“WE ARE HUMAN BEFORE WE ARE LABELS” TRANSFIGURING TESTIMONIOS WITH ADVENTURE THERAPY. AN EXPLORATORY STUDY TO RE-SHAPE MENTAL HEALTH STORIES WITH HISPANIC ADULT WOMEN IN A SUBSTANCE ABUSE TREATMENT PROGRAM.

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ABSTRACT

By employing a counternarrative approach, this phenomenological research analyzes the extent to which testimonios might be used in Adventure Therapy to challenge existing colonial interpretations of adult Hispanics, Latina/xs and races outside of deficit frameworks with co-occurring disorders residing in addiction treatment program. The terms Hispanic and Latinx are used interchangeably to identify racial identity, but it is important to note the term Hispanic was primarily used by the participants. Nonetheless I weave in Latinx to place an emphasis on intersectionality. I use testimonios as a qualitative method to amplify women's voices rather that impose labels of mental illness used in scientific psychiatry to illuminate the transformation of cultural hybridization. My research concerns holistic, culturally congruent, and trauma-informed therapeutic approaches grounded in decoloniality that counters the deficit-framing of the medical model and reclaim the voices of people diagnosed with co-occurring disorders.

I argue by defining diagnostic labels of mental illness place an emphasis on "othering" rather than taking a person-centered approach. A person-centered approach views the human before defining labels. To counter this othering, I weave in testimonio as a method with mental health to elevate the participants voices, as an informant asserted, "We are human before we are a label." Additionally, this research moves beyond statements to praxis, examining how accountability can guide deep implementations of culturally responsive care that honors the experiences of Hispanic women beyond surface-level adjustments to Western medical standards. Hence, decolonial epistemology works towards reclaiming mental health narratives by addressing the therapeutic intervention of Adventure Therapy. The resulting approach recenters Latina/x voices and lives that have infused the outdoors for decades. Even more importantly, the adoption of a decolonial approach in adventure therapy results in a strength-based perspective

when examining mental health that counters myths about how "high risk" youth use the outdoors.

As a result of implementing this combined approach, the thematic analysis with 11 participants yields four key themes: 1) challenges to mental health included trauma and unhealthy responses to trauma, 2) mental health was associated with holistic wellness, self-awareness, and self-determination, 3) adventure therapy taught coping skills, built confidence, regulated emotions, and brought enjoyment, and 4) healing meant gaining or regaining self-determination and self-acceptance. Through narratives, these findings demonstrate the ability to reframe mental health narratives about Hispanic women diagnosed with mental illness.

In conclusion, this dissertation addresses significant research gaps in the implementation of social justice work within the field of Adventure Therapy by spotlighting theories and methods. To illustrate, I intertwine Gloria Anzaldúa's stages of conocimiento with Adventure Therapy, to uplift voices of Latinx/Hispanic communities and illustrate the potential for collaboration across the humanities and social sciences.

Key Terms: Adult Women, Latinx, Hispanic, Substance Abuse and Mental Health, Adventure Therapy

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LIST OF ABBREVIATIONS

AT	Adventure Therapy
CBMHS	Community Based Mental Health Services
EBP	Evidence Based Practice
IRB	Institutional Review Board
NASW	National Association of Social Work
PLTP	Powerful Lives Transforming Program (pseudonym for treatment prog)
SBA	Strength Based Approach
SFBT	Solution Focused Brief Therapy
TAP	Therapeutic Adventure Program
TIA	Thriving and Persevering (pseudonym for outdoor activity program

INTRODUCTION

"Testimonialistas narrate their own stories and also challenge dominant notions of who can construct knowledge" (Delgado Bernal et al., 2016, p. 4). In this exploratory study I investigate the perceptions of mental health and the outdoors with adult primarily Hispanic women by applying a cultural analysis across social sciences and humanities with a commitment to self-discovery and collective testimonios. I use testimonio to illustrate collective voices that amplify mental health in Latinx communities. The intention of *my* testimonio is to spotlight the important role that my father played in my life which has resulted in my advocacy and passion for mental health. While mi testimonio is one perspective I share the story as an act of cariño y esperanza that works towards shifting assumptions of mental health both inside the Latinx community and outside the Latinx community. This testimonio is presented in honor of mental health across identities.

In 2020, I virtually presented on "*Community is at the heart of what keeps us together*" as an ActivatEE Speaker for the Association of Experiential Education International Conference to call attention to mental health and how it was coped with in my home. Mi testimonio that follows begins during the pre-adolescent phase of life, then into adolescence stage of life, and concludes with my current phase in older adulthood. Scholars support that "blossoming narratives in which Latinas make their private health stories public to access crucial information about diverse health status" (Chabram-Dernersesian & Torre, 2008, p. 13). In this way I see sharing my one testimonio as an act of solidarity and advocacy. As Cherríe Morraga (1983, p. vi) asserts "The only way to write for la comunidad is to write so completely from your heart what is your own personal truth. This is what touches people".

In the next section, I offer mi testimonio con puro cariño towards social justice in mental

health before transitioning to the introduction section of this chapter which addresses my objectives, problem statement and identifies a rationale for this study.

Pre-Adolescent Phase: "Mujer de la Calle" moment.

"Mujer de la calle" translates to "prostitute," says my father. It's late at night. I live in a house where my studio bedroom is on the second floor. There are no doors or walls to block the sound of my father who is lying at the bottom of the stairs. After these disruptive nights, I get up, go to school and perform. My math teacher assumes that I do not care about my education. Little does he know that I care a lot about school, but I struggle specifically in Algebra. The pace of the class has high expectations and standards that entail a lot of homework and other projects. A math course where "no excuses" is emphasized. I am interrogated by my math teacher, about why my homework is not completed, and am told to "get it together." It was those experiences that resulted in distorted images of self, and difficulty focusing.

Adolescent Phase: How Family dealt with adversities. Reaction Fails."Just Pray"

I become aware of how my parents met and coping strategies they used to deal with adversities. Somewhere in Northern Michigan, I ask my mom where exactly she met my father, and her response is "oh mija, we met at church and in the fields. I know we picked cherries, tomatoes, pepinos." My parents were migrant workers, and they met in the fields. Eventually they settled in a rural town in Southeast Michigan which is where I was born and raised. Both of my parents had a middle school education, but later in life, they both obtained their General Education Diploma. Education was important to them. Like most migrant families their goals and aspirations centered around providing a better life for their children.

During my childhood, mental health was coped with in three ways: Substance Abuse, Prayer and Silencing. I recall a few times when I came home from school and did not see my

father. It was my father who suffered from serious mental illnesses, which led him to be admitted several times to psychiatric hospitals. As a child, I had no clue what was going on, and when I asked for details about my father's condition, I was told by my mother "just pray." With great respect for God and people of faith, I say "just pray" might work for some but not all. It diminishes the physical causes and environmental factors that cause serious mental health concerns. The "just pray" response sometimes felt like it was a bandage to the problem that, in a way, masked a wound that never really healed. "Just pray" was a form of silence which meant "what happens in the home, stays in the home," meaning my siblings and I knew that what we saw were stories to be shared amongst us, only. In my family, when my father was drinking, a lot of hurtful words were said and wounds were created, and instead of getting help our family's solution of "just pray" and silencing discussion of problem behaviors contributed to the mental health stigma faced within Latinx communities.

Despite the complexities that my father endured, when he was stable and had access to community, he found hope and strength with his social network which entailed three friends that he would periodically meet at Dom's Bakery. Occasionally, I was invited to join him. Dom's Bakery is a small shop that sits on the corner of the block. As my father and I walk into the shop we smell the aroma of fresh baked pastries. They serve the best conchas and glazed doughnuts. I listen and hear stories of historical trauma, stories of discrimination, racism, and stories centered around family, food and politics.

Both of my parents had a tight relationship with their communities which stuck together. A community that was bound by their roots, helping each other through tough times and celebrating the good times.

Adolescents Phase: How Family Unit Coped. Reaction Fails: "home projects."

Since my father suffers from mental illness, it is my mother who was the primary breadwinner of our family. Mother copes with adversities by praying, leaning on her church family to help during the challenging times. When my father is hospitalized, my mother copes by doing household renovations. One time, she buys some paint, and we paint the living room. Another time, our basement is leaking, and she has it repaired. Another time she purchases new living room furniture. Keeping busy, along with prayer, helps her cope with the pain she feels.

Find Help/New Insight

I watch all of this. I join in and help with the projects. I even pray, but none of this works for me. It isn't until I am standing in the open air of Camp Barakal, the week-long summer camp program offered through the church, that I truly feel joy. Here, I ride horses, I go canoeing, I climb tall walls, and I access long nature trails. I even get to sleep in bunk beds! When I first arrive at Camp Barakal, I explore the trails. It is the first time I have access to resources outdoors. Here, I am at one in nature without a care in the world. Nature is a place where I feel safe and at peace. My time in nature gives me strength, and I begin to see nature, community and education as sources of resilience and transformation. Just like my father leaned on family and his social network, and my mother leaned on family and her faith community, I have begun to build a community that helps me thrive, and I realize, like my family did, that community is at the heart of what keeps us together.

Older Adulthood Phase:

So, I go into the field of Adventure Therapy. I meet amazing mentors. One day, we conduct an Adventure Therapy family session, and I walk into the room where there's an African American foster mom, with three African American adolescents. Based on her body language, I

can see the hesitancy she has about the process. As a woman of color, I know what it is like to walk in a room and know there are unconscious biases that don't support me. It's just like what happened to me in math class--sometimes, these systems don't have the full story.

The goal of this particular day is to learn how to cope successfully with challenges, to interact with each other in a safe manner. As the family begins doing the activity in their minds, they are failing. However, the facilitator says, "You are doing such a great job," and the son says "What do you mean? We are failing miserably." Then the facilitator of the activity says, "That's part of the process, just like life's ups and downs. The important thing is persevering." The bottom line is that the family has an experience of being safe with one another even when things are going wrong.

As I watch this happen, I am struck by the beauty of the moment. This family has what my family did not have. They have overcome silence. They are vulnerable, they are willing to push through unconscious biases, they are willing to fail, and they seek guidance from a mental health professional. My family could not take advantage of these opportunities.

Silencing is like a two-edged sword. Silencing, when at the core of trauma, perpetuates trauma. By sharing my testimonio of my family's trauma, I am no longer "just praying"; I am now giving power to the girl who once felt powerless. Voice to the girl that once felt voiceless. And hope to the girl that felt hopeless. It is in reading and writing that I find animo, strength and healing by shedding light on mental health. My testimonio is one of a mujer that now has the power to say "no mas" insults, no more.

As a Latinx community we need to do better with respecting mental health. I echo Cherríe Moraga (1983) statement that "to be critical of one's culture is not to betray that culture. We tend to be very righteous in our criticism and indictment of the dominant culture and we so

often suffer from the delusion that, since Chicanos are so maligned from the outside, there is little room to criticize those aspects from within our oppressed culture which oppress us" (p. 108). A critique that comes from puro cariño is that I know from my experiences with mental health that the Latinx community may endure silencing, as it was in my family. But what I also know about the Latinx community is that we find resilience and solidarity with one another because community change happens when we activate. By sharing my testimonio I join Cherríe Moraga (1983) promoting subjective work by using collective voices to elevate our community. What I mean by this is that I not only seek to gain knowledge from la comunidad but that I also share my own testimonio with how mental health influenced my life and how I use those experiences to drive my research, specifically as it relates to outdoor based interventions by infusing Adventure Therapy (AT) at nonprofit agencies. Adventure Therapy has been defined as "the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings, that kinesthetically engage clients on cognitive, affective, and behavioral levels" (Gass, et al., 2020, p. 1). I am interested in nonprofit agencies because of my own experiential knowledge and several years advocating in my community with most of my work and research focused on non-profit organizations. Equally important I am interested in exploring perceptions of mental health and if Adventure therapy is conducive with Hispanic women.

Co-Creation of Knowledge

Building on my own testimonio, this chapter uses main themes drawn from interdisciplinary scholars as it pertains to trauma, silencing and adventure therapy, as a nature based mental health intervention. Co-creation of knowledge is a reciprocal process to demonstrate how not only does this work take data from the informants, but I also share my own

experience with mental health with the goal of our collective work to be a way to re-center mental health in Latinx communities. I provide background and context information by presenting my objectives with my own testimonio with trauma by interrogating the production of scientific psychiatric knowledge. I offer prevalence of co-occurring disorders from Substance Abuse and Mental Health Service Administration and address factors influencing treatment outcomes. Additionally, I analyze the historical construction of Latinx/as and psychiatric discourse to describe the imperial power of Eurocentric discourse. I present my problem statement by identifying some of the salient issues via a cultural analysis pertaining to cultural dimension and context rooted in Latinx families. Sarah Wald et al., (2019) suggests cultural analysis examines the influence of cultural representation beyond social science that includes humanities. I build on Wald's cultural analysis to critique mental health as it pertains to silence, racial trauma, but more specifically sexual trauma and adventure therapy that integrates the outdoors. By building on the concept of cultural analysis I spotlight the important role of traditional cultural assumptions of biomedicine and psychiatry to demonstrate the unique predicaments of individuals which are tied to cultural context and values (Kirmayer et al., 2014; Zayas et al., 2005). Next, I provide a context of statistics with co-occurring disorders in the United States. Then, I define counternarratives and discuss how they shape this. After that, I analyze the historical construction of Latinx and mental health and psychiatric discourse. Later, I describe the role of cultural analysis as it pertains to this study. Finally, I provide a demographic overview of people impacted by mental health concerns and end with identifying the broad aims and objectives of my research. The last section of this chapter explains the significance and rationale of this dissertation.

Background and Context

In general, approximately 9.2 million adults in the United States have a co-occuring disorder (Substance Abuse and Mental Health Service Administration [SAMHSA], 2019). Co-occurring disorder is having a diagnosis of two mental illnesses. Some of the most common co-occurring disorders are substance abuse and anxiety. Notably, some of the most effective treatment approaches to help meet this service needs include substance abuse counseling, 12 step facilitation and brief intervention (SAMHSA, 2019). In chapter 2 I will take a closer look at brief interventions, such as solution focused therapy and adventure therapy, where I will shift the focus to a more specific group with the Latinx community. Recent statistics suggest 2.9 percent of Whites had an illicit drug use disorder compared to 3.4 percent of Blacks and 3 percent of Latinos. Illicit drug use and alcohol prevalence was higher among Whites of 5.7 percent compared to 4.5 percent Black and 5.3 percent among Latinos. Correspondingly, the statistics of mental illness among these three groups range from approximately 20.4 percent for Whites, 16 percent for Black and 16.9 percent for Latinos (SAMHSA, 2020). Although the numbers of mental illness appear to be disproportionate the primary reasons are centered on lack of access and lack of culturally sensitive treatment. The reasons for the mental health disparity are primarily due to stigma and preferences to use traditional medicines. To illustrate, traditional medicine may relate to spirituality, nature and healers such as curanderismo to cope with illnesses (Cervantes & McNeill, 2020; Medina & Gonzalez, 2019). However, if traditional medicines are not effective for treating serious mental health, then lives could be at risk. Latinx scholars suggest “safety is the primary emphasis of any trauma treatment” (Cervantes & McNeill, 2020 p. 122). The benefits of weaving testimonios with AT is the emphasis on safety and promoting agency that are principles from a trauma informed approach.

I argue that labels of mental illness continue to place an emphasis on "othering" rather than taking a holistic approach to the matter. Mindbodyspirit is based on the idea that to heal the body is to do so in a manner that does so from a holistic lens, believing that these entities are not divided but rather they are connected (Waldron, 2002). Building on this holistic approach, evidence suggests "cultural brokers and cultural context make a difference to how descriptions of mental illness shape experience, diagnosis and treatment" (Kirmayer et al., 2014, p. 14). These cultural dimensions help providers understand the narratives and experiences of the patient. In contrast to considering cultural dimensions, providers focus on specific aspects of illness that fit the expectations of the medical model. Many patients present to their primary care provider with bodily symptoms known as somatoform disorders, which is where there is no physiological explanation, and the provider assumes that psychological factors must therefore account for the condition. This assumption reflects the mind-body dualism of biomedicine, but we can instead take mental illness a step further when understanding how systems shape illness behavior and experiences. Evidence suggests "social and emotional dimensions of distress may be suppressed or hidden because of the potential for social stigmatization" (Kirmayer et al., 2014, p. 14). I build on the work of Gloria Anzaldúa and Loida Pérez to connect expressions of emotional distress that will be detailed in Chapter Two and Chapter Three.

My project proposes a decolonial epistemology combined with a trauma informed approach to reclaim experiences of Latinx women to transform inner psychological scars into strength by fusing the outdoors with testimonio as part of the healing practices. Critics of decolonial epistemology such as Tuck & Yang (2012) assert that decolonization is not a metaphor because land cannot be given back. In parallel with Tuck & Yangs work, I argue that trauma--which is broadly used across disciplines, but more specifically, I am contending that

sexual trauma--is not a metaphor and what was forcibly taken can never be retrieved. I use diverse scholars to demonstrate how pioneers of the field of Ethnic Studies (ES) and beyond have intertwined nature as part of their healing process. The term trauma is vaguely used throughout literature, which means that there are multiple meanings for the term (Ramirez, 2018; Anzaldúa, 2007; Levins Morales, 1998; Moraga, 1983). SAMSHA (2020) suggest 80 percent of women with co-occurring disorders have a history of childhood physical or sexual trauma. The Center for Health Care Strategies supports there is "no universal definition of trauma" (Menschner & Maul, 2016, p. 2). Hence, for the sake of this dissertation, one of my main goals is to build on a trauma informed approach to challenge the idea of defining some terms, including trauma. For me to define the term "trauma" would be to comply with the exact same system that I am challenging, which is the medical model or golden standard system. As a result, I leave this definition participant centered.

I build on ethnic studies scholars regarding the outdoors and roots with Latinx. Anzaldúa asserted, "Chicano and Chicana have always taken care of the growing things and the land... The land was Mexican once was Indian always and is. And will be again" (Anzaldúa, 2007, p. 113). Scholars argue that Latinx cultures redefine and broaden what counts as environmentalism even as they sometimes reject the term entirely (Wald et al., 2019). I challenge the term environment by analyzing outdoor scholars to illustrate how communities of color have weaved in the outdoors for centuries, as part of their healing practices. For example to re-think environment, Wald asserts, "Part of this redefinition concerns how Latinx cultures make evident the racism inherent in some of the assumptions of environmentalism through a variety of forms of rejection, acceptance or revisions of the term itself. This insight emerges both from the variety of cultural values that circulate in different Latinx communities, including indigenous and Afro-Latinx

communities and from the lived experiences of being exploited alongside the land through the processes of colonization and present day coloniality and ongoing neoliberal abstraction" (Wald et al., 2019, p. 3). Here we see an implicit connection between the damage of colonization to both the land itself to Latina/x relationship with land and the sexual violence that is part of colonization. Therefore, interweaving testimonios with Adventure Therapy can address this complex set of relationships because this combination promotes agency and empowerment.

Counternarratives

Using a counternarrative approach, I am examining how testimonios could potentially be utilized in Adventure Therapy to challenge the colonial interpretation of adults Latinx with co-occurring disorders who are undergoing treatment at a recovery program. A counternarrative approach integrates co-constructed reflective narratives to re-center voices by weaving in skills such as empathy during the testimonio process. For this study, I define testimonio as a method used in mental health that disrupts silence of trauma by choosing to share mental health stories that take into consideration the cultural dimensions of mental health expressed within their narratives as a form of cultural congruence. Cultural congruency is done by recognizing that culture plays a significant role in shaping mental health experiences. In comparison to talk therapy, which is a type of treatment where the individual talks with a trained mental health professional explore thoughts, feeling and behaviors to improve mental health symptoms. I see the integration of testimonio as more of a story telling process that takes into consideration cultural dimensions of mental health expressed with their narratives. Dolores Delgado Bernal et al. (2016) interweave counternarratives with testimonio to work towards collective healing while pointing to the power dimensions that create these realities. The goal of the "poor youth" in sharing these experiences was to counter deficit narrative by raising awareness of "collective

efforts to re-invent their stories and communities beyond tragedy" (p. 20). I borrowed the concept of counternarrative by validating the participants narratives with actively listening to their own definitions of mental health that challenges stereotypes and promotes self-determination. I parallel counternarratives with agency because they both work towards elevating clients' choice and voice. This understanding is echoed by Tony Alvarez et al. (2021) and Anita Tucker et al., (2016) who connect agency to "choice, empowerment, and allowing clients to determine their own level of challenge" (p. 20). Likewise, Adventure Therapy relies on an underlying understanding of agency and choice. For example, activities are facilitated with the policy of challenge by choice, in mind the client chooses their own limits to take risks. The benefit of challenge by choice is built on integrating a trauma informed approach (TIA) that is centered on empowerment by focusing on the strengths of the participants. A limitation of Challenge by Choice is the fact that getting triggered is a risk, but staff are trained in TIA. If a client is triggered, qualified staff are available to offer their expertise and guidance. The way I weave in agency with this study from a decolonial perspective is centered on reclaiming voices that have been dismissed those entails listening to the participants narratives. By reclaiming voices in mental health with Latinx/Hispanic women in a transitional living program by elevating their lived experiences and sharing their testimonios of cariño, and esperanza. Incorporating cariño and esperanza as part of self-determination helps participants become aware of their own power to reclaim their authentic care and hope for their future.

Some factors influencing Latinx underutilization of mental health services include stigma, lack of culturally adapted services, and acculturation level (Corona et al., 2017). A deficit framework defines people by their problems and weaves in terms such as "high risk youth" which perpetuates negative labels that are harmful. Whereas "culture-specific models

have the potential to positively influence and improve functional skills for Latinos with diagnosed mental illness" (Delgado 2007 p. 93).

Different from a deficit approach, a counternarrative challenges deficit frameworks. Franco (2021) suggests counternarratives is a technique used to reclaim stories. In my work, I employ a counternarrative approach that centers on promoting agency and challenging negative stereotypes surrounding mental health. This approach involves actively listening to participants' mental health testimonios and transforming the testimonios through cultural resonance to re-imagine stories of cariño, esperanza, confianza and safety. To build a safe and supportive environment that empowers participants, I draw on pillars of safety, support, hope and trust, as presented by Dr. Robert Ortega, a social work scholar (2013). These pillars are typically associated with child maltreatment, but they are also fundamental elements of a Trauma Informed Approach which was developed by Substance Abuse and Mental Health Administration under the Department of Health and Human Services. In the process of re-imagining mental health testimonios, I use the technique of cultural resonance to re-shape narratives (Ettema, 2005). Cultural resonance involves elevating and valuing participants' voices in a way that validates their mental health and focuses on empowerment. This technique is a powerful vehicle for change as it enables participants to take control of their mental health narratives and to see themselves as active agents in their recovery.

This study explores how mental health is described by Latinx/as residing in a residential treatment program and demonstrates how healing practices with the outdoors may have been integrated into their recovery. I weave in decolonial epistemology by using testimonios to amplify women's voices rather than imposing labels of mental illness used in scientific psychiatry. Through this work I illuminate the transformation of cultural hybridization. Research

suggests cultural hybridization is a technique used to re-shape clinical practice (Kirmayer et al., 2014). I propose cultural hybridization as a transformational process via storytelling to offer ideas of esperanza, cariño, confianza and safety. I intertwine these approaches with cultural hybridization as a technique to transform clinical practice by infusing a method of testimonio that scholars support as a culturally congruent method (Cervantes & McNeill, 2020), combined with AT and focus groups. In the next section, I trace important historical events that relate to this study.

Historical Construction of Latinx/as and Psychiatric Discourse

The objective of this study is to challenge labels and assumptions placed on those with mental illness. I do so by examining scientific work and beyond to critique ways that Latina/x women have disrupted silence with racial trauma but more specifically with sexual trauma to heal and transform their lives. This study works towards liberation from labels and stereotypes in mental health. The approach is pivotal because of the history surrounding the medical model which is used in the scientific world as the golden standard of research. Michel Foucault's concept of medical knowledge as illustrated in *The Birth of The Clinic* is constituted with historical regimes of power (1973). Research suggests, since its origins in Europe psychiatry has been used to oppress the colonized, legitimize slavery and offer scientific theories to justify racial discrimination. These so-called scientific theories were themselves rooted in false and racist medical theories that provided fertile ground for psychiatric theories to flourish (Waldron, 2002). This study works to dislodge the paradigm with the golden standard medical model that implicitly values mainstream culture. The medical model sees things from a binary perspective. Contrary to the binary way of thinking is a holistic approach that places an emphasis on bodymindspirit connection. Bodymindspirit is based on the idea that to heal the body is to do so

from a holistic lens, believing that the entities are not divided but rather they are connected (Waldron 2002). In like manner, a holistic approach in Experiential Education considers bridging the entirety of bodymindspirit. If our mental health is not well, emotions have a way of transporting illness or toxicity to other parts of our bodies.

Adventure therapy has philosophical roots with John Dewey's work as the "father of Experiential Education" and the overarching umbrella of learning by doing (Alvarez et al., 2021). Although the premise started in education it evolved towards mental health treatment. Adventure therapy emerged from the field of education to become evidence-based mental health practice.

A Cultural Analysis Examines The Influence Of Cultural Perspectives Rooted In Latinx Families

The environmentalist team of Sarah Wald suggests that a cultural analysis brings attention and awareness to representation, imagination and memory, and the need to call attention to examine complexities that exceed social science tools to spotlight the importance of humanities literature (Wald et al., 2019). Evidence also suggests the combination of frameworks across humanities and social science can broaden the mainstream clinical framework considers unique situations and alternative ways of health practices (Kirmayer et al., 2014). Building on these concepts of cultural analysis and an interdisciplinary approach. I illuminate this possibility with the role of cultural institutions to spotlight alternative forms of health systems and healing practices.

I shift the deficit framework towards a strength-based approach by integrating a cultural analysis to spotlight the importance of combining both scientific and humanities work to demonstrate ways to re-imagine stories that disrupt silence in its creative forms through

empirical studies and beyond. I start by analyzing the role of important cultural perspectives rooted in Latinx communities. I borrow from Sáenz & Morales (2015) to illuminate the nuances of whether family patterns started from culture or structure. Here I focus on cultural perspectives rooted in Latino families that can be controversial which are marianismo and machismo. The concept of marianismo is based on the Catholic idol of the Virgin Mary, used to highlight women's role as the self-sacrificing mother who suffers for her children. In Latin America, mothers are expected to self-sacrifice for the sake of the family. In contrast to marianismo, machismo emphasizes the role as head of household versus fatherhood. Early feminist perspectives describe machismo as "male chavinism" (Sáenz & Morales, 2015).

