described as a "mystical experience" (Dein, 2005, p. 530). A mystical experience, or transcendence, creates a sense of awe (Smith & Grob, 2004) and exuberance (Bartocci & Dien, 2005). Fear and fascination felt simultaneously describe this sense of awe, whereas exuberance is an intense feeling of energy and life within oneself, giving a sense of meaning and purpose (Smith & Grob, 2004). Transcendence is more than the news of a different world, but is the experience of a different world (Smith & Grob, 2004).

Transcendence can also be described as a form of detachment. According to Dein (2005), detachment relieves stress and encompasses the sense of identity. An individual with a strong sense of identity will detach to relieve stress and experience a spiritual moment; whereas an individual with a weak sense of identity will detach to relieve stress and may be unable to experience spirituality in a healthy way (Bartocci & Dein, 2005). This unhealthy experience may lead to psychopathology or momentary psychosis (Bartocci & Dein, 2005).

The experience of spirituality and the experience of alcohol or drug use can often be indistinguishable (Smith & Grob, 2004). The difference relates to whether an individual has a strong sense of identity or a weak sense of identity (Bartocci & Dein, 2005). To illustrate, an individual with a weaker sense of identity may detach to relieve stress by abusing alcohol and eventually will experience some form of psychopathology whether it be alcohol abuse/dependence and/or depression, continuing to limit the self to experience healthy spirituality. The sacred element of spirituality is lost. Individuals with a weaker sense of identity may have a difficult time with the recreational use of alcohol because of unclear boundaries within oneself, leading to the profane use of the substance (Smith & Grob, 2004). As a result, a major goal and a fundamental part of change within the sobriety and recovery processes involve taking a path that leads to the development of a stronger sense of identity and experiencing a healthier form of spirituality.

As stated previously, Native American tribes are one of many groups who struggle with displacement within a dominant society. Displacement of a population impacts the sense of identity as a group and as an individual (Miller & Weisner, 2002). In the 1930's and 1940's, well-known psychologist, Erik Erikson, was taught about how the

cycle of life works from a Native American perspective (White Bison, 2002). He lived with the Sioux people of the Dakotas and the Yurok people of Northern California and was taught about life experiences and whether we are in harmony with our needs (Merten, 1992; White Bison, 2002). Erikson (1959) believed that ethnic identity was located in deep structures of the psyche. Based on Native American belief systems, he developed the eight general stages of psychosocial growth (White Bison, 2002). The resolution of the identity crisis (Stage 5: *identity versus role confusion*) appears to be a significant period of disorganization within the life cycle (White, Montgomery, & Fischer, 2003). Furthermore, the earlier stages have been linked to identity development and the later stages 6 through 8 are dependent upon adequate resolution of the identity crisis. The goal of Stage 5 is to achieve a sense of personal identity in areas such as values, beliefs, and relationships (White, Montgomery, & Fischer, 2003). The *identity versus role confusion* stage is broken down into four identity statuses: (a) diffusion; no exploration of identity, (b) foreclosure; forced exploration of identity, (c) moratorium; freedom to explore identity, and (d) achievement; commitment to an identity based on the freedom to explore (Bishop, Weisgram, Holleque, Lund, & Wheeler-Anderson, 2005). Studies show that substance misuse is higher in groups of people who experience greater challenges in reaching the identity achievement status (Bishop, et al., 2005; White, 2000). Groups who are culturally displaced face greater challenges in achieving a strong sense of identity (Miller & Weisner, 2002). However, it is not an impossible feat, given the history of many Native Americans who overcame addictions through the process of exploring their own cultural values and belief systems (White, 2000).

Spirituality and identity can be conceptualized in different ways across different cultures, leading to a sense of obscurity when scientists attempt to define them (Dein, 2005). Furthermore, the two concepts appear to be intertwined; each dependent on each other in order to grow stronger (Smith & Grob, 2004). Sobriety and recovery allow the opportunity to see how spirituality and identity are created or reborn. The process of change and recovery within Native American cultures appear to place spirituality and identity as a foundation in order to develop harmony and balance within oneself, the family, and the community.

The complexities of cultural affiliation and alcohol misuse recovery within Native American populations involve enculturation issues, historical recovery, spirituality and identity. These complexities encompass change and adaptation. Change is often a process that includes seeking balance in order to achieve a sense of harmony. Understanding the process of change and balance within a cultural context may offer a clearer pathway and perhaps a more meaningful experience through the complexities of substance misuse recovery.

Two models, the Medicine Wheel and the transtheoretical model, observe the adaptation to change and the process of change. These theoretical frameworks will be discussed within the next two chapters in order to understand their appropriateness concerning the complexities of cultural affiliation and alcohol misuse recovery.

The Medicine Wheel

Theoretical Framework

Symbols give order to the beliefs held by members of a society (Summer, 1991). Symbols represent a complex set of experiences, motives, knowledge, and desire (Leach,

1989). They are a device to express underlying ideas and ideals. The analysis of a symbol should reveal a social/cultural pattern that is perceived as reality by its members (Dolgin, Kemnitzer & Schneider, 1977). Symbols arouse emotions and can alter the state of an individual (Leach, 1989). A powerful symbol that exists in cultures throughout history is the circle. It has often been called the mandala or "magic circle", which represents unity and wholeness (Young-Eisendrath & Dawson, 1997). Jung described the mandala as representing inseparable relationships with all levels of existence (Young-Eisendrath & Dawson, 1997). To some Native American cultures, the circle is considered to be sacred (White Bison, 2002) and is described in detail below:

> When we sit in a circle, we are sitting in the exact design of the universe. The atom is in a circle and Mother earth is in a circle. The moon circles around the earth and the earth circles around the sun. Therefore, when we sit in a circle all the natural laws are designed to support anything that is taking place in a circle. When we recover we form circles of recovery. We heal in a circle and we talk in a circle. We experience the power of the circle. (White Bison, p. 17)

According to this quote, the circle can represent the experience of feeling a sense of connectedness, safety and trust. Through this emotional experience, thoughts and behaviors are simultaneously affected. A sense of empowerment is created, which can lead to progression and growth that is circular in nature, permitting the process of life to continue in a balanced fashion. Within the circle, the sense of empowerment is created by the use of "medicine." The term "medicine" in most Native American cultures has been described as "the way of things or the way of life" (Garrett, 1994, p. 137). Herbs,

traditional prayers and ceremonies; traditional healers, the wisdom of elders, and a sense of belongingness can be some references to the ideas of what medicine means to most Native American cultures (Nebelkopf & Phillips, 2004). This "circle with medicine", or the Medicine Wheel, can be a way to describe how we seek empowerment and balance on the path we choose in life. Some Native American cultures perceive the Medicine Wheel as representing existence in these ways: (a) a continuous process of change, (b) a continuous process of adapting and healing from change, (c) the understanding that change is natural, and (d) through change, there is always a struggle for balance and harmony (Dapice, 2006; Montour, 2000; Roberts, Harper, Tuttle-Eagle Bull, & Heideman-Provost, 1998).

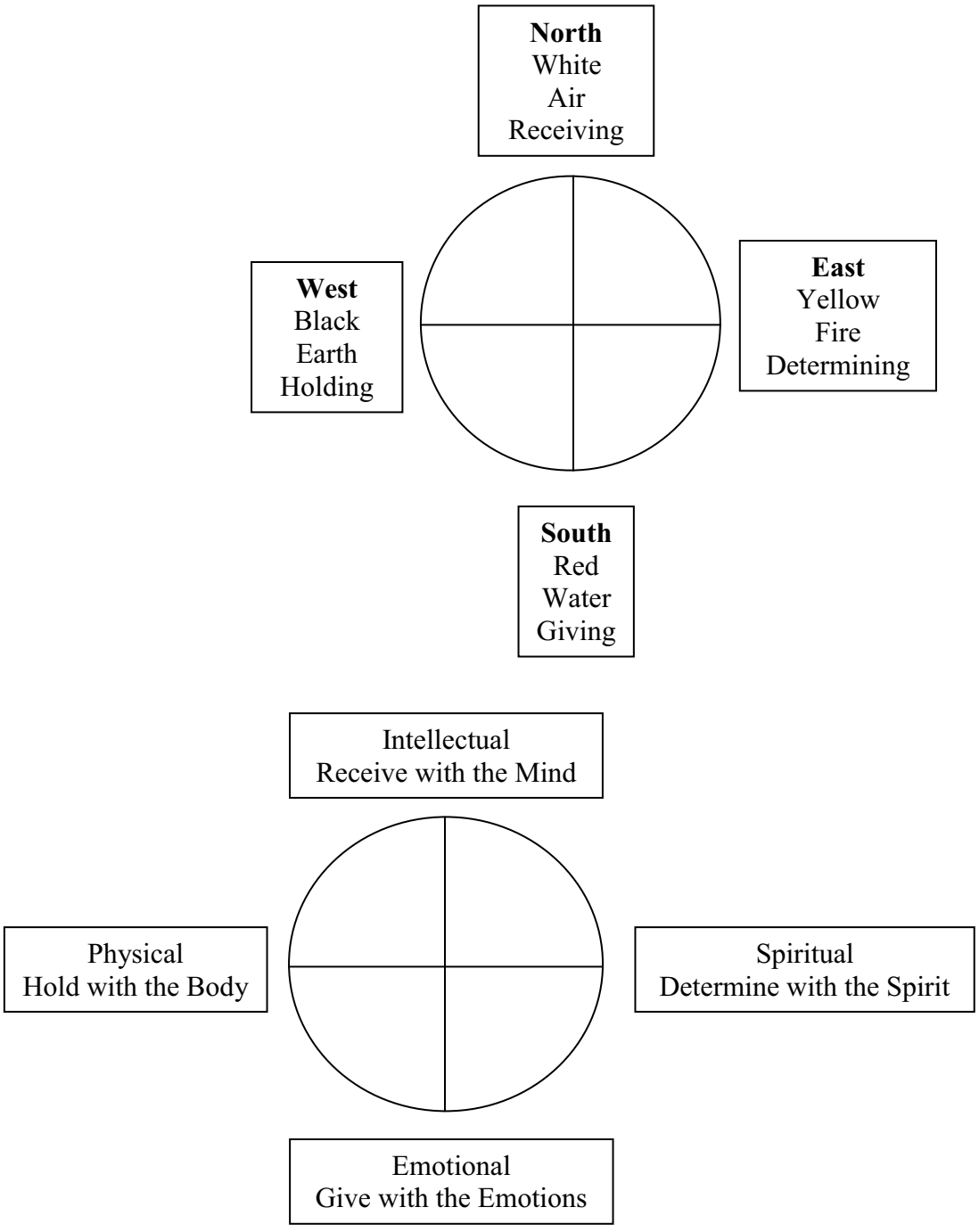
Montour (2000), a medical doctor and member of the Mohawk Six Nations Iroquois Confederacy, provides a description of the origins of the Medicine Wheel based on his tribal background:

> The Medicine Wheel has been handed down from generation to generation in oral form. Its message was made available to the general public with publication of The Sacred Tree in 1985. Its story tells of the Great Paradox: Everything comes out of No-thing and to No-thing Everything returns. Out of No-thing (the Great Spirit) came the Great Everything (Shonkwaia'tison), whose name means "He who creates or makes all things, beings, bodies, possible."
>
> Another translation of Shonkwaia'tison is "He who made possible our bodies with perfection." From all this, the shamans knew a universal and unvarying cosmic law that no Force or Matter is ever destroyed or lost or comes to an end – it merely changes its form and the way it manifests. Nothing ends, but

> only follows a cycle of change. Everything that manifests comes into physical being and goes out of manifestation only to return to manifest once more in accordance with the Circle of Change.
>
> This is the teaching of the Medicine Wheel – that everything comes from the same source of all existence, Shonkwaia'tison, the Creator. From the Creator all things come into existence; and to the Creator all things return. (p. 22)

The Medicine Wheel is a pan-Indian symbol and can be understood in many different ways from tribe to tribe but what is universal about it is that it represents change, balance, and harmony within the natural order of life. According to Adlerian theory, "the whole is greater than the sum of its parts" (Watts, 2003, p. 10). This represents the idea that supposed parts cannot be separated or considered unequal. They are all necessary to understand the whole. Within Native American groups, "connection and belonging are strongly held values, and the whole is considered to be more sacred than the sum of its parts" (Roberts, Harper, Caldwell, & Decora, 2003; p. 16). Figure 3 shows the Medicine Wheel's four quadrants, which represent the Four Primary Forces or the Four Great Powers (Montour, 2000). Superimposing the Wheels shows that the system was designed to be expressed in the most balanced way when we *Determine with the Spirit, Receive with the Mind, Give with the Emotions*, and *Hold with the Body* (Montour, 2000).

Figure 3. Four Quadrants of the Medicine Wheel (Montour, 2000)



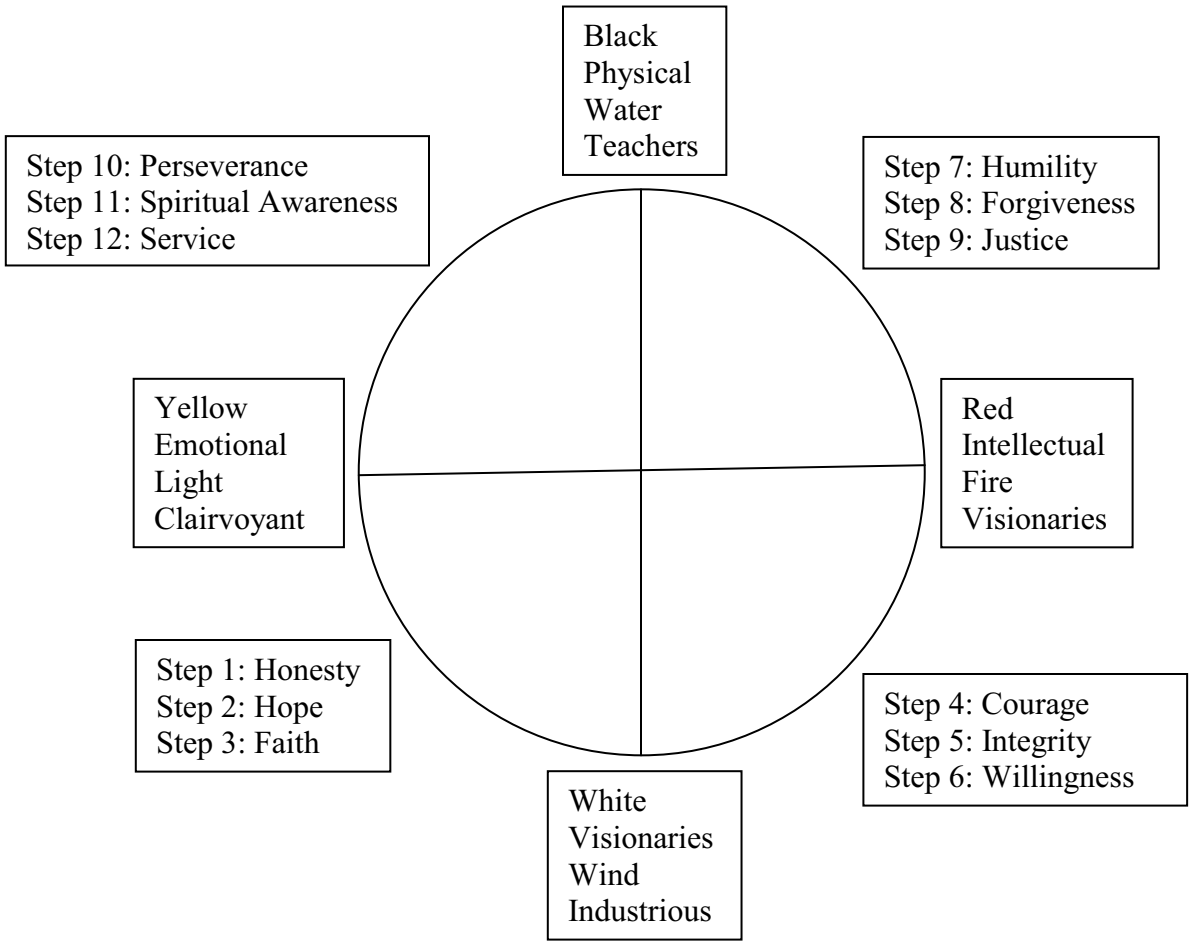
Treatment Modalities

The Medicine Wheel has been used within the treatment of drug and alcohol abuse and dependence (Garrett, 1994; Nebelkopf & Phillips, 2004; Thomason, 2000; White Bison, 2002). It has also been used in treatments of other illnesses such as diabetes trauma, HIV, and depression (Nebelkopf & Phillips, 2004). The Medicine Wheel has been a foundation to understand psychosocial illnesses such as the grieving process, domestic violence, and poor community cohesion (Dapice, 2006; Nebelkopf & Phillips, 2004). The commonality of all of these illnesses is that they have a severe imbalance that affects the individual, the family, and the community. These illnesses have tendencies to switch focus on one quadrant of the Medicine Wheel, while disregarding the other three quadrants. This tendency stunts the process of change and adaptation of healing from change, making change seem unnatural and resulting in imbalance and disharmony.

One philosophy that addresses recovery from alcohol misuse in Native American communities, called the Red Road to Wellbriety, integrates the Medicine Wheel and the practices of Alcoholics and Narcotics Anonymous Twelve Step process (White Bison, 2002). The "Red Road" represents a journey of hope and healing and "Wellbriety" is the idea of moving beyond sobriety and into recovery. In other words, "Wellbriety" represents the behavioral, cognitive, and emotional restructuring process happening within a spiritual realm – the "Red Road". This philosophy focuses heavily on the importance of achieving balance, identity, and connection through the understanding of one's culture. "The solution is in the culture" (White Bison, 2002, p. 9) states that the use of medicine in one's culture will provide meaning and purpose, leading to the process of

change and recovery. See Figure 4 to view the integration of the Medicine Wheel and the Twelve Steps according to White Bison philosophy (2002).

Figure 4. Integration of the Medicine Wheel and the 12-Steps (White Bison, 2002).

