again) with: Reconnect with myself as a Dakota person; Reconnect with our *tiwahe* (family); Reconnect with our *tiospaye* (extended family); Reconnect with our *oyate* (Dakota community); and Reconnect with our Global Indigenous community?" Participants answered each question on a 6-point scale ranging from *never* (1) to *very frequently* (6). The questions related to desire to engage in a behavior (i.e., do you want to) were combined within each of the three sections resulting in three Indigenous Healing Strategies Desire (IHSD) subscales: IHSD Kiksuya (n = 4, remember); IHSD Kiyuwaste (n = 4, reclaim); and IHSD Kiciyuwaste (n = 5, reconnect). The questions related to actual engagement in a behavior (i.e., do you actually) were combined within each of the three sections resulting in three Indigenous Healing Strategies Actual Engagement (IHSAE) subscales: IHSAE Kiksuya (n = 4, remember); IHSAE Kiyuwaste (n = 4, reclaim); and IHSAE Kiciyuwaste (n = 5, reconnect).

Procedure

At a Tiwahe[3] gathering, women from the Daktoa Wicohan community were invited to fill out a questionnaire that included demographic information, the Wicozani Instrument, and the Indigenous Healing Strategies Scale. Research assistants provided directions for filling out the questionnaire, answered any questions, and explained that participation was voluntary. Participants were not requested to sign a consent form given the history of broken treaties between Indigenous communities and government agencies. The women took the questionnaires home and returned them within a two-week period.

Results

The means, standard deviations, and intercorrelations for questions two (i.e., mental health), four (i.e., physical health), six (i.e., spiritual health), seven (i.e., importance of mental health to quality of life), eight (i.e., importance of physical health to quality of life), and nine (i.e., importance of spiritual health to quality of life) on the Wicozani Instrument are presented in Table 4 (N = 35). Internal consistency reliability was examined for the Wicozani Self-Knowledge subscale (i.e., questions two, four, and six) with a coefficient alpha of .72, which is acceptable, and the Importance of Wicozani to Quality of Life subscale (i.e., questions seven, eight, and nine) with a coefficient alpha of .98, which is excellent. A paired-samples t-test was conducted to compare participants' scores on the Wicozani Self-Knowledge subscale (M = 2.90, SD = .61) and

[3] Tiwahe (family) gatherings are one of Dakota Wicohan's programs, rooted in the strategy of reclaiming and reconnecting family through social gatherings (e.g., meals, fun, and social events rooted in language).

the Importance of Wicozani to Quality of Life subscale (M = 4.30, SD = 1.29), $t(33)$ = -6.09, p = .00. Participant scores were significantly higher on the Importance of Wicozani to Quality of Life subscale than the Wicozani Self-Knowledge subscale.

Table 4
Means, standard deviations, and intercorrelations of the Wicozani Instrument's questions

Question	*M*	*SD*	1	2	3	4	5	6
1. Mental health	3.18	.63	-	.44**	.71***	-.12	-.12	-.14
2. Physical health	2.44	.93		-	.35*	-.17	-.06	-.19
3. Spiritual health	3.09	.70			-	.04	-.06	.07
4. Imp. of mental	4.34	1.14				-	.94***	.98***
5. Imp. of physical	4.23	1.14					-	.92***
6. Imp. of spiritual	4.40	1.14						-

Note. Higher scores for items one through three indicates a higher self-rating of that aspect of health. Higher scores for items four through six indicates a higher perceived importance of that aspect of health to their quality of life.
* p < .05. ** p < .01. *** p < .001.

The Wicozani Self-Knowledge subscale score had significant positive correlations with all three IHSAE subscales (r's ≥ .37, p's ≤ .03) and non-significant correlations with all three IHSD subscales (r's ≤ -.34, p's ≥ .053; see Table 5). The Importance of Wicozani to Quality of Life subscale had non-significant correlations with all IHSAE and IHSD subscales (r's ≤ -.06, p's ≥ .75; see Table 5).

Table 5
Intercorrelations between the Wicozani Instrument's Subscales and the Indigenous Healing Strategies Scale

Question	1	2	3	4	5	6	7	8
1. Wicozani Self-Knowledge	-	-.11	.02	.37*	.25	.53**	.34	.53**
2. Imp. of Wicozani		-	.03	-.06	-.00	-.05	-.05	-.13
3. IHSD *Kiksuya*			-	.49**	.62***	.21	.69***	.44**
4. IHSAE *Kiksuya*				-	.56**	.69***	.39*	.55**
5. IHSD *Kiyuwaste*					-	.42*	.56**	.50**
6. IHSAE *Kiyuwaste*						-	.27	.51**
7. IHSD *Kiciyuwaste*							-	.82***
8. IHSAE *Kiciyuwaste*								-

Note. Wicozani Self-Knowledge = Wicozani Self-Knowledge subscale; Imp. of Wicozani = Importance of Wicozani to Quality of Life subscale; IHSD = Indigenous Healing Strategies Desire subscale; IHSAE = Indigenous Healing Strategies Actual Engagement subscale; *Kiksuya* = remember; *Kiyuwaste* = reclaim; *Kiciyuwaste* = reconnect.
* p < .05. ** p < .01. *** p < .001.

