SUPPORTING NATIVE COLLEGE STUDENTS:
A CRITICAL ASSESSMENT OF MENTAL HEALTH NEEDS

by
Maria M. Denny

A Master’s Report Submitted to the Faculty of the
COLLEGE OF NURSING
In Partial Fulfillment of the Requirements
For the Degree of
MASTER OF SCIENCE
In the Graduate College
THE UNIVERSITY OF ARIZONA

2006
STATEMENT BY AUTHOR

This report has been submitted in partial fulfillment of requirements for an advanced degree at The University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this report are allowable without special permission, provided that accurate acknowledgement of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his or her judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: _______________________________________

APPROVAL BY PROJECT DIRECTOR

This report has been approved on the date shown below:

______________________________________     _______________________
Mary Vincenz                                                  Date
Clinical Associate Professor
ACKNOWLEDGEMENTS

Mary Vincenz has guided me through the PMHNP program with the generosity of her knowledge, patience, and humor. Encouragement was freely administered, and criticism was always constructive and insightful. I am grateful for her support and contributions as Chair of this project committee.

My gratitude also goes to Elaine Jones, committee member, who rekindled my interest in nursing theory and showed me how fresh and exciting it can be.

Completion of this project and the PMHNP program would not have been possible without the day-to-day support of my husband Michael and daughters Maddy and Joni: cooking, cleaning, grocery shopping, and moral support…that’s what made it happen. Many thanks also go to my mother Mary who helped to make my education possible, and decided to stay around to see it through. Thanks to all the wonderful people in my life who care that I achieve my goals!
# TABLE OF CONTENTS

**LIST OF ILLUSTRATIONS** ........................................................................................................6

**ABSTRACT** ..................................................................................................................................7

1. **INTRODUCTION** .......................................................................................................................8
   - Problem Statement ..................................................................................................................8
   - Significance ............................................................................................................................11
   - Purpose of the Project ............................................................................................................12
   - Definition of Terms ................................................................................................................13
     - *Ethnicity* ............................................................................................................................13
     - *Culture* ...............................................................................................................................14
     - *Native American/Native* ....................................................................................................14
     - *Euro-American* ..................................................................................................................15
     - *Health/Mental Health* ........................................................................................................16
     - *Health Disparity* .................................................................................................................16

2. **CONCEPTUAL FRAMEWORK** ....................................................................................................17
   - Relevant Theories ..................................................................................................................17
     - *Indigenist Stress-Coping Paradigm* ..................................................................................17
     - *Middle-Range Theory of Transitions* ..............................................................................19
     - Resilience Theories ..............................................................................................................21
       - *Middle-range theory of resilience* ..................................................................................21
       - *Family education model* ................................................................................................21
     - *Conceptual Framework of Nursing in the Native American Culture* .............................22
     - *Critical Theory* ..................................................................................................................23
   - Summary of Key Theoretical Relationships ............................................................................25

3. **LITERATURE REVIEW OF MAJOR THEORETICAL CONCEPTS** ........................................26
   - Transitions ..............................................................................................................................26
     - *College Students* ..............................................................................................................26
     - *Native American College Students* ..................................................................................30
   - Traumatic Stress ....................................................................................................................36
     - *Historical Trauma* .............................................................................................................36
     - *Racism* ................................................................................................................................39
     - *Traumatic Life Events* .......................................................................................................40
   - Cultural Resilience ..................................................................................................................42
     - *Family/Community* ..........................................................................................................42
     - *Spiritual Coping/Traditional Health Practices* .................................................................43
     - *Identity Attitudes* ..............................................................................................................44
     - *Enculturation* ....................................................................................................................45
LIST OF ILLUSTRATIONS

Figure 1 Model of conceptual relationships impacting Native college students’ health...18
ABSTRACT

The unique challenges, strengths, and health status of Native American college students are described utilizing a synthesized conceptual model for promoting the mental health of Native college students. The model’s constituent theories are the indigenist stress-coping paradigm, middle-range theory of transitions, middle-range theory of resilience, family education model, conceptual framework of nursing in the Native American culture, and critical theory. Review of the literature illuminates the major theoretical concepts and summarizes current epidemiologic and other pertinent research.

A community of Native American college students is described in terms of demographic information and resources. Plans for participatory self-assessment, collaboration, and nursing therapeutics are described, along with limitations of the project and implications for nursing practice.
INTRODUCTION

With the dramatic expansion of knowledge about the neurobiologic basis of mental illness (Flaskerud & Wuerker, 1999), psychiatric-mental health nursing is in danger of reducing complex human phenomena to simple biochemical alterations requiring like solutions. Nowhere is nursing’s holistic perspective needed more than for the multi-faceted context of Native college students’ mental health concerns.

In this chapter the problem and challenge of providing appropriate mental health services is described. The significance of the project and its purpose are identified, and the terms used throughout this paper are defined.

Problem Statement

The mental health of college students has received increased attention in recent years. Suicide is the second leading cause of death in college students (American Psychiatric Association, n.d.), and a recent survey indicated that 45.7% felt so depressed in the previous school year that it was difficult to function (American College Health Association [ACHA], 2005). There are many possible explanations for these statistics. Increased recognition because of growing awareness of the problem, stress associated with transition to college life and academic pressure, and greater ability of students with mental health problems to attend college because of improved treatments, may all account for the magnitude of the problem (“APA launches,” 2005; Voelker, 2003). Whatever the causes, campus health and counseling centers are experiencing increased demand for their services (Benton, Robertson, Tseng, Newton, & Benton, 2003; Rudd,
Difficult decisions about allocation of scarce resources must take into account the need for crisis services, intensive services for students with great need, and preventive mental health programs (Voelker).

Campus mental health services are responsible for meeting the needs of a culturally diverse population (Fennell, 2003). There is tremendous diversity within, as well as among ethnic groups, as exemplified by the indigenous peoples of the American continent. The U.S. Government recognizes 556 Native sovereign nations, and over 200 indigenous languages are spoken (Beals, Manson, Mitchell, Spicer, & the AI-SUPERPFP Team, 2003). The resulting cultural heterogeneity increases the challenge of providing empathetic and meaningful care to Native students by both non-Native and Native mental health professionals.

Native students may experience unique challenges in the college environment. Many grew up in reservation communities and experience minority status for the first time when entering the college milieu. Cultural differences between Native students’ cultures and mainstream culture may result in feelings of alienation (Tierney, 1992). “A Native student unfamiliar with mainstream life can become quickly overwhelmed when encountering large numbers of non-Natives with concomitant stereotypical beliefs about those outside the dominant culture, insensitive teachers and classmates, and the stressful university life, in addition to being forced to conform to differing worldviews, values, and social skills” (J. K. Mihesuah, 2004). While it is known that the suicide death rate for Native youth age 15 to 24 years is double the rate experienced by that age group in the
general U.S. population (Brenneman, Handler, Kaufman, & Rhoades, 2000), literature about psychiatric morbidity and mortality in Native college students is sparse.

For Native students who experience symptoms of depression, anxiety, and other mental distress, it is unclear whether the mental health services available to them can meet their needs. Students from reservation communities are geographically removed from their usual sources of care such as Indian Health Service (IHS) and tribally controlled mental health services, which are located on or near reservations. Manson (2001) reports that 54.9% of Native families are either uninsured or entirely reliant on the IHS for health care (p. 181). The 26% poverty rate among Native Americans, which is twice the national rate (Centers for Disease Control and Prevention [CDC], 2003a), limits the ability of Native students to pay out of pocket for health care. Some Native college students may prefer discussing their concerns with Native mental health professionals (J. K. Mihesuah, 2004), of whom there are few or none on most college campuses. The mental health professionals available to them may be unfamiliar with Native cultures and even ascribe stereotypes to their Native clients.

Culturally appropriate mental health services take into consideration clients’ worldviews, including their concepts of health and illness, historical events with continuing relevance, and treatment strategies preferred by clients. Models of care which do not consider historical, social, and political circumstances contributing to the problem are not relevant and may further alienate those who do seek care. Expectations upon clients to conform to Western methods of evaluation and treatment are not only ineffective but reinforce the historical pattern of forced acculturation which Native
peoples have experienced for centuries. Practitioners may become frustrated about what they see as noncompliance and high treatment drop-out rates. Consequently, negative stereotypes are reinforced without understanding the complexities of specific cultures.

This situation presents a challenge for psychiatric-mental health nursing, to understand the unique circumstances of Native college students in order to provide appropriate supportive services. The difficulty of this challenge is mitigated by nursing’s holistic perspective which is compatible with traditional Native worldviews. Native nurses and other human service professionals have developed models of appropriate care for Native peoples, which can guide non-Native professionals in this shared endeavor. Increasing the numbers of Native nurses and other mental health professionals will improve the availability of culturally relevant knowledge within the disciplines, but it will not be possible to match each client with a culturally similar caregiver in our ethnically diverse society. Therefore it is incumbent upon all mental health professionals to educate themselves about the clients they serve, and to accept the guidance of those with cultural knowledge as relevant models of care are developed.

Significance

Greater understanding of transitional and other stressors experienced by Native college students as well as the array of coping skills they utilize will likely result in more appropriate care which incorporates cultural choices. Although not proven, it is thought that culturally competent health care processes lead to improved outcomes for minority group members, thereby reducing health disparities (Brach & Fraser, 2000). Identification of particular stressors experienced by Native college students also makes it
possible to address societal factors such as political and social power imbalances, racism, and problems with access to care (Flaskerud & Nyamathi, 2002).

