Part 2: TRAINING

AMERICAN INDIAN MENTAL HEALTH AND THE ROLE OF TRAINING FOR PREVENTION[1]

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Another death occurred in the small Indian community. Two teenagers returning home from a drinking binge at the beach failed to make a turn in the road and crashed into a grove of tall firs. As always, a large gathering of family and friends turned out for the funeral. It seemed to many of the mourners that these gatherings were occurring more frequently—too frequently for it to be considered another chance accident among reckless youths.

Toward the end of the funeral the attention of the crowd was directed to the section where the elders of the community usually sat. An elderly man, clearly burdened with grief, began to speak. He was barely audible but attention was guided by his well formed words accumulated from the wisdom of his years. The message was poignantly clear:

> We are losing the hold we once had over the younger ones. They no longer hear our words of caution. Our suggestions are seen as foolish. Many laugh at the outdated ways of our ancestors. We are forgetting that the wise words passed through the elders are not weak ones. They are full of the experience of the past. . . the very words that can help us prevent the thing that brings us here today. Can't we seek ways to bring those words back into the community? We must or else continue to mourn the tragic deaths of our people.

He continued talking about the old days but I didn't hear him. My attention was captured by the faces riveted to the elder and those around him. I wondered about their thoughts. I also wondered then if they were being polite and respectful and just passively listening to another romantic old man who had nothing better to do than talk about times gone by.

I know it was just another rainy afternoon and the roads were as wet as they usually are around here. But I don't remember much more than that about the scenery as I drove home again from another sad occasion. My thoughts rambled through the problems experienced by these people over the years that I have known them—tragic deaths, alcoholism, unemployment, child abuse, rape, vandal-

ism. All are problems of many American communities, but for some reason they seem to be more intense in this one small area. I know that old man was right; years ago there were ways to prevent such problems from happening. But are those ways appropriate to the social and economic demands placed upon a small Coast Salish community today? The question demands an answer or the elder's prophecy may continue to be borne out.

The prevention of community turmoil, individual emotional disturbances and deviant sociopathic behavior is not uncommon in Indian communities, in either the present or ethnographic past. Decades ago rigid, normalized standards of social and individual control persisted among tribal groups. Knowledge of the "causes" of deviant and destructive forms of individual and social behavior was deeply embedded in the folk tradition. Moreover, procedures for treating the attendant problems were linked directly to the ecological fabric of the community, which also assured that this knowledge was passed on from generation to generation. Tightly knit interpersonal relationships enabled individuals and groups to survive by maintaining a stable, reliable system of control. Prevention, rehabilitation, treatment and training were intimately intertwined within tribal folk traditions to such an extent that one process was usually indistinguishable from another.

Knowledge of these traditional systems persists and is enjoying a revival in some Indian communities (Attneave, 1974; Bergman, 1974). The primary emphasis has been to encourage the treatment and rehabilitation of emotionally distraught individuals by traditional medicine and spiritual healers. Similarly, an upswing in interest is occurring in the delivery of mental health services to Indian communities (Manson & Trimble, 1982); some federal and state supported programs work closely with indigenous approaches to effect culturally appropriate health care strategies (cf. Beiser & Attneave, 1978; Ostendorf & Hammerslag, 1977). Yet **prevention,** despite its intrinsic importance, has received less attention than former emphasis would suggest, not unlike the development of mental health programs for the dominant society. Fortunately, this trend seems to be changing (Klein & Goldston, 1977).

This paper deals with training people to work effectively in the area of mental illness prevention. A related theme centers on the training of people to work **with** and **in** Indian communities to promote positive mental health and to develop programs which prevent social and individual disruptive and destructive behavior. The two themes incorporate aspects of sometimes clashing philosophical orientations—the present-day, conventional culturally encapsulated approaches to prevention and training and cultural and tribal-specific orientations. As a point of departure for this discussion, the paper first explores "training as usual" with appropriate comment and

criticism. It then turns to the inclusion of an emphasis on American Indian ethos in training providers to deliver preventive services. The paper concludes with some suggestions for future programmatic development.

TRAINING AS USUAL: MAINTAINING CULTURAL ENCAPSULATION

To understand the basic premise of the predominant mental health training philosophies, the meaning of prevention first must be considered. At a general level prevention efforts imply that one attempts to increase the likelihood that individuals will develop conditions and behavior which are socially and personally constructive. Another perspective emphasizes a reduction or elimination of causal sources which are considered to be socially or personally destructive. Promotion and reduction therefore dominate generalized approaches to prevention.

