

# APPLYING A CULTURAL MODELS APPROACH TO AMERICAN INDIAN SUBSTANCE DEPENDENCY RESEARCH

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*Abstract: The cognitive anthropological method of deriving cultural models from ethnographic discourse analysis is illustrated in relation to case studies yielding nativistic insights regarding American Indian substance dependency and recovery. Discussion focuses on the broader applicability and local community relevance of incorporating cultural models directly into the design and implementation of prevention and intervention programs. Such an approach may benefit local community cultural revitalization efforts while enhancing the cultural relevance and effectiveness of substance abuse programs.*

In cognitive anthropology, *cultural models* have been defined by Quinn and Holland (1987) as “presupposed, taken-for-granted models of the world that are widely shared (although not necessarily to the exclusion of other, alternative models) by the members of a social group and that play an enormous role in their understanding of that world and their behavior in it” (p. 4). Keesing (1987) adds that such models “comprise the realms of (culturally constructed) common sense,” serving a pragmatic role as “models of everyday reality” (p. 374). Cultural models research in current cognitive anthropology generally utilizes ethnographic interviewing along with discourse analysis, participant observation and statistical techniques such as multidimensional scaling in order to uncover and represent composite cognitive models of subject groups in alignment with a connectionist theory of cognitive processing (Strauss & Quinn, 1994). Some notable examples of cultural model analysis reported on in the anthropological literature include Holland and Skinner’s (1987) study of folk semantics and related behavioral schemas associated with vernacular gender terms by a population of college undergraduates, D’Andrade’s (1995, pp. 152-157) discussion of Gladwin’s (1970) account of Caroline Islanders’ model of sea navigation by triangulating the position of various

constellations with points of origin and destination conceived of as in motion relative to a static canoe, and Johnson's (1987) examination of body metaphors from a cross-cultural perspective. More informal theoretical conceptions of folk, 'emic' or cultural models have been represented in many ethnographic works, including particularly in medical anthropology (e.g., Schepher-Hughes, 1984) and cross-cultural psychological research (e.g., Hsu, 1985; Kleinman, 1980, 1986; Levy, 1973; Shweder, 1985).

Representations of cultural models in current cognitive anthropology provide simplified, schematic models of collective mental constructions of some aspect of everyday life. They are derived from qualitative interview data and represent common sense knowledge schemas more or less shared by a culturally related group of subjects and considered to inform appropriate, culturally situated behavior. Such models are not necessarily articulated in consciously coherent accounts by individual informants, yet to be considered culturally valid and relevant the models should be intuitively correct and satisfying to at least a representative sample of persons interviewed and, at best, to other persons from the same socio-cultural group. A cultural model seeks to account for culturally relevant knowledge schemata of at least some segment of a community pertaining to a particularly meaningful and culturally salient domain of their everyday experience.

This paper reports primarily on findings from two ethnographic studies conducted by the author that have yielded American Indian-based cultural models of substance dependency and recovery: one based on interviews with clients at a progressive American Indian rehabilitation clinic in Phoenix, the other constructed from interviews with youths at a New Mexico pueblo community. In addition, some other American Indian cultural models pertaining to substance dependency and recovery that are being used in nativistically designed prevention and intervention efforts will be discussed. The main objectives of this paper are to consider the value of incorporating global and/or local cultural models directly into prevention and intervention efforts and to illustrate a technique of ethnographic discourse analysis useful in deriving local models.

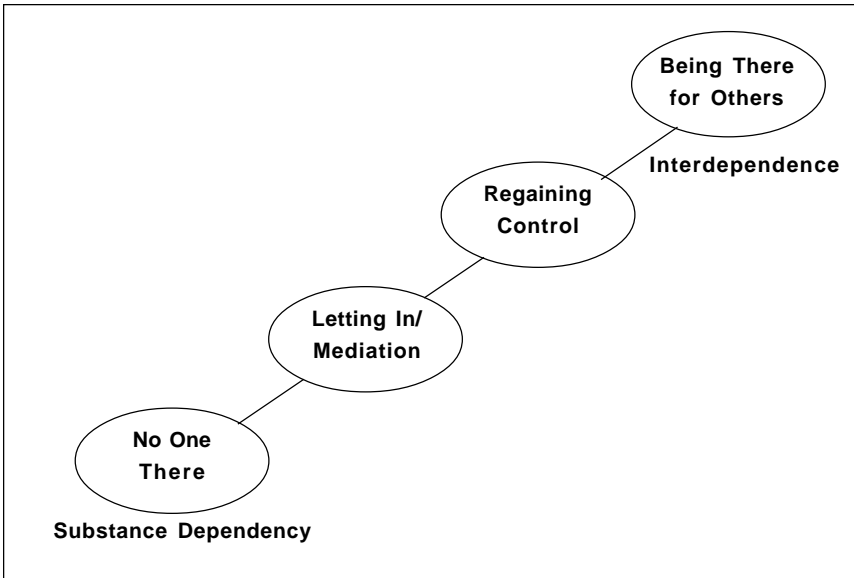
### **The Phoenix Indian Rehabilitation Center and Guiding Star Lodge**