Mental illness is highly disabling (U.S. Department of Health and Human Services [USDHHS], 2001). It is possible that improved mental health services would permit some Native students to remain in school, who might otherwise drop out. Diverse college environments enrich everyone’s education. A more educated Native American population would experience less poverty and improved quality of life, and society would benefit from their increased knowledge and productivity.

In particular, the educational persistence of Native nursing students would result in a more diverse workforce, enriching the profession and providing guidance in the care of Native clients. More baccalaureate prepared Native nurses are needed to plan, implement, and evaluate community programs, and to promote efforts that reduce health disparities (Parker, Haldane, Keltner, Strickland, & Tom-Orme, 2002). As of 2005, there were fewer than 20 doctorally prepared Native nurses (Moss et al., 2005). Native nurse scientists are needed to conduct culturally appropriate research which addresses disparities in health care and health outcomes (Parker et al.). Understanding and addressing the mental health needs of Native college students represents one small step toward expanding Native nursing careers.

Purpose of the Project

The purpose of this project is to enhance the provision of mental health services to Native college students with culturally appropriate models of care in collaboration with Native professionals knowledgeable about the needs of these students.
Definition of Terms

Ethnicity

Definitions of ethnicity and race are controversial, in part because of advances in genetics research and proposed applications such as medical therapies tailored to race. Opponents of a biological definition of race point out that humans share 99.9% of their DNA in common, and that 90-95% of genetic variation occurs within so-called races (Fine, Ibrahim, & Thomas, 2005, p. 2126). The human populations that have been known as races have also shared their genetic material with other races through slavery and other forms of domination, as well as intermarriage, further demonstrating that races are not mutually exclusive categories (Tashiro, C. J., 2005). In 2000 the U.S. Census allowed citizens to report more than one race for the first time, within the categories of White, Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, and “some other race” (U.S. Census Bureau, 2002). The Hispanic or Latino origin category required a separate response.

Racial categories are not discrete, biologically meaningful distinctions, but can be useful designations of social groups of shared heritage for the purposes of health disparities research (Takeuchi & Gage, 2003). However it is important that racial categories be recognized as arbitrary, often self-defined, and not an excuse to blame health disparities on biology or individual behaviors (Phillips & Drevdahl, 2003). A detailed discussion of ethnicity and race is beyond the scope of this paper, but the preceding background explains the author’s decision to use the term ethnicity instead of race for this project, and lays the groundwork for a discussion of racism in Chapter 3.
The term ethnicity is used to denote the common heritage shared by a group of people, including similar history, language, rituals, and preferences for music and foods (USDHHS, 2001, p. 9). Large population groups such as European Americans and Native Americans are described as ethnic groups in this paper, with the realization that there is great diversity within these groups. Native Americans are referred to as an ethnic group to indicate some degree of shared heritage and history, but also in the plural to recognize the considerable diversity of ethnicities represented within this group of people.

Culture

The meaning of ethnicity overlaps with meanings of culture. For this project, culture is defined as a fluid system of shared values, beliefs, and norms shared and transmitted among a group of people through symbolic interaction (A. Smedley & B. D. Smedley, 2005; USDHHS, 2001). A key aspect of this definition is the fluidity of culture, which is “…constantly changing vis-à-vis new environments and inconstant physical, social, economic, and political circumstances” (Dreher & MacNaughton, 2002, p. 184). As culture demonstrates flexibility, so also do individuals selectively embrace aspects of their reference cultures.

Native American/Native

Native Americans have expressed various preferred terms for self-designation as a group. A joint resolution by the National Congress of American Indians and the National Tribal Chairmen’s Association in 1977 states the preferred designation for people indigenous to North America is American Indian and/or Alaska Native (USDHHS, 2001), and this terminology is used by the U.S. government and many publications and
organizations. However the term American Indian is based on a geographic mistake made by Christopher Columbus, and is offensive to some Native people (Bird, 1999; D. A. Mihesuah, 2005). The frequently used term Native American can be ambiguous because some non-Native people claim that they’re Native Americans because they were born in America, and find it offensive that Native peoples designate that term for themselves (Bird).

There is some consensus that Native people appreciate the use of their own tribal designation, such as Dine (Navajo), when referring to a specific person or ethnicity. As a general term, the terms Native or Indigenous peoples seems to be the most accurate, meaning original to a particular place, and least offensive. The terms Native and Native American are used throughout this paper to refer to peoples original to the North American continent.

In no way does the use of these terms imply homogeneity. Ironically because of the great diversity of Native peoples, it is necessary to make some generalizations in order to carry out this project. This is done respectfully with full acknowledgement of the limitations of doing so (Duran & Duran, 1995, p. 16).

**Euro-American**

The designation Euro-American, an abbreviation of European American, is used to indicate Americans whose ancestors originated in European countries. This term is used instead of White in an effort to separate ethnicity from skin color, and as a more specific indicator of heritage and cultures. Because of intragroup cultural diversity, this term is also acknowledged to be a generalization.
Health/Mental Health

The concepts of health and mental health are discussed in detail in Chapter 3. It is noted here that in this paper which considers mental health in a Native context, these terms are not separate concepts. Health is used to describe overall health and well-being, and mental health is used when calling attention to emotional aspects of health.

Health Disparity

The term health disparity is used to indicate an inequality in health between one group and another. Unequal does not imply that the situation is unjust or unfair, but does indicate a need for further scrutiny. If the reasons for the health disparity are related to circumstances such as access to health care, poverty, or discriminatory practices, there is an avoidable and inequitable disparity (Carter-Pokras & Baquet, 2002). When it is known that there is unequal access to care, the term health care disparity is used.
CONCEPTUAL FRAMEWORK

For a project such as this, a conceptual framework can provide a fresh perspective on situations into which insight is sorely needed. Hartrick Doane and Varcoe (2005) describe a pragmatic approach to theory in which a system of meaningful ideas translates into responsive nursing actions to produce a desired reality. By focusing on the consequences of theory, it is possible to “draw upon multiple theories, ideas, and perspectives examining their contradictions and complementary contributions in terms of consequences” (Hartrick Doane & Varcoe, p 85). A model for promoting the mental health of Native college students which is a synthesis of several relevant theories is introduced (Figure 1).

Relevant Theories

Although there is not a situation-specific theory (Im & Meleis, 1999) addressing the mental health needs of Native college students, several theories lend insight into the challenges and strengths of Native students. Each of these theories is examined in turn for its relevance to this project.

Indigenist Stress-Coping Paradigm

The concepts of stress and coping within the context of Native traumas and strengths provide the basic framework for examining the situation of Native college students. The starting point of Walters and Simoni’s (2002) model is the Fourth World context of original peoples around the world whose existence is “structured as internal colonies in relation to the larger nation-state….whose lands have been expropriated and who have become subordinate politically and economically to an immigrant population (O’Neil,
"An indigenist perspective recognizes the colonized position of indigenous peoples…and advocates for their empowerment and sovereignty in a postcolonial world" (Walters, Simoni, & Evans-Campbell, 2002, p. S105; Churchill, 1996). The historical trauma experienced by Native peoples, defined as “cumulative and
collective emotional and psychological injury over the life span and across generations” (Struthers & Lowe, 2003, p. 258), includes forced relocation, genocide, boarding school placement, and other efforts to terminate Native language, religion, and culture.

The indigenist stress-coping paradigm incorporates historical trauma as well as other stressors, including discrimination, traumatic life events, and physical and sexual assaults/abuse. These are moderated by cultural buffers which include family and community, spiritual coping, traditional health practices, identity attitudes, and enculturation. Health outcomes of the stress-coping process are grouped as health, alcohol/drug, and mental health categories. The authors have utilized the model to study Native women’s health (Walters & Simoni, 2002) and substance use (Walters, Simoni, & Evans-Campbell, 2002). The model’s concepts and relationships are discussed in greater detail in Chapter 3.

**Middle-Range Theory of Transitions**

The concept of transition offers an additional perspective into the potential stressors of Native college students. An emerging middle-range theory of transitions describes types, patterns, properties, conditions, and indicators of transitions (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). It also adds the element of nursing therapeutics, although specific therapeutics are not addressed. The theory was developed from 5 nursing studies of people experiencing transitions: first-time African American mothers, Korean immigrant menopausal women, parents of children diagnosed with congenital heart defects, migrant workers, and family caregivers.
Types of transitions identified in the theory include developmental, situational, health and illness, and organizational. A person may undergo more than one type of transition simultaneously or sequentially, and they may be related. For example, as college students matriculate many of them are on the verge of adulthood as they enter a new learning environment. Native students may be entering a new cultural environment as well. Properties of transitions affect the person’s comfort and mastery, such as engagement in the process, acceptance of change and difference, and time span. Conditions of transitions may facilitate or inhibit processes and outcomes. Associated meanings, cultural beliefs, socioeconomic status, preparation and knowledge, as well as community and societal conditions, affect the transitional experience. Meleis et al. (2000) describe patterns of response in terms of process indicators of feeling connected, interacting, creating new meanings, and developing confidence and coping, and outcome indicators of mastery and fluid (not static) integrative identity.