Prevention can assume specific as well as nonspecific strategies. Specific strategies are implemented to reduce behavior known to cause a problem. Nonspecific strategies emphasize changes in intermediate variables such as self-image, interpersonal communication and problem-solving techniques.

The above orientation provides a useful backdrop against which to reflect on past and present prevention training efforts. At one time within the mental health arena there was a clear lack of qualified staff to provide treatment, a lack of an array of treatment styles and approaches, and varying levels of the effective provision of services. The need to train professionals arose out of these deficiencies (Rappaport, 1977) with the added assumption that training for prevention will ultimately reduce the long-term need for treatment services.

In his seminal work in mental illness prevention, Caplan (1964) identifies three types of prevention. Primary prevention "is a community concept (which) involves lowering the rate of new cases of mental disorder in a population over a certain period by counteracting harmful circumstances before they have a chance to produce illness. . . It seeks to reduce the risk for a whole population" (p. 26). Secondary prevention involves the early recognition and isolation of potential problems and either eliminating the root causes or altering them to prevent or reduce the effects of problems. Tertiary prevention involves the reduction of social or personal problems at the community level and "encompasses programs aimed at large-scale rehabilitation of people already suffering from mental disorder so as to reduce its duration and destructiveness" (Rappaport, 1977, p. 63); (See Manson, Tatum, and Dinges in this volume for a more detailed discussion.)

Education and intervention are implicit in the introduction and implementation of prevention strategies at the individual and group level. On one hand, prevention strategies, regardless of the type, **intervene** to effect a change in psychosocial growth and development. On the other hand, education can be seen as an intimate part of the intervention in that individuals are informed and presumably influenced by information. Whether education alone prevents problems from surfacing or becoming more intense is debatable (cf. Bry, 1978); nonetheless, education plays a fundamental role in preventing psychosocial problems.

The Academic Model

Mental health training programs, whether in psychiatry, psychology, social work or psychiatric nursing, follow conventional academic curricular models. Medical schools in particular promote a very narrow, biomedical orientation.

Regardless of whether the objective is to learn about primary, secondary or tertiary prevention strategies, training principally occurs in higher education institutions, most notably at the graduate level. A typical program in counseling and clinical psychology, for example, involves the accumulation of a fixed hourly or credit minimum of intensive coursework involving everything from principles of psychopathology to research methods. Sandwiched in the program are clinical practicums, supervised instruction and internships and some sort of resident practicum. Following the completion of coursework and successful defense of a dissertation or thesis, the trainee is granted a degree (usually the doctorate). The trainee subsequently may seek a state license to practice his or her chosen profession.

Culturally Encapsulated Practitioners

Over the last decade the conventional academic model has received great criticism, as has the very core of academic training. Gordon (1979), a research psychiatrist, best summarized this concern when he pointed out that "during the last several decades the mental health establishment has adopted two major approaches to the American people's problems in living: biomedical research and the establishment of local mental health facilities. Neither has lived up to expectations. Both have been flawed by the pervasive and narrowing influence of the "medical model of mental illness" (p. i). More importantly, the training, services and facilities have largely **ignored** and in many instances **excluded** certain ethnic life style perspectives. This is most apparent among counseling psychologists and psychotherapists and is likely derived from their encapsulation as academically trained "mainstream" practitioners.

When the counselor faces a life style which is culturally different

from his or her own for any length of time, he or she typically experiences acculturation, which may result in: (1) cultural assimilation, where the dominant culture enforces its adoption; (2) integration, where certain elements of another culture are incorporated; and (3) adaptation, where the individual or group accommodates the foreign environment. The person undergoing acculturation must recognize that his/her own style of behavior, attitudes, beliefs and personal assumptions will direct the extent to which they will allow themselves to experience another culture as a means of learning about that culture. If a person doesn't recognize this, most likely they may substitute his own criteria of desired social effectiveness for alternative criteria more appropriate to a client's environment (Kanfer & Phillips, 1970). Bloombaum, Yamamoto, and James (1968) described ways in which psychotherapists are culturally conditioned in their responses. Other research reveals how cultures either directly or unconsciously condition client responses to suit their theoretical orientation (Bandura, Lipher, & Miller, 1960; Bandura, 1961).