The first ethnographically derived model to be considered was constructed on the basis of qualitative interview data obtained from 58 American Indian clients mainly at two residential treatment facilities in Phoenix, Arizona, one for men and the other for women and both administered by the same organization. Individual interviews were conducted near the end of a three-month treatment program as an addition to a series of two sets of quantitative interview instruments administered at the start and near the end of clients' programs (Gutierrez, Russo, & Urbanski,

1994). Clients were from fifteen tribes representing a wide cross-section of contemporary American Indian communities and lifestyles. There were 30 males and 28 females interviewed. The mean age was 28.5 years.

Informants were asked to discuss the factors that, in their own view, had led to their problems with alcohol or drugs; factors that had most helped them to overcome these problems; and advice that they would share with young persons beginning to experience problems with substances. Interview data were coded for recurring response patterns, revealing several salient themes. Analysis of interrelationships among these salient themes allowed the derivation of a cultural model (Watts & Gutierrez, 1997) of the form that Quinn and Holland (1987, p. 32) identify as a “prototypical event sequence” involving four stages. These stages are represented as cyclical in nature, since there is always a recognized risk of relapse or falling back into the inertia of any given stage within the overall cumulatively positive process. Figure 1 illustrates the cultural model that emerged from these interview data.

Figure 1  
An American Indian Based Cultural Model of  
Substance Dependency and Recovery



The primary factor mentioned as having led to the development of substance dependency was some significant person or persons “not being there” during a critical stage of an informant’s early family life, either because of a broken family situation, parental figures who were themselves

substance dependent, or the significant loss of a close family member due to divorce or death. Almost every informant also spoke in similar terms of the later importance of some particular person, usually an elder family or community member or else a close friend, “being there” for them and speaking out consistently against their drinking until, at a critical stage of either maturation or recognition of the damage substance use was doing to themselves or to others, they could finally “let in” these good role models’ advice—and often their direct interventive assistance—and finally take steps toward “regaining control” over the otherwise overwhelming influence of the substance. According to this prototypical event sequence, informants expressed the view that eventually (i.e., after successfully completing the treatment program and returning to their communities) they would be in control of their own lives again and would be able to “be there” as good role models for others.

Substances themselves, especially alcohol, were often regarded in these interview data as potent agencies in and of themselves, to which the informant had relinquished autonomy. This was evident through linguistic analysis. The noun *alcohol* (most often substituted for in English simply by the pronoun *it*) was almost always employed in data about factors causative to the subjects’ problems with substances as an agentive nominal argument; that is, as the active subject of a transitive verb. For example, an informant I will name Denise’s advice to young people was: “...*it* will take your life and *it* will take the good part of you, your self-esteem and all that.” Another informant, Michael, stated: “The more I did, the more *it* got me into trouble and put me on probation.”

Traditional American Indian belief systems from many tribal backgrounds emphasize the powerful, even animate character of certain substances, including natural substances used in ceremonies such as sage, sweetgrass, tobacco smoke, jimsonweed, and peyote. Smoking native tobacco in a sacred pipe ceremony is a sacrament in the sweat lodge ceremony associated with purification as a form of communion (Steinmetz, 1984, p. 47). Peyote is clearly regarded by many Native American Church practitioners as a positive agency in and of itself (Aberle, 1966, pp. 213-214). Natural forces such as medicine powers, thunder and lightning are also often recognized as having both potentially helpful and harmful influence as potent agencies. When peyote is referred to as “Old Man (or Grandfather) Peyote,” that is intended as a literal statement. When a Navajo speaks of succumbing to the deleterious influence of natural forces or to less intelligent beings, it is recognized that such agencies “cannot control or act upon beings of higher intelligence unless the beings of higher intelligence willfully or inadvertently yield to the control of beings of lower intelligence” (Witherspoon, 1977, p. 77). Thomas, for instance, a middle-aged client at the Phoenix facility who had been in and out of prison for some twenty years from alcohol related charges, characterized his relationship with alcohol as follows: “...*It’s* cunning, baffling and powerful,