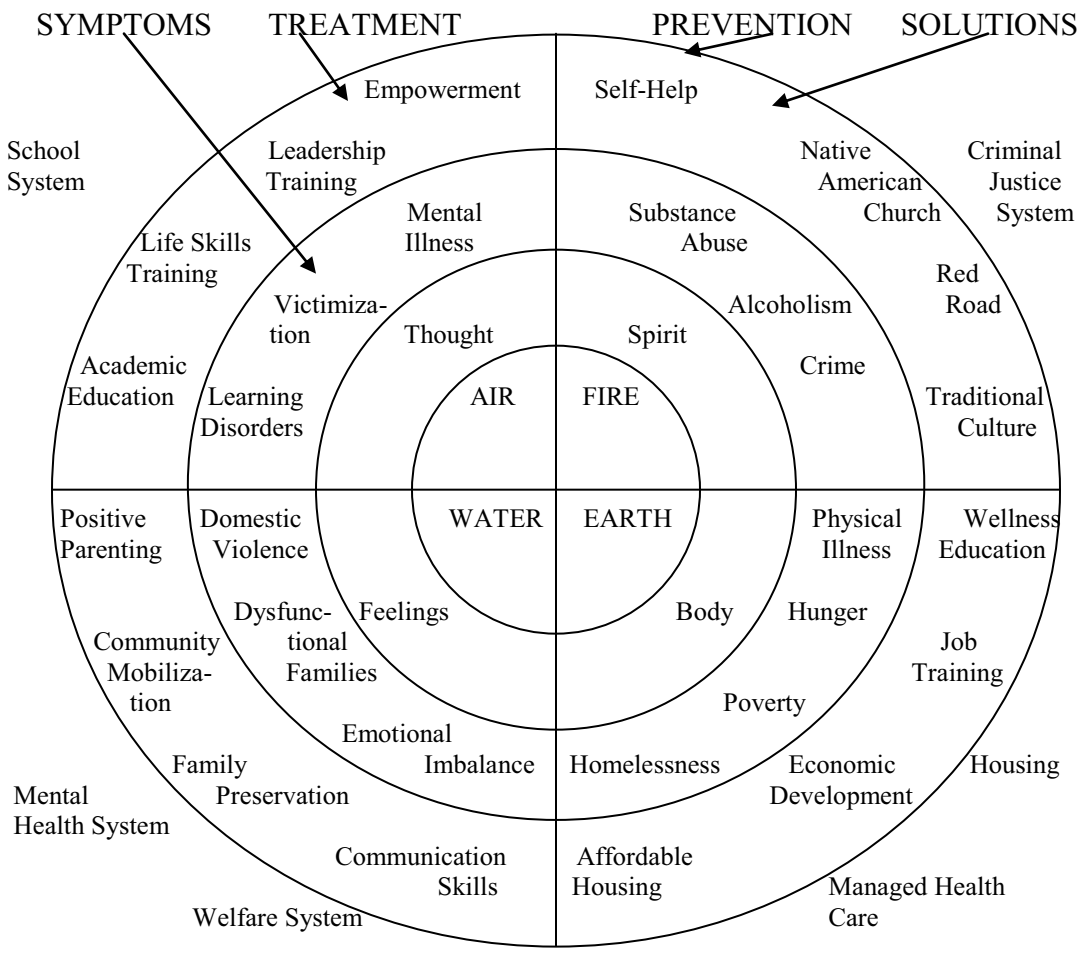


Another way to understand the sobriety and recovery phases through the Medicine Wheel is through Montour's (2000) viewpoint. Although he used the Medicine Wheel to form an understanding of trauma from sexual, physical, and emotional abuse; this model can also be applied to substance misuse recovery. For example, Determine with the Spirit is making the decision to not allow alcohol to enter the body. Once the decision is made by the Spirit, then the healing process begins. Hold with the Body is the physical body preparing itself for the healing process by abstaining from alcohol use –

the body no longer holds the substance. Receive with the Mind and Give with the Emotions is the mind and emotions gradually becoming affected in a healthy way if the healing process continues. Through this continuation, the recovery phase begins. It is important to note that the spiritual part of the sobriety process is needed at the beginning phases because it is the decision to change. According to this model, the motivations, strengths, and specific mechanisms through which the maintenance of sobriety and recovery work begin with a spiritual component and a gradual development of a strong identity. Furthermore, the cultural view of Medicine can be used as a tool to create the transcendence to spirituality that leads to behavioral, cognitive, and emotional restructuring.

Recovery from illness and the use of the Medicine Wheel has shown to be effective in many areas within Native American communities. The Native American Health Center (NAHC) is a community-based, nonprofit urban Indian organization that has provided medical and social services in the San Francisco Bay Area. NAHC implements a holistic system of care and uses the Medicine Wheel as a model to address mental illness, substance abuse, HIV/AIDS, homelessness, poverty, crime, and violence (Nebelkopf & Phillips, 2004). See Figure 5. Historical trauma, family dysfunction, and spiritual imbalance are recognized as important factors to the development of these illnesses. The NAHC described their treatment as the "Circle of Care" (p. 47), focusing more on the solutions rather than the problems (Nebelkopf & Phillips, 2004).

Figure 5. Holistic system of care for Native Americans in an urban environment.



Adapted from Nebelkopf & Phillips, 2004, p. 47.

Combining theories with the Medicine Wheel has been a current practice to develop culturally competent approaches within Native American communities. A treatment model that focuses on four central themes found in Native child socialization practices (belonging, mastery, independence, and generosity) uses the Medicine Wheel approach called the "Circle of Courage" (Gilgun, 2002, p. 66). This model integrates the theories of human development and the Medicine Wheel for adults to provide culturally appropriate guidance, modeling, and affirmation. It is used to promote resilience in children and youth in out-of-home care (Gilgun, 2002).

Roberts, Harper, Tuttle-Eagle Bull, and Heideman-Provost (1998) combined the Medicine Wheel and individual psychology of Adlerian theory to develop a more culturally sensitive counseling method when working with Native Americans. They found common themes relating to holism by looking at social embeddedness (the East), lifestyle (the West), goal orientation (the North), and striving for mastery or life tasks (the South).

Dapice (2006) utilized the philosophy of the Medicine Wheel to develop an understanding of why Native Americans suffer the highest numbers of preventable diseases. The study recognizes the current high rates of suicide, homicide, domestic violence, and accidents, being higher than any other group in the United States. She discusses the major losses within Native American cultures and the neuroendrocrine and behavioral responses to these losses. Dapice stated that the changes needed for repair and healthy adaptation are using the mental, emotional, physical and spiritual aspects of the Medicine Wheel as a guide.

These developments of combining theories to the Medicine Wheel can create a sense of meaning within that culture and increase motivation for healthy change. Wiebel-Orlando (1989) discusses the many different treatment programs and modalities that have been used with Native Americans. These five common treatment modes are: (a) the medical model, treating alcohol misuse as an illness or disease; (b) the psychosocial model, treating alcohol misuse as it relates to social conditions and mental health; (c) the assimilative model, treating alcohol misuse according to normative beliefs of the dominant culture; (d) the culture-sensitive model, treating alcohol misuse according to normative beliefs of a particular culture; and (e) the syncretic model, treating alcohol

misuse according to normative beliefs of a specific community within a particular culture.

Many different alcohol treatment programs and modalities have been used with Native Americans. Where does the Medicine Wheel fall within these categories? Thomason (2000) stated that it falls in the syncretic model because it is primarily a Native American orientation. Other researchers, such as Gilgun (2002), Roberts, Harper, Tuttle-Eagle Bull, and Heideman-Provost (1998), and Dapice (2006) appear to view the Medicine Wheel as a mix between psychosocial and culture-sensitive orientations. While Montour (2000), White Bison (2002), and Nebelkopf and Phillips (2004) appear to view the Medicine Wheel as a mix between all the orientations (the medical, psychosocial, assimilative, culture-sensitive, and syncretic). Although there is no universal explanation for drug and alcohol misuse among Native Americans, it is important to note that the factors involved may be understood through the use of a more universal model that is flexible enough to fit on a continuum that is able to address the different acculturation statuses and treatment modalities involved within Native American alcohol problems. The Medicine Wheel has been a symbol of change and balance within many cultures throughout history. Furthermore, it has the ability to adjust to universal, culture-specific, and individual issues.

Transtheoretical Model of Change

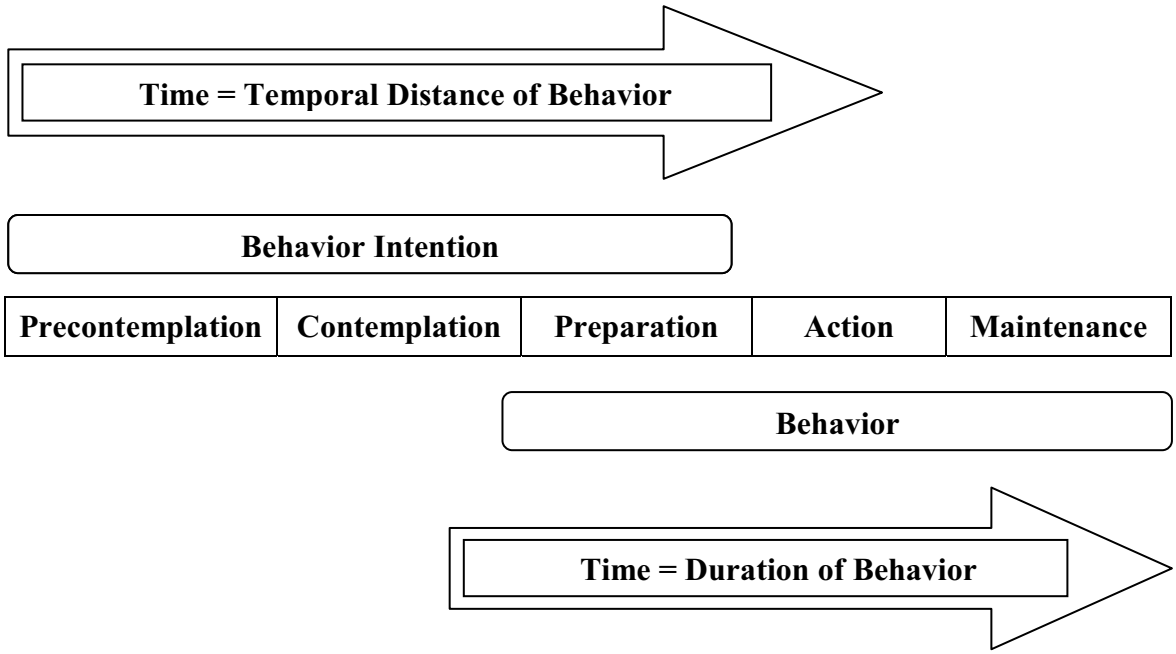
Theoretical Framework

The transtheoretical model of change (TMC), better known as the stages of change model, was originated by James Prochaska, PhD and Carlo DiClemente, PhD. The stages of change model is considered to be a comprehensive model that integrates an

eclectic approach to change, explaining and predicting how and when individuals discontinue high-risk behaviors or adopt healthy behaviors (Prochaska, J. O., Prochaska, J. M., Cohen, Gomes, & Laforge, 2004).

In developing the stages of change model, Prochaska combined key constructs from other theories to describe the process of intentional behavior change along a continuum. In his work with smoking cessation and the treatment of drug and alcohol addiction, Prochaska described behavior change as a process rather than an event. He and his colleagues posit that individuals are at varying levels of motivation, or readiness, to change. Because of this, a key component of the model is its temporal dimension. See Figure 6. Time is conceptualized in two stages within the model: (a) Before the behavior of interest occurs, the temporal dimension focuses on behavioral intention; and (b) After the desired change in behavior, the temporal dimension focuses on duration of behavior.

Figure 6. The temporal dimension as the basis for the Stages of Change



Illustrates how the temporal dimension is represented in the model. Two different concepts are employed. Before the target behavior change occurs, the temporal dimension is conceptualized in terms of *behavioral intention*. After the behavior change has occurred, the temporal dimension is conceptualized in terms of *duration of behavior,* Velicer et al., 1998 (http://www.uri.edu/research/cprc/TTM/detailedoveriew.htm).

Stages of Change

This model appears to be applicable in this study as behavior change is an integral part of recovery from alcohol addiction. The TMC reveals that individuals go through stages prior to and as they are making behavior changes. The stages of change are the temporal, motivational aspects of an individual's behavior change (Prochaska & DiClemente, 1984). The model posits that successful behavior change involves progression through stages. It is a circular model rather than a linear one, as the process

of change often involves regression and relapse on the path to progress and success. Furthermore, it places importance on the specific processes or strategies that people use at each stage because a mismatch between strategy and stage may result in an increased likelihood of failure to achieve change (DiClemente, 1991).

The stages involving behavior change in progression are: (a) precontemplation, the individual is not considering change (b) contemplation, the individual is examining the current behavior and considering change (c) preparation, the individual makes a commitment and develops a plan for change (d) action, the individual takes steps to change and begins creating new patterns of behavior and (e) maintenance, the new behavior is sustained and consolidated into the lifestyle of the individual (Prochaska et al., 1994). To illustrate each stage, an individual struggling with substance misuse might say something similar to these statements if he/she were in the: (a) precontemplative stage – "I don't feel I have a problem and have no intention of making any changes regarding my use," (b) contemplative stage – "I'm considering quitting but have not made a decision yet," (c) preparation stage – "I have decided to quit and am preparing to quit for good," (d) action stage – "I quit using and have been sober for a while but I still miss the lifestyle," and (e) maintenance stage – "I quit using and have been sober for quite a while, I see things differently and no longer miss the lifestyle when I used alcohol/drugs."

In order to use the stages of change model effectively, it is important to be familiar with the other specific components of the model: Processes or Mechanisms of Change, Self-Efficacy/Temptations, and the Decisional Balance. Understanding and combining these components can help reduce a mismatch error of strategy use and stage.

This, consequently, will maximize the potential for success to recovery from alcohol addiction.

Processes or Mechanisms of Change

The common elements associated with intentional behavior change that facilitate movement through the stages have been identified as the Processes or Mechanisms of Change (Prochaska, Velicer, DiClemente, & Fava, 1988). This involves the cognitive-experiential and behavioral approaches useful in helping a person change behavior. The cognitive-experiential processes represent the ways of thinking and feeling that facilitate change. The behavioral processes involve commitment and actions designed to break old patterns and engage the individual in the new patterns of behavior (Prochaska, Velicer, DiClemente, & Fava, 1988). See Table 1 for examples of cognitive-experiential processes and behavioral processes. See Figure 7 for these processes of change by stage of change. As with the Processes or Mechanisms of Change, other constructs that DiClemente (2003) refers to as the markers of change in the TMC (i.e. self-efficacy, temptation, and decisional balance), are critical indicators of stage status at any point in the change process and are substantial contributors to an overall profile of change (Carbonari & DiClemente, 2000; DiClemente, 2003; Prochaska, et al., 1994).

Table 1. The TMC Processes of Change

Cognitive/Experiential	
Consciousness-raising	Increasing awareness of a problem and its potential solutions
Dramatic relief	Intense emotional reactions to problem-related events and information
Self-reevaluation	Changing appraisals of self and problem
Environmental reevaluation	Changing appraisals of problem's impact on others
Social liberation	Creating new alternatives in the environment
Behavioral	
Self-liberation	Increasing commitment and creating new alternatives for self
Counter-conditioning	Changing one's reaction to stimuli
Stimulus control	Changing one's environment to minimize occurrence of stimuli
Contingency management	Creating or changing reinforcers and contingencies for a behavior
Helping relationship	Positive, supportive relationship that facilitates change

Source: http://www.uri.edu/research/cprc/TTM/detailedoverview.htm,
Velicer et.al., 1998

Figure 7. Processes of Change by Stage of Change

	Stages of Change				
Processes of Change	Precontemplation (PC)	Contemplation (C)	Preparation (PA)	Action (A)	Maintenance (M)
	Consciousness raising	Self-reevaluation			
		Dramatic relief			
		Helping relationship			
			Self-liberation		
				Contingency management	
				Counter-conditioning	
				Stimulus control	

Carbonari & DiClemente, 2000.

Self-Efficacy and Temptations

Bandura's concept of self-efficacy is defined as an individual's belief about his/her capability to perform at a level sufficient to influence events that affect his/her life (Bandura, 1997). Adapted from Bandura's work, the notion of self-efficacy in the TMC represents an individual's confidence in performing a particular behavior. Additionally in the TMC, the notion of self-efficacy is coupled with another marker of change, temptation. Temptation is defined as the strength of one's desire, craving, or inclination to perform the negative behavior in particular situations (DiClemente, 2003). Individuals have less confidence and greater temptation in the early stages, with the pattern reversing itself in the later stages when individuals feel more confident and less tempted to return

to previous behaviors (DiClemente, 2003). Furthermore, efficacy expectations have been shown to be strong predictors of lasting change (Carbonari & DiClemente, 2000).

Decisional Balance

Decisional Balance, the decision-making component of the TMC, originating from the work of Janis and Mann (1977), represents the individual's personal reasons for or against (pros and cons) making a behavior change. Decisional Balance is an especially strong indicator of movement through the earlier stages of change (Prochaska et al., 1994). Within the precontemplation and contemplation stages, the cons of changing are perceived as outweighing the pros. During the action and maintenance stages, the pattern reverses and the pros of changing are perceived as outweighing the cons (Prochaska, Velicer, DiClemente & Fava, 1988). This is important to note since precontemplators do not perceive that there is a problem and discussing solutions to the problem will only increase resistance. Attempts to force resolution in a particular direction can lead to a paradoxical response, even strengthening the very behavior that was intended to be diminished (Miller & Rollnick, 2002) This is an example of the importance of matching the stage of change the individual is in to the intervention strategy.

Complexities of Cultural Affiliation and the TMC

When using the strategies involved in the TMC, it is important to consider how cultural background can interplay with cognitive-experiential processes, behavioral approaches, self-efficacy and temptations, and weighing the pros and cons. For example, within Native American tribes, there is a level of cultural displacement and specific cultural processes for understanding change (Miller & Weisner, 2002). These factors may have an impact on how Native American cultures perceive and progress through the

stages of change. The history of change, the importance of spirituality and identity, and a striving for balance and harmony are all a part of the process of current change within Native American cultures. How do these components fit into the TMC? This leads in the direction of qualitative research on understanding the stages and the process of change within Native Americans in recovery from alcohol misuse.

Application of the TMC to Native Americans

The TMC has been applied to a wide range of behaviors, including smoking (Pollack et al., 1998; Prochaska, Velicer, DiClemente, & Fava, 1988), smoking and pregnancy (Stotts, DiClemente, Carbonari, & Mullen, 1996), numerous alcohol abuse studies beginning with Prochaska & Diclemente, (1984), diet and weight loss (Glanz et al., 1994), safer sexual practice (Bowen & Trotter, 1995; Harlow et al., 1999), mammography screening (Rakowski, Fulton, & Feldman, 1993) exercise (Marcus, Rossi, Selby, Niaura, & Abrams, 1992), coping in battered women (Fiore & Kennedy, 2000), lifestyle change with diabetes (Calhoun, 2005) and many others.

Although the TMC has been widely researched, its applicability in Native American communities is needed. One study found using the TMC within a Native American population looked at the lifestyle changes of individuals with diabetes among the Eastern Shoshone and Northern Arapaho tribes (Calhoun, 2005). The study focused mainly on the use of Motivational Interviewing and found these approaches to be effective, stating that more research needs to be done. Other research that discusses ethnicity and the TMC involve condom use and HIV risk, stating that there are differences in assertiveness in sexual behavior across ethnicities and that this places cultural groups in particular stages (Harlow et.al, 1999). Bowen and Trotter (1995) also

reported a difference in stages of change according to ethnicity regarding condom use and HIV risk. They indicated that White participants were more likely to be in the action stage, Hispanic participants were more likely to be in the contemplation stage, and African American participants were more likely to be in the preparation stage. Another study relating to ethnicity and the TMC looked at physicians and the stages of change they go through to recommend colonoscopy to their patients (Honda & Gorin, 2006). The study indicated that there were sociocultural influences with the TMC when these physicians recommended colonoscopy. Physicians were less likely to communicate with patients about colonoscopy and less confident in their ability to counsel patients if they perceived a wider gap between their normative beliefs and their patient beliefs. These studies reflect the usefulness of the TMC and yet, a need to understand how the TMC works within specific populations. It also is important to note, based on the literature, how cultural perceptions and belief systems about change can affect specific populations either in a positive or negative way based on normative beliefs. The application of the TMC to Native Americans should address these factors and provide an integration of a cultural component that can develop more accuracy to understanding an individual within the process of change.

