2013

A culture specific grief intervention and its affects upon coping behavior and perceived social support among American Indians: A treatment development study

William Henry Shunkamolah
The University of Montana

A CULTURE SPECIFIC GRIEF INTERVENTION AND ITS AFFECTS UPON

COPING BEHAVIOR AND PERCEIVED SOCIAL SUPPORT

AMONG AMERICAN INDIANS: A TREATMENT DEVELOPMENT STUDY

By

WILLIAM HENRY SHUNKAMOLAH

Master of Arts, The University of Montana, Missoula, Montana, 2009
Bachelor of Science, University of New Mexico, Albuquerque, New Mexico, 2001

Dissertation

presented in partial fulfillment of the requirements
for the degree of

Doctor of Philosophy

The University of Montana
Missoula, MT

October 2012

Approved by:

Sandy Ross, PhD, Dean of The Graduate School
Graduate School

Gyda Swaney, PhD, Chair
Psychology

Paul Silverman, PhD
Psychology

Jennifer Waltz, PhD
Psychology

Nadine Wisniewski, PhD
Psychology

Gilbert Quintero, PhD
Anthropology

Shunkamolah, William, Ph.D., Autumn 2012   Clinical Psychology

A culture specific grief intervention and its effects upon coping behavior and perceived social support among American Indians: A treatment development study

Chair: Gyda Swaney, Ph.D.   *Gyda Swaney*
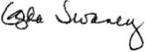
  Numerous theorists have linked centuries of historical trauma to continued unresolved grief, a high level of distress (e.g., depression), and high rates of social problems (e.g., substance use/abuse) in American Indian communities, but interventions aimed at addressing the losses experienced by this population are virtually non-existent.

  Members of a tribe in Montana identified historical unresolved grief and personal grief, as the most salient underlying factors related to health disparities in their community. Collaboration between the tribal community, the tribal Community College, The University of Montana, and Montana State University led to the development of a culturally anchored grief intervention for historical trauma and grief which was guided by two M.A. level tribal professionals.

  A quasi-experimental research design with pre-, post-, 1 month, and 3 month follow-up repeated measures was utilized to examine the efficacy of the 3-daylong Grief Retreat interventions. More specifically, the current research project examined the effects that the grief intervention has upon participants' self-reported coping behaviors and perceived social support of members of the American Indian community by which and for whom the intervention was developed. This study is part of a larger project.

  A repeated measures ANOVA test was used to analyze data obtained from participants' response scores completed pre- and post-intervention. Additionally, memo/journal notes and participants' responses to two open-ended questions were maintained throughout the study to inform the statistical analysis and results.

  Pair-wise comparison of pre-intervention (T1) and 1 month post-intervention (T3) time points revealed significantly lower substance use and self-blame coping behavior utilization among participants who completed the intervention. However, no statistically significant changes in participant's perception of social support were observed. Practical and clinical significant findings are discussed.

  Qualitative information indicated that participants benefitted from exposure to various aspects of the two major components of the retreat (i.e., enculturation and education) which led to the use of more adaptive grief coping (i.e., active emotional coping) and growth.

  Although this study was intended primarily to benefit this tribal community, findings limitations, and recommendations are identified and discussed with hopes that future research will benefit other American Indian people.

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CHAPTER I. Introduction

"What is life? It is the flash of a firefly in the night. It is the breath of a buffalo in the

wintertime. It is the little shadow which runs across the grass and loses itself in the sunset."

Crowfoot - Blackfoot Chief

(Retrieved from http://en.wikiquote.org/wiki/Crowfoot)

Throughout our lifetime, our understanding of death is continuously shaped by our personal

experience as well as factors such as culture and religion (Braun & Nichols, 1997; Cable, 1998;

Catlin, 1992; Clarke, Hayslip, Edmondson, & Guarnaccia, 2003; Eyetsemitan, 2002; Gire, 2002;

Mantala-Bozos, 2003; McGoldrick, 1991; Rubin & Yasien-Esmael, 2004; Weaver, Flannelly,

Garbarino, Figley, & Flannelly, 2003). Differences from one loss to another are influenced by

factors such as mode of death (e.g., sudden) or our relationship to the deceased, which ultimately

influences our bereavement outcome. Although the human bereavement experience is not as

general and simple (or linear) as the above description might suggest, research has identified

examples of the bereavement experience that appear to apply to all individuals.

After a loss, bereaved individuals generally experience reactions which often manifest in a

variety of ways (e.g., thoughts, emotions, etc.). A review of the literature, conducted by Stroebe,

Hansson, Stroebe, and Schut (2004), revealed that a large number of common reactions to grief

have been repeatedly and consistently found across numerous bereavement studies. They

categorized these normal grief reactions according to the manner in which they manifest in

bereaved individuals (i.e. affective, behavioral, cognitive, and physiological and somatic). It is

worth noting that these common grief reactions are discussed in terms of symptoms because

bereavement research has historically been concerned with the negative effects grief has upon the health (mental and physical) of bereaved individuals.

Although bereaved individuals typically have little control over their experience of the aforementioned common grief reactions, they may actively respond to a death with actions and behaviors that allow for adaptation to the situation in which they find themselves. Such responses are attempts to adapt to or manage the reactions experienced during bereavement and are referred to as coping behaviors. Historically, coping behavior effectiveness has been judged based on the particular behaviors ability to reduce symptomology and produce a more adaptive outcome. However, research (Parkes, as cited in Worden, 1982; Stroebe & Schut, 2001) has shown that coping behavior utilization is typically based upon a number of variables making it a very unique and individual process.

Despite the fact that our experiences with death are very unique and personal it is rare we engage in this life process alone. It has been postulated that coping with grief in a larger social context, in addition to coping with grief on a personal individual level, leads to better (more adaptive) bereavement outcomes. Grief within a larger social context (e.g., families, communities, etc.) likely influences our reactions, which may influence our use of coping behaviors, which may ultimately influence the outcome of our grief. Studies have shown that individuals who possess large/strong social networks, rely upon family for support, participate in supportive community bereavement services, and were able to strengthen old bonds and find new social support sources experienced better outcomes and/or more personal growth than their counterparts (Dimond, Lund, & Caserta, 1987; Lauer, Mulhern, Bohne & Camitta, 1985; Martinson & Campos, 1991; Norris & Murell, 1990).

Although the utilization of coping behaviors and available social support is thought to lead to adaptive bereavement outcomes, could the lack or absence of coping behaviors and/or social support lead to or predict a maladaptive or complicated bereavement outcome?

Literature Search

An initial PychINFO literature search using the keywords grief, bereavement, and death resulted in 55,914 publications. The keywords complicated grief and traumatic grief were added to the search, which narrowed the results to 550 publications. Further, the keywords intervention, treatment, and coping were added, which resulted in 291 results. Finally, the keywords outcome and improvement were added to the search resulting in 55 published works. These 55 publications included 41 journal/peer-reviewed publications, 8 dissertations, 5 book chapters/essays, and 1 book review. A review of the abstracts revealed that only approximately half of these 55 publications appeared to be relevant to the current study.

A second more focused PsychINFO search using the following keywords: Grief, bereavement, death; intervention, treatment; and outcome study, treatment development study, and effectiveness study produced 19 published works (13 journal/peer-reviewed publications, 4 dissertations, 1 book chapter, and 1 book). A review of the abstracts of the 19 publications resulted in the identification of 6 publications that appeared to be relevant to the current study. However, the majority of interventions and treatments that have been studied target bereaved children (e.g., group interventions for bereaved children, camp intervention for bereaved adolescents, etc.).

In summary, while a great deal of literature in the areas of bereavement/grief, trauma, and coping exists, there appears to be a lack of research examining the effective interventions or

treatments for adult individuals coping with grief and bereavement. Additionally, the number of studies exploring grief/bereavement intervention or treatment outcome are virtually non-existent.

<div align="center">**Bereavement**</div>

Bereavement Research

Although much of the bereavement research has historically focused upon identification of negative and impeding aspects of an individual's bereavement experience, research focus has shifted away from negative effects of bereavement (i.e., symptomology) toward more positive aspects of grief (Frantz, Trolley, & Farrell, 1998) such as coping, growth, and the continuation or extension of relationships.

Theory has moved from viewing the grief and mourning process as a series of stages, tasks, or phases, through which the bereaved individual must navigate to meet the primary goal of "returning-to-baseline," to viewing the process similarly to a growth theory model. From the psychoanalytic perspective of Freud to Bowlby and Parkes' (1970) stage model theory, Kubler-Ross' (1969) stage model theory, Marrone's (1999) phase model theory, Worden's (1982, 2002) task model theory, and Walsh and McGoldrick's (2004) task model theory, which has influenced the current direction of the field, bereavement theory has reflected the view of mainstream Western (i.e., European American) society (Rothaupt & Becker, 2007; Stroebe et al., 2004).

Despite these historical trends, a number of studies and publications examining grief and bereavement have discussed the importance of acknowledging cross-cultural differences among individuals, as cultural and sub-cultural differences are likely to influence how frequently these reactions are experienced by bereaved individuals (Baydala, Hampton, Kinunwa, L., Kinunwa, G., & Kinunwa, L. H., 2006; Braun & Nichols, 1997; Catlin, 1992; Eyetsemitan, 2002; Gire, 2002;

Hsu, Khan, Lee & Lee, 2004; Kaufert, Putsch, & Lavallee, 1999; McGoldrick, 1991; Putsch, 1988; Rosenblatt, 1993; Shapiro, 1996; Stone, 1998; Stroebe et al., 2004).

Acknowledgement of cross-cultural differences is particularly important considering that evidence from bereavement intervention research suggests that psychotherapeutic interventions aimed at reducing grief symptomology are not efficacious and may even be harmful when targeted at bereaved persons not at special risk or who have not self-selected into therapy (Hansson, Hayslip, & Stroebe, 2007; Lilienfeld, 2007).

Grief and bereavement research responsible for expanding knowledge regarding the application of appropriate research methods, the advancement of theoretical foundation or framework, and the development of effective services and treatments for American Indian (AI) people experiencing grief and bereavement appears to have grown and evolved at a different pace via different pathways.

American Indian Bereavement

It is estimated that there are approximately 4.4 million AIs (1.5% of the US population) residing in the US (US Census Bureau, 2005), and AIs accounted for 12,415 or 0.5% of the total deaths in the United States (Pleis J. R., & Lethbridge-Çejku M., 2006). The death rate among AIs in the Billings Area[1] for all causes of death is 83% above the US death rate of all races, and 34% above all Indian Health Service (IHS) areas. The average life expectancy of AIs in the Billings Area is 67.2 years, which is 3.9 years shorter than the average life expectancy of all US AIs. The life expectancy of AIs in the Billings Area is also 8.6 years shorter than the total US average of all races (Andersen, Belcourt, & Langwell, 2005).

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[1] The Indian Health Service (IHS) Billings Area Office includes Montana and Wyoming.

AI peoples' experience with death also differs significantly from the experience of individuals of other races. It is estimated that AIs experience 1-2 losses per year compared to 1-2 losses every 9-13 years among non-AIs (T. D. O'Nell, personal communication, 1994). The death rate among AIs in the Billings Area was 83% above US national (all races) rates and 34% above all IHS area rates. Disparities among AI people and non-AI people existed among two causes of death: Suicide and Injury and Poisoning. The rate of suicide among Billings Area AIs was 117% percent above the US rate for all races, and 26% above the suicide rate for AIs in all IHS service areas in the US. The rate of death among Billings Area AIs caused by injury and poisoning was 316% above the US rate for all races (Andersen et al., 2005).

These statistics suggest that AI people's experience of death deserves special attention from the research and healthcare community. With the magnitude of the aforementioned statistical analysis on losses and mortality rates, special consideration should also be given to areas such as grief and bereavement.

The focus of AI grief and bereavement research has evolved over several decades with concurrent expansion of knowledge and development of theory. In general, early studies of grief and bereavement within AI communities were conducted for the purposes of identifying and highlighting trends relating to cause of death and health disparities (Bechtold, 1988; Larose, 1989; Li, Smith & Baker, 1994; Mahoney, 1991; May & Dizmang, 1974; Westermeyer, 1976). The knowledge gained from the aforementioned research appeared to shift the focus of additional research to specific problems or disorders (i.e., Chemical Dependency, Post-Traumatic Stress Disorder (PTSD), etc.) and their relationship to specific common causes of AI deaths (e.g., suicide).

Additionally, researchers began to question the "fit" between AI and non-AI theoretical concepts surrounding grief and bereavement. Theorists utilized non-AI theory and research, coupled with the unique history of loss experienced by AI people, to develop a framework for conceptualizing grief and bereavement within an AI context (Brave Heart-Jordan, 1996; Brave Heart & DeBruyn, 1998; Duran & Duran, 1995). Researchers also began to explore bereavement practices, rituals, and meaning surrounding death and grief (Brokenleg & Middleton, 1993; Garroutte, Goldberg, Beals, Harrell, Manson, & the AI-SUPERPFP Team, 2003; Grossman, Putsch, & Inui, 1993; Nagel, 1988; Putsch, 1988; Stone, 1998). The exploration of cultural beliefs and practices, and the development and advancement of theory regarding the unique nature of the AI grief/bereavement experience marked a shift in focus toward identification and acknowledgement of the many strengths possessed by AI people.

The knowledge gained from the focus of these early directions of research was instrumental in establishing guidelines for best practices and cultural sensitivity/competency for working researchers and healthcare professionals with AI experiencing grief and bereavement (Clements et al., 2003; Lawson, 1990). Currently, the focus of AI grief and bereavement research appears to be placed upon the advancement of theory and treatment or intervention based upon AI people's strengths and knowledge (Walker, 2009; Walker & Thompson, 2009). Two examples of studies that have used AI peoples' knowledge and experience to guide treatment (Stone, 1998) and future research (Shunkamolah, 2009) follow.

In his qualitative study, Stone (1998) explored the beliefs surrounding the loss of life (death, dying, grief, and bereavement) of the Lakota. He then compared these findings to mental health and substance counselor beliefs about intervention surrounding bereavement. In general, a rather significant difference was found to exist between mental health/substance abuse workers

and Lakota tribal members' beliefs regarding the importance of traditional beliefs/practices involved in the bereavement process. Lakota tribal members were more likely to place a high value on the aspects of ceremonies that integrated "the bereaved, the family, the community, and the tribe into a group working to resolve grief" (p.121). Stone (1998) reported two main clinical findings; "a careful clinical assessment of the bereaved Lakota client's level of enculturation (i.e., participation in cultural or traditional practices, etc.) is required as a prerequisite to treatment planning," and "intervention with grieving Lakota clients should include informed attention to both 'western' bereavement treatment methods and traditional Lakota family, community, and social bereavement practices" (p. iv). Stone's study (1998) also found several key clinical, tribal, and theoretical results. For example, Stone found that elder Lakota tribal members preferred bereavement interventions that "included family, social, community, tribal, and ceremonial activities" (p. iv).