and *It's...* the worst thing that you can ever get into...When you think you're dominating the alcohol, you're going to find out in the long run that *It's* going to be dominating you." The fact that Thomas makes this statement as an almost verbatim quote from The Big Book of Alcoholics Anonymous (Alcoholics Anonymous, 1976, pp. 58-59) reflects his involvement with the Alcoholics Anonymous (AA) program at the Phoenix center, but it is noteworthy that the material quoted pertains so closely to nativistic conceptions.

American Indians from many tribal groups regard intoxicated individuals as not being in autonomous control and hence as not to be considered by community members as responsible for their behaviors while they are, quite literally, under the influence of alcohol or drugs. Bea Medicine has reported for the Lakota that intoxicated persons may be referred to as *t'an ables ya han*, translated as "gone" or "not at home" (Medicine, 1983, p. 128). The nativistic cultural model of interaction with alcohol or drugs expressed in these interview data characterizes a process of moving from *relinquishment of control* to *letting in* advice and *mediation* for help in *regaining control* to achieving *interdependence*. This is quite distinctive from the schema of progressing from *addiction* to *recovery* in the western medical model wherein alcoholism is regarded as an illness associated with biochemical effects. In traditional American Indian spiritual practices a medicine person or shaman might intervene on behalf of a person understood to have succumbed to the deleterious influence of a potent substance or force, though the person succumbing to this influence might be conceived to have brought this condition upon himself or herself by wrongful conscious or unconscious actions (e.g., Bahr, Gregorio, Lopez, & Alvarez, 1974). Likewise in these interview data, it appears significant that the turning point from relinquishing control toward reclaiming autonomy and interdependence is almost always reported to involve a familial or community elder or close friend who assumes a directly interventive, though not "pushy," *mediational* role on behalf of the substance dependent person. Extended family or communal role models were often reported to have stepped in to assist a person in connecting with a treatment program. Such mediators were said to have provided constant and persistent support both before and throughout the 'recovery' process. This role of the familial/elder mediator draws upon community-based cultural constructs associated with extended family seniors, spiritual advisers, and shaman-type healers.

It should be noted that the Phoenix treatment program utilizes a twelve-step based AA counseling program along with several traditional American Indian spiritual treatment modalities, including participation in sweat lodges and talking circles, visits by American Indian spiritual advisers, and attendance at local cultural events such as powwows. In addition, a component of this program that has been found to contribute to an unusually high rate of completion by clients (Gutierrez, Russo, & Urbanski, 1994, p. 1779) is the participation of family members. At the women's facility,

children are allowed to stay with their mothers throughout the program, and at both facilities, spouses or other family members are encouraged to live in the local vicinity during the course of the program or to visit or call often to communicate while the client resides at the facility.

Clearly the traditional treatment modalities mentioned above are concordant with the cultural model uncovered in this study. The direct involvement of close family members along with talking circles and shared ceremonial participation provide a familial and community-oriented context consistent with the themes of *being there*, *letting in*, and *mediation* considered crucial to facilitating the process of *regaining control* and *interdependence*. The sweat lodge and visitations by spiritual advisers further facilitate the mediation process during ceremonies wherein alternative, positive substances (e.g., sage, smoke, and cedar) and shamanistic-type spiritual advisement are employed to strengthen the individual's ability to regain control over the harmful substances.

A policy recommendation for intervention strategies based on this cultural model is that the role of the counselor and of the "buddy" or "sponsor" in an AA program might be directly patterned after locally defined familial/elder mediator roles. While the standard, western-based Alcoholics Anonymous program attributes a sense of powerlessness (viz., loss of autonomy) to character defects within the individual which the addict must first confront internally and then correct by a powerful act of will aided by acceptance of a morally superior higher power (Alcoholics Anonymous, 1967, p. 327), the American Indian based cultural model discerned in the Phoenix study places responsibility for relinquishment of control not directly on the individual but rather more so on family or community disturbances such as poor role-modeling or broken family conditions. Recognition of the relinquishment of control and then acceptance of advice and/or direct mediation is required for a substance-dependent person to regain control and achieve interdependence. Mediators (both human and positive, non-human agencies) assist the substance dependent person to raise impaired self-esteem and to regain control over the harmful substance so that s/he might again be capable of being integrated as a positive role model in the family and community. Thomason (1991, p. 322), who describes an American Indian model of healing to educate non-Indian counselors, points out that to many American Indian clients with traditional backgrounds, it may be that "curative powers are assumed to lie with the healer, not the patient." Thomason also recognizes the mediational role of family and community members. He notes that since psychological disorders such as those connected with substance dependency may be considered traditionally as being "rooted in the community" (Thomason, 1991, p. 322), then "the extended family, friends, and neighbors are mobilized to support the individual and get them integrated into the social life of the group." Many community based prevention and treatment programs serving American Indian communities already incorporate this traditional mediator