Wrenn (1962) described encapsulation as a process which follows from a dogmatic adherence to some universal notion or truth that leads to the disregard of cultural variations among clients. Kagan (1964) suggested that counselor education programs may actually contribute to the encapsulation process, by implanting cultural biases, however implicit such biases may be, in their curricula.

Counselors and clinicians who are most different from their clients, in race and social class, seem to have the greatest difficulty effecting constructive changes; whereas counselors/clinicians who are most similar to their clients in these respects have a greater facility for appropriate helping (Carkhuff & Pierce, 1967). Mitchell (1970) argued that most White counselors cannot be part of the solution for a Black client since the former are so frequently part of the problem. Radical Blacks likewise assert that the White mental health worker cannot successfully counsel the "Black Psyche." Similarly, Ayres (Note 3) and Russell (1970) described an implicit, sometimes explicit bias in the counseling process itself that is frequently perceived as demeaning, debilitating, patronizing and dehumanizing.

Encapsulation and Training Procedures[4]

Torrey (1972) concluded that there is sufficient evidence from cross-cultural studies of counseling and psychotherapy to raise many questions about our system of selecting, training and certifying therapists. Stranges and Riccio (1970) found that counselor trainees preferred counselees of the same racial and cultural background. Yet, it appears that professional psychologists are currently trained toward the ultimate goal of serving the psychological needs of the middle class (Gordon, 1965). Lewis and Locke (1969) pointed out specific examples of racism in the training of counselors, while

Vontress (1969) called for more in-service and pre-service training designed to help counselors examine their attitudes toward the culturally different by exposing them directly to the culture of their clients. As previously indicated, there is increasing evidence that many trained counselors are not prepared to deal with individuals who come from racial, ethnic, or socioeconomic groups whose values, attitudes and general life styles are different from their own (Padilla, Boxley, & Wagner, Note 5).

One of the recent innovations in counselor training which appears most promising for cross-cultural counseling involves the use of a "micro-counseling" model developed by Ivey, Normington, Miller, Merrill, and Haase (1968) to teach interviewer skills in attending behavior, reflection of feeling and summarization of feeling (Moreland, Phillips, Ivey, & Lockhart, Note 6). Micro-counseling emphasizes the systematic acquisition of facilitative interviewer behaviors. These behaviors are applicable to a variety of theoretical orientations which can bridge the gap between classroom learning and initial experience in a program designed to supplement traditional counselor education curricula.

"Role play" techniques have become increasingly popular in micro-counseling counselor training programs (Delaney, 1969). The successful use of coached clients in simulated interviews has also been well documented both in therapy and research (Carkhuff & Alexik, 1967; Pierce, Carkhuff, & Berenson, 1967). The simulation of critical incidents has likewise proven to be effective in programs which focus upon cross-cultural communication (Fiedler, Mitchell, & Triandis, 1970; DeCrow, 1969) for it teaches skills that parallel those required by counselors.

Counseling can be described as a function of "push and pull" factors in which the counselor seeks fulfillment by being helpful, the client seeks to reconcile internalized ambiguity and the problem—viewed as an active rather than a passive entity—seeks to survive and to increase its power over the client. In cross-cultural counseling, this suggests that one must be aware of three major elements: stress, response to it, and ameliorative intervention, all potentially subject to cultural mediation (Draguns & Philips, 1972).

In an extensive review of the cross-counseling literature, Pedersen (1981) argues that some training oriented practitioners attempt to "de-encapsulate" the counselor. But the "de-encapsulation" is limited by the use of clinical models which are grounded in the conventional wisdom of contemporary psychology. Counselors therefore are attempting to deliver services in culturally different settings with models and techniques that were developed in another culture. The counselor may be more aware of and sensitive to cultural differences, but be no more effective because of the very nature of the concepts underlying the counseling and psychotherapy process itself.

Cultural sensitivity is related to an awareness of indigenous resources within the other culture. Torrey (1970) provided an example of why urban Mexican-Americans fail to utilize modern mental health services. The western delivery system is frequently inaccessible. Moreover it is plagued by language problems, is limited in the quality of treatment which, to a great extent, depends on the individual's socio-economic class, and is insensitive to other world views. Trimble (1981), Saslow and Harrover (1968), Suchman (1964), Bryde (1971), Morales (1970), Dinges et al. (1981), and Madsen (1969) likewise described the types of problems and resources which are unique to various ethnic groups, but are frequently overlooked by insensitive counselors. Each life style provides its own structures, rules and mechanisms to cope with aggression and anxiety; though potentially different from one another in these respects they are able to promote and preserve mental health within their respective communities (Mechanic, 1969; Glazer & Monihan, 1963).