DISCUSSION

The results from Study 1 and Study 2 provide evidence of the reliability and validity of the Wicozani Instrument and the usefulness of assessing *wicozani*, overall health and well-being, from an Indigenous epistemology. Results indicate that Native and European American youth and Dakota Women perceive a strong inter-relationality between mental, physical, and spiritual health, providing empirical evidence for the Dakota concept of *wicozani* (overall health and well-being). The idea that overall health or well-being is reflective of physical, spiritual, and mental health is in line with other definitions of holistic health (Matthews, Kilgour, De Rossi, & Crone, 2011). Regarding reliability, the coefficient alpha scores for Native and European American youth and Dakota women suggest adequate to good internal consistency for the Wicozani Self-Knowledge subscale and adequate to excellent internal consistency for the Importance of Wicozani to Quality of Life subscale. The consistent results, between the Wicozani Instrument and the ACS and PSSM, across Native and European American youth, except for one PSSM subscale, provides evidence that the Wicozani Instrument possesses external validity. The measure possesses strong face validity because on the surface it appears to measure (i.e., *wicozani*, overall health and well-being) what it does measure (i.e., mental, physical, and spiritual health). The Wicozani Instrument demonstrates strong convergent validity in that its subscales correlated with measures (i.e., ACS, PSSM, SIQ, IHSAE subscales) that it should theoretically correlate with. Further, as expected, the Wicozani Instrument demonstrates discriminant validity because both subscales did not significantly correlate with the IHSD subscales. This finding is in line with Dakota worldview because desire to engage in a behavior, in and of itself, will not improve health. Together, these findings provide evidence of the reliability and validity of the Wicozani Instrument.

Although only a few Native (n = 17) and European American (n = 8) youth completed the SIQ, three out of the six possible correlations were significant. Further, the non-significant correlations ranged from moderate (e.g., - .44) to quite strong (e.g., -.87; Evans, 1996). These results demonstrate, in line with Dakota worldview, a strong inverse relationship between suicidality and *wicozani*. Thus, preliminary evidence suggests, youth at risk for suicidal ideation may be identified from a strengths-based approach by focusing on *wicozani* and using the Wicozani Instrument. However, given the small sample size further research is warranted before health professionals begin using the Wicozani Instrument in place of currently used measures of suicidal ideation.

The fact that only 17% of youth who completed the Wicozani Instrument completed the

SIQ highlights some advantages of taking a strengths- versus deficit-based approach. Specifically, our school partner allowed the administration of the Wicozani Instrument during class but required that the SIQ be administered outside regular school hours. Further, IRB protocols required parental consent and student assent before completion of the SIQ but not the Wicozani Instrument. Further, stigma regarding suicidal ideation still exists (e.g., Scocco, Castriotta, Toffol, & Preti, 2012) and may have prevented youth participation. Thus, our results suggest that taking a strengths-based approach (e.g., overall health and well-being; the Wicozani Instrument) is more appealing to community partners, provides more data, and is less stigmatizing than taking a deficit-based approach (e.g., health disparity; SIQ).

The significant differences found between participants' scores on the Wicozani Self-Knowledge subscale and the Importance of Wicozani to Quality of Life subscale can be used to facilitate healthy behaviors and address health disparities from an Indigenous perspective. For example, health professionals often work from a Western approach (i.e., value expert opinion and objective data) when they provide empirical evidence as to why Native people or communities should eat healthy foods, exercise, or monitor their glucose levels. Alternatively, from an Indigenous perspective, health professionals could incorporate the Native person's self-knowledge and subjective truth. By completing the Wicozani Instrument participants demonstrate to themselves that they believe their *wicozani* is important to their quality of life, yet they rate their *wicozani* lower than its importance. Thus, health professionals can illicit from the client information about why and how their *wicozani* is important to their quality of life and strategies they would like to engage in to increase their *wicozani*. This approach is in line with some of the central tenants of motivational interviewing, such as raising awareness of the discrepancy between the goal and actual behavior, an emphasis on personal choice, and facilitating change. Motivational interviewing is an effective strategy for increasing healthy behaviors (Miller & Rollnick, 1991) and suggests the usefulness of the Wicozani Instrument and its potential positive impact on Native people and their communities.

The Wicozani Instrument begins to disrupt the Cycle of Native Health Disparities. Specifically, the Indigenous view of multiple realities is at the center of the Wicozani Instrument in that each person has the opportunity, and ability, to define what a healthy mind, body, and spirit mean to them. Giving Native people the opportunity to create their own definitions and factors of health, and valuing their perspective and knowledge, gives the individual power to create their own narrative, identify where they are at on their continuum of health, and take ownership over

their health. This strengths-based approach, which focuses on overall health and well-being, facilitates Native people seeing themselves as healthy and as having the ability to build on existing areas of healthy behavior. Further, this approach assumes that Native people innately possess strength and "a natural capacity for behaving, thinking, or feeling in a way that allows optimal functioning and performance in the pursuit of valued outcomes" (Linley & Harrington, 2006, p. 88). This agency begins to disrupt the external locus of control and learned helplessness that has emerged from decades of health professionals perceiving Native identity as a risk factor for poor health. After witnessing the negative impact health care workers' prescriptive stereotypes had on elderly residents, Solomon (1982) recommended that health care workers be educated in order to destroy the myths and work in a growth-oriented context. These recommendations are similar to our calls for health professionals to stop perceiving Native identity as a risk factor for poor health and to begin viewing culture as integral to Native health and part of the solution to health disparities.