role into their programs simply by employing locally respected spiritual advisers and medicine persons as part of their regular staff and by providing access to positive agencies in traditional ceremonies. Further, employing former substance dependent persons as individuals who have successfully confronted the same difficulties and emerged victorious has often been found helpful in imparting a positive motivation for clients (e.g., Ben, Lansing, & Dereshiwsky, 1992; Edwards & Edwards, 1988; Hall, 1986; Kahn, Lejero, Antone, Francisco, & Manuel, 1988).

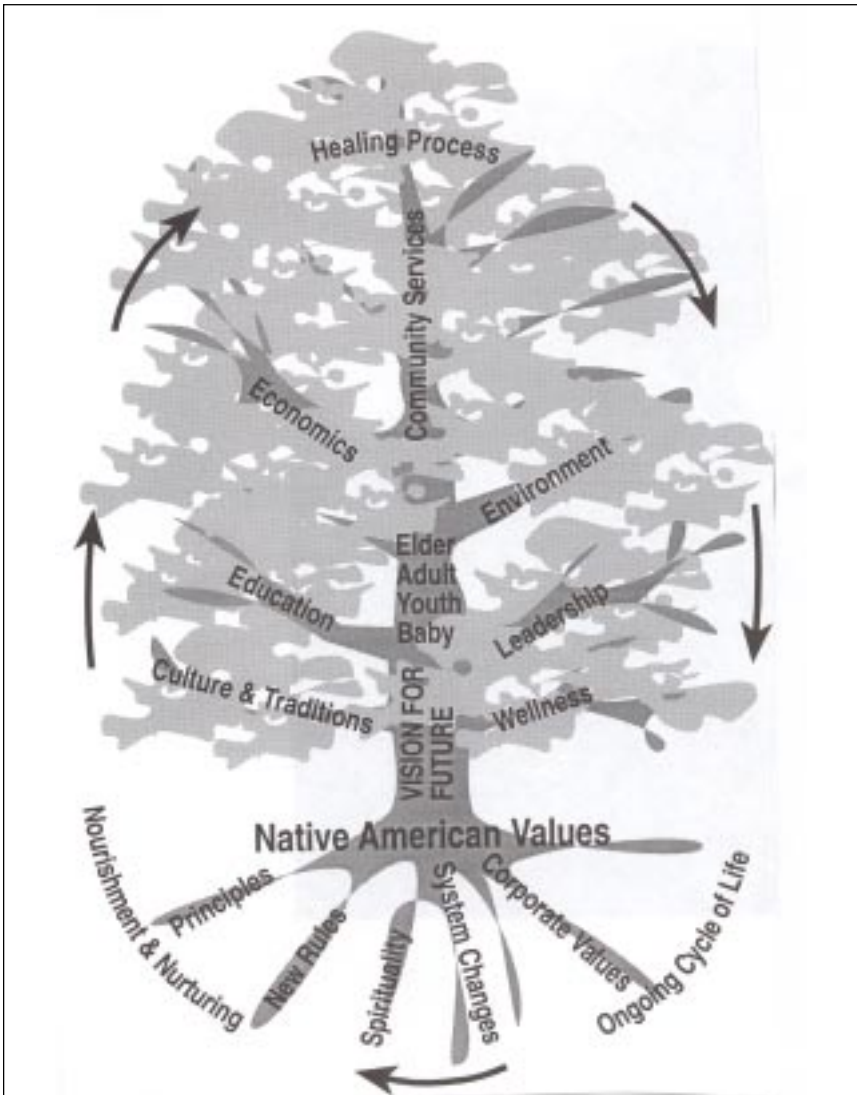
#### **The Medicine Wheel and Healing Forest Models of White Bison, Inc.**