Additionally, I briefly explore the value of Familismo. Scholars suggest that familismo prioritizes the family over individual needs and conceptualizes family beyond the nuclear to the extended.. Familismo is the most significant part of life for Mexican American and in South Texas as it is the main source of obligations, emotional and economical support. Second, the value also emphasizes the importance of contributing to the well-being of both the nuclear and extended family. But this concept of familismo has several points of contention. A main critique of the concept has been connected to pressure that women feel as it relates to choices (Sáenz & Morales, 2015). Although this research is not focused on values of familismo, I critique familismo to spotlights the nuances of cultural values within the Latinx family system, especially relating to the commitment to family unity. Here I take this a step further by focusing on disclosure of sexual abuse. I borrow from the work of Cindy Cruz (2001) as they use the term cultural constraints by illustrating a poem written by Christine Soto that defies unspoken rules about abuse. I combine this term of cultural constraints with cultural scripts of silence to shed light on the complexities with disclosure of sexual trauma. But as illustrated in the text,

regardless of circumstances the survivors choose to defy family expectations by disrupting the silence. I borrow a quote from Gayle Waldron to illustrate how women are the silenced and the silencer, by which I mean in some cases women perpetuate the silence especially as it pertains to disclosure of sexual trauma, "Understanding our systems of domination interlock and sustain one another allows us to examine the contradictory ways in which implicated in each other's lives. It can reveal how we as women take on a multiplicity of subjectivities in which we are the oppressed and the oppressor" (Waldron, 2002, p. 150).

Statistics Of Those Impacted By Mental Health Concerns

The National Alliance for Mental Illness (NAMI) reports approximately 35% Latinx receive mental health services compared to the U.S. average of 45% (NAMI, n.d.). These health disparities put communities at risk for mental health to worsen especially when effective treatment is not sought. As a matter of fact, it is not uncommon to resort to self-medication which may result in substance abuse which is known as a co-occurring disorder because there is a mental illness diagnosis combined with a substance abuse disorder. Although there are various traditional treatment including spirituality, evidence suggests there can be some areas of concern as it pertains to psychiatric disorders versus spiritual encounters, with the main emphasis on accepting the fact that safety is the most important (Cervantes & McNeill, 2020). The reality is if traditional medicines are not working then lives could be at risk. When mental health treatment is sought by Latinx they are typically done at community health agencies. Some effective approaches have integrated strength-based models, such as cuento therapy and the outdoors as an alternative to talk therapy (Alvarez et al., 2021; Arrendondo et. al., 2014; Delgado, 2007). However, barriers that interfere with Latinx seeking services include cultural stigma, lack of culturally tailored services and culturally competent mental health professionals, and problems

identifying psychiatric symptoms when chief complaints are somatic symptoms (Villarruel et al., 2009; Delgado, 2007).

Therefore, in this study I will integrate a non-liberal approach to therapy using Adventure Therapy as an alternative form to treatment because it integrates creative techniques with the outdoors compared to solely focusing on talk therapy models. A nondeliberative approach weaves in tools such as metaphors, music, storytelling and the outdoors to help guide the therapeutic process. Scholars suggest a non-liberal approach places an emphasis on agency and empowerment (Tucker, et al., 2016) which aligns with the strength-based model. A strengths-based model focuses on empowerment and shifts the focus from a deficit perspective by probing questions of *what happened to you* compared to what is *wrong with you* (Norton et al., 2019). The problem is there has been a plethora of quantitative studies that suggest the benefits of Adventure Therapy in for-profit programs but there has been a lack of research with Adventure Therapy in community-based agencies (Norton & Watt, 2014). Hence this study is working to close the gap with literature in Adventure Therapy and community-based agencies. This work builds on scholars with scientific backgrounds combined with literary works to spotlight the importance of interdisciplinary works. Sarah Wald, (2019) an environmental scholar supports the idea that measures of science limit the ability to see beyond the scientific silos, which affects the ability to appreciate works in humanities.

Broad Aims and Objectives

Accordingly, the objective of this phenomenological study is to conduct a cultural analysis across social sciences and humanities that ties together mental health and healing practices. I do this by analyzing how Latinx/a describe mental health which is based on listening to their lived experiences. The design framework includes identifying data types via testimonios,

field notes from observations and focus groups on the lived experiences of mental health and outdoor based interventions of the participants at Powerful Lives Transforming Program (PLTP). I use PLTP as a pseudonym for confidentiality purposes to represent the residential program located in the Southwest region of the nation. Scholars support the method of testimonio and decolonial epistemologies that work towards self-determination (Franco 2021; Smith, 2012). The three main research questions that guide this study are:

1. How do participants in my study describe mental health?
2. What is the participant~~s~~ testimonio of how they arrived at PLTP?
3. Do participants see a connection between the outdoors and their mental health, or not?

Significance and Rationale

The director of National Institute of Mental Health confirms that public health response should increase intervention and prevention efforts with historically underrepresented groups to address mental health conditions (Gordon, 2018). Therefore, this work is important because there is limited research that offers supportive mental health interventions that are effective for Latina/x. Also, research is lacking that details methods specific to adventure-based therapy with Latina/x adults.

While Adventure Therapy can be traced back to the 1800's in the United States (Gass et al., 2020), the initial camps were designed for and by elite boarding schools focused on the success of white men which limited accessibility for those that did not fit into that category. Michael Gass et al., (2020) defines Adventure Therapy as a "prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on cognitive, affective, and behavioral levels" (p. 1). Although the outdoors camps were initially created for elite White men, I join social justice scholars such as

Dr. Nina Roberts, Dr. Christine Norton, Dr. Anita Tucker, Elizabeth Warren and Tony Alvarez with the Association of Experiential Education (AEE) who strive toward social justice advocacy. Evidence suggests that social justice work started in AEE in the 1970's (Warren et al., 2014). Although social justice work started several decades ago, Dr. Nina Roberts points out a gap of cultural representation across the AEE literature that illuminates the importance of racial identity as it pertains to the outdoors. To illustrate Dr. Nina Roberts sheds light on pioneers frequently heard about such as John Muir, but the field lacks knowledge and understanding of pioneers that identify from historically underrepresented groups (Roberts & Spears, 2020). I build on Dr. Nina Roberts' works by linking Latinx pioneers with the outdoors such as Rigoberta Menchú, Gloria Anzaldúa, and Sarah Wald's research team demonstrate how these pioneers are "bearers of environmental knowledge and as practitioners of sustainable infuse cultural praxis with traditions that stretch longer than contemporary U.S. environmental thoughts" (Wald et al., 2019, p. 11). I adopt the term of cultural praxis to illuminate traditions that move beyond mainstream knowledge. I weave into cultural practices with mental health to discuss in Chapter Two the effects of cultural context and cultural scripts. I build on the work of scholars that infuse cultural practices to illustrate idiosyncratic ways that mental health is linked to personal and family histories (Kirmayer et. al., 2014). To date there has been a plethora of quantitative research that includes meta-analysis with for profit agencies in Experiential Education and Adventure Therapy. But evidence suggests limited data is available in community-based health settings using Adventure Therapy (Norton et al., 2014). Given that there is limited empirical research on the effectiveness of nature-based interventions in community-based health setting with Latina/x adults, this project will serve to fill a gap in Chicano Latino studies. I will do this by conducting testimonio and focus groups to examine the perceptions of mental health and outdoor based

interventions with primarily Hispanic adult women residing at PLTP.

Organization of Dissertation

In my literature review I conduct a cultural analysis across humanities and social sciences to examine how representation helped construct Latina/x parameters as they pertain to mental health. I begin by illustrating how labels converge to the Latina/s that were viewed as deviant and pathological. Here I borrow the term countercultural rebellion (Espinoza et al., 2018) to challenge racial labels by disrupting silence in social work, but in the other case study I demonstrate how silence was used as a tool that challenged assumptions. Then I examine how psychiatric knowledge adopts socially constructed images of Latina women by examining cultural scripts and cultural scripts of silence specifically as it relates to sexual trauma. Finally, I end this section by examining strength based and solution-focused therapy combined with the effects the outdoors has on mental health.

Chapter Summaries

I borrow terms of cultural assumptions in biomedicine and psychiatry and cultural scripts to connect personal and family histories with disclosure of silencing with Latinx/as and shed light on alternative visions of health (Kirmayer et al., 2014). Further details of these concepts are discussed in Chapter 1. In Chapter 2 I critique a piece by Tuck & Yang (2012) regarding the metaphorical use of decolonization and Indigenous sovereignty. This perspective is relevant to repatriation efforts and parallels my argument that trauma should not be treated as a metaphor. I argue a decolonial framework involves the repatriation of land and the healig of emotional scars. In Chapter 3 I build on qualitative researchers' work and provide details of Testimonio and focus groups to place an emphasis on empowerment and liberation by building on work of scholars

(Delgado et al., 2016; Latina Feminist Group, 2001), combined with social work scholars (Ortega & Garvin, 2019; Alvarez et. al., 2021). Additionally, I join outdoor social justice researchers to embody the concept of cultural resonance to re-imagine narratives (Warren et al., 2019). By re-imagining narratives, I am borrowing the term cultural hybridization. Kirmayer et al (2014) utilizes the concept of cultural hybridization to infuse Gloria Anzaldúa seven stages of conocimiento with an Adventure Therapy Model developed by Tony Alvarez and Gary Stauffer discussed in chapter three to reshape clinical practice (Anzaldúa & Keating, 2002; Alvarez et al., 2021). I adopt Gloria Anzaldúa's stages of conocimiento with physical illness and racism then apply it to the impact of mental health by describing what the client goes through for transformation. I connect the stages of conocimiento and Adventure Therapy to describe the process of treatment to reshape clinical practice via cultural hybridization as it relates to outdoor-based interventions by integrating observations from focus groups and observations with groups at PLTP. Cultural hybridization merges techniques to reshape clinical practice (Kirmayer et al., 2014). Then in Chapter 4 I share the findings from the data collection. Finally in Chapter 5, I conclude with implications for pedagogy where I offer recommendations for practitioners and the need for further research.

CHAPTER ONE: LITERATURE REVIEW

Historically underrepresented communities are disproportionately affected by mental health concerns due to a lack of trauma informed models specifically tailored to their needs. Likewise, there is a critical lack of treatment interventions that are optimal for ethnic minorities who have experienced complex and historical trauma (Hoskins et al., 2018). Since this study will be conducted with participants diagnosed with co-occurring disorders as defined in chapter are two mental illnesses one that included substance abuse. I use a trauma informed approach (TIA) that is recommended when working with folx impacted by trauma. Substance Abuse and Mental Health Service Administration (2014) developed six guiding principles for TIA that include safety, trustworthiness, peer support, collaboration, empowerment, and choice, and cultural, historical and gender issues. This TIA model provides cultural awareness and cultural sensitivity with the impact of trauma. However, many interventions tend to be focused on the individual. But scholars support models that integrate a collective approach rather than an individual approach. An individualistic approach implicitly prioritizes European American cultural values and norms, which can be problematic for individuals from cultural backgrounds who may have different perspectives on mental health treatment (Chang et al., 2017; Norton & Hseih, 2011).

There is a need for mental health interventions that are culturally congruent in adventure therapy. In a recent article in *Frontiers in Public Health*, researchers advocated for bringing outdoor therapies into mainstream mental health (Buckley et al, 2018). One way to integrate culturally specific models and outdoor therapy may be to implement AT in community-based, non-profit settings. Although there is a plethora of literature with AT in for-profit agencies, usually in wilderness therapy programs, the goal of this study is to focus on non-profit agencies that implement culturally congruent methods with AT. As demonstrated in chapter one adventure

therapy has been defined as "the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings, that kinesthetically engage clients on cognitive, affective, and behavioral levels" (Gass, et al., 2020, p. 1). Scholars suggest asset-based interventions can meet the mental health and cultural needs of populations by promoting agency and empowerment (Tucker et al., 2016; Delgado, 2007). The intervention emerges clients to be active participants in the therapeutic process (Norton, 2012). Therefore, adventure therapy (AT) may be promising with Latinx groups because AT seeks integrative ways to examine the therapeutic process through experiential activities and behavioral activation. Hence, I seek to fill the gap with implementation of culturally congruent approaches that elevate historically underrepresented groups in adventure therapy.

Community-Based AT with LatinX Clients

I begin with a critique and synthesis of the current literature on adventure therapy with LatinX youth in community-based mental health settings (CBMHS), to highlight the lack of literature in this specific area. LatinX is a gender-neutral term that refers to people of Latin American descent (Salinas & Lozano, 2019). This study examines Latinx obtaining services in CBMHS in the United States. Evidence suggests 40% of Latinas/os have symptoms of high anxiety and depression, often related to discrimination, acculturation, and lack of access to culturally adapted services (Corona et al., 2017). The existing rates of mental health needs suggest that this research is important because it will serve as a vehicle for change by weaving in integrative and adaptive approaches of AT.

Though the LatinX community needs mental health services, they are less likely to utilize these services, in comparison to their white counterparts (Chang & Biegel, 2018). Most of the current modalities used in mental health treatment implicitly value mainstream European

American culture that relies on individualistic perspectives rather than taking a collective perspective. Scholars argue clinical adaptations enhances coping skills. Such as Cuento therapy that has been effective for Latinx communities (Arredondo, et al., 2014). Cuento therapy relies and integrates narratives focused on Latin heroes to help attain treatment goals. It is by placing focus on strengths via creative ways that enhance the therapeutic process. To illustrate, a study used two cases to demonstrate how the outdoors can be a catalyst for therapeutic change if guided properly. For example, in the first case the social worker was at a middle school. The social worker conducted group therapy for fifty minutes with 21 eighth grade students where adventure activities were used. To illustrate, in this case study the group was asked to build a pyramid, as the social worker observed to gain a deeper understanding of side chatting and how decisions were made within the group. It was through these adventure therapy activities that the social worker employed a nondeliberative process that allowed the group to reflect on the activities and process the experience. Whereas case study two conducted at an alternative school that ran weekly meetings with adventure therapy. The group went backpacking trip that the students planned. However, on the first day of hiking a student was injured. After being assessed by assessed by a first responder it was decided to take the student to the emergency that resulted in the student not having any injury, but the event impacted the hiking trip. The social worker processed the highs and lows of the experience where most of the students talked about a high being that the injury resulted in the group uniting to help, and as a low was that the backpacking trip was shortened. In this scenario the social worker was able to permit the students to make decisions of how to keep safety in the forefront of the situation. As indicated in Chapter one a nondeliberative approach infuses integrative tools such as metaphors as dance and nature that are a conduit in conjunction with talk therapy where the facilitator is not viewed as the expert rather

the facilitator is viewed as a vehicle for change (Tucker et al., 2016).

According to a scholar the application of experiential education in therapeutic settings should infuse the outdoors as integrative tool as agents in the therapeutic process. The findings of this study illuminate that "ecological and social perspectives are not mutually exclusive" (Norton, 2012, p. 306). For instance, the outdoors is not a binary perspective as it relates to overall health. In other words, the outdoors and humans are not separate entities. Not only are the outdoors supported with integrating them in the therapeutic process but also it is equally important to respect the land. Below I illustrate how studies suggest the health benefits of the outdoors. By shedding light on existing limitations to mental health services for Latinx clients and the need for culturally relevant and empowering interventions that move beyond binary Eurocentric models. A review of current research examines AT with LatinX clients in community based mental health services (CBMHS), with the goal of highlighting promising practices, as well as identifying gaps in the body of knowledge and areas for future research and practice.

Identifying LatinX Experiences in Community-Based Health

A primary literature review borrowing techniques suggested by Torraco (2016) was implemented to review, critique, and synthesize representative literature on AT in CBMHS. The inclusion criteria included the age of the participants, which ranged from adolescents to young adults; United States residents; and those receiving outpatient treatment with a mental health provider at a CBMHS. From this search, four peer-reviewed empirical studies met the criteria and were analyzed; however, these interventions were not specifically targeting LatinX clients, but included them in their overall samples. Due to this lack of empirical data specific to AT with LatinX clients in CBMHS, this literature review also included additional sources of research that

looked at other examples of culturally adapted therapeutic outdoor programs with underrepresented populations in order to make recommendations for how AT can be adapted to specifically serve the LatinX population. A study found there is a lack of theories in adventure therapy to work with populations beyond mainstream. The findings suggested a model to shed light on basic beliefs and value structure with historically underrepresented groups (Chang et al., 2017). Beyond the detailed review of the literature, this study builds on accounts from ethnic studies and social work scholars to analyze silence, including explanations relevant to cultural scripts. I demonstrate how cultural scripts of silence provide justification for multiple oppressions of Latinx/as which can impact their perceptions. Cultural scripts of silence occurs when silence is disrupted which can lead to emotional distress (Szlyk et al., 2018). I critique existing literature on trauma, silencing and mental illness to show how these cultural concepts are connected to produce unique experiences for Latinx/a women. I examine how socially constructed labels collide to produce particularly damaging stereotypes of Latinx within mental health.

AT with LatinX Clients

In the four empirical studies that met the criteria for inclusion, there were a total of 1,272 AT participants in various CBMHS. All studies included LatinX clients in their samples; however, they represented less than 2% of the sample population. Notably, in one study with 31 participants, only 4 identified as a racial minority (Koperski et al., 2015). Another study had a sample size of 41, only two identified as Hispanic representing less than five percent of the sample. In the largest study of 1,135 participants, approximately one quarter identified as non-Caucasian with less than one percent reporting Hispanic or Native American heritage. Although the sample size for minority was small, the most compelling evidence suggest black female

youth demonstrated positive outcomes by infusing Adventure Therapy in a CBMHS (Tucker et al., 2013). Yet one study suggested more diversity with the sample size with participants identifying as Caucasian or Hispanic (Norton et al., 2019). In these studies race was not a significant moderating variable; however, given this lack of representation of LatinX clients in community-based AT research, it makes it hard to generalize the effectiveness of AT on this particular population. Overall findings in these studies shows AT is a promising practice for addressing trauma symptoms and family functioning (Norton, et al, 2019), developing coping skills for stress management (Koperski et al., 2015), and improving youth psychosocial functioning and behavior (Vankanegan, et al, 2019; Tucker, et al, 2013).

More importantly, the additional studies shed light on promising practices that challenged the deficit model by spotlighting preventative programs that embraced values and tradition of American Indian Youth in Project Venture. Carter suggests "experiential approaches should continue to be examined for not only American Indian youth, but all underrepresented youth" (Carter et al., 2007, p. 399). When communities of color decide to obtain mental health services, they are frequently seen at CBMHS. This observation is based on the clinical practice conducted at a non-profit agency located in the southeastern region of the state. A study spotlighted the need to focus more on AT with youth in CBMHS (Norton et al., 2014). Lastly, research suggested that in order to develop engagement, outdoor practitioners must provide not only activities, but also foster culturally relevant beliefs and attitudes about nature within the communities they are serving (Lekies et al., 2015).

The primary literature review uncovered a profound gap in the research on AT with LatinX clients in CBMHS. This is largely due to underrepresentation in research samples, which is a direct result of underrepresentation in programming. Often people assume that

underrepresented groups do not have socioeconomic access to these types of programs, and while that may be true in some cases, we also need to consider whether AT interventions have been appropriately adapted to meet the cultural needs of diverse populations. Furthermore, this review sheds light on future implications for research and practice which include evidence of the need for AT to move towards evidence-based practices (Norton et al., 2014).

Like trauma-informed interventions, the studies included in this literature review highlight the need for a strengths-perspective in both practice and research. AT must continue to focus on training professionals in the field in AT practices that are culturally relevant (Norton et al., 2014). As AT services become more accessible and culturally relevant, there will be more opportunities for research on the efficacy of community-based adventure therapy, the utilization of services, and LatinX mental health. This research is particularly important to me as it intersects with my identity as a Person of Color (POC) social and behavioral science researcher. Finally, researchers should start to consider a research track with the potential starting point of a more diverse sample that includes the global majority, within the United States. Furthermore, gaps in the literature need to be addressed that infuse testimonio as a method and decolonial epistemology congruent with Latinx/as culture. Before this research can be conducted, it is critical to examine the literature regarding culturally specific experiences of mental health and treatment.

Culturally Specific Experiences of Mental Health Treatment

Expressions of distress are shaped by cultural scripts, and cultural scripts can provide ways of disrupting silences. In this dissertation, I define cultural scripts as articulations of mental health symptoms that can be expressed in ways that are beyond mainstream forms of thinking and knowing. As a result of their expression beyond mainstream presentations, they may

resemble symptoms of dissociative disorders and be misdiagnosed as psychotic in cross-cultural settings, complicating the recognition of other co-occurring conditions. When mental health is of concern a cross cultural setting with spirituality cause nuances due to the symptoms of mental illness may "resembling possessions of spirits or other agents" (Kirmayer et al., 2014, p. 14). For instance, the nuances with spirituality belief compared to serious mental illness can be connected with a belief that there is a demonic possession that caused a serious mental illness. This spiritual belief may inhibit families from getting the services needed. In the next chapter, I use *Loida Marita Pérez, Geographies of Home (1999)* to examine the complexities with spirituality and serious mental illness. In *Geographies of Home* the congregation of the church assumed there was demonic spirits instead of recognizing serious mental illness. Although there are cultural assumptions that impede mental health practices there are unique circumstances that affect alternative visions of health. At the same time, it is important to note that lives can be at risk if mental health services are not given in situations that involve serious mental illness (Cervantes & McNeill, 2020). Accordingly, cultural scripts can decrease stigma, but can also redirect people to their primary care providers, rather than mental health specialists. Social and cultural context relating to cultural models are integral to understanding experiences of mental distress, then offering appropriate diagnosis and treatment. Research suggests there is limited ethnic-specific research that focuses on mental health with Latinx/a women (Chabram-Dernersesia & Torre, 2008).

Accordingly, a general overview across ethnic studies research on trauma and mental health is analyzed. I critique existing literature on racial trauma, silencing and mental illness. I analyze the strengths and challenges within the literature to show how these concepts of silencing, trauma, and more specifically sexual trauma and mental illness are connected and

produce unique experiences for Latinx women. Silencing is a form of keeping secrets that have the potential to decrease stress or increase stress with disclosure. I recognize that while silencing can be liberating for some folx, there is literature that offers support for the risks involved, too, with disrupting silence. Critiques of disrupting silence suggest that serious consequences may result from those involved with disclosure of sexual abuse especially across cultures as it pertains to power dynamics (Gilligan, 2018; Caprioli & Crenshaw, 2017; Jeremiah et al., 2017).

Cultural Scripts as a Culturally Acceptable Method to Express Mental Health Concerns

The language of distress is embedded in cultural scripts and may influence the ways in which women present symptoms of "mental illness" by disrupting silence. Scholars suggest that cultural scripts of silence are models of how to communicate sensitive topics within one's specific community but defying cultural scripts of silence may lead to emotional distress (Szlyk et al., 2019). The "cultural symbols of their environment provide them with culturally acceptable ways in which to interpret, label and resolve their mental health concerns" (Gayle Waldron 2002, p.111). Scholars find how social and cultural context influence treatment plans (Kimayer et al., 2014).

Many patients present to their primary care provider with bodily symptoms known as somatoform disorders, which is where there is no physiological explanation on the assumption that psychological factors must therefore account for the condition. A critique of holistic health is that biomedicine sees the body as a separate entity. Hence during times of psychological distress emotions are hidden because of the stigma within the culture (Kirmayer et al., 2014). In a cultural context, there are implicit connections with how cultural scripts shape a person's expression of mental distress. In this next section, I build on Ethnic Studies literature to illustrate how cultural scripts shape experiences and expressions of mental health. An example of terms

that are more acceptable to express mental health concerns is borrowed from Gloria Anzaldúa "Sweating, with a headache, unwilling to communicate, frightened by sudden noises, *estoy asustada*. In Mexican culture it is called *susto*, the soul frightened out of the body. The afflicted one is allowed to rest and recuperate, to withdraw onto the "underworld" without drawing condemnation" (Anzaldúa 2007, p. 70). In this piece we see Anzaldúa describe somatic symptoms to express underlying feelings that may be connected to mental health concerns. I see this piece connecting with my work as it relates to the importance of holistic health, and how if we as individuals do not have a supportive space to express our feelings then those feelings become toxic within our own bodies which ultimately impacts the bodymindspirit because they are all connected.

"Ataques de nervios, and mal del ojo disorders have been viewed within the Latino community as part of the overall repertoires of disorders to be diagnosed and treated by curanderas that integrates the social network with familial and communal" (Chabram-Dernersesian & Torre 2008, p. 185). In this piece we see Spanish terms that are culturally accepted to use in an effort to seek treatment within the community that may be more culturally respected.

Although Salomè was seen as a paragon of upright Dominican womanhood, the "femininity" section of the biography starts with the statement that "Salomé Ureña was extremely feminine. But we can never know truly why Ureña preferred to remain indoors; the letter between Salomè Ureña and her husband highlighted that she was "*profundamente melancolica*" (Ramirez, 2018, p. 96). This piece is inserted because it illustrates expressions beyond the Mexican culture to demonstrate Spanish expressions of mental health distress through literary work. This literary work articulates in Spanish the struggle that Ureña endured

as she juggled with her roles as a Dominican woman.

In these pieces I briefly spotlight ethnic study scholars combined with literary work that articulate cultural scripts used to describe symptoms of mental illness. I chose these scholarly works because they articulate culturally acceptable Spanish terms to articulate mental illness. In this way we see how Spanish terms help decrease the stigma placed on labels of mental illness. However, there is evidence to suggest that this results in folx obtaining services through their primary care physician compared to seeking guidance from experts in the field, which leads to ineffective outcomes and treatments (Kirmayer et al., 2014). One way to mitigate this problem is when clinicians build partnerships with primary care providers so that case management can be a conduit to ensuring appropriate culturally congruent therapy services are being offered.

Cultural Scripts of Silence: The Intersection Between Survivors of Sexual Abuse and Health Care Providers

Building on concept of cultural scripts, I examine empirical works to analyze how culturally constructed conceptualizations of sexual trauma and "mental illness" collide -to cause particularly damaging stereotypes and labels of Latinx/a and mental health across -Latinx cultures. The term *cultural scripts of silence* was coined by scholars examining adolescents' need for autonomy in identity and sexuality and their deep regard for family unity that stems from cultural socialization of families (Zayas et al., 2005), and this term has been connected to trauma (Gulbas & Zayas, 2015; Szlyk et al., 2018). In the following section, I build on Zayas' work and link empirical studies to illuminate the impact of cultural silence in two ways. First, I illustrate how silencing pertaining to sexual abuse was perpetuated by mothers, then I share how adult survivors used their voices to shift their feelings of shame to feelings or ideas that they are worthy of healing.