Shunkamolah (2009) identified three categories of commonly used bereavement coping behaviors (i.e., people-oriented, environment-oriented, and a combination of people & environment-oriented) following analysis of the interviews of 12 AI adults from various Northern Plains and Plateau tribal groups. These categories of coping behaviors represented major components of one central or core category (i.e., culture), which provided the framework for all of the coping behaviors used by the participants. Additionally, participants described their view of "normal" grief and the bereavement process as ever evolving.

Participants described the death of a loved one as irrevocably life changing and discussed using a number of coping behaviors which allowed them to maintain or improve their relationship with the deceased, which supports the findings of Moules, Simonson, Prins, Angus & Bell (2004),

but they noted that their individual experience and choice of coping behaviors were often in conflict with or contrary to their familial and cultural beliefs.

Finally, participants' experiences (Shunkamolah, 2009) suggested that sudden (versus anticipated) deaths and deaths of family members by potentially traumatic means (i.e., accidents, suicide, homicide, health problems, and substance abuse) were key factors affecting the bereavement process and outcome of AI people, but that deaths of older family members often resulted in the loss of culturally unique coping resources (e.g., tribal spiritual guides).

The findings of the aforementioned studies (Shunkamolah, 2009; Stone, 1998) illustrate the vast amount of knowledge regarding coping with grief and bereavement possessed by AI people, and imply that additional research that collaboratively involves or is conducted by AI tribal members/tribal government/tribal healthcare workers, may provide a foundation of knowledge and respect that is encouraging to AI people interested in healing their respective communities.

Tribal Bereavement

A Northern Plains tribe is the focus of the current study. Although a complete picture of this tribe's culture is beyond the scope of this research project, the following description is meant to provide a brief introduction and framework for understanding death within this population. It should also be noted that numerous variations exist among families and communities of this tribe and the following is based upon one generalized description.

In general, the traditions of the tribe preserve and communicate important historical information, as well as values and beliefs about all aspects of the world. Adherence to tradition is a central tenet of life because the information contained within these traditions provides valuable support and protective benefit to tribal people throughout the entire life cycle. These beliefs and traditions are essential to the development of all people's identities as individuals and community

members of this particular tribe. The development and advancement of an individual's social or communal identity is, in many ways, more important or valued than their individual advancement.

Traditions that reinforce the importance of active engagement in various types of social interactions with others are numerous as evidenced by ceremonies for occasions such as pregnancy, birth, adolescence, and death. Social support is one form of social interaction that is specifically important surrounding the loss of life, and appears to be a core component of the bereavement coping process for the people of this tribe.

Coping behaviors are often experienced through rituals that begin upon learning of the death of an individual. For example, a period of four days is observed after a death during which various tribally significant rituals/behaviors that provide opportunities for remembrance and celebration of the life of the deceased individual, acknowledgement of and acceptance of changes in relationships, and fortification of emotion are provided communally (Tribal elder and community member, personal communication, 2008)[2]. It is worth noting that bereavement and grief literature indicated that regardless of culture, individuals often coped with a death by engaging in mourning rituals that provided some sense of psychological precautions for participants (Balk, 1997; Imber-Black, 1991). Additionally, Hanson (1978), Linderman (1944), Rees (1972), and Steele (as cited in Stone, 1998) note that experiences such as hallucinations and suicidal behaviors observed in bereaved AI individuals were reduced, and that physical and mental functioning improved upon completion of culturally appropriate ceremonies or rituals.

Family and community members fulfill multiple formal and informal roles, which are often specifically designated to individuals based upon various qualifications (e.g., age, knowledge, etc.). The individuals fulfilling these roles provide support, directly and indirectly, to all bereaved

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[2] Name withheld for confidentiality purposes.

individuals. Support can be provided by ensuring the bereaved are allowed to express expected emotions without interference. Social support might also be provided in the form of physical assistance (e.g., cooking, greeting, running errands, guidance, etc.). Support is also provided in the form of materialistic or monetary assistance for traditional and funerary needs (Tribal elder and community member, personal communication, 2008).

Although the support benefits the bereaved immediate family, support is also meant to benefit everyone (i.e., deceased individual, friends, and community members) who participates in this communal approach. For example, extended family and community members prepare food to serve to visitors who come to pay their respects or visit with the family. The preparation and service of food by extended family and community members provides care and support to the bereaved family, honors the deceased, and communicates or expresses gratitude to visitors (Tribal elder and community member, personal communication, 2008).

Bereaved individuals continue to engage in coping behaviors and rituals throughout and well beyond the immediate grieving period that seemingly encourage both focusing upon actively grieving (e.g., emotional expression) the loss and focusing upon the continuation of everyday life experiences/responsibilities.

In summary, the people of this particular tribe appear to have utilized their most reliable and readily available resources (i.e., traditional thoughts and behaviors, social connections and relationships) to develop and refine effective coping behaviors. One may assume the people of this tribe possess a vast amount of unique expertise necessary for collaborating in the development of a relevant grief intervention for their people.

<center>**Grief**</center>

Prolonged Grief

The Prolonged Grief Disorder diagnostic criterion, proposed for inclusion in the fifth edition of the American Psychological Association Diagnostic and Statistical Manual (DSM-V), is the result of research of previously proposed criteria sets (i.e., traumatic/complicated grief) by Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 1997 and Prigerson, Shear, Jacobs, Reynolds, Maciejewski, Davidson,… & Zisook, 1999). Recent research and literature indicates that Prolonged Grief Disorder criteria represent a distinct and psychometrically valid set of symptoms, and that bereaved individuals who meet criteria for Prolonged Grief Disorder may be at higher risk for enduring distress and dysfunction compared (Prigerson, Horowitz, Jacobs, Parkes, Aslan, Goodkin,… & Maciejewskil, 2009).

Despite the development and more recent use of Prolonged Grief Disorder diagnostic criteria and assessment tools (i.e., the Inventory of Traumatic Grief – Revised), Traumatic Grief diagnostic criteria developed in association with the Inventory of Traumatic Grief were used in the larger study.

Traumatic Grief

The grief experienced after a death varies greatly from person to person and from death to death, and is influenced by a number of factors (e.g., relationship, mode of death, etc.). Studies suggest that experiencing a traumatic loss may result in greater risk of developing both complicated grief and PTSD (Stewart, 1999).

The term Traumatic Grief variously referred to as Complicated Grief (CG) and Complicated Grief Disorder (CGD) is a stress-related disorder or stress-response syndrome characterized by maladaptive grief symptoms associated with poor bereavement outcome (Jacobs,

1999; Prigerson et al., 2009). These maladaptive grief symptoms appear to "form a unified component of emotional distress" that are clearly distinguishable from symptoms (i.e., depression and anxiety) commonly experienced by bereaved individuals (Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 1997; Jacobs, Mazure, & Prigerson, 2000; Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 1999; Prigerson & Jacobs, 2001; Stroebe et al., 2004. Although Traumatic Grief has yet to be recognized as a DSM diagnosis by the American Psychiatric Association, Traumatic Grief symptomatology appears to be distinguishable from DSM-IV diagnoses such as Major Depressive Disorder, Adjustment Disorder, and Posttraumatic Stress Disorder.

Prigerson and Jacobs (2004) evaluated the results of several studies using the taxonomic principles outlined by Robins and Guze (1970), and found unity among proposed traumatic grief symptoms. They noted that Traumatic Grief symptoms fell into one of two categories [i.e., symptoms of separation distress (Sd) and symptoms of traumatic distress (Td)]. Examples of symptoms reflective of separation distress include preoccupation, longing/yearning, and loneliness, and symptoms reflective of traumatic distress include difficulty with acceptance/disbelief, and anger.

Johnson et al. (2009) found that more than 90% of the Yale Bereavement Study participants with Complicated Grief would be relieved to know that Complicated Grief is a recognizable psychiatric condition. Additionally, all participants reported that they would be interested in receiving treatment for their Complicated Grief symptoms. It is postulated that AI participants of the current study will experience similar feelings.

Trauma

Historical Trauma and Historical Unresolved Grief

A national study conducted by the Centers for Disease Control and Prevention (CDC) examined the self-reported mental distress among a large representative sample of adults and found that AIs experienced a higher and more frequent level of distress than the general population (CDC, 1998). AI people also experienced high rates of social problems (e.g., addiction, suicide, domestic violence) thought to be exacerbated by racism and various forms of oppression. The high levels of distress and high rates of social problems experienced by AI people are thought to be closely related to AI people's experiences with traumatic events (i.e., assimilation strategies and genocide).

Several authors have theoretically linked the aforementioned problems experienced by AI people to chronic trauma and unresolved grief that has been passed from generation to generation (Abadian, 2000; Brave Heart-Jordan, 1996; Brave Heart & DeBruyn, 1998; Duran & Duran, 1995; Evans-Campbell, 2008; Tafoya & Del Vecchio, 2005; Whitbeck, Adams, Hoyt & Chen, 2004; Yellow Horse & Brave Heart, 2004). This trauma has been labeled Historical Trauma and is defined as "cumulative emotional and psychological wounding over the life span and across generations, emanating from massive group trauma" (retrieved from http://www.historicaltrauma.com, 2010). The grief that accompanies Historical Trauma has been labeled Historical Unresolved Grief (retrieved from http://www.historicaltrauma.com, 2010).

Maria Yellow Horse Brave Heart, PhD, who has been a major contributor to Historical Trauma exploration and conceptualization, is the president/director/co-founder of TAKINI Network. Formed in 1992, TAKINI Network is a non-profit organization dedicated to educating and assisting in the healing of AI people and AI communities.

The TAKINI Network historical trauma intervention model offers three major hypotheses for their community intervention model: Education increases awareness of trauma; Sharing effects of trauma provides relief; and Grief resolution through collective mourning and healing creates positive group identity and commitment to community. The TAKINI model (retrieved from http://www.historicaltrauma.com, 2010) proposes the following six phases of Historical Unresolved Grief:

1. First Contact: Life shock, genocide, no time for grief. Colonization Period: Introduction of disease and alcohol, traumatic events such as Wounded Knee Massacre.

2. Economic Competition: Sustenance loss (physical/spiritual).

3. Invasion/War Period: Extermination, refugee symptoms.

4. Subjugation/Reservation Period: Confined/translocated, forced dependency on oppressor, lack of security.

5. Boarding School Period: Destroyed family system, beatings, rape, prohibition of Native language and religion; Lasting Effect: Ill-prepared for parenting, identity confusion.

6. Forced Relocation and Termination Period: Transfer to urban areas, prohibition of religious freedom, racism and being viewed as second class; loss of governmental system and community.

Finally, the TAKINI model includes four major community intervention components: Confronting Historical Trauma; understanding the trauma, releasing the pain of Historical Trauma; and transcending the trauma (retrieved from http://www.historicaltrauma.com, 2010).

In addition to the traumatic losses faced in present day life, AI people continue to be impacted by the effects of trauma experienced by previous generations. Theories regarding the transmission of AI Historical Trauma have largely been built on research that emerged from the

traumatic experiences of Jewish Holocaust survivors. The various symptoms (e.g., denial, anxiety, and guilt) experienced by Holocaust survivors were postulated to affect their parenting effectiveness, which studies found (Prince, 1985; Kestenberg, 1972; 1980; Yehuda, R., Kahana, B., Schmeidler, J., Southwick, S. M., Wilson, S., Giller, E. L. (1995a, b) resulted in symptomatology (e.g., depression) in first generation survivors.

Similar to the experiences of Jewish Holocaust survivors, AI people's thoughts and feelings related to historical loss interfere with functioning which negatively affects parenting and contributes to maladaptive behavior (Whitbeck et al., 2004). Whitbeck and colleagues (2004) also found that Historical Trauma is remarkably prevalent among the contemporary AI parent generation suggesting that Historical Trauma has been transmitted from the previous (i.e., elder) generation. Their findings also suggest that AI people's perceptions of historical loss lead to emotional responses related to: a) anger and avoidance, and b) anxiety and depression. Finally, Whitbeck et al. (2004) believe that AIs perceptions of historical loss, and the experience of actual losses, will progressively impact AI people's psychological and physical health. These factors are particularly important considering that historical antecedents have been found to be one of six factors that determined how an individual would respond to a death (Parkes, as cited in Worden, 1982).

Although Historical Trauma has provided a theoretical framework for explaining and understanding how the effects of trauma may contribute to social difficulties of AI people, only a small number of attempts have been made to develop and/or evaluate grief and bereavement coping/recovery treatments or interventions specifically for AI populations (i.e., Brave Heart-Jordan, 1996; Gone, 2009). The current study will assess the outcome of a grief intervention aimed at reducing Historical Unresolved Grief symptoms associated with Historical Trauma which

members of this particular tribal community, along with a high incidence and frequency of deaths,

identified as one major contributor to the health disparities, experienced within their community.

The current study, however, will focus primarily on social supports and coping of the participants.

Social Support

Social support is believed to be an important aspect of positive or adaptive grief and

bereavement adjustment, because it is thought to facilitate coping and "accelerate" recovery from

deficits and the deleterious effects of a loss (Cohen & Willis, 1985). Cohen and Willis suggest

social support assists the "focal person" (i.e., individual utilizing support) in appraisal of and

reaction to the stressful event (i.e., death). Additionally, lack of social support has been found to

be a risk factor for the development of a number of psychological (e.g., Complicated

Grief/Traumatic Grief) and physiological (e.g., lowered immune function) complications (Burke,

Neimeyer, & McDevitt-Murphy, 2010; Onrust, Cuijpers, Smit, & Bohlmeijer, 2007; Piper,

Ogrodniczuk, Joyce, & Weideman, 2009).

Despite findings in a recent study (Stroebe, W., Zech, Stroebe, M., & Abakoumkin, 2005),

social support may serve as a protective or buffering factor for individuals experiencing deficits in

support (e.g., loss of emotional support) resulting from the death of a loved one (Martinson &

Campos, 1991; Morgan, 1994; Yazgan, 2006). Some researchers have reported findings that

bereaved individuals with large social networks experience greater life satisfaction following the

death of a spouse than bereaved individuals lacking a social network (Martinson & Campos,

1991).

Stroebe & Schut (2001; as cited in Genevro, 2004) stated interpersonal factors such as the

availability of social and emotional support from family and friends was one of three factors found

to positively influence individuals' bereavement outcomes (p. 34). Parkes (as cited in Worden,

1982) found that social variables (social support, cultural context, etc.) were one of six factors that determined how an individual would respond to a death. The belief that social support influences grief and bereavement outcome in a helpful and positive way is supported by evidence from numerous studies (Andrews, 2004; Fitzgerald, 2005; Medina, del Alamo Jimenez, Criado, & Laborda, 2003; Ogrodniczuk, Piper, Joyce, McCallum, & Rosie, 2002).