It is not surprising to find that most mental health delivery services are provided by white middle class males and, in sharp contrast, that the vast majority of clients who receive these services are non-white, from lower socio-economic levels, and differ significantly from their counselors in terms of socialization and values (Pederson, 1976, 1978, Note 7; Sue, 1977; Manson & Trimble, 1982). The literature on the relationship of cultural values to mental health services vividly depicts the need for increased awareness of the assumptions made by culturally different clients, of the ways in which culturally biased counseling lowers service utilization, and of the importance of coordinated training to increase the cultural sensitivity of mental health professionals.

Indeed, from all available evidence the very nature of present day training approaches represent an encapsulated view; it is presumed that the best counselor training comes from professionals in the context of the academic model. Further there is every reason to believe that the philosophy behind the delivery of services and the training of professionals is not likely to change significantly. Witness the orientation of the present U.S. federal administration towards training and ethnic minorities. Massive cutbacks in mental health appropriations include first and foremost those involving culturally different groups. This position is disappointing since the previous administration took great pains to respond to the claim that in regard to America's ethnic and racial minorities available mental health personnel and services are woefully inadequate and for the most part fail to account for cultural differences.

One of the solutions to the training problem, unfortunately, seems to be tied to the idea that education and training in their present forms will improve and promote cultural relations. This idea itself is an example of the rigid and entrenched nature of our cur-

rent training philosophies. Room and Sheffield (1976) questioned whether academic institutions should be used for moral training and the prevention of social problems, especially alcohol abuse.

There is every reason to believe that mental health training will continue as usual. Very little attention is likely to be given to the mental health needs and concerns of America's ethnic and cultural minorities in the near future. Academic institutions will continue to provide the personnel most likely to be skilled in the most popular techniques. Despite this grim projection the need for developing programs sensitive to the needs of American Indians exists.

AMERICAN INDIANS, TRAINING AND PREVENTION

Of the ethnic minority groups in the United States, the American Indian has been the least understood and consequently the most neglected in terms of social reform. While many factors account for this unfortunate reality, two major considerations are (1) the great diversity of tribes, which reside in all sections of this country, has resulted in a lack of systematic focus on their problems and (2) until recently, Indians, unlike other major ethnic groups, did not have significant numbers of influential, civil liberty spokespersons to point to areas of neglect and need.

One of the consequences of this relative neglect, especially with regard to mental health, is scarcity of competent Indian mental health personnel to work with their own or other Indian groups (Trimble & Ryan, Note 9). This scarcity is even more noticeable when one considers the insignificant numbers of Anglos who are considered competent in counseling relationships with Indian clientele. Programs are urgently needed to address the training of mental health workers among American Indians.

Given only modest understanding of the conditions that characterize an effective cross-cultural counselor, and few programs to use as a basis for research, little has been done in the way of identifying criteria that contribute to the development of cross-cultural counseling skills (Trimble & Lee, Note 8). Part of this problem is reflected in the cultural encapsulation of academic programs that possess the untapped potential to be used as a means to begin the development of an awareness of and sensitivity to cultural diversity.

Training Progress

Historically, scant progress has been made in the training of American Indians and Alaska Natives in the mental health related sciences. Although exact figures are difficult to determine, the best estimates indicate that there are no more than 70 American Indians and Alaska Natives with doctoral degrees in the fields of anthropology, psychiatry, psychology, social work, and sociology. Only a

few of these persons actually work in positions in which their efforts directly impact American Indian and Alaska Native mental health programs (Trimble & Ryan, Note 9). Moreover, because of the lack of graduate-level trained Indian mental health professionals, many mental health programs within the Indian Health Service (I.H.S.) have become almost solely dependent on Indian **paraprofessional** mental health workers (Bergman, 1974). The I.H.S. prefers, however, more trained Indian and Native psychologists, psychiatrists, social workers, medical sociologists and anthropologists.

The lack of trained Indian persons usually results in the lack of representation in programs designed to provide mental health services to Indian and Native people. In the early planning and staffing stages of the Center for Minority Group Mental Health at the National Institute for Mental Health (NIMH), Indian professionals were not sought because there were ". . . so few Indian mental health professionals that the identification of one or two to represent the total population of Indians in American pose(d) a significant problem" (Ochberg & Brown, 1973, p. 56). To this date the NIMH still has not hired an American Indian to assist the Center with programming to meet Indian and Native mental health needs.