Change and balance is a process that may involve stages to reach a sense of harmony. Utilizing a model that enhances the understanding of this process, such as the TMC and the theoretical framework of the Medicine Wheel may create a culturally appropriate tool to grasping specific mechanisms at work. The TMC addresses specific phases of change and the varying levels of motivation within these phases. The Medicine Wheel and the transtheoretical model appear to be an appropriate combination to

developing a deeper understanding of the recovery process of alcohol misuse within Native American populations.

The Present Study

The present research is designed to investigate the concepts of change and recovery from alcohol misuse from Native American perspectives. Furthermore, the applicability of two theoretical models will be examined: the Medicine Wheel and the Transtheoretical Model of Change (TMC). This examination aims at developing a more appropriate theoretical model in order to understand the recovery process within a Native American cultural belief system.

The concept of the Medicine Wheel has been used within many tribal communities in order to understand change and recovery but no empirical studies on the effectiveness of this model have been found. Similarly, very little empirical research has been done examining the effectiveness of the TMC within Native American populations. Do these concepts fit within the recovery process of Native Americans, or is there another model yet to be identified?

Within the concept of the Medicine Wheel, factors that often predict one's ability to deal with stressful situations and challenging tasks in the process of change are closely tied to the idea of balance, connectedness, and relationships. The Medicine Wheel provides an observation of how alcohol misuse realigns the sense of balance and connectedness. It shows the strong relationship with alcohol and the severed relationships with most everything else.

The TMC addresses the decision-making process through understanding the psychological and behavioral preparations needed for healthy change and recovery. The

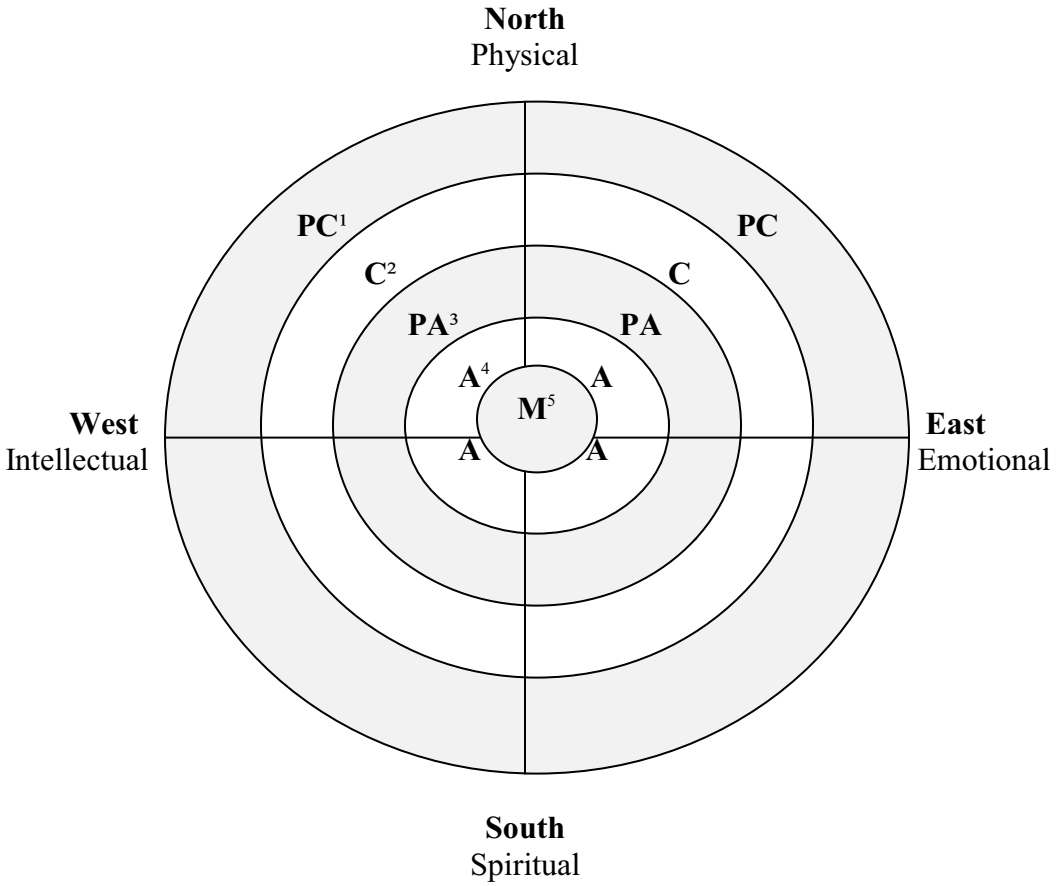
TMC can be looked upon as the "energy" that moves around the Medicine Wheel. In other words the present study is using both concepts to understand how the decision-making process circulates, changes, and adapts through the process of achieving balance and harmony within an individual attempting to recover from alcohol misuse. See Figure 8.

The process of change and adaptation are tied to level of motivation, and motivation is tied to cultural factors. What an individual believes as meaningful are clues to understanding specific motivating factors. Meaningful beliefs are created from one's cultural background. For most Native American tribes, the Medicine Wheel is a representation of the belief systems within that community. It can be looked upon as a broad understanding of Native American culture and used as a tool to understanding the process of change and adaptation within that culture.

Motivation and the process of change and adaptation are moving forces. Since the concept of the TMC is based on moving from one stage to another, it is considered to be a moving force and appears to be a good fit within the Medicine Wheel.

In the context of alcohol recovery, it is important to understand motivations and the process of change and maintenance within Native American cultures. This leads to Native American individuals providing their interpretations of these elements. Through this understanding, effectively addressing the high occurrence of alcohol problems and alcohol-related problems within Native American communities will come closer to reality.

Figure 8. The Transtheoretical Model (TMC) and the Medicine Wheel focusing on the Action (A) and Maintenance (M) Stages of Change within the Four Quadrants.



PC[1] = Precontemplation, C[2] = Contemplation, PA[3] = Preparation, A[4] = Action, and M[5] = Maintenance

Purpose

Substance abuse recovery is an arduous path to begin, involving an intense process of behavioral changes, cognitive restructuring, and emotional awareness. To begin the process, the path may involve understanding one's own personal belief system within the context of a cultural background. Peeling away the layers at the early stages of recovery may very well include understanding cultural beliefs. In turn, this understanding can attach purpose and meaning to the unfamiliar path, thus adding the spiritual

component to recovery. When working within the area of substance abuse, the models of change mainly follow a path based on the views of the dominant culture. Although this can be a helpful tool, cultural belief systems of Native Americans, based on acculturation level, may also play a key role in the process of change and recovery. This study was designed to provide a more in-depth understanding of Native Americans in recovery. To accomplish this goal, a Native American model of change and balance (Medicine Wheel) was added to the dominant culture's view of the stages of change (transtheorectical model) in order to understand change and recovery through the lens of Native Americans. Questions focused on how change occurred, how they maintained sobriety/recovery, and how they defined sobriety and recovery. The questions guiding the study were:

1. Is there a point of focus in the sobriety and recovery phases in regards to emotional, intellectual, physical and spiritual domains?
2. What were the specific mechanisms at work within the emotional, intellectual, physical and spiritual domains?
3. What support systems, tools, and resources have been instrumental in improving the lives of these individuals or have facilitated the process of recovery?
4. What were some temptations these individuals experienced on their path to recovery?
5. What were some motivating factors that began the sobriety/recovery process?
6. How did these individuals maintain sobriety?
7. What was gained and what was lost through the recovery process?

8. What were the personal reasons for making a behavior change for sobriety and were these individuals confident in performing this behavior change?
9. Is there a spiritual component within the processes of change?
10. Is there a connection between tribal cultural beliefs and recovery?
11. How do these individuals define sobriety and recovery?

CHAPTER II

METHODS

Research Design

This qualitative study was exploratory and descriptive in nature. Qualitative research methodology was chosen for this study because both the underlying assumptions and the methods of qualitative research are well suited to the nature of what is being investigated. Qualitative research is essentially concerned with describing, interpreting and understanding the lives of people and the meanings they give to the events they have experienced in specific settings (Glesne, 2006). Researchers who use this approach are interested in the ways people make sense out of their lives. In this study, the subject of research and inquiry was the life experiences of Native American men and women in recovery from alcohol misuse. The research sought to gain an understanding of the recovery process from the perspectives of Native Americans in recovery. The meanings that they had made of the experience were of primary interest to the researcher.

Because research in this area is in its infancy, a qualitative study using the frameworks of Charmaz (2005) and Creswell (2007) were chosen as methodological approaches. Charmaz (2005) describes qualitative research methods as "a set of flexible analytic guidelines that enable researchers to focus on their data collection and to build inductive middle-range theories through successive levels of data analysis and conceptual development" (p. 507). Qualitative methods interrogate meanings created within a group and attempt to discover how these individuals define their realities (Fassinger, 2005). This approach allows for a systemic analysis of the components supporting the maintenance of sobriety within Native American individuals.

In addition to studying the systemic and contextual factors of maintenance of sobriety, it is important to recognize if current models of change, in particular the Medicine Wheel and the TMC, fit with these participants' perceptions and experiences of the process of change and recovery. At this point in time, no research has been done examining the applicability of the Medicine Wheel and the TMC within Native American populations. Since a qualitative approach in research has the ability to address the ways of "knowing and being" within ethnic communities (Smith, 1999), it is important to utilize this method as a possible way to bridge gaps and build a stronger model that supports individuals in the process of change and recovery within a culturally relevant context. This study examines if participants voluntarily include and discuss components of the Medicine Wheel (e.g., physical, emotional, intellectual, and spiritual balance) within their alcohol recovery process. Furthermore, the study examines if these Native American individuals, in the action and maintenance stages, define components of the TMC (the pros and cons as well as the temptations) as similar to current research on this subject.

Quantitative measures were used for describing participants and as way to strengthen instrumentation when addressing the complexities of cultural affiliation. Although it is viewed within this study that acculturative factors are an ever-evolving and changing process throughout the lifespan and across different domains, the quantitative measures provided a general idea of where individuals were at within their sobriety/recovery process. In addition, two quantitative measures were used to examine the pros and cons of drinking as well as the temptations to drink. These measures were scored and interpreted *after* qualitative methods were interpreted (reduce bias). This was

done for the purposes of understanding if recovery looked differently between the two different approaches (qualitative and quantitative) within this group.

In sum, the use of qualitative methods in this research stems from both a grounded theory perspective and a multicultural one, which together recognize the importance of understanding the experience from Native American perspectives and sees each as the "expert" in naming and defining reality (Hage, 2006). Furthermore, this approach considered acculturative factors when attempting to understand their perspectives. Finally, this research attempts to investigate the applicability of two models that are often utilized within Native communities. The methodological approach taken in this study advocates for the integration of multicultural issues in research in order to develop theories appropriate to the socially constructed realties within a particular population.

Conceptualizing the Study

This study was conceptualized through the assumptive lenses of a constructivist paradigmatic inquiry, with specific interest in how Native Americans maintain sobriety from alcohol misuse. A constructivist paradigm "maintains that human beings construct their perceptions of the world, that no one perception is 'right' or more 'real' than another, and that these realities must be seen as wholes rather than divided into discrete variables that are analyzed separately" (Glesne, 2006, p. 7). The approach encourages researchers to remain close to their studied worlds, synthesizing and interpreting concepts that show processual relationships (Fassinger, 2005). Through this approach, constructivism adopts grounded theory guidelines as tools and realizes objectivity falls on

a continuum because the researcher's interpretive frame of reference is inevitably added to the analysis of participant data. Charmaz (2005) states:

> No qualitative method rests on pure induction – the questions we ask of the empirical world frame is what we know of it. In short, we share in constructing what we define as data. Similarly, our conceptual categories arise through our interpretations of data rather than emanating from them or from our methodological practices. Thus, our theoretical analyses are interpretive renderings of a reality, not objective reportings of it. (p. 510)

This research intends to generate some form of theoretical framework based on the narratives of Native American men and women diverse in age, tribal affiliation, and family variables. Representing their experiences clearly and effectively (e.g., using their own words) so that practical benefits (e.g., understanding of an often-ignored population, improved services) might ensue was the overarching goal. A team approach was used because the diversity of perspectives and the opportunities to manage unwanted bias contribute to the rigor of research. The team, as a whole, had minimal familiarity with the literature in the early stages of conceptualizing the study and collecting the data in an attempt to prevent high immersion in existing perspectives or constructs. Wrestling with data, making comparisons, developing categories, and integrating an analysis are the ways that grounded theory studies emerge (Fassinger, 2005). The focused examination method within grounded theory has the ability to "move the work theoretically and cover more empirical observations than other approaches. In this way, a focused grounded theory portrays a picture of the whole" (Charmaz, 2005, p. 530).

Participants and Recruitment

The participants of this study were a sample of 8 Native Americans, ages 29 to 64, who have been in substance misuse recovery for a minimum of 3 years. The reason for the 3 year marker comes from the personal stories from the book "Came to believe" (Alcoholics Anonymous World Services, Inc., 1983), which reveals a 3 to 5 year span from sobriety to recovery. All participants were members of Northern Plains tribes from either Montana or Wyoming several individuals as a consequence of their tribal affiliation are citizens of the United States and Canada. Participants were reimbursed with a $15.00 gift card for participating in the study. Counselors and sponsors working in the area of substance misuse recovery were asked to provide information about the proposed research study to clients/sponsors. Furthermore, flyers were posted in an urban Indian center. The individuals who responded were given information by the researcher about what would be involved if they volunteered. They were informed about the one-to-one interview process that focused on their substance misuse and the characteristics that helped in their lifestyle change. Initially, an interview time and place were scheduled with the interviewer. Interviews were held at an urban center near their area of residence.

Procedure

In this study, the research project director went to an urban Indian Center closest to where the participants resided. She visited the site to meet with the Indian Center's director and counselors from the chemical dependency program to discuss the research project. A presentation of the research project was offered to interested counselors at the Indian Center. A letter of support was obtained from the Indian Center, providing

permission to conduct the study and a flyer was posted at the Indian Center, providing information to contact the research project director or assistant researchers by phone.

Without intending it, a "snowball effect" occurred, meaning the receptionist at the Indian Center knew someone who would be a good candidate for the study and then she would have this individual call the project director. The individual called and scheduled an appointment with the project director. This individual knew other people who he/she thought would be good candidates for the study and shared information about the study with them. As a consequence, six participants agreed to be part of the study and left their phone numbers at the Indian Center for the project director. The project director called these individuals and scheduled appointments to meet at the Indian Center within a few days. Exchange of information included the date, time, and meeting place of the interview. Furthermore, assurance of Native heritage and substance misuse were also briefly assessed. All 6 participants were interviewed at the Indian Center within one week. Two more individuals called the project director months later, stating that they were interested in being part of the study based on the information shared by past participants. Date, time and meeting place were scheduled over the phone and the individuals were interviewed a few weeks later at the Indian Center.

Once the participants arrived at the scheduled interview, they were given an explanation of the role of the interviewer. The interviewer provided the purpose of the study: "The title of this project is, 'Change and Recovery'. I am interested in finding out a little about your life experiences. I have a few questions that I would like to ask. Please discuss your answers as best you can. If a question does not make sense to you, please let me know and I will try to re-phrase it." Furthermore, the interviewer explained to the

participants that they did not have to discuss anything in detail if they felt any type of discomfort about it. For example, if they mentioned attending a ceremony, they would not be expected to provide details about the mechanics of the ceremony itself. Participants were told that boundaries would be respected and to feel comfortable speaking out if they felt otherwise. Participants were informed that note-taking may take place during the interview as a way to help the interviewer remember things she may want to ask about. Then, they were told that paperwork needed to be filled out before beginning the interview. The participants were asked to sign a consent form to verify their knowledge of the requirements of the study. Assurance of confidentiality was written on the consent form and verified by the interviewer verbally during the introduction of participants to the interviewer. The participant's name was noted on the consent form and in no other place in the study. Moreover, the participants were asked if they would be interested in receiving general information based on the findings from this study. Participants who were interested in this filled out a Contact Information Sheet. Participants filled out a Demographic Information sheet (Apppendix A), the Native American Acculturation Scale (Garret & Pichette, 2000 revised by Trahan, 2004; Appendix B), the Decisional Balance Scale (Cancer Prevention Research Center; Maddock, 1997; Appendix C), and the Self-Efficacy Scale (Cancer Prevention Research Center; Maddock, 1997; Appendix D). After the paperwork was completed, the researcher conducted the interview based on a semi-structured Interview Schedule (Appendix E). When the interview came to a close, the researcher restated the purpose of the study, asked for and answered any questions, and thanked the participant for his/her time. A copy of the Consent Form, Contact Information Sheet, and a Referral Information

Sheet was given to each participant. Finally, a Participant Reimbursement Record was completed in order for the participant to receive compensation for their time. Each participant was interviewed and audio-taped for approximately two hours in order to derive data that described the process of change and recovery of substance misuse.

Collecting the Data

Data were collected by means of a demographic questionnaire, an acculturation measure, pros and cons of alcohol use measure, temptations to use alcohol measure, and a semi-structured interview. The principal method of data collection was in-depth interviewing. As stated previously, quantitative measures (demographic questionnaire, acculturation measure, alcohol measures) were used for describing participants, strengthening instrumentation when addressing the complexities of cultural affiliation, and as a validity check of current alcohol measures.

Demographic Information Questionnaire. The Demographic Information Questionnaire (Appendix A) assessed gender, age, tribal affiliation, tribal enrollment, religious/spiritual preference(s), level of education, occupation, household income, household structure, treatment received and misuse of other drugs. The Demographic Information Questionnaire also assessed the stages of change throughout the alcohol misuse process by age and number of relapses within the stages. Furthermore, questions about relationships during the process of change and recovery were assessed.

Native American Acculturation Scale. The Native American Acculturation Scale (NAAS; Garrett & Pichette, 2000; revised by Trahan, 2004) was specifically modified to be used with Native Americans. It is an 18-item self-report questionnaire that assesses the degree of endorsement of Native American behaviors and traditions. Each question is

multiple choice with options labeled 1 through 5. A score of 1 would indicate high affiliation with Native values and beliefs and 5 would indicate high acculturation to the dominant culture. Responses were reverse scored for the current study so that higher scores indicated more traditional endorsement. This scale is calculated by obtaining a mean score with possible scores ranging from 1 to 5. After reverse scoring, a mean score of 1 would indicate one was fully acculturated, a score of 3 would indicate bicultural behaviors, and a score of 5 would indicate traditional Native behaviors. Garret and Pichette (2000) reported an alpha coefficient of .91 for the NAAS.

Alcohol Measure: Decisional Balance Scale. The Decisional Balance Scale (Cancer Prevention Research Center, http://www.uri.edu/research/cprc/Measure/Alcohol03.htm, Maddock, 1997) is a 16-item measure that assesses the pros and cons of alcohol. There are eight items assessing the pros and eight items assessing the cons. The scale asks the question, "How important to you are the following statements in your decisions about how much to drink or if not to drink at all?" and includes items such as "I am more sure of myself when I am drinking" (pro) and "Drinking could get me addicted to alcohol" (con). Respondents answer on a 5-point Likert scale ranging from 1 (Not at all important) to 5 (Extremely important). Previous research using a similar 20-item measure reported coefficient alpha at 0.93 for pros and 0.86 for cons (Migneault et al., 1999). The current measure was based on, and is thus similar to, previously developed measures in this area (Migneault, 1995; Migneault et al., 1997); although, as college students were under study, the measure was framed around one's decision about how much to drink or not drink at all. The Decisional Balance Scale was scored after qualitative methods were interpreted.