After completing the Phoenix project and deriving the cultural model presented above, the author learned of a substance dependency treatment program based on the concept of the Medicine Wheel that matches phase for phase the four cyclic stages identified in the Phoenix study model. Don Coyhis and Richard Simonelli of White Bison, Inc. have somewhat revised and grouped the twelve steps of a standard AA program into four sets of three, associating each set of steps with a seasonal character (i.e., spring, summer, fall, and winter). These seasonally identified stages correspond closely with the four phases identified by clients at the Phoenix facility described in Figure 1 (Simonelli, 1993; Watts & Gutierrez, 1997, p. 16). Generally, steps associated with the east involve the process of coming to recognize the Great Spirit as *being there* “to help us regain our responsibilities and model the life of our forefathers” (Simonelli, 1993, p. 2). Steps associated with the south involve *letting in* helpful advice by opening oneself to one’s place in the circle of life, admitting weaknesses, and praying to the Creator for intercession. The west directional steps involve *regaining control* via mediation, as the individual gains strength through reliance on the Great Spirit’s assistance and actively makes amends for weaknesses while practicing sobriety. The north stage involves *being there for others*, as the individual maintains a life of no longer being dependent upon alcohol or drugs and actively engages in “sharing the message of these steps with others.”

Coyhis, a Mohican, has developed another cultural model of healing used in conjunction with the Medicine Wheel approach which he calls the “Healing Forest” model. White Bison, Inc. utilizes this approach in consulting with American Indian communities to assist their implementation of community-based substance dependency recovery programs. The Healing Forest program starts with the premise that an ailing individual tree, once healed and returned to a forest where the soil remains diseased, will become diseased again itself. A forest cannot heal unless harmful elements present in its soil are removed and replaced with healthy elements. Accordingly, as illustrated in Figure 2, the Healing Forest program engages various segments of an American Indian community, from political

and service sector agencies to school and family units, in a comprehensive program involving talking circles, the construction of individual and group mind-maps, and other workshop modalities. The purpose is to ‘weed out’ deleterious, non-traditional concepts seen as polluting the community value system and to replace these by re-instilling traditional cultural values in keeping with a specific, collectively agreed upon community vision.

Figure 2  
 The Healing Forest Model of White Bison, Inc.  
 (From Wocawson, 1994, p.3)





The White Bison program further employs traditional concepts which Coyhis refers to as “Four Principles (or Laws) of Change” to implement the Healing Forest and Medicine Wheel models (Simonelli, 1993). These are: (a) change is from within, (b) vision brings development, (c) a great learning needs to occur, and (d) a Healing Forest must be created. The program assists communities in first establishing a seed vision and then following through to nourish and bring that seed to fruition.

The Healing Forest program has been so successful in its implementation among the Passamaquoddy peoples in Maine that within the first ten months the program claimed a greater than 60% sobriety recovery rate for local participants (Coyhis, personal communication; see Wocawson, 1994). The Medicine Wheel and Healing Forest models both demonstrate the value of applying some relatively global (i.e., pan-tribal) cultural models directly to the design and implementation of prevention and treatment programs. American Indian traditions provide a naturally rich source of concepts, ceremony, and inspiration to draw from in designing culturally relevant prevention and intervention strategies. The more directly these concepts and practices can be incorporated into programs specifically designed for American Indian clients or in American Indian reservation communities, presumably the greater will be their effectiveness.

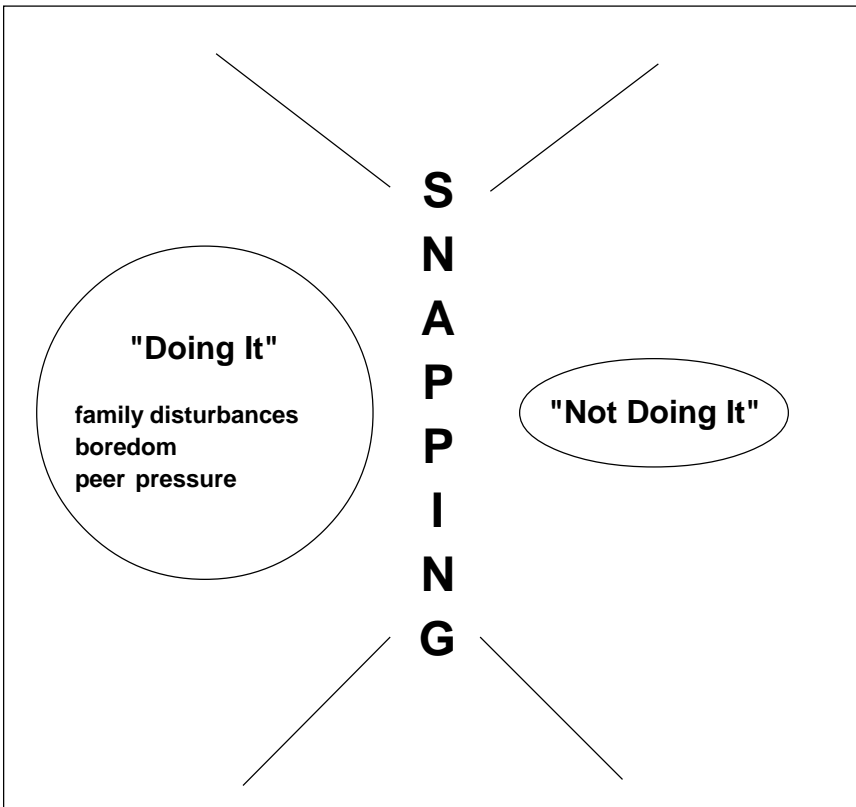
### “Doing It” and “Snapping”