The theory offers a multidimensional perspective of the nature of transitions, which can be developed further as it is applied to other transitional experiences. “Understanding the properties and conditions inherent in a transition process will lead to the development of nursing therapeutics that are congruent with the unique experiences of clients and their families, thus promoting healthy responses to transitions” (Meleis et al., 2000, p. 27). The theory’s model indicates a bidirectional relationship between nursing therapeutics and the nature of transitions, transition conditions, and patterns of response. Thus there are at least three opportunities for nurses to assist clients through the transitional process.
Resilience Theories

Middle-range theory of resilience. Polk (1997) performed a concept synthesis from the resilience literature in order to clarify the patterns of resilience and postulate a synergistic pattern relationship. She identified dispositional, relational, situational, and philosophical patterns, characterized as a personal web of support and a unitary unfolding pattern which leads to a higher level of organization and functioning. Polk’s placement of resilience within the paradigm of nursing suggests “the value of assessing and strengthening natural resilience in understanding a client’s overall pattern of health” (para. 33). The role of culture in resilience can be inferred from descriptions of the relational and philosophical patterns, but is not explicated in this theory. Because of the importance of culture to this project, a model which explicitly addresses cultural resilience in Native college students is described.

Family education model (FEM). The FEM was developed in the fields of social work and education to address the needs of Native college students and their families (HeavyRunner & DeCelles, 2002). It is based on the assumptions that many Native students and families need college staff to be their liaison with health and social services during times of crisis, and that college must involve family members in the college community and develop their ability to support students’ efforts. Cultural resilience is key to the FEM. Existing resilience research is the foundation of the concept, to which are added “cultural factors that nurture, encourage, and support Indian students, families, and communities” (HeavyRunner & Marshall, 2003, p.16). Factors include spirituality, family strength, elders, ceremonial rituals, oral traditions, tribal identity, and support
networks. Resilience is seen as an innate quality fostered by Native culture. The model emphasizes the potential of students rather than problems and adversity.

*Conceptual Framework of Nursing in the Native American Culture*

The essence of Native American nursing is described in a conceptual framework derived from focus groups of Native nurses, nursing students, and others who provide health care to Native peoples (Lowe & Struthers, 2001). Dimensions identified as being essential to nursing in Native American culture are: caring, traditions, respect, connection, holism, trust, and spirituality. These dimensions are interrelated and form a circle depicting the holistic world view of Native cultures. Each dimension is relevant to nursing in other cultures, but has special significance within Native cultures. For example, the historical record of contact between Euro-Americans and Native peoples is likely to create a sense of caution by Native clients, especially in relationship with non-Native nurses. Development of trust may take time before an effective caring relationship can be established.

The conceptual framework of nursing in the Native American culture is intended to pertain to all Native cultures, for nursing practice, education, research, and administration (Lowe & Struthers, 2001). Although created by Native nurses, Non-Native nurses can also utilize the framework to guide their caring relationships with Native individuals, families, and communities. It illustrates the importance of Native values which form the context for care, and is suggested as a framework for providing mental health care to Native people who suffer from historical trauma (Struthers & Lowe, 2003).
Critical Theory

This project incorporates an indigenist perspective of mental health, which recognizes the role of colonization in the lives of Native peoples today. Critical theory forms the basis for understanding the historical and political context of the present-day lives of Native college students.

Much of contemporary critical nursing theory is based on the critical social theory of Jurgen Habermas, a second-generation theorist of the Institute for Social Research in Frankfurt, Germany, also known as the Frankfurt School (Rodgers, 2005). His ideas that knowledge is imbedded in social processes and power structures still resonate with those seeking emancipation from oppressive ideologies. Another key contribution was his theory of communicative action which promotes mutual understanding through an equal and open exchange of ideas.

The work of Paolo Freire, a Brazilian educator, is another important influence on contemporary critical theory. His philosophy of education calls for people to engage in a mutual process of liberation from the dehumanizing influence of oppression (Freire, 1970/2000). This is done through conscientizacao, translated as critical consciousness, “learning to perceive social, political, and economic contradictions and to take action against the oppressive elements of reality” (Freire, p. 35). Action which occurs simultaneously with reflection is called praxis, and it transforms reality. Knowledge and liberation cannot be bestowed upon others; oppressed people must engage in the process of praxis for themselves.
Nursing’s commitment to society and interest in all conditions which promote or detract from health is enhanced by critical theory (Fontana, 2004). By engaging in a mutual process of learning and healing with clients, nurses encourage growth and empowerment. Falk-Rafael (2005) has developed a hybrid middle-range theory of critical caring for public health nursing. It combines elements of Watson’s caring science with critical feminist theories, which restores the social justice agenda to public health nursing. For example, Falk-Rafael transformed Watson’s carative factor of creative problem-solving caring process to a carative health-promoting process of “incorporating a systematic, reflexive approach to caring” (p. 44). An instance of this factor is a community assessment which is intended to build community capacity, with decision-making by the community.

Development of a critical theory of mental health nursing was suggested by Hopton (1997), a British nurse lecturer. Although the context for theory development was largely the British mental health system, lessons applicable to American nursing include the possibility that “Mental distress is a product of the social, political, and cultural environment” (Hopton, p. 497) and that treatment has sometimes been used for social control, so appropriate action addresses the social and political forces which led to the distress. Hopton advised a critique of mental health nursing by consumers as a starting point for reform.

Critical theories are commonly used to guide nursing research that includes critique, context, politics, emancipatory intent, democratic structure, dialectic analysis, and
reflexivity (Fontana, 2004). As indicated by the preceding discussion, critical theory also inspires deep reflection upon the root causes of clients’ living conditions.

Summary of Key Theoretical Relationships

Elements of each of the preceding theories are used to structure and inform the literature review which follows. The overall framework is provided by the Indigenist stress-coping paradigm. The middle-range theory of transitions is added in order to examine the unique challenges of Native college students, as well as to suggest potential nursing therapeutics throughout the stress-coping process. Traumatic stress is paired with transition in the stress domain of the paradigm. Categories of traumatic stress include historical trauma, racism, and traumatic life events.

Resilience theories inform the coping domain of the stress-coping paradigm. The FEM provides the concept of cultural resilience, similar to Walters and Simoni’s (2002) cultural buffers but grounded in the Native college experience. The concepts family/community, spiritual coping, traditional health practices, identity attitudes, and enculturation are reviewed in the context of cultural resilience.

Native conceptualizations of health and mental health, along with mental health disparities, form the health outcomes domain of the Indigenist stress-coping paradigm. Stress, coping, and health outcomes are not envisioned as a linear process; therefore the organization of concepts into a circular framework may suggest appropriate nursing therapeutics which address these 3 domains (Figure 1).
LITERATURE REVIEW OF MAJOR THEORETICAL CONCEPTS

A great deal of theoretical and investigative work targeting the concepts of interest to this project has been published. In this chapter, discussion of relevant published work is organized according to the conceptual framework.

Transitions

College Students

It is generally agreed that transition to college is a unique process for each individual “...characterized by change, ambiguity, and adjustment” across many aspects of the person’s life (Bray & Born, 2004, p. 181). The college transition has been studied as a context for adjustment to the increased level of social and personal stress experienced by college students. Larose and Bernier (2001) investigated the relationship of attachment state of mind to social support processes and personal adjustment in 62 French Canadian 16 and 17-year-olds during the college transition. They found that students with insecure attachment profiles demonstrated increased stress, distrust of potential support providers, difficulty seeking help, and loneliness.

A European study conducted in the United Kingdom (UK) and The Netherlands (NL) collected information from a somewhat older sample of 762 new college students, with a mean age of 19.6 in the NL sample and 18.8 in the UK (Stroebe, van Vliet, Hewstone, & Willis, 2002). There was a high prevalence of homesickness, in 50% of the Dutch students and 80% of the British students, strongly associated with distress and depression. The UK students, whose college was farther from their homes, had more intense symptoms of loneliness and rumination about home. Students with insecure attachment
profiles tended to have poorer emotional stability, loneliness, and depression. Stroebe et al. conceptualized homesickness as a mini-grief experience with some similarity to the consequences of bereavement, although not as extreme, which affects all cultures and age groups.

During the immediate transition to college, students’ usual health behaviors may change. Bray and Born (2004) discovered a significant decline in physical activity among a sample of 145 new Canadian college students, from 66.2% physically active during their last 2 months of high school to 44.1% physically active at the end of their first 2 months of college. The active students reported lower levels of tension and fatigue, and higher levels of vigor, than the physically inactive students. The transition to college can also result in a transition to binge drinking. In a national U.S. sample of 1894 first-year college students age 19 or younger, 494 took up binge drinking in college (Weitzman, Nelson, & Wechsler, 2003). Environmental factors found to be associated with the uptake of binge drinking included ease of accessibility, low cost, being a white male in a Greek letter organization, previous non-binge drinking in high school, and favoring a lower legal age for drinking.

College students who frequently binge drink are more likely to use other substances and to meet dependence criteria for nicotine, cannabis, and cocaine use, as well as other unhealthy behavior including driving under the influence of alcohol and engaging in unplanned and unprotected sexual activity (Vickers et al., 2004) It is interesting that Vickers et al. did not find an association between binge drinking and depression among a convenience sample of 412 college women age 18 to 24 years attending a midwestern
U.S. public university. However other possible risk factors for poor mental health have been identified.