Finally, the results of a qualitative study (Shunkamolah, 2009) of coping with bereavement found that social support was one of two component categories comprising the core category of culture identified by AIs. Bereaved AI people reported that coping behavior was closely tied to their perception of the availability and the adequacy of social support/resources. Although research indicates (Haber, Cohen, Lucas, & Baltes, 2007) received or objective support (i.e., assessment of the specific supportive behaviors provided by support network) provides a greater approximation of coping assistance from social support, participants from the aforementioned qualitative study appeared to base decisions regarding coping behaviors upon their perceptions of availability and adequacy of support.

Perceived Support

Haber et al. (2007) note that social support has been described as a ''meta-construct'' consisting of several sub-constructs (Heller & Swindle, 1983; Vaux, Riedel, & Stewart, 1987). Cohen, Underwood, and Gottlieb (2000) suggest that perceived support is a sub-construct of social support and is particularly important to health and adjustment (Cohen & Hoberman, 1983; Holahan & Moos, 1981; Procidano & Heller, 1983; Sarason, Sarason, & Pierce, 1990; Turner, Frankel, & Lavin, 1983).

Perceived support (i.e., the appraisal of available interpersonal resource could be accessed should the need for such support arise) is thought to influence an individual's appraisal of the

stressfulness associated with a particular event or situation, and lead to the prevention of responses that could negatively affect health (Blazer, 1981; Cohen & McKay, 1984; Cohen, et al., 2000; LaRocco, House & French, 1980; Lazarus, 1977). Cohen, Underwood, & Gottlieb (2000) state that the findings of a number of studies provide support for the "buffering" effect that perception of available social resource has against stress.

The current study will assess perceived social support (i.e., perception of available support and satisfaction with or adequacy of support provided) within this particular tribal community to identify possible connections to improvement in grief symptomology and health disparities.

<p align="center">**Coping**</p>

The relationship between specific coping responses and traumatic loss or between coping and Traumatic Grief and PTSD is not clearly understood, but coping could mediate the relationship between traumatic loss and Traumatic Grief (Schneider, Elhai, & Gray, 2007). Some studies found people who experience traumatic loss are at great risk for meeting both traumatic grief and PTSD criteria (Stewart, 1999). The larger study has postulated that the symptoms of grief experienced by bereaved tribal community members will be reduced through the use of culturally appropriate coping behaviors and increase the likelihood of a positive outcome which, according to Stroebe et al. (2004), is indicative of effective coping. This study will assess participants' coping responses prior to, and after experiencing, a grief intervention.

Bereavement/grief literature and research indicate that, regardless of culture, individuals cope with death by engaging in mourning rituals that provided psychological precautions for participants (Balk, 1997; Imber-Black, 1991). LaFromboise and Bigfoot (1998), Putsch (1998), Krache (1980), and Mazur-Bullis (1984) have identified and documented tribal/indigenous beliefs (e.g., spirits or "ghosts," moving of spirit to another location) and practices (e.g., songs,

dressing/burial of the loved one, prayers). These beliefs and practices can also be described more

simply as cognitive and behavioral coping strategies, which are the two types of coping strategies

participants in Muller and Thompson's 2003 phenomenological study described. Additionally,

these ways of coping are a source of resilience for AI people which, according to Bonanno (2004),

are important in maintaining "relatively stable, healthy levels of psychological and physical

functioning" for people "exposed to an isolated and potentially highly disruptive event, such as the

death of a close relation" (p.20).

The utilization of cultural practices or rituals (e.g., making a trip, feeding/eating, singing,

burning or giving away clothing/possessions) as coping behaviors may facilitate positive

adjustment to bereavement because they help reduce symptoms and stress commonly experienced

during bereavement. In addition to being coping behaviors within themselves, cultural practices

and rituals also provide AI people with coping "guidelines" or coping guidance for navigating

grief and bereavement. For example, the beliefs regarding the amount of time that should be

observed prior to a burial following a death provide bereaved individuals of the tribe in the current

study time to prepare emotionally and obtain or gather resources.

The coping "guidelines" contained within bereavement coping behaviors (i.e., cultural

practices and rituals) incorporate the various types or dimensions of coping strategies (i.e.,

problem vs. emotion-focused and confrontation vs. avoidance) that have been postulated to be

instrumental in dealing with stressful situations (Carver & Scheier, 1994; de Ridder, 1997).

Problem-focused coping & Emotion-focused coping

Problem-focused coping is characterized by an attempt to solve, manage, or change a

problem that is a source of stress or distress. Often viewed as an adaptive mode of coping,

problem-focused coping involves active planning or engagement in specific behaviors to overcome distress caused by a problem (Folkman & Lazarus, 1985).

Emotion-focused coping is directed at management or regulation (i.e., control and expression) of emotion resulting from distress caused by a problem (Billings & Moos, 1981; Holahan & Moos, 1987; Lazarus & Folkman, 1985). Whereas, problem-focused coping is thought to be more appropriately utilized in situations that can be altered, emotion-focused coping may be more appropriate in situations that cannot be changed.

Problem-focused coping and emotion-focused coping may both be required for successful outcome, and numerous examples of situations in which both types of coping are appropriate and beneficial exist (Stroebe & Schut, 2001). For example, the active use of a problem-focused coping behavior (i.e., venting of emotional distress) and active use of an emotion-focused coping (i.e., reframing of stressor impact) are both likely to be labeled adaptive coping (Folkman & Lazarus, 1985).

Conversely, problem-focused and/or emotion-focused coping may be considered maladaptive and lead to mental health problems if they are used out of sync or their use extends past a certain threshold or time frame (Holahan & Moos, 1987). Problem- and emotion-focused coping may also be labeled adaptive or maladaptive based upon whether they are used to confront or avoid coping with grief.

Confrontative coping & Avoidant coping

Historically, theories and models of bereavement have acknowledged the importance of "working through" grief. Grief work refers to a cognitive process through which bereaved individuals face the reality of loss, focus upon memories and details surrounding the death, and attempt to detach from the relationship with the deceased. While a few studies (i.e., Lepore,

Silver, Wortman & Wayment, 1996; Nolen-Hoeksema & Larson, 1999; Pennebaker, 1997;

Pennebaker, Mayne & Francis, 1997; Rubin, 1996; Stroebe & Stroebe, 1991) support the value of

"working through grief, other research suggests that coping behaviors that help bereaved

individuals "work through" grief cannot always be assumed to result in adaptive coping (Stroebe,

et al., 2004; Wortman & Silver, 2001).

Coping strategies that are focused upon "facing" grief (i.e., confrontative coping) are

generally considered adaptive, while avoidant coping strategies on generally considered

maladaptive. However, circumstances under which the contrary may be true make such

generalization impossible. Although the relationship between bereavement outcome and the use of

coping that focuses upon confronting versus avoiding is unclear (Archer, 1999), it is easy to

provide examples of when each might be adaptive or maladaptive when problem- and emotion-

coping are also considered.

Studies have found avoidant emotion-focused coping is generally related to worse overall

mental health outcome (Coyne & Racioppo, 2000). For example, the use of avoidant emotional

coping to avoid the source of distress (e.g., denial) and a lack of problem-focused behavior (e.g.,

verbal acknowledgement) are likely to be seen as maladaptive. Although avoidant coping may

help individuals manage their day-to-day activities soon after a crisis, reliance on this coping style

over time can lead to mental health problems (Holahan & Moos, 1987).

The current study will examine the effects of a grief intervention developed by members of

a Northern Plains tribe upon coping and social support. It is postulated this intervention will also

have an effect upon perceived social support and dimensions of coping behaviors and strategies

utilized by the people of this tribe, as studies (Shunkamolah, 2009; Wallace & Swaney, 2006) have

shown that AIs utilize relationships and interactions to cope with adverse situations.

Grief Recovery: The Grief Recovery Method and the Grief Recovery Handbook

The intervention that will be examined in this study was partly developed utilizing some of the principles of The Grief Recovery Method which are presented in *The Grief Recovery Handbook: The action program for moving beyond death, divorce, and other losses* (James & Friedman, 1998). The Grief Recovery Institute was founded by John W. James with the primary objective of delivering assistance with grief recovery to many individuals in the shortest time possible. The institute offers an outreach program, a community education program, and a grief recovery certification program in the United States and Canada. Recognized as an authority on grief recovery, the institute has provided program services for organizations such as the National SIDS Foundation and the National AIDS Network. *The Grief Recovery Handbook: The action program for moving beyond death, divorce, and other losses* provides additional support to individuals who have participated in any of the programs mentioned above and anyone else seeking to recover from grief. First published in 1988 and written by John W. James and Russell Friedman, Executive Director of The Grief Recovery Institute, the current edition of the handbook (20th Anniversary Edition) has been expanded to address losses related to health, career, and faith.

Individuals "learn to see the problem" and are provided with an alternative perspective regarding grief and loss. Individuals are asked to challenge their perspective which may include misconceptions and myths regarding grief (e.g., confusion regarding stages of grief); examine factors that compound grief reactions and/or limit grief recovery (e.g., societal messages underlying consolation phrases; disenfranchised grief); explore deficits in preparation for loss and the unpreparedness of others in providing assistance for dealing with loss (e.g., intellectualization, avoidance of the subject, inability to listen); and recognition of the minimal relief provided by short term solutions (e.g., alcohol use). Utilization of the aforementioned approach to address

grief and loss associated with Historical Trauma experienced by AIs would appear to be in accordance with findings and recommendations of several authors and theorists (Brave Heart, & DeBruyn, 1998; Brave Heart-Jordan (1996); Whitbeck, et al., 2004; and Yehuda, et al., 1995a).

After gaining alternative information or perspective regarding grief, individuals can then make behavioral choices which will allow them to recover from the emotional pain caused by any significant emotional loss. Individuals engage in the following actions: Gaining awareness of the existence of an incomplete emotional relationship; accepting responsibility as part of the cause for incompleteness; identifying undelivered communications (i.e., amends, forgiveness, or emotional statements); taking action to make communications; and saying goodbye to undelivered communications and pain which allow them to regain a sense of well-being and return to a full range of emotion rather than isolation and avoidance.

<div align="center">

Culture Specific Historical Trauma/Grief Intervention

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In the current study, a culturally anchored grief intervention was developed by two tribal professionals and the community facilitator in consultation with Ray Daw (Navajo Nation Department of Behavioral Health) and Maria Yellow Horse Brave Heart (University of New Mexico). In addition, knowledge wisdom, and healing practices were offered by Tribal Spiritual Leaders and Tribal Elders. Developers of the intervention then incorporated major tenets (i.e., group format, emotion oriented approach) of the Grief Recovery Method, and other therapeutic techniques, into tribal beliefs and perspectives, to create a basic grief retreat format with a unique blend of retreat/intervention components.

Core elements of Grief Retreats

Format. The grief intervention is delivered using a three daylong (8 to 12 hours per day) retreat format. The two grief retreats in the current study, which were actually the 5th and

6th retreats conducted in the community, differed slightly as a result of the evolution of the intervention and the preferences of the primary retreat facilitators (Appendix A).

Participation requirements. While participants were informed about the importance of completing the retreat, from beginning to end, they were allowed to make the decision to "choose recovery." The utilization of the group format (large and small) was a cultural adaptation which was a particularly important component because of a tribal belief is that the participants' progression to and through the actions for completing the pain caused by grief (i.e., gaining awareness of the existence of an incomplete loss, acceptance of responsibility for a participant's role in maintenance of incompleteness, identification and delivery of undelivered recovery communications, and moving beyond loss) cannot be achieved without assistance from the community.

Education. In addition to education regarding various misconceptions (e.g., potentially harmful societal messages regarding the grief process) and behaviors that potentially limit grief recovery (e.g., substance use, numbing of feelings), the presentation of AI historical loss (general theory and historical loss unique to the tribe) as a factor that may compound the disenfranchised grief experienced by retreat participants was particularly important because it addressed specific deficits in the participants' knowledge (gaining awareness).

The availability of historical resources (elders, documentation, and tribal community members' knowledge) and their construction of Ancestral Tree and Life Circle graphs further increased participants' knowledge and awareness of loss experienced by previous generations and their connection to the tribal group.

Tradition. Education about and use of tribal traditional factors (e.g., geographical landmarks, stories, and the use of various traditional practices and activities) that facilitate grief

recovery were presented and engaged in by participants throughout the entire retreat. Given the sacred nature of some of these activities and rituals, they will be discussed in general manner throughout the rest of this document.

Experiential. The Loss History and Relationship graphs, the Ancestral Tree and Life Circle graph were used in the grief intervention of the current study as both educational and experiential components. The construction of the Grief Recovery Method completion letter, which can also be considered to be an experiential exercise, was utilized in earlier versions of the grief intervention under study but was replaced with an adaptation of the empty chair exercise for the current retreats. The healing chair exercise was utilized in a small group format as the manner in which participants communicated their undelivered emotion surrounding a loss. Following communication of their own undelivered emotion, they also delivered emotion they hoped they would have received from the deceased or estranged individual of their choosing.

Completion. In terms of the Grief Recovery Method, completion refers to the communication of what was unfinished in all aspects of a relationship and is generally believed to have been achieved following the composition and reading of a completion letter. It is believed that individuals are prepared to move beyond their loss, following completion (reading completion letter), but little recognition is given to the accomplishment of the individual. Tribal traditions which recognize and honor individuals for accomplishments and which also provide encouragement for future success were incorporated into the conclusion of the intervention developed for the grief retreat under study. Again, these traditions will only be discussed in general terms given their sacred nature.

Hypotheses

In general, it is expected post-intervention analysis will show differences between participants' pre-intervention (T1) and post-intervention (T2, T3, and T4) score means indicating increases or decreases in specific coping behaviors and perception of available social support following the intervention. Data collected at 1-month (T3) and 3-months (T4) post-intervention are expected to show that participants are continuing to use fewer problem-focused coping behaviors and that perceived social support (i.e., total support and subscale) score means are higher than pre-intervention (T1) score means.

Coping

It is hypothesized that participants will endorse items that reflect changes in coping behavior following intervention. In general, it is hypothesized that the intervention will lead participants to view grief recovery as a primarily emotion-oriented process, which requires more emotion-focused coping behaviors and fewer problem-focused coping behaviors. Specifically, it is hypothesized that post-intervention score means of the BC self-distraction, substance use, and self-blame subscales will decrease, and that the positive reframing, acceptance, humor, and use of emotional support subscale score means will increase to levels differing from pre-intervention.

Changes in the utilization of the aforementioned behaviors, as a result of their participation in the grief retreat, may reflect a transition in participants use of a maladaptive (avoidant emotional) grief coping style to a more adaptive (active emotional or confrontative) grief coping style.

Perceived Social Support

It is hypothesized that participants will endorse more items on the several aspects of perceived social support that reflect changes in their perception of available social support.

Specifically, it is hypothesized that post-intervention score means of the ISEL overall support and ISEL appraisal, tangible support, self-esteem support, and subscales will increase to levels differing from pre-intervention.

Increases in participants' perception of the availability of various types of social support may assist in their coping with or recognition of resources for coping with grief. It is believed that qualitative information will help inform the manner in which the intervention led to changes in participants' bereavement process.