Alcohol Measure: Self-Efficacy Scale. The Self-efficacy Scale (Cancer Prevention Research Center, http://www.uri.edu/research/cprc/Measure/Alcohol05.htm: Maddock, 1997) is a 39-item measure that assesses temptations and the confidence not to drink in particular situations. There are 20 items assessing temptations and 19 items assessing confidence in not to drink. The scale asks the questions, "How tempted are you to drink in each situation?" and "How confident are you that you would not drink in each situation?" Items included are "When I see others drinking at a bar or at a party" and "When I am feeling angry inside." Respondents answer on a 5-point Likert scale ranging from 1 (Not at all important) to 5 (Extremely important). Previous research using a similar measure reported internal consistency estimating at 0.97 (Snow, 1991). The current measure was based on, and is thus similar to, previously developed measures in this area (Migneault, 1995; Migneault et al., 1997; Snow, 1991). This measure was framed as one's confidence in performing a particular behavior when placed in a situation involving alcohol use. The Self-efficacy scale was scored after qualitative methods were interpreted.

The Interview Schedule. A semi-structured interview schedule was used to ensure a greater degree of focus and structure than informal conversational interviews, and maintain more flexibility than standardized open-ended interviews. The interview schedule asks two questions focusing on the Action and Maintenance stages of change; the four domains of the Medicine Wheel and Processes of Change were included for the benefit of the researcher to "check off" if the participant discusses anything relevant to these areas. The participants were not be probed to address all four domains of the Medicine Wheel and Processes of Change if they happen to leave one or more out during

the interview – again, the purpose of the "check off" list was for the researcher's understanding of the model (Medicine Wheel). The last section of the interview included a list of questions focusing on the recovery process at more in-depth levels. They addressed support systems, tools, resources, temptations, motivating factors, maintenance of sobriety, what were gained/lost, personal reasons for making a change, self-efficacy, spirituality, the possible connection to tribal culture, and their views on sobriety and recovery. The interview schedule formed the topics and issues covered in the interview, but also allowed for adapting the sequencing and wording of questions to each particular interview as noted by Weiss (1994). The use of the interview schedule afforded the researcher the freedom to probe unanticipated responses and issues as they emerged. By using this semi-structured interview format, the researcher had the opportunity to gain more substantive information and learn from the participants about the meaning of their experiences with substance misuse, change, and recovery.

Field Notes. Field notes were used as another data collection strategy. The researcher recorded observations during interviews. Expanded field notes were written following each interview. Glaser and Strauss (2006) point out the value of field notes even in studies using in-depth interviews, noting the important role observation plays in capturing the participant's body language and affect in addition to his/her words. Observation often enables the researcher to draw inferences about someone's meaning and perspective that could not be obtained by relying exclusively on recorded interview data (Weiss, 1994). The researcher's field notes provided the context for analysis of the interview data.

Data Protection. Paperwork and qualitative interviews were conducted at the urban Indian Center. In arranging interviews, attention was given to confidentiality issues and was strictly maintained. Program staff was not present during interviews or privy to study participants' responses. Interviews were audio-taped with the permission of the participants in an effort to capture verbatim interview data. All participants were interviewed once and most interviews were approximately 2 hours in duration.

Interview audiotapes were transcribed verbatim into a research lab computer by research assistants and checked for accuracy by another research assistant. The research assistants were undergraduate students from the University of Montana and received research credits for their assisting in the study. Each transcribed interview required a password to open the document on the computer. Audiotapes and interview transcripts were identified by a number and the date of the interview. Audiotapes were destroyed after transcription. A backup copy of the project was saved routinely on the server. Field notes were attached to a hard copy of the corresponding transcript and maintained in a hard copy and kept in a locked file for coding and data analysis. The file was organized chronologically and kept in a secure location. Informed consent forms and contact information were kept in separate file folders and also maintained in a locked file in a secure location.

Constant comparison. The detailed coding procedures made explicit by Glaser and Strauss (1967) are accepted and used widely among qualitative researchers, even if those researchers do not utilize other aspects of the grounded theory approach (Fassinger, 2005). Although the three types of coding (open, axial, selective) are discussed sequentially in most grounded theory accounts, they actually occur recursively according

to a method of constant comparison, wherein each new piece of data is compared to existing data to generate coherent categories of meaning (Charmaz, 2005). Charmaz (2005) and Fassinger (2005) note that the constant comparative method includes (a) comparing data from different individuals, (b) comparing data from individuals to their own data at different points in their narratives, (c) comparing incidents with other incidents, and (d) comparing categories with other categories. Creating a theory grounded in the lived experiences of the participants is the overarching goal and coding for interpretation and construction of meaning provides the building blocks to reach this goal.

Open coding. The first level of coding is open coding, in which transcribed data are broken down into units of meaning (concepts), labeled (often with words close to those of the participant), and interrogated (for alternative interpretations, conditions surrounding the meaning, and gaps left unfilled; Camic, Rhodes & Yardley, 2003; Fassinger, 2005). These are the first steps in theorizing from the data. The size of concepts or units of meaning differs among researcher's preference. Some use line by line coding while others prefer specifying units of meaning as small as a word, as large as a paragraph, or working with a page or two. These coded units of meaning are compared to other coded units of meaning, the concepts gradually being grouped together into categories that encompass those concepts (Camic, Rhodes & Yardley, 2003). As additional data are gathered, coded concepts continue to be compared to existing data and (re) categorized (Fassinger, 2005).

Coding in this research project began with line-by-line coding. The project director and lab assistants read interviews together as a group and discussed coding labels

line-by-line. Initial coding included: staying close to the data, keeping codes simple and precise, constructing short codes, preserving actions, comparing data with data, and moving quickly through the data (Charmaz, 2005). For example, a line in a transcribed interview read, "that was the worst scariest feeling I ever had," and was coded by the group as "feeling scared." Another line in another transcribed interview read, "All the losses that I experienced due to my drinking, all the losses that I had " and was coded "experiencing losses."

Axial coding. The second level of coding in a grounded theory analysis is axial coding, in which relationships among categories are organized and further explicated, grouping them into more encompassing (key) categories that subsume several (sub) categories; thus, axial coding puts the fractured data back together in the form of categories and their interrelationships, the next step in generating theory (Camic, Rhodes & Yardley, 2003). A constant comparison method is used, with four different kinds of comparisons: (a) comparing and relating subcategories to categories, (b) comparing categories to new data, (c) expanding the density and complexity of the categories by describing their properties (attributes of a category) and dimensions (ordering of the properties along a continuum), and (d) exploring variations (e.g., disconfirming instances) in the data and reconceptualizing the categories and their relationships as necessary (Charmaz, 2005; Fassinger, 2005). Data collection and incorporation cease when categorical saturation is reached, that is, when no new information is being discovered about the categories or their properties, when the categories are dense and complex enough to capture all the variations in participants' experiences, and when the relationships among categories have been delineated satisfactorily (Fassinger, 2005).

Axial coding in this study included: breaking the data up into their component parts or properties, defining the actions on which they rest, looking for tacit assumptions, explicating implicit actions and meanings, crystallizing the significance of the points, comparing data with data and identifying gaps in the data (Charmaz 2005). The project director and the research assistants utilized the Medicine Wheel model in order to perform these actions. For example, the "feeling scared" open code was further coded under the Emotional domain by the project director and research assistants. The "experiencing losses" open code was further coded under the Physical domain due to the content of what the participant described as losses. The project director and the research assistants color coded the open codes according to the domains of the Medicine Wheel and discussed reliability of their coding process. For example, all open codes that fell under the Emotional domain were color coded yellow and all open codes that fell under the Physical domain were color coded green. Coding was done as a group and discussed.

At this point, identifying the properties and dimensions of the categories becomes important. This step is critical in helping the researcher to consider what categories actually mean in terms of individual participants (e.g., whether they fit participants' experiences as described) and what the relationships are among categories. Properties refer to the attributes or characteristics of a category or key category, and dimensions refer to the relative positions of derived data (from observations or participants) along a continuum. For example, the key categories "sobriety phase" and "recovery phase" emerged and contained a number of properties, specifically the domains of the Medicine Wheel. Another domain emerged from the data, which included utilizing all four domains

simultaneously. This dimension allowed research assistants to place an open code within more than one domain due to the content of what was said by the participant.

The project director and research assistants next utilized the TMC in order to identify processes of change. This required coding paragraphs of transcribed interviews and changing the "lens" in order to code the material. More specifically, open coding appeared to be meaningless when examining the processes of change in each participant and required coding by paragraphs and combining these open codes together to form a process of change. This type of coding helped researchers understand specific mechanisms involved in the process of change. Axial coding is designed to help researchers think more systematically and complexly about their data and to examine more clearly the cause and effect implications of their emergent theories (Charmaz, 2005).

Selective coding. The final stage of analysis involves the creation of substantive theory. This analytic stage begins with "selective" coding, in which a central or "core" category is selected that integrates all of the other categories into an explanatory whole (Charmaz, 2005; Creswell, 2007). A core "story' is generated, which is a brief narrative of the most important aspects of the data, subsuming all of the other categories and articulating their relationships to the core story (Fassinger, 2005). As in previous stages of analysis, the emerging theory is constantly compared to the data to ensure that it is grounded in participants' experiences and it also is compared to the existing literature to enrich understanding and explanatory power (Camic, Rhodes & Yardley, 2003).

Coding/Interpreting Data and Articulating Theory

NVivo. Data evaluation included NVivo, which is a computer assisted qualitative analysis. NVivo makes it possible to import documents directly from a word processing package and code these documents on screen. It allows the researcher to write memos about particular aspects of documents and link these to relevant pieces of text in different documents. The memoing tools in NVivo applies a "coding paradigm" which is neither inductive nor deductive, but a mixture of both (Welsh, 2002). Morse, Barret, Mayan, Olson, and Spiers (2002) discuss the criteria for reliability and validity within the naturalistic (qualitative) paradigm as ensuring credibility, fittingness, auditablity, and confirmability – otherwise called "rigor." Welsh (2002) explains that:

> Nvivo can add rigour to the analysis process by allowing the researcher to carry out quick and accurate searches of a particular type (the researcher may be reluctant to carry out these searches manually, especially if the data set is large), and can add to the validity of the results by ensuring that all instances of a particular usage are found, this searching needs to be married with manual scrutiny techniques so that the data are in fact thoroughly interrogated. (p. 74)

The software program can be used to explore systematically basic material, creating broad agreement amongst researchers about what is being dealt with. Hence, the quality and rigor of the research is enhanced.

After the project director and research assistants agreed on open coding, axial coding, and selective coding procedures, the data was placed into NVivo and further evaluated in order to create a theoretical model.

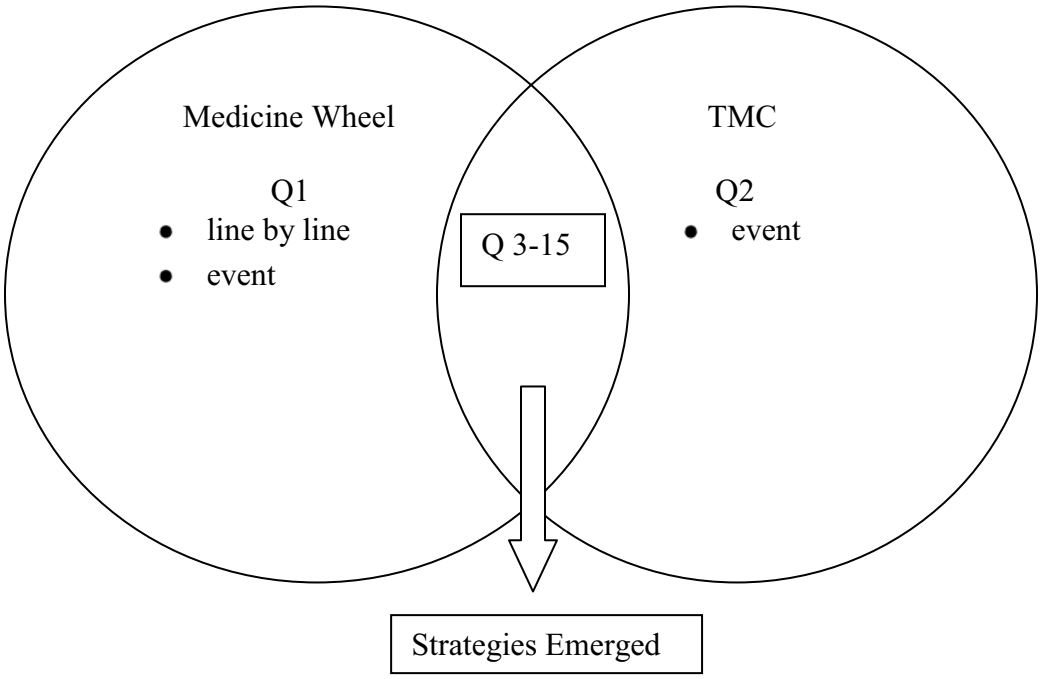
Analysis of Theoretical Frameworks

Many theories are available to help explain the process of change and recovery from alcohol misuse. Most are useful in providing a general framework, but are limited when applied to underserved communities. A major limitation of the available theories is that they do not consider the unique effects of cultural factors on the process of change. Culture has a powerful influence on people's motivation to change because it sets the stage for healthier behaviors and practices. The Medicine Wheel is a frequently used model in most Native communities and is best known for its holistic approach. The Medicine Wheel has increased our understanding of people's substance misuse by emphasizing individual beliefs and their predictive qualities. However, it may be too broad and abstract when considering changes in barriers that people face as they increasingly adopt a healthier behavior. Also, no empirical research addressing its effectiveness has been done. These are important considerations when examining the attitudes and behaviors within Native communities where collective norms have a powerful effect on individuals' processes of change and recovery.

An alternative to models that use single equations are stage models. A stage model, such as the TMC, seems appropriate for incorporating the complexities of change and recovery from alcohol misuse. Also, the TMC provides a useful framework for examining the effects of cultural factors and acculturation on the process of change and recovery. Research is needed to examine the process of change that Native Americans utilize as they progress toward maintenance so that appropriate interventions can be developed. This study attempted to analyze the two theoretical frameworks and their applicability to this sample of Native Americans with at least three years of sobriety.

This study analyzes the frameworks of the Medicine Wheel and the TMC, examining if participants' stories identify with these models of change. Because there may be group specific determinants and differences relating to change and recovery from alcohol misuse, this research takes the stance of examining if the models fit within the participants' interpretations of change and recovery rather than the other way around. It will also examine acculturative factors within this process. Figure 9 explains the analyses of the Medicine Wheel and the TMC within this study.

Figure 9. Data analyses per the Medicine Wheel and the Transtheoretical Model for Change (TMC).



CHAPTER III

RESULTS

Demographics

Five males and 3 females participated in the study. All participants were from Northern Plains tribes, e.g., from either Montana or Wyoming tribes; several individuals as a consequence of their tribal affiliation are citizens of the United States and Canada. The age range was large, spanning from as young as 29 to 64 years. The majority of participants reported practicing tribal traditional spiritual ways. Most of these participants practiced a combination of tribal traditional spirituality with Christianity. One participant reported his/her religious preference as fundamental Christianity. The majority of the participants were well-educated. Most participants had a Bachelor's degree or higher and they were employed as counselors and social workers. Some participants had a high school diploma and some college. As a consequence, their incomes ranged from less than $7,500 a year to more than $40, 000 a year. A laborer, a college student, and a clerical worker earned the least, e.g., less than $25,000 a year. The majority earned more than $25,000 a year. With regard to relationships, most were married and/or living with their children or adult children. Several participants lived alone, although one traveled back and forth to his/her home reservation. When asked if they knew someone through the entire process of alcohol misuse to recovery, most reported that their relatives maintained relationships with them and that they still have contact. Most of these participants indicated that the relationships with their relatives have improved now that they are in recovery. More specifically, it was the communication between them that has improved.

In addition to misusing alcohol, participants also reported using other drugs, more specifically, marijuana, methamphetamines, "mushrooms," and prescription pain-killers.

As a check of treatment received, participants were asked to indicate and evaluate their experience with different types of modalities to address substance misuse. See Table 2.

Table 2. Treatments experienced and evaluated

	N	Poor	Fair	Good	Very Good	Excellent
Court-ordered	4	1		1	2	
Self-referred	6		1		4	1
Individual therapy	5		1		2	2
Group therapy	4			2	1	1
AA meetings	7		2		4	1
Intensive Outpatient	4				2	2
Residential -- State	4		1	1	2	
-- Tribal	4		2		1	1

After participants reported their demographic information, they were interviewed. The first question focused on the time they decided to quit for good but had not been sober for 3 years yet. Their responses were coded using Charmaz's (2005) framework. Participants' ages during the stages of change were recorded in Table 3.

Table 3. Stages of Change of Participants

Participant and Age	Precontemplative	Contemplative	Preparation	Action	Maintenance
#1: 64	Adolescence	30s	30s	30s	30s
#2: 58	Adolescence	20s	30s	40s	50s
#3: 38	20s	20s	20s	20s	20s
#4: 51	20s	20s	20s	20s	30s
#5: 51	Adolescence	20s	20s	20s	30s
#6: 48	Late Childhood	30s	30s	30s	30s
#7: 35	Adolescence	20s	20s	20s	30s
#8: 29	20s	20s	20s	20s	20s

Most participants experienced 1 relapse or had not relapsed at all. Furthermore, participants' numbers of relapses were recorded in Table 4.