College students’ perceived stress has been correlated with their mental health. A Swiss university undertook a study of the mental health care needs of students to assist health services planning (Bovier, Chamot, & Perneger, 2004). They determined that there was a strong relationship between higher perceived stress and poor mental health among a random sample of 1257 students with a mean age of 26 years. Students’ internal resources of mastery and self-esteem had a beneficial effect on mental health and buffered the negative effects of stress on mental health (Bovier et al., 2004, p. 169). Social support appeared to exert a beneficial effect indirectly by bolstering students’ internal resources and/or lowering the perception of stress. In a random sample of 462 students living in residence halls at a midwestern U.S. university, reports of frequent stress were associated with reports of depression, anxiety disorder, and seasonal affective disorder (Dusselier, Dunn, Wang, Shelley II, & Whalen, 2005). Alcohol use was a positive predictor of stress in this study.

Two studies have assessed the prevalence of psychological distress among college undergraduates. A Canadian study found a 30% prevalence of elevated psychological distress among 7800 randomly selected students from 16 different universities (Adlaf, Gliksman, Demers, & Newton-Taylor, 2001). The comparison of a sample subset of 1251 Ontario college students with a sample of the general population of Ontario adults aged 19 to 25 years demonstrated that psychological stress was significantly higher for college students at 41.1% prevalence, contrasted with 22.8% prevalence in the general sample.
Students at greatest risk of distress were first-year students. There was no association with living arrangement (e.g. residence hall, off-campus without family, or in parents’/family home).

Using a different assessment tool, Rosenthal and Schreiner (2000) investigated the prevalence of psychological distress within a convenience sample of 595 first-year students attending an ethnically diverse public college in the northeastern U.S. The majority (57%) were African American, 17% were Latino/Hispanic, 10% were Asian, 4% were Euro-American, and 12% were unspecified other ethnicities. There was a 15% prevalence of clinically significant levels of anger, anxiety, and depression, with no statistically significant differences among the diverse groups. The authors speculated that the unexceptional prevalence observed in this group of ethnic minority college students could be related to resilience arising from their cultures, subcommunities, and families.

A large national U.S. study surveys college students annually regarding their health, preventive health measures, risk behaviors, and academic impact (ACHA, 2005). The spring 2005 data collection yielded responses from 54,111 randomly selected students from 71 different colleges. The prevalence rate for self-reported depression was 19.6%, 13.4% reported an anxiety disorder, 8.9% reported seasonal affective disorder, and 16.3% of the sample reported negative academic impact from one or more of these problems. Stress was identified as the top impediment to academic performance, reported by 35% of female and 26% of male students. The ethnicity demographics of this sample as compared with 2002 U.S Department of Education enrollment information (2005) under represents African American students (4.3% in sample/11.9% in U.S. college enrollment)
and Latino/Hispanic American students (5.9%/10%), over represents Asian or Pacific Islander American students (10.8%/6.5%) and Euro-American students (74.9%/67.1%), and is representative of Native college students (1%/1%). Ethnic comparisons of the 2005 data are not available.

Almost all of the study samples are predominantly composed of either Euro-Americans, Europeans, or Canadians, and few fully represent the ethnic diversity of the populations they represent. The preceding literature does provide a perspective on the general stressors associated with the college environment and prevalence of psychological distress. The specific situation of Native college students is addressed in the following section.

Native American College Students

Matriculation of Native students may involve multiple and complex transitions for themselves and their families, with unique personal and cultural meanings which influence their feelings of connectedness and mastery (Meleis et al., 2000). Garrod and Larimore (1997) presented a collection of essays by Native men and women, about their experiences attending Dartmouth College, within the context of their larger lives. Several common themes emerged from these stories: the importance of connection to family and home, difficulty adjusting to a strange cultural environment, discomfort and discrimination experienced because of differences from mainstream student culture, inner strength derived from cultural history and values, and appreciation of the support received from Native American program staff and other Native students.
Garrod and Larimore (1997) described the meaning of family and community connection to these student authors:

For Native students raised to think of themselves as parts of an interconnected whole, leaving home to attend college can cause intense feelings of loss and isolation. To separate oneself from this intricate tapestry of interconnections is to leave behind the entire fabric of one’s identity. (p. 4)

Grandparents, parents, and other family members figured prominently in the stories, usually as a source of strength, love, and traditional teaching. Fortunately this mitigated the challenges presented by the dominant culture, which ranged from unfamiliarity with pop icons like “The Boss” (musician Bruce Springsteen) to culture shock upon confronting a “competitive, fast-paced East Coast mentality” (p. 104) of “fragmentation and compartmentalization of aspects of life” (p. 4). Native students found their values, beliefs, and expectations differed from those of their non-Native peers. “The less Native students are aware that others around them are playing by a different set of social and moral rules, the more confused, angry, alienated, and off balance (emotionally, physically, and spiritually) they can become” (p. 11).

The sense of culture shock was compounded by the discrimination and overt racism encountered by many of the Native students. Dartmouth tradition included an “Indian symbol,” or unofficial college mascot, which generated controversy. It was hotly defended by many of the non-Native students who approved of the image it projected, but struck Native students as an offensive caricature. Some of the Native students were variously stereotyped as having the ability to run silently through the forest (Garrod &
Larimore, 1997, p. 146), relying on affirmative action to succeed, and having a problem with alcoholism (p. 158). Others found themselves being the “token Indian” in the class, called upon to explain aspects of Native culture with which they were unfamiliar (p. 148). One Native woman found the words “Indian Bitch” painted in red on her door in a residence hall (p. 159). These experiences increased the stress of adjusting to an unfamiliar, and at times hostile, culture.

These Native student authors found ways to retain, and in some cases discover, their own cultural values as a source of inner strength, while learning to navigate mainstream Dartmouth culture. A Tlingit man from Alaska “learned to convert being eccentric into being exotic and to capitalize on my differences (Garrod & Larimore, 1997, p. 70). His freshman roommate helped him learn to communicate and interact with non-Native people, thus playing “an important role in my effort to balance the Indian world with the Dartmouth/non-Indian world” (p. 71). A Sioux woman initially “locked my spirit and heritage away in an effort to fit in” (p. 156) until remembering that for her the path to success involved combining “my cultural heritage with Eurocentric standards of success” (p. 155).

The Native American community at Dartmouth was frequently cited as a source of strength, becoming “surrogate tribal members” and helping to sustain a sense of identity, values, and humor (Garrod & Larimore, 1997, p. 73). Students remembered times of crisis when support staff in the Native American Program helped them through the problem-solving process in an unfamiliar situation, resulting in crisis resolution and an enhanced sense of mastery and ability to problem-solve. A support program for Native
students can help them to “recognize that a predominantly white college is not run according to a Native American cultural frame of reference,” so students “can begin to use their own upbringing and beliefs as a moral compass with which to navigate a path through school” (p. 12).

A qualitative study of 15 Native students’ college experiences verified the importance of family support and structured social support, as provided by Native American student organizations and student support services (Jackson, Smith, & Hill, 2003). Faculty and staff warmth was also identified as an important factor in student success, because it gave students a personal connection to the institution, and increased their confidence about asking for help. Previous positive experiences in a college environment, development of assertiveness, and reliance on traditional spiritual resources were also identified by students as adaptive factors. Native students also described racist experiences similar to those described by Dartmouth students, which were offensive and isolating. The students in this study followed a nonlinear path to their degree, each having attended at least 3 schools in the process. Another theme involved their experience of “conflicting pressures to (a) be successful in college and (b) maintain their identity as a member of their reservation community” (Jackson et al., p. 558). Although they reported the support of family and community, they expressed uncertainty about their acceptance as students or college graduates in terms of relevance to their Native communities.

Social support was the strongest predictor of likelihood to remain in school, in a study of 83 Native undergraduate students (Gloria & Robinson Kurpius, 2001). Support of family and friends, and the perception of being mentored, were all included in the social
support variable, but faculty/staff mentoring had the strongest relationship with academic persistence. Self-belief, including self-esteem and self-efficacy, and comfort in the university environment were also positively correlated with remaining in school. Perceptions of the university environment and cultural congruity also contributed to Native students’ persistence, but college stress by itself was not a predictor. The authors speculated that “the manner in which students cope with stress may be more important than the simple presence of stress” to academic persistence (Gloria & Robinson Kurpius, p. 97).

Native students leaving home to attend college reported that that people were significantly less friendly to them than did non-Native students at the same college, or Native students attending a tribal community college near their homes (McDonald, Jackson, & McDonald, 1991). The 3 study groups each consisted of 50 students who volunteered to participate. Both groups of Native students were significantly less confident in their academic ability and felt less well-prepared for college, than did their non-Native peers.

Tierney (1992) analyzed the challenges of Native college students through critical ethnography, by engaging students’ perspectives on institutional practices that enhance or detract from their empowerment. Because of ethnic differences in postsecondary educational persistence, sometimes referred to as student retention, educators are concerned about possible causes and solutions for ethnic groups with lower completion rates.
Although the number of Native Americans enrolling in postsecondary educational institutions more than doubled between 1976 and 2003, only 17.7% of Native Americans ages 18 to 24 were enrolled in colleges or universities in 2002 compared to 37.8% of the total population in that age group (Freeman & Fox, 2005, p. 99). A study of 12th-graders in 1992 who were likely postsecondary participants, as indicated by transcript requests or enrollment information, found that 15% of Native students had attained a bachelor’s degree or higher by 2000, compared with 45% of the general study population (Freeman & Fox, p. 106).