CHAPTER II. Methods

Design

The current study employed a quasi-experimental research design with pre-, post-, 1-month and 3-month follow-up repeated measures. The primary investigator also utilized several techniques (i.e., memo writing/journaling and open-ended questions) that provided qualitative data to inform intervention development and efficacy.

Participants

Participants in this study were 40 self-selected male and female adult AI tribal community members who were volunteered to participate in Grief Retreats undertaken to explore the grief currently experienced by tribal adults, explore the relationship between grief and historical trauma currently experienced by tribal adults, and to pilot and evaluate a culturally anchored grief recovery intervention. Participants were recruited through collaboration between a tribal community organizer, tribal community members and elders, the tribal community college, Montana State University College of Nursing, and The University of Montana. The study was funded by a grant from the Montana IDeA Networks of Biomedical Research Excellence (INBRE), Montana State University. Research indicates that collaboration between academic or professional entities and indigenous groups or professionals is important for developing and evaluating culturally sensitive/relevant interventions (Gone, 2009; Weinstein, 2007).

Sixteen subjects ($n = 16$) participated in Grief Retreat #1 that took place between May 13, 2011 and May 15, 2011, and 24 subjects ($n = 24$) participated in Grief Retreat #2, which took place between June 14, 2011 and June 16, 2011. Although it is undesirable to utilize a small N when conducting a treatment outcome study, few research opportunities exist for examining culturally based interventions developed by AI people for AI people; as such, this is a pilot project.

The researcher used ethical and traditional caution to explain the purpose and possible benefit of the study results (Catlin, 1992; DiCicco-Bloom & Crabtree, 2006; Grossman, Putsch, & Inui, 1993; McGoldrick, Almeida, Hines, Rosen, Garcia-Preto & Lee, 1991; Nagel, 1988 Parkes, 1995; Putsch, 1988). The Consent Form provided participants with contact information regarding obtaining counseling services upon debriefing. The principle investigator also took additional precautions to prevent or minimize possible stress and harm to respondents by adhering to guidelines for conducting bereavement research, namely: Ensuring that the design of the research is consistent with the care needs of service users; and safe guarding of community members rights (i.e., provision of adequate/clear information about the research, no explicit/implicit pressure to participate, right to withdraw, confidentiality/anonymity, provision of feedback to participants/community members, conveyance of appreciation of their commitment to the research process should be to participants/community members (Parkes, 1995).

Measures

Demographic. Participants' demographic information was gathered using a seven item "Tell Us About You" questionnaire (Appendix B). Participants were asked to provide information about their age, gender, marital status, education level, and spiritual activity in an organized religion and traditional practices. Haynes & Haraldson (2010) indicated that the poverty rate in this tribal community is approximately 25%; hence the questionnaire did not ask participants to disclose information regarding level of income.

Grief history questionnaire. The grief history of participants was assessed using a seven item questionnaire (Appendix C). Participants were asked the number of months since the last death they had experienced and the number of deaths they had experienced in the last 5 years, to

identify the relationship, their age at the time of the death, the cause of death, the age of the deceased, whether or not the death was expected, violence related, or addiction related.

The Grief History questionnaire was mailed to all participants at the 1-month follow-up and they were asked if they had experienced any deaths since the Grief Retreat. The Grief History was mailed again to all participants at the 3-month follow-up and they were asked if they had experienced any deaths in the past two months.

Coping. Participants' coping responses were assessed using the Brief COPE (BC; Carver, 1997). Derived from the COPE scale (Carver, Scheier, and Weintraub, 1989), the BC is a 28-item measure (Appendix D) which assesses 14 facets of coping reactions. Similar to the COPE scale, the BC items assess various dimensions of problem-oriented coping (i.e., active coping, planning, and using instrumental support), emotion-oriented coping (i.e., positive reframing, acceptance, religion, using emotional support, and denial), and other types of coping (i.e., humor, self-distraction, venting, substance use, behavioral disengagement, and self-blame) thought to be associated with stress response.

COPE scale items that possessed ease of readability and items that generated high factor analytic results within each of their respective coping dimensions were selected for use in the BC. Two COPE scales (i.e., restraint coping and suppression of competing activities) were omitted from the BC because they proved to be of low value in previous research or were contained items that were redundant with items of other dimensions. Additionally, several dimensions were modified to "sharpen their focus" (i.e., positive reframing, venting, and self-distraction) and one new dimension (i.e., self-blame) was added.

The BC, therefore, includes the following subscales with scores ranging from 2-8: Active coping; planning; positive reframing; acceptance; humor; religion; using emotional support; using

instrumental support; self-distraction; denial; venting; substance use; behavioral disengagement; and self-blame.

Exploratory factor analysis of the BC dimensions and items yielded a factor structure which was consistent with that reported for the COPE scale: Active coping ($\alpha = .68$); planning ($\alpha = .73$); positive reframing ($\alpha = .64$); acceptance ($\alpha = .57$); humor ($\alpha = .73$); religion ($\alpha = .82$); using emotional support ($\alpha = .71$); using instrumental support ($\alpha = .64$); self-distraction ($\alpha = .71$); denial ($\alpha = .54$); venting ($\alpha = .50$); substance use ($\alpha = .90$); behavioral disengagement ($\alpha = .65$); and self-blame ($\alpha = .69$) (Carver, 1997). Further examinations of the BC have produced satisfactory reliability and validity results (Perczek, Carver, Price, & Pozo-Kaderman, 2000).

Culturally vetting the BC. The BC was critically examined for relevance (i.e., is this question relevant to the beliefs of this tribal group?) and for potentially offensive content (i.e., is this question offensive?) in a focus group. The focus group consisted of three tribal scholars, (three individuals with Master's degrees, of which two were fluent speakers of the tribe's language. All items were worded in present tense and modifications such as the omission of excessive and irrelevant wording, changes in wording, addition of words, and restructuring of questions for greater clarity were made to six of the BC questions. Consulting with members of the target population, using a focus group format, is believed to enhance instrument content validity and the overall validity of a study's findings (Vogt, King, & King (2004).

The three focus group members, similarly, posed a number of questions regarding item wording and specificity. For example, they questioned whether changing the rating system to include more specific details about the time frame in which participants were using various coping behaviors (e.g., daily, weekly, monthly) would be more helpful. Also, they questioned whether

adding keywords (i.e., death) to the items, versus using more vague words (i.e., it, things, and situation), would keep participants more focused.

In general, the focus group members were in agreement that BC item relevance was high and suitable for the purposes of evaluating coping behaviors utilized by members of the tribal community. Overall, they agreed that the items of the BC would not be deemed offensive by members of the tribal community with the exception of item 28 ("I've been making fun of the situation"). The focus group members suggested modifying item 28 from "I've been making fun of the situation" to "I've been remembering humorous stories and memories."

Following consultation with and the primary investigator's dissertation committee chair and further examining BC scale scoring, the decision was made to not alter the wording of item 28 because it could significantly affect the humor subscale score which is simply the sum of two items. Additionally, the wording change suggested by the focus group would likely alter the content validity of the item (e.g., from measuring humor to measuring distraction).

Social support. Social support was assessed using the Interpersonal Support Evaluation List (ISEL; Cohen, Mermelstein, Kamarck, and Hoberman, 1985). The ISEL is a 40-item instrument (Appendix E) which assesses several facets of perceived social support (i.e., belonging, appraisal help, tangible support, and self-esteem support). The ISEL utilizes a four point Likert type scale response format ranging from zero (definitely false) to three (definitely true), with a low sum of scores indicating low level of perceived social support and a high sum indicating a high level of perceived social support. The ISEL has shown high internal consistency (.88 to .90) and good test-retest reliability (.74) with the general population (Cohen et al., 1985; Brookings & Bolton, 1988; Schonfield, 1991).

Culturally vetting the ISEL. Again, in an effort to improve content validity and the validity of the overall study findings, the ISEL was culturally vetted by the same focus group participants who examined the BC.

Similar to feedback regarding the BC, the focus group agreed that ISEL items were not likely to be offensive to participants. The focus group members' feedback indicated that overall relevance of ISEL items was high. However, focus group members noted that participant response to several ISEL items could be affected by factors such as lower socioeconomic status and availability of resources. The members of the focus group noted that the wording of a number of the ISEL items were not culturally relevant and did not coincide with the reality of life for most tribal community members.

Following consultation with the focus group members and the primary investigator's dissertation committee chair, the decision was made to alter the wording of items 6, 8, 9, 11, 15, 19, 21, 22, 23, 29, and 40) to make them more relevant to the experience of the community members and to increase the ease of reading level. The changes in item wording were as follows:

The word "intimate" was removed from item number 6 ("There is no one that I feel comfortable talking to about intimate personal problems"), because it was believed that "intimate" was a word that the participants would not know or use. The resulting statement was: "There is no one that I feel comfortable talking to about personal problems."

The wording of item number 8 was changed from "Most people I know think highly of me" to "There are people I know who think highly of me." Consistent with other collectivist cultures, the members of the focus group discussed the value of modesty within their culture and felt that the original wording would have likely resulted in skewed responses/scores.

The wording of item number 9 was changed from "If I needed a ride to the airport very early in the morning, I would have a hard time finding someone to take me" to "If I needed a ride to an appointment very early in the morning, I would have a hard time finding someone to take me." The members of the focus group noted that the availability of transportation (e.g., car, gas money, etc.) to the nearest airport, which was several hours drive away from their community, was not an option for most members of the community.

Item number 11 was changed from "There really is no one who can give me an objective view of how I'm handling my problems" to "There is anyone who can help me see how well I'm handling my problems." The focus group members suggested rephrasing the question in this manner indicating that their cultural values/beliefs did not reinforce being judgmental or critical of others, but did reinforce support and encouragement.

Again, considering poverty and unemployment rates relevant to this population (Haynes & Haraldson (2010), and the location of the community (i.e., unlikelihood that tribal members would go on a trip and have access to a beach) the word "trip" was replaced with "drive" and the word "beach" was removed. Hence, item number 15 was changed from "If I wanted to go on a trip for a day (e.g., to the mountains, beach, or country), I would have a hard time finding someone to go with me" to "If I wanted to go for a drive (e.g., to the mountains or country), I would have a hard time finding someone to go with me."

The wording of item number 19 was changed from "There is someone I can turn to for advice about handling problems with my family" to "There is someone I can turn to for helpful words about handling problems with my family." Focus group members suggested rephrasing this item because they indicated that assistance to others was generally provided in a non-aggressive or unobtrusive manner, and that "advice giving" was not valued by their culture.

Item number 21 was changed from "If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me" to "If I decided one afternoon that I would like to go out to dinner that evening, I could easily find someone to go with me." In addition to the fact that the tribal community does not have a movie theater, the impoverishment of community is not consistent with the original phrasing of this question which assumed that the respondent possessed discretionary funds to go to a movie or to dinner.

Item number 22 wording was changed from "When I need suggestions on how to deal with a personal problem, I know someone I can turn to" to "When I need helpful words for how to deal with a personal problem, I know someone I can turn to." Similar to item 19, this item was rephrased in manner that corresponded with cultural values and beliefs.

The words "of $100" were removed from item number 23 ("If I needed an emergency loan of $100, there is someone (friend, relative, or acquaintance) I could get it from"). Again, given that this is an impoverished community, focus group members suggested that changing the dollar amount would allow for responses that would not skew scoring.

The words "for a few weeks" were removed from item number 29 ["If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.)"].

The wording of item number 40 was changed from "I have a hard time keeping pace with my friends" to "I have a hard time keeping up with my friends," because focus group participants didn't believe that "pace" was a word that participants would use or know.

Memos/journal notes and interviews. Descriptive/observational notes and memos and qualitative data regarding the study, retreat process, and participants' views about specific aspects of the intervention that may have contributed to changes in their perceptions and experience

surrounding grief were collected for the purposes of: improving future grief retreats; and informing the results of the statistical analyses (Birks, Chapman & Francis, 2008).

Themes that emerged from the primary investigator's descriptive/observational notes and memos regarding the study and retreat process were categorized into subcategories and general categories (Charmaz, 2003). Participants' thoughts about the intervention were assessed using the following open-ended questions:

1. "What aspects of the grief intervention did you find helpful?"

2. "What do you wish would have been included in the intervention?"

The themes that emerged from these interview questions were organized by core categories and subcategories.

More complex analysis of the qualitative data (e.g., qualitative data analysis software) was not utilized because the data generated was used to inform the results of statistical analysis and provide a foundation for speculative discussion regarding the effectiveness of the intervention.

Procedure

Upon approval from the tribal community's Institutional Review Board, The University of Montana's Institutional Review Board, Montana State University's Institutional Review Board, and the principle investigator's dissertation committee, the principle investigator began work with the Community Organizer to set up a consultation meeting, with a focus group composed of tribal community members with education and expertise related to grief and historical trauma, to ensure the measures (i.e., BC and ISEL) were relevant to the tribal belief systems and ethically and respectfully appropriate. The focus group members were selected from a group who were instrumental in evaluating the relevance and cultural appropriateness of the items of several measures used in the larger study.

In the current study, the primary investigator hand delivered information to members of the focus group prior to meeting with them to discuss their thoughts and opinions. The packet of information included: a) an introductory letter (Appendix F) describing measurement evaluation instructions, and b) templates of the measures to be used in the current study (i.e., BC and ISEL), which also provided instructions and expanded margins in which evaluators could write their critiques and provide comments. The primary investigator met, in person, with two of the focus group members and reviewed each item of the BC and ISEL item-by-item. The focus group examined each item word by word, while it discussed the cultural relevance and whether or not a participant from the community would find wording or content to be offensive. The primary investigator also received written feedback from the third group member who was unable to attend the scheduled meetings.

Prior to discussing their critique/comments regarding the BC and ISEL, the focus group members provided the primary investigator with a description of coping from their tribal-cultural perspective, which they emphasized was transmitted to them from elder family and community members. The primary investigator's attempt to paraphrase the information that was communicated follows.

They related that historically the traditional approach to coping with grief has been deeply rooted in spirituality. The focus group members noted that the reason their tribe has approached coping with grief from a spiritual perspective is directly related to tribal-cultural beliefs regarding the nature of an individuals' physical and spiritual life in relation to the physical and non-physical world. The tribal-cultural beliefs surrounding death influenced the grieving process and the type and use of coping behaviors in which tribal members engaged. Coping with grief in a spiritual manner placed a focus upon the relationship between the deceased and the grieving individual.

The focus group members related that, in addition to spiritual coping, tribal members may also engage in emotional coping as a way of maintaining and strengthening the stability and health of the tribal community. They stated that more behavioral coping behaviors generally took place following a period of time which was observed for the spiritual (individual) and emotional (community) forms of coping. They stated that various factors (e.g., health problems and substance abuse) and losses (e.g., language, land, elders, etc.) led to changes in the aforementioned process, which have contributed to a great deal of difficulty in tribal members' ability to cope with grief, which has an effect upon other areas of life for individuals, their families, and the tribal group.