Cultural Ambiguity in Empirical Studies

Like many Latina survivors of sexual abuse**,** I weave in three pieces of literature on silencing with Latinx families by keeping it a secret from everyone except her mother who did nothing about it; this silencing is common among abuse survivors. First, *I'm Neither Here nor There* does a reflection of a case where Minifred was sexually abused by a male relative. As a result, Minifred kept the secret with most of her family but disclosed the sexual abuse to her mother who remained silent, which is not uncommon. This type of silence of sexual abuse also impacted Minifred from seeking mental health services. As an adult Minifred sought professional help to come to terms with the abuse: "It's only been recently that I even admitted to myself and actually went to counseling for it" (Zavella, 2011, p. 184). In this piece we can see the impact of silencing as it pertains to feeling of shame and guilt. Building on various rape story I build on a sexual assault narrative within a family system from Chile where money was a lure to promote silencing (Hernandez-Wolfe, 2015). Finally, I pull from the first empirical study from 2005-2006 with 60 women and men that endured sexual abuse in Mexico. The women and men represented in these stories validated the influence of silence and confusion around sexuality were standard (González-López, 2015). Furthermore, González-López asserts "in general the silence around sexual activity in Mexican families creates an atmosphere of ambivalence and ambiguity in which sexual secrets fester. The cultural ambiguity is reinforced by the double standards of morality that disadvantage women within both the family and society, and family ethics promoting the idea that women should serve the men in their families all of which makes girls and young women especially vulnerable" (González-López 2015, p. 5). In the final empirical study we see how cultural ambiguity where sexual secrets fester and are supported by the double standard of morality that has the potential to impact even more vulnerable women.

Cultural ambiguity, as it pertains to sexual trauma, is complicated due to various cultural elements.

As evidenced by the literature, cultural scripts have the capability of perpetuating silence within some Latinx family systems but the goal of this analysis is to illuminate various ways that agency is promoted via disrupting silence or remaining silent as a form of advocacy. To further illustrate the power in silencing, these creative and empowering forms of silence are built on activism cases from California in the next section.

Cultural Activism- Countercultural Rebellion

Levins Morales shares her perspectives on the importance of cultural activism in support of individual abuse and collective oppression that are not different things or even different orders of magnitude. To put it differently advocacy is a helpful strategy to deal with common systematic abuses that are equally hurtful. As a result of traumatic experiences, the survivors find ways through cultural activism to reclaim their truth. After all there is no one way to cure nor heal trauma. But more importantly is the power in sharing and listening to survivors of trauma at individual or group sessions. “if you have come to save me…..rather what I want you to do is to sit with the trauma”(Levins Morales, 1998, p. 4). I derive from Levins Morales because to demonstrate how listening to stories matter. Some instances of racial trauma may result in obtaining therapeutic services. In those cases, I see how medical model influences mental health treatment via health insurance. The medical model and the binary body/mind split are rooted in histories of racialized sexual abuse stemming from early colonialism through the present, socially constructed labels collide to produce particularly damaging stereotypes. Notably the medical model utilizes manualized modalities that effect treatment plans by dictating how many sessions are allotted per calendar year.

Culturally Specific Experiences of Mental Health Treatment

In addition to silencing, I analyze *Chicana Movidas* below, cases of racial trauma to spotlight how labels and assumptions were made by social workers in 1970 in Los Angeles that resulted in families not obtaining adequate services they deserved. Racial trauma is abuse that negatively impacts mood due to racial biases. The main point with illuminating the case in Los Angeles was to spotlight activism strategies used to help families cope with the racial biases endured in the 1970's. Both African American women and Latina women disrupted their silence and advocated for social justice.

Another form of activism includes the Welfare rights movement in greater Los Angeles in the 1960's and 1970's focusing on Chicana leadership and coalition building with African American women. The coloring of public assistance was met by a racist backlash against families of color, cuts to welfare budgets, and punitive disciplinary measures to control the behavior of poor mothers. "These changes also laid the groundwork for women of color in Los Angeles to organize and advocate for adequate income, full access to social services, and an end to arduous application process and degrading welfare policies" (Espinoza et al., 2018, p. 231). Moreover, "A 1967 report by the Department of Los Angeles Mental Hygiene portrayed white recipients as psychologically damaged individuals in contrast to recipients of color, who were assigned a collective cultural pathology" (Espinoza et al., 2018, p. 233) Cultural pathology takes a deficit perspective. Below, I draw parallels between the 1967 report from the Department Los Angeles to current times to demonstrate the continuation of stigmas and stereotypes in social work. To illustrate while 1967 report pertained to racism with women seeking welfare assistance I examine similarities with stigmas regarding mental health that are systemic. Although cultural scripts can perpetuate silence, I am most concerned with using the concept of agency to show

how Latinx women create and use knowledge that is rooted in an experiential, subjective and intuitive frame of reference to interpret life experiences of oppression and understandings of "mental illness" (Gayle Waldron, 2002, p. 105).

First, I demonstrate how socially constructed notions of racial trauma contribute to stereotypes of Latinx/a. Then I analyze a government case from Los Angeles in the 1970s to spotlight activism strategies used by women of color to advocate for social justice. I conclude this chapter by analyzing studies that link the benefits of nature with short term treatment, such as solution focused therapy, to examine how Latinx/a women exercise agency by challenging deficit perspective through reclaiming their own narratives. Finally I summarize the main ideas that emerged from the analysis.

Not only is the use of negative stereotypes and assumptions of historically underrepresented groups by social work a new experience. But the Covid-19 pandemic continues to shed light on health disparities in communities of color. I see this work of advocating for mental health as building on the work of creative advocacy groups that have raised awareness to social welfare injustices by calling attention to the double standards placed on Chicanas who did not have partners and who depend on government assistance. For example in *Chicana Movidas* during the 1960 to 1970 "Chicana welfare recipients seemed to clash with movement themes of a unified Chicano- family and racial self-determination" (Espinoza et al., 2018, p. 229). For example the women seeking assistance were often stigmatized by the staff working in social services. Although these movement referred to as "*countercultural rebellion"* with men involved with gangs as a form of rebellion (Espinoza et al., 2018). Yet, I see countercultural rebellion, with women that challenge stereotypes with mental illness. For example, counter cultural rebellion is a form of activism that emphasizes agency and empowerment and that disrupts

silence to offer a space where participants can share their experiences, value, and worth. But part of the process of challenging cultural scripts is also acknowledging the risks for those who speak up within their culture. In addition to the movements in 1960's to demonstrate in *Traddutora, Traditora: A Paradigmatic Figure of Chicana Feminism* the use of negative labels within the culture. Norma Alacrón referred to the women as "malinches or vendidas" for those who chose to rupture silence (Alacrón, 1989, p. 63) that sheds light on weaknesses within our own culture. Specifically for the women that choose to defy cultural constraints. Cindy Cruz defines cultural constraints as breaking family rules when disclosing trauma. In reconstructing the memory of the trauma, Soto reconstitutes the experience, making sense of her own history as a survivor, and begins the process of transformation (Cruz, 2001). Cindy Cruz deconstructs the "discourse in scripted in the brown body the images of racialized discourses of capitalism, and how the lesbian mouth is marked as sexual and transgressive –"muchachitas bien criadas, good girls don't talk back" (Cruz, 2001, p. 664). I analyze cultural constraint with cultural scripts of silence to illustrate the implications of disrupting silence. Research demonstrates how cultural scripts of silence defy family expectations (Szlyk et al., 2018). Counter-cultural rebellion disrupts the silence of racial trauma by advocates for transformative welfare policies. At the same time counter cultural rebellion in mental health shifts the label from a deficit lens to advocacy through activism. A counter cultural rebellion promotes forms of liberation that challenges stereotypes and labels that have been imposed by social services on marginalized communities for a long time. However, as demonstrated above stereotypes and negative labels are found within welfare systems and policies, and beyond. As demonstrated above, Norma Alarcón and Cindy Cruz illuminate stigma also exists the Latinx culture. As a matter of fact, Cherríe Moraga (1983) reveal how we, as a Latinx culture have a shared experience with systemic racism, but we Latinx

culture need to take a closer look at our weaknesses by doing a better job with supporting mental health through counternarratives. The problem is although there is limited research on how the process works with Adventure Therapy and Latinx communities. This study explores if testimonio and counternarratives are viable vehicle for change.

I conclude this section of advocacy to illuminate stories of silence and activism as it pertains to the transcripts of the Sleepy Lagoon Trial in Los Angeles which demonstrates the absence of words used as another form of advocacy by Bertha Aguilars refusal to conform in the People v Zamora case (Ramirez, 2009). Aguilar is a fourteen year old that was given time at a detention center in connection with Jose Díaz death. It was determined by the police it was a murder case and convicted twenty-two defendants on January 15, 1943. Later, a feminist sociologist Robin Tolmach Lakeoff examines the differences with treatment of gender, race and proper etiquette of women. Lackeoff asserts "while the giver of information (the speaker) usually holds power in everyday speech, in court, the giver of information (the witness) does not control topics for discussion" (Ramirez, 2009, p.102). This demonstrates roles of power of who speaks, and whose voice is heard between the attorneys and the witnesses. Notably Aguilar provides strategies of defying unspoken rules by making a decision of when she remained quiet or not. Silence does not have to be disrupted to equate with power. Silence is used as a form of resistance. "Aguilar's strategic use of silence reveals that the absence of words has its own contours, its own texture. It compels us to rethink resistance and to recognize the many contradictory and hidden forms it may take" (Ramírez, 2009, p. 103). To put it another way the courtroom case holds a lot of rhetorical power that is linked back to the idea of rupturing silence with presenting rupturing through speech and refusal through silence as two paired forms of activism and resistance. Equally important is the nuances of silence. For example, in the

courtroom case is about refusal to conform by remaining silent. Whereas disclosing sexual violence may cause some feelings of confusion due to defying family expectations with keeping secrets inside the family. Both are examples of women that use silence but have been stereotyped and misjudged. The contrasting forms of silence illustrate the complexities of defying expectations either in the courtroom and family expectations due to repercussions of disclosure. To illustrate, I bridge legal scripts of silence with cultural scripts of silence to offer contrasting perspectives of silence. Findings suggest cultural scripts of silence are when disclosure occurs with painful circumstances, and how one feels towards defying family expectations about disclosure (Szlyk et al., 2018). Whereas, legal scripts of silence used in the Los Angeles court case as an example of power. While on the one hand sharing trauma stories can be liberating on the other hand it can lead to distress. In fact, it is important to also note that just because I identify as a Latina researcher and clinician that does not mean that similar folks that identify like me will find me as a good match to share their stories, and this too can lead to distress. Later, in this dissertation I will offer an illustration with an informant of silencing to demonstrate her advocacy skills but also to illustrate how she was misjudged with the Latinx community.

Moving beyond the implications of cultural scripts, and forms of collective activism cases in the United States I narrow this final section toward mental health models and build on various scholars to spotlight the benefits of mental health with solution focused approaches and nature.

Benefits of Strengths-Based, Solution-Focused Models and the Outdoors

I start by analyzing a strengths-based, solution focused model of mental health treatment, then examine the literature on the benefits of the outdoors on overall health. I do this to capture the nuances of human life and social phenomena among powerless and marginalized and

subsequently oppressed Latinx women. To do so, I demonstrate the significance of using strengths-based models in mental health to construct knowledge with Latinx/as.

Strength Based Approach

A strengths-based approach (SBA) in mental health draws on strengths rather than placing an emphasis on the illness. Evidence suggests through a mixed study conducted over a two year period with a sample size of 58 college participants that used a web based instrument. The study abroad course used SBA approach that placed an emphasis on strength and benefits of integrating the outdoors to health, instead of solely focusing on correcting weaknesses. The three key findings of a strength-based approach included, first positive outcomes as attention was geared towards personal development, second there was enhanced relationships, third a strength based approach helped respond to physical challenges (Passarelli et al., 2010). Strength based approach in my research is important because it works towards validating mental health by promoting agency, listening to their experiences without judgment. A SBA in mental health challenges assumptions, categories and labels. Substance Abuse and Mental Health Administration (2022) suggest a SBA places an emphasis on what is working. To demonstrate a research team conducted a mixed method study on 32 families affected by abuse. Of the 32 families 18 youth participated in the study and 14 youth in the comparison group. The participants identified as largely Hispanic and Caucasian. The study used adventure therapy that included kayaking, and rock climbing. A strength-based approach centered on tell me what happened to you compared to what is wrong with you (Norton et al., 2019). An emphasis with this approach place and emphasis aptitude to spotlight strengths, talents and gifts the student achieve. A SBA combines both strengths and weakness by infusing empowerment tools and bringing awareness to the importance of supportive networks that can offer guidance during

times of adversity (Passarelli et al., 2010). I argue that a strengths-based approach with mental health is more about validation and support, specifically when stories and experiences are shared about the process of living with mental health concerns, that are not linear. Nonlinear means circuitous which is indirect, and the mental health journey is different for everyone. As illustrated above an SBA focuses on aptitude rather than weaknesses. Therefore, a nonlinear approach means the medical model cannot use manualized treatments that tend to put all groups in an intervention that is supposed to work for all. Yet, the manualized treatment suggests the evidence based models are the golden standard for treatment (Shedler, 2018). The reason therapy cannot be conducted via an instructional manual since narratives can be complicated that may results in unexpected adaptations, especially with communities that have lost trust with the system.

Solution Focused Brief Therapy

On the other hand, a solution-focused brief therapy (SFBT) entails short term therapy. The SFBT may include a minimum of three sessions required to bring about change. Additionally, SFBT promotes the co-creation of stories between the therapist and the client to identify a treatment goal and learning coping techniques. To illustrate, an autoethnography with SFBT of a teacher that worked with vulnerable adolescents. The study was done adolescents that exhibiting distraught emotions in the UK on fundamental elements used with adventure activities, that lead to positive changes in lives. Techniques such future focused, scaling questions and debriefing were effective with SFBT because it focused on the now rather than remembering problems from the past. This research used metaphors as illustrations of AT elements for good practice which include “low visibility navigation, duty of care, and leave not trace” (Natynczuk, 2014, p. 28). Although this study referenced a backpacking trip I also see

how these metaphors, listed above can be adapted to enclosed spaces, as well. The first metaphor, low visibility navigation equates to the perspective of the client to identify strategies that have aided in their life to help cope with difficulties. The second metaphor is centered on autonomy of the client compared to the therapist offering advice that can lead to the client feelings of being forced to do something. The third metaphor focuses on safety during the activities. The findings of study illustrate core elements that can be adapted to outdoor settings and inside settings using adventure activities.

Benefits with The Outdoors

Building on a strength-based approach and solution focus brief therapy as illustrated above, I infuse testimonio because scholars suggest testimonio is a culturally congruent method that interweaves core principles of social work that include the ideas of elevating collective stories, more specifically as it relates to promoting mental health and the outdoors. Rigoberta Menchú suggests testimonio amplifies a collective voice rather than solely focusing on one voice (Menchú & Burgos Debray, 2009). Such as amplifying voices of social injustices with Mayan communities in Guatemala. For example, Menchú advocates to defend their land from rich landowners and government. The way testimonios will be weaved in is by offering empathy that works towards revealing painful and enriching experiences that promotes agency to allow redefinitions of mental illness (Delgado Bernal et al., 2016).

I make the connection with testimonio and culture to spotlight various scholars that support the benefits of nature with diverse communities. To illustrate, Anzaldúa, who asserted "Chicano and Chicana have always taken care of the growing things and the land...The land was Mexican once, was Indian always and is. And will be again" (Anzaldúa, 2007, p. 113). These scholars illustrate how nature has historically played a positive role in the lives of historically

marginalized groups, yet we do not learn about pioneers of color with the outdoors. But there is a lack of cultural representation in outdoor literature (Roberts & Spears, 2020).

Literature supports reconnecting with the outdoors restores and rejuvenates overall health (Jones & Segal, 2018; Baur et al., 2013; Buijs et al., 2009). Additional studies illustrate, these studies reveal how outdoors can be adaptable and geared more towards communal spaces (Vankanegan et al., 2019; Koperski et al., 2015; Tucker et al., 2013; Passarelli et al., 2010; Buijs et al., 2009; Gómez, 2006). In fact, the findings of one study demonstrate how immigrants hold different preferences and perceptions with the outdoors. To demonstrate Islamic and Christian cultures to be practical spaces as a way to bring the outdoors into culture (Buijs et al., 2009). Another empirical study included 311 Puerto Ricans in Massachusetts that examined the concepts of the outdoors. The study found that Puerto Ricans do use parks (Gomez, 2006). Also, another study used a mixed method to focus on strength based approach that infused adventure therapy. The findings support how building on talents help overcome difficult activities. Another benefit include the ability to process experience. Finally, as illustrated in this chapter studies find that behavior is enhanced when adventure therapy was implemented (Vankanegan et al., 2019; Koperski et al., 2015; Tucker et al., 2013). A combination of core elements that interweaves strength-based approaches with testimonios, and the positive effects of the outdoors is centered on co-creation of knowledge that entails a reciprocal process where agency and empowerment are promoted via storytelling are connected between the researcher and the researched.

Conclusion

I was better able to understand the information I was obtaining from the women in my study because of the experiences we share as Latina women and as women that have endured various forms of adversities. It was this self-knowledge that allowed me to shoulder up with the participants to make sense of the data rather than detach myself. A strengths-based model promotes agency with the client to share their story and re-frame negative labels placed upon those diagnosed with co-occurring disorders in order to reclaim stories of mental health by shifting the narrative to collective resistance and solidarity with healing. Rigoberta Menchù suggests testimonio amplifies a collective voice rather than solely focusing on one voice (Menchú & Burgos Debray 2009). I build on this idea of collective resistance with Rigoberta Menchu's concept of shifting ideas of individualism to a collective perspective that integrate traditional healing. Neuroscience suggests the "process of healing from sexual trauma helps create unique strengths and perspectives that in turn create post traumatic wisdom" (Perry & Winfrey, 2021, p. 200). In other words, weaving in the outdoors, music and healers can help to create a journey that build on strengths.

The concepts of cultural scripts, silencing and activism are core to understanding the complexities within Latinx culture and how cultural scripts are pivotal with disclosure. Equally important is awareness of the nuances with silencing and becoming aware of the risks and benefits of disrupting silence. Finally, an examination of activism was offered to illustrate the creative forms of silencing that goes beyond disrupting silence. In addition to these important concepts, I draw on research to illustrate how strengths-based approaches are used to promote agency and empowerment, which are key elements of culturally congruent models, such as testimonios. The primary purpose of this study is to fill that gap by exploring how adult Latinx/a

articulate mental health in a recovery treatment program. As illustrated in the introduction, this research is focused on exploring whether adventure therapy is an effective model with adult Latinx/a in a non-profit recovery treatment program. Scholars suggest that there is a lack of evidence in non-profit agencies (Norton & Watt, 2014).

The next section is the theoretical framework where I weave in various scholars to spotlight the importance of reclaiming stories and self-determination by integrating a decolonial epistemology (Franco, 2020; Smith, 2012), combined with a trauma informed approach.

CHAPTER TWO: THEORY

Theory and epistemology help make sense of reality by enabling us to make predictions about the world we live in (Smith, 2012). To begin, the two primary research elements that guide this study are interpretivism combined with a decolonial epistemology because they offer elements that elevate the clients' voice and promote agency. Theory is a framework based on philosophical assumptions that guide what the researcher hopes to find (Creswell & Poth, 2018). For example, ontology pinpoints what the researcher views as reality. Considering philosophical assumptions, epistemology recognizes how the researcher knows reality. Equally important is axiology which values the method and methodology used in the study. As described in chapter two, I build on scholars that describe the nuances of silencing as it pertains to disclosure of abuse. My work builds on this theoretical concept of interpretivism to shed light on mental health with Latinx/a adults in a recovery transitional living program by analyzing their way of articulating mental health and healing practices with the outdoors to challenge assumptions and labels with mental health. Interpretivism means awareness of cultural dimensions of how informants described their lived experiences with mental health. I combine both concepts of interpretivism theory with decolonial epistemology as frameworks that strive towards amplifying these women's voices. The relationship between these two frameworks place an emphasis on re-centering the voices of historically marginalized populations in research.

Interpretivism theory is central to canonical work in the social sciences and is used to elevate the voices of participants as they articulate their perception of mental health. Research suggests an interpretivist approach "looks for culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998, p. 67). Interpretivism's roots date back to the 1800's with links to Max Weber, a sociologist, Wilhelm Dilthey, a German philosopher.

Originally, German terms such as Verstehen (understanding) and Erkläen (explaining) were used in the social sciences to explain human and social realities. The historical order of appearance using interpretivist approaches are hermeneutics, phenomenology, and symbolic interactionism. I see hermeneutics as the object being studied, a phenomenology is an examination of lived experiences and symbolic expressions such as metaphors used to articulate meaning.

Frameworks of this study

Phenomenology treats culture from an ontological lens to examine the nature of the participants' realities (Saldaña, 2016). I see phenomenology working in the study because this study analyzes the lived experiences of the participants that have been diagnosed with co-occurring disorders of mental illness and substance abuse. Although I start by borrowing research elements by Crotty, of an interpretivist meaning to explore how cultural constraints affect mental health services by examining the participants' meaning of mental health and healing practices in the outdoors. I expand my approach to include trauma informed, decolonial epistemologies to better explore how cultural constraints affect mental health services through examining participants' experiences of mental health and healing practices in the outdoors with Hispanic women.

Critics of positivist methods argue that research elements that include ontology, epistemology, methodology and axiology should not be viewed as separate entities but rather are components that are interrelated. Shawn Wilson asserts "An indigenous research paradigm is relational and maintains relational accountability" (Wilson, 2008, p. 71). Wilson's indigenous epistemology allows researchers to see our systems of knowledge in their context. In this way we see a more holistic viewpoint. Wilson (2008) suggests it is the responsibility of the researcher "to ensure respectful and reciprocal relationships becomes the axiology of the person who is making

the connections We must be responsible in our choice of where we will build these powerful connections as we choose the topics of our research" (p. 79) because "indigenous research must maintain accountability to all the relationships that it forms" (Wilson, 2008, p. 137). Connecting these research elements with cultural context helps guide this study by illuminating nuances of disclosure of sexual abuse with Latinx communities. I borrow the term cultural constraints from Cindy Cruz (2001) to illustrate how there are unspoken rules about abuse within the Latinx culture. The intention of this study is to use a phenomenology approach to gain a deeper understanding of lived experiences of Hispanic women and mental health. Additionally, this study seeks to gain awareness of how the Latinx culture is enabling but paradoxically it is also crippling as it relates to mental health. To that end, I weave in frameworks that focus on self-determination. I build on culturally congruent frameworks including a Trauma informed approach with Decolonial Epistemology as these two frameworks promote agency, liberation and empowerment. These frameworks combined shed light on self-determination by considering the complexities of disclosure. The caveat with disclosure can induce stress because there is a sense of defying family expectations, in some Latinx cultures. I argue that cultural practices specifically with sexual trauma influences the disruptions of silencing due to cultural socialization. The term cultural socialization was used in a study by Luis Zayas and his team (2005) where they linked cultural socialization with a metaphor of "two edged sword" as it pertains to disruption of silence and the complexities within Latinx cultures that create confusion about disclosure with sexual abuse.

The purpose of this phenomenological research is to analyze the lived experiences of Latinx adult women that are living with mental health concerns. I listen for key concepts of cultural practice, cultural ambiguity, cultural hybridization, cultural memory, and cultural

resonance. I adopt the term cultural practice to analyze "how practices are tied to personal and family histories in complex and idosyncratic ways" (Kirmayer et al., 2014, p. 4). To say nothing of the complexity with the role of culture in the disruptions of silence would also be a continuation of silence. Then I build on the term of cultural ambiguity to spotlight the silence and confusion around the double standards of morality as it pertains to disclosure of sexual trauma and how cultures can even perpetuate the silence (González-López, 2015). Next, I build on the idea of cultural hybridization to examine how techniques via storytelling weaves in cultural memory to support healing. Cultural hybridization "infuses techniques to reshape clinical practice" (Kirmayer et al., 2014, p. 17). Finally, I explore the concept of cultural resonance to re-imagine stories of mental health (Warren et al., 2019). This study will employ phenomenological research to explore the meaning of mental health as a methodology to reclaim truth.

Trauma Informed Approaches & Decolonial Epistemology in Latinx/a Mental Health

As discussed in chapter one a TIA is a model supported by SAMSHA to work with folx that have been impacted by trauma. TIA includes six principles of: 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment voice and choice 6) cultural, historical and gender issues (SAMSHA, 2014). I employ an approach to treatment that modifies TIA with a culturally congruent element and decolonial epistemology to reclaim mental health stories by illuminating the importance of cultural context. Evidence suggests traditional interventions are poorly suited for minority cultural groups because studies lack examination of cultural factors, such as cultural context that can affect treatment outcomes (Davidson et al., 2015). Cultural context is disclosing of sensitive topics such as sexual trauma. But this also includes awareness of feelings such as ambiguity. Disclosing trauma leads to a

sense of defying family expectations (Szlyk et al., 2019; González-López, 2015; Cruz, 2001). Cultural contexts are dimensions of distress that are hidden because of the threat of stigmatization within historically underrepresented groups (Kirmayer et al., 2014). Hence, a (TIA) focuses on strengths of clients by promoting agency, empowerment and infuses techniques the weave in skills to increase safety and trust. I employ a trauma informed approach that places an "emphasis on safety as the primary emphasis of any treatment" (Cervantes & McNeill, 2020, p. 122). There is a need to understand the roots of mental health disparities among historically underrepresented groups. Latinas are projected to form nearly one third of the United States female population by 2060 (Szlyk et al., 2018). Next, I will weave in TIA principles to guide this study and will focus on cultural, historical, and gender issues.

Trauma Informed Approach

Even though traditional medicine and tools have historically been used, Latinx scholars suggest "safety is the primary emphasis of any trauma treatment" (Cervantes & McNeill, 2020, p. 122). Safety is a space where protection is felt and trust is built, which looks like PLTP which includes trained TIA staff. But when traditional medicines and cultural tools are not enough, there is a need to identify practices outside of traditional medicines to acknowledge the serious impact that mental illness can have on life. As a result of cultural barriers that include stigma, many clients find it difficult to articulate their emotions. A Substance Abuse and Mental Health Services Administration resource guide adapts elements of evidence-based practices for historically underrepresented groups (SAMHSA, 2022). Evidence based practice models are the golden standard medical model's for therapeutic treatment. Although the medical model is frequently assumed as the gold standard model, I argue that it is inadequate for historically underrepresented communities because it dismisses the effects of cultural context that affect

treatment outcomes. Evidence-based practices (EBP) mean there has been a plethora of consistent scientific evidence that indicate improvement in outcomes but SAMSHA supports that most EBP studies are not equally representative of efficacy with historically underrepresented groups (SAMSHA, 2022). Equally important scientific evidence prioritizes randomized control groups, an approach which was not used for this study. I draw on some similarities with adaptations that are more compatible with the culture. For example, the SAMSHA report supports eight core elements of Ecological Validity Model for Cultural Adaptation of EBP (SAMSHA, 2022). The eight dimensions start with the main circle of cultural sensitive elements, then the eight smaller circles are as follows: the person; the role of ethnic/racial similarities between client and therapist; culturally appropriate language; consideration of changing context in assessment, during treatment, or intervention; metaphors, symbols, and concepts shared with population; cultural knowledge of values, traditions and practices; treatment concepts consistent with cultural content; and the transmission of positive and adaptive cultural values, method development and/or cultural adaptation of treatment method (Bernal et al., 1995). These eight circles resonate with the concepts of cultural memory and cultural context used throughout my research.