These data indicate a systemic problem with the college experience for Native students. Tierney (1992) found that in 2 mainstream universities and a community college there was institutional indifference about the situation of what they considered a small minority of the student body, and the expectation that Native students adapt by learning survival skills. Attempts to make students fit the mainstream mold flow from the assumptions that “Postsecondary institutions are ritualized situations that symbolize movement from one stage of life to another,” requiring that the previous stage be left behind, and that individuals become fully integrated into the institution’s mores and goals (Tierney, 1992, pp. 24-25). Tierney suggested that educators construct rituals of empowerment instead of integration, acknowledging the value of diversity and conflict (p. 148). Native students attending Dartmouth were able to “reframe their educational experience and rediscover their sense of purpose” by adapting rather than assimilating (Garrod & Larimore, 1997, p. 16). Self-determination, the power to decide and make choices, defines the line between adaptation and assimilation (Garrod & Larimore).
The experiences of Native college students, while unique for each person, contain common themes which form transitional patterns. Students’ stories indicate multiple, simultaneous transitions into new social, educational, and cultural situations which test all of their personal and environmental resources. Effectively confronting difference, “exemplified by unmet or divergent expectations, feeling different, being perceived as different, or seeing the world and others in different ways” (Meleis et al., 2000, p. 20), is critical to healthy resolution of their transition process.

Traumatic Stress

In addition to transitional stressors experienced by Native college students, there are traumatic stressors that are more likely to affect Native students than their non-Native peers.

Historical Trauma

Because Euro-American perspectives have defined the meanings of mental health and response to trauma, appreciation and understanding of other cultural perspectives of trauma is limited (Antai-Otong, 2002). However, it is difficult to understand the mental health needs of Native Americans without knowledge of the concept of historical trauma and its aftermath. Brave Heart and DeBruyn (1998) generated a comprehensive description of this phenomenon, based on their mental health work with Lakota, Pueblo, and other Native peoples in the U.S. and Canada.

Tactics employed by Europeans in the conquest of the Americas are responsible for historical trauma and unresolved grief experienced by Native peoples today. Native populations were decimated by infectious disease that was sometimes intentionally
introduced, armed conflict, arduous forced marches to reservation lands, and starvation (Brave Heart & DeBruyn, 1998, p. 62). Beginning in the 19th century, mission and Bureau of Indian Affairs (BIA) boarding schools designed to teach Native children the values, language, and ways of the dominant culture instituted compulsory attendance. Numerous physical, sexual, and emotional abuses of these children have been documented. Their own cultural practices were forbidden, thus destroying their language and cultural identity, along with their connection to family.

Assimilation practices continued in the 20th century when the BIA administered a program to shift large numbers of Native people from reservation lands to urban areas (Brave Heart & DeBruyn, 1998). Relocation frequently resulted in family separations, poor living conditions, and feelings of alienation in their new homes. The history of Native people post-contact is bluntly summarized by Whitbeck, Adams, Hoyt, and Chen (2004):

After military defeat, American Indians experienced one of the most systematic and successful programs of ethnic cleansing the world has seen. They were relocated to what amounted to penal colonies, starved, neglected, and forbidden to practice their religious beliefs. Their children were taken from them and reeducated so that their language, culture, and kinship patterns were lost to them. (p. 121)

The authors contend that because there are continual reminders of these losses, including reservation living, discrimination, and a sense of cultural loss, there is immediacy to the historical trauma which explains Native people’s unresolved grief.
Brave Heart and DeBruyn’s (1998) explanation of unresolved historical grief parallels that of the children of survivors of the Jewish holocaust. It involves “perceived obligation to share in ancestral pain as well as identification with the deceased ancestors” (p. 66), and a desire to protect parents and grandparents from the painful ancestral past. Additionally, “In the dominant United States culture, grief is recognized and considered legitimate only when the relationship to the deceased is an immediate kinship tie” (Brave Heart & DeBruyn, p. 66). Grief that is not sanctioned to be openly acknowledged and mourned is called disenfranchised grief. When suppressed, it can lead to more intense “emotional reactions such as anger, guilt, sadness, and helplessness” (Brave Heart & DeBruyn, p. 67). Unsanctioned grief is passed on for generations through transposition, a transfer of grief from generation to generation.

Contemporary college students may be affected by historical trauma and unresolved grief passed through generations. As stated by one of the Dartmouth students, “It is impossible for me to separate my own adventures from those of my family. We are all tightly connected, and what might be considered distant anecdotes by others are actual parts of me” (Garrod & Larimore, 1997, p. 27). In the traditional Native world view, history is conceptualized as spatial rather than temporal, so events are viewed as “a function of space or where the event actually took place” (Duran & Duran, 1995, p. 14), contributing to the immediacy of historical loss and grief. Whitbeck et al. (2004) developed 2 scales to measure historical loss and associated symptoms in Native people, and preliminary use of the scales indicated that the current generation of adults may have
frequent thoughts about historical loss, with significantly associated symptom complexes
of anxiety/depression and anger/avoidance.

Racism

As previously discussed, Native college students have experienced racism directed
towards them in their educational settings. Jackson, Smith, and Hill (2003) expressed
surprise at the high prevalence and degree of racism reported by Native students in their
interviews. Racism has been defined as “institutional and individual practices that create
and reinforce oppressive systems of race relations whereby people and institutions
engaging in discrimination adversely restrict, by judgment and action, the lives of those
against whom they discriminate” (Krieger, 2003, p. 195). Health can be harmed by
racism through 5 key pathways:

(1) economic and social deprivation; (2) toxic substances and hazardous conditions;
(3) socially inflicted trauma (mental, physical, and sexual, directly experienced or
witnessed, from verbal threats to violent acts); (4) targeted marketing of commodities
that can harm health, such as junk food and psychoactive substances (alcohol, tobacco,
and other licit and illicit drugs); and (5) inadequate or degrading medical care.

(Krieger, p. 196)

People’s responses to the discrimination of racism, such as internalized oppression or the
abuse of psychoactive substances, can extend the harm. Positive responses like reflective
coping or community organizing may improve health.

The psychology of internalized oppression as experienced by Native peoples was
elucidated by Duran and Duran (1995). The historical trauma that Native Americans were
subjected to can result in feelings of powerlessness and despair. In Freire’s (1970/2000) words,

…the behavior of the oppressed is a prescribed behavior, following as it does the guidelines of the oppressor….The oppressed…have adapted to the structure of domination in which they are immersed, and have become resigned to it, are inhibited from waging the struggle for freedom so long as they feel incapable of running the risks it requires. They are at one and the same time themselves and the oppressor whose consciousness they have internalized. (p.47)

The psyche wants to gain the power of the oppressor. However, because this is not possible, the person becomes more despairing and filled with self-hatred. Internalized hatred causes psychological distress, and can result in self-destructive behaviors such as alcoholism or suicide (Duran & Duran).

Traumatic Life Events

The self-hatred resulting from internalized oppression can be externalized, leading to a high level of violence within Native communities. The perpetrator of externalized aggression achieves “momentary catharsis and relief while at the same time destroying the part of him/herself that reminds him/her of that helplessness and lack of hope” (Duran & Duran, 1995, p. 30).

A study of trauma exposure in 2 Native American reservation populations revealed a higher prevalence of witnessing traumatic events, experiencing trauma to loved ones, and suffering physical attacks than that in the general U.S. population (Manson, Beals, Klein, Croy, & the AI-SUPERPFP Team, 2005). This study was part of the American Indian
Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP), which randomly sampled 3084 tribal members ages 15 to 57 years. Lifetime rates of exposure to at least one traumatic event ranged from 62.4% to 69.8%, with equivalent rates for men and women in contrast to the differential U.S. pattern of increased trauma exposure by men. Two unexpected findings were the association of greater educational attainment with increased trauma exposure, and poverty with less trauma exposure, another difference from the general U.S. population.

The occurrence of child abuse and neglect is also relatively higher for Native populations. Walters, Simoni, and Evans-Campbell (2002) reported the maltreatment rates for Native children to be significantly higher than those of most other ethnic groups. They were almost twice as likely to be placed in foster care, which may be experienced as another trauma. Delayed trauma reactions may become apparent during adolescence or adulthood, resulting in psychological distress and other negative health outcomes. Nearly half of a small convenience sample of urban Native women attending a prenatal clinic experienced physical and/or sexual abuse during childhood, and then were revictimized as adults (Bohn, 2003). There were significant relationships among childhood abuse, substance abuse, and adult revictimization, and also among cumulative lifetime abuse events, substance abuse, and depression. While the findings of this small study cannot be generalized outside of that clinic population, they illustrate relationships which require further study.

The burden of these traumatic life events, racism, and historical trauma can be overwhelming. However, adversity can also be experienced as an impetus for change,
creating greater diversity from chaos (Polk, 1997). The stories of Native students revealed strength and resilience which carried them through the challenges of college.

Cultural Resilience

Garrod and Larimore (1997) remarked upon the “character and resolve” of the Native Dartmouth students whose stories they collected (p. 13). The Indigenist stress-coping paradigm identifies several coping mechanisms, also referred to as cultural buffers (Walters, Simoni, & Evans-Campbell, 2002). These are explored in the following sections.