The primary investigator then worked with the Community Organizer to schedule dates for the two grief retreats. The individuals selected[3] to participate in Grief Retreat #1 were called, by telephone, by the Community Organizer and provided with information regarding date, time and location of the retreat. On the first day of Grief Retreat #1, the principle investigator was given the opportunity to introduce the study and extend an invitation to participate.

Individuals interested in participating were provided with both written and verbal details about the study (i.e., purpose, procedure, compensation). Participants were informed of how their anonymity would be protected and that they may choose to stop participation at any point during the survey. Participants were then provided with an explanation of how their demographic information and survey data will be secured, and informed of the possible effects of participation (e.g., sadness). Participants who decided to participate gave their consent by signing their name at the bottom of the consent form. That consent form was assigned a number that corresponded to a

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[3] Some 28 participants volunteered to participate in Grief Retreats following a day-long conference on Historical Trauma featuring Dr. Yellow Horse Brave Heart. Individuals continued to inquire about participating in future retreats.

number on a survey packet. Participants were given unsigned and unnumbered Consent Forms to take away with them which provided information on how to contact the primary investigator and his faculty advisor.

Participants who chose to continue were provided with packets which included the following measures at the four data collection time points:

1. A seven item Demographic and Personal Information Questionnaire (Appendix B) which took approximately 2 minutes to complete.

2. The seven item Tell Us About You demographic/personal information questionnaire asked participants a number of standard questions regarding demographic information (e.g., age and gender).

3. The eight item Grief History Questionnaire (Appendix C), which also took approximately 10 minutes to complete. The Grief History questionnaire asked participants about the amount time that had passed since the last death they experienced, the deaths they had experienced in the last 5 years, their relation to the deceased, the cause of death, the participant's age at the time of death, the age of the deceased at the time of their death, and whether the death was expected or unexpected.

4. The 12-item Historical Loss Scale, which took approximately 5 minutes to complete.

5. The 12-item Historical Loss Associated Symptoms Scale, which took approximately 2 minutes to complete.

6. The 28-item BC (Appendix D), which took approximately 5 minutes to complete.

7. The 40-item ISEL (Appendix E) assessed participants' life stressors and social resources, and took approximately 10 minutes to complete.

8. Participants' grief experiences were assessed with the 34-item Inventory of Traumatic Grief, which took approximately 10 minutes to complete. The Brief Resilience Scale (BRS), which took approximately 2 minutes to complete; The Kessler-6 Psychological Distress Scale (K6-PDS), which took approximately 1 minute to complete; The Positive and Negative Affect Schedule (PANAS).[4]

Participants were compensated $20 upon completion of the pre-intervention control assessment battery on the first day of Grief Retreat #1.

Following the completion of the closing ceremony for Grief Retreat #1, 3 days after the collection of pre-intervention data, participants were asked to complete a post-intervention assessment battery consisting of eight measures (i.e., HLS, HLASS, BC, ISEL, BRS, K6-HDS, and PANAS; (see Table 1 in Appendix I) and asked two qualitative questions regarding the intervention. Participants' oral responses to these two open-ended questions were recorded by pen and paper for later analysis.

The primary investigator and Community Organizer made arrangements to meet with or collect data from participants who elected to complete the post-intervention assessment battery after the completion of the final day of the retreat. Participants received $20 upon completion of the post-intervention assessment battery, were provided with debriefing information (e.g., contact information of the principle investigator and principle investigator's advisor, and cultural resources and psychological services) and reminded that they would have the opportunity to participate again in 1 month and in 3 months.

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[4] ITG, BRS, K6-PDS, and PANAS were all collected by the primary investigator as a courtesy to the larger research team.

A 1-month follow-up assessment battery consisting of nine measures: the Grief History Questionnaire ("Have you experienced a death since the Grief Retreat?" If so, please identify your relation to the deceased, the cause of death, your age at the time of death, the age of the deceased at the time of their death, and whether the death was expected, violent, or drug related), HLS, HLASS, BC, ISEL, BRS, K6-PDS, and PANAS) were mailed to participants 4 weeks following Grief Retreat #1. Participants who completed and returned the assessment battery back to the primary investigator or Community Organizer were hand-delivered $20. Participants who did not complete and return the assessment battery after 4 weeks following Grief Retreat #1 were mailed a reminder postcard before they are contacted by the Community Organizer by phone a week later. The Community Organizer made arrangements to meet the participants who had not returned the assessment battery after 5 weeks. Participants were hand delivered $20 for completing the assessment battery if the completed assessment battery was collected in person.

Similar to the 1-month follow-up, a 3-month follow-up assessment battery consisting of 10 measures: Tell Us About You Questionnaire; Grief History Questionnaire; ITG; HLS; HLASS; BC; ISEL; BRS; K6-HDS; and PANAS were mailed to the participants 12 weeks following Grief Retreat #1. The data collection was similar to the procedure mentioned above and participants received $20 for completion of the 3-month follow-up assessment battery.

The above procedure was repeated with participants who attended Grief Retreat #2, which was held approximately 4 weeks after Grief Retreat #1. The principle investigator was present at Grief Retreat #1 and Grief Retreat #2 to collect pre- and post-intervention data. The Community Organizer and his dissertation committee chair mailed and collected 1- and 3-month follow-up data for this project and the larger study.

The primary investigator maintained a journal of observational memos and notes pertaining to the intervention process and participants' comments and behaviors in an effort to identify and highlight factors that may have affected participant scores (e.g., events and changes in the tribal community, and details and changes related to retreats and intervention delivery). As the study progressed, memos and notes moved from observationally descriptive to critical and comparative (Charmaz, 2003) resulting in further advancement of the primary investigator's understanding and exploration of effects of the intervention.

CHAPTER III. Results

Descriptive Statistics

Descriptive statistics were generated and explored through analysis of means for pertinent participant demographic data. Participants' self-reported grief history and information related to details surrounding the losses they have experienced are also presented.

Demographic

The mean age of the 40 participants was 38 years, and the age of participants ranged from 18 to 60 years. Twenty participants (50%) are between the ages of 25 and 45, 13 participants (32.5%) between the ages of 45 and 60, and seven participants (17.5%) are 25 years old or younger. Twenty male and 20 female subjects participated in the two Grief Retreats.

Nine participants (22.5%) reported they live alone and 29 participants (72.5%) are unemployed. Fourteen participants have partial college training (35%), eight participants have their high school diploma or GED (20%), six participants are college graduates (15%), four participants have graduate/professional training (10%), four participants have partially completed high school (10%), and two participants have completed school up to the 6th grade (5%).

Twenty-six participants (66.7%) reported that they are spiritually active in an organized religion, and 24 participants (61.5%) reported that they are spiritually active in tribal traditional practices.

Grief history

At pre-intervention (T1), 19 participants (50%) reported more than 12 months had passed since the last death they had experienced; conversely, 19 participants (50%) reported that they had experienced a death in the last year. The 38 participants experienced a total of 165 deaths in the

last 5 years. Additionally, participants experienced an average of 4 deaths, with a range of 1-20 deaths.

Further examination of the Grief History revealed that, 3 of the 19 participants that responded at the 1-month follow-up had experienced 4 additional deaths, of which 3 were health related (Cancer related, brain related, and breathing related) and 1 was a car accident.

Finally, 3 of the 7 participants that responded at the 3-month follow-up had experienced additional deaths, but did not indicate mode of death.

Identity of deceased

Of the deaths experienced by the 40 participants in the past 5 years, they reported the deaths of: 32 aunts and uncles; 17 friends; 14 parents; 12 cousins; 10 grandparents; 10 siblings/1 step-sister; 4 children; 3 nephews/1 niece; 2 mothers-in-law; and 1 death of a great aunt, spouse/partner, and brother-in-law.

Mode of death

As a group, the 40 participants experienced a total of 87 deaths by illness; 70 deaths by alcohol/drugs; 25 deaths by suicide; 14 accidental deaths (including 9 deaths by car accident).

<center>**One-way Repeated Measures ANOVA**</center>

The IBM Statistical Package for the Social Sciences (SPSS 19) data analysis software was used to conduct the repeated measures ANOVA test to determine whether there were any differences between the means of participant BC and ISEL scores. F value (*F*), degrees of freedom (*df*), and significance values (*p*) are reported.

The reporting of effect size estimates, in addition to null-hypothesis significant testing, has been recommended to provide a "truer," more "scale-free" measure of the magnitude of effect or strength of association between two or more variables (Ferguson, 2009; Hojat & Xu, 2004; Snyder

& Lawson, 1993; Wilkinson & Task Force, 1999). Hence, the effect size estimate partial eta-squared ($\eta\rho^2$) for the BC (Table 2 in Appendix I) and the ISEL total scores and subscale scores (Table 3 in Appendix I) are reported. Cohen (1992), based upon values for *d* and *r*, suggested values of .10, .25, and .40 for small, moderate, and large effect sizes respectively, but did not intend to have them serve as guidelines across various effect size estimates. Ferguson (2009), based upon the previous reviews, suggested the use of: .04 as the minimum value representative of a "practically" significant effect size (RMPE)[5]; .25 to represent moderate effect size; and .64 to represent a strong effect size for squared association indices such as partial eta-squared within social sciences research.

It should be noted that although 40 individuals participated in the two grief retreats, the attrition rate from pre-intervention (T1) to 3-month post-intervention (T4) and incomplete item responses contributed to reductions in sample size for statistical analyses pertaining to BC and the ISEL subscales.

Brief Cope

Positive reframing. There was no statistically significant effect per the grief intervention on participants' BC Positive Reframing subscale score means at the $p < .05$ level for T1-T4; $F(3, 27) = .069$, $p = .976$, $\eta\rho^2 = .008$. Increases in the mean scores from: T1-T2; T1-T3; and T2-T3 are observed.

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[5] RMPE is the abbreviation for the Recommended Minimum Practical Effect Size for the social sciences suggested by Ferguson (2009).

Table 4.

Brief COPE Positive Reframing subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	6.00	1.41	10
Post-intervention (T2)	6.10	.88	10
1-month post-intervention (T3)	6.20	1.81	10
3-month post-intervention (T4)	5.9	1.97	10

Acceptance. The repeated measures ANOVA with a Greenhouse-Geisser correction determined that there was no statistically significant effect of the grief intervention on participants' BC Acceptance subscale score means at the $p < .05$ level for T1-T4; $F(1.77, 15.96) = .593$, $p = .545$, $\eta\rho^2 = .062$. Increases in the mean scores from: T1-T2; T1-T3; T1-T4; T2-T3; T2-T4; and T3-T4 are observed.

Table 5.

Brief COPE Acceptance subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	5.40	1.43	10
Post-intervention (T2)	5.90	1.19	10
1-month post-intervention (T3)	6.00	1.33	10
3-month post-intervention (T4)	6.20	2.04	10

Humor. An analysis of the participants' BC Humor subscale score means using a one-way repeated measures ANOVA with a Greenhouse-Geisser correction determined that there was no statistically significant effects as a consequence of the grief intervention [$p < .05$ level for T1-T4; $F(2.59, 23.34) = .702$, $p = .541$, $\eta\rho^2 = .072$]. No increase in mean scores is observed.

Table 6.

Brief COPE Humor subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	5.30	1.25	10
Post-intervention (T2)	5.30	1.25	10
1-month post-intervention (T3)	4.60	.966	10
3-month post-intervention (T4)	5.20	1.81	10

Using emotional support. The repeated measures ANOVA with a Greenhouse-Geisser correction determined that there was no statistically significant effect of the grief intervention on BC Using Emotional Support subscale score means at the $p < .05$ level for T1-T4; $F(2.56, 20.50) = 1.07$, $p = .377$, $\eta\rho^2 = .118$. An increase in the participants' mean scores from T1-T2 is observed.

Table 7.

Brief COPE Use of Emotional Support subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	5.44	1.23	9
Post-intervention (T2)	6.33	1.41	9
1-month post-intervention (T3)	5.33	2.06	9
3-month post-intervention (T4)	5.22	1.48	9

Self-distraction. The repeated measures ANOVA with a Greenhouse-Geisser correction determined that there was no statistically significant effect of the grief intervention on participants' BC Self-Distraction subscale score means at the $p < .05$ level for T1-T4; $F(2.00, 14.03) = .324$, $p = .729$, $\eta\rho^2 = .044$. No decrease in Self-Distraction subscale score means is observed.

Table 8.

Brief COPE Self-Distraction subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	4.38	1.41	8
Post-intervention (T2)	4.50	1.77	8
1-month post-intervention (T3)	5.00	1.93	8
3-month post-intervention (T4)	4.88	2.23	8

Substance use. There was a statistically significant effect of the grief intervention on BC

Positive Reframing subscale score mean at the $p < .05$ level for T1-T4; $F(3, 27) = 3.89$, $p = .020^*$,

$\eta\rho^2 = .302$. The pair-wise comparison of BC Substance Use subscale score mean shows a

significant decrease ($p = .038^*$) from T1-T3. Additionally, decreases in subscale score means

from: T1-T2; T1-T3; T1-T4; T2-T3; and T2-T4 can be observed.

Table 9.

Brief COPE Substance Use subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	5.30	2.49	10
Post-intervention (T2)	4.80	1.93	10
1-month post-intervention (T3)	3.10	1.73	10
3-month post-intervention (T4)	3.40	1.84	10

Self-blame. The repeated measures ANOVA with a Greenhouse-Geisser correction

determined that there is not a significant effect of the grief intervention on BC Self-Blame subscale

score mean at the $p < .05$ level for T1-T4; $F(1.99, 17.87) = 1.23$, $p = .315$, $\eta\rho^2 = .120$. The pair-

wise comparison of BC Self-Blame subscale score mean shows a significant decrease ($p = .041^*$)

from T1-T3. Additionally, decreases in subscale score means from: T1-T2; T1-T3; T1-T4; T2-T3; and T2-T4 can be observed.

Table 10.

Brief COPE Self-Blame subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	4.80	1.55	10
Post-intervention (T2)	4.60	1.89	10
1-month post-intervention (T3)	3.90	1.45	10
3-month post-intervention (T4)	4.10	1.73	10

Interpersonal Support Evaluation List

Overall support. Repeated measures ANOVA analysis with a Greenhouse-Geisser correction results in the finding of no significant effect of the grief intervention for ISEL overall support score mean at the $p < .05$ level for T1-T4; $F(1.97, 11.82) = 1.26$, $p = .319$, $\eta\rho^2 = .173$. Increases in score means from T1-T2 and T1-T3 are observed.

Table 11.

Interpersonal Support Evaluation List Overall Support subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	78.14	17.88	7
Post-intervention (T2)	86.29	16.17	7
1-month post-intervention (T3)	83.29	24.49	7
3-month post-intervention (T4)	78.00	28.76	7

Appraisal support. There is no significant effect of the grief intervention on ISEL

Appraisal Support subscale score mean at the $p < .05$ level for T1-T4; $F(3, 27) = .399$, $p = .755$,

$\eta\rho^2 = .042$). An increase in subscale score mean from T1-T2 is observed.