Decolonial Epistemology

The Tuck & Yang (2012) article, "Decolonization is Not a Metaphor" critiques the metaphorical use of decolonization and emphasizes concrete actions that prioritize Indigenous sovereignty. This perspective is relevant to repatriation efforts, which involves acts of reconciliation. Similarly, I argue that trauma, particularly sexual trauma, should not be treated as a metaphor. Like Tuck & Yang (2012) I believe that once land is taken, it cannot simply be given back, and I draw a parallel between land and the body in relation to sexual trauma. However, I

propose that healing can be achieved by challenging cultural silence and empowering survivors through self-love and self-acceptance in sharing their testimonios. I argue a decolonial framework involves repatriation of land and the nonlinear healing of emotional scars by weaving in tools such as cariño, as a conduit towards healing. The term cariño is defined as authentic care (Delgado Bernal et al., 2016). Cariño means pure authentic care, that is an added framework during the data collection phase. Cariño places an emphasis on individual mental health by building a therapeutic relationship based on trust empathy and promotes autonomy and dignity.

I join scholars of decolonial epistemology to help understand psychological problems in context, reduce stigma and address healing. A "decolonization perspective is a conceptual framework for interpreting and articulating how the world looks to some of us when we know, experience, speak, and imagine it while situated in the dwellings of double consciousness, border thinking, and subaltern epistemologies" (Hernández Wolfe, 2013, p. 17). In this case, I see a decolonial epistemology in mental health employs a strength-based perspective that reclaims narratives to challenge assumptions and labels of mental health.

I infuse a decolonial epistemology combined with culturally adapted trauma-informed approaches by tailoring the content that involves metaphors. A metaphor is a figure of speech that compares two unrelated things to convey meaning in a creative way. Metaphors involves using words or phrases to evoke imagery or enhance communication. Later, in this chapter I illustrate how metaphors such as music are used to tell stories through a song *Paloma Vagabundo* by Quetzal to narrate a story of a bird (NPR Music, 2014). I use the song as a metaphor with mental health to illustrate the impact of labels and assumptions. Also, I reference two narratives to examine the roles of cultural scripts of silence. With attention to this study, I interweave the outdoors as a metaphor connected with mental health. In doing so, I weave in

Testimonios with Adventure Therapy to re-shape participants' narratives in the outdoors to demonstrate acts of liberation, love, and healing. Metaphors are integrated through adventure therapy by using tools that can include the outdoors and can be adapted to indoor environments. An example of a metaphor used in adventure therapy are challenge courses some use high ropes that can be used as a means to demonstrate trust and enhance communication. Metaphors can also be used as a bridge to describe how and what clinical work is with a new client. The bridge would represent the clinician that guides the client to get to their goal. As noted above a decolonial framework is centered on border thinking (Hernández-Wolfe, 2013). In this way border thinking from a clinical perspective challenges deficit model in mental health. A deficit model focuses on pathology whereas a strength-based approach builds on talents while mitigating weaknesses. A decolonial epistemology in mental health is a framework that challenges assumptions and labeling of mental health. A decolonial epistemology combined with a trauma informed approach in mental health infuses cultural dimensions that are pivotal when working with Latinx clients. Even though cultural dimensions are important it is equally important to remain aware that Latinx is not a monolithic group. Building on various scholars including Tony Alvarez et al., (2021), Luis Zayas et al., (2005), Nelly Rosario (2003), Cindy Cruz (2001), and Loida Maritza Pérez (2000), I connect literature in multiple ways that demonstrate how scholars coexist. Coexisting in this context is by weaving in various scholars from disciplines that promote work beyond the silos of solely social work and, or solely ethnic studies. Here I use co-existing with a metaphor of a puzzle. The pieces of the puzzle represent various disciplines that are connected to make one whole puzzle rather than pulling from one discipline. The challenge of mainstream knowledge is that it promotes manualized models such as evidence-based approaches that fail to consider the nuances across cultures. Put another way,

interdisciplinarity shows that the idea of co-existing can be represented through holistic health and how different entities of our body are all connected. Similarly, I see the advantages of interweaving various disciplines for greater insight that illuminates the importance of cultural context. Specifically, as I analyze mental health cultural explanations relevant to cultural constraints demonstrated through poems, fiction, and songs related to silencing the sexual abuse. The poem *250 Pounds* unpublished manuscript by Christine Soto illustrates how mothers perpetuated the silence with sexual abuse (Cruz, 2001), I define cultural constraints as barriers within the Latinx culture that can be seen as perpetuating silence as it relates to sexual trauma. I borrow from child welfare scholar, Dr. Robert Ortega (2013) that taught about the four primary pillars required when conducting clinical therapy with children that have been impacted by trauma. The pillars include safety, support, hope and trust. I build on the pillars offered by Dr. Robert Ortega but adjust the pillars that support adult women as they work towards disrupting their silence. The adjusted pillars include safety, confianza, cariño y esperanza. In conjunction with adopting the pillars listed to guide this study I will analyze the nuances of cultural practices by examining cultural constraints, in the next section.

Merging social sciences and humanities literature

A cultural analysis questions representation, futurity, imagination, and memory. Latinx scholars examine complexities that exceed social science tools. Sarah Wald et al (2019) asserted "Although I still very much identify and work as a social scientist, I am convinced that whatever impact my work has had is due to my propensity to borrow concepts and tools from any intellectual tradition, including humanities" (Wald et al., 2019, forward). I align with Wald et al., (2019) to adapt a cultural analysis examining humanities beyond Chicana literature to demonstrate how mental health symptoms were articulated after rape occurred with women in the Dominican

Republic. A cultural analysis values "the perspectives of humanities and social sciences that can help clinicians move beyond the frameworks of conventional mental health practice to appreciate the unique predicaments of individuals as well as the alternative visions of health and healing that are part of the riches and resources of a diverse society" (Kirmayer et al., 2014, p. 4 & 5). Beyond addressing the value of interdisciplinary research, it is equally important to note that my work draws on diverse scholars that may identify as Latinx and beyond. In parallel with crossing disciplines, I see diverse scholars as offering richness to this study that promotes inclusivity compared to exclusively borrowing from solely certain scholars. As described in Chapter 2 a strength-based lens focuses on empowerment and agency.

In this next section, I move onto the nuances of sexual trauma by focusing on two pieces of literature in the humanities. Although these pieces are fiction rather than academic research, their cultural context narratives exemplify the cultural scripts, experiences with silencing, and need for culturally congruent care. Accordingly, I analyze these passages to highlight main points, drawing on this interdisciplinary foundation.

Analyzing the nuances of cultural scripts and cultural context

The way I see cultural scripts is with symptoms such as out of the body experiences or psychotic episodes as illustrated by Loida Maritza Pérez (2000) and Nelly Rosario (2003) connected with sexual trauma. However, sometimes in Latinx culture, confusion sets in pertaining to mental health and stigma. Scholars argue that cultural scripts resemble symptoms of dissociative disorder that can be misdiagnosed as psychotic in cross cultural settings complicating the recognition of other co-occurring disorders (Kirmayer et al., 2014). I borrow the term Cultural Scripts of Silence to examine the complexities pertaining to defying family expectations (Szlyk et al., 2018) that occur after the disruption of sexual trauma and that can result in cultural ambiguity.

Cultural ambiguity is the confusion with double standards of morality (González-López, 2015). I borrow these two concepts, cultural ambiguity, and cultural scripts of silence, to spotlight the complexities of disclosure of sexual trauma within the Latinx culture. As shown above I build on the work of two humanities scholars that have roots connected with the Dominican Republic - Nelly Rosario (2002) and Loida Maritza Pérez (2000) to demonstrate how symptoms described in the text invoke distinctive notions of out of body experiences that were endured after rape. I build on these two scholars' work to illustrate the importance of cultural congruent interventions, and spotlight how mental health is not linear, it is very complex.

Next, I analyze cultural context and ways that mental health symptoms are articulated which may be less stigmatizing in certain communities. I offer cultural context of how mental health was described after rape. To demonstrate, in *Geographies of Home* some members of the family unit supported mental health, but some did not respect mental health. Additionally, their religious community lacked an understanding of mental health, too. As a result, Marina on several occasions attempted to commit suicide. Research suggests there is a serious consequence with life if mental health treatments are not sought out. Luis Zayas and his research team have made significant strides in analyzing the connection with generational sexual trauma and suicide attempts (Szlyk et al., 2019; Gulbas & Zayas, 2015; Zayas et al., 2010). Although the focus of this paper is not centered on suicide, the research team of Luis Zayas findings illustrate the importance of culturally effective interventions that support the overall health of Latinx communities. In like manner with interventions is an awareness of cultural ambiguity. Evidence suggests that silence, gendered oppression, and violence transcend generations, highlighting the need for research that can elicit narratives from multiple family members when exploring life threatening issues (Szlyk et al., 2019). Notably, both Nelly Rosario (2003) and Loida Maritza

Pérez (2000) weave into these pieces the roles of multiple family members.

As mentioned at the beginning of this section these two stories of rape illustrate how mental health was supported, or not. I critique these two pieces from a clinical lens that takes up a nondeliberative interventions. A nondeliberative intervention infuses adventure therapy uses hands on experiences and activities to promote personal growth. A nondeliberative approach with AT involves engaging the participants to facilitate the transformation (Tucker et al., 2016).

In the text *Geographies of Home* the main characters included Papito Illiana's father, Aurelia her mother and their thirteen siblings included Illiana María -a college student that endured racial injustices. It was the stress of family dynamics that caused Illiana to leave her academic endeavors and return home. Some additional siblings included Rebecca, Marina, Beatriz, Vicente, Tico, and Gabriel. But Illiana feared that "only by leaving home had she, on occasion, acquired the confidence to express her opinions, and she feared that by returning she would fall silence once again" (Pérez 2000, p. 10). Despite Illiana's fear of being silenced she also felt that she could be a conduit to change by bringing attention to mental health services. To illustrate Illiana advocating for Rebecca to obtain psychiatric help due to her history with residing in domestic violence relationships. A core value of this Dominican family is built on the Seventh-Day Adventist church that follow strict guidelines of not going to bars nor cinemas because those were locations where "Satan preyed on souls" (Pérez , 2000, p. 2). Here what we see is the important role that faith partakes in family life but it can also diminish the consequences of one living with serious mental illness. In combination with adhering to the values of the faith practiced at home, there were family dynamics that lacked an understanding of mental health. Also, the Seventh Day Adventist lacked an understanding of mental health because the response of the faith community placed negative assumptions and fears with Marina

when she had an episode during a church service. Marina's "madness" had not been diagnosed as schizophrenic. Here, I build on the work of cultural context to demonstrate how emotional distress is hidden because of potential stigma (Kirmayer et al., 2014). Marina's doctors mentioned it only as a possibility, which meant that Marina might instead have suffered, simply, a "nervous breakdown" (Pérez, 2000, p. 41). According to the family the breakdown occurred after Marina was raped. "The man grew unexpectedly still inside her. When she dared imagine he had finished, he gripped her hips and thrust himself deeper into her womb. Her stomach convulsed with nausea. Her thoughts scattered. Unable to see his face, she detailed it from memory so as to draw courage from her hate" (Pérez, 2000, p. 17). I insert this context in this section to illustrate the influence of cultural scripts of silence. The effects of painful circumstances models how sensitive topics are expressed and the risks of not obtaining adequate mental health services. The important piece in this literature is to examine how cultural scripts of silence lead to forms of expression that resulted in nuances of mental health and complexity with diagnosis. For example, it is possible that Marina was misdiagnosed with schizophrenia.

Similarly, I draw on *Song of the Water Saints* by Nelly Rosario (2003) to describe an out of body experience as she endured rape. In song of the water saints Leila described how she felt during a forceful sexual encounter "Miguel was soon rough again, and Leila floated back to the ceiling and waited by the curtain rods" (Rosario, 2003, p. 34) of exploitation, rape. The main point of this narrative is to illustrate how three generations endured sexual assault and kept the sexual assault silent to not defy family expectations. I build on the work of Nelly Rosario to demonstrate how Luis Zayas' works suggests cultural scripts of silence are linked with generational sexual trauma by illustrating how three generations of Latinas described mental health symptoms after the endured rape. Although I focus on one quote from the book to analyze,

what I explore is how Leila did not seek out mental health services. But if she did, what could help guide modalities that clinicians may follow? First, I start by acknowledging that therapy is not for everyone. But also, I offer various research that points to the potential risk of losing life by suicide if mental health services are not obtained. Below, I critique how clinicians can adapt interventions that infuse metaphors such as narratives and music that work towards reducing stigma of mental health in Latinx communities.

I build on key principles of trauma informed care adopted by Substance Abuse and Mental Health Services Administration (2014) that include: Safety, Trustworthiness and Transparency, Peer Support, Collaboration and Mutuality, Empowerment-Voice and Choice, Cultural-Historical and Gender Issues. Borrowing these key principles to shift from a deficit lens on folx that endure mental illness that challenges questions of "What is wrong with you," to a strength-based approach that focuses on empowerment and promotes agency. If I had a client like Marina show up at my office door I would start by building rapport with the client while reviewing the consent forms the is centered on safety, and agency policies pertaining to services allotted per calendar year. After that I would work towards building rapport from a strength-based perspective with Marina by building on her strengths that include her communication skills while also working towards mitigating her symptoms. Then I would focus some of the session on psychoeducation with mental health that strives toward an understanding that mental illness does not define the person, and stress the importance of compliancy to help us achieve the identified goal of treatment.

Infusing cultural hybridization to examine cultural memory

Building from this analysis of cultural scripts, I further demonstrate how Latinx/a use storytelling, experiences, and knowledge to transform injustices via cultural memory. I infuse cultural hybridization as a technique to reshape ideas of clinical practices. Cultural Hybridization "examines specific ideas and techniques in reshaping clinical practice as social systems interact ever more rapidly and intensely in our globalizing world" (Kirmayer et al., p. 17). Infusing cultural hybridization with cultural memory I build on the work of Patricia Zavella to illustrate the advocacy and power in music (Zavella, 2011). A cultural memory reflects upon the power relations that affect social categories and social identities. To draw attention to the plight of migrants, cultural activists produce repertoires of cultural memory "through performance in music allows the audience to participate" through music and movement that trauma destroys (Zavella, 2011, p. 223). Cultural memory is a guiding force in the development of Adventure Therapy by promoting agency of the client, building on their voice and elevating it through stories, and empowering clients through the opportunity to share if they choose. I borrow a song to demonstrate cultural memory as it pertains to the environment. The song titled "Paloma Vagabundo" by the Quetzal band shows how, in the words of the musician, no matter how "filthy and dysfunctional the bird appeared to not have the ability to love and be loved." This song illuminates how urban animals living in unnatural spaces that tell us "we don't belong" can impact our health (NPR, 2014). The NPR Tiny Desk concert offers a song titled "Paloma Vagabundo," sung by Martha Gonzalez who has her PhD in folk music, that is infused with social justice, activism and education. I focus on activism via a song conducted by Quetzal Flores connected with a paloma/pigeon to represent the life of urban animals and how we relate to them. I use music as a metaphor to connect the metaphor with stigma on mental health.

Specifically, with the interpretation of lyrics “ability to love and be loved regardless if we are in a space that says we don’t belong.” Although this song relates to race, I draw on similarities for those with mental illness and not feeling understood by society. For example, with mental illness it is about advocating towards challenging labels. Despite these hardships, we find creative spaces to practice self-love. Similarly, we can connect this song to stories of the impact of sexual trauma. Mental health within Latinx communities can be exclusive which is based on stigma. By the same token, I argue that perceptions are changing slowly as treatment models become more conducive with Latinx group. As a collective community, we challenge labels to reduce the stigma of mental health by validating stories that empower Latinx communities to continue to strive to move forward, fuerte y con cariño. As such I adopt cultural resonance to re-create and re-imagine narratives (Warren et al., 2019 & Ettema, 2005). The NPR tiny desk song “Paloma Vagabundo" by Quetzal (2014) is a direct example of media creating cultural resonance and changing the narrative around mental health, to re-imagine culturally congruent modalities.

Cultural memory and Adventure Therapy

Building on this idea of storytelling through music we can also draw on strategies that include art, metaphors, dichos and beyond that have been used to express trauma narratives (Arrendondo et al., 2014 & Zavella, 2011). These elements of storytelling can also be adapted with Adventure Therapy. As illustrated in the introduction adventure therapy is an integrative and interactive form of mental health treatment. Scholars suggest adventure therapy takes a nondeliberative approach because AT uses tools that include the outdoors as part of the therapeutic process to empower clients. A nondeliberative approach fuses an AT tool that promotes agency by encouraging participants to participate, then process through debriefing how the activity is connected in life, beyond the therapeutic setting. AT is adaptable in various health

care settings and with diverse groups (Alvarez et al., 2021; Tucker et al., 2016). outdoor social justice pioneers, Warren et al (2014) suggests a way to re-imagine outdoor research is to integrate counter-narratives that include a conscious multicultural approach. A counternarrative approach can be done through building on the work of Dr. Nina Roberts and Alan Spears (2020) the importance of moving beyond teachings of White outdoor pioneers such as John Muir and Rachel Carson to include awareness of pioneers of color such as Lancelot Jones and Martha Aikens that embraced the outdoors since time immemorial. I am challenging ideas with labels and assumptions that are placed on women with co-occurring disorders. Stories align with the importance of cultural representation. Cultural representation spotlights the importance of visibility beyond mainstream forms of knowing (Wald et al., 2019). Scholars demonstrate cultural representation by illuminating Black Indigenous People Of Color historical pioneers such as Lancelot Jones and Martha Aikens in the outdoors literature to draw attention to the fact that their stories have been omitted (Roberts & Spears, 2020).

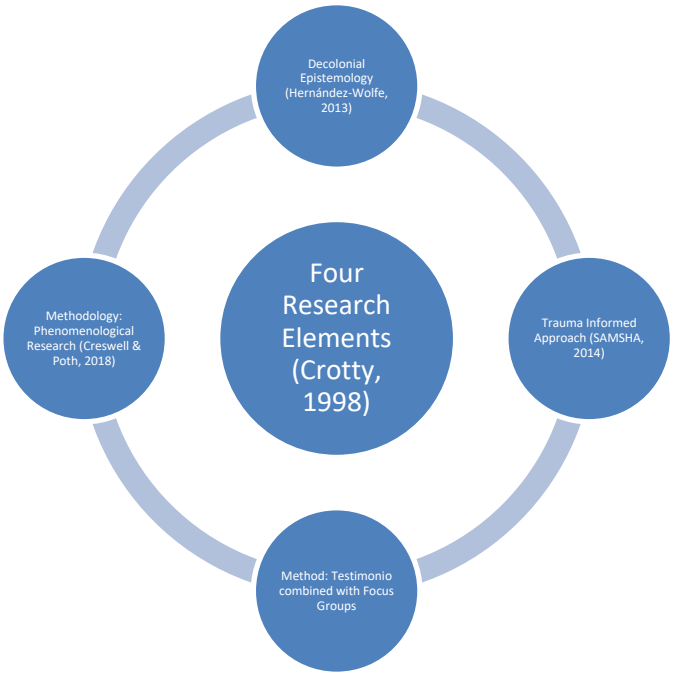
Hence a way to re-imagine the outdoors that is more inclusive for Latinx is to bring awareness of pioneers that have infused the outdoors for centuries as part of healing. To illustrate, a Latinx pioneer Rigoberta Menchú & Burgos-Debray (2009) conducted an ethnographic study that incorporated a collective testimonio to advocate for social justice in her home country of Guatemala to shed light on injustices being done in the community. In sharing Menchú's testimonio we also see how the outdoors were sacred places that were used for healing. Scholars, like David Stoll, have critiqued Menchú' & Burgos-Debray research study, exigent the idea of who has the power to share the narrative (Flores Carmona, 2014). In contrast to those critiques, a decolonial approach can find implications for practice. David Stoll an opponent of the book is a white anthropologist, who argues there was not accurate translations of

the testimonios. I see David Stoll as another white researcher that have historically gone into communities of color to take data for their benefit, only. Not for the benefit of community. Menchú & Burgos-Debray (2009) talks about how testimonio is not only sharing stories but ones that benefit the entire community. In the next chapter I offer further details of the benefit with combining cariño with testimonios to elevate voices with lives that have been affected by mental health to challenge deficit frameworks that places an emphasis from a pathological perspective.

CHAPTER THREE: METHODS

In this chapter I discuss the approaches used for my data collection that aided with analyzing and interpreting the data. The chapter is comprised of four sections. Part One - *Research Method* examines how I infused testimonio as a culturally congruent method to collect data. It is important to note that because this study focuses on elevating the voices of participants, I refer to participants using the demographic terms they used during the testimonios, *Hispanic/Mexican American*, but also I infuse *Latinx* throughout more general discussions because it spotlights the importance of intersectionality and builds on the idea of challenging labels. In Part Two-*Data Collection*, I address the efficacy of using strength-based approaches in mental health to capture the nuances of human life and social phenomena among powerless and marginalized and subsequently oppressed Latinx/Hispanic women. In Part Three, I discuss *Cultural Hybridization* that combines Gloria Anzaldúa seven stages of conocimiento with a model Adventure Therapy to deal with complex social constructed realities of marginalized women. I conclude with Part Four- *Barriers with Research,* an account of limitations and what I had to consider in doing research with Hispanic/Latinx communities during the COVID-19 pandemic, as well as an assessment of what I would have done differently if I had the opportunity to conduct research again. Below, I build on (Crotty, 1998) research elements by adjusting the elements that re-center the voices of the participants.

Figure 1: Infusing four research elements



In this research, I interweave ethnic studies epistemology with social work methods that are culturally congruent for Latinx communities. A decolonial approach counters hegemonic norms which has traditionally taken a deficit lens in addressing mental health in historically marginalized communities (Franco, 2021 & Breunig, 2019; Gadhoke et al., 2019). A decolonial approach, however, works towards challenging the deficit models by challenging assumptions and biases. In addition, it supplies a foundation in examining psychological problems in context, reducing stigma, and promoting healing (Hernández-Wolfe, 2013). A decolonial epistemology further shifts existing paradigms of mental health research and practice by challenging dominant assumptions and labels and progressing towards forms of self-love and healing. In many ways, decolonial epistemologies undergird efforts to create spaces that support sharing and validation of mental health experiences.

Although this framework begins with Crotty's interpretivism theory, I note that this theoretical framework process is transformational, as discussed in the previous chapter. The focus of this study weaves in decolonial epistemology with trauma informed elements to amplify voices of Latinx/a adult women obtaining services at PLTP by infusing culturally derived frameworks and historically situated interpretations of mental health. As illustrated above, I list out the research elements that will be implemented to ensure soundness for this study (Crotty, 1998). For example, in this research at least two validation strategies should be implemented to ensure reliability (Creswell & Poth, 2018). Hence this study weaves in strategies that include corroborating evidence through data triangulation (Padgett, 2017). I employed data triangulation by using more than one data source; to illustrate, I conducted testimonios with participants and staff, and participated in observations of groups, combined with facilitating two focus groups. Also, I clarified researcher bias by consulting with committee members, by engaging in reflexión. "reflexión is a dialectical process that we followed in formulating a collective consciousness among ourselves and with established scholars" (Delgado Bernal et al., 2016, p. 93). I generated a thick description by documenting themes and quotes, and debriefing with committee members about the data and research process.

Then, I combined Testimonio (Delgado Bernal et al., 2016; Latina Feminist Group, 2001) with focus groups. Some scholars integrate testimonios as a method to advocate for social injustices from a community perspective (Menchú & Burgos Debray, 2009). Hence this study builds on a collective approach to amplify voices of Latinx/a adults. Research supports that testimonio is a culturally congruent method, and therefore this method seemed advantageous to combine with focus groups, too (Cervantes & McNeil, 2020).

A key innovation of this study is that it integrates testimonios via focus groups into the

core principles for data collection, alongside pláticas. What I mean by this is that time was allotted to get to know the participants by attending groups and other events, beyond just the data collection. I see this quality time as a conduit to help build trust with the participants. A further comparison of platicás and focus groups (see Appendix C), but similar key components are found in both platicás and focus groups, such as group dynamics and relationality, intersectionality and cultural congruency, reflexivity and self-awareness, and the co-construction of knowledge (Fierros & Delgado Bernal, 2016 & Ortega & Garvin, 2019). By weaving core practices of focus groups and pláticas, this study combines their key principles to re-imagine stories of mental health from a social justice focus group perspective.

The summary audio recording and written documentations summarizes the main events of the session and includes a few direct quotes of statements made by participants and staff of Powerful Lives Transforming Program (PLTP) is used as a pseudonym for the purposes of confidentiality. Content of the focus groups "included the date of the session, the members present and absent, the goals of the session, information on the activities or discussion held during the session and future plans made at the session" (Ortega & Garvin, 2019, p. 275)

Part One: Research Methods-Testimonio

This work builds on scholars that use testimonio as a method (Delgado Bernal et al., 2016). Testimonio has its roots from Latin America that was used to call attention to social injustices (Latina Feminist Group, 2001). Scholar's support testimonios as an advocacy method that promotes agency through various political movements to denounce injustices in Latin America (Latina Feminist Group, 2001; Menchú & Burgos-Debray, 2009; Reyes & Curry Rodriguez, 2012). One way to destigmatize mental health is by connecting individuals with collective histories of oppression and stories of marginalization via testimonios to elicit social

change. The reality is the outdoors have been used with historically underrepresented groups for decades, but as Roberts & Spears (2020) noted, there is limited research with pioneers of color that moves beyond dominant narratives. Despite the injustices that people of color have faced, they have weaved in creative tools with nature that have been a part of the embodied belief about with promoting health for centuries (Cervantes & McNeill, 2020; Medina & Gonzalez, 2019; Arrendondo et al., 2014; Menchú & Burgos-Debray, 2009). Latinx scholars call attention to how Indigenous communities have incorporated tools such as the outdoors, rituals, music, metaphors, and other practices to promote holistic health for centuries.

Cherríe Moraga (1983) views humanity's relations with the earth as fundamental to achieving justice. But this idea of cultural representation requires a reciprocally respectful relation with land must include regard for land memory-which takes place outside of Western conceptions of time (Wald et al., 2019). Other Latinx scholars reclaim nature as a sacred space where they feel protected and call for a commitment to a reciprocal relationship where respect is equally exemplified (Wald et al., 2019; Menchú & Burgo Debray, 2009; Anzaldúa, 2007; Viramontes, 2007). Such perceptions of nature harmonize with the Native American view of "earth as our mother" (Oles, 1992, p. 21). Hence the idea of integrating testimonios to analyze the benefits the outdoors has on health is a viable option. This re-storying process weaves in techniques such as reflection and trust. Testimonio serves to connect, generations of displaced and disenfranchised communities across time (Delgado Bernal et al., 2016).