Family/Community

All of the Native Dartmouth College students identified their families and communities as the source of their inner strength (Garrod & Larimore, 1997). Because they were far away, they created a substitute family, and chose role models “who resonated most with the people they knew in childhood” (p. 13). Family resilience within the relational, non-linear world view held by many Native people incorporates “holistic and complex interrelationships that come into harmony and allow a family to not only survive but also to grow strong” (Cross, 1998, p. 151).

Dimensions of relational family resilience include the context of cultural heritage, historical challenge, and interdependent systems of care. The mental dimension provides traditional stories of coping, positive self-talk, and helping others in spite of pain and grief. Family structure, roles, and an extended kinship network form the physical framework of family resilience. The family’s spiritual beliefs and practices “provide a
great deal of the energy needed to face adversity” (Cross, p. 154). The complex interplay of all these areas creates the balance and harmony of family resilience.

In traditional Native families, young adult college students may continue close interdependence with family instead of increasing independence which is thought to be normative in the Euro-American culture (Montgomery, Miville, Winterowd, Jeffries, & Baysden, 2000). By supporting family-student connections and engaging in strengths-based decision making at the college level, student support staff can help families become empowered to claim the needed resources for their student’s educational persistence (HeavyRunner & DeCelles, 2002).

**Spiritual Coping/Traditional Healing**

Traditional Native spirituality is integral to daily life, and the cornerstone of survival (HeavyRunner & Marshall, 2003). Although traditional religious practice was forbidden during the 19th and into the 20th century, Native peoples demonstrated great tenacity in their resistance of this proscription. A unique feature of Native spirituality is its connection to the natural world, and sacredness of land. Being away from the homeland can be quite traumatic (Walters, Simoni, & Evans-Campbell, 2002).

In a health survey at a small Native American postsecondary school, 76% of respondents reported the importance of spirituality in their lives, and 35% reported talking with a spiritual advisor to cope with stress (Ambler et al., 2003). Spirituality as contributing to academic persistence emerged as a theme in the personal stories of 14 Native college students approaching graduation or recent graduates, ages 21 to 52 years
(Montgomery et al., 2000). Spiritual practice required traveling home for some students, while others were able to incorporate traditional spirituality while living at college.

Spirituality and traditional healing are intertwined concepts. Although practices vary among Native peoples, restoration of balance and harmony requires reuniting the person in need of healing with family and community (Walters, Simoni, & Evans-Campbell, 2002). This has particular relevance for Native college students living away from home. In order to participate in ceremonial healing, travel to the home community is required, sometimes for several days. Faculty may not understand this, and penalize the student academically.

Traditionalism, as determined by Native language use, cultural participation in ceremonies, and time spent off the reservation, was significantly associated with health protective behaviors in adult Hopi women (Coe et al., 2004). Traditional healing is an important source of care for many Native people, and may correlate with the strength of ethnic identity (Novins et al., 2004).

**Identity Attitudes**

A positive cultural identity towards self and other Native Americans is crucial for mental health (Swinomish Tribal Mental Health Project, 1991, p. 105). Personal identity and cultural identity are inseparable, so internalization of negative cultural attitudes and overvaluing mainstream culture is psychologically damaging. By shedding internalized stereotypes and integrating positive cultural identity into personal identity, Native people may develop a psychological buffer that protects them from depression, anxiety, and
other health problems (Walters, Simoni, & Evans-Campbell, 2002). More study is needed to determine the extent of protection conferred by a positive cultural identity.

Two of the qualitative studies of Native college students identified a related theme of resolving Native identity with academic identity (Jackson et al, 2003; Montgomery et al., 2000). Specific cultural identity attitudes were not reported, but the students discussed some difficulty integrating the concepts of self as students and self as accepted members of their Native communities. Several of the Dartmouth students (Garrod & Larimore, 1997) discussed their perceptions of the school’s Indian symbol as deeply offensive, which can be interpreted as experiencing an assault on their Native identities. Their inclination to protest rather than accept the mainstream culture’s depiction of Native identity indicates a positive identity attitude. Taken together, these findings suggest that positive identity attitudes are a salient issue for Native college students.

Identity attitudes are not to be confused with the degree to which individuals maintain cultural beliefs and practices. It is possible to have a negative cultural self-identity while practicing a very traditional lifestyle. Confusion of identity attitudes with degree of acculturation may create confounding and discrepant findings in health research (Walters, Simoni, & Evans-Campbell, 2002, p. S113).

Enculturation

Historical traumas such as boarding school placement and proscriptions against religious practice deprived Native peoples of traditional culture. Cultural deprivation continues to occur when children are placed in foster care outside their ethnic group, or internalized oppression and self-hatred cause people to ignore or reject cultural teachings.
The truly culturally deprived person is a person in limbo, a person without a sense of belonging, a person who neither knows nor accepts himself….At best, a culturally deprived person is out of balance, incomplete, and vulnerable. At worst he is confused, depressed, anxious, or amoral. (Swinomish, 1991, p. 107)

In the indigenist stress-coping paradigm enculturation is a buffer that restores traditional culture, and mitigates the negative effects of a risk factor or enhances the effects of another buffer (Walters, Simoni, & Evans-Campbell, 2002). It is defined as “the process by which members of a minority group learn about and identify with their cultural heritage, norms, and traditional values” (Walters, Simoni, & Evans-Campbell, p. S113).

One of the Native Dartmouth students described his own enculturation process that evolved from his college experiences (Garrod & Larimore, 1997). “When I came to Dartmouth as a young man, I realized that my life was not well balanced because I had never learned the Lakota language and culture from my grandmother” (p. 137). She and his mother had been afraid he would be teased, and they wanted him to succeed in the white world. He made a conscious decision “to learn how to be a Lakota” (p. 150) by studying Native history, language, and culture at Dartmouth, and learning from his family on his visits home. This man reported feeling “angry that a place like Dartmouth was necessary for me to figure out my identity and direction in life” (p. 153). In his situation the Native American studies program served dual academic and enculturative roles.

The concept of resilience takes on unique meanings in the lives of Native college students. Although the study of resilience from childhood to adulthood has revealed a pattern of stability within individuals, Masten et al. (2004) identified the intriguing
possibility of a late-emerging resilience during the transition to adulthood. They
described this developmental period as a time when “neurobehavioral and ecological
changes converge to create new possibilities for consolidating positive development or
shifting development in new directions through the actions of self and others: (p. 1092).
Although their longitudinal study was conducted within the general population, their
sample was ethnically diverse, including 7% Native Americans. The resources that
appeared to make a difference for the small group whose resilience status changed from
maladaptive to resilient were planfulness/future motivation, autonomy, and adult support
outside the family. Further study of factors contributing to the late emergence of
resilience could lead to health-promoting interventions for college students in general and
Native students in particular.

Health and Mental Health

A comprehensive description of the concept of health and mental health in Native
cultures is beyond the scope of this project. However it is important to think about Native
perspectives on the relationship between health and mental health, and to be aware of
health outcomes produced in the indigenist stress-coping cycle.

Native American Perspectives

Although there are various perspectives among and within diverse Native cultures,
some commonalities of vision describe health. Holism of person and world permeates
this vision, and “the idea of balance or of being in the right relation to the world, and
especially to one’s family, kin and significant others, is of central importance in most
Indian cultures” (Swinomish, 1991, p.138). Contrary to the compartmentalization inherent in Western medical model of health and illness,

Native people have traditionally viewed health and personal development as inextricable parts of a complex whole; one’s physical, intellectual, emotional, and spiritual aspects are seamlessly interwoven, and one can maintain health and well-being only by achieving balance among all of them. To be healthy, one must have access to caretakers (such as medicine men and women, other elders, and members of the immediate and extended family) whose knowledge, training, and life experiences overlap and interact with one another. (Garrod & Larimore, 1997, pp. 4-5)

Unfortunately the health care available on mainstream college campuses is frequently not in tune with this vision of health and healing. There are a variety of professionals to address parts of the person rather than to heal the whole being in relation to environment.

Because traditional Native world views make limited distinctions between physical and mental symptoms, some Native Americans attach little or no stigma, or negative stereotyping, to persons experiencing mental health problems (Grandbois, 2005). Although degree of stigma may be related to the extent to which Native persons ascribe to traditional or to mainstream Western culture, generalizations are not possible. As is true for many Americans, fear of stigmatization may prevent emotionally troubled Native people from seeking help.

Mental Health Disparities

Mental health disparities exist for Native Americans in terms of health care and health outcomes. As reported by Grandbois (2005), there are 101 mental health professionals
per 100,000 Native Americans, compared with 173 mental health professionals per 100,000 European Americans. Native Americans are underrepresented in mental health professions, and for some Native clients who prefer to see ethnically similar professionals, this limits the acceptability of services. Racism and stereotyping by health care providers, such as assuming a Native client’s health problem is alcohol-related, has been anecdotally reported (Joe, 2003).

Poverty and the lack of health insurance are also barriers to mental health care. Many Native Americans lack health insurance because of unemployment and the historical provision of care by the IHS. Manson (2001) reported 54.9% of Native families to be either uninsured or entirely reliant on the IHS for health care (p. 181). Some insurance plans do not cover mental health services to the same extent that other health care is covered.

Location of services can also be a problem. Mental health services provided by the IHS and tribal health authorities are located primarily on reservations, usually in rural areas. Because more than half of the Native population lives in urban areas (Snipp, 2000), the distance to affordable mental health care is a significant structural barrier. Native college students from rural areas experience the same barrier. Many urban Native Americans do not qualify for IHS or tribal health care at all. Urban health care facilities for Native Americans charge fees for services, creating a financial barrier for some. The combination of all these factors has created a disparity in access to mental health care.