Table 12.

Interpersonal Support Evaluation List Appraisal Support subscale
score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	22.30	4.57	10
Post-intervention (T2)	22.80	5.51	10
1-month post-intervention (T3)	22.30	5.76	10
3-month post-intervention (T4)	21.20	7.11	10

Tangible support. Repeated measures ANOVA analysis with a Greenhouse-Geisser

correction results in the finding of no significant effect of the grief intervention on ISEL Tangible

Support subscale score mean at the $p < .05$ level for T1-T4; $F(2.01, 16.08) = .822$, $p = .458$, $\eta\rho^2 = $

.093. Increases in mean scores from T1-T2; T1-T3; and T1-T4 are observed.

Table 13.

Interpersonal Support Evaluation List Tangible Support subscale
score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	17.44	3.84	9
Post-intervention (T2)	19.78	5.31	9
1-month post-intervention (T3)	19.67	7.11	9
3-month post-intervention (T4)	19.33	7.94	9

Self-esteem support. Repeated measures ANOVA analysis with a Greenhouse-Geisser correction results in the finding of no significant effect of the grief intervention on ISEL Self-Esteem Support subscale score mean at the $p < .05$ level for T1-T4; $F(1.82, 14.68) = .458$, $p = .624$, $\eta\rho^2 = .054$. Increases in score means from T1-T2 and T1-T3 are observed.

Table 14.

Interpersonal Support Evaluation List Self-Esteem Support subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	17.89	3.76	9
Post-intervention (T2)	18.67	3.54	9
1-month post-intervention (T3)	18.56	4.79	9
3-month post-intervention (T4)	17.22	5.63	9

Belonging support. A significant effect of the grief intervention on ISEL Belonging Support subscale score mean at the $p < .05$ level is not found for T1-T4; ($F(3, 24) = 1.56$, $p = .224$, $\eta\rho^2 = .164$). Increases in score means from T1-T2; T1-T3; and T1-T4 are observed.

Table 15.

Interpersonal Support Evaluation List Belonging Support subscale score mean summary

	Mean	Std. Deviation	N
Pre-intervention (T1)	19.78	6.08	9
Post-intervention (T2)	22.89	4.08	9
1-month post-intervention (T3)	21.67	5.22	9
3-month post-intervention (T4)	20.56	7.73	9

Qualitative Analysis

Core elements of the Grief Retreats

Participants' responses to questions regarding helpful aspects of the intervention and descriptive and observational memos regarding aspects of the retreat (i.e., content, processes, and format) are examined with the goal of providing the developers and the community with information to assist with further development and improvement of their intervention.

Analysis of the primary investigator's memo/journal notes regarding the content of the intervention implemented by the facilitators of the retreat reveal core elements which appear to strongly support the provision of enculturation and education.

Enculturation

Traditional knowledge. The facilitators utilized storytelling and provision of explanations about tribal beliefs and customs throughout the retreat. The transmission of this traditional knowledge appears to be aimed at accomplishing the goals of: Helping participants establish a group connection/identity; creating a comfortable environment; highlighting strengths/resources; and teaching (i.e., values, history, importance of the continuation of tradition). Despite the primary investigator's decision to divide the two major areas of focus (i.e., enculturation and education) for organizational purposes, retreat presentation of each of these areas was not mutually exclusive. For example, one facilitator described how traditional mourning practices were spiritually beneficial on both an individual and a communal level when the topic of coping behaviors was discussed.

Education

Environment. The environment in which the retreats are held (i.e., classroom) and the "teacher-student" type of interaction between facilitators and participants appear to be very conducive to learning. Facilitators' provision of written (i.e., dry erase board and handouts) retreat

"rules" and directions for understanding and completing intervention components, historical documents (i.e., reference materials), video media, and other supplies (e.g., pencils) also contribute to participant preparation and ease of leaning.

Historical Trauma and Historical Loss. Facilitators' provide participants with a definition and explanation of historical trauma theory, and examples of how tribal specific historical trauma/loss impacted their own life. Facilitators continue educating participants about historical trauma/loss on a more personal basis following their engagement in various parts of the retreat. For example, one facilitator provided a participant with an explanation of how the information contained within their complete Life Circle was not intended to "paint a bad picture" of their parent, but did indicate that his lack of knowledge and skill as a parent was the result of loss experienced by his own parents (who were placed in Boarding School at a young age).

Grief/Loss. Facilitators provide participants with information regarding grief/loss. Specifically, participants are provided with knowledge (i.e., common reactions/experience associated with grief) and information regarding misconceptions and societal messages about the grief process from both non-native culture (e.g., Kubler-Ross stages of grief) and tribal tradition (e.g., taboos). Facilitators also address how these misconceptions and messages often lead to beliefs and behaviors that may limit loss recovery.

Emotion. The facilitators provide participants with education about emotion with the goals of teaching them: How to identify/label emotions; the importance of expressing emotion; how emotions can affect behavior; and tolerance of emotion. Facilitators not only provide education about emotions verbally and in written form, but also through role modeling by sharing their own emotions and role modeling supportive attention to other participants who experience or express emotions associated with grief and loss.

Behavior. Early discussion of behavior (beginning of retreat) is aimed at priming or preparing participants for engagement in the intervention and describing the importance of being "mindfully" present throughout the retreat. Facilitators also present information about differences between healthy and unhealthy coping behaviors, and how these behaviors may impact participant grief/loss recovery throughout the retreat. Education regarding behavior also focuses upon describing change and recovery as a processes rather than an instant change.

Open-ended questions

Question 1

A number of themes emerge from the analysis of participant responses to the qualitative question: What aspects of the grief intervention did you find helpful? The two core categories, tribal-oriented and retreat-oriented, are divided into subcategories (see Appendix G and H). In addition to their identification of helpful aspects of the grief intervention, participants also indicate why they felt that they were helpful (i.e., led to gains in knowledge, an increase in ability, change or improvement in their experience, or growth and development).

Tribal-oriented

Social support. A majority of participants identified the social support aspects of the retreat as helpful in several ways. A number of participants reveal that their trust and comfort level increased as a result of being in a group setting, which led to ease in their ability to verbally express their grief. For example, one participant states, *"Seeing others take the chance to share helped me share."* Another participant states, *"Listening to everybody's stories made me feel like I was not alone and that let me trust and share without holding back."*

Several participants note that their tolerance for various experiences (i.e., negative emotions, being in groups, etc.) increased as a result of their participation. One participant states,

"I found it helpful to watch peers even though I don't like being in groups." Another states, *"It helped with my tolerance with people, and added to my compassion for others."*

Several participants state that they experienced changes in their usual behavior. For example, one participant reveals that, *"I'm generally more shy and quiet, it helped open me up."* One participant observes how her engagement with the group led to the identification of positive aspects of her life stating, *"Listening to everybody's stories helped me realize how fortunate I am to have my parents."*

Spirituality. Several participants identify the provision and availability of spiritually-oriented items and knowledge as facilitative. One participant states, *"Smudging and talking to the creator helped me be in the group,"* indicating that his use of spirituality increased his tolerance which helped facilitate his engagement in the group setting. Additionally, one participant notes that the retreat helped re-establish the importance of spiritual faith in her life and states that her ability *"to keep spirituality in mind all the time"* is bolstered following completion of the retreat.

Finally, a few participants state that participation in the retreat helped them address grief associated with their loss of a spiritual connection or faith as a result of the death of a loved one.

Traditions. A number of participants identify the incorporation of traditional thoughts/beliefs, rituals/practices, and explanations about the history of the traditions as helpful in a number of ways. For example, one participant states, *"(traditional practice) really helped, I felt cleansed yesterday. I had a strong feeling of goodness, I felt comforted, and I felt reborn."*

Retreat-oriented

Components and format. The majority of participants relate that they experienced an increase in self-exploration and self-awareness as a result of their exposure to the major components (i.e. tradition, education, and other) of the retreat. One participant states, *"I'm seeing*

some of why I'm an alcoholic." Similarly, another participant states, *"Understanding my addiction is directly related to grief and loss was good."*

Another participant, referring to how the education component of the retreat was helpful, states, *"Realizing simple little things could change a person's outlook, like hearing people say, 'let it go,' or 'move on.'"* Finally, one participant states, *"Learning that it is okay to talk and that talking about grief is needed to heal, as well as the need to go back and understand how grief was passed down generationally,"* is affirming and informative.

Some participants identify specific components of the intervention as critical to their ability to express their emotions. Referring to the Healing Chair exercise, one participant states, *"It was best. I had a breakthrough because I was able to express my feelings about my father."* Another participant, also referring to the healing chair exercise, states, *"I had suppressed feelings, hurt and pain, about my father."* Although one participant states, *"the chair exercise was good"* they also express concern regarding their ability to manage their emotions as they continue their grief work. *"I'm worried about my reaction and using my other parent."* Finally, one participant simply refers to the Healing Chair component as *"the only"* helpful part of the retreat because it allowed them to experience and communicate his emotion.

Referring to the retrospective nature of the Life Circle component, one participant states, *"To be able to open up, being able to talk about (death) has been hard. I let stuff out that has been held since childhood."*

A participant, referring to her construction of an Ancestral Tree, states, *"It helped me learn more about my family loss."* Another participant states that having *"the past brought up"* while constructing her Ancestral Tree helped her identify what she thought was *"unimportant."*

Several participants state that retreat guidelines such as focusing upon the grief and loss surrounding one relationship (e.g., mother, father, etc.) is helpful because they led to the identification of existing grief/loss within that relationship as well as the potential existence of grief/loss in other relationships.

One participant states that the combination of two components (i.e., Life Circle and Healing Chair) allow him to forgive his father and led to his desire to work through his grief surrounding his relationship with his stepfather and, *"quit being resentful toward him."*

Guidance/direction. Several participants identify facilitators' efforts as key to their ability to experience and communicate their emotions. One participant stated, *"I didn't think they'd break me, but they did and it was good."* Participants also identified how the specific action of facilitators is helpful. For example, one participant states that she was able to understand how societal messages influence an individual's expression of emotion as a result of *"being shown, on a (dry erase) board or being told"* by the facilitators. Another participant refers to the general importance of the facilitators' role, *"They guide you through the healing process."*

Previous retreat participation. Participants who had participated in one or more previous retreats made observations about how their experiences had evolved as a result of their participation. One participant states, *"The retreat in 2010 didn't touch on stuff then, I didn't open up about family then. This time was painful, but helped me open up."* Another participant states, *"This is my third retreat. This one exposed stuff I thought I had dealt with."* A participant who attended two previous retreats states, *"The last two times I was dealing with other stuff, this time I focused on myself,"* indicating that the availability/accessibility of grief retreats provides additional opportunities for him to be at a good place to deal with grief. Additionally, several participants

express interest in attending additional retreats or intend to utilize the information they gained in the retreat to further address their grief.

Question 2

Participant's post-intervention interview responses to the second question ("What do you wish would have been different in the retreat?") are less in-depth than responses to the first questions but are very informative. The majority of the changes suggested by participants are related to the organization of the retreat (i.e., time/schedule changes, different exercises, more opportunities to process emotion, changes in groups, and improved debriefing). A number of participants suggest changes in cultural facets and consideration or accommodation for physical health and comfort (e.g., prolonged sitting). Finally, several participants state that they did not have any suggestions or recommendations regarding changes to the intervention/retreat.

CHAPTER IV. Discussion

The members of a tribe located in the northwestern US combined elements of their traditional belief system with the tenets of a grief recovery method to develop a culturally anchored intervention to address historical loss and unresolved grief. The current study examines the affect this intervention had upon the coping behavior and perceived social support in the group of tribal community members for whom the intervention was developed.

Overall, changes in participants' perception of available social support and use of active emotion focused coping behaviors were observed following exposure to rich cultural resources (e.g., knowledge, ceremony) and education about behaviors that appeared particularly adaptive for coping with grief within this population.

Statistically significant findings

The results of the statistical analysis reveal significantly lower substance use coping behavior utilization among participants who completed the intervention. Significant pair-wise comparison differences for substance use ($p = .038$) and self-blame ($p = .041$) were observed between pre-intervention (T1) and 1 month post-intervention (T3). Participants' use of fewer substances at this time point is consistent with the findings of Conner and Conner (2008). Although results of the statistical analysis are limited to the aforementioned statistically significant findings, an examination of significant practical findings provides additional information about intervention effects experienced by the AI participants.

Significant practical findings

Following the guidelines suggested for social science research by Ferguson (2009), a minimum effect size estimate value of .17 is observed for ISEL overall support, while effect sizes for appraisal support, tangible support, self-esteem support, and belonging support subscales range

from .04 to .16. Only a small effect size was observed for overall support and belonging support utilizing the more stringent guidelines suggested by Cohen (1992).

Again, utilizing Ferguson's suggested values small to moderate effect size estimate values range from .04 to .30 for BC positive reframing, acceptance, humor, use of emotional support, self-distraction, substance use, and self-blame subscale scores. A small effect size was observed for both the use of emotional support and self-blame, and a medium effect size was observed for substance use utilizing Cohen's guidelines.

These effect size values are also consistent with the findings of several meta-analytic studies of treatment effect estimates for existing grief interventions for children and adolescents and adults (Allumbaugh & Hoyt, 1999; Currier, Neimeyer, & Berman, 2008; Rosner, Kruse, & Hagl, 2010). These findings are very encouraging given the fact that grief treatment effectiveness research has typically shown mixed results, and very few interventions to specifically address grief experienced by AI's have been developed and studied.

The aforementioned significant statistical and practical findings have implications for the prevention and treatment of several grief and health related issues which are addressed in the following section.

Clinically significant findings

Following the intervention, with the exception of two of the BC subscales (i.e., humor and self-distraction), participants' score means of the coping behaviors of interest appear to have changed in the direction hypothesized by the primary investigator (i.e., increases in positive reframing, acceptance, using emotional support; and decreases in substance use, and self-blame). These small changes may reflect participants' ability to absorb and use the knowledge they receive regarding adaptive and maladaptive coping behaviors which led to decreases in their use of

avoidant coping behaviors (e.g. substance use). Similarly, increases in participant's active-emotional coping (i.e., positive reframing, acceptance, and using emotional support) probably reflect their use of additional knowledge provided by the intervention (i.e., information about emotion, grief specific information, and traditional information. Additionally, participants identify the learning/educational components of the intervention/retreat as influential in expanding their knowledge regarding their grief. They report that the acquisition of knowledge in two specific areas (i.e., tribal history and family history) was helpful. Most participants note they possess little to no understanding of how historical group loss (i.e., tribal losses and family losses) may contribute to their personal life experiences and difficulties; and, it appears that the provision of specific and more extensive education contributes to the small changes in the coping behaviors that participant's exhibit at post-intervention. However, it would appear unadvisable for an outsider or unaffiliated tribal group member to provide such knowledge. Consistent with suggestions by Stone (1998) behavioral healthcare workers, therapists, and chemical dependency counselors assisting AI individuals with grief should consult with, work in concert with, or make a referral to a community member (i.e., elder) with appropriate knowledge.