A second ethnographic interview project that resulted in a local cultural model of substance abuse and recovery was conducted by the author at the New Mexico pueblo of Santa Clara in 1995. Results from this study suggest the value of incorporating a specifically *local* cultural model of substance abuse and recovery in prevention or intervention strategies (Watts, 1996). The data in this study included demographic and qualitative interview data collected from nine young persons (ages 10 to 21) who served as a representative sample of youth selected from a summer youth work program at the pueblo, along with documentary information on 21 additional community youths who had been admitted to a Youth Emergency Shelter because of substance-related incidents between 1991 and 1995. The qualitative interview schedules included questions similar to those used in the Phoenix study along with questions concerning family background situations and the matter of youth gang involvement at the pueblo.

Findings revealed a high rate of prevalence of the use of controlled substances by seven of the nine youths sampled and within their families, indicating high risk for youth in general at the pueblo, granting that this conclusion is based on a small, pilot study sample. Several factors emerged particularly from the qualitative interview data that allowed construction of a local cultural model (Figure 3). Attributions of situations

contributing to substance dependency were expressed quite similarly as in the Phoenix study, with most of these youths mentioning broken family situations as the most highly significant factor involved in the development of their own use of illicit substances. Six of the nine informants also reported *boredom* as a significant factor along with *emotional stress*. Their characterization of the use of substances generally was summed up in a local community idiom: "doing it." Several of the youths interviewed used this expression as a means of talking about their own drinking or drug use. While broken family situations, stress, and boredom emerged as the major factors attributed as contributing to the phenomenon of "doing it," peer pressure, mainly expressed in terms of gang participation, was also frequently mentioned. Several of the youths reported that they participate in gangs mainly to protect themselves from members of other gangs, and substance use was reported as very high at gang activities. Youths who expressed little knowledge of gang activity still acknowledged peer pressure as a significant influencing factor.

Figure 3  
A Local Vernacular Cultural Model



Along with the colloquial concept of “doing it” as a cultural theme among youths within this particular pueblo community, another distinctive theme that emerged as salient within the interview data was a phenomenon referred to as “snapping.” After noting this term as being used similarly by several of the youths, I asked directly for definitions in follow-up interviews and discovered that the local use of this expression is apparently quite different from the notion inherent in Anglo usage. Rather than meaning “going over the edge” or losing control over one’s actions—which is what ‘snapping’ generally refers to in Anglo parlance—youth interviewed at the pueblo used the term to refer to something similar to what Phoenix informants had called “letting in.” “Snapping” was defined locally as a matter of “finally seeing the light.” One girl clarified the phenomenon rather succinctly, explaining: “Like you realize what you’ve been doing; where you catch yourself doing something.” After “snapping” occurs, these youths said, a person may choose to simply stop using alcohol or drugs and instead make major, positive life changes.

A summary of the cultural model of “doing it” derived from this study is illustrated in Figure 3. Family problems creating stressful situations, along with general boredom based on there being little in terms of community activities or recreational facilities at the pueblo, leads to “doing it” as an acceptable youth activity heightened by peer pressure and gang participation. Youth who stop “doing it” are reported to have commonly first experienced the phenomenon of “snapping,” whereby some event occurs such as their ending up in a hospital, knowing a relative who has been hospitalized, or hearing of a catastrophic event which has befallen a family or community member as a direct result of excessive alcohol or drug use. Such events were said to have made the youth suddenly fully aware of the negative consequences of “doing it” and brought upon the locally recognized phenomenon of “snapping.” Where “snapping” has not occurred, youth generally said they acknowledge that “doing it” is acceptable social behavior in that it may appear to effectively help youths deal with the situations of boredom and emotional stress that are a part of everyday life experience at school and at home in the community.