This research design recognizes that respondents of color are holders and creators of knowledge (Delgado & Stefancic, 2012; Delgado Bernal 2002). Research suggests testimonio elicits "exposing inconsistencies and debunks myths and long-standing stereotypes" by challenging assumptions (Romo et al., 2019, p. 7). The findings demonstrate how participants

navigated the college process by using cultural wealth to challenge inequities and negative stereotypes they endured by some school staff. Testimonio works to debunk myths in mental health by challenging assumptions of mental illness. Similarly, to testimonios, a strength-based approach infuses counternarratives as a tool that involves using qualitative techniques to disrupt a dominant narrative. A counternarrative approach aligns with mental health in that it utilizes a strength-based approach by amplifying voices. A strength-based approach challenges deficit frameworks (Carter et al., 2007). A counternarrative in mental health pushes back on labels and assumptions with mental illness. This includes shifting the focus of pathologizing mental health. But evidence suggests scientific rigor, validation and authenticity are rooted in Eurocentric perspectives where logical reasoning holds superiority (Pérez-Huber, 2009). However, logical reasoning does not value the holistic aspects and value of lived experiences and strength-based support systems. There is no logical method to describe the realities of mental health that are gained through testimonio. While validity is driven by Eurocentric frameworks, I interweave phenomenological methodology with this study by linking concepts in ethnic studies and social work. Scholars support "at least two validation techniques to be identified for qualitative research" (Creswell & Poth, 2018, p. 259). The strategies used for this phenomenological study are drawn from qualitative researchers that include reflexión through journaling and summarizing field notes, and triangulation. Scholars suggest reflexión is a way to affirm that what was shared via testimonio is accurately replicated through the process of (re)telling through writing (Delgado Bernal et al., 2016). Whereas "triangulation involves the use of different sources to establish credibility, for instance informants, methods, investigators or theories" (Creswell & Poth, 2018, p. 256). Since I relied on multiple and diverse data sources (demographic data), methods (testimonio and focus groups using the interview protocol) and

participatory observations from groups, and theoretical approaches (decolonial epistemology combined with a trauma informed approach), I was able to obtain rich and complex data to understand the research issues under this study.

Methodology: Phenomenological Approach

Scholars propose that a phenomenological approach describes commonalities of the participants' lived experiences with a phenomenon (Creswell & Poth, 2018; Padget, 2017, Saldaña, 2016). In this study, the focus of the phenomenon is with mental health and healing practices with the outdoors amongst adult Latinx/a. The four philosophical perspectives in phenomenology include "1) a return to traditional forms of understanding, 2) the suspension of judgment, 3) the intentionality of consciousness, and 4) the meaning of the experience of an individual" (Creswell & Poth, 2018, p. 76). Borrowing these four assumptions with Ethnic Studies scholars, I draw parallels that promote holistic health by infusing these philosophical assumptions with culturally congruent methods to serve as vehicles for change (Delgado Bernal et al., 2016) and to empower Latina/x with mental health by offering a space to share knowledge that recreates and reconstructs new narratives challenging assumptions and labels of mental health.

As discussed in the preceding chapter, this study infuses decolonial epistemology to reclaim stories. Decolonial epistemology challenges positivist research. The positivist approach can broadly be denoted with three main features: first, it contends there is one truth only; second, it focuses on objective knowledge; and third, it dismisses subjective knowledge. As a result, qualitative researchers are often criticized for being subjective, unreliable, and irrational. "Positivist perspectives argue qualitative research is based on opinion rather than logical facts" (Waldron, 2002, p. 165). This study is qualitative work that utilizes empathy as a skill to amplify

the clients voice rather than imposing labels of mental health on them. Because this study is subjective, personal and intuitive, I demonstrate the validity via testimonio in this exploratory study with Hispanic women residing in a transitional living program. I employ the method of testimonio to disrupt silence in mental health. I am strongly aware that I was better able to understand the information I was obtaining from the women in my study because of the experiences we share as Brown Latina women who have been historically viewed as marginalized and oppressed. It was this self-awareness combined with cultural humility that allowed me to align with the participants and make sense of the data in ways that may not have been possible if I had detached myself emotionally from the research.

Part Two: Data Collection Inclusion and exclusion criteria

I have chosen a qualitative research method that is multimethod in focus and that involves a variety of empirical materials including testimonios, group observations, staff meetings and documents. The inclusion criteria for this study includes adult Latinx/a over the age of 18 years old who obtained services at Powerful Lives Transforming Program (PLTP) which is a pseudonym of the program used for confidentiality purposes, during the summer of 2022. The exclusion criteria entailed those who are not registered with PLTP. Each adult Hispanic participant who agreed to participate in the study reviewed an informed consent and signed a hard copy that was kept in a locked security file. The director of PLTP preferred a hard copy of the consent form over using a digital consent form, so participants were offered a copy of the consent form that was stored in a locked office of the clinical manager at PLTP (see Appendix A for informed consent). Also, the participants were notified that they can withdraw from the study at any time.

The Ethics and Politics of Research

As decolonial researchers, it is vital that we strive towards building an equitable and reciprocal research environment. some specific principles included the following areas: 1) access 2) informed consent 3) confidentiality by using pseudonyms 4) protecting informants from harm by using my licensed social work skills to ensure participants are comfortable describing their stories in a safe space with minimal disruption. 5) disseminating the research, my goal is to offer a copy of the dissertation to the director of PLTP as a token of gratitude.

This study used purposeful sampling, which helped best inform the researcher about the phenomenon under analysis (Creswell & Poth, 2018). I obtained informed consent from all individual participants who agreed to partake in this study. This project was approved by the Michigan State University Institutional Review Board. I adhered to MSU Human Research Protection Program. Below I illustrate a scenario where I used the ethical principles listed in the Belmont Report, which includes respect for persons, beneficence, and justice.

A Latinx scholar, Cherrie Moraga alluded to the fact of how society does a good job at looking at communities of color as deficient lens but it is hard when we as Latinx/as share or find weakness in our own communities where we need to do better. What I mean by this is I am illustrating through a quote from a participant that declined recording of the testimonio, that was respectfully granted. Later, I asked the informant if she would be open to sharing why she declined the recording and she indicated how "folks in our community have lost my trust because in the past they have done me wrong." While this may be true, it is important to recognize that even in our own culture we have failed amongst our own kind, which has resulted in a loss of trust.

As demonstrated in chapter two, we can draw on strategies with how silence displayed

acts of self-determination. For example, in chapter two the People v Zamora case was used with the defendant, Aguilars use of silence in the courtroom systems (Ramirez, 2009). Compared to this study we see how an informant declined a recording of the testimonio as an act of agency due to her history of a traumatic events that occurred with someone from her community, the Hispanic community. Although the terms of systems and culture are different, I do link these two cases to represent forms of self-determination. Even though systems and culture represent different scenarios I draw parallels with both cases by illuminating advocacy techniques used to reclaim their voices. The idea of silence is predominately viewed as acts of liberation when silence is disrupted. But, as demonstrated above, we see how remaining silent can be an act of resilience because, as illustrated above, remaining silent is centered on agency.

As indicated above I followed the MSU ethical principles. Particularly, I followed the principles in the Belmont Report that details strategies to protect participants with research which include respect for persons, beneficence, and justice. To ensure respect for people, the study was with participants 18 years and older. The second principle, beneficence, ensured that benefits were maximized, and harm was minimized. The third principle, justice, recognized the participants were a vulnerable group and gave them agency. Therefore, I used the principles to guide me with scenarios I confronted during my data collection. For instance, I respectfully draw from a participant that declined to record the testimonio and humbly continue to be aware of my own assumptions and biases. I went to PLTP with the notion that the informants would engage with me because we had similar backgrounds without recognizing that because of the color of our skin that I could trigger someone. I reiterated to the informant that she had the choice to proceed or not and there would be no repercussions. But the informant chose on her own free will to share her testimonio, that I recorded in my own writing. I see the willingness of

the informant to disclose her testimonio as a conduit to the healing process. Given the points listed in the Belmont Report, I frequently reflected on the principles and integrated them during my time at PLTP.

Recruitment of participants

A purposive sampling made up of adult Hispanic participants that fall within the age range of 18+ years old from PLTP were recruited for this study. Evidence suggests purposeful sampling is an "intentional group of people that can best inform the research" (Creswell & Poth, p. 148). The first contacts with key stakeholders from PLTP via Zoom in 2021 to begin discussions for this project with my search for informants. I should state that since my main objective was to understand how Latinx women describe mental health and healing practices in the outdoors, I was notified by the director of PLTP that the specific demographic for this study may not be feasible because the program has no control over resident demographics or their enrollment timelines. While being mindful of the director's concern, I negotiated access with the Program and Clinical Manager of PLTP to the participants to provide them with the research process. Once approval was given by the stakeholders and IRB was granted, a timeline for data collection was approved.

Research Study Instrument

The data collection was conducted from July 27, 2022, until August 4, 2022, at a non-profit residential treatment facility located in the southwest region of the United States. I began my search for participants by consulting with the main stakeholders of PLTP, including the executive director and program manager. I used a purposeful sampling technique to recruit appropriate informants for this study. This study followed an interview protocol (see Appendix B). The program director informed the participants about my study and collected the signed

copies of the informed consent. When I arrived, I met one-on-one with the Clinical Director to review policies of PLTP and reviewed weekly schedules of events with the participants that consisted of group meetings, therapy sessions, outdoor activities, and Nature Based Program. At that time, I received copies of the signed consent forms from staff and participants that granted permission to collect data via participatory observations, testimonios, and focus groups (see Appendix A). After the first meeting with the clinical director, I was invited to attend a PLTP event where we sat around a large table, each staff member and participant introduced themselves, and I briefly shared my background and research interest.

A pseudonym was given to protect the privacy of the program and the participants of this study. The participants of this study consisted mostly of historically underrepresented groups. A total of twelve participants were eligible for the study but one declined due to her family commitments. Hence of the eleven active participants, most of them identified as Hispanic or Mexican American, one identified as bi-racial, one Native American, and one identified as Caucasian, all of whom belonged to age groups between the mid 20's and early 40's. In this exploratory study, I seek to understand how Hispanic women describe mental health and healing practices, while residing in an outdoor transitional living program. Hence, at the time of this study, a total of eleven that participated but two declined recording, each of whom identified as adult women ages 18 years old and above who have a primary diagnosis of co-occurring disorders. This study seeks to contribute to culturally congruent theory and culturally relevant methods as well as to provide evidence-based information to mental health providers and consumers regarding the options available for women affected by co-occurring disorders, especially for those seeking treatment at non-profit agencies. The National Alliance on Mental Illness suggests historically underrepresented groups face health disparities that include quality

of treatment (NAMI, n.d.). This study serves to close this gap by integrating culturally congruent theory and methods that have been shown to support Latinx communities.

Rapport Building

I had to walk a fine line with my desire to encourage participation with my study and my desire to respect the ethical guidelines that governed the lengths to which I would be persuading the participants through the study. Since I understood as a licensed clinical mental health therapist the importance of rapport building, I tried to attend invitations by participants to gatherings where I engaged in conversation with the participants so that we could build rapport. In the discussion it was mentioned that participation was voluntary. By building rapport with the participants, I was able to place an emphasis on choice, trust, empowerment, and respect. As a result of the rapport built, PLTP, only one participant declined the study. The one participant gave me approval to share that her reason for dismissing participation was because she was reunited with her child and preferred spending quality time with her child rather than participating in the study. Because I saw this as an act of resilience and compassion, I collaborated with the PLTP staff to offer this participant an incentive because she was demonstrating strength and agency to advocate for not only her own needs but the needs of her child.

Trustworthiness of this Study

The validity of the research recognizes that students and participants of color are holders and creators of knowledge (Delgado & Stefancic, 2012; Delgado Bernal 2002). The techniques of researcher reflexivity and member checking and peer support were used to increase the trustworthiness of the data. As a Black, Indigenous, Person of Color (BIPOC) researcher, I used this method of testimonio to transform mental health stories by listening and validating their

lived experiences with mental health while using principles from a Trauma Informed Approach that include safety, support, hope and trust. Some recommendations to ensure trustworthiness of the data are to code as transcriptions, then keep a reflective journal and finally confirm with the participants the interpretations of the data (Saldaña, 2016) - which was done with testimonios then bridging themes during the focus groups. Research suggests testimonio elicits "exposing inconsistencies and debunks mythos and long-standing stereotypes" (Romo et al., 2019, p. 7) by challenging negative labels. To that end, I infuse with Testimonio a counternarrative that involves using qualitative rigor to disrupt dominant narratives. A counternarrative re-centers voices. A counternarrative re-claims voices and promotes agency. Testimonio seeks to challenge assumption with opponents of who determines truth, which is rooted in Eurocentric thinking by prioritizing logical reasoning (Pérez-Huber, 2009). However, logical reasoning does not entail and value the holistic approach. There is no logical method to describe realities that are gained through testimonios. As a matter of fact, testimonios allow for an in-depth understanding of the lived experiences with mental health and the outdoors.

Risk and benefits of participation

The participants were informed they might experience some distress by reflecting on their past experiences with trauma. To account for this risk, I incorporated a trauma informed approach and consulted with the PLTP staff on services available, if needed. The participants were notified that although they would not necessarily benefit from this study, their testimonios would help others in similar situations. The participants were given an incentive of a $10 gift card as a small token of gratitude for their time.

The method of testimonios is culturally congruent for this population to shed light on lived experience with mental health and healing practices via storytelling. Testimonio is a

method that allows flexibility by allowing me to set the stage to address the three primary questions while allowing time for clarification with their responses. On some occasions, the responses given by the participants helped shed light on certain topics that I had not considered prior to the interview. Consequently, I was able to incorporate these surprises in my findings section.

The one-hour face to face testimonios and two focus groups were audio recorded and transcribed using a Sony ICD-UX570 digital video recorder. See appendix for the interview protocol. Although the sample size for this qualitative study is small, the small size allowed time for the importance of building trust and getting in-depth information. Evidence suggests group size may vary in size from 3-4 participants to 10-15 (Creswell & Poth, 2018). The goal of this study was to conduct an initial one-hour testimonio per participant over an eight-day timeframe, combined with two focus groups that were scheduled for one-hour sessions each.

The main drawback to using testimonios with focus groups was due to unforeseen circumstances; the group sizes had to be re-adjusted hence the first focus group had four participants whereas the second focus group had seven participants. This was a challenge because it affected the amount of time allotted for reflections and hearing their experiences with participating in the study.

Positionality

I am strongly aware that I was better able to understand the information I was obtaining from the women in my study because of the experiences we share as a Latina women, and as women that have endured various forms of adversities. Testimonio is a method that disrupts silence with mental health in Latinx communities. This entails breaking the cycle of silence and shame. The goal of this project is to reclaim culturally congruent methods through Adventure

Therapy with Hispanic women. Testimonios is a reciprocal process. For example, I use a metaphor of a bridge as a symbol of the reciprocal process between the research and the researched. Once the testimonio is shared, the bridge symbolizes co-creation of knowledge. As a result of the bridge, healing and transformation begin to evolve. Equally important is my position of privilege as it pertains to education and social economic status. I am aware that although some of our lived experiences are similar with mental health, they are also different based on my privilege and access to resources.

Part Three: Interweaving Cultural Hybridization

Cultural hybridization is a combination of techniques, as demonstrated below. Cultural hybridization infuses techniques to reshape clinical practice (Kirmayer et al., 2014). This study of phenomenology is about gaining a deeper understanding of participants' lived experience and uses quotes to explain their perspectives (Saldaña, 2016). Hence, I borrowed the quotes offered by the participants to call attention to the mental health phenomenon. Testimonio provides methods for analysis that are collaborative and attentive to myriad ways of knowing and learning in our community (Delgado Bernal et al., 2016). What I mean in this way is that testimonios was a method used to analyze the nuances of mental health. However, there is a process that illuminates techniques to reshape clinical practice referred to as cultural hybridization. Next, I borrow from Gloria Analdúas stages of conocimiento with adventure therapy, which was used during the focus group meetings.

I drew from Gloria Anzaldúa's (2002) stages of seven stages of conocimiento with a focus on describing the process of change combined with the process for treatment, with adventure therapy. By reflecting, recounting, and remembering processes endured during various forms of trauma (Delgado Bernal et al., 2016) with adaptations of adventure therapy model

geared towards mental health in order to demonstrated the connection with the seven stages. Adventure therapy entails a model that includes six steps that are interconnected including: "First Assessment Point A, Shape of the environment, Matching, Facilitation the Challenge and Guide learning. Shape the environment conditions, Facilitate the experience, Guide the learning throughout the process and evaluate the process" (Alvarez et al., 2021, p. 30). A quick summary will be given of the adventure therapy six stages of process for change. First, Point A is understanding the lived experience of the participant. Second, shape the environment the researcher strives to develop rapport with the participant. Third, Matching an activity is done with a purposeful intent. Fourth, Facilitate the Challenge an emphasis is put on safety, choice and belonging with as activities are selected. Fifth is Guide the learning which is where the facilitator chooses to respond based on where the participant is. Sixth Step is evaluating the process. In the next section a demonstration of the stages merging with AT that was demonstrated during data collection at PLTP (Alvarez et al., 2021).

Infusing stages of conocimiento with mental health

Gloria Anzaldúa asserts "Often nature provokes un "aja" or "conocimiento" one that guides your feet along the path, gives you el ánimo to dedicate yourself to transforming perceptions of reality, and thus the conditions of life" (p.540). I build on Anzaldúas quote with a technique via adventure therapy to re-create narratives as it pertains to how the participants of this study described their experiences with the services provided at PLTP that infused outdoors as part of their process.

Before discussing how Anzaldúa's stages of conocimiento interact with adventure therapy, we must describe the stages themselves to bridge the concepts. In my analysis, I build from the seven stages of conocimiento.. Conocimiento is "a way of knowing" that includes el

arrebato, nepantla, the Coatlicue state, the call, putting Coyolxauhqui together, the blow up and shifting realities (Anzaldúa & Keating, 2002, p. 541). While scholars such as Gloria Anzaldúa infuses the seven stages of conocimiento with stories of epistemic violence, I adapt these seven stages of conocimiento to demonstrate how the consequences of trauma were weaved in with mental health with the participants of this project to reclaim their truth by connecting each stage with adventure therapy. Of course, conocimiento is a conduit to healing that hurts as the process is taking place especially as it pertains to therapy "but not as much as desconocimiento" (Anzaldúa & Keating, 2002, p. 557). Desconocimiento means a lack of understanding. In this case, I see conocimiento in alignment with those seeking mental health services by having awareness of cultural constraints and recognizing that the pain felt during the therapeutic process will reveal itself as a strength, in the future. Whereas desconocimiento is linked with cultural scripts of silence that factor into seeking professional treatment when traditional medicines are not enough, and when there are assumptions of mental health treatment.

First, I build on Gloria Anzaldúa's conociemiento stages by briefly reflecting on these binary concepts that relate to nature. Anzaldúa shares that "the planet and every species are caught between two cultures" (p. 541). The binary perspective in concocimiento can be linked with mental health that can cause either confusion or confidence, especially as it pertains to stigma. Confusion in mental health relates to the fear of obtaining adequate treatment and struggling to follow a treatment plan. Whereas confidence is demonstrated when participants of this study shared their experiences in PLTP and the importance for those to adhere to their treatment plans. Anzaldúa suggests that conocimiento "questions conventional knowledges current categories and classifications" (p.541). Borrowing from Anzaldúa's description I see this connected with mental health by moving beyond negative labels. Moreover, Anzaldúa asserted

conocimiento is about “reflective consciousness, which is about the freedom to choose” (p. 542). I relate this concept of choice with adventure therapy because the participants have a choice to participate in adventure therapy activities, or not.

The seven stages of conocimiento include: The first stage, el arrebato...a rupture, at this stage Anzaldúa asserts this is a labor of re-visioning and re-membering (p. 546). “With each arrebatamiento you suffer un “susto” a shock. I see this stage with mental health by analyzing testimonios with the PLTP participants. In this study the participants realized they had to gain awareness of tools to help reshape their negative narratives. As one participant asserted “when I arrived to PLTP, I felt shameful and unworthy”. A way to reframe this negative narrative the participants integrated coping tools they learned at PLTP to reclaim their truth. The second stage, nepantla...torn between ways (Anzaldúa p. 547). With mental health I interweave this stage by calling attention to effects of ruminating thoughts with remolinos. Remolinos (whirlwind) with “you face divisions within your culture” (p. 548). As one participant indicated “Trust is an issue for me because I trusted the wrong people in my life, from my community”. The third stage is the Coatlicue stage in this stage you can “relinquish your victim identity” (p. 555). Anzaldúa shared her emotional journey after finding out about her illness. Here I bridge the Coatlicue stage with the participants descriptions with infusing the outdoors as part of their treatment plan at PLTP. The participants shared when they are outside they “feel freedom, and liberation”. The fourth stage is el compromiso. “Reinterpret your past you reshape your present” (p. 556) it is a stage where “one worthy of self-respect and love” (p. 557). A participant asserted, during focus group “In my addiction, I lost the ability to love and be loved”. In PLTP there were various groups the participants attended where they learned skills centered on compassion and empowerment. The fifth stage is Coyoxauhqui in this stage “it motivates you to expose

oppressive cultural beliefs" (p. 561), here I link this with a quote from one of the participants "I am human before I am a label", this stage "places and emphasis on "stories that lead out of passivity and into agency" (p. 563). The quote from the participant offers an expression that shifts the negative labels with mental health to a strength-based approach by reshaping stereotypes towards empowerment. The sixth "stage is the blow up...a clash of realities" (p. 563). "Where before we saw only separateness, differences, and polarities, our connectionist sense of spirit recognizes nurturance and reciprocity and encourages alliances among groups working to transform communities" (p. 568). I bridge this stage with a quote from the focus group that identifies a common goal with the PLTP participants is their desire to "reengage with society". The resources required, after discharge to reengage back into society include therapy services that are referred to as after care services.

Effective culturally congruent services will be a conduit to the transformation process. Finally, "shifting realities...acting out the vision or spiritual activism is the ability to act from choice (p. 569), again I borrow a quote from the participant of a common goal that they wanted was "self love" and as Anzaldúa notes this means "when you relate to others, not as parts, problem, or useful commodities, but form a connectionist view compassion triggers transformation (p. 569). As has been noted, the most imperative aspect of mental health is safety (Cervantes & McNeill, 2020). Hence accepting the fact that sometimes trauma-informed culturally adapted approaches may be needed, as a guide to reshape negative narratives to one's worthy of self-love, cariño and compassion.

Reshaping the stages of Conocimiento with the Wave Model techniques

By combining the wave model, specifically steps two and three, with Anzaldúa's stages of conocimiento, I build on this idea of remolinos or whirlwind thoughts that can influence mental

health. The first stage of concimiento is el arrebato - the rupture. I see this stage linked with mental health by descriptions of how folx notice something is either lacking or amplified with their thinking patterns. The second stage is Nepantala where individuals are caught in "remolino/whirlwinds." I build on this idea specific to mental health for those who have been impacted by sexual trauma by linking remolinos with intrusive thoughts. Neuroscientists suggest a result of sexual trauma leads to ideas of experiencing intrusive thoughts (Perry & Winfrey, 2021). I combine remolinos with ruminating thoughts to spotlight the powerful influence that negative thought patterns can have with the brain and overall body. Sometimes those with mental illness feel negative ruminating thoughts feel like whirlwinds or remolinos. The third stage is Coatlicue state" which is a stage of resistance, healing and transformation. I parallel Anzaldúas' stages of conocimiento with the adventure therapy through this exploratory study. By exploring the participants lived experience with mental health and what brought them to the program. Then examine mental health techniques they learned in the PLTP program to shift the negative thought patterns. Finally, analyze their aspirations of their new identity where participants identified terms which represent healing and transformation. Below is a table that illustrates ways that the stages of conocimiento and adventure therapy were merged during the data collection.

Table 1: Cultural hybridization with the stages of Conocimiento with Adventure Therapy

	7 Stages of Conocimiento (Anzaldúa & Keating, 2002, ch. 80)	Concise Meaning of Stages	Adventure Therapy Model (Alvarez et al., 2021, ch. 4)	Concise Meaning of Model	Connection of AT with Stages
1	El arrebato…rupture, fragmentation…	Labor of revisioning and remembering (p. 546).	Point A refers to individual and or group work (p. 31). The rupture occurs in the individual testimonios facilitated by the researcher that reveal valuable data about each person's way of describing mental health, managing conflict, stress, and trauma.	Individual assessment entails qualities the person brings including strengths and challenges.	Testimonios include exploring background, attitudes and beliefs. The researcher/facilitator strives for understanding the uniqueness of everyone.
2	Nepantla…torn between ways but also is a site of transformation (p. 548).	Face divisions in culture that can lead to conflicting ideas (p. 548) But remolinos is a place for transformation.	Assess Shape a group environment that can contain this conflict and whirlwind.	The unfairness of rules this leads to obstacles referred as squiggly. Squiggly are an opportunity for growth (p. 32).	Connecting rules with cultural constraints refer to defying hidden rules that can lead to distress. But squigglies are distractions that equate to remolinos because transformation occurs.
3	The Coatilcue State..desconocimiento and the cost of knowing (p. 550).	Emotional pain is dealt with through addiction. But this is also a space to reclaim and Relinquish your victim identity (p. 555).	Shape Facilitates the Experience of giving and listening to genuine and honest testimonios. The researcher/guide keeps an eye on whether the core beliefs are operating well enough in the group to allow this to happen.	The activities are purposeful with the intent of helping participants reach their goal.	This was done in PLTP group observation facilitated by a clinician. The group used a book titled Seeking Safety. A treatment manual for PTSD and Substance Abuse by Lisa Najavits. Awareness of self neglect with substance abuse, and importance of self care. For example the first question ask if the participants associated with

Table 1 (cont'd)

					safe people who do not abuse or hurt them.
4	The call…el compromiso..the crossing and conversation (p. 554)	Reshape cultural imposed limits (p. 556) and Create new narrative (p. 558)	Facilitate the Experience (p. 36) of going into the outdoors with one's pain and turbulence (remolinos)	Refers to the actions done outdoors or inside that work towards goals.	In two Focus Groups I ran at PLTP where we reviewed AT core beliefs and instruments used to set behavioral expectations and norms in a group. (p. 35)
5	Putting coyolxauhqui together…new personal and collective stories (p. 558)	"Personifies the wish to repair and heal as well as rewrite the stories of loss and recovery that includes using metaphors that tell you what you need to know" (p. 563)	Guide the learning (p. 36) researcher/PLTP staff guides the learning of the individuals bringing their outdoor experience of el compromiso to the comunidad. It is gathering back with their community that will support them in transferring their transformation into their daily life	the facilitator chooses how they respond based on goals	Connect with participatory observation at PLTP…challenge by choice experience (ie: high ropes)
6	The blow up..a clash of realities	"Reframe the conflict and shift the point of view" (p. 567)	Evaluate the process (p. 37)	Evaluate client progress and review the effectiveness of their own facilitation	Offer a few written evaluations of their experience with sharing testimonios
7	Shifting realities ..acting out the vision or spiritual activism (p. 568)	Ability to act from choice (p. 569) and empowerment is the bodily feeling of being ale to connect with inner voices/resources (images, symbols, beliefs, memories) during periods of stillness, silence, and deep listening or with kindred others in collective action (p. 571)	Point B	The primary goal or purpose for the group (p. 33)	The groups heard at the beginning that this was a co-creation of knowledge. Hence, I this as a collective action that was created by the participants in the FG of New Identity entailed reengaging in society, sobriety, self care, self love, "step by step", gratitude

Part Four: Barriers with This Research

Limitations

Critiques of testimonios suggest the samples are small, but as noted earlier in this chapter the small sizes influence the ability to focus on building rapport and trust with informants. Another critique with testimonio is the fact that the concept is rooted by women. As a result, most literature has been elevated by and for women which dismisses the voices of men. However, that was out of the scope of this study. But studies have been conducted infusing testimonios to amplify voices additional perspectives. Another limitation of this method is it is not generalizable and cannot be replicated. Hence it does not fall within the golden standard of research which in scientific/medical research is considered necessary for billable services with insurance companies. Of course, it is important that billable services can be combined by integrating evidence-based treatment models.