Table 4. Relapses

Participant	Relapses
#1	1
#2	1
#3	0
#4	0
#5	1
#6	3
#7	> 3
#8	0

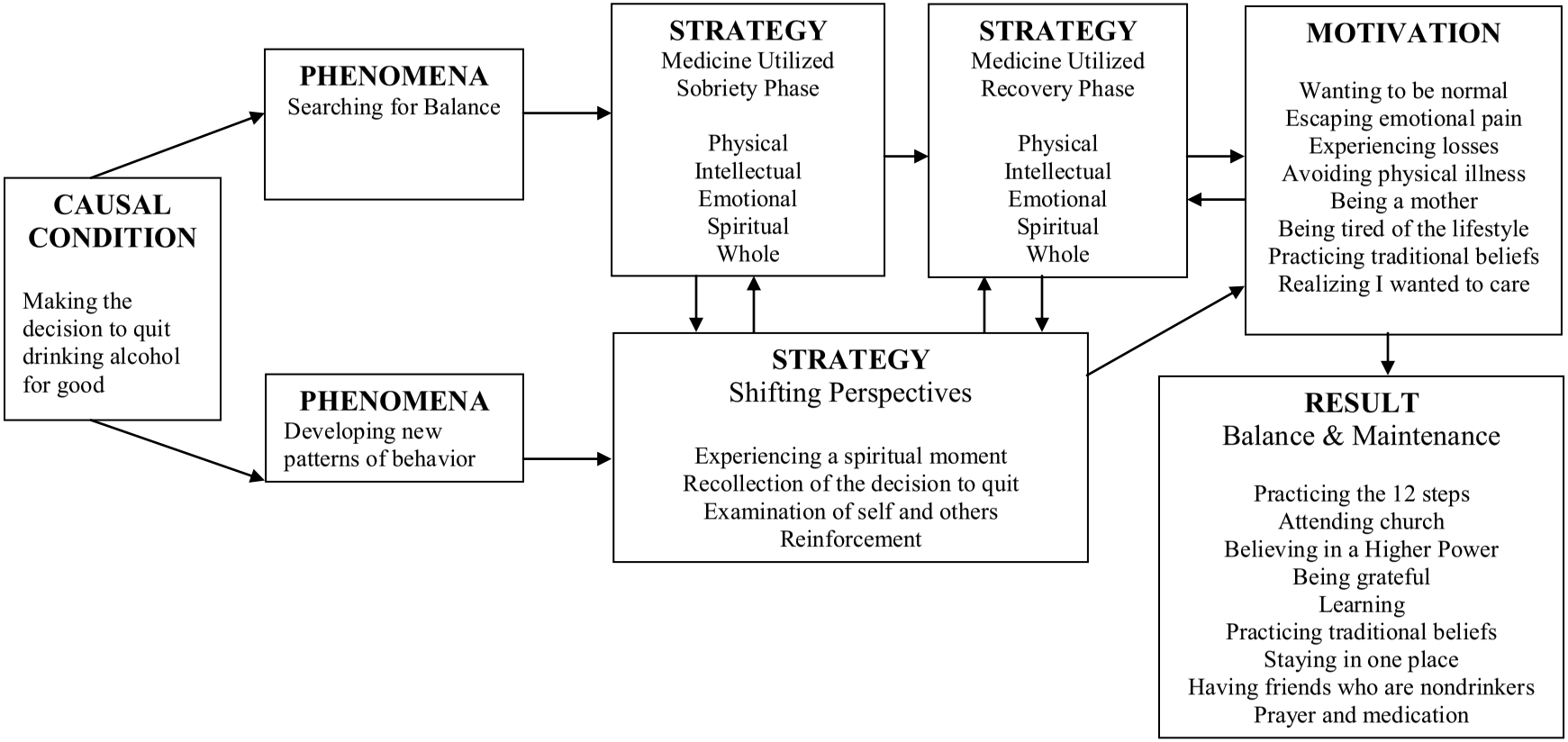
Qualitative Data Analysis

Themes of change and recovery from alcohol misuse evolved from Charmaz's (2005) framework and developed from the present investigation. Open coding and axial coding were utilized in order to identify the content and tag thematic labels. Furthermore, axial coding and selective coding were utilized in order to sort, summarize, and integrate themes into a cohesive nature. A theoretical model for change and recovery from alcohol misuse emerged by utilizing Creswell's (2007) framework (see Figure 10). In the following pages the development of this model, e.g., The Theoretical Model for Change and Recovery from Alcohol Misuse, will be delineated.

Causal Condition of Phenomena Related to Change and Recovery

One single causal condition emerged from the data which ultimately led to certain phenomenological experiences related to change and recovery from alcohol misuse. This causal condition was participants making the decision to quit drinking alcohol for good. Attempting to regain balance in life formed the bedrock on which change and recovery from alcohol misuse occurred. All participants' experiences reflected instability and the

Figure 10. Theoretical Model for Change and Recovery from Alcohol Misuse



attempt to stabilize or find balance. For example, one participant described her lifestyle in early sobriety as: moving from place to place, changing jobs, being involved in an abusive relationship, getting pregnant, experiencing legal problems, feeling depressed, and returning home to take care of her dying mother.

Taking steps to change and beginning to create new patterns of behavior also led to recovery from alcohol misuse. All participants explained their attempts at taking steps toward change. Taking steps included an array of attending inpatient treatment and Alcohol Anonymous to drinking bottles of alcohol for days in order to create an event a participant labeled as "my last drunk." This type of causal condition ultimately led to certain phenomenological experiences related to change and recovery from alcohol misuse.

Phenomena Resulting From Making the Decision To Quit For Good

Causal condition – making the decision to quit for good – resulted in two core categories of subjective phenomena as reported by participants: (a) attempting to gain balance in life and (b) creating new patterns of behavior. These two core categories of phenomena were strictly comparable to the two models discussed previously in this study: The Medicine Wheel, which addresses balance and the Transtheoretical Model of Change (TMC; Prochaska and DiClemente, 1984), which addresses the process of change. Some examples in the present study show strong similarities to both models, including different participants stating:

> "Today I am in recovery, and I have been in recovery because recovery is about change, about making positive changes in order to maintain our sobriety, we have

to make those changes spiritually, emotionally, physically, and mentally and if we don't we will go back to drinking." (Participant #1)

"My foundation is my culture, my Native American culture and traditions, and the whole spiritual part. So now I live amongst the teachings of the Medicine Wheel, you know, the physical health, the mental health, the spiritual health and the emotional health. I live amongst those four, it all affects each other. If I'm not emotionally well, then I'm probably not mentally well or physically well, or spirit . . .so it's about trying to maintain the best balance that I can with that Medicine Wheel, so those teachings have really helped me." (Participant #3)

"I changed in a lot of ways, when I look back on when I was using . . . I didn't like that. And I changed, but it was like, in recovery it is a long process . . . until you're good, practice these things . . . deal with the physical, emotional, mental, spiritual." (Participant #6)

Strategies for Searching for Balance and Creating New Patterns of Behavior

Two overarching phenomena led to the development of two parallel strategies for change and recovery: (a) utilizing medicine and (b) shifting perspectives.

The strategy of utilizing medicine.

The strategy of utilizing medicine was broken down into two phases: (a) sobriety phase and (b) recovery phase. These phases were suggested from the book "Came to Believe" (Alcoholics Anonymous World Services, Inc.,1983) and from most of the participants who similarly defined the differences between sobriety and recovery. Furthermore, Prochaska and DiClemente's (1984) description of the Action and

Maintenance Stages show close similarities to the sobriety and recovery phases defined in this study. Examples of participants' brief definitions of sobriety and recovery are cited below:

> "Sobriety is being abstinent. Recovery is about recovering from all of the internal dysfunction." (Participant #1)
>
> "Sobriety is like you're just clean. Recovery is like you're working a program like you're always learning." (Participant # 6)
>
> "Sobriety is the state of being sober. . . recovery is being able to have positive relationships, being able to be a mother . . . understanding the reciprocal of the give and take. (Participant #3)
>
> "Sobriety is sobering up. Recovery is the process of the little baby steps . . . like growing up again. It's like going from a child to an adult." (Participant #4)
>
> "Being sober is eliminating the drugs or alcohol part . . . I think recovery is definitely a lifelong process and continuing to work on you know, the things in your areas in your life that need work on." (Participant #7)
>
> "Sobriety means you are sober from the substance but you're just trying to stay away from it. Recovery is your living your life, your going out there doing what you want to do, you've found yourself, you see who you are." (Participant #8)

Clear distinctions between sobriety and recovery are evident. Participants described sobriety as an event and recovery as a process. In addition, they suggested that sobriety was more of a physical event and recovery was a process involving the physical, emotional, intellectual and spiritual. The next step was to examine these events and processes from the Medicine Wheel perspective.

The Medicine Wheel Analysis.

Within the two phases of sobriety and recovery are the domains of the Medicine Wheel – (a) Physical, (b) Intellectual, (c) Emotional, (d) Spiritual, and an additional domain based on the emerging data, which was labeled (e) Whole. The "Whole" domain includes the Physical, Intellectual, Emotional, and Spiritual domains appearing together. Open codes were placed accordingly into these five domains. According to the Medicine Wheel model, the open codes that were placed into these five domains are considered to be "medicine" and this medicine is considered to be one of the strategies utilized in this study. See Figures 11 through 15.

Physical. All participants reported utilizing the Physical domain of the sobriety phase. Approximately twenty-five types of medicine emerged: accepting help, accepting spiritual help, attending AA, attending inpatient treatment, attending outpatient treatment, being incarcerated, being single, continue doing, doing it myself, exercising, experiencing hangovers, experiencing legal problems, experiencing losses, having family, having no temptations, hearing others' stories, loss of parental rights, physically exhausted, physically ill, seeing mother's disappointment, taking classes, volunteering, and witnessing others' accomplishments. All participants reported accepting help. Some examples include:

> "They're able to give me feedback, or at least with how to come up with a solution. 'Cause in recovery, it's about solution. Problems and issues, that's when you go to people." (Participant # 6)

"He's like, 'Okay, well come down here as soon as you can.' I'm like, I expected a bigger response like, 'Why?' and 'What?' and 'Where?' Anyways it was my uncle and my spiritual father that kinda really helped me along." (Participant #8)

The majority of participants reported experiencing losses. Some examples include:

"It was because of the things that happened to me as the result of the alcohol, all the losses that I had." (Participant #1)

"I lost everything, self-respect, anything, everything, and I used to forget [emphasis] all that for, momentarily, you know [when drinking]." (Participant #3)

Most participants reported attending AA. Some examples include:

"So that first five years, for me, in recovery, had to be very close to AA." (Participant #1)

"I worked a twelve-step recovery program for, not only for my use, but also because my spouse at the time was a recovering alcoholic also, so I went to Al-Anon meetings for that." (Participant #5)

"And meetings was the key to part of my recovery as going to Alcoholics Anonymous." (Participant #7)

Most female participants discussed losing their parental rights while they were still misusing alcohol. In contrast, only one male participant discussed losing parental rights while he was drinking. All participants who reported losing parental rights while they were drinking also reported re-obtaining parental rights in the recovery phase.

Almost all participants reported utilizing the Physical domain in the recovery phase. Seven types of medicine emerged: attending AA, attending church, doing

exercises, earning parental rights, gaining geographical stability, having friends who are nondrinkers, and having job stability. Most participants reported attending AA. Some examples included:

"I have to give all the credit to AA (participant #1),"

"AA was a big tool for me, having the support of AA." (Participant #7) and

"The steps, I really believe in the steps." (Participant #6)

Figure 11. *Strategies for utilizing medicine: Physical domain*

Strategies For Attempting to Gain Balance: Utilizing Medicine Physical Domain	
Sobriety Phase	Recovery Phase
Accepting help Accepting spiritual help Attending AA Attending inpatient treatment Attending outpatient treatment Being incarcerated Being single Meeting a supportive person Moving place to place Obtaining parental rights Physical exhaustion Physical illness Seeing mother's disappointment Taking classes Volunteering Witnessing others' accomplishments Continue doing Doing it myself Exercising Experiencing hangovers Experiencing legal problems Experiencing losses Having family Having family Having no temptations Hearing others' stories Loss of parental rights	Attending AA Attending church Exercising Earning parental rights Geographic stability Having friends who are nondrinkers Having job stability

Intellectual. All participants reported utilizing the Intellectual domain in the sobriety phase. Eleven types of medicine emerged: getting an education, learning, making better decisions, negative thinking, questioning parenting style, realizing something was wrong, realizing what alcohol did to family, realizing can't do it on my own, realizing the power of alcohol, realizing what I think about myself, and seeking spiritual knowledge.

Half of the participants reported that learning was a significant part within the sobriety phase. Some examples include:

> "Learning how to deal with anger, learning how to care about others, learning how to trust others, learning how to overcome . . . the values and the morals, that created a lot of dysfunction for me." (Participant #1)
>
> "It was a lot of learning, and just more teachers . . . continued learning." (Participant #3)
>
> "She taught me how to communicate . . . So, my wife really helped me in that sense of communicating, and you know my children really helped me, taught me a lot of things about communication." (Participant #7)
>
> "I went back to college." (Participant #5)

Half of the participants reported that they experienced a realization of what alcohol did to their families. Some examples include:

> "But then I just realized what drinkin' been doin' to my family . . . it just killed a lot, a lot of, a lot of my people, my own blood." (Participant #2)
>
> "I wanted to do somethin' different than, umm, what my, the way my folks lived their lives." (Participant #5)
>
> "I wanted to know, 'Why did this substance get a hold of my dad?'" (Participant #3)

Almost all participants reported utilizing the Intellectual domain in the recovery phase. Seven types of medicine emerged: believing in a Higher Power, believing in AA, learning about addiction, positive thinking, realizing internal dysfunction, realizing it

takes time to stabilize and recognizing past self. Six participants reported believing in a Higher Power. Some examples include:

"I was able to come to believe, not just to believe, but to develop a relationship with the Creator." (Participant #1)

"Talk to the spiritual leader in heaven who is God."(Participant #2)

"It made me see the power of prayer and that there is a Higher Power." (Participant #3)

"I need to, you know, trust in Creator." (Participant #7)

Figure 12. *Strategies for utilizing medicine: Intellectual domain.*

Strategies For Attempting to Gain Balance: Utilizing Medicine Intellectual Domain	
Sobriety Phase	Recovery Phase
Getting an education Learning Making better decisions Negative thinking Questioning parenting style Realizing something is wrong Realizing what alcohol did to family Realizing can't do it on my own Realizing the power of alcohol Realizing what I think about myself Seeking spiritual knowledge	Believing in a higher power Believing in AA Learning about addiction Positive thinking Realizing internal dysfunction Realizing it takes time to stabilize Recognizing past self

Emotional. Most of the participants reported utilizing the Emotional domain in the sobriety phase. Sixteen types of medicine emerged: Escaping emotional pain, feeling a need or urgency to quit, feeling angry, feeling comforted, feeling confident, feeling depressed, feeling like a bad person, feeling lucky, feeling no confidence, feeling out of control, feeling overwhelmed, feeling scared, wanting a sense of belonging, wanting to be

normal, wanting to be with old friends, and wanting to identify with other Native Americans. Half of the participants reported feeling depressed. Some examples include:

> "All that pain, that hopelessness, that despair, the sadness." (Participant #1)
>
> "I have a lot of shame, a lot of guilt." (Participant #3)
>
> "The ickiness went away, the depression went away." [discussing recovery] (Participant #4)

Half of the participants reported a lack of confidence. Some examples include:

> "Not very confident but, umm, so I kind of struggled for the first couple of years until I felt like I had the second step[1] down." (Participant #5)
>
> "Ha, I wasn't [confident] you know . . . I didn't think I was going to be able to really, to be honest with you. I didn't think I was going to do it." (Participant #6)

Half of the participants reported utilizing the Emotional domain in the recovery phase. Seven types of medicine emerged: becoming a caring person, feeling a sense of accomplishment, feeling a sense of belonging, feeling an identification with other Native Americans, feeling grateful, feeling strong, and trusting others. Some participants reported feeling a sense of belonging. Some examples include:

> "For me, learning who I was as a Native American or Indigenous person, gave me that identity I was seeking." (Participant #3)
>
> "I'd say the biggest one is a sense of who I am, because I struggled with that all my life . . . not being raised on a reservation . . . I always had an identity crisis and I always had a hard time fittin' in you know." (Participant #7)

[1] The second step in AA is, "Came to believe that a power greater than ourselves could restore us to sanity."

Figure 13. *Strategies for utilizing medicine: Emotional domain.*

Strategies For Attempting to Gain Balance: Utilizing Medicine Emotional Domain	
Sobriety Phase	Recovery Phase
Escaping emotional pain Feeling a need or urgency to quit Feeling angry Feeling comforted Feeling confident Feeling depressed Feeling like a bad person Feeling lucky Feeling no confidence Feeling out of control Feeling overwhelmed Feeling scared Wanting a sense of belonging Wanting to be normal Wanting to be with old friends Wanting to identify with other Native Americans	Becoming a caring person Feeling a sense of accomplishment Feeling a sense of belonging Feeling an identification with other Native Americans Feeling grateful Feeling strong Trusting others

Spiritual. All the participants reported utilizing the Spiritual domain in the sobriety phase. One type of medicine was used: prayer and meditation. Some examples include:

"I'd pray." (Participant #2)

"Initially prayer; and then the sage and sweet grass." (Participant #3)

"I'd always, they'd always be praying, my grandpa would pray for a long time." (Participant #5)

"I'd run the sweat lodge." (Participant #7)

"I'm gonna sun dance." (Participant #8)

All the participants reported utilizing the Spiritual domain in the recovery phase. Five types of medicine emerged: combining religion and tribal traditional spiritual

beliefs, depending on relationship to Higher Power, strengthening spirituality through AA, believing in a Higher Power and prayer and meditation. All the participants reported that they used prayer and meditation. Most of the participants reported believing in a Higher Power.

Figure 14. *Strategies for utilizing medicine: Spiritual domain.*

Strategies For Attempting to Gain Balance: Utilizing Medicine Spiritual Domain	
Sobriety Phase	Recovery Phase
Prayer and meditation	Combining religion and tribal traditional spiritual beliefs Depending on relationship to Higher Power Strengthening spirituality through AA Believing in a Higher Power Prayer and meditation

Whole. All the participants reported utilizing the Whole domain in the sobriety phase. Nine types of medicine emerged: being humbled, being tired of the lifestyle, experiencing a spiritual moment, practicing the twelve step program, practicing tribal traditional spiritual beliefs, prayer and meditation, taking care of self, taking it day by day, and tired of the lifestyle. All participants reported prayer and meditation. Most participants reported practicing tribal traditional spiritual beliefs. Some examples include:

"My culture ways like when I go to a sweat . . . I'm thankful for it."

(Participant #2)

"She introduced me to sage and sweet grass and to offerings." (Participant #3)

"I went to sweats and ceremonies." (Participant #5)

"Being able to smudge everyday." (Participant #6)

"I was doing sweats every Friday." (Participant #7)

"The ceremonies and stuff, those are tools, prayers, smudge." (Participant #8)

All participants reported utilizing the Whole domain in the recovery phase. Ten types of medicine emerged: being a father, being a mother, caring for others, developing ongoing healthy relationships, gaining self-respect, letting go, practicing the twelve-step program, practicing tribal traditional spiritual beliefs, prayer and meditation and taking care of self. All participants reported prayer and meditation. Most participants reported practicing tribal traditional spiritual beliefs.

Figure 15. *Strategies for utilizing medicine: Whole domain.*

Strategies For Attempting to Gain Balance: Utilizing Medicine Whole Domain	
Sobriety Phase	Recovery Phase
Being humbled Being tired of the lifestyle Experiencing a spiritual moment Practicing the 12 step program Practicing traditional beliefs Prayer and meditation Taking care of self Taking day by day Tired of lifestyle	Being a father Being a mother Caring for others Developing ongoing healthy relationships Gaining self-respect Letting go Practicing the 12 step program Practicing tribal traditional spiritual beliefs Prayer and meditation Taking care of self

The strategy of shifting perspectives.

The next step in coding was to analyze events the participants described. The events developed into processes that required axial coding and selective coding (Charmaz, 2005). These processes required changing their perspectives. These shifting perspectives required the utilization of medicine and a process of change. Through attempts to gain balance, a process was developed that created new patterns of behavior. Each development of new patterns of behavior was strikingly similar to the Transtheoretical Model of Change – Processes of Change (Velicer et al., 1998; See Table 1) and included these specific strategies that eventually produced new patterns of

behaviors: (a) experiencing a spiritual moment, (b) recollection of the decision to quit, (c) examination of self and others, and (d) reinforcement.

The Transtheoretical Model of Change Analysis.

Within each participant's process of change, cognitive/experiential and behavioral events evolved. These events included most or all of the following: consciousness-raising, dramatic relief, self-reevaluation, environmental reevaluation, social liberation, self-liberation, counter-conditioning, stimulus control, contingency management, and a helping relationship (Velicer et al., 1998). The events involved utilization of medicine that maneuvered, deleted, or added medicine in order to develop new patterns of behavior. In other words, these events involved a strategy of shifting perspectives. The following information describes the specific mechanisms at work within the participants' shifts in perspectives.