Although there is little information about the extent of mental health problems among Native college students, it is known that psychiatric morbidity and mortality is
disproportionately high within the general Native population. Joe (2003) reported an age-adjusted death rate from suicide that was 72% higher for Native Americans than for the general U.S. population, based on data from 1994-1996. The death rate from alcoholism was 627% greater for Native people. Other disproportionately high health problems, including diabetes mellitus, accidents, and homicide, contribute to mental distress as well.

A prevalence study of 489 Native women attending an urban IHS primary care clinic, ages 18 to 45 years, indicated high rates of alcohol use disorders, anxiety disorders, and anxiety/depression comorbidity compared with non-Native women in primary care settings (Duran et al., 2004). The investigators noted that “rates of periodic binge drinking may overestimate the proportion of women with an ‘alcohol abuser’ diagnosis in the DSM-IV algorithm” (p. 75), and that consumption patterns tend to be bimodal, with large numbers of abstainers and heavy drinkers. They also found that more than two thirds of women with alcohol use disorders had a co-occurring anxiety disorder.

The large psychiatric epidemiology study called AI-SUPERPFP studied alcohol use and prevalence of depression in 2 reservation populations. They found that Native people in these samples were less likely to use alcohol than the general U.S. population, but those who drank consumed more per drinking occasion. The findings also supported the variation of alcohol use by gender, age, and tribe, (Beals, Spicer, et al., 2003). The prevalence of depression was unexpectedly low in these samples, only 30% of that reported in the U.S. population (Beals, Manson, et al., 2005). Reinterview of 10% of the original samples by psychiatrists or clinical psychologists did not significantly change the
results. Detailed analysis of the study instrument and interview process led to the conclusion that major depressive disorder may present a different social construction or patterning of symptoms in these cultures, suggesting “the importance of integrating qualitative and quantitative methods for understanding depressive and other disorders within the purview of the DSM” (Beals, Manson, et al., p. 1721).

Any discussion of health disparities based on ethnicity runs the risk of framing culture as a problem to be solved, when actually it is a resource for mental health (Cross, 2003), as demonstrated by the indigenist stress-coping model (Walters & Simoni, 2002). Disparities indicate the work that needs to be done. Cross (2003) asserts that culture provides the resources for positive emotions, and is key to a strengths-based approach to improving mental health (p. 358).

**Nursing Therapeutics**

The central position of nursing therapeutics in the model of conceptual relationships impacting the health of Native college students (Figure 1) indicates the potential for nurses to influence positive change within the dimensions of transition and traumatic stress, cultural resilience and coping, and health outcomes. If the goal of nursing is “to facilitate motion toward wholeness” (Polk, 1997, ¶ 25), all aspects of the person in connection with the environment are considered.

This project’s conceptual themes of indigenism, transition, historical trauma, racism, cultural resilience, and health disparities are congruent with a nursing therapeutic of empowerment. Crawford Shearer and Reed (2004) reformulated a participatory perspective of empowerment in which:
…there is an awareness of the mutual process of power that is inherent in the nurse-client system itself, rather than located in either the nurse or client alone….Health involves the client’s purposeful participation in developing self-awareness and choosing health patterns. Clients exercise their power by participating in their healthcare and healthcare decisions. The nurse’s approach is to inspire, not dictate this process, to be facilitative, not authoritative. (p. 256)

The conceptual framework of nursing in the Native American culture endorses the participatory nature of the nurse-client relationship by emphasizing caring as a partnership in healing (Lowe & Struthers, 2001). Partnerships are formed at the individual, family, and community level. Mental health programs are designed with the community’s participation as experts in their own health care needs. Families are considered essential to the healing process, whether or not they are physically present. The abilities and strengths of clients are recognized, respected, and valued (Canales, 2000), and engaged as resources contributing to mental health. The basis for the partnership is true listening, even when the client’s perspectives are unfamiliar or inconsistent with those of the nurse (Canales, 2000). By taking active interest in the realities of clients’ lives, nurses can get beyond the stereotypes which interfere with understanding (Canales, 1997).

The core of nursing therapeutics is the quality of relationship nurses create with their clients. On this basis they are able to offer the support and therapy that clients choose in a mutually empowering process.
PROMOTING THE MENTAL HEALTH OF NATIVE COLLEGE STUDENTS

In order to implement the conceptual framework for promoting the mental health of Native college students, a community is selected and described so that potential needs can be identified. Partnerships at the community, family, and individual levels are described.

Demographic Information

This community of over 1200 Native students attends a university located in northern Arizona, and represents 7% of the undergraduate and 4.5% of the graduate student population, or 6.5% overall (Northern Arizona University [NAU], n.d.). Statistics available at the university’s Native American Student Services (NASS) website (n.d.) show there is great intertribal diversity, although predominant representation of Navajo, Hopi, Cherokee, White Mountain Apache, and San Carlos Apache nations (NAU, n.d.). One third of the Native students come from the county surrounding the university, which includes rural reservation communities (NASS, n.d.). It is not known what proportion of students are permanent residents of the immediate area, but at least two thirds are residents of more distant areas, requiring them to live in the campus area.

Community Resources

A dedicated Native American Student Services (NASS) staff serves this community, offering intensive support, mentoring, and advisement, concentrated during students’ first year of enrollment. NASS staff also organizes social activities for Native students and their families. It can be difficult to gain university support for programs that benefit a Native population that represents a small part of the student body (Tierney, 1992).
However, there is administrative support for the NASS mission at the top level of the university, whose strategic plan includes the goal of becoming the nation’s leading university serving Native Americans (NAU, 2005).

A campus health center and counseling center are available to the entire student population, with user fees for services. The health center employs a full-time psychiatric mental health nurse practitioner (PMHNP). Family nurse practitioners and family physicians also provide mental health services for less complex mental health problems. The counseling center provides therapy by psychologists, counselors, and social workers, including alcohol and other drug counseling.

An urban Native American clinic is available off-campus, requiring transportation, and also charges fees on a sliding scale basis. A local hospital contracts with the IHS and tribal governments to provide urgent and emergent health care to Native Americans who are away from their reservation communities. A separate mental health facility off-campus provides inpatient and outpatient services to anyone requiring care, although fees are collected and insurance is billed.

A mental health needs assessment conducted by a Native American community-based agency serving Native people living off-reservation in the county surrounding the university indicated a high level of distress and need (Chester, Mahalish, & Davis, 1999). Out of 184 Native adults and adolescents surveyed, 38% reported feeling depressed, 27% had experienced attempted or completed suicide of family members, and 31% reported personal drug and alcohol abuse.
It was recommended that mental health services for this community take an integrated approach by considering “the impact of physical, social, and economic concerns on mental and emotional health” (Chester et al., p. 37). Age-specific prevention programs would address the “progression of both problems and coping mechanisms which, if handled well at critical developmental levels, might reduce crises and enhance coping in later life” (Chester et al., p. 38). The authors affirmed the importance of integrating cultural variables into mental health programs in order to utilize the inherent strength of people who can maintain traditional cultural integrity while adapting to another culture. The assessment also found that “lack of information about mental health and available services is a strong barrier to service utilization”, indicating the essential role of outreach for this population (Chester et al., p. 38). The assessment’s final recommendation was to reconsider the value of mental health screening conducted in the medical clinic setting, because of underreporting of psychological distress when compared with information collected by trained bilingual interviewers in community settings.

It is not known whether all of these findings and recommendations from the Native community surrounding the university can be applied to Native college students. However, most of the information is consistent with other reports from the literature review, and may be of use in the initial planning for culturally appropriate mental health services for Native college students.

Collaborative Plan

A critical assessment of Native students’ mental health needs takes a collaborative and participatory approach, based on the recognition that “Native communities can identify
their needs, determine courses of action, and achieve the goals they have set for themselves” (Caldwell et al., 2005, pp. 8-9). Therefore the essential and first element of the plan is to establish collaborative relationships with the community and with appropriate agencies. The remainder of the plan is provisional upon discussions with the community. The components of the plan that follow are based on the literature review.

1. Meet with the director of NASS to discuss the mental health needs of Native students, and elicit suggestions of any needed improvements in the services that are currently available. Invite the NASS director and staff to serve as consultants and participate in activities to improve health services. If indicated by this meeting, initiate discussion with the director of the student health and counseling centers to follow up on recommendations and offer assistance.

2. Provide an educational seminar to inform student health and counseling center staff about the transitions, stressors, cultural resilience factors, and health perspectives of Native college students. It is important to invite all staff, since personal connections with clients begin in the reception area. Proposed content of the seminar is described in the following section.

3. Investigate possible relationships among campus health and counseling centers and the IHS and tribal health systems, to offer a seamless health system for Native students. Limit the conceptual division between health of the body and health of the mind by promoting smooth transitions between the health center and the counseling center. Implementation of these steps would require a strong collaborative relationship with the student health center and counseling center, and their commitment to the project purpose.
4. Provide appropriate outreach to Native students, in consultation with NASS, to increase students’ familiarity with campus health and counseling services. A PMHNP could offer initial contact in settings where Native students congregate. Knowledge of available resources may increase utilization, and also offers the opportunity for students to provide feedback to health services staff. Native students’ participation in the health care planning process could take the form of an advisory committee that would liaise between the Native student community and campus service providers.