One recommendation based on the cultural model obtained from this study was directly called for by the youths interviewed. Recreational facilities might be established as “drug free zones” at the pueblo in order to counter the youths’ perceived experience of boredom. Several informants specifically expressed a desire to have a park developed in the community that would be designated as a drug-free and alcohol-free area. Youth activity groups focused on traditional crafts or special interests or hobbies supervised by older youths or local elders was another practical recommendation suggested, to offset the motivation for gang involvement within the community.

Other recommendations based on this study that could help in applying the cultural model obtained by developing a locally relevant prevention and intervention program could include:

1. Production of videotapes presenting the stories of local or otherwise well-known individuals who have experienced the ravages of substance dependency in their own words. Such videotapes might be discussed in talking circles with youth, treatment facility staff or counselors, family members and elders in order to facilitate the “snapping” phenomenon.
2. Ethnographic research concerning traditional modes of dealing with substance addiction. Ethnographic sources about the pueblo, for instance, revealed that around the turn of the twentieth century, alcohol abuse was treated as a serious matter that was dealt with internally by local medicine persons. Reintroducing traditional methods of counseling substance dependent individuals could be a helpful means of addressing the contemporary situation.
3. Reintroduction of a specific, traditional form of family conflict resolution that involves allowing all points of view to be expressed and listened to respectfully, sometimes including mediating members of the extended family to reinforce fairness. Three of the youths interviewed—specifically the three informants least involved in the use of alcohol or drugs at the time of the interviews—reported that this practice in their families had been a very strong preventive or interventive factor. Ethnographic sources reveal that as late as the 1950s, there was a cultural tradition within this pueblo of bringing in extended family members or respected community elders to directly mediate family disputes. Here is an example of how reintroducing traditional values and practices could potentially have a positive impact on reducing the ravaging effects of substance dependency on families and their wider communities.

## Discussion

The construction of cultural models on the basis of discourse analysis of open-ended interview data provides a fairly simple and direct means of deriving locally relevant, culturally sensitive treatment constructs for implementation in substance dependency programs. Programs targeted to address the specific local needs of ethnic communities stand to benefit by ethnographic research that examines prototypical cultural conceptions regarding involvement with alcohol and drugs, traditional manners of dealing with problems of addiction, and sociological and psychological patterns culturally attributed to the development and recovery from substance dependency.

The way local people talk about and understand substance dependency and recovery may illuminate not only ways by which members of a particular speech community tend to regard the difficult issues involved

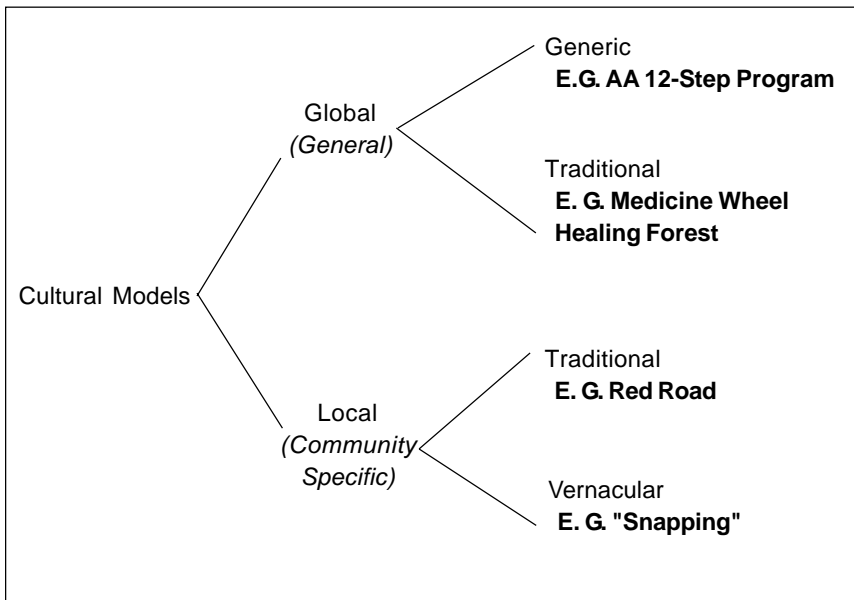
but may also suggest locally recognized prevention and recovery strategies with which they are familiar and, in that sense, with which they might be more comfortable participating than with externally introduced strategies (Thomason, 1991, p. 325). Furthermore, program designers and staff who are themselves members of the ethnic population they serve can utilize their own cultural knowledge more effectively by utilizing local cultural models as a means of incorporating local knowledge and traditional practices into their programs. This may allow better communication of program objectives and policy design in a collaborative framework inclusive of the knowledge and key experiences of members of the practitioners' own local communities in accordance with the vision and perceived objectives of individuals within that community. As Coyhis emphasizes from American Indian teachings in the Healing Forest workshops (Simonelli, 1993): "When the people lead, the leaders will follow" (p.1).