Experiencing a spiritual moment. The process of experiencing a spiritual moment was experienced by several participants who described the process of shifting perspectives in their own way. Few participants experienced a spiritual moment. Another few accepted spiritual help. The processes of experiencing a spiritual moment included: (a) Accepting spiritual help from a supportive person and (b) Creating an event and changing the outcome. See Figures16 and 17.

Figure 16. *Strategy of shifting perspectives: Experiencing a Spiritual Moment*

Figure 16. Strategy of Shifting Perspectives: Experiencing a Spiritual Moment

Accepting Spiritual Help from a Supportive Person

"…my mind was going, my heart was going, I wanted to get up from that hospital bed, but I couldn't, I was like, froze. My body just had it, I physically wanted to run out of there, but I couldn't. I couldn't even talk, I remember, I felt like I was in my own prison, I made my own prison within my body, and that was the worst, scariest feeling I ever had . . .so I laid there. I remember a Native American nurse came walking in, and she was checking my vitals, and um I had tears running out of my eyes and she was looking at me and she was like, 'my poor girl,' and she said, 'Can I pray for you?' And I told her, well, kind of nodded [laughs briefly], you know, 'yeah,' you know. So she put her hands on my head, and she prayed and umm, gosh [emphasis] . . . that feeling that I had . . . more tears came and she prayed and she stayed with me and she held my hand. She just, you know she was done and after she was done she comforted me and she walked out, and I fell asleep and I slept . . . I slept and I slept [laughs briefly]. I slept I don't know, for a couple days, you know it seemed like 'cause I was just so exhausted. When I met that Native American nurse you know, she was an angel, you know I don't know who she is today, you know. I don't know her name, I don't know who she is but, and I never did see her again after that, that time. You know, but she was a Native American nurse and she made me see the power of prayer because I was you know, like I said I was a prisoner in my own body. That's how I felt and I was going stir crazy and she came to me and did her prayer. Just release something watching over me, you know. And that was a miracle for sure."

Process of Change: Accepting spiritual help from a supportive person

Physically ill
Feeling Scared
Meeting a supportive person
Accepting spiritual help
Becoming Stronger

Figure 17. *Strategy of shifting perspectives: Experiencing a spiritual moment*

Figure 17. Strategy of Shifting Perspectives: Experiencing a Spiritual Moment

Creating an event and changing the outcome

"Okay, the main reason I quit [clears throat] is they, I thought back to this day that alcohol took my family and I said, 'I'm going to make this my last drunk. I'm going to drink wine, just like my grandma and grandpa did, when it took them.' And so, I got myself about 13, 14 MDs, and I sat home until I drank them. Slowly, wake up drinking' it . . .I forget how long it lasted me . . .about 4, 5 days, something like that. I told myself that I'm gonna finish this all up and I'm going to quit. And, 'cause, I wante—to go out of this alcohol business drinking what my grandparents drank. And that's what I did. And after I finished all those bottles, you know, it was on Christmas day, the next day, and that's when I prayed with [evangelist] on TV, and I said, 'I quit this day. I never want to touch it again. Take the cravings and everything away from me. Give me freedom.' And man, that's, I can't believe that myself, I guess. It was just, it's a miracle."

Process of Change: Creating an event and changing the outcome

- Realizing what alcohol did to family
- Repeating drinking patterns of family
- Praying and meditation
  - Believing in a Higher Power
  - Accepting spiritual help
  - Temptations to drink were taken away
  - Feeling Freedom

Recollection of the decision to quit. The process of recollection was used by all participants who described the process of shifting perspectives in their own way. Each process of recollection was given its own title with the exception of three participants sharing a title (a) Just me and the alcohol, (b) Being a mother to my children, (c) Realizing something is wrong, (d) Seeing mother's disappointment, (e) Being a father to my children and (f) Feeling out of control. See Figures 18, 19 and 20.

Figure 18. *Strategy of shifting perspectives: Recollection of the decision to quit*

Figure 18. Strategy of Shifting Perspectives: Recollection of the Decision to Quit

Just me and the alcohol

"What happened? That caused me to stop drinking or make the decision? I'll tell you what, you know, and I've thought about this a lot. You know, I never could get sobered up for, uh, you know, a wife, I lost my family due to alcohol. Parents, never, you know, always, uh, on me about, you know, not drinking. Judges, jails, you know, you name it. But I'll tell you what, there was only one thing, and one thing only that gave me the willingness to do something about my drinking and you know what that one thing was? It was the alcohol itself. Because I think if anybody drinks long enough . . . if they're lucky, if they're lucky, the alcohol in itself will humble them enough where they're going to reach out and ask for help. It was only the alcohol, because it came down to it for me, my last days of drinking . . . all the losses that I experienced due to my drinking, all the losses that I had . . . it came down to just me and the alcohol. And when that gave out, when that gave out, the alcohol reduced me to a state where I, it brought me to my knees, and humbled me, enough to where I said, 'I can't do this no more, I cannot go on living this way, with all this pain, with all this loneliness, despair, hopelessness,' couldn't do it no more. And that's when I said, 'I need help. I need help.'"

Process of Change: Just me and the alcohol

- Experiencing losses
- Relationship with Alcohol
  - Feeling depressed
  - Being humbled
- Realizing can't do it on own
  - Feeling lucky

Figure 19. *Strategy of shifting perspectives: Recollection of the decision to quit*

Figure 19. Strategy of Shifting Perspectives: Recollection of the Decision to Quit

Seeing my mother's disappointment

"this is towards the end of my usage, um…I borrowed my mom's car, I lied to her, I told her I was going to another rez, to go get a quilt for gifts. Uh, and so she trusted me, and she loaned me her car, and uh, but all of my intention was not that, it was, I was going on a drug run, wanted to get some dope. So, it was there, and I had the money, then in the process I totaled her car out, and…even though it happened, I still…crawled out the car and, even though I was kind of hurt, I still catch, caught a ride over and got the dope, and went back into town and, you know, used until it was gone, and then I didn't call my mom or anything, didn't let her know, you know, and she was worried about me, and I think she was…you know I did that sometimes with her, you know, 'cause like when I got stabbed, you know I didn't tell her about it, she called. Well I got stabbed a couple times, and it's like, and guess, it was my way of I thought keeping her safe and the family safe, by staying away. So, you know, when I totaled her car, it was, and going back and telling her, was uh, again, for me it was that, seeing her and her eyes, was hard. So that was one of the things that helped me, I mean that made me decide to, you know, trying quit and stuff. . . . It was because I was sick of it. I was sick of my life. I was sick of what this disease was doing to me, it was just hard."

Process of Change: Seeing my mother's disappointment
Being dishonest
Being in physical danger
Experiencing losses
Seeing hurt in mother's eyes
Realizing dishonesty
Getting tired of the lifestyle
Feeling a need to do something
Wanting to earn trust

Figure 20. *Participant examples of processes of change:*

Recollection of the decision to quit

Figure 20. Participant Examples of Processes of Change:

Recollection of the Decision to Quit

Being a mother to my children (1)
- Losing parental rights
- Feeling a need or urgency to quit
- Attending inpatient treatment
  - Meeting a supportive person
  - Accepting help
- Getting back into the real world
  - Feeling scared
- Obtaining parental rights
  - Being a Mother

Being a mother to my children (2)
- Losing parental rights
- Feeling an urgency to quit
- Attending inpatient treatment
  - Meeting a supportive person
  - Finding a mentor
- Attending AA and Al Anon meetings
- Practicing tribal traditional spiritual beliefs
- Going to school
- Obtaining parental rights

Realizing something is wrong
- Realizing how alcohol affected the family
- Creating an event and changing the outcome
- Experiencing a spiritual moment
- Prayer and meditation
- Believing in a Higher Power
- Quitting immediately

Examination of self and others. The process of examination of self and others was used by all participants who described the process of shifting perspectives in their own way. Each process of examination of self and others was given its own title (a) questioning beliefs, (b) questioning Higher Power, (c) questioning parenting style, (d)

questioning religious upbringing, (e) questioning what I want, (f) questioning what is normal, (g) questioning fears and (h) questioning priorities. See Figures 21, 22 and 23.

Figure 21. *Strategy of shifting perspectives: Examination of self and others*

Figure 21. Strategy of Shifting Perspectives: Examination of Self and Others

Questioning what I want

"Okay well, [clears throat] I was court ordered to quit. I mean I was court ordered to treatment or jail. So I went to treatment and then, um, while I was in treatment, um, I, um, you know, I really didn't think I could stay sober, ah, when I was in treatment I was totally like, "This isn't gonna work. Oh okay, um [clears throat] lets see I had uh well after I sobered up I did realize that I did, I knew you know, you, I always had a drinking problem, but I just didn't want to sober up. And the loss of friends, um, the, I lost a lot of friends to my drinking, black outs, the police. In the last part of my drinking I was really getting involved with the police were watching you with my drinking and driving thing, just going down hill uh, made changes in my life from that. . . . there was, I think [emphasis] he was a Catholic priest, was there, and he, he was there talkin' to everybody, and…. I felt like, you know, I am not [emphasis] going to stay sober, nothing, like, it's going to take a miracle 'cause I've never [emphasis] been able to stay sober on my own, never. And my family, it was a joke to them, bein' in treatment, was one great big joke because, you know, my father owned a bar, and most of my family's alcoholic…. So I, umm, there was this priest there, and I asked him, or he asked me, if I wanted to pray with him, and I said "Yes!" I said, you know, "What could it hurt? It would take, and I, you know, really [emphasis] didn't do much praying at the time, didn't, wasn't spiritual, but when he prayed with my me, he held my hands, I think he had anointed me, too, with holy water, I'm not sure. But, um, while we were praying, I, um, I had like this really weird feeling, like, through my whole body, "swoosh," like just a little tingly feeling, and I, I don't know if it was the emotional part of praying or what it was, but I, you know, it was a pretty awesome feeling, and I somehow mentally or physi—you, know I don't know what it was—felt that there was just a little [emphasis] bit of hope, that gee, maybe I can stay sober, you know."

Process of Change: Questioning what I want

1) Wanting to drink
2) Experiencing legal problems
3) Experiencing losses
4) Experiencing physical illness
5) Attending treatment
    Lacking self-confidence
    Experiencing a spiritual moment
        Meeting a supportive person
        Accepting spiritual help
            Prayer and meditation
                Feeling hope
6) Gaining self-confidence

Figure 22. *Strategy of shifting perspectives: Examination of self and others*

Figure 22. Strategy of Shifting Perspectives: Examination of Self and Others

Questioning priorities

"And, then it just took that one moment of that verge were you're almost to that edge, you know where you're just like, "do I not care and keep drinking? Or do I step back and say, chill out and I am grateful for that cause' a lot of people don't have that; and I have that. And that was luck I think, I was really luck or that was within' myself, my own, support system I guess, within myself like, my mom (impersonates mom) "what are you doin' gettin' blacked out?" or, you know or, my family cussing me out, uncles, aunties, you know "you know better than that" so forth and so on. And um, so I realized, and I walked home, I said I'm never gonna ever get that drunk again, EVER, you know ever, drink you know, and then it didn't take; that was an event that made me start wanted to quit. Then I had one or two up till like the new years, I think. Then I had like maybe three or four at new years and after new years I quit totally. I was like, "I'm done, you know, I'm just, this is dumb, you know it was just like.." so, um, so I wanted to uh, so that's when I realized I need to do something you know. I don't know what's goin' on and all a sudden "boop" the sun dance came. (Realization, Whispers) I was like, "oh, my god sun dance". You know like, 'cause that's my uncle, so my uncle was really influential. My quest for the sun dance and I say "hey unc- I'm gonna sun dance" (impersonating Uncle) "oh-yeah, that's good, okay, well you better call [uncle]" and called our spiritual father, "hey I'm gonna, I'm gonna um, dance" and he's like "okay, well come down here as soon as you can." I'm like, and you don't have to…I expected a bigger response like, why and what and where anyways an, um, so it was my uncle and my spiritual father that kinda really helped me along."

Process of Change: Questioning priorities
1) Experiencing physical illness
2) Feeling disappointment in self
3) Imagining family's disappointment
4) Realizing that I want to quit
    Feeling lucky
5) Having supportive people
    Practicing traditional beliefs

Figure 23. *Participant examples of processes of change: Examination of self and others*

Figure 23. Participant Examples of Processes of Change: Examination of Self & Others

Questioning beliefs
- Negative thinking
- Feeling like a bad person
- Attending AA
  - Believing in a Higher Power
    - Questioning beliefs
    - Prayer and meditation
    - Feeling grateful
    - Depending on relationship to Higher Power
- Feeling strong
- Positive thinking

Questioning a Higher Power
- Negative thinking
- Seeking spiritual knowledge
  - Feeling disconnected to religious upbrining
  - Wanting to identify with other Native Americans
- Accepting spiritual help from a supportive person
  - Practicing tribal traditional spiritual beliefs
    - Believing in a Higher Power

Questioning Parenting Style
- Realizing I wanted to do things differently than my parents
- Attending inpatient treatment
  - Meeting a supportive person
- Practicing traditional beliefs
- Going to church
- Going to AA and Al Anon
- Raising children who are nondrinkers
  - Feeling proud
  - Feeling a sense of accomplishment

Reinforcement. The process of reinforcement was used by all participants who described the process of shifting perspectives in their own way. Each process of reinforcement was given its own title (a) finding a pathway to spirituality, (b) accepting help, (c) finding a pathway to abstinence, (d) discovering abilities, (e) reaching out to

spiritual people, (f) earning trust, (g) being accountable, and (h) gaining opportunities.

See Figures 24, 25 and 26.

Figure 24. *Strategy of shifting perspectives: Reinforcement*

Figure 24. Strategy of Shifting Perspectives: Reinforcement

Earning trust

"Getting plugged back into the traditions, the culture, the spiritual part. That was, and I was thinking about.., and then like in my early recovery, those things were happening and also, somewhat my family started to trust me again. That was, that, that was good. Um, you know, going to meetings, going to AA meetings all the time. Learning to become responsible, learning to, that's mostly important too is (clears throat) going through the steps. And once completing them…having a lot of burden and relief of all the stuff that I was carrying with me also. And all that was, and then, getting into – some of my family I guess they were – I think the good thing, too, is with that, that helped me was some of my older brothers and sisters were like already in recovery and being able to, um, being able to see what they had. And seeing how they were enjoying life, was…part of the magnet for me to, uh, to work this program, Alcoholics Anonymous."

<u>Process of Change: Earning trust</u>

Attending AA
- Becoming responsible
- Releasing the burdens
- Witnessing others' accomplishments

Practicing traditional beliefs
- Becoming responsible
- Releasing the burdens

Earning trust from family

Figure 25. *Strategy of shifting perspectives: Reinforcement*

Figure 25. Strategy of Shifting Perspectives: Reinforcement

Being accountable

"You know my uh, my probation officer told me that I needed to go to ninety meetings in ninety days. Or that, if I don't do that they're gonna put me back in jail and uh, um, send me back to prison. So that was you know, that was a big motivator um, you know that ninety meetings you know I really, I've heard it lots and lots and you know everybody's different but, for me it really helped. You know, it helped me to uh, be accountable you know, being able to, you know, make ninety meetings in ninety days. Throughout that period of time, I was doing sweats every Friday; I was helpin' a friend uh, run sweat lodge. And you know I made some commitments there."

Process of Change: Being accountable

Being incarcerated
- Attending AA
- Attending outpatient treatment

Practicing tribal traditional spiritual beliefs
- Taking responsibility

Figure 26. *Participant examples of processes of change: Reinforcement*

Figure 26. Participant Examples of Processes of Change: Reinforcement

Finding a pathway to spirituality

Attending AA
- Hearing others' stories
- Witnessing others' accomplishment

Believing in AA
- Believing in a Higher Power

Depending on relationship to Higher Power

Finding a pathway to abstinence

Practicing the twelve steps
Prayer and meditation
Being a mother

Gaining opportunities

Learning how to communicate
Learning behaviors
Respecting tribal traditions through sobriety

Motivating Factors for Change and Recovery

The strategies used by participants produced motivation for them to continue searching for balance and to develop new behavior patterns. Wanting to be normal motivated one participant, who stated, “Make me normal – but I didn’t know what normal was; but that’s how I felt. That’s what I wanted to do. I just wanted to jump up and say, ‘Please make me normal’ – that’s what motivated me.” Escaping emotional pain was another type of motivation as well as avoiding physical illness. One participant stated, “almost overdosing, almost killing myself,” when asked about what motivated this individual to quit. Being tired of the lifestyle, practicing traditional beliefs and realizing that I wanted to care about myself were other motivating factors by other participants. Experiencing losses were forms of motivation for two participants who stated, “I just . . . I think it was, I got tired of having nothing” and “mostly it was my, losing custody of my children.” Finally, being a mother motivated two of the participants. When asked what were the motivating factors, they stated, “My daughter was a big, big, big one, I never wanted her to, uh, to see me in a blackout,” and “They were toddlers at the time, and um, I really loved them, but I just couldn’t see me not being with them.”

Motivating Factors Resulted in Balance and Maintenance

The motivating factors resulted in balance in life and maintenance of the new patterns of behavior. Some motivating factors that participants discussed were being tired of the lifestyle and being able to practice tribal traditional spiritual beliefs. One participant said, “Just being sick and tired of my life . . . where I was, where I’m at, I was tired.” Another participant stated, “I was finally ready to give all that stuff up and our traditional stuff, our healers and stuff that was really, was somethin’ I’ve wanted to do.”

Many participants explained that alcohol use was not allowed in any type of tribal traditional spiritual practices and that being sober allowed them the privilege to practice and connect with their traditional ways.

Theoretical Model for Change and Recovery from Alcohol Misuse

When these processes were mapped, the model emerged: The Theoretical Model for Change and Recovery from Alcohol Misuse. (Review Figure 9.) Creswell's (2007) methods of qualitatively examining a theoretical model were utilized. Briefly, the steps involved familiarization of data, coding (tag the content with thematic labels), sorting and summarizing, and synthesizing (integrating themes into a cohesive nature). Analysis of content fit smoothly with the Medicine Wheel. Analysis of processes required a "changing of the lens" and fit smoothly with the Transtheoretical Model of Change. These two types of analyses were useful tools for examining specific mechanisms at work during the process of change when one makes the decision to quit drinking alcohol for good.

Data from the Guiding Questions

Question 1 and Question 2 lent themselves to be analyzed qualitatively. Questions 3 through 8 produced lists of support systems, tools, resources, temptations, motivating factors, maintenance of sobriety, gains and losses, personal reasons for making a change, and confidence to change. Furthermore, questions 9 through 11 produced short answers in regards to the spiritual component to the process of change, a connection between tribal cultural beliefs and recovery, and the differences between sobriety and recovery. The following information provides the data for the guiding questions.

Question 1: Is there a point of focus in the sobriety and recovery phases in regards to emotional, intellectual, physical and spiritual domains? The data that answered this question comes from the strategy of utilizing medicine – the Medicine Wheel analysis. The Physical and Spiritual domains in the sobriety phase appeared to be a point of focus for the participants in this study in regards to being out of balance. Participants discussed the desire to find the spiritual component in their lives while at the same time, struggled with balancing many physical components. The recovery phase showed more of a balance within the domains.

Question 2: What were the specific mechanisms at work within the emotional, intellectual, physical and spiritual domains? The data for this question comes from the strategy of utilizing medicine – the Medicine Wheel analysis, and the strategy of shifting perspectives – the Transtheoretical Model of Change analysis. Specific mechanisms at work involved the process of shifting perspectives through experiencing a spiritual moment, recollection of the decision to quit, examination of self and others, and reinforcement. Through this process, different types of medicine were utilized in order to produce change.