*Educational Seminar*

NASS staff is invited to participate in the planning and implementation of an educational seminar for the staff of the student health center and the counseling center. There are approximately 35 employees with diverse roles: nurses, pharmacists, counselors, psychologists, patient services staff, physicians, medical technologists, and nurse practitioners including a PMHNP. Two hours are allotted for the seminar, with a short break midway.

*Learning objectives.* The following objectives for seminar participants are learner-centered. Outcome behaviors will not be evaluated by seminar facilitators, but the participants’ ability to perform the desired behaviors (Ferguson, 1998).

1. The learner will identify his or her own cultural identity and influence.
2. The learner will recognize unique and diverse cultural and geopolitical backgrounds of Native college students.
3. The learner will avoid stereotyping by seeking individualized information about clients.
4. The learner will apply knowledge of Native perspectives of health to clinical situations.

5. The learner will describe disparate stressors, health care, and health outcomes affecting Native peoples.

6. The learner will recognize the concept of historical trauma as a factor in the mental health of Native peoples.

7. The learner will apply knowledge of Native students’ cultural resources and coping mechanisms to their care.

8. The learner will employ the concept of empowerment in providing health care to clients (Ferguson, 1998).

9. The learner will identify specific actions to support the transition and health care needs of Native college students.

Introduction. The purpose and content of the seminar is described. A seminar evaluation form is distributed so participants can evaluate each component of the program as measured by relevance to learning objectives. Personal introductions are done via a cultural self-identity exercise to facilitate awareness that culture influences everyone, not just minority groups. Group members, including presenters, partner with adjacent person to describe personal cultural background and one way it influences him or her. Each group member is introduced by partner’s summary of cultural self-assessment.

Diversity of Native student backgrounds. A slide show with a brief commentary depicts the varied cultural backgrounds and geographic locations of Native students at
this university. Some examples include rural reservation, Alaska village, and urban settings. This is used as an opportunity to remark upon stereotyping as an unintentionally harmful way of overgeneralizing and ignoring unique, diverse attributes of clients.

*Commonalities of Native worldviews.* With the disclaimer that there is not one universal Native worldview some commonalities are presented, particularly regarding health and mental health. The natural difficulty of attending to unfamiliar concepts in order to achieve understanding is discussed.

*Historical context of the present-day lives of Native peoples.* A brief synopsis of broad historical events leading to the present-day lives of Native peoples is discussed, including unique health care delivery systems, health disparities including depression, anxiety, and alcohol abuse, racism, and traumatic life events. The concept of historical trauma as relevant to contemporary mental health is discussed.

*Transition to a mainstream university setting.* The unique challenges identified by Native students in the literature review are summarized.

*Cultural resilience and strengths.* The coping mechanisms identified in the literature review are described in the context of supporting the college transition. The importance of family and community, spiritual coping and traditional healing, identity attitudes, and enculturation are suggested as strengths that Native students may want to utilize, depending on their individual cultural orientation. A few concrete examples are given, such as the possible need to include family members in health care decisions. The concept of empowerment as development of a participatory relationship to encourage client decision-making is discussed.
Specific supportive actions. The main group “counts off” to form small groups for a brainstorming session, to identify specific ways the student health center and counseling center can support the transition and health care needs of Native college students. Small groups record all suggestions on large poster paper. At the conclusion of a 15-minute session, the entire group reconvenes for presentations by a representative from each small group to summarize suggested actions. Seminar facilitators make note of the suggestions and underscore any identified consensus.

Wrap-up. Plans for organizational representatives to explore the impact and feasibility of specific supportive actions are formulated. Seminar facilitators take the poster paper lists from the brainstorming session to compile the suggestions for later distribution to seminar participants. Seminar evaluation forms which include space for additional suggestions are completed by participants and collected by facilitators.

 Desired Project Outcomes

Mental health problems arising from transitional stressors have been theoretically linked to the educational persistence of Native college students (Garrod & Larimore, 1997). Although educational persistence is a worthwhile goal which may be related to mental health, it is not the primary purpose of this project. The purpose is to provide culturally appropriate and empowering care that promotes the mental health of Native college students, which is the desired outcome. Improved well-being and choice may contribute to educational persistence or to achievement of other goals. Native students sometimes choose to “stop-out” of college for a semester or longer because of family responsibilities, returning once their responsibilities have been fulfilled (Yurkovich,
2001, p. 262). This should not be considered a failure of either the students or the university community (Tierney, 1992), as long as the students have received necessary support and make an empowered choice.

Collaboration among NASS and student health agencies, a seminar to increase campus health providers’ knowledge of Native students’ needs and the strategies to address those needs, improved access to student health care through linkages with IHS and tribal agencies, and mental health outreach to Native college students, are all intended to improve students’ mental health and thus their capacity to achieve personal goals. Criteria that would measure project processes include increased utilization of student health and counseling centers by Native students, and Native students’ satisfaction with services.

Outcome criteria to assess Native students’ mental health are available through an annual survey of student health and wellness administered by the student health center which queries ethnicity as part of the demographic data (J. Rudy, personal communication, August 24, 2005). The survey includes students’ perceptions of their health, stressors, coping mechanisms, alcohol use patterns, and symptoms of depression. Health center staff could assess the data as part of their continuing quality improvement program, utilizing the information for program planning as well as evaluation. This type of ecologic assessment would not link individual mental health outcomes to project interventions, but would provide valuable population-level indicators of mental health trends and program needs (Aschengrau & Seage, 2003).
This university has a relatively large Native student population of 6.5% in comparison to the general Native population of 1.5%, so this project has the potential to reach more than 1200 Native students. Because the university’s strategic plan includes an objective to “Develop specific programs to support Native American student needs and demand” (NAU, 2005, p. 14), it is possible that a collaborative plan made by NASS and the student health and counseling centers would garner university support and the necessary resources for implementation.
CONCLUSION

Limitations of the Project

Sustainability of this project is a limitation, in view of the author’s unofficial capacity with the agencies involved. The author plans to initiate the project, and it is possible that the community will desire implementation and continuation of the plan (Holkup, Tripp-Reimer, Salois, & Weinert, 2004). If so, university administrative support and the campus agencies involved in the plan are resources that can sustain the project. Community participation and the educational workshop were positioned as numbers one and two in the collaborative plan with the idea that the linking of these agencies would stimulate interest to proceed.

The author’s non-Native ethnicity may have limited insight into the dynamics and perspectives required by this project. This limitation was addressed by including Native voices as much as possible, by calling upon the voices of Native college students in personal accounts and qualitative studies, and Native theorists and investigators. The project plan includes additional contribution by the Native college community via the NASS director.

The scope of this project was potentially broad, and the author chose to limit consideration of Native students’ mental health concerns to factors outlined by the selected theoretical framework. The range of nursing therapeutics was intentionally limited to prevent predetermined notions from minimizing the community’s input.
Directions for the Future

Beyond the implementation of this project, the synergy of a strengthened collaborative relationship between NASS and university health and counseling services would facilitate future mutual endeavors.

The prevalence of psychological distress is not known in this Native university population. Additional information would contribute to effective program planning. The heterogeneity of Native Americans makes it difficult to generalize from one setting to another. It is possible that Native students would be willing to share their opinions about students’ needs and preferences for care in the format of focus groups or surveys. This could be an empowering action as students participate in the health care decision-making process.

Recruitment and retention of Native nursing students will improve the profession’s diversity and thus the knowledge base for providing care to diverse ethnic groups. It is possible that providing appropriate and sensitive mental health services to Native college students will help them to persist toward their educational goals, thereby increasing the number of Native nurses.

As mental health professionals work with Native students, other environmental factors contributing to their stress and coping will become apparent. It is important that nurses extend their advocacy to all aspects of the environment, including sociopolitical structures, which negatively influence their clients.
Implications for Nursing Practice

The theoretical framework for this project identified relevant issues which impact the mental health needs of Native college students, and reinforced the usefulness of culturally specific theory. The literature review also identified potential cultural variation in the symptom presentation of mental health problems such as depression. PMHNPs and other mental health professionals should be aware that strict adherence to DSM-IV-TR criteria may not capture significant psychological distress experienced by Native Americans. The holistic perspective of PMHNPs prepares them to be sensitive to cultural variation in DSM-IV-TR based diagnoses.

All program evaluation or research “should be informed by an understanding of the issues and dynamics of postcolonial trauma and stress faced by individuals, families, and communities” (Caldwell et al., 2005 p. 11). It is important that PMHNPs providing care to Native peoples be aware of historical trauma and its possible influence on the health of their clients (Struthers & Lowe, 2003). An emphasis on inherent strengths and cultural resilience of clients promotes mental health, an essential component of the PMHNP role.

Flexibility is still an important practice attribute of effective nurses. Considering what is best for clients sometimes takes nurses outside of their usual practice milieu, as in the proposal for PMHNP outreach to Native students outside the clinic setting.

As Dreher and MacNaughton (2002) stated, cultural competence is nursing competence. It is not necessary, or even useful, to have an encyclopedic knowledge of cultural traditions to provide effective nursing care. Cultures change and there is great variation within cultures. However, it is crucial to take the time to provide individualized
care by seeking information about the issues of importance to our clients and ensuring that they are partners in their own care.
References


Beals, J., Manson, S. M., Whitesell, N. R., Mitchell, C. M., Novins, D. K., Simpson, S.,