If nothing changes, propects are dim for increasing the number of trained American Indians and Alaska Natives in the mental health fields. This is true even though some academic institutions (e.g., Oklahoma State University) have shown an interest in attracting Indians to their programs. Other institutions (e.g., Department of Psychology, University of Utah) have made conscious efforts to provide their students with training that reflects something about their cultural background. This is characteristic of service-oriented graduate schools such as the social work programs at the University of Denver and Arizona State University. Although graduate fellowship programs (e.g., Ford Foundation and the American Psychological Association Minority Fellowship Program) are desperately seeking qualified Indian and Native candidates, most universities are not making a concentrated effort to publicize their programs so that Indian candidates will be attracted to apply.

In the same vein, recruiting efforts at the graduate level not only ignore the need to develop the interest of qualified applicants at the undergraduate level, but also fail to recognize the need to consistently offer positions to alternate minority graduate applicants. Participants at a recent conference on ethnic minority education reported that many of the institutions that attempt to recruit Indians and other minorities stop offering positions to minority students after the first round of invitations (i.e., for a given school year) has been refused. This practice does very little to increase the minority enrollment at the graduate school level. First, those students who are able to refuse offers obviously have the ability to select the univer-

sity of their choice. Secondly, the contents of the applications of this type of student (i.e., outstanding) typically reflect excellent levels of academic performance regardless of ethnicity. Yet, when most minority applications are reviewed, they are rated as below average and labeled as "high risk." Thus many institutions that have offered positions to and are subsequently turned down by outstanding minority students fail to create an alternate list of minority applicants to whom these positions can then be offered. Unfortunately, these institutions may very well have lost a highly capable and contributing group of minority individuals who, in turn, become increasingly frustrated with the system and develop a negative attitude towards professionals and the professions within the mental health related sciences.

The problems associated with the disproportionately small number of minority students and professionals in the field are not solely those of the training institutions themselves. The perceptions of career opportunities among Indian and Native students, particularly undergraduates, have traditionally excluded the mental health related sciences. Consequently, Indians and Natives tend to avoid selecting such areas of study because many fail to see the relevance of these disciplines to their people and to themselves. Moreover, there are very few Indian role models to convince them otherwise. In the process of attempting to adjust to this lack of role models, some institutions have conducted in-house searches for "instant Indians," which involves identifying faculty members who may claim some degree of Indian heritage. Clearly the students do not benefit nor, in the long-run, do the faculty in question.

The Need for Training

The need for increased educational advancement of Indians in the mental health professions is clearly warranted. Statistics available from the Indian Health Service indicate that the prevalence of mental health related problems among Indians is high in comparison to majority group norms (Shore & Manson, 1981). For example, alcoholism causes 6-1/2 times more deaths of Indians than in the general population (Westermeyer, 1972). Yet, between 1970 to 1980 only six academic institutions throughout this country provided specialized training in Indian and Native alcoholism rehabilitation. Although these institutions provided specialized training in alcoholism, they generally did not offer related credentials. Interestingly, only one of these six remains.

The above factors are being taken increasingly seriously. It is now implicitly, if not explicitly, realized that if sufficient numbers of members of specific ethnic groups cannot be trained to work within their own groups, then a more enlightened and culturally sensitive aspect of "mainstream" mental health training programs must

carry much of the responsibility. A variety of authors have recently outlined problems and programs concerning the training of culturally effective counselors (cf. Pedersen et al., 1981). A recent article describes some of the characteristics that a "bilingual-multicultural education" program might have (Arrendondo-Dowd & Gonslaves, 1980). With the exception of the bilingual aspect of their guidelines, the list of attributes that should characterize a culturally effective counselor is quite similar: specifically, counselors should be able to "(1) assess the appropriateness of the counseling approach regarding culturally different clients; (2) develop appropriate counseling interventions to stimulate personal growth; and (3) work directly with the community in identifying and using cultural resources that may better facilitate the counseling process" (pp. 659-660). While not exhaustive, the competencies recommended by Arrendondo-Dowd and Gonsalves offer some direction for future training.