Considerations with research because of COVID-19 pandemic

As a result of the COVID-19 pandemic, some modifications were discussed and agreed upon with both the director of PLTP and members of the committee. The MSU COVID-19 policies along with PLTP were followed. If an alternative to face-to-face meeting was required, the MSU Zoom platform was a viable option that met the Health Insurance Portability and Accountability Act (HIPAA) standards.

The initial plan to conduct one-hour testimonios and two one-hour focus groups within a two-week time period needed modifications. Due to unforeseen circumstances, the timeline of the data collection was shifted. The data collection started July 27-August 4, 2022, which was later than anticipated, due to COVID related issues. This adjustment also affected the plan to collect data. But adjustments were made by consulting with the PLTP staff and working with

their schedule to assure the face-to-face interviews were conducted. Not only on my part did adjustments need to be made, but PLTP staff also had unforeseen circumstances that shifted their daily weekend schedule. This adjustment allowed me the opportunity to collect data.

If an opportunity arose to collect data again, I would have recommended three things. First, the length of time to collect data should have been longer. For example, a three-week period rather than the planned two weeks would have been helpful. But I also recognize funding for another week would have been more costly. Also, if given the opportunity to collect data again I would coordinate Zoom meetings as an option, if not with the participants with the staff. But this is considering that no unforeseen circumstances arise, which seems to be inevitable during these times of COVID-19.

CHAPTER FOUR: FINDINGS

In this chapter I present the findings that emerged when the data collection and data analysis. The data was collected using four methods, including: (a) one-to-one testimonios with 11 primarily Hispanic women who were in residential treatment for co-occurring disorders at PLTP, (b) focus groups with the same 11 mostly Hispanic women, (c) one-to-one interviews with five staff members at PLTP, and (d) researcher observations of treatments provided to patients in residential treatment at PLTP. This section of the study has two major subsections. First, the residential patients' demographic characteristics are reported. Second, the data analysis procedure is described, and a high-level overview of the findings is provided. Third, a more detailed presentation of the findings is provided, including evidence in the form of direct quotes from the data. I draw quotes that resonate with the four findings include: 1) challenges to mental health involved unhealthy coping strategies to deal with trauma, 2) mental health was linked with holistic wellness and self-determination, 3) Adventure Therapy taught coping skills, built confidence, and brought enjoyment and 4) healing meant self-acceptance. For instance, in the first theme connected to trauma P6 expressed her "substance use numbed the effect of trauma". The second theme P1 articulated holistic wellness as the ability of "feelings affecting action, but we have the ability to learn through our actions". The third theme relating to tools weaved in with Adventure Therapy was expressed by P4 that "rafting was fun and adventurous, because it gives us a change to try something new that we can respect". The final theme pertains to healing P3 illuminated "healing means mending or repairing". Overall, the findings highlight the importance of addressing trauma, promoting holistic wellness, teaching coping skills through Adventure Therapy, and achieving self-acceptance for healing. Unhealthy coping strategies are not sustainable. Instead, individuals can develop self-awareness to make healthier choices.

Adventure Therapy offers a unique opportunity to build confidence and learn coping skills. Healing involves self- acceptance and self-love, enabling individuals to move forward positively from past experiences through testimonios. Testimonios listens to their voices and humanizing their experience as the participants work towards healing. In the focus group a participant described how it felt to share her testimonio, she asserted “nobody has ever asked me about my mental health or substance us at the same time”. Testimonios “made me feel like someone actually cared, for once”.

Demographics

The 11 patient participants in this study were mostly Hispanic who were at least 18 years old and who were in residential treatment at the PLTP at time of the study. All patient participants were female, and all patient participants reported that they resided in the southwest region of the nation. Table 1 indicates other relevant demographic characteristics of the individual study participants.

Table 2: Patient Participant Demographics

	Age	Self-reported racial or ethnic identity	Education	Annual income	Number of previous treatment programs	Treatment voluntary or court-mandated
P1	30	Latinx	Some college	$20,000	0	Mandated
P2	30	Hispanic	GED	$0	1	Voluntary
P3	35	Native American	High school	$0	2	Mandated
P4	24	Asian Latina	Some college	$0	2	Voluntary
P5	38	Caucasian	Some college	$30,000	3	Mandated
P6	35	Mexican American	Bachelor's	$0	1	Voluntary
P7	24	Hispanic	High school	$0	1	Voluntary
P8	39	Hispanic		$0		Voluntary
P9	43	Black, Hispanic, Cherokee	High school	$0	1	Mandated
P10	31	Hispanic, Caucasian	Bachelor's	$10,000		Mandated
P11	23	Caucasian, Hispanic	8th Grade	$0	1	Mandated

Data Analysis

The analysis procedure applied to the data was the inductive, thematic method recommended by Creswell and Poth (2018) and Saldaña (2016). The procedure had the following five steps: (a) managing and organizing the data, (b) reading and memoing emergent ideas, (c) describing and classifying codes into themes, (d) developing and assessing interpretations, and (e) representing and visualizing the data (Creswell & Poth, 2018).

Step 1: Managing and Organizing the Data

Managing and organizing the data involved preparing the data files and selecting the mode of analysis (Creswell & Poth, 2018). To prepare the data files, the audio-recorded interviews and focus groups were transcribed verbatim into Microsoft Word documents. The observation notes were also transcribed verbatim into MS Word documents. NVivo 12 computer-assisted qualitative data analysis software was selected as the mode of analysis. Further preparation of the files therefore involved importing the interview transcripts, the focus group transcripts, and the observation notes into NVivo 12 as source files. In total, there were 25 files (nine transcripts of testimonios with mostly Hispanic women patients, two sets of notes from interviews with two additional patients who declined to have their interviews recorded, five transcripts of interviews with PLTP staff, three transcripts of focus groups, and six transcripts of observation notes).

Step 2: Reading and Memoing the Data

All 25 data files were read and reread in full to gain familiarity with their contents (Creswell & Poth, 2018). Handwritten notes were made, both to summarize the data holistically and to indicate points of potential analytical interest, including repeated words, phrases, and ideas. This memoing process resulted in a preliminary identification of patterns of meaning within each transcript and across transcripts.

Step 3: Describing and Classifying Codes into Themes

The coding process was inductive, meaning that it consisted of labeling the meanings that emerged from the data itself rather than sorting the data into predefined categories (Creswell & Poth, 2018). First, the data in each of the 25 source files was broken down into units of text, which each consisted of a phrase or a group of phrases. Each unit of text expressed one meaning relevant to mostly Hispanic women's experiences of mental health in PLTP. For example, P2 stated during her interview, "Meth was my DOC, my drug of choice." This statement was identified as a relevant text unit because it indicated a mental health challenge that contributed to P2's entrance into residential treatment at PLTP.

A first cycle of open coding was then conducted, as defined by Saldaña (2016). A descriptive label was then assigned to each unit of text. The unit of text quoted from P2 was labeled, 'substance use,' to indicate the kind of challenge to mental health that it named. When different text units had similar meanings, they were assigned to the same label. For example, P4 stated in her testimonio, "I shoot up meth." This statement had a similar meaning to the previously quoted statement from P2, so it was assigned the same label, 'substance use.' The cluster of similar units of text labeled 'substance use' constituted one initial code. Overall, 272 relevant units of text from across the 25 source files were assigned to 20 initial codes. Table 2 indicates the initial codes and the number of units of text assigned to them from each type of data.

Table 3: Initial Codes

Initial code (alphabetized)	*n* of text units assigned from: Patient interviews	Staff interviews	Focus groups	Researcher observations
Anxiety	7			
Being heard	2		4	
Building confidence	11	2		1
Cultural barriers to help-seeking	12	6		
Depression	9			
Emotion regulation	14	2		4
Experiencing enjoyment	17			
Having coping skills	3			
Holistic health	9			
Isolation	5			
Learning coping skills	13	1	2	3
Legal trouble	25			
Loss of control	7			
Reduced distress	2			
Self-acceptance	8	2	1	
Self-awareness	2			
Self-determination	9	9		1
Sense of loss	4			1
Substance use	20			
Trauma	8	2		

Table 1 also indicates how the data was triangulated. In methodological triangulation, data from different sources is compared to identify similarities and discrepancies, in order to arrive at a more robust and comprehensive description of a phenomenon than data from a single source would be likely to yield (Creswell & Poth, 2018). As an example of triangulation in this study, the code ‘building confidence’ was identified in the patient interviews, the staff interviews, and the researcher observations. The data assigned to this code indicated that Hispanic and Caucasian women at PLTP experienced building confidence during adventure therapy (AT). Identifying this

finding in three of the data sources enhanced its credibility. It was a limitation in this study that methodological triangulation was not available for all the codes. The reason that triangulation was not available for all codes was that the *testimonios* offered in the patient interviews included more comprehensive descriptions of the participants' lived experiences than the focus groups, staff interviews, or researcher observations were able to furnish. The comprehensiveness of the *testimonios* made them particularly effective means of gaining insight into the participants' experiences, but it also meant that some findings from the *testimonios* could not be reproduced through the other three data collection methods.

A second cycle of coding was then conducted, per Saldaña (2016). To ensure that the major findings in this study had robust support from at least one data source, the initial codes were grouped into a smaller number of broader themes (Creswell & Poth, 2018; Saldaña, 2016). The themes were formed by grouping related codes that indicated different aspects or elements of a single, overarching idea. For example, the code 'substance use' was grouped with five other codes, including 'bereavement,' 'cultural barriers to help-seeking,' 'heredity,' 'legal trouble,' and, 'trauma.' The six codes were identified as related and grouped to form a theme because they all indicated challenges to mental health that the patient participants in this study had experienced. The code 'building confidence' was grouped with six other codes, including but not limited to 'emotion regulation,' 'experiencing enjoyment,' and, 'learning coping skills,' because the seven codes all indicated patient experiences with adventure therapy. Overall, the 20 initial codes were grouped to form four themes. Table 3 indicates how the codes were grouped to form the themes.

Table 4: Grouping of Codes into Preliminary Themes

	n of text units assigned from:			
Preliminary theme label Initial code grouped to form theme	Patient interviews	Staff interviews	Focus groups	Researcher observations
Challenges to mental health	75	8		
Cultural barriers to help-seeking				
Legal trouble				
Substance use				
Trauma				
Mental health symptoms	41			1
Anxiety				
Depression				
Holistic health				
Isolation				
Loss of control				
Self-awareness				
Sense of loss				
Experiences with adventure therapy	73	5	2	11
Building confidence				
Emotion regulation				
Experiencing enjoyment				
Learning coping skills				
The meanings of healing	24	11	5	1
Being heard				
Having coping skills				
Reduced distress				
Self-acceptance				
Self-determination				

Step 4: Developing and Assessing Interpretations

Step 4 involved developing the themes identified during Step 3 into propositions that would serve as the major findings in this study (Creswell & Poth, 2018). Developing the themes into propositions involved reviewing the data assigned to each of them to identify its meaning in relation to the study objectives. The propositions developed to indicate the meanings of the data

assigned to each theme are indicated in Table 4.

Table 5: Development of Propositions from Themes

Preliminary theme label	Finalized theme name, in the form of a proposition indicating a study finding
Challenges to mental health	**Theme 1:** Challenges to mental health included trauma and unhealthy responses to trauma
Mental health symptoms	**Theme 2:** Mental health was associated with holistic wellness, self-awareness, and self-determination
Experiences with adventure therapy	**Theme 3:** Adventure therapy taught coping skills, built confidence, regulated emotions, and brought enjoyment
The meanings of healing	**Theme 4:** Healing meant gaining or regaining self-determination and self-acceptance

Step 5: Representing and Visualizing the Data

Representing and visualizing the data involved displaying and reporting the findings (Creswell & Poth, 2018). The findings were displayed and reported by composing this section of the study, which includes a high-level overview of the findings, and the following section, which is a more detailed presentation.

Presentation of Findings

The research question used to guide this study was: How do Hispanic women describe mental health? Two sub-questions were also developed to provide additional focus for the study. The first sub-question was: What is your testimonio and how you came to PLTP? The second sub-question was: I am curious to know how the outdoors is supporting your mental health, or not? During data analysis, four themes were identified as the major study findings. This presentation of the findings is organized by theme. In the summary of each theme, its relevance to the research question or sub-questions is addressed.

Theme 1: Challenges to Mental Health Included Trauma and Unhealthy Responses to Trauma

All 11 patient participants described substance use as a challenge to their mental health, and some of them also described substance use as a way in which they coped with other challenges to their mental health. P1, whose drug of choice was alcohol, described how her drinking dominated her life:

> I did a lot of binging, so that means I would stop myself, and I wouldn't drink every day, but then when I would drink, it would be for months or weeks or days. And I lost a lot of time in that time.

However, P1 also described drinking as a way of coping with grief about the loss of a romantic relationship:

> When that relationship ended the way that it did, I continued to drink heavily after that, and it just was a cycle of continuing to do that . . . I just didn't want to feel. And so, yeah, I lived alone in my house, and it was super easy to drown myself in my bottle.

P3 said of how her use of methamphetamine harmed her mental health, "I was in and out of mental institutions for substance-induced schizophrenia . . . when I'm on amphetamines, I hear stuff that isn't there. And I see stuff. And I feel differently." P3 was an example of a patient participant who did not explicitly describe her substance use as a means of coping. P4 reported that she was sexually abused by a relative during her childhood, and she said, "I've been an injection drug user for the last five years. I started right after I graduated high school . . . I shoot up meth and heroin and fentanyl." However, like P3, P4 did not explicitly connect her drug use to her childhood trauma. P7, whose drug of choice was the opioid fentanyl, said of the challenge her substance use posed to her mental health and basic functioning: "I've been using drugs

actively for the last 10 years of my life. It got to a point where I didn't consider myself functioning anymore." P7 reported trauma and explicitly associated its effects with her substance use: "I had some childhood trauma that happened to me, that I didn't really know how to cope with, and because of that I started using drugs at a really young age." P7 added of her fentanyl use,

> My substance use is a big way of the part that I coped with the trauma that I was going through. Also, because I identify to be a lesbian, which it was frowned upon in my family, with my parents being so old-fashioned and the way that they were. They didn't accept that. So, that was another way of me helping with my sexuality since my family and the people closest to me didn't accept it.

P2 said of her addiction to methamphetamine and the challenge it presented to her mental health, "It started taking control, I guess. And it came to the point where it wasn't fun anymore. It was becoming something that I was codependent on. So, if I didn't have it, I would get sick." P5 reported that her drug of choice was methamphetamine, of which she said, "I self-medicate with meth for my depression." P8, whose drug of choice was also methamphetamine, spoke of her inability to stop using the substance: "I just kept using it, and then it became a habit, and then [I] couldn't stop." P8 added that her addiction began as a way of coping with the trauma of an abusive relationship, saying that her reason for using the substance was, "I guess just really wanting to forget, not really forget, but ease the pain of my past with my abusive relationship with my husband and the divorce." P10 also referred to an abusive relationship as a cause of her substance use: "My drugs of choice are alcohol and fentanyl . . . The addiction numbed the effects of trauma. I was in a domestic violence relationship." P11, whose drugs of choice were heroin and cocaine, reported using substances to cope with a childhood history of having her

Mexican heritage rejected by her racist white stepfather:

> Mental health is fear and anxiety. Mental health is a disaster because I was raised in a culture of whites only that had connections to the KKK from my stepdad. My mom was white. Although my dad was Mexican, I was not allowed to see him.

P6 reported that her addiction to opioids had begun during a period of unemployment and progressed until she was unable to function. Like P3 and P4, P2, P5, and P6 did not explicitly relate their drug use to a history off trauma. However, staff interviewees provided another perspective on the patient participants' substance use, offering responses that placed the focus on trauma effects as the primary challenges to mental health. Staff Member 2 (S2), the Executive Director and Clinical Manager, said of the patient participants, "Most of the women have a history of some form of trauma. More than half endured trauma before the age of six years old." S4, a clinical therapist, said of the primary challenge to the patient participants' mental health, "Most of the participants have a background of sexual trauma and co-occurring disorders." Legal issues were challenges to nine of the patient participants' mental health, and these issues were also among the reasons why they sought or were required by the courts to seek treatment at PLTP. P1 was under a court mandate to seek treatment for her alcohol use because she had been cited for driving while intoxicated (DWI) four times in two years. P1 said of these legal issues as a challenge to her mental health,

> I'm just so nervous with those [four DWIs on my record]. I think just worry would come off my shoulders [if the DWIs were resolved], because that's my biggest worry right now. That's the only thing that's holding me back from being the person that I know that I have potential to be.

P2's treatment was not court mandated as a condition of parole, but it was court mandated as a

condition of regaining custody of her four children. P2 said,

> My kids recently got taken away about a year ago . . . I have four kids, three girls and one boy . . . My oldest is four. My second, she'll be three in November. She's two. My son is a year and a half. And my baby is going to be three months.

P2 elected to undergo treatment at the PLTP because the facility allowed her to have her three-month-old infant in residence with her. P3, whose treatment was court-mandated, said of her legal issues, "I had a DUI charge, a drug-abuse charge, child-abuse charge, and a resisting lawful arrest charge. I had all that on me. I was in and out of jail all last year." P9 was undergoing mandatory treatment after being charged with possession and fraud: "What brought me here was being incarcerated, and the judge said I needed rehab. It was this or getting sent to prison." P11 said, "I got caught with having possession of drugs and was court mandated for the program," and P10 stated, "I got two Driving Under the Influences and the court system put me in a sobriety . . . I am court mandated to be here." P4 was in treatment voluntarily, but her legal issues were a significant source of stress: "I was charged with non-residential burglary, larceny, conspiracy to commit burglary. So I caught charges, went to jail . . . I was in prison for six months." P5, whose treatment was court-mandated, reported that she had served prison time associated with her methamphetamine use and transitioned directly from prison into residential treatment as a condition of her parole.

Seven patient participants described Latinx culture as silencing mental health issues, and no participants disagreed with this view. P1 said of how mental health was regarded in her childhood family and community, "I feel like it was something everybody was afraid to admit and something that was looked at as shameful." As an example of how mental health issues were stigmatized and silenced, P1 cited her mother's experience: "My mom has bipolar [disorder,] and

she has depression as well, and a lot of social anxiety . . . 'Crazy,' usually, is what everybody would say, or she's weird. I've never heard anything positive." Asked how mental health was addressed when she was growing up, P2 said, "I don't think it was ever addressed, honestly." P2 added that mental health issues in her family were addressed through substance use: "My grandpa used to smoke weed, and it would help him mentally, and I guess with anxiety too . . . So, I guess that's pretty much how it [mental health] was dealt with in my family." P3 said of mental illness when she was growing up, "Whenever something happens like that in your family, it's just shunned, and you don't speak about it, because it brings shame on your family." P6 said of mental health, "I think it was looked down upon. I think for the older generations to go to a therapist, 'Oh, you're broken. Why are you having to talk to a therapist? There must be something wrong with you.'" P7 said that mental health was silenced in her childhood family: "It was avoided. My mom, I know that she has a lot of mental health struggles and traumas as well, but she doesn't really talk to us about it or share anything about it with us." After affirming that members of her family suffered from schizophrenia, bipolar disorder, and learning disabilities, P8 said that the diagnoses and symptoms were not discussed. P10 indicated that members of her family used alcohol as a means of silencing mental health issues: "When I was growing up, I did not talk about it, meaning feelings . . . In my family it was normal for those that felt stressed to drink. The stress was silenced by drinking." Staff interviewees corroborated patient participants' perception of cultural scripts that silenced mental health in Latinx and Native American cultures. S2, the Executive Director, said of Latinx culture, "Cultural scripts of silence sound similar with Native American trauma and silence." S3, a Residential Assistant, affirmed, "The Hispanic community tends to say, 'No tienes nada' [you don't have anything], regardless if there are strong feelings of depression. I have heard, 'No más es la juventud' [it just part of being an

adolescent].” S5 confirmed of the similarities between Native American and Latinx cultures, “I do similarities . . . In my [Native American] community, some moms perpetuate trauma by staying silent. It’s kind of how things are culturally run.”

Theme 1 Summary. This theme was relevant to addressing the primary research question about how Hispanic women describe their mental health. It is also relevant to addressing the first sub-question, regarding how the patient participants came to PLTP. The data associated with this theme was drawn primarily from the individual testimonios with the patient participants, with some support from the staff interview data. There was some divergence between the respective findings from those two data sources. The patient participants indicated in their testimonios that the challenges to their mental health included substance use, legal trouble (i.e., convictions for crimes ranging from driving while intoxicated to burglary), and cultural barriers to help-seeking (i.e., the silencing of mental health issues in Latinx culture). A few patient participants mentioned childhood or adulthood traumas as challenges to their mental health, but most patient participants focused on substance use as the primary challenge to their mental health, without choosing to delve deeply into the perceived reasons for their substance use. Data from the staff interviews corroborated patient participants’ perceptions of cultural barriers to seeking evidence-based care, but staff members’ responses were focused more on trauma as the ultimate cause of substance use than on substance use as a proximate cause of treatment-seeking. Taking data from both sources into consideration, it may be concluded that substance use was both a challenge to mental health and a strategy for coping with effects of trauma, with trauma effects being the primary challenge to mental health.

Theme 2: Mental Health Was Associated with Holistic Wellness, Self-Awareness, and Self-Determination

Three patient participants indicated that they thought of mental health in terms of holistic wellness. P2 suggested that restoring mental health could involve healing the body as well as the mind: “It's different healing. Some of it could be helped by talking and therapy, I guess, and then there's some where you're sick to where you need medicine.” P4 described mental health as requiring a perspective that incorporated the whole person, not just their disorder: “It should be person focused. We shouldn't be classified just, ‘The girl with schizophrenia.’ It's ‘the girl who suffers from schizophrenia,’ not all we are.” P4 said of her fellow patients and of the staff members at PLTP “They see me as the person I am who has a disorder, not just the disorder.” P6 described mental health as affected by the body as well as the brain:

> Mental health, to me is, when I think about it that way, this homeostasis occurring in your body emotionally that's connected to your brain . . . It's all interconnected. And that's why I feel like the mental health sector is getting so much better, is because we're realizing it's connected to so many other things that are going on in the body.

P3 and P7 associated mental health with self-awareness. P7 described mental health as being able to recognize emotions and their influence on behavior: “I would describe mental health as being able to deal with, or just recognize, the feelings and emotions that you have, and how it affects you in your everyday life.” P3 spoke of mental illness as an inability to recognize or distinguish emotions, saying that it was, “Probably having trouble distinguishing your moods, I guess.”

Six patient participants associated mental illness with a loss of self-control, or the capacity for self-determination. As will be seen in the presentation of Theme 4 later in this section, the

participants also expressed the converse, associating mental health with a capacity for self-determination. P1 said of mental illness, “It makes us someone that we don't really get to choose who we want to be.” P3 associated mental illness with a lack of agency in emotion regulation, saying that it affected, “How to control your anger, or how to be happy whenever you should be happy. Or if you're depressed, how to deal with your depression in a healthy way.” P4 associated mental illness with a loss of control over the self and the environment, saying that during an episode of mental illness, “You never know what's going to happen.” P4 elaborated: “If you're not on the right meds, anything can happen. I've seen people on the streets that weren't on any meds end up splattered on the pavement because they thought that they were seeing something that they weren't.” P7 associated mental illness with a loss of control over cognition that resulted in a loss of control over actions: “It triggers your thinking patterns to be different, and then that makes your actions different.” For P8, mental illness meant being unable to make herself function without using methamphetamine (“being able to cope with things without them [drugs] was very hard for me”), and mental health meant not losing control under stress: “The way I perceived the way normal life was, being able to function when under stress.” P11 also described mental health as being able to control herself, without undue influence from external sources: “We can stop the negative cycle of generational trauma. This means, for me, learning what I want to be and stopping the world from influencing my behavior. It’s about having the courage to stand up for what I believe in.”

Four patient participants indicated that they associated the challenges to their mental health with a sense of loss. P2 felt that her children had suffered loss because of her substance use: “It was taking a lot from my kids, a lot of time, a lot of attention.” P2’s incentive to heal was to stop her children and herself from losing what they deserved: “I'm already 30. I don't want to be 60 years

old, still getting high, and my kids, they deserve so much better. I deserve so much better." P4 felt that she had lost time with her family because of her substance use:

> I have pictures of my nephew, my mom, and people that mean a lot to me. And I feel bad for all the time I missed out on in their lives. My nephew's about to be three, and I've seen him maybe for an hour out of his whole life. It's sad to say that I chose drugs over my family. But at the end of the day, the drugs won out over the love of my family. And if I'm able to look at them and not feel the bittersweet tears of the regrets for time lost, I would know I'm better.

In a researcher observation of a group therapy session, one of the participants described a different kind of loss, the loss of self-worth, saying, "In my active addiction, I lost how to love myself." In her interview, P1 also described a loss of self-worth: "I felt like I didn't know who I was, and I felt like I was unworthy of even being alive. When I was heavy in my [alcohol] addiction, all I felt like was a complete waste of space."

Six patient participants associated the challenges to their mental health with depression. P3 described her depression in the following terms: "When I feel depressed, I'm usually in a dark place. I don't reach out to very many people. Nothing makes me happy. I'll put on a smile. But deep inside, I feel like it doesn't even matter." P5 associated her depression with a loss of motivation and focus that she had coped with in the past through substance use: "Sometimes I can't get out of bed. I lose all focus. I have no sense of responsibilities and priorities. And whenever I'm off my [prescribed antidepressant] medication, I turn to street drugs." P1 also described herself as self-medicating for depression when she began to binge drink: "My addiction I started off because I was depressed, and I didn't want to be depressed." For P9, being depressed meant masking her feelings, both to others and to herself, by numbing her spontaneous

emotions with substances: “My major depression, that's what gets me bad. I was using [drugs] to hide a lot of my depression, to hold back a lot of feelings, actually. To numb, to not show anything, just act like everything was okay.” P10 used alcohol to mask her depression: “I have a dual diagnosis of depression and addiction. It’s a type of issue that needs alcohol to escape feelings.”