Whereas changes in coping behavior reflected the education participants received, increases in ISEL overall support and ISEL subscale score means indicate that participants not only viewed social support as a source for coping with grief, but their actual experience of such support facilitates: a) tolerance of various experiences, b) acknowledgement of difficulties associated with grief; c) engagement in new or different coping behaviors, and d) comfort and willingness to verbally express feelings/emotion that they have experienced difficulty expressing in the past. Participants' exposure and utilization of emotional support resulted in reassurance and

security which according Carver, et al. (1989), may foster a participant to focus upon problem-focused coping strategies for grief.

Further, several individuals who have participated in at least one of the previous retreats described the manner in which they incorporated new knowledge and experience about grief into their current lives as a process that evolved with each Grief Retreat. The fact that participants experienced a number of incremental benefits following intervention suggests that AI people of this population will continue to experience long-term grief coping benefits with continued participation in both small and large group processing and learning opportunities. In addition to improving individuals' psychological state (Cohen & Willis, 1985), the continued provision of Grief Retreats and availability of social support may positively effect the mortality rate of the community (Rosenberg, Orth-Gomer, Wedel, & Wilhemsen, 1993).These finding are also supported by previous studies examining coping within AI populations (Aldrich, 2008; Jefferies, 2001; Stander, 2000), and suggestions by a number of clinical and counseling practitioners (Edwards & Edwards, 1984; LaFromboise, Trimble, & Mohatt, 1990) regarding the use of social support and communal coping.

Participants describe strong views regarding the importance and benefit of the cultural components/rituals (e.g., smudging) that were included in the Grief Retreats. Additionally, several participants identified their engagement in both cultural (e.g., ancestral tree and sweat lodge) and non-cultural retreat exercises (i.e., healing chair and life circle) as helpful for actively addressing specific losses. These points reinforce the suggestions of several authors and clinicians (Conner J. L. & Conner, C. N., 2008; Garrett et al., 2011; Reeves, 2011; Roberts et al., 1998; Stone, 1998) regarding the importance of utilizing enculturation as a strategy for facilitating or maximizing therapeutic benefit to AI people. Future efforts should continue to use enculturation to facilitate

grieving individuals to use various facets of their own tradition/culture (i.e., spirituality, guidance facilitators and elders, rituals) as well as western coping resources (i.e., mental health, medical) needed to address the numerous layers of grief and associated health issues experienced by members of this community. These findings also highlight the importance of assessing AI individual's views of traditional/cultural activities or intervention to identify participants for whom retreat variation may be indicated.

In addition to contributing to improvements in grief coping behavior and experiences, the results of the current study have implications for the treatment of substance use disorders which deserves attention considering that the rate of alcohol dependence for AI people living on Montana reservations (12.8%) is three times higher than for the US adult population (3.7%) (SAMHSA, 2001).

Given that retreat participants were self-referred (including some who were in substance use treatment during their participation) and considering that substance use coping responses have been typically thought to "impede or interfere" with individuals' ability to engage in active emotional or confrontative coping (Carver, Scheier, & Weintraub, 1989), future exploration of this population could attempt to assess whether readiness for change increases intervention efficacy. Utilization of the stages of change model developed by Prochaska and DiClemente (1984) might reveal differences between participants in earlier stages (e.g., pre-contemplative) and advanced stages (e.g., contemplative or action).

Further, impeding or interfering coping responses (i.e., substance use and self-blaming), also referred to as avoidant coping behaviors, have been found to be positively correlated with Complicated Grief and PTSD severity as well as a predictor of PTSD (Schneider, Elhai, & Gray, 2007; Stewart, 1999). A greater understanding of the typical coping response utilized by

individuals within this community may clinically inform healthcare professional's (i.e., substance use counselors, therapists, and physicians) use of assessment tools, selection of effective treatment, or appropriate referral. For example, although assessment tools such as the Beck Depression Invention (BDI-II)[6] include items that ask about substance use the measure does not assess in frequency of use. The use of a substance use assessment tool such as the Addiction Severity Index (ASI)[7] in addition to the BDI-II would help assess history and frequency of substance use, but assessment of an individuals' use of coping behaviors or coping style using a brief measure like the BC would inform selection of an approach to help the individual build coping skills or adjust their coping style.

Following assessment, selection of treatment approaches should differ from approaches used to deal with other issues or symptoms typically associated with grief (e.g., depression).This approach may help improve members of this community's experience of Western therapeutic approaches because it takes the focus off of symptoms and individualizes treatment for AI people. For example, the results of the current study indicate that the educational approach participants found most helpful may differ from typical psychoeducational approaches. In the current study, decreases in participants' use of avoidant coping behaviors (i.e., substance use and self-blame) appear to be linked to the educational foundation of the intervention which, consistent with Maria Yellow Horse Brave Heart's historical trauma intervention model, focuses upon heightening participants' awareness of historical trauma. It is possible that heightened awareness of historical trauma and the ways in which intergenerational losses may impact the lives of participants (e.g.,

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[6] The Beck Depression Inventory (BDI-II) is a commonly used general purpose measure of depression)

[7] The Addiction Severity Index (ASI) is an interview measure of substance use which also assesses areas that may contribute to continued use (e.g., health issues)

deficits in parenting knowledge) led them to view some of their grief as shared, or as more global than they previously believed. Further, this finding may lend support to the argument that those educational programs aimed at increasing area and population specific historical knowledge (e.g., Montana Indian Education for All, IWFA).

Changes in participants' beliefs regarding personal responsibility for various deficits or difficulties may allow them to explore or re-evaluate thoughts and/or feelings that may have been influencing their use of avoidant emotional coping behaviors (e.g., substance use) following education about grief and loss. Given that the self-blame subscale of the BC is a measure of criticism of oneself for responsibility in a situation (Carver, 1997); it is probable that the historical trauma education is a mediating variable.

In addition to exploring or re-evaluating and changing their self-blame beliefs following education about historical trauma and loss, participants reported using fewer substance use behaviors following education about the ways in which they limited their grief recovery. Again, participants may have begun to explore or re-evaluate their substance use and began to utilize the newly learned active emotional coping behaviors taught in the retreat (e.g., use of emotional support).

Finally, a number of individual and community strengths identified in this sample offer several clinical implications. For example, consistent with previous literature and studies regarding resiliency within AI culture (Belcourt-Ditloff, 2006; Garrett & Garrett, 1994; Goodluck, 2002; Herring, 1994), a number of participants identify humor and "good thoughts" as the ways in which they typically cope with issues such as grief and bereavement. Although no change in mean scores were observed following participation in the intervention, this observance is noteworthy because it suggests that participants are able to slightly modify their coping approach (e.g., active emotional

coping) to be congruent with the stressor. It appears that although they initially overused several maladaptive behaviors (i.e., substance use and self-blame) and underused more grief appropriate coping behaviors (e.g., positive reframing, use of emotional support, and acceptance) at pre-intervention, participants re-adjusted their use of these behaviors at post-intervention.

Regarding community strengths, participants indicated that they experienced a sense of empowerment and increased self-esteem associated with the cultural and educational aspects of the Grief Retreats to which researchers have referred to as essential for successful therapeutic outcome for AI individuals experiencing substance use issues (Longhi, 1999). AI people within this community are likely to experience empowerment and self-esteem in other environments (e.g., healthcare settings) if providers utilize personalized approaches to assess, treat, and take into account the generations of grief experienced by members of this community.

Study Limitations and Future Research

Although it is the belief that the findings of the current study contribute to the AI experience of grief and coping literature, it is important to point out several notable limitations. First, the observed results are unique to this particular tribal community and should not necessarily be assumed to apply to other tribal communities or to all sub-groups within the tribal community population.

Generalizations of the results are limited due primarily to small sample size. Although the size of the sample is impressive given some of the difficulties experienced by this population (e.g., SES, availability to transportation, transient or homelessness), sampling error generally increases when sample size is small which decreases the likelihood of finding statistical significance.

The ability to detect statistical significance is also greatly reduced due to attrition and missing data. Regarding the attrition rate for the BC, approximately 80% ($n = 32$) of the total

sample completed post-intervention (T2) measures, only 37.5% ($n = 15$) completed 1 month post-intervention (T3) measures and only 30% ($n = 12$) of the total sample completed 3 month post-intervention (T4) measures. Regarding the attrition rate for the ISEL, 92% ($n = 37$) of the total sample completed pre-intervention (T1) measures, 70% ($n = 28$) completed post-intervention (T2) measures, only 45% ($n = 18$) completed 1 month post-intervention (T3) measures and only 35% ($n = 14$) of the total sample completed 3 month post-intervention (T4) measures.

Further, the limited number of complete cases with which analysis could be conducted ranges from 7 to 10 participants due to attrition. The current study is intended to provide an exploratory investigation of the grief intervention developed for AI people of this specific community and the hypotheses and design of the study allowed for a number of issues related to error (e.g., Type II error), but it is clear that future research should attempt to address the issues with missing data and attrition by exploring the use of imputation procedures such as: last observation carried forward; mean substitution; multiple regression imputation; or expectation maximization imputation (Meyers, Gamst, & Guarino, 2006). The researchers in the larger project firmly believe that with a full-time Community Coordinator, almost 100% follow-up could be accomplished and thereby remove the transportation barriers inherent in a rural and economically disadvantaged community.

Next, the current study design does not include a control group (e.g., no intervention) with which comparisons can be made. Although an experimental design in which a treatment group and control group, is considered the "gold standard" in treatment efficacy research, the lack of resources made such a design unfeasible for the current study. While ensuring that no individuals are denied treatment, the use of a wait-list control group for future exploration will also provide a better understanding of the effects of this intervention. The use of a more sophisticated statistical

procedure (e.g., multi-level modeling or multiple regression analysis) also needs to be considered with the addition of a wait list control group. Again, the researchers in the larger project are convinced that a wait-list control group is both possible and feasible.

Additionally, the inclusion of an alternative treatment group may be feasible given that more than half of the participants were engaged in substance use treatment during and following their participation in the current study. It is likely that they receive additional education regarding the negative effects of their substance use, and the benefits of utilizing healthier alternative coping behaviors in their treatment program which contribute to decreased BC substance use.

An additional limitation of the study relates to the choice of outcome measures. The coping and perceived social support measures used in the current study (i.e., BC and ISEL) were not developed to measure grief specific coping or social support. Further, although the BC is a simplified measure of general coping with low respondent burden, it did not address specific circumstances surrounding levels of complex grief experienced by AI people (e.g., Historical Trauma). Also, each of the 14 BC subscales is comprised of only two items which provides a very limited view of the full range of behaviors commonly used to cope with grief. Additionally, subscale score totals are greatly affected by items that were scored extremely high or low and missing items. Regarding the ISEL, despite the inclusion of items that address advice and guidance, a separate subscale for these types of support would have provided a better measure of this type of support which emerged as important to participants in the current study.

Finally, given the complexity of the effects of this intervention an exploration of mediating and moderating factors will provide a greater understanding of the effectiveness of the intervention. The probability that participants continue to gain additional coping resources (i.e., financial, social, etc.) between post-intervention (T2) and 1 month and 3 month post-intervention

time points is very high and an examination of those potential mediating and moderating variables will also call for more extensive follow-up.

Conclusions

The members of this tribal community identified unresolved grief as the most salient underlying factor related to health disparities within their community, which they sought addressing using an intervention that combined tribal traditional and Western knowledge and resources. Although statistically significant findings are limited, a closer examination of effect size estimates, changes in mean scores, and qualitative data revealed findings of practical and clinical significance.

Participants cited increases in exposure to the various tenets of the intervention (i.e., increased education about and awareness of historical grief and historical trauma, sharing of grief and trauma experiences, and collective healing, etc.); expansion or extension of participant support networks; and/or increased connection to tribal culture/community as helpful and instrumental in their development/adjustment of coping behaviors for dealing with distress (i.e., psychological and social) associated with grief.

Although the current study may provide support for, and inform the existing grief research and literature, it is the sincere hope of the primary investigator that this study contributed to the knowledge and benefit of the people of this tribal community.

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APPENDIX A

Culture Specific Historical Trauma/Grief Intervention Schedule

Retreat #1

Day 1. Belonging (Birth/Infancy/Discovery)
1. Prayer
2. Breakfast
3. Song
4. Facilitator – Shared knowledge (Cultural)
5. Song
6. Facilitator – Historical Trauma, Grief, Shared knowledge/experience (Personal)
7. Introduction of Presenters/Facilitators/Elders
8. Elders - Shared knowledge/experience (Cultural, Personal)
9. Introduction of Participants
10. Presentation - "rules"
11. Lunch
12. Facilitator - Shared knowledge (Historical, Cultural)
13. Small group process - Information presented to this point
14. Facilitator - Shared knowledge (Historical, Cultural)
15. Presentation – Experiencing/Expressing Emotions
16. Presentation - Ancestral Tree

Day 2. Mastery (Faith/Personal Growth)
1. Large group – Construction of Ancestral Tree
2. Facilitator & Elder – Shared knowledge (Spiritual)
3. Facilitator - Shared knowledge/experience (Cultural, Personal)
4. Songs
5. Elder - Shared knowledge/experience (Cultural, Historical)
6. Songs
7. Elder - Shared knowledge/experience (Cultural, Historical)
8. Singer - Shared knowledge/experience (Cultural, Personal)
9. Song
10. Facilitator - Shared knowledge/experience (Cultural, Personal)
11. Song
12. Facilitator - Shared knowledge/experience (Cultural, Personal)
13. Presentation - "rules"
14. Facilitator - Shared knowledge/experience (Cultural, Personal)
15. Song
16. Small groups process – Ancestral Tree
17. Smudge

18. Presentation – Lost History Graph, Life Circle
19. Lunch
20. Ceremony

Day 3. Independence/Generosity (Autonomy/Freedom/Recovery)
  1. Breakfast
  2. Facilitator – Check-in, Shared knowledge/experience (Cultural, Personal)
  3. Songs
  4. Facilitator - Shared knowledge/experience (Cultural, Personal)
  5. Song
  6. Elder - Shared knowledge/experience (Cultural, Personal)
  7. Facilitator - Shared knowledge/experience (Cultural, Personal)
  8. Facilitator – Shared knowledge/experience (Spiritual)
  9. Presentation – Revisited Life Circle
  10. Presentation – Revisited "rules"
  11. Small group process – Life Circle
  12. Large group – Learned song
  13. Small group – Healing Chair exercise
  14. Lunch
  15. Post-intervention data collection

Retreat #2

Day 1. Belonging (Birth/Infancy/Discovery)
  1. Smudge
  2. Breakfast
  3. Songs
  4. Explanation of models
  5. Facilitator shared knowledge/experience (Cultural, Personal)
  6. Introduction of Presenters/Facilitators/Elders
  7. Lunch
  8. Presentation - "rules," confidentiality
  9. Presentation of Historical Trauma - Boarding School Video
  10. Break
  11. Song
  12. Identification of small groups
  13. Small group process – Information presented to this point
  14. Dinner
  15. Smudge
  16. Prayer
  17. Song