Substance Abuse and Prevention Training

The substance abuse fields also lack a significant number of skilled, trained professionals in Indian mental health. The picture is all the more grim when one searches for information on alcohol and drug studies, treatment and prevention efforts and general research on American Indian youth in particular. The available substance abuse studies typically emphasize the high prevalence and incidence of alcohol and drug use (e.g., Kaufman, 1973) in different communities. Swanson et al. (1971) considered alcohol use to be the most researched area among American Indians. However, Dinges, Trimble and Hollenbeck (1979) observed that the emphasis is more on adults and not adolescents and concluded that "we are left a patchwork picture with significant connecting links. . . in our image of Indian adolescence in general" (p. 51).

The significant lack of specific studies on alcohol abuse among Indian adolescents extends to the area of alcohol prevention. Many experimental alcohol prevention programs targeted for youth in general are still in varying stages of development. Most focus on testing alcohol education models (e.g., Blane, 1976; Blane & Hewitt, Note 10; Goodstadt, Note 11). While some of these educational efforts are effective among non-Indian youth, there is little evidence that similar strategies are effective with Indian youth, regardless of tribal affiliation or residential status (i.e., urban, reservation or rural).

Most of the alcohol prevention strategies in operation today focus on a specific arena and emphasize educational/prevention content. Debate continues on the feasibility of using educational strategies with youth. Cahalan et al. (1976) and Straus (Note 12) argued that since alcohol use and abuse arise in youth-related social events or settings, prevention efforts should emphasize the social and cultural setting in which alcohol abuse occurs. Miller (Note 13) agrees, but

argued that certain cultural orientations must be considered in developing alcohol prevention strategies for Indian youth.

Dorothy Miller (Note 13) currently is directing an alcohol prevention program targeted for Indian youth. By developing culturally relevant recreational alternatives and educational materials, the investigators anticipate reducing alcohol consumption among California Indian youth from the Tule River and Rincon areas, though it is too early in the project to determine actual outcomes.

A number of tribes have initiated alcohol education programs. These efforts typically involve the distribution of educational materials, holding classes on a sporadic basis and, in general, attempting to sensitize the community to the "evils of drinking." In these instances no efforts have been made to analyze systematically the effects of the promotion and educational efforts (Turner, Note 14).

In summary, alcohol and drug abuse is considered by many to be the number one mental health problem among American Indians. Survey results show that the alcohol abuse rate is greater for Indian youth when contrasted with other groups. While alcohol prevention efforts targeted for youth alone are meager in comparison to programs designed for individuals at other developmental stages, the efforts to prevent such abuse are even fewer for American Indian youth.

Illustrative Training Efforts

Over the past ten or so years exemplary prevention efforts have been initiated in Indian communities. These efforts represent isolated attempts to introduce mental health related prevention services in communities, to evaluate the effectiveness of said services and, if successful, to seek ways to assure their continuation. The unique aspects of these ventures involve the following:

1. The prevention effort occurred in a non-academic setting;
2. involved collaborative relationships with local Indian community residents;
3. demonstrated the feasibility of placing a prevention scheme in the hands of lay persons or paraprofessionals; and
4. that the behavioral sciences can blend existing knowledge with traditional Indian philosophical orientations.

Dinges and his colleagues (1974; also this volume) introduced a preventive intervention on the Navajo reservation that sought to instruct Navajo mothers in the use of presumed parent-child effectiveness interaction skills. Their approach blended known competency-based parenting skills with traditional patterns of Navajo kinship relations. In the main, Dinges demonstrated that culturally specific approaches to mental health prevention can be taught to

paraprofessionals and that indigenous staff subsequently can continue to train and to intervene in the absence of professional staff.

Self-destructive behavior is a major problem in many Indian communities (Dizmang et al., 1974). Little is being done to alleviate the problem on a national level. Further, few if any even address suicide prevention in the training of Indian professionals and paraprofessionals. Shore and his associates (1972), as an example, developed a suicide prevention program on a Pacific Northwest Coast Indian reservation. The prevention scheme was oriented to the ethos of the community, involved the use of local resource persons such as traditional healers, and maintained on-going follow through with clients. Though the program was considered a success in the short 3 years of its existence, it was not refunded. Yet, despite the lack of external support, their program was continued in an abbreviated form.

Goldstein (1974) described the effects of placing surrogate parents in dormitories in an Indian boarding school. Overall, the children responded more favorably to the atmosphere created by the Navajo instructional aides than their control counterparts. More importantly the "Model Dorm" project demonstrated once again the value in training paraprofessionals in the use of effective interpersonal skills and placing them in settings known to engender socially disruptive behavior. The "Model Dorm" concept was also discontinued for lack of grant funds.