A distinction which might prove helpful in considering the application of a cultural models approach based on the examples herein as well as in the large, growing literature of program designs and research relating to American Indian substance dependency is a distinction between *global*-level and *local*-level cultural models. Figure 4 presents a typology of cultural models based on this distinction. The Medicine Wheel as articulated by Coyhis and Simonelli or as variously employed by others is an example of a *global traditional* model that has pan-tribal significance and, for many, perhaps also a revitalizing appeal. Though associated historically mainly with Sioux and some other Plains tribes' ceremonial traditions, certainly the seasonally based medicine wheel model has a pan-Indian contemporary significance for a wide range of tribal groups. The sacred significance of the four-season cycle and four colors are nearly universal symbolic motifs in American Indian cosmology.

An example of a *global generic* cultural model, i.e., one presented as trans-cultural in application and relevance, is the 12-step program in its various formats developed by Alcoholic Anonymous. This has certainly been a powerful tool used effectively in many programs treating American Indian clientele, often modified or supplemented with traditional models.

*Local* cultural models can also be further distinguished as being either of *local traditional* or *local vernacular* type. The "snapping" model derived from the interview study with youth at Santa Clara Pueblo is an example of a local vernacular model, as is the four-phase model uncovered in the Phoenix study. Some informants at the Phoenix facility from Hopi Pueblo also spoke in terms of another local traditional model when speaking of the abuse of deleterious substances as "taking a wrong path or road" versus "the right road" of sobriety. This latter schema may also be understood to correspond with a more generic traditional model of "walking the Red Road" (Wocawson, 1994, p. 31).

Figure 4  
A Typology of Cultural Models



Finally, in designing prevention and treatment strategies, one might wish to consider which sorts or levels of cultural models are more culturally relevant or will be potentially more effective for a specific community setting or client base. Global generic models may require significant modification in order to be culturally relevant for a specific ethnic group or within a particular community setting. Traditional models, of either local or global origin, may have more appeal especially in a reservation community, for instance, where they might serve the purpose of enhancing or augmenting pan-Indian identification and traditional, nativistic value systems as well as fitting well within local cultural revitalization programs. Local traditional models may be employed to reintroduce and revitalize some ancient traditional concepts and practices. Local community elders might be consulted in clarifying traditional customs and practices associated with such approaches, or they might be directly enlisted to assist with teaching about these traditions within the community or treatment facility. There is an added value to conducting community-based ethnographic research to derive local vernacular models in that there may be the opportunity to address the immediate life experiences of community members in very contemporary terms in the vernacular of local experience.

The significance of global models generally—as perhaps with cultural models on the whole—is that they represent, often in mythic heroic terms, a “path;” i.e., a process with an entry point, a fairly well delimited set

of stages or conditions for change and growth, and, perhaps most importantly of all, an exit or emergence place leading out of the turmoil associated with the hardships undergone in the passage. All of the models discussed herein represent a process of learning, maturation, growth, and positive transformation of consciousness. They represent, in anthropological terms, rites of passage whereby an individual, family, or community may be understood to undergo a series of ordeals, learning to meet challenges associated with those ordeals in traditionally prescribed ways or by appealing to traditional practices, sacred assistance, and wisdom. By appropriately meeting the obstacles described by a model, persons may aim to emerge from those ordeals victorious and stronger for having undergone them. Such positively oriented cultural schemas may in fact help afflicted persons or groups to look beyond the immediately painful difficulties of their personal situations and to undertake a patterned 'road to recovery' that may readily be shared with others of their own community or ethnic heritage who have undergone similar experiences and who have sometimes succeeded in negotiating similar hardship.

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