Questions 3 through 8. Figure 27 shows specific support systems, tools, resources, temptations, motivating factors, maintenance of sobriety, gains and losses, and personal reasons for change.

Figure 27. *Responses to Guiding Questions 3 through 8.*

3. Support Systems	**3. Tools**	**3. Resources**
"Me"—realizing internal dysfunction, being tired of the lifestyle, being a mother Meeting a supportive person Being incarcerated Having a family	Attending AA meetings Practicing spirituality Experiencing a spiritual moment Prayer and medication Practicing tribal traditional spiritual beliefs Exercising Attending church Attending outpatient treatment	Practicing spirituality Attending AA Doing it myself Getting an education Meeting a supportive person Attending inpatient treatment Attending out-patient treatment Practicing tribal traditional spiritual beliefs

4. Temptations	
Feeling overwhelmed Feeling anger	Having no temptations Wanting to be with old friends

5. Motivating Factors	
Wanting to be normal Experiencing losses Being a mother Practicing tribal traditional spiritual beliefs	Escaping emotional pain Physically ill Tired of a lifestyle Realizing I wanted to care about self

6. Maintenance of sobriety	
Attending church Being grateful Learning Staying in one place Prayer and meditation	Believing in a Higher Power Getting an education Practicing tribal traditional spiritual beliefs Having friends who are non-drinkers

7. What was gained?	**8. What was lost?**
Developing healthy relationships Gaining self-respect Having job stability Staying in one place Being a mother Practicing tribal traditional spiritual beliefs Feeling a sense of belonging	Internal dysfunction Feeling depressed Friends Family members who continued using Experiencing hangovers
8. Personal reasons for change	**8. Self-efficacy**
Escaping emotional pain Taking care of self Being a mother Experiencing a spiritual moment Seeing mother's disappointment Wanting a sense of belonging Having ability to make better decisions	Irrelevant, "Just did what I had to do." Attending AA Taking day by day Most stated they felt no confidence in sobriety phase One participant stated feeling confident in sobriety phase.

Questions 9 through 11. Figure 28 provides participants' brief answers to spiritual components to the process of change, connection between tribal cultural beliefs and recovery, and the differences (if any) between sobriety and recovery.

Figure 28. *Responses to Guiding Questions 9 through 11.*

9. Spiritual component
Prayer and meditation Combining religion and traditions Experiencing spiritual moment Depending on relationship to Creator Strengthening spirituality through AA Practicing tribal traditional spiritual beliefs
10. Recovering and connection to tribal culture
Feeling pride as a Native American Practicing tribal traditional spiritual beliefs One participant stated not knowing tribal culture Prayer and meditation
11. Differences between sobriety and recovery
Sobriety is abstinence Recovery is making positive changes Recovery is a growing-up process Sobriety is experiencing difficulties One participant stated no differences Recovery is practicing the 12 steps

Quantitative Measurement Checks

Table 5. Quantitative Measurement Checks

Participant	NAAS	Decisional Balance Pros	Decisional Balance Cons	Self-Efficacy Temptations	Self-Efficacy Confidence
#1	2.78	1	1	1	5
#2	3.35	1	1	1	5
#3	3.11	1	5	1	5
#4	2.40	1	4.50	2	4.10
#5	3.83	1	4.70	1.60	5
#6	4.17	1	5	1.30	5
#7	2.72	1	5	1.25	5
#8	3.33	1.38	3.88	1.70	5

Participants completed the Native American Acculturation Scale (NAAS) and averaged a group score of 3.21, which indicated bicultural behaviors. The scores ranged from 2.40 (bicultural/acculturated) to 4.17 (bicultural/traditional).

Participants completed the Decisional Balance Scale and averaged a group score of 1 on the pros of drinking, indicating that they found little to no pros to drinking alcohol. Participants averaged a group score of 4 on the cons of drinking, indicating that they found many cons to drinking alcohol.

Participants completed the Self-efficacy scale and averaged a group score of 1 on the temptations to drink alcohol, indicating no temptations to drink alcohol. Participants averaged a group score of 5 on the confidence not to drink alcohol, indicating high confidence that they will not drink alcohol.

CHAPTER IV

DISCUSSION

Although the literature in psychology is rich with descriptions of the process of change in substance misuse, this study is distinctive in its systematic examination of the strategies utilized in finding balance and shifting perspectives in order to produce motivation to maintain newly developed behaviors. The examination focused on the perspectives of eight Native Americans who are in recovery from alcohol misuse. The participants' responses helped to construct a theoretical model of the strategies they utilized, the specific motivating factors, and the specific behaviors in maintaining sobriety. This theoretical model was constructed using a mixed model approach, which included qualitative data analysis, quantitative measures to check and verify the qualitative findings, and combining two existing theoretical models from two different cultural perspectives. The two models were: (a) the Medicine Wheel, which derives from the broad perspectives of Native American culture and addresses balance in life, and (b) the Transtheoretical Model of Change (TMC; Prochaska & DiClemente, 1984), which addresses the process of change. The TMC provides little research on Native Americans, leading to interest in examining the applicability of this model as well as the applicability of the Medicine Wheel to this Native American sample. The model that was created in this study establishes, from a multitude of strategies of finding balance and shifting perspectives, a coherent, construct-focused framework for understanding the often-confusing constellation of the process of change and maintaining changed behaviors from alcohol misuse.

Searching for balance

Attempting to gain balance in life set the stage for the process of change. As Montour (2000), Nebelkopf and Phillips (2004), and White Bison (2002) emphasized, it is important to utilize the tools of medicine in the Medicine Wheel to create physical, intellectual, emotional, and spiritual restructuring and develop a sense of balance in life. In the life of substance misusers, there is a significant amount of imbalance, which leads to many treatments in Native American communities that focus on the idea of finding balance (Dapice, 2006, Gilgun, 2002; Roberts, Harper, Tuttle-Eagle Bull, & Heideman-Provost, 1998). In this study, the participants' search for balance began in the sobriety phase and they utilized physical, intellectual, emotional, and spiritual forms of medicine. Also, there was an additional domain that emerged, which was labeled "Whole." The Whole domain included the utilization of all four domains simultaneously. Within the sobriety phase, the emerging data showed an imbalance amongst the five domains. The physical domain in the sobriety phase was "loaded" heavier than the other four domains, with the spiritual domain having only prayer and meditation as a form of medicine utilized. Most participants described prayer and meditation in the sobriety phase as somewhat mechanical, meaning that they continued doing this spiritual act even though they didn't believe and had no feelings towards it. Within the recovery phase, the four domains became more balanced amongst each other. These findings convey that attempts to gain a more balanced life within the physical, intellectual, emotional and spiritual domains lead to well-being. Furthermore, these findings correspond to the literature on the Medicine Wheel (Dapice, 2006, Gilgun, 2002; Roberts, Harper, Tuttle-Eagle Bull, & Heideman-Provost, 1998).

Developing new patterns of behavior

Making steps to change was a process that maneuvered, deleted and/or added medicine in order to form a template for these participants to use for the development of new patterns of behavior. The templates were strategies of shifting perspectives. These shifts in perspectives involved cognitive-experiential and behavioral approaches useful in helping a person change behavior. Furthermore, shifting perspectives placed importance on the specific processes or strategies that people use within the TMC's Action and Maintenance stages of change. DiClemente (1991) stressed the importance of understanding the specific processes or strategies within in each stage because a mismatch between strategy and stage may result in an increased likelihood of failure to achieve change. This study revealed specific strategies utilized, which led to the development of new patterns of behavior. Prochaska and colleagues' (1994) research on the TMC processes of change and stages of change, particularly the action and maintenance stages, fit well within this study in order to find specific strategies utilized by this Native American sample.

Experiencing a spiritual epiphany

The strategy of shifting perspectives when experiencing a spiritual moment allowed participants to become stronger and overcome the addiction, gain self-confidence to quit using, and gain freedom from the substance. These experiences created a moment of balance between all domains, resulting in a form of reinforcement for these individuals that motivated them to create that sense again. For example, one participant's spiritual moment involved reaching a point of near death due to not wanting to ask for, or accept help. This individual lay in a hospital bed, unable to move or talk and finally nodded for

acceptance of help. Through this acceptance of help, which involved praying for her, she felt comforted, and her mind and body rested. A moment of balance between all domains happened and she remembered this moment and repeated this type of experience through her process of maintaining abstinence from alcohol. Explaining further, when she was confronted with problems throughout her abstinence, her utilization of medicine was strikingly similar to the medicine she used in her spiritual moment. This shift in perspective motivated her and helped maintain change. Learning from the spiritual moment appeared in all the participants who discussed experiencing a spiritual moment. This finding, based on the research of the processes of change by Velicer et al. (1998), showed cognitive/experiential and behavioral processes happening at a rapid rate and resulted in change. This also fits within the Medicine Wheel model of experiencing balance in all four domains in order to achieve well-being.

Recollection of the decision to quit

The strategy of shifting perspectives when recollecting the decision to quit allowed participants to find meaning in sobriety. All participants described the sobriety phase as a struggle in all domains. Finding meaning in the struggle produced motivation and maintenance. For example, some participants' decisions to quit involved being a parent. A few of these participants lost parental rights, which motivated them to get treatment and stabilize their lives in order to obtain parental rights and become a loving mother or a positive role model as a father. Recollection of the physical, intellectual, emotional and spiritual experiences when losing their children produced a shift in perspectives and motivated these individuals to maintain change. Qualitative studies on Native American substance abusers and their view of alcohol misuse show re-occurring

themes involving the point of focus in the decision to quit (Hazel & Mohatt, 2001; Quintero, 2000; Spicer, 1998; Watts & Gutierres, 1997; Wing & Thompson, 1995). Quintero (2000) stated that the focus was on how they followed through once they made the decision to quit and were less concerned about the events that happened to them when they made the decision to quit drinking. The current study appears to counter Quintero's findings, meaning that these Native American participants found purpose in recollecting the moment they decided to quit drinking alcohol. Most of the Native Americans in this study were able to describe in detail (physical, intellectual, emotional, and spiritual) the moment they decided to quit and this provided them motivation on how to follow through with the decision.

Examination of self and others

The strategy of shifting perspectives when examining self and others allowed participants to think critically about their own sense of identity and how they wanted to change their lifestyles. One participant who was raised in an alcoholic family and started drinking at age 12, began to question what was normal when he reached his thirties. Through this questioning process, he realized that alcohol was a way to deal with his anger. Specifically, he would self-medicate in order to escape feelings of anger. Attending AA and practicing tribal traditional spiritual beliefs was the beginning process of learning about different lifestyles. He saw others enjoying life and dealing with anger without using alcohol and he began to shift perspectives. This examination of himself and of others motivated him to maintain sobriety. Bartocci and Dein (2005) discussed the importance of developing a strong sense of identity when adapting to significant changes in life. Moreover, they explained that a strong sense of identity allows the spiritual

component to develop in a healthier way. Other studies show that substance misuse is higher in groups of people who experience greater challenges in reaching identity achievement status (Bishop, et al., 2005; White, 2000). Findings in this study are comparable, showing that most of the Native American participants began to develop stronger identities through examination of self and others. Furthermore, practicing tribal traditional spiritual beliefs and allowing themselves to experience different lifestyles other than the alcoholic lifestyle, gave them the opportunity to build on the development of stronger identities.

Reinforcement

The strategy of shifting perspectives during reinforcement allowed participants to find, discover, or earn a pathway to recovery. For example, one participant's reinforcement was attending AA, hearing other's stories and witnessing others' accomplishments. Through this process, he began believing in AA and eventually accepted the belief that his Higher Power was a loving God and not a punishing one. His depending on the relationship to his Higher Power was a shift in his perspective. Through this shift, the spiritual component became stronger and he experienced more balance and stability in life. Researchers emphasize the "maturing out" process, changes in social relations, health concerns and spirituality/religion in Native Americans when their drinking behaviors change (Kunitz & Levy, 1994; Quintero, 2000; Spicer, 2001; Westermeyer & Nieder, 1985). Moreover, these researchers stated that there appears to be something at work in the lives of Native American people that leads them to change their drinking behavior as they get older, as relationships change, as stronger connections develop with spiritual/religious experiences, and as their health changes. The Native

Americans in this study explained that reinforcement was at work in their lives and this reinforcement led them to change their drinking behaviors.

Motivation

Motivation developed through the strategies. The concept of motivation to continue sobriety emerged through the process of experiencing balance and developing new patterns of behavior. Miller and Rollnick (2002) describe motivation to change as appearing to "arise when the person connects it with intrinsic value, something important, something cherished (p. 12)." Furthermore Miller and Rollnick state that people often feel ambivalence when it comes to change and the exploration of their own perspectives are important in order to find acceptance, meaning and empowerment in maintaining new patterns of behavior. One participant discussed the realization of wanting to care about him self and this process of beginning to value who he was, motivated him to continue sobriety. As mentioned previously, some participants discussed being a parent, and the values of expressing love and caring for their children. These values gave them the motivation to maintain new patterns of behavior. The findings on motivation within this Native American sample support Miller and Rollnick's (2002) description of having connection to values. Furthermore, the findings support Spicer's (1998) research on the connection to culture and changes in drinking behaviors among Native Americans. In this study, the values were found through some form of connecting to their culture, indicating the importance of developing motivation to change through acknowledging and emphasizing culturally specific factors.

Finding balance and maintaining change

The result of motivation in this study is finding balance in life and maintaining new patterns of behavior. Prochaska et al. (1994) described the maintenance stage as new behaviors that are sustained and consolidated into the lifestyle of the individual. Participants described not only sustained behaviors but also balance in their lives. Practicing the 12 steps, practicing traditional beliefs, and prayer and meditation appeared to be important types of medicine utilized in this sample of Native American participants in order to find balance in life and maintain change. Again, connecting to their culture appeared to be a protective factor while maintaining new behaviors.

Applicability of the two models

The two models – the Medicine Wheel and the TMC – appeared to be applicable in this study and seem to compliment each other in providing a deeper understanding of developing balance and taking steps to create changes. When examined alone, The Medicine Wheel provided a broad understanding of alcohol misuse, possibly leading to many forms of interpretation of the individual. On the other hand, the TMC provided a narrow and concise understanding of addiction, leading to a possible misinterpretation of the individual. The closest way to describe the differences between the two models when they were applied to the participants, can be parallel to examining an individual putting together a puzzle (Medicine Wheel) or swinging on a swing (TMC). Pieces of a puzzle show distinct boundaries when pulled apart and allow the individual to understand that separate piece and how it might fit into the whole. In the Medicine Wheel, pieces of the puzzle pull emotions apart from thoughts, allowing for examination, and developing an understanding of how these two might interact when put together. In the TMC,

examining an individual swinging on a swing can become meaningless if the action is broken into parts and examined. It requires examining the entire process because the model diffuses emotions and thoughts in such a way that it may be difficult to distinguish one from the other. One participant in the study described this process as a "swoosh," and the process of change began. Examining and combining both perspectives provided a clear picture of the process of balance and change in each individual in the study.

Data from the guiding questions

The point of focus in the sobriety phase was an imbalance, particularly in the Physical and Spiritual domains. The Physical domain included many negative experiences as well as attempts to make steps for change. Some examples of negative experiences in the Physical domain included: physical exhaustion, losing parental rights, experiencing legal problems and moving place to place. Some examples of making steps to change were: attending AA, attending inpatient treatment, volunteering, and going back to school. On the other hand, the Spiritual domain in the sobriety phase showed an imbalance due to having only prayer and meditation as a way to reach the spiritual component of change. The findings fit within the work of Montour (2000), Nebelkopf and Phillips (2004), and White Bison (2002) regarding balance within the physical, intellectual, emotional, and spiritual domains of life in order to achieve well-being. Moreover, the findings reveal that sobriety is an event that begins the search for balance.

The point of focus in the recovery phase was the balance between the domains. Participants appeared to utilize medicine in a more balanced way across the domains that matched their values and this motivated them to maintain sobriety. The findings show

that the participants were in recovery due to having a more balanced lifestyle and this balance was mostly due to cultural factors of finding meaning in change.

The specific mechanisms at work that involved the process of change were the participants' shifts in perspectives. Utilizing the concepts of the Medicine Wheel and the Transtheoretical Model of Change allowed themes to emerge that described specific mechanisms. These mechanisms were: experiencing a spiritual moment, recollection of the decision to quit drinking alcohol, examination of self and others, and reinforcement. Qualitative researchers (Kunitz & Levy, 1994; Quintero, 2000; Spicer, 2001; Westermeyer & Nieder, 1985) questioned what was specifically at work when Native Americans made the decision to quit drinking alcohol. This study revealed a few strategies that explained specific mechanisms at work.

The support systems, tools, and resources that have been instrumental in improving the lives of these individuals or have facilitated the process of recovery included meeting supportive people, having a family, and wanting to become a caring parent. The support systems, tools, and resources in this Native American sample appeared to be value-oriented and culturally-specific. For example, attending ceremonies, sweats, and seeking knowledge through Native American elders were part of the process within the support systems and were instrumental in improving the lives of these individuals.

Some temptations experienced were feeling overwhelmed, feeling angry, and wanting to be with old friends. Most participants felt these temptations in the sobriety phase and eventually learned ways to balance their lifestyles in order to reduce these temptations. The findings support DiClemente's (2003) work on self-efficacy, showing

that the participants had less confidence and greater temptation in the early stages of sobriety and reversing the pattern in the later stages of sobriety by feeling more confident and less tempted to return to previous behaviors.

Some motivating factors included the desire to be "normal," not wanting to experience the level of losses when they drank alcohol, and practicing tribal traditional spiritual beliefs. Some ways these participants maintained sobriety were believing in a Higher Power, being grateful, and having friends who are nondrinkers. Through the sobriety/recovery process, these Native American participants gained healthy relationships with others, self-respect, and a sense of belonging. They reported losing old friends, hangovers, and the internal dysfunction. Some personal reasons to quit drinking alcohol were: wanting to be a caring parent, wanting to escape the emotional pain, and wanting a sense of belonging. Based on the research of Prochaska, Velicer, DiClemente and Fava (1988), the findings are comparable to weighing the pros and cons of drinking alcohol. The research states that, within the action and maintenance stages, individuals' personal reasons for making behavior changes begin to develop a pattern of finding more cons and less pros to drinking alcohol. The participants in this study revealed similar patterns.

All participants stated that there was a spiritual component within the process of change. Most described the spiritual component related to their tribal cultural beliefs while a few explained that they found spirituality through attending AA or attending church. Developing the spiritual component allowed a more balanced lifestyle and revealed a stronger sense of identity. For these participants, most developed a stronger sense of identity through connection to their cultural beliefs.

Most participants defined sobriety as abstinence from alcohol and recovery as becoming more balanced in life physically, intellectually, emotionally, and spiritually. Understanding the distinction between sobriety and recovery is important in light of a history in which individuals with only a fragile hold on their own sobriety have been recruited to work as professional helpers, leaving them increasingly vulnerable to relapse (McGovern, 1992; White, 2000). Most participants in this study have revealed a distinction between sobriety and recovery.