The training of Indian alcohol paraprofessional counselors was at one time a major program effort within the training branch of the National Institute of Alcoholism and Alcohol Abuse. In the mid 1970's no less than 15 programs provided training to Indian alcohol counselors across the country. Today, only 2 of these programs are in operation; both are scheduled to close by late 1982. Nevertheless, one of the programs, the Northwest Indian Training Institute (NWITI), represents the essence of Indian alcohol training during this era.

NWITI existed for approximately 5 years and provided various forms of alcohol counseling training to over 1500 people. Nearly 200 Indians received state certification through NWITI's training efforts. The uniqueness of NWITI stemmed from its community-based training orientation in lieu of reliance on the conventional academic model. Courses, practicums, seminars, and workshops usually took place in communities that both requested such activities and which maximized the Institute's attempt to serve the greatest number of people. Trainees received credits through local community colleges and accumulated enough credit hours to earn associate degrees. The NWITI training staff integrated the general perspective of the academic model with the conventional learning styles of Indian people to produce a reasonably effective program. NWITI no longer exists; nonetheless the training model merits careful review and consideration.

There are many other, smaller scale examples of programs that provide training of a similar nature. Little is known about them as the project initiators and organizers have little time to disseminate the results. Training Indians and non-Indians to promote positive mental health at the primary, secondary and tertiary levels of service is long overdue. We need to provide mechanisms for the dissemination of such information and at the same time accelerate training efforts.

SUMMARY AND RECOMMENDATIONS

In recent years mental illness prevention among disadvantaged and ethnic minority populations has been strongly encouraged. Among American Indians prevention efforts are limited in number and are mainly educational and informational in nature. Very few of these are sensitive to the diverse cultural orientations of Indian communities.

There is a definite need to accelerate the training of American Indians and non-Indians to work in the field of mental health. From my perspective the most immediate need is in the counseling field. The lack of skilled culturally sensitive counselors is sufficient to support this claim; however, there is additional evidence to substantiate the need at the community level.

Substantiating the Need

To achieve some sense for the extent and the nature of job opportunities likely to be available, a survey was conducted in 1980 of a sample of 84 mental health agencies in the State of Washington.[4] The agencies were chosen from the directory of the Mental Health and Mental Retardation Boards, Mental Health Agencies, and County Commissioners supplied by the Mental Health Division of the Washington State Department of Social and Health Services. Of the 84 surveys distributed, 51 (61%) were returned during a six week period.

Interestingly, 94% of the returns indicated that there is a need for students to receive counseling training which addresses problems attributable to ethnic and cultural diversity. Similarly, 75% of these agencies said they could employ the skills of a counselor who had experience in working with ethnic-minority groups. This need was further supported by the finding that only 2% of the agencies had on staff a counselor(s) who worked primarily with ethnic-minority clients. In response to a question that asked which ethnic groups(s) require trained counselor representation, 28% said American Indians, 27% Hispanics, 18% Asians, 17% Blacks, 7% all groups, and 3% other (e.g., Gays and veterans).

Barring unforeseen circumstances, at the time of the survey each agency anticipated that, on the average, 7.5 counseling-related posi-

tions would be available in the next five years. Of these openings, 37%, or 2.8 positions, were expected to be filled by people skilled in counseling ethnic clients. From these estimates, extrapolating over the next five to ten years, one can conclude that there will be 120 to 130 counseling-related positions open in Washington State which demand people specifically trained to deal with ethnic and cultural diversity. This is a modest figure in terms of **need**, but probably an unrealistic one in terms of the number of slots that will actually be filled by individuals with such experience.

The survey also inquired about mental health professional opinion with regard to a typical training curriculum for Masters level counselors. The overall response was that even though basic psychology courses (e.g., learning, developmental, research design, etc.) are important, the most essential areas are those directly related to counseling; that is, supervised internships, counseling techniques and theory. Fifty-six percent of the surveys returned said that the major deficiency in a typical program was the lack of practical experience or personal maturity on the part of the graduates. Specialized courses in vocational, group, and marriage/family counseling were also rated as important training needs.