Four patient participants described social isolation as a consequence of challenges to their mental health. P1 said that when she was depressed and drinking,

> I wanted to be alone all the time, cried a lot, was feeling a lot of shame. I hardly ever went out, and when I did, I was fully covered: sweater, glasses, a hat. I didn't want anybody to notice me. Just in a shell.

P3 said that when she was depressed, “I don't reach out to very many people.” P6 said that when her mental health was challenged by addiction, “I was just self-isolating. No friends, any relationships of any kind. I had been, for the last three years of my active addiction, alone.” P11 suggested that she isolated herself out of a sense that she was not in control of her mental health: “The issues with mental health were avoided cause I didn’t like to think there was a problem with me, but I felt like I was losing my marbles. I isolated myself.”

Five patient participants associated the challenges to their mental health with anxiety. P2 described her experience of anxiety by saying,

> When I get anxiety, I either can't stop moving, or my mind wanders. It just goes and goes. I get restless, I guess. Either I have to be moving, or I have to be messing with something. I'll play with my hair a lot, or my leg will shake. I noticed that my leg shakes a lot.

P2 also reported that she experienced panic attacks, saying that when they occurred, “You can't breathe, or you hyperventilate, where you get to the point where your body gets numb or tingly

and you want to pass out." P1 said of her embodied experience of anxiety, "Usually, for me, it's in my chest. I feel like something's sitting on me, or in my throat, and I get that feeling that I need to cry, usually." P8 described her anxiety as a diagnosis: "When I saw a therapist for the first time, or a psychiatrist, they diagnosed me with PTSD, bipolar II, depression, and anxiety."

Theme 2 Summary. Data associated with this theme was drawn from the patient interviews. This theme was relevant to addressing the primary research question, regarding how Hispanic women describe their mental health. It is also relevant to addressing the first sub-question, which was focused on how the patient participants came to the PLTP. Patient participants associated their mental health with self-awareness, self-determination, and holistic wellness. Challenges to mental health of the kinds discussed under Theme 1 were associated with a loss of self-control, a sense of loss (of time with loved ones or self-worth), depression, anxiety, and social isolation.

Theme 3: Adventure Therapy Taught Coping Skills, Built Confidence, Regulated Emotions, and Brought Enjoyment

Data from patient testimonios, staff interviews, focus groups, and researcher observations supported the finding that adventure therapy and being outdoors were associated with learning positive coping skills. Thriving And Persevering (TAP) is a pseudonym used for confidentiality purposes, in lieu of the program name. P2 said during her interview that the outdoor activities at PLTP such as (TAP), could become coping skills for her when she left treatment:

> The outdoorsy part, in my active addiction, I would not have played volleyball, I would not have been able to come out here and take a walk, go to TAP, I wouldn't do any of that, and the things that I learned here like that, even art and stuff, I could take it home, and instead of using, it's a coping skill, I could do all this stuff with my kids.

P3 described the coping skills she had learned for dealing with flares of anger, citing going for

walks outdoors as one of them: “If you're feeling angry, how to defuse from that. How to calm yourself down. Either breathing techniques or doing what you like and enjoy. To go for walks, or just walk away from the situation.” P5 also described outdoor activities as contributing to skill-building: “With the outdoor program, we get to challenge ourself with the high events. We do skill building with trusting your partner on high events. You have to work together . . . they all have a meaning behind them.” In the second focus group, a participant reported experiencing relaxation during an outdoor meditation exercise in which, “I was just feeling the wind. I might have a clear mind though, but that wasn't feeling anything.” P9 spoke of the skills she was gaining as tools for managing her depression and anxiety: “I'm not depressed, and I'm learning the tools not to be depressed and not have anxiety.” P9 said of the overall effect of the coping skills she was gaining, “They're giving me the ability to just mentally be there, be present without doing drugs.” P11 spoke of walking in the outdoors as an effective coping skill for her: “When I think of how the outdoors effect my mental health, I have noticed when I am frustrated, I know I can go for a walk. Walking lets me that I am free.” In the first focus group, a participant performed a grounding exercise involving the five senses, using the outdoors as contact points for sensory grounding:

> It's the five-senses breathing technique. First you name five things you can see, like the cars next to us, the cemetery next to us, the tree, the garage, the trash cans. Then four things you can touch. Like our clothes, the shoes, our rocks. Three things you can smell. The fresh air, the rain clouds coming in. Unfortunately, the trash. Two things you can hear the cicadas and the wind, and one thing you can taste. I taste my lip gloss.

In a staff interview, S4, a Clinical Therapist, spoke of the connection between patient participants’ trauma histories and using the outdoors as a safe space in which to teach coping

skills:

> Most of the [patient] participants have a background of sexual trauma and co-occurring disorders . . . my goal is to provide an empathetic place to understand what led them to their addiction and demonstrate alternative skills that will help them protect themselves and their families.

Notes from the third researcher observation indicated how a meditation exercise taught the patient participants to ground themselves in the outdoors through awareness of their contact with the ground: “The instructor on the video suggests that we take a seat and ground ourselves with our body/touch. H starts by instructing us to ground ourselves with our butt, with our feet, spread our toes.”

Data from the patient interviews, staff interviews, and researcher observations supported the finding that adventure therapy and the outdoors supported the patient participants’ mental health through emotion regulation. P1 described how going outside released her anxiety:

> I just feel like I can breathe outside. I don't really have a lot of anxiety lately, but when I'm outside—you know when you have anxiety, and you feel a little tense? And when I'm outside, I just don't feel any of that at all. I feel like I'm open to the world. I don't need to worry about anything when I'm out there.

P2 described the outdoors as improving her mood: “It's nice when you're in a bad mood, or you're irritated, to be able to go outside and get some fresh air, and just take your mind off of things, I guess, different scenery, nature.” P2 specifically referred to outdoor volleyball and walks as helping to improve her and other patients’ mood: “They bring us outside, and we get to go on walks, or play volleyball, and especially when you're in a bad mood, and we come out and we play volleyball, it gets everybody in a good spirit.” P4 described the outdoors as emotionally

cleansing: “The more I'm outdoors, the more at peace and the more happy I am . . . I feel like the wind washes away our pains and stuff like that. Just like the weather changes, our emotions change.” P5 said of being outdoors, “It's refreshing. It would just open your eyes to nature and enlighten your mood, make you think of things you're grateful for, all the things around you in nature. Just puts a smile on your face.” P7 reported that a nature hike had helped to alleviate her stress:

> We went on a hike not too long ago, maybe last weekend. I was feeling stressed and overwhelmed before we went on it, just because of different things going on. But I noticed that after, and while we were hiking, I was a lot more able to clear my head and think about things rationally.

P8 joined other participants in describing the outdoors as lifting her mood:

> I just feel like when I'm outside, all of my thoughts and worries and my concerns or whatever are just released into the atmosphere and I'm able to receive the goodness that is towards me. And then just the sunlight . . . I just really feel like the sunlight gives me lots of nourishment and energy. And when I'm down or anything like that and we come outside to play, my mood changes right away.

P9 said that when she was outside, she could, “Release anything, any tension, any built up anger, just any built up anything that you have. And you could just release it to the universe and let it take it away.” P9 added that after releasing her negative feelings outdoors, “I felt a whole weight was lifted off my shoulders and everything. And it felt like I was cleansed. It gave me a lighter feeling.” P10 said of how outdoor activities helped with her emotion regulation through grounding, “The outside gets me out of my [negative] mindset through activities and movement. Some skills we do are meditation, yoga, and outdoor activities. These skills help me live in the

moment. I can connect with my five senses." In a staff interview, S3 described the outdoors as helping the patients to regulate their emotions by challenging and empowering them: "I see how the outdoors help regulate the nervous system. By using trauma-sensitive approaches that empower clients to step out of their comfort zone that results in them feeling safe and secure." S4 said that going outdoors contributed to patients' emotion regulation because, "Outdoor activity allows the group members use their five senses to stay grounded." In the second researcher observation, notes indicated that a Residential Assistant described the outdoors as helping patients to regulate their nervous systems through grounding in a challenging but safe environment:

> She talked about seeing the connecting with the outdoors and nature by helping the group members of the program regulate their nervous system in outdoors activities such as hikes, playing volleyball, or TAP. She offered that TAP allows the group to "step out of their comfort zone where they feel safe and secure and no harm will be done."

Outdoor activities also contributed to building patients' confidence, according to patient interviews. Most patients specifically referenced the high-ropes event as contributing to building their confidence, so P6's response is quoted first, because she described how one of the high-ropes events worked:

> One [event]'s a courage pole. So, you climb a pole 25 feet. You stand on a disc. They make it wobbly on purpose. You're held up by a harness with these ropes on it. And the clients here, other clients, are the ones who are actually holding you up and supporting you, so they're the ones who ultimately prevent you from falling . . . And so, you're in the harness, you climb 25 feet, you're on a wobbly disc. And not only that, but you're facing the wrong direction, so you have to turn around. [The disc you're standing on is] not big

> enough, it's smaller than your feet, so you have to do it a certain way. And then there's a rope about eight feet out that you jump, and you can touch. And so that's one of them [the high-ropes events]. And each one, you're supported by these people here.

P1 described the high-ropes activity as increasing her confidence by improving her ability to tolerate stress in a safe environment:

> We do a lot of high-ropes events, and so it allows you to go into a space that you're completely uncomfortable with, and that's scary, and it's an unknown what's going to happen when you're up there. And I think that's a huge part of recovery, or healing in general, is being able to be uncomfortable in places that you're usually not or getting uncomfortable and being okay with that.

P3 also spoke of the high-ropes events as confidence-building: “They [staff] try to build your self-esteem up and make you more confident, because when I got down from there [the high-ropes platform], I was just proud I made it up just the ladder.” P4 described the wall-climbing event as helping her to challenge her fear:

> I really love the challenges like we do because it's challenge by choice. If you're scared to do it, you don't have to do it, but they invite you to take the chance. I've done the climbing wall twice already because I'm scared of heights, and they let me try and try again until I get it out of my system. They don't judge you for not being good at it. We do the high ropes, and I'm scared of heights again. And so, I didn't climb the whole ladder. But they don't judge you, and they just let you down.

However, some folx with a trauma history may struggle with the notion of AT Challenge by Choice. Another option to challenge by choice with Latinx groups may be Support with Curiosity and Cariño rather than the challenge aspect. Support with Curiosity and Cariño suggest

that the participants will receive support as they engage in the activity and that there is an element of curiosity and warmth involved in the process. Although I offer a suggestion it is best to consult with group members to determine most appropriate action for them. P7 described the high-ropes event as helping her to face challenges: “We do high rope events and things like that. That's therapeutic because it's challenging you to face something.” P7 said that in part because of activities like the high-ropes events, her confidence had increased: “I have a different mindset than when I first got here. I'm a lot more willing to try things and believe in myself, that I'm able to succeed in my recovery.”

Findings from the patient testimonios also indicated that the outdoors supported the participants’ mental health by enabling them to experience enjoyment. P1 said of going outdoors at PLTP “Incorporating adventure for me, it allows me to regain that passion that I had before my addiction.” Asked to elaborate on what she meant by “passion,” she described the intense enjoyment in physical activity that she had lost when her alcohol use got out of her control: “My passion for just life, like passion, and I love sports and being athletic and all those things. And so, it really helps bring me to a state of mind that is healthy for me.” P1 added that when she was using alcohol, she had forgotten how to experience enjoyment: “I forgot that there's fun things out there, and there's things out there that can make you feel happy, and bring joy to your life, and change the way that you see your life.” P1 said of adventure therapy, “It's just given me a whole different level of energy to find adventure when I go home.” P2 said of TAP, “It’s all about having fun while we’re sober,” when substance use had left no room for enjoyment: “When we're in our addictive behavior, we don't play games, we don't go outside and take a walk. The only reason we're walking is if we're walking to get our drugs or running outside to get high.” Asked if she saw a connection between the outdoors and her mental health, P3 said,

“Yeah. I guess so. It makes me, I guess, joyful. And more uplifting.” P6 said of the connection between the outdoors and her mental health that the outdoors “balanced” her through enjoyment:

> I thrive in the city, but then half the year I go in the woods to get away [before I started using substances]. And it does involve work, but I'm passionate about it. So, it doesn't feel like work. It's really enjoyable. So, I feel like it balances me out.

P8 also described being outdoors as enjoyable: “I just really enjoy being outdoors now, which I don't really know how to explain it. I guess I just get more oxygen to my brain and it just helps me be able to process.” P9, who normally disliked swimming and being in the water, described her enjoyment of an outdoor rafting experience: “It was just so fun because I don't like water. And it was in the river. And it was just adventurous. It was fun. It was something that I was nervous about, but I tried it.” P9 also contrasted the enjoyment and freedom of being outdoors with the more internalizing experience of remaining indoors:

> It makes me feel good to be outside. It helps to clear my mind, because being cooped inside a lot, I stay stuck in my head. And it's not good to stay stuck there, because sometimes I get too depressed, or my anxiety gets too high.

P10 also described enjoyment of the outdoors, speaking of an endorphin rush that she experienced when she became grounded in the sights and sounds of the outdoors:

> I would describe the connection between mental health and the outdoors as liberating because I use all my senses. I breathe in fresh air. I listen to the birds. I see the sky. I touch mud. This morning we went for a walk on the trail, and I saw sunflowers. And I felt like it was an endorphin boost.

Theme 3 Summary. This theme was relevant to addressing the second research sub-question, which was focused on how the outdoors was supporting the patient participants’ mental health.

Data assigned to this theme was drawn from all four data sources (patient interviews, staff interviews, focus groups, and researcher observations). The patient participants' accounts of adventure therapy emphasized the high-ropes activity, which they described as building their confidence. Emotion regulation was also supported by being outdoors, the patient participants said. Overall, outdoor adventure therapy was associated with learning positive coping skills and experiencing enjoyment, when many patient participants reported that they had lost the ability to experience enjoyment while they were using substances to cope.

Theme 4: Healing Meant Gaining or Regaining Self-Determination and Self-Acceptance

Patient interviews, staff interviews, and observations indicated the finding that healing was associated with gaining or regaining a capacity for self-determination. P1 said that for her, healing would mean, "Not letting outside influences or anybody else affect the way that I am. Because I think, for me personally, a lot of my bad choices in my addiction came from allowing someone else to control my emotions." P11 used similar language about not letting herself be influenced, saying, "We can stop the negative cycle of generational trauma. This means, for me, learning what I want to be and stopping the world from influencing my behavior." P5 spoke of gaining the capacity for self-determination by learning from her "fall" into substance addiction, with her choice of the word "fall" suggesting her experience of a loss of agency in relation to the substance and her mental health: "I'm going to learn from the experience of how hard I fell. I'm going to stay on my medication. I'm going to do the things that I've learned from the past and not repeat that." P10 also spoke of healing as no longer letting herself be unduly influenced by the past: "I see the outdoors and the program as part of my healing because we learn in a group to put the past behind and find healthy ways to function in society." P7 thought of healing as becoming like a river, which goes around obstacles to maintain its overall course instead of being

balked or turned aside: “I would think of [healing as] maybe a river, because it’s flowing, and it keeps moving. Yeah, there are rocks and obstacles that get in its way, but it doesn't let it stop it.” P7 also discussed healing as a process of gaining self-determination, as opposed to letting the past control her:

> I have learned that I don't have to let my past control me, and that I design my own future. Even though I messed up for so many years in my life, because I was in active addiction for 10 years, I still am young, and I still am able to change the future that I have ahead of me.

Staff interview data corroborated the patient participants’ view that gaining or regaining the capacity for self-determination was part of the healing process. S2, the Executive Director, spoke of employing a guest speaker to help empower patients: “This program has a mother figure coming in once a week to empower the participants to make good choices, which lead to good outcomes.” S4, a clinical therapist, described an exercise to reinforce goal-setting and self-determination for patients:

> The members were asked to create their value statement that reflects on how their life aligns with their goals. Each member shared their statement, and then they used the *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* by Lisa Najavits. The participants had an opportunity to check in on their weekly commitment. After the verbal check-in, the group will be asked to go outside and walk the trail while they reflect on the question: “What do I want to be remembered by when I am gone?”

An example of a goal reported by a patient in the group S4 ran to support goal setting and self-determination was, “In the future, I would like to not drop out of my nephew’s and niece’s lives. Its not fair to them. I want to be consistent in their life.” A second participant in the group

responded to S4's exercise by saying, "I want to be remembered by my loved ones as someone that is dependable and reliable. I want to make them proud, but I tend to put too much pressure on myself, which has resulted in me using drugs." Notes from the first researcher observation described another group therapy session, in which the patient participants were discussing what they would do when they returned to the communities in which they had used substances in the past. One patient participant spoke of the need to regain the capacity for self-determination by confronting the mental health challenges that led to substance use as a negative coping strategy:

> The real awareness comes from trying to understand what we are running from. Maybe that deep, dark secret that we continue to try to mask. We need to tap into the courage to speak up and change things. We are a big key toward advocacy for a healthier life.

As the patient participant quote from the first researcher observation suggested, the patient participants understood healing as a process of not only regaining the capacity for determination, but as a process of gaining self-acceptance ("trying to understand . . . that deep, dark secret that we continue to try to mask"). A participant in the second focus group discussed how she had become more accepting of her body, so that self-consciousness about her body's shape was no longer a barrier to participating in breathing exercises:

> I was thinking about my stomach rolls, because I used to be so uncomfortable with the fat in my stomach, and just not worrying about it. I remember having to do these breathing exercises, and I was so self-conscious about my stomach expanding. Just being able to do it honestly and not having to be so self-conscious is awesome.

In her interview, P1 described healing as accepting herself: "I feel like it's [healing is] coming to a place within myself that allows me to be okay with who I am, and to accept myself for everything that I've done or that has happened to me." P2 said that if she healed, "I'd be happy,

I'd be content with myself." P4 spoke of learning to accept and value herself, saying that she had learned in the program, "That I am worth the change. My life is worth living. I am worth changing for. I am worth living. Because before here [PLTP], I literally didn't care if I was alive or dead." P6 said that for her, healing was, "Growth from a harmful or traumatic event, and eventually leading to the forgiveness of yourself, or whoever else was involved in that traumatic event." P8 spoke of being able to accept and trust her gut feelings, or intuition: "I had the feeling of heaviness . . . And this program has helped me understand when you feel that feeling, you know your body's talking to you and your mind's talking to you about the situation." Notes from the third researcher observation indicated that during a group therapy session, a patient spoke of her healing process as one of gaining a sense of self-worth: "Coming here was a turning point for me. Seeing the other girls motivated me and helped boost my confidence. I now have a sense of worth."

Focus group findings suggested that some patient participants associated healing with being heard. A participant in the first focus group said of her reaction to conducting a testimonio for this study, "It felt nice to have someone interested in my past or my testimonial. I felt like I wanted to share more. And it was a way to be heard. I often feel not heard a lot in my life." A different focus group participant suggested that doing a testimonio helped her to heal by making her feel heard: "It felt as if a weight was lifted off me. It felt like someone wanted to hear my voice." A third participant in the same focus group perceived being heard as a way to initiate change in her life: "It felt really good to share my life and get out of my comfort zone. I feel that's another way to not be afraid to change." A fourth focus group participant responded positively to being heard and not being judged: "It was nice to be able to be heard and not judged about my addiction and my actions and how it all led to me wanting a different and sober life for

me and my children."

Theme 4 Summary. This theme was relevant to addressing the primary research question, which was focused on Hispanic women's experiences of mental health. Data assigned to this theme was drawn from all four data sources. The findings indicated that the patient participants conceived of healing as a process of gaining or regaining the capacity for self-determination that they had lost or never had because of the challenges to their mental health. Some patient participants also thought of healing as a process of gaining or regaining self-acceptance. Some patient participants referred to another dimension of healing, that of being heard.

Summary

During data analysis, four themes were identified as the major study findings. The first theme was: challenges to mental health included trauma and unhealthy responses to trauma. This theme was relevant to addressing the primary research question about how primarily Hispanic women describe their mental health. It is also relevant to addressing the first sub-question, regarding how the patient participants came to PLTP. The data associated with this theme was drawn primarily from the individual testimonios with the patient participants, with some support from the staff interview data. There was some divergence between the respective findings from those two data sources. The patient participants indicated in their testimonio that the challenges to their mental health included substance use, legal trouble (i.e., convictions for crimes ranging from driving while intoxicated to burglary), and cultural barriers to help-seeking (i.e., the silencing of mental health issues in Latinx culture). A few patient participants mentioned childhood or adulthood traumas as challenges to their mental health, but most patient participants focused on substance use as the primary challenge to their mental health, without choosing to delve deeply into the perceived reasons for their substance use. Data from the staff interviews corroborated patient

participants' perceptions of cultural barriers to seeking evidence-based care, but staff members' responses were focused more on trauma as the ultimate cause of substance use than on substance use as a proximate cause of treatment-seeking. Taking data from both sources into consideration, it may be concluded that substance use was both a challenge to mental health and a strategy for coping with effects of trauma, with trauma effects being the primary challenge to mental health.

The second theme was: mental health was associated with holistic wellness, self-awareness, and self-determination. Data associated with this theme was drawn from the patient interviews. This theme was relevant to addressing the primary research question about how Hispanic women describe their mental health. It is also relevant to addressing the first sub-question, regarding how the patient participants came to the PLTP. Patient participants associated their mental health with self-awareness, self-determination, and holistic wellness. Challenges to mental health of the kinds discussed under Theme 1 were associated with a sense of loss, a loss of self-control, anxiety, depression, and social isolation.

The third theme was: adventure therapy taught coping skills, built confidence, regulated emotions, and brought enjoyment. This theme was relevant to addressing the second research sub-question, which was focused on how the outdoors was supporting the patient participants' mental health. Data assigned to this theme was drawn from all four data sources (patient interviews, staff interviews, focus groups, and researcher observations). The patient participants' accounts of adventure therapy emphasized the high-ropes activity, which they described as building their confidence. Emotion regulation was also supported by being outdoors, the patient participants said. Overall, outdoor adventure therapy was associated with learning positive coping skills and experiencing enjoyment, when many patient participants reported that they had lost the ability to experience enjoyment while they were using substances to cope.

The fourth theme was: healing meant gaining or regaining self-determination and self-acceptance. This theme was relevant to addressing the primary research question, which was focused on primarily Hispanic women's experiences of mental health. Data assigned to this theme was drawn from all four data sources. The findings indicated that the patient participants conceived of healing as a process of gaining or regaining the capacity for self-determination that they had lost or never had because of the challenges to their mental health. Some patient participants also thought of healing as a process of gaining or regaining self-acceptance. Some patient participants referred to another dimension of healing, that of being heard.

CONCLUSION

These research findings will help guide culturally adapted trauma informed treatment that places an emphasis on the importance of cultural interventions. I discuss practical implications that fall under three main categories (1) communicative (2) pedagogical and (3) institutional. I address the communicative issues arising out of my research findings by looking at public discourse and conversations that people engage in to understand the critical issues with mental health. I specifically address the cultural socializations around mental illness in Latinx communities and the failure by the wider community to acknowledge the impact of mental health and how "mental illness" is conceptualized in Latinx communities. The bulk of the research supports the effectiveness of adventure therapy (Chan & Biegel, 2021; Karoff et al., 2017; Lewis, 2013; Tucker et al., 2013). Nonetheless most of the studies have been on white youth and young adults. However, there are limited studies that examine if adventure therapy is effective beyond the white culture. This study sought to expand the literature with Hispanic adult women. The data that emerged from this exploratory study supports that adventure therapy was useful with Hispanic adult women. However, due to the limited sample size it cannot be generalized that adventure therapy is for everyone. Furthermore, a presentation on *The Psychological Pitfalls of Adventure Therapy* (2019) supports the contraindicate includes folx with serious mental illness, such as schizophrenia, and it is suggested to use with caution for folx impacted by sexual trauma. Conversely, when a Trauma Informed Approach is weaved in with adventure therapy, as done in PLTP the model is effective because the intervention infuses the importance of self-determination, voice and choice.

I build on Cherríe Moraga's (1983) work "to be critical of one's culture is not to betray that culture. We tend to be very righteous in our criticism and indictment of the dominate culture

and we so often suffer from the delusion that, since Chicanos are so maligned from the outside, there is little room to criticize those aspects form within our oppressed culture which oppress us" (p. 108). I demonstrate the nuances, and even sometimes perpetual silences, of mental health that occur within Latinx communities to not cause tension.

This study is about reclaiming truth that disrupts the myths of mental illness within some Latinx communities by infusing a decolonial epistemology with a trauma informed approach. The problem is historically underrepresented communities continue to be affected more by mental health disparities. Social work must work outside of their own silos and Eurocentric models to mitigate ways to meet the needs of historically marginalized groups that go beyond diversity and equity statements to a plan for treatment modalities that amplify client voices.

In this chapter I give an overview of the findings which include six subsections, then give suggestions to pedagogical implications and addresses the institutional implications by examining how health concerns of Hispanic women and additional groups can be addressed and resolved in mental health policies, programs, and services.

Examining the public debates around "mental illness" in Latinx communities.

Practice implications can be effective if appropriate structures are in place. This starts by acknowledging the debates surrounding the validity of psychiatry as a medical science (Shedler, 2018). Therefore, I propose cultural hybridization as an effective combination of tools to reshape clinical practice (Kirmayer et al., 2014). By merging techniques with humanities and adventure therapy which was illustrated in chapter 5, these techniques include awareness of cultural socialization that affect disclosure. For example, cultural constraints such as a fear of being misjudged by the community for seeking mental health services and misguided by traditional medicines that have not worked. Most of the participants did not talk about feelings when they

were growing up. Therefore, having creative techniques to express feelings in outdoor settings was helpful. To illustrate, a few informants shared specific activities such as high ropes at PLTP that helped them process emotions. Even though in these cases disruption of silence was liberating, I encourage researchers and practitioners to remain curious about who really benefits from disrupting silence. In contrast, disrupting silence can confine children or adults which may lead to serious consequences. I urge researchers and clinical practitioners to be aware of the types of supportive services and resources available for women when they return to their communities.