Measurement checks

The quantitative alcohol measures of self-efficacy and the pros and cons of drinking appeared to reflect similarities to participants' interviews, showing that participants were confident that they would not drink alcohol and that they found more cons to drinking alcohol than pros. However, some participants experienced problems understanding how to answer the questions and asked the researcher for assistance. The acculturative measure indicated a score in the bicultural category. This score appeared to reflect similarities to participants' interviews, describing more bicultural lifestyles. However, research assistants questioned the validity of this measure due to specific questions on the measure and recent writing on acculturation.

More specifically, Smith (1999) argues that acculturation has never been a goal for indigenous people; indeed, she writes that the goals of indigenous peoples were to resist and survive. As a consequence, this "influential ideology within and without of Indian Country that categorizes Indian people as 'traditionalist' or as 'assimilationist'" (Tall Bear, 2000, p. 5) calls into question the ethics of doing so. Tall Bear goes on to

argue that scientific inquiry should "be consistent with tribal cultural values and spiritual tenets of tribal communities" (p. 5).

Theoretical model for change and recovery from alcohol misuse

The importance of the development of this theoretical model allows researchers and practitioners to think beyond one perspective of change and recovery from alcohol misuse. The Native American participants in this study appeared to have a bicultural form of cultural understanding, meaning that they are simultaneously able to know, accept, and practice both mainstream values and traditional values and beliefs (LaFromboise, Trimble & Mohatt, 1990). Further examination of the strategies that lead to motivation would benefit Native American communities when addressing alcohol misuse. Moreover, treatment plans should be modeled around these strategies in order to become more effective. Understanding what is reinforcing for the individual and allowing for recollection of the reason(s) why he/she quit using can provide motivation for maintenance of sobriety. Examination of self and others appears to be a good predictor of developing a stronger sense of identity in the individual. Allowing individuals to "pull apart" the thoughts from the emotions and how it affects behaviors can be beneficial as well as maintaining the behaviors of positive, supportive relationships that facilitate change or, in other words, adding the spiritual component. The theoretical model for change and recovery from alcohol misuse basically states that experiencing all four domains of the physical, intellectual, emotional, and spiritual at once and/or having the ability to recollect that experience provides balance and potential for change. Furthermore, the model states that this "balancing" requires a process and through this process emerges the potential for developing motivation to continue maintenance of

balance and new patterns of behavior. The present findings may facilitate a reevaluation of the strategies utilized and offer clients and their therapists a conceptual framework to facilitate balance and change.

Strengths and limitations

The strengths of this study include the utilization of qualitative methods, generalizability to Northern Plains individuals in recovery, and finding specific mechanisms at work within the process of change. This qualitative research methodology sought to gain an understanding of the recovery process from the perspectives of Native Americans in recovery. Through this understanding, meaningful concepts emerged that might have been missed through use of quantitative methodology. Because cultural factors, the process of change, motivation, and maintenance of new behaviors are extremely complex, qualitative methodology can capture meaningful fragments of these components and connect them. Furthermore, the use of research assistants throughout the interpretation process allowed for reliability checks.

The study findings are generalizable to Northern Plains tribes due to the participants' affiliation with Northern Plains tribes. The participants emphasized the importance of practicing tribal traditional beliefs within the process of change and recovery. Moreover, these cultural beliefs helped them to develop the motivation to continue sobriety and progress into recovery.

The specific mechanisms at work were revealed from these participants and may be helpful for other Native Americans in the sobriety phase in order to develop a better understanding of the difficult and complicated struggle to change behaviors. The limitations of the study included having a small sample size and having it limited to

Northern Plains tribes. Also, half of the participants were counselors within the substance abuse field and well-educated. This indicates a homogenous group that is generalizable to more highly educated Native Americans within an urban area setting.

Future research

Recommendations for future research includes replicating this study with Native American tribal members from other regions of the country. Replication will reveal generalizability to other tribes or specific mechanisms at work according to their belief systems. Moreover, considering the information that emerged from this study, it might be interesting to incorporate the idea of balance and shifting perspectives in research with survivors of trauma due to the majority of those individuals experiencing problems with addictive behaviors and seeking change. A similar qualitative study may be useful for this population. Finally, as stated previously, the present findings may facilitate a reevaluation of the strategies utilized and offer substance-abusing clients and their therapists a conceptual framework to facilitate balance and change.

A quantitative study building from the findings of this study would also be a next important step. Identifying a measure that captures the ideas of balance and shifting perspectives might be a challenge, but verifying these findings with a large sample would be useful.

Finally, examining enculturation (rather than acculturation) or acculturation stress may be a more useful route when examining substance misuse with Native Americans.

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APPENDIX A

Participant #_____
Date of Interview:_____
Interviewer's Initials:_____

Demographic Information

Gender: _____

Age: _____

Tribal Affiliation:_____

Tribally Enrolled (Circle): Yes No

Religious/Spiritual Preference(s): _____

Level of Education:
___Grade School (grades 1-6)
___Middle School (grades 7-9)
___High School (grades 10-12)
___Vocational Education
___Some College Classes
___College Degree
___Post College Professional Degree
___Graduate, Medical or Law Degree

Occupation: _____

Household Income:
___Less than $7,500
___$7,500 to $14,999
___$15,000 to $24,999
___$25,000 to $40,000
___Over $40,000

Do you live:
___Alone
___With Child(ren)
___With a Friend
___With a Spouse
___With a Sibling
___Other:_____

Treatment received (check all that apply):

		Overall Treatment Effectiveness (circle one)				
☐	Court ordered/DUI	Poor	Fair	Good	Very Good	Excellent
☐	Self-referred Treatment	Poor	Fair	Good	Very Good	Excellent
☐	Individual Therapy	Poor	Fair	Good	Very Good	Excellent
☐	Group Therapy	Poor	Fair	Good	Very Good	Excellent
☐	AA Meetings	Poor	Fair	Good	Very Good	Excellent
☐	Intensive Outpatient	Poor	Fair	Good	Very Good	Excellent
☐	Residential					
☐	State	Poor	Fair	Good	Very Good	Excellent
☐	Tribal	Poor	Fair	Good	Very Good	Excellent
☐	Other _____	Poor	Fair	Good	Very Good	Excellent

Use of other drugs? _____, If yes, what were they? _____

Age when you were using and you didn't feel you had a problem and had no intention of making any changes regarding your use: _____

Age when you considered quitting your substance use but had not made a decision yet: _____

Age when you decided to quit your use and prepared to quit for good: _____

Relapses during this time? _____ If so, approximately how many?____

Age when you quit using, but have not been sober for 3 years yet: _____

Relapses during this time? _____ If so, approximately how many?____

Age when you quit using, and have been sober for more than three years: _____

Is there someone that knew you through this entire process who could tell your story (friend, children, spouse, relative)? State whether it was a friend, son/daughter, spouse, relative, or other: _____

_____

Do you still have contact with the person/people you listed?

Has the relationship changed now that you are in the recovery process?
If so, how?

APPENDIX B

Native American Acculturation Scale

(Garrett & Pichette, 2000 revised by Trahan, 2004).

Please select the ONE choice with which you identify in the space provided. Please only select ONE answer per question.

1. **What language do you speak?**
   - □ Tribal language only
   - □ Mostly tribal language, some English
   - □ Tribal language and English about equally well (bilingual)
   - □ Mostly English, some tribal language
   - □ English only

2. **What language do you prefer?**
   - □ Tribal language only
   - □ Mostly tribal language, some English
   - □ Tribal language and English about equally well (bilingual)
   - □ Mostly English, some tribal language
   - □ English only

3. **What language do you understand?**
   - □ Tribal language only
   - □ Mostly tribal language, some English
   - □ Tribal language and English about equally well (bilingual)
   - □ Mostly English, some tribal language
   - □ English only

4. **How do you identify yourself?**
   - □ Native American
   - □ Native American and some non-Native American (e.g., White, African American, Latino, or Asian American)
   - □ Native American and non-Native American (bi-cultural)
   - □ Non-Native American and some Native American
   - □ Non-Native American (e.g., White, African American, Latino, and Asian American)

5. **Which identification does (did) your mother use?**
   - □ Native American
   - □ Native American and some non-Native American (e.g., White, African American, Latino, or Asian American)
   - □ Native American and non-Native American (bi-cultural)
   - □ Non-Native American and some Native American
   - □ Non-Native American (e.g., White, African American, Latino, and Latino, and Asian American)

6. **Which identification does (did) your father use?**
   - □ Native American
   - □ Native American and some non-Native American (e.g., White, African American, Latino, or Asian American)
   - □ Native American and non-Native American (bi-cultural)
   - □ Non-Native American and some Native American
   - □ Non-Native American (e.g., White, African American, Latino, and Asian American)

7. **What was the ethnic origin of friends you had as a child up to age 6?**
   - □ Only Native American
   - □ Mostly Native American
   - □ About equally Native Americans and non-Native Americans
   - □ Mostly non-Native Americans (e.g., White, African Americans, Latinos, and Asian Americans)
   - □ Only non-Native Americans

8. **What was the ethnic origin of friends you had as a child 6-18?**
   - □ Only Native American
   - □ Mostly Native American
   - □ About equally Native Americans and non-Native Americans
   - □ Mostly non-Native Americans (e.g., White, African Americans, Latinos, and Asian Americans)
   - □ Only non-Native Americans

9. **Who do you associate with now in your community?**
   - □ Only Native American
   - □ Mostly Native American
   - □ About equally Native Americans and non-Native Americans
   - □ Mostly non-Native Americans (e.g., White, African Americans, Latinos, and Asian Americans)
   - □ Only non-Native Americans

10. **What music do you prefer?**
   - □ Native American music only (e.g., powwow music, traditional flute, contemporary, and chant)
   - □ Mostly Native American music
   - □ Equally Native American music and other music
   - □ Mostly other music (e.g., rock, pop, country, rap, metal, classical, and opera)
   - □ Other music only

11. What movies do you prefer?

- Native American movies only
- Mostly Native American movies
- Equally Native American and other movies
- Mostly other movies
- Other movies only

12. Where were you born?

- Reservation, Native American community
- Rural area, Native American community
- Urban area, Native American community
- Urban or Rural area, near Native American community
- Urban or Rural area, away from Native American community

13. Where were you raised?

- Reservation, Native American community
- Rural area, Native American community
- Urban area, Native American community
- Urban or Rural area, near Native American community
- Urban or Rural area, away from Native American community

14. What contact have you had with Native American communities?

- Raised for one year or more on the reservation or other Native American community
- Raised for 1 year or less on the reservation or other Native American community
- Occasional visits to the reservation or other Native American community
- Occasional communications with people on reservation or other Native American community
- No exposure or communications with people on reservation or other Native American community

15. In what language do you think?

- Tribal language only
- Mostly Tribal language
- Tribal language and English about equally well (bilingual)
- Mostly English, some Tribal language
- English only

16. How much pride do you have in Native American culture and heritage?

- Extremely proud
- Moderately proud
- A little proud
- No pride, but do not feel negative toward other Native Americans
- No pride, but do feel negative toward other Native Americans

17. How would you rate yourself?

- Very Native American
- Mostly Native American
- Bicultural
- Mostly non-Native American
- Very non-Native American

18. Do you participate in Native American traditions, ceremonies, occasions, and so on.

- All of them
- Most of them
- Some of them
- A few of them
- None at all

APPENDIX C
Decisional Balance Scale

Alcohol: Decisional Balance
Cancer Prevention Research Center,
http://www.uri.edu/research/cprc/Measures/Alcohol03.htm
(Maddock, 1997)

How important to you are the following statements in your decisions not to drink alcohol at all.

1 = Not at all Important
2 = Not Very Important
3 = Somewhat Important
4 = Very Important
5 = Extremely Important

Pros of Drinking

1. Drinking gives me a thrilling feeling. Circle one: 1 .2 .3 .4 .5

2. Drinking gives me more courage. Circle one: 1 .2 .3 .4 .5

3. I feel happier when I drink. Circle one: 1 .2 .3 .4 .5

4. I can talk with someone I am attracted to better after a few drinks.
   Circle one: 1 .2 .3 .4 .5

5. Drinking makes me feel more relaxed and less tense. Circle one: 1 .2 .3 .4 .5

6. Drinking helps me have fun with friends. Circle one: 1 .2 .3 .4 .5

7. Events with alcohol are more fun. Circle one: 1 .2 .3 .4 .5

8. I am more sure of myself when I am drinking. Circle one: 1 .2 .3 .4 .5

Cons of Drinking

1. I might end up hurting somebody. Circle one: 1 .2 .3 .4 .5

2. Drinking could get me addicted to alcohol. Circle one: 1 .2 .3 .4 .5

3. Drinking could land me in trouble with the law. Circle one: 1 .2 .3 .4 .5

4. I can hurt people close to me when I drink too much. Circle one: 1 .2 .3 .4 .5

5. Some people close to me are disappointed in me because of my drinking. Circle one: 1 .2 .3 .4 .5

6. I could accidentally hurt someone because of my drinking. Circle one: 1 .2 .3 .4 .5

7. I am setting a bad example for others with my drinking. Circle one: 1 .2 .3 .4 .5

8. Drinking causes me to fail to do what is normally expected of me. Circle one: 1 .2 .3 .4 .5

APPENDIX D
Self-Efficacy Scale

Alcohol: Self-Efficacy
Cancer Prevention Research Center,
http://www.uri.edu/research/cprc/Measures/Alcohol03.htm
(Maddock, 1997)

How **tempted** are you to drink in each situation?
Circle the number that best describes the feelings of **temptation** in each situation **at the present time** according to the following scale:

1 = Not at all Tempted
2 = Not very Tempted
3 = Moderately Tempted
4 = Very Tempted
5 = Extremely Tempted

1. When I am concerned about someone. Circle one: 1 .2 .3 .4 .5

2. When I see others drinking at a bar or at a party. Circle one: 1 .2 .3 .4 .5

3. When I am very worried. Circle one: 1 .2 .3 .4 .5

4. When I am in agony because of stopping or withdrawing from alcohol use.
   Circle one: 1 .2 .3 .4 .5

5. When I have the urge to try just one drink to see what happens.
   Circle one: 1 .2 .3 .4 .5

6. When I dream about taking a drink. Circle one: 1 .2 .3 .4 .5

7. When people I used to drink encourage me to drink. Circle one: 1 .2 .3 .4 .5

8. When I sense everything is going wrong for me. Circle one: 1 .2 .3 .4 .5

9. When I am physically tired. Circle one: 1 .2 .3 .4 .5

10. When I am feeling depressed. Circle one: 1 .2 .3 .4 .5

11. When I feel like blowing up because of frustration. Circle one: 1 .2 .3 .4 .5

12. When I experience an urge or impulse to take a drink that catches me unprepared.
    Circle one: 1 .2 .3 .4 .5

13. When I am feeling angry inside. Circle one: 1 .2 .3 .4 .5

14. When I am experiencing some physical pain or injury. Circle one: 1 .2 .3 .4 .5

15. When I want to test my willpower over drinking. Circle one: 1 .2 .3 .4 .5

16. When I am being offered a drink in a social situation. Circle one: 1 .2 .3 .4 .5

17. When I am excited or celebrating with others. Circle one: 1 .2 .3 .4 .5

18. When I am on vacation and want to relax. Circle one: 1 .2 .3 .4 .5

19. When I am feeling a physical need or craving for alcohol.
Circle one: 1 .2 .3 .4 .5

20. When I have a headache. Circle one: 1 .2 .3 .4 .5

How **confident** are you that you **would not** drink in each situation?
Circle the number that best describes the feeling of **confidence** in each situation **at the present time** according to the following:

1 = Not at all confident
2 = Not very confident
3 = Moderately confident
4 = Very confident
5 = Extremely confident

1. When I am concerned about someone. Circle one: 1 .2 .3 .4 .5

2. When I see others drinking at a bar or at a party. Circle one: 1 .2 .3 .4 .5

3. When I am very worried. Circle one: 1 .2 .3 .4 .5

4. When I am in agony because of stopping or withdrawing from alcohol use.
Circle one: 1 .2 .3 .4 .5

5. When I have the urge to try just one drink to see what happens.
Circle one: 1 .2 .3 .4 .5

6. When I dream about taking a drink. Circle one: 1 .2 .3 .4 .5

7. When people I used to drink encourage me to drink. Circle one: 1 .2 .3 .4 .5

8. When I sense everything is going wrong for me. Circle one: 1 .2 .3 .4 .5

9. When I am physically tired. Circle one: 1 .2 .3 .4 .5

10. When I am feeling depressed. Circle one: 1 .2 .3 .4 .5

11. When I feel like blowing up because of frustration. Circle one: 1 .2 .3 .4 .5

12. When I experience an urge or impulse to take a drink that catches me unprepared. Circle one: 1 .2 .3 .4 .5

13. When I am feeling angry inside. Circle one: 1 .2 .3 .4 .5

14. When I am experiencing some physical pain or injury. Circle one: 1 .2 .3 .4 .5

15. When I want to test my willpower over drinking. Circle one: 1 .2 .3 .4 .5

16. When I am being offered a drink in a social situation. Circle one: 1 .2 .3 .4 .5

17. When I am on vacation and want to relax. Circle one: 1 .2 .3 .4 .5

18. When I am feeling a physical need or craving for alcohol. Circle one: 1 .2 .3 .4 .5

19. When I have a headache. Circle one: 1 .2 .3 .4 .5

APPENDIX E

Participant #_____
Date of Interview:_____
Interviewer's initials:_____

Interview Schedule

Q1. Sobriety

Let's begin with the time when you decided to quit for good but you haven't been sober for 3 years yet. You were ____ years old, is that correct? (State age based on participant's answer from the demographic questionnaire – "Age when you quit using, but have not been sober for three years yet") **Tell me what was happening within this time up to age _____** (State age based on participant's answer from the demographic questionnaire – "Age when you quit using, and have been sober for more than three years").

___Action Stage
- ___Physical (Medicine Wheel) and/or
  Behavioral (Processes of Change)
- ___Emotional (Medicine Wheel) and/or
  Experiential (Processes of Change)
- ___Intellectual (Medicine Wheel) and/or
  Cognitive (Processes of Change)
- ___Spiritual (Medicine Wheel)

Q2. Recovery

When you were age ____, you have been sober for more than three years. Is that correct? Tell me what was happening within this time up to the present.

___Maintenance
- ___Physical (Medicine Wheel) and/or
  Behavioral (Processes of Change)
- ___Emotional (Medicine Wheel) and/or
  Experiential (Processes of Change)
- ___Intellectual (Medicine Wheel) and/or
  Cognitive (Processes of Change)
- ___Spiritual (Medicine Wheel)

Now I'm going to ask you a few more questions. You might have already answered them within in the last question.

Q3. Support Systems

What things/events/people made you decide to quit?

Q4. Tools
What helped you to quit?

Q5. Resources
What resources did you use to quit?

Q6. Temptations
What were some temptations on the way to recovery?

Q7. Motivating factors
What motivated you to begin your sobriety process?

Q8. Maintenance of Sobriety
How do you maintain your sobriety?

Q9. What was Gained?
Through this recovery process, what was gained?

Q10. What was Lost?
Through this recovery process, what was lost?

Q11A. Personal Reasons for Making a Change
What were your personal reasons for making the change to quit using?

Q12B. Self-Efficacy in Changing
At that time, how confident were you that you could change?

Q13. Spiritual Component
Was spirituality a part of your process of change? Explain.

Q14. Recovery and Connection to Tribal Culture
Is your recovery process connected to your tribal culture in any way? Explain.

Q15. Differences between Sobriety and Recovery?
Is there a difference between sobriety and recovery? Explain.