Limitations and Future Research

One limitation of the two studies is that the populations included participants from two Native communities from a limited geographical area. Further, the composition of our non-Native youth were all European American. This over- and under-representation of identities within society is problematic. Thus, future researchers should replicate this work with different Native and non-Native communities. Although the findings between the Wicozani Instrument and the SIQ were strong, only 17% of youth completed the SIQ. Thus, further research is warranted before health professionals begin using the Wicozani Instrument in place of currently used measures of suicidal ideation. Additionally, future researchers should examine the relationship between the Wicozani Instrument and other measures of health disparities, which are less stigmatizing than suicidal ideation, in an attempt to gather more participation. Also, future researchers could utilize qualitative approaches to work with community and health professionals to gather feedback regarding their perspectives of the Wicozani Instrument. A next step for our research team entails examining the qualitative data provided on the Wicozani Instrument, specifically, participants' definitions of a healthy mind, body, and spirit (i.e., "How does someone know if their Mind (body or spirit) is healthy"). Lastly, although, we focused on an Indigenous-based measurement tool, there is great need for cultural interventions (Allen et al., 2011) that disrupt the Cycle of Native Health Disparities and focus on the actual causes of health disparities (e.g., colonization, historical

trauma, social determinants of health) rather than the symptoms.

CONCLUSION

The results demonstrate the Wicozani Instrument is a valid and reliable measure of overall health and well-being, is in line with Native epistemology, and disrupts the Cycle of Native Health Disparities. Taking an Indigenous, rather than Western approach, to address health disparities can begin changing the current perception that Native identity is a risk factor for poor health and disrupt the ensuing cycle of prescriptive stereotypes, external locus of control, learned helplessness, and the self-fulfilling prophecy which perpetuates health disparities between Natives and the broader U.S. population. Further, the Wicozani Instrument begins to address the frustration of those who feel like they are overly-measured solely by narrowly-defined and compartmentalized instruments (e.g., weight, blood pressure). The Wicozani Instrument focuses on overall health and well-being through a holistic lens and relies upon the understanding of relationality and the interdependence between physical, mental, and spiritual health. This instrument gives health professionals an additional measurement tool that places the power in the hands of the individual, values their ways of knowing, and views their perspective as valid. Further, health professionals can use the discrepancy between a participant's Wicozani Self-Knowledge subscale score and their Importance of Wicozani to Quality of Life subscale score, to increase an individual's internal motivation for healthy behavior change. Additionally, the Wicozani Instrument, because of its strengths-based approach and focus on overall health and well-being, was more appealing to our community partners, provided more data, and was less stigmatizing than the deficit-based approach which focused on suicidal ideation. Approaches which place Native people and their ideologies at the center of the solution, rather than on the receiving end of Western ideology and health care, support a movement of decolonization and reclamation of Native identity and epistemologies as strengths and facilitate effective approaches that align with community-defined health and well-being.

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ACKNOWLEDGEMENTS

Research reported in Study 1 was supported by the National Institute on Minority Health and Health Disparities of the National Institutes of Health under Award Number U54MD008164 (Elliott). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. Research reported in Study 2 was supported

by the Grant in Aid program at the University of Minnesota. The authors contributed equally to the manuscript. We especially express gratitude to the Dakota Wicohan staff, family, and youth for sharing their truth.

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Appendix A

The Wicozani Instrument

Please complete each question to the best of your ability.

1) How does someone know if their *"Mind"* is healthy? (your thoughts and emotions)

_____

_____

2) How do you rate your "*mental health"* (please circle)? (your thoughts and emotions)

Extremely Poor	Below Average	Average	Above Average	Excellent
1	2	3	4	5

3) How does someone know if their *"body"* is healthy?

_____

_____

4) How do you rate your "*physical health"* (please circle)? (your body)

Extremely Poor	Below Average	Average	Above Average	Excellent
1	2	3	4	5

5) How does someone know if their *"spirit"* is healthy? (your religious or spiritual beliefs)

_____

_____

6) How do you rate your *"spiritual health"* (please circle)? (your religious or spiritual beliefs)

Extremely Poor	Below Average	Average	Above Average	Excellent
1	2	3	4	5

7) How important is your "*mental health"* to your quality of life (please circle)?

Very Unimportant	Unimportant	Neither Important or Unimportant	Important	Very Important
1	2	3	4	5

8) How important is your *"physical health"* to your quality of life (please circle)?

Very Unimportant	Unimportant	Neither Important or Unimportant	Important	Very Important
1	2	3	4	5

9) How important is your *"spiritual health"* to your quality of life (please circle)?

Very Unimportant	Unimportant	Neither Important or Unimportant	Important	Very Important
1	2	3	4	5