As discussed in the theory section, a trauma informed approach with decolonial epistemology frameworks focuses on empowerment, and self-determination through counternarratives to re-center voices. It is by shifting this paradigm from a deficit lens to a strength-based approach that will help demystify the perceptions of mental illness. A strength-based approach takes the focus off pathologizing mental health and focuses on empowerment. Evidence suggests Adventure Therapy places an emphasis on agency (Tucker et al., 2016). What I mean by agency is that the clients have the right to choose and commit to the work that will enhance their mental health through using these integrative approaches to treatment. Latinx scholars (Menchú; Burgos-Debray, 2009; Wald et al., 2019) along with prominent scholars in the Association of Experiential Education (Alvarez et al., 2021; Roberts & Spears, 2020; Norton et al., 2014; Warren et al., 2014) demystify concepts and perceptions which mainstream has used to suggest that historically underrepresented groups do not use the outdoors. These scholars have advocated for ways to re-imagine engagement of the outdoors with communities of color. In AEE, research teams have used cultural dimensions to understand cultural values that are different from Western approaches that shift the focus from the individual to a collectivist

approach (Chang et al., 2017; Norton & Hsieh, 2011). This collectivist approach fits well with the methodology of testimonio because it disrupts the silence by elevating voices of the community that have been dismissed. This method of testimonio can be viewed as stories of transformation that promotes self-love, and acceptance.

Mental Health and Cultural Socialization

The resistance in defining labels in mental health is difficult. Critics argue there is no universal definition of trauma (Menschner & Maul, 2016). Additionally, patients may be able to relate more from a holistic perspective by explaining how trauma affects their overall health rather than solely focusing on the experience of trauma itself. SAMSHA defines trauma as "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individuals functioning and mental, physical, social, emotional or spiritual well-being" (SAMSHA, 2014, p.7). By gaining a continued understanding of cultural socializations that connected with the idea of "two-edged sword", we can continue to be aware of the nuances that play into forms of expression with mental illness (Zayas, 2005).

Transforming Pain into Power

These collective experiences with mental health can be articulated in diverse ways. But what was heard from the lived experiences in this exploratory study was influenced by cultural dimensions. Most of the participants shared that feelings were not discussed during their childhood. All the participants shared how substance abuse impacted their families. Some participants offered labels such as anxiety and depression that connected mental health with substance abuse. The participants were able to share somatic symptoms they felt when their anxiety increased. In other words, they shared how the symptoms felt in their body. For example,

some participants shared when they were anxious, they had ruminating thoughts – having the same negative thoughts repeatedly – and felt knots in their stomach. However, most of the participants were grateful to have the opportunity to be at PLTP where the outdoors was integrated as part of their treatment plans. The participants shared when they were outdoors in PLTP they felt a sense of freedom and liberation from shame. The first research question demonstrates via testimonios how descriptions of mental health are more about transforming pain from the past into power via acts of cariño and liberation by sharing our testimonios. Transforming techniques include culturally congruent strategies to support mental health. This research is important because too many lives have been lost because mental health services did not culturally meet the needs of historically underrepresented groups. Effective mental health treatment will help close the gap among historically marginalized groups.

I am most concerned with providing recommendations on how social constructions may be incorporated into knowledge production, interrogation, and dissemination within the mental health field via counternarratives. I also discuss how a decolonial epistemology which is about self-determination can be incorporated into education and service delivery. I build on culturally congruent methods of testimonios to shift discursive power to Hispanic women in constructing knowledge. A decolonial framework challenges larger social inequities that explores the critical consciousness of oppression (Delgado Bernal et al., 2016). As illustrated throughout the previous chapters a decolonial framework in mental health by challenging labels while striving towards reclaiming truth.

Counternarrative Perspectives of the outdoors in Latinx communities

Counternarrative is a tool used with testimonios to re-center voices. The participants used the outdoors during a span of their lives. In fact, most of the participants shared how they played outdoors as children. For example, in their communities the outdoors meant playing in their backyards, going for walks, or going to parks. However, one participant noted she did not like the outdoors because of the bugs but she stated she has been adjusting with the outdoors since being in the PLTP program. Considering these findings, it seems that most of the participants, including myself, had access to the outdoors as children and continue to find creative ways to integrate the outdoors into our adult lives. The outdoors was pivotal during most of our childhood and adult lives. Metaphorically, the outdoors is medicine for our souls.

Many of the participants articulated that PLTP served as a vehicle that re-connected outdoors while supporting their mental health. At the same time, one participant shared how their addictions tainted their perspective with the outdoors. One of the participants disclosed during her addiction years she would go out to the woods with her partner and get inebriated. Under those circumstances the participant mentioned how her addiction interfered with her ability to appreciate the outdoors. Despite the past, the participant revealed through the help of the PLTP and her sobriety skills that helped reframe her feelings of shame from her past to gratitude for her network. Gratitude for her sobriety. Gratitude for her health. Gratitude for her awareness and ability to appreciate the outdoors. This brief snapshot of this counternarrative demonstrates how one informant reclaimed their narrative by shifting her gratitude with PLTP of tools she intends to use to support her overall health when she transitions out of PLTP.

Although critics will challenge methods and theories that fall outside of mainstream, it is imperative for researchers and practitioners to continue to build on frameworks that integrate

tools to enhance the therapeutic process. These acts of disrupting silence in mental health with Latinx using Adventure Therapy can be viewed as acts of liberation and self-love by creating social awareness. This research has contributed empirical evidence that can guide researchers and practitioners in designing therapeutic alternative plans to current mental health treatment.

Reshaping Mental Health to amplify historically underrepresented groups in the Outdoors.

Re-shaping the deficit narratives with the outdoors in Latinx communities is linked with cultural representation. Building on pioneers such as Dr. Nina Roberts and Spears (2020) demonstrates the need for research that goes beyond teachings of Western Scholarship. This entails re-shaping and reimaging outdoor pioneers that identify as Latinx. The findings of this exploratory study help reshape the narratives.

It was not in the scope of this study to do in-depth detail of substance abuse yet, surprisingly some of the participants shared that their addictions started during loss. The loss was not only death, but also connected to loss of relationships, and one testimonio connected with loss of defying rules, such as cultural constraints. This participant shared that at a young age she knew she was a lesbian but since her family could not accept her identity it resulted in her coping with her pain through addiction.

These findings support how participants connected mental health with substance abuse. Notably, the participants saw a connection between the outdoors and mental health. Most participants shared how the outdoors was metaphorically a bridge that connected with their mental health by weaving in adventure therapy techniques. For example, informants discussed how the challenge by choice helped build their self-confidence. Additional participants discussed how adventure therapy tools such as challenge courses which included climbing walls or white-water rafting lent an opportunity to have a choice to participate or not, take risks and feel

empowered.

To put it differently, one participant alluded to her realization of how in her "active addiction" she lost the ability to self-love. In the PLTP program she was able to make the connection with the outdoors and her mental health which evolved into her awareness of reclaiming her ability to self-love and re-shape her narrative. Bridging the concept of self-love, means seeing us as survivors rather than victims. Self-love means accepting us for who we are and choosing to nurture our bodies with cariño. Self-love entails the ability to accept the things we can not change. Self-love involves cariño y esperanza. Meaning we as survivors can honor and nurture our bodies with authentic care and hope via a reciprocal relationship with the outdoors.

Drawing upon common themes of empowerment and self-love from this research I bridge this with my own personal experience. As a collective and co-creation piece I demonstrate through testimonios how amplifying voices with mental health is about challenging labels, stigma and negative assumptions through counternarratives to demonstrate acts of liberation, self-love, and self-determination.

Pedagogical Implications

The shift to a decolonial, trauma informed culturally-responsive mental healthcare model prompts a need to change the way practitioners are trained. The trainings would build on research that suggests "how the world looks to some of us when we know, experience, speak, and imagine it while situated in the dwellings of double consciousness, border thinking, and subaltern epistemologies" (Henandez-Wolfe, 2013 p. 17). Borrowing this idea of double consciousness in the context of mental health would use culturally congruent methods, like testimonios and counternarratives, as a vehicle to transform deficit narratives. Franco (2020)

supports counternarrative as a means for reclaiming stories. I see counternarratives in mental health as a tool used to re-center informants' voices to challenge labels with mental illness by transforming their stories to hope.

Building on the concept of borderlands with mental health, I see a connection between how cultural socialization or scripts of silence can be complicated especially with the notion of "two-edged sword" that impedes families from seeking treatment (Zayas et al., 2005) and positioning social workers as borderland guides to help change the narrative and Kirmayer et al.'s (2014) suggestion of cultural hybridization to reshape clinical practice. Therefore, if we consider the factors that promote mental health, then perhaps cultural hybridization can be the conduit that links Testimonios and Adventure Therapy in clinical practice, using counternarratives.

This starts by moving beyond statements illustrated in the National Association Social Work Code Ethics (NASW, n.d.). The value principles include: Service, Social Justice, Dignity and Worth of the Person, Importance of Human Relationships, Integrity, and Competence with the final principle suggesting a continuous enhancement of their knowledge. Although the NASW advocates for continuous knowledge, the way I see competence is through consistent training and accountability. Scholars support cultural competence as a mastery model that does not account for systems of oppression (Franco, 2020). I propose this change begins with doing a consistent analysis of how historically underrepresented groups have been negatively impacted by labels in mental health and how social workers could do a better job in the field of competency. Rather than seeing cultural competency from a binary perspective meaning you either attain a master level or not, I build on Franco's (2020) work to suggest a continuation of reflection to address stereotypes and assumptions, that mean a lifelong commitment with accountability. My point here is not only to call awareness and accountability but also to

recognize that Latinx/Hispanics are not a monolithic group. We come from very diverse backgrounds. Hence, when it comes to mental health it is important to be mindful of our own biases as we as researchers and clinicians continue to work on mental health strategies to meet their needs.

As noted in the theory section this research infuses a decolonial epistemology by converting negative narratives into ones that build on self-determination, agency and empowerment. Knowledge is based on Eurocentric knowledge that uses a deficit perspective on historically underserved groups (Franco, 2020). But Franco argues that rather than learning from hegemonic pedagogy, we should challenge those perspectives by weaving in counternarratives via testimonios as a method to spotlight forms of resistance and empowerment that have been used as a vehicle for positive change. Testimonios are creative unconventional methodologies and conceptualizations that connect the outdoors as part of the healing process. Scholars support the outdoors has played a sacred role in marginalized groups. However, there is a lack of understanding with cultural representation by offering names of active pioneers of color that have been role models in the outdoors. For instance, Dr. Nina Robert & Spears focused on organizations that have worked toward engaging minority populations. For example, The Minorities in Agriculture, Natural Resources, and Related Sciences at Michigan State University held their first conference in 1986 (Roberts & Spears, 2020). Another organization promoting the outdoors specifically with Latinos is called Latino Outdoors that was started by José González in 2010. Hence, teaching beyond mainstream knowledge of ways that people of color have historically embraced the outdoors is beneficial to the community, at large. Cultural representation matters.

Educators must be equipped with skills and knowledge. To deal with "mental illness"

from diverse groups, educators must be equipped with skills and knowledge that consider conceptualization and treatment modalities. I suggest educators utilize creative unconventional pedagogies to help facilitate ways to re-imagine treatment modalities that go beyond the evidence-based practice models. I recommend integrating knowledge by infusing cultural hybridization to illuminate "specific techniques to reshape clinical practice" (Kirmayer et al., 2014). Here I am referring to building on literature that offers an understanding of testimonios and the role of counternarrative and linking these methodologies with modalities such as Adventure Therapy to shed light on cultural practices. Scholars support cultural practices as "beliefs tied to personal and family histories in complex and idiosyncratic ways" (Kirmayer et al., 2014, p. 4). This requires educators to be open to learning techniques via testimonios, which have historically been ignored in mainstream knowledge, while also bringing awareness to our own assumptions, stereotypes, and biases. This awareness can be done through reflection. By gaining knowledge of cultural practices this reflexivity will aid in the process of continuous learning. I bridge the reflection with time allotted in treatment to process the activity. Hence, Adventure Therapy can be an unconventional pedagogy that weaves in integrative ways that can guide course discussions. As discussed in a previous chapter, Adventure Therapy uses various tools to aid in treatment. Educators can be equipped with skills and knowledge to value diverse experiences by reviewing the plethora of literature that shows how to apply the tools in various settings, including non-profit and for-profit agencies. Pulling this together I see pedagogical implications are centered on counternarratives with adventure therapy to re-shape narratives with the outdoors.

Institutional Implications

Further research funding should invest in regular training for trauma informed culturally congruent approaches. Substance Abuse and Mental Health Service Administration (2014) reports the key principles of trauma informed care are patient empowerment, autonomy, collaboration, safety and trustworthiness. Therefore, a trauma-informed culturally sensitive program should integrate required trainings that address techniques to address expressions of trauma that can be expressed in complex forms requiring an understanding of cultural constraints that affect treatment. What I am trying to say here is that the idea of the principles of trauma informed care can be viewed by some as a positive act of liberation, but that assumption is not for all groups that identify within the Latinx community. I am suggesting that trauma informed culturally sensitive training work with cultural constraints rather than against them to re-shape trauma narratives. Integrating trainings that are open to awareness and sensitivities to cultural practices may help social work regain trust with communities who have been affected by our historical negative patterns that have had long term negative effects on historically underrepresented communities. This requires ongoing training and culturally sensitivity supervision that addresses our stereotypes and assumptions that we as social workers own, through reflexivity to acknowledge how our perceptions shape the way we, practitioners and researchers work with clients.

Although the trauma informed approach offers principles to follow, the caveat is that each principle may take longer time than allotted in the medical model to build from communities that have mistrust with the system. The medical model works with insurance companies to offer a certain amount of sessions per year. But in programs such as PLTP, the standard time to stay in the program is three months and within those three months “intensive

services" are provided. Borrowing from the Substance Abuse and Mental Health Service Administration on a payment and policy level, reimbursement structures must support provider incentives to implement a trauma-informed approach (SAMSHA, 2014). This means an investment further in research and a consensus around standardized measures related to trauma. Since the field of trauma informed care is new, there is a lack of consensus about what can be achieved or how to measure it. Health care providers from historically underrepresented groups and policymakers need more guidance on how to collect data and track outcomes specific to trauma informed care.

Avenue for further research

To put into practice a combined modality interweaving Adventure Therapy and with Anzaldúa's Seven Stages of Conocimiento, there must be a transformation process that changes the mental health policies affecting health concerns of Hispanic women and additional populations. This transformation must value perspectives that fall outside of mainstream knowledge's cultural assumptions by integrating perspectives from the humanities and social sciences as they pertain to frameworks of conventional mental health.

Health care providers and policymakers need more guidance on how to collect data and track outcomes specific to trauma informed care. A recommendation to mitigate the data and outcomes is to consider when creating evaluations the researchers should represent the global majority, meaning the researchers should come from diverse backgrounds, rather than a hegemonic group.

Conclusion

This exploratory study has offered a broad range of recommendations primarily focused on calling attention to cultural dimensions that require trauma informed culturally congruent trainings. These findings from this research illustrated how substance abuse relates to mental health. Additionally, most participants felt in their adult lives that substance abuse addictions tainted their ability to connect with their feelings. Nonetheless, the participants reflected on the ways the outdoors looked in their communities. Also, the participants made a connection with how the outdoors support their mental health based on their experiences with the PLTP program.

A combination of decolonial epistemology with principles from the trauma informed approach and Adventure Therapy with Latinx communities is centered on reclaiming voices in mental health. I see testimonio through counternarratives to re-center voices as a technique to reshape mental health narratives that promote solidarity and hope. Together with the participants, I shared my own testimonio with mental health, as illustrated in the introduction. Hence, this research project is a co-creation of knowledge regarding the lived experiences with mental health. I have borrowed the idea of co-creation from scholars (Franco, 2020; Delgado Bernal et. al., 2016) that support testimonio as a reciprocal process with informants rather than simply taking their testimonios for research purposes, only.

Building on the reciprocal process I merge our testimonios, as a collective piece to illuminate how mental health stories were acts of liberation, love and cariño. Cariño are acts of authentic care (Delgado Bernal et al. 2016). I have seen cariño aligning in this work because cariño focuses on the individual and collective needs. Cariño was used with testimonios through listening skills and skills to be listened to. Together with the informants, we stand in solidarity to reclaim our truth with mental health. A testimonio worthy of being shared and heard to

enumerate the creative ways the outdoors, in the United States has been part of reshaping Latinx narratives to restore mental health and challenge negative stereotypes and assumptions.

Even though Cherríe Moraga (1983) alluded to speaking about the weaknesses within our culture that can be challenging due to the negative presumption by society. The idea of disrupting silence, in some cases, can be complicated because of the unspoken rules with disrupting silence in the Latinx community. Again, Hispanic are not a monolithic group and recognize what works for one individual may not work for another. Despite the differences within group culture, what I conclude with is the importance of building on mental health strength-based interventions that look at the "person before a label" as asserted by a participant of this study. This requires a shift with reframing the pain from the past into power to persevere through life, despite the complexities. The power to reshape testimonios with mental that amplifies the importance of autonomy and dignity by uplifting Latinx voices that infused the outdoors with Adventure Therapy at PLTP as part of their healing process.

To that end, the key findings demonstrate the ability of Hispanic women diagnosed with co-occurring disorders to reshape their own stories and lived experiences.

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APPENDIX A: LETTER OF INFORMED CONSENT

Study Title: "We are Human Before We are Labels" Transfiguring Testimonio with AT: An Exploratory Study to Re-Shape Mental Health narratives with Hispanic Adult Women in a Substance Abuse Treatment Program.
Researcher and Title: Esther Ayers, PhD candidate
Department and Institution: Chicano Latino Studies Program at Michigan State University
Contact Information: ayersest@msu.edu
Sponsor: Dr. Eric Gonzalez Juenke

BRIEF SUMMARY

You are being asked to participate in a research study because you identify as a Latinx/a adult that is receiving services at the Powerful Lives Transforming Program (PLTP).

This study analyzes how Latinx/a describe mental health and healing practices weaving outdoor therapy in PLTP. Participation in the study will require a 2-hour commitment; one hour for the face-to-face interviews and one hour during the focus groups. Individual interviews will explore the following questions: How do Latinx/a women describe mental health? What is the participants testimonio of how they arrived at PLTP? Do the participants see a connection with the outdoors and their mental health, or not? The focus group will seek to discuss and explore themes identified during the individual interviews.

You will receive a small stipend or equal valued hygiene package for your participation. This study will not influence your care received at the program. However, your participation in this study may contribute to understanding culturally congruent methods that amplify voices of Latinx/a with mental health concerns and healing practices using outdoor therapy.

The potential risks of participating in this exploratory study are minimal because the study is asking you to describe in your own way how you tell your story with mental health and healing practices with outdoor therapy. Answers to questions are voluntary and participant driven; you may stop participating at any time.

PRIVACY AND CONFIDENTIALITY

Information about you will be kept confidential to the maximum extent allowable by law. The interviews will be audio recorded and transcribed by me. In place of your name I will use de-identified information by using pseudonyms, and will be stored in an encrypted locked area. In addition, the hard copies of the signed consent forms will be stored in a locked cabinet. The data for this project will be kept confidential, those that will have access to the data are me and the primary investigator, Dr. Eric Gonzalez Juenke. The results of this study will be published or presented at professional meetings, but the identities of all research participants will remain anonymous.

VOLUNTARY STATEMENT

Participation is voluntary. You may choose not to participate at all, or you may refuse to participate in certain procedures or answer certain questions or discontinue your participation at any time without consequences.

COSTS AND COMPENSATION FOR BEING IN THE STUDY

You will receive either a $10 gift card or an equal valued hygiene care package to compensate you for your time in accordance with accepted practice at the PLTP.

FUTURE RESEARCH

Information that identifies you will be completely removed from the research study. After such removal, the Testimonio and demographics could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from you.

CONTACT INFORMATION

If you have concerns or questions about this study, please contact the researcher: Esther Ayers, at email: ayersest@msu.edu

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu or regular mail at 4000 Collins Rd, Suite 136, Lansing, MI 48910.

DOCUMENTATION OF INFORMED CONSENT.

Your signature below means that you voluntarily agree to participate in this research study.

_____ _____

Signature Date

You will be given a copy of this form to keep.

The interviews and focus groups will be audiotaped. The audio recording data will be stored for a period of at least three years following the submission and publication of final research reports in the sole possession of the primary researcher. Following this period all data will be destroyed. You may decline to participate the in the audio recording and will still be interviewed. Declining the audio recording will not exclude you from this study.

- I agree to allow audiotaping of the interview.

Yes No Initials_____

APPENDIX B: INTERVIEW PROTOCOL

TIME & MATERIALS	DAY ONE
10 Minutes Materials needed: Private room Laptop Handheld Recorder Tissue Hand sanitizer	As the participant enters the PLTP space the facilitator will work towards building rapport by integrating social work skills with the participants. Once the participant is settled in their space I will introduce myself: • **Example:** Thank you for agreeing to be a participant in this study, and I appreciate your time. I am a PhD student at MSU in Chicano Latino Studies Program, and a licensed social worker focused on mental health. My research interest in mental health stems from family members affected by serious mental health concerns. I am collaborating with PLTP to look at how you explain mental health and describe healing practices within PLTP. This is a two day process that will entail up to one hour interviews. The first interview will focus on mental health and the second interview will focus on healing practices at PLTP. Then I will review a hard copy of the informed consent with the participants and inquire if there are any questions or concerns. I will ask you some basic demographic information that include how you racially identify, your education level, what state you reside in and your annual income. As noted on the consent form, the information and answers will remain anonymous. Please keep in mind you are allowed to skip any questions that you do not feel comfortable answering.
	TESTIMONIO DAY 1
40 minutes	As mentioned earlier, we are going to be discussing mental health specifically how you explain mental health and describe healing practices used in PLTP. I want to listen to your ideas to help understand how your mental health stories can work towards elevating voices of historically underrepresented groups in community mental health settings. I will present questions one at a time as stated earlier the questions will cover two topic areas: engagement in mental health services and to draw from healing practices at PLTP. Do you have any questions before we begin? Beginning with Demographic Information, please note these questions are being asked because my research interest is focused on non-profit organizations such as PLTP. 4. How do you racially identify? 5. What is your age (Passarelli et al., 2010) 6. What is your previous experience with weaving the outdoors as part of the therapeutic process? 7. What is the highest level of education have you attained? 8. What is your annual income? 9. What state do you reside in?

	This interview will focus on mental health. There will be three questions and probes to guide the questions. (each question will last ~ 7-10 mins). 10. Tell me your story about what brought you to PLTP? 11. I am wondering, how would you describe mental health? a. Probing: When you say (description of mh) Help me understand what you mean. 12. I am curious about other issues that might be affecting your mental health. For instance, have you had a history with substance abuse? b. Probing: Can you talk more about that?
10 minutes	**Debrief and discuss** • The facilitator will debrief by reinforcing gratitude for their time. Also summarize main points learned from the stories. • The discussion from the information provided today will be used towards developing a plan that de-stigmatizing mental health in Latinx communities. • Please note that this work could not be done without your participation. Gracias.
	TESTIMONIO DAY 2
10 minutes recap Materials needed: Private room Laptop Handheld Recorder Tissue Hand sanitizer	Check in with participants about the first interview. Recap on the two main topics of mental health and healing with an understanding that today will focus on healing practices accessible at PLTP via the outdoors. As mentioned in our previous discussion, your participation is voluntary and I want to take a moment to express my gratitude to you for your time and bravery.
40 minutes:	To reiterate the focus of our discussion will be on healing practices to support your mental health. The difference from today is there will be several open ended questions. The questions are adopted from an article that suggests techniques for solution focused brief therapy that include scaling, third person perspectives and questions that prompt thinking about the preferred future (Natynczuk, 2014) Before we begin I wanted to see if you have any questions? Correct me if I am wrong, the PLTP residents use the outdoors as part of the

	healing process in the program. What differences do the outdoors make to you (adopted as a way to increase clients autonomy and responsibility to change from Natynczyuk, 2014), as it pertains to healing? Or not? Help me understand what healing means to you? Imagine that you wake up tomorrow and your problems are gone. What would the very first sign be that it was gone? What else would you notice? What does the outdoors in your community look like? 2. Scales, where zero is the worst resources and ten the best resources help me understand what strengths and resources you have used to maintain your journey towards healing? Tell me about your story as it pertains to history using the outdoors? Do you see a connection with the outdoors and mental health? How will you know that PLTP has been useful? If things did not go so well, what stopped them from getting worst? Is there anything else you would like to share with me: 3. Probe: i. Lessons learned after PLTP ii. Services you need after PLTP iii. Challenges/Barriers
10 minute	Debrief • Thank you for your time and cooperation. • As a way to express my gratitude for your time, a small incentive may be given. I will consult with the director of PLTP to inquire PLTP policies around this matter. • A final report of this study will be given to PLTP • Thank you for sharing your testimonio with me.
	FOCUS Group 1
	Thank you for sharing your testimonio with me. Today, I will focus on themes from the testimonios and, I am curious to hear why you chose the PLTP over other similar programs?

APPENDIX C: COMPARISON OF PLÁTICAS AND FOCUS GROUPS

Table 6: Comparison Table

Concept	Author	Pros	Cons
Platicás	(Fierros & Delgado Bernal, 2016)	• Scholars support 5-Core principles of Pláticas: first; how multiple systems of oppression influence lives and finds ways to reimagine new possibilities with emphasis on critical reflexive process. Second co-construct knowledge that calls attention to layers of cultural and political socialization that evolves over time. Third is connection with lived experience and research inquiry that can be connected to mental health model that use an individualistic model compared to collective model. The fourth principle is offering a space for healing via reflexivity. The fifth principle is the relations of reciprocity and vulnerability and researcher reflexivity. Most important ingredient is trust.	• Culture viewed as a static entity • Some research suggest pláticas is not valid as a data collection strategy rather pláticas used as key component to establishing trust (Scaff et al., 2002 p. 314)
Focus Groups in social work	(Ortega & Galvin, 2019)	Social Justice group work-core practice principles 1. The groups goals must be inclusive of social justice goal which is often influenced by forces from the larger environment. With attention to key social and cultural symbols, rituals and moral ideals that influence what group members value (p. 7) 2. Member relevance including unique intersectional social identities, needs and experiences. The relevant practice requires practitioners to assist members to examine how they have internalized their experiences of oppression and how to learn skills to empower themselves. Scholars aspects of social just practice include solidarity, tolerance, inclusion, transformative trust, cultural humility, empowerment and shared leadership (p. 9) 3. The groups norms must support socially just participation (p. 6). Evidence suggest through self-	"A problem with some evaluation methods is that the kind of data may be determined by the agency with little regard for the workers' and the member desires, a highly unjust circumstance. Under these conditions, workers and members may not take the evaluation seriously, and group workers and members may complete agency forms in a perfunctory manner" p). 266)

Table 6: (cont'd)

		awareness, all group participants can reflect on unique differences from each other. (p. 9) 4. Conflict regarding social differences should be resolved in the group. If addressed successfully confcit can promote positive group development and movement towards its desired purpose (p. 10) 5. The group worker facilitates and supports each members contribution. Leadership must consider how safe members feel, as safety, trust and support are undermined when unjust practices are imposed and restoration are imperative prior to gaining confidence that positive change is possible. (P. 10) 6. Group process must consider whether issues are conceptualized and understood. (p. 6) 7. Practice dimensions as a whole must consistently demonstrate and adhere to socially just knowledge and skills. (p. 6)	