Day 2. Mastery (Faith/Personal Growth)
  1. Announcement/Explanation
     - Sweat lodge
     - Praying/tobacco

2. Songs
3. Facilitator shared knowledge/experience (cultural, personal)
4. Elder
   - Joke
5. Break
6. Presentation – Emotion (healthy/unhealthy)
7. Small group process - Smudge
8. Presentation – Ancestral Tree
9. Prayer
10. Lunch
11. Songs
12. Ceremony

Day 3. Independence/Generosity (Autonomy/Freedom/Recovery)
1. Breakfast
2. Smudge
3. Prayer
4. Songs
5. Announcement/Appreciation - Rules
6. Small groups process – Ancestral Tree
7. Presentation – Life Circle
8. Large group process - Life Circle
9. Lunch
10. Small group process – Life Circle
11. Ceremony
12. Dinner
13. Post-intervention data collection

APPENDIX B

TELL US ABOUT YOU

For the questions below, please fill in the blank or circle the correct response. For example, for the question: "Are you male or female?" draw a CIRCLE around 1 if you are female, like this ①

1. **How old are you?**

   Age: _____ years

   Date of birth: ____/____/_____
            mm   dd   year

2. **Are you male or female?**

   Female ……………………………… 1
   Male …………………………… 2

3. **Do you live alone?**

   Yes ………………………............ 1
   No ………………….…..………… 2

4. **Are you employed?**

   Yes …………………………….. 1
   No ………………………………… 2

5. **What is the highest grade in school that you completed?**

   Completed 6th grade or less …………. 1

   Junior high school ($7^{th} – 9^{th}$ grade) …. 2

   Partial high school ($10^{th} – 12^{th}$ grade). 3

   High school graduate or GED …..…… 4

   Partial college training …………….. 5

   Completed college ………………..... 6

   Graduate professional training …..….7

   Other _____ …….. 8

6. **Are you spiritually active in an organized religion?**

   Yes …………………………………. 1
   No …………………………..…….. 2

7. **Are you spiritually active in traditional practices?**

   Yes …………………………………. 1
   No …………………………..…….. 2

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APPENDIX C

Grief History Questionnaire

1. **How many months has it been since the last death you have experienced**? _____
                                                                    (months)

2. **How many deaths have you experienced since 2006 or in the past 5 years?** For example,
   a. Father, I was 56, chronic obstructive pulmonary disease, he was 85
   b. Aunt, I was 57, I don't know what she died from, she was elderly, she was 89, expected
   c. Uncle, I was 58, non-Hodgkin's lymphoma, he was 70, expected
   d. Cousin, I was 55, suicide (he shot himself), he was 57, drinking at the time, Vietnam vet, unexpected
   e. Nephew, I was 55, car accident, he was 21, his 21st birthday, unexpected, drinking
   f. Grandniece, I was 58, pneumonia, she was 2, unexpected

   Be sure to consider all your relationships including family, friends, and community members. After you've listed the deaths you've experienced, please note whether or not the deaths were expected, unexpected, violence related or addiction related.

Relationship	My Age at the time of their death	Cause of Death	Their Age at the time of their death	Expected Yes/No	Violence Related? Yes/No	Addiction Related? Yes/No Alcohol, drugs
Example: Close friend	55	Lung cancer	57	Yes	No	Yes, tobacco

APPENDIX D

Brief COPE Inventory

These items deal with ways you've been coping with grief since the last death you experienced. There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent (How much or how frequently) you've been doing what the item says. **Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it**. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

 1 = I don't do this at all
 2 = I do this a little bit
 3 = I do this a medium amount
 4 = I do this a lot

1.   I turn to work or other activities to take my mind off things.
2.   I concentrate my efforts on doing something about the situation I'm in.
3.   I say to myself "this isn't real."
4.   I use alcohol or other drugs to make myself feel better.
5.   I get emotional support from others.
6.   I give up trying to deal with it.
7.   I take action to try to make the situation better.
8.   I refuse to believe that it has happened.
9.   I say things to let my unpleasant feelings escape.
10. I get help and advice from other people.
11. I use alcohol or other drugs to help me get through it.
12. I try to see it in a different light, to make it seem more positive.
13. I criticize myself.
14. I try to come up with a plan about what to do.
15. I get comfort and understanding from someone.
16. I give up trying to cope.
17. I look for something good in what is happening.
18. I make jokes about things to cope.
19. I do something to think about it less, such as watching movies or TV, reading, taking a drive sleeping, or shopping.
20. I accept what has happened as reality.
21. I express my negative feelings.
22. I try to find comfort in my religion and/or spiritual beliefs.
23. I try to get advice or help from other people about what to do.
24. I am learning to live with it.
25. I think hard about what steps to take.
26. I blame myself for things that happened.
27. I pray or meditate.
28. I remember humorous stories and memories to cope.

APPENDIX E

INTERPERSONAL EVALUATION SUPPORT LIST

This scale is made up of a list of statements each of which may or may not be true about you. For each statement check "definitely true" if you are sure it is true about you and "probably true" if you think it is true but are not absolutely certain. Similarly, you should check "definitely false" if you are sure the statement is false and "probably false" is you think it is false but are not absolutely certain.

_____ definitely true (3)
_____ probably true (2)
_____ probably false (1)
_____ definitely false (0)

1. There are several people that I trust to help me solve my problems.

2. If I needed help fixing an appliance or repairing my car, there is someone who would help me.

3. Most of my friends are more interesting than I am.

4. There is someone who takes pride in my accomplishments.

5. When I feel lonely, there are several people I can talk to.

6. There is no one that I feel comfortable talking to about intimate personal problems.

7. I often meet or talk with family or friends.

8. Most people I know think highly of me.

9. If I need a ride to the airport very early in the morning, I would have a hard time finding someone to take me.

10. I feel like I'm not always included by my circle of friends.

11. There is no one who can help me see how well I'm handling my problems.

12. There are several different people I enjoy spending time with.

13. I think that my friends feel that I'm not very good at helping them solve their problems.

14. If I were sick and needed someone (friend, family member, or acquaintance) to take me to the doctor, I would have trouble finding someone.

15. If I wanted to go for a drive (e.g., to the mountains or country), I would have a hard time finding someone to go with me.

16. If I needed a place to stay for a week because of an emergency (for example, water or electricity out in my apartment or house), I could easily find someone who would put me up.

17. I feel that there is no one I can share my most private worries and fears with.

18. If I were sick, I could easily find someone to help me with my daily chores.

19. There is someone I can turn to for advice about handling problems with my family.

20. I am as good at doing things as most other people are.

21. If I decide one afternoon that I would like to go out to dinner that evening, I could easily find someone to go with me.

22. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.

23. If I needed an emergency loan of $100, there is someone (friend, relative, or acquaintance) I could get it from.

24. In general, people do not have much confidence in me.

25. Most people I know do not enjoy the same things that I do.

26. There is someone I could turn to for advice about making career plans or changing my job.

27. I don't often get invited to do things with others.

28. Most of my friends are more successful at making changes in their lives than I am.

29. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).

30. There really is no one I can trust to give me good financial advice.

31. If I wanted to have lunch with someone, I could easily find someone to join me.

32. I am more satisfied with my life than most people are with theirs.

33. If I was stranded 10 miles from home, there is someone I could call who would come and get me.

34. No one I know would throw a birthday party for me.

35. It would be difficult to find someone who would lend me their car for a few hours.

36. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.

37. I am closer to my friends than most other people are to theirs.

38. There is at least one person I know whose advice I really trust.

39. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.

40. I have a hard time keeping pace with my friends.

APPENDIX F

Thank you for agreeing to consult with me about the relevance and appropriateness of using the Brief COPE and the Interpersonal Support Evaluation List with the (Tribal) community. I look forward to meeting with you at 10:00 am on Friday, April 29, at the Community Action Program room in (Tribal territory town).

Attached to this e-mail are 4 documents:
1. The Brief COPE (BC)
2. An article titled "You want to measure coping but your protocol's too long: Consider the Brief COPE."
3. The Interpersonal Support Evaluation List (ISEL)
4. An article titled "Measuring the functional components of social support."

I would like to structure the consultation in the following manner:
1. Before attending the focus group, please read the BC and ISEL paying special attention to whether or not it fits with the (tribal) worldview.
   a. Looking at each item please respond to the following questions (found on the Inventory)
      1. Could this item be offensive? (Yes or No)
      2. How relevant is this item? (Likert Scale [1 = not relevant, 2 = somewhat relevant, 3 = quite relevant, and 4 = highly relevant])
   b. Please feel free to make notes and bring those with you to the focus group.
2. Please come to the focus group ready to discuss your impressions about the inventory and to respond to the following questions:
   a. What is your overall impression of the inventory?
   b. Do the items on these inventories reflect (tribal) coping and social support?
   c. What's missing?
   d. Because these inventories focus on only one death, how can it be used for individuals who are grieving multiple or layered (one death after another after another) deaths?
   e. Others?

Again, thank you so much for consulting with me on these inventories. I look forward to meeting with you.

Respectfully,

William Shunkamolah M.A.
Clinical Psychology Graduate Student
The University of Montana
Missoula, MT

APPENDIX G

Core Elements of the Grief Retreats

I. **Enculturation**

    A. Transmission of traditional knowledge (stories, experiences, ways)

        1. To establish connection/identity

            a) Person to person

            b) Person to group

            c) Group to group

            d) Past to present to future

            e) Group within group

        2. To teach (i.e., spirituality, history, values, etc.)

            a) Continuation of tradition

        3. To create comfort

            a) Encouragement

        4. To highlight strengths/resources

            a) People (e.g., elders)

            b) Groups (societies, areas)

II. **Education**

    A. Retreat components

        1. Rules

        2. Provision of security/confidentiality

        3. Directions

    B. Historical Trauma/Historical Loss (e.g., Acculturation, etc.)

        1. General theory

         2. Examples from personal life/experience

    3. Examples from family life

    4. Examples from tribe/area

C. Grief/Loss

    1. GRM tenets (e.g., correct knowledge, choosing to recover)

    2. Specific to tribe/area

D. Emotion

    1. Identification/labeling

    2. Expression of emotion

        a) Healthy and unhealthy

        b) Role modeling

        c) Attention to expressed emotion

    3. Effect on behavior

    4. Tolerance

E. Behavior

    1. Helpful and unhelpful

        a) Old and new

    2. Change as a process

    3. Mindfulness/presence in moment

        a) Openness

F. Strengths

    1. Power/freedom

        a) Decision

        b) Action

        c) Identity

        d) Self-esteem

        e) Humor

APPENDIX H

Participant qualitative themes (pre-intervention)

Seeking
- Healing
- To deal with death
- To get most out of intervention/retreat
- To be more open
- Emotion regulation

Emotions
- Internalized
- Resentment
- "Hardened heart"
- Anger

Expression of emotion/thoughts
- Avoidance
- Withheld/Does not share

Thoughts
- Grief/loss reason for substance use
- People of area are grieving and do not know it

Behavior
- Return to reservation 1 year after a death
- Aggressive toward others

Personal History
- Grew up in fostercare
- Abuse

- Family use of substances to cope with grief/loss

Deficits
Coping
- Unable to attend a funeral
- Never let self grieve

Knowledge
- Confused about what grieving over

Support
- Lack of support/felt abandoned
- Lack of family stability

Strengths
- Knowledge/experience dealing with previous loss
- Traditional knowledge about grieving period
- Attendance in other retreats

Death specific
- Loss of important family member
- Caretaker of deceased/health issues
- No close loss
- Death of estranged parent
- A lot of loss

Participant qualitative themes (post-intervention)

Tribal oriented
- Social support
- Spirituality
- Traditions

Retreat oriented
- Components and format
- Leadership
- Previous retreat participation

- Knowledge
  - Identity
- Exploration
  - Discovery
    - Growth (e.g., tolerance)
- Action
  - Plan/desire to continue

Effect
- Openness
  - Expression of emotion/process

APPENDIX I

Tables

Table 1.

Data collection schedule of the (larger project and the) current project*

Measures	Pre	Grief Retreat (Intervention)	Post		
	Time 1 1st day		Time 2 1 day >	Time 3 1 mo >	Time 4 3 mo >
Demographic	X				
Grief History Questionnaire	X				
Grief History Questionnaire: Follow-up 1. Have you experienced another death since the Grief Retreat? or, …in the last 2 months?				X	X
Qualitative Questions: 1. What was helpful? 2. What do you wish was included?			X		
Historical Trauma					
Historical Loss Scale (HLS)	X		X	X	X
Historical Loss Associated Symptom Scale (HLASS)	X		X	X	X
Traumatic Grief					
Inventory of Traumatic Grief (ITG)	X				X
Resilience/Coping					
*Brief COPE Inventory (BC)	X		X	X	X
Brief Resilience Scale (BRS)	X		X	X	X
*Inventory of Support Evaluation List (ISEL)	X		X	X	X
Psychological					
K-6 (PDS)	X		X	X	X
Positive and Negative Affect Schedule (PANAS)	X		X	X	X
Approximate time to complete the packet	50 min		35 min	40 min	50 min

Table 2.

One-way ANOVA and effect size summary for Brief COPE Subscales

BC Subscale (T1-T4)	n	df	F	p	$\eta\rho^2$
Positive Reframing	10	3, 27	.069	.976	.008
Acceptance	10	1.77, 15.96	.593	.545	.062
Humor	10	2.59, 23.34	.702	.541	.072
Using Emotional Support	9	2.56, 20.50	1.07	.377	.118
Self-distraction	8	2.00, 14.03	.324	.729	.044
Substance Use	10	3, 27	3.89	.020*	.302
Self-blame	10	1.99, 17.87	1.23	.315	.120

*$p < .05$

Note: Cohen (1992) suggested the use of .10 as representative of a small effect size, .25 to represent medium effect size, and .40 to represent a strong effect size. Ferguson (2009) suggested the use of .04 as the minimum value representative of a "practically" significant effect size, .25 to represent moderate effect size, and .64 to represent a strong effect size within social science research.

Table 3.

One-way ANOVA and effect size summary for Interpersonal Support Evaluation List Overall and Subscales

ISEL Total and Subscale (T1-T4)	n	df	F	p	ηρ²
Overall Support	7	1.97, 11.82	1.26	.319	.173
Appraisal Support	10	3, 27	.399	.755	.042
Tangible Support	9	2.01, 16.08	.822	.458	.093
Self-Esteem Support	9	1.82, 14.68	.458	.624	.054
Belonging Support	9	3, 24	1.56	.224	.164

Note: Cohen (1992) suggested the use of .10 as representative of a small effect size, .25 to represent medium effect size, and .40 to represent a strong effect size. Ferguson (2009) suggested the use of .04 as the minimum value representative of a "practically" significant effect size, .25 to represents moderate effect size, and .64 to represent a strong effect size within social science research.