Several observations selected from a section of the survey that invited individual comments provide additional insight into the issues at hand:

> While a sensitivity to minorities is essential, I find most Master's level individuals lacking in basic experience.
>
> We have found it exceedingly difficult to locate qualified ethnic mental health workers, and feel that the universities need to make a concentrated effort to locate and train them—and perhaps provide a listing of newly graduated seniors.
>
> While people skilled in ethnic counseling are in demand within our agency, finding them in the Northwest is extremely difficult. Ethnic and cultural training of counselors at all levels are encouraged.
>
> Any counselor with ethnic skills and knowledge is a more desirable employee.
>
> There is a deficit of counselors trained in special needs of minority populations—i.e., the three areas of alcoholism, mental health, and drug abuse in our County currently need counselors with experience in these minority fields, sometimes qualifications have to be re-written.
>
> I feel it is most important to get minority students into Masters level programs.

One can safely conclude that according to the majority of mental health professionals surveyed there is a need to train counselors in the area of ethnicity and cultural diversity. Related to this is the fact

that 75% of the agencies surveyed desire counselors who have experience in working with ethnic-minority groups. In addition to this verbal support, it also appears that there are positions available for ethnically skilled counselors and that the agencies are actively seeking such individuals.

It should be emphasized that almost all of the returned surveys expressed the need for greater quality internships for counseling trainees at the Masters level. Similarly, there was frequent comment on Masters level counselors' lack of personal maturity to handle themselves in the counselor's role and to deal with the political/administrative realities that exist in a community mental health agency. These last observations indicate the need for counselor training curriculums to address the realities that their students will confront. One of these realities is that their service population will be multi-cultural and that the present delivery and treatment models must be sensitive to this diversity.

Recommendations

Training in cross-cultural counseling can provide a means to respond to state and national labor force needs in the mental health delivery field. The training effort also can advance the field of psychology, especially in regard to a number of objectives established by the American Psychological Association's Board of Ethnic Minority Affairs in 1981, specifically:

1. Expand certain psychological concepts, theories and methodologies to account for cultural variations and characteristics, especially among American Indians;
2. Development of unique and innovative counseling intervention approaches which can complement and expand traditional counseling intervention approaches;
3. Demonstrate and document the appropriateness of cultural variations through application in field settings;
4. Increase the awareness of psychology departments to the needs of ethnic minority students, particularly Indians; and
5. Increase the pool of graduate level American Indians to provide psychology with a broader base from which to draw resources.

If there is a strong need to meet manpower demands through training in cross-cultural counseling, then there is a strong need to promote the training of service providers in prevention. Few reliable prevention strategies exist, fewer still in the cross-cultural arena. We need to generate interest, commitment and involvement in developing and testing culturally sensitive prevention strategies and at the same time develop evaluation schemes to assess the relative impact of these strategies. Prevention training for American Indians re-

mains virtually unexplored, has roots in the traditional setting in which culture-specific strategies have long existed. Efforts should be taken to examine these traditional approaches and, as appropriate, build them into the fabric of contemporary Indian life with an eye to assessing the consequent effects.

NOTES

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2. I am grateful to Professors Frank Nugent, Western Washington University and Paul Pedersen, Syracuse University, for their generous assistance in reviewing earlier drafts of the article. Paul also generously provided me with reference materials in the counselor training section.
3. Ayers, G. *The disadvantaged: An analysis of factors affecting the counselor relationship*. Paper read at the Minnesota Personnel and Guidance Association Mid-Winter Conference, Minneapolis, February, 1970.
4. The survey was conducted by John Lee then a graduate student in the counseling psychology program at Western Washington University. John was assisted by Professor Walter Lonner and myself.
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DISCUSSION

John Red Horse: With regard to training counselors, we have to introduce the natural setting as the learning laboratory: the setting of the community, the setting of families, the setting of culture. . . What are the resources in the community? I'm frightened of academic models because of the impact that they have on the community, drawing away some of its greatest resources and placing them in the university for four to six years. The community suffers. We should move out into the laboratory to teach.

Harriet Lefley: I wish to address the question of psychological training generally, training for any of the professions. While I too think it's best to get it out of an academic setting, I'm concerned about the lack of reciprocal feedback to the academic training process itself. It's as if, here's academia, here's the field, and the two are divorced. It's very important for people to bring back their personal field experiences to academia. This way, then, we can discover the extent to which they can't apply that which they've been trained to do and the extent they think it needs modification. There are ways of looking at things that have to be taught to those who teach clinical psychologists, for example. The only way one can do that is not to divorce it from cultural training but to make the latter part of the curriculum.

I wish to make a further point with respect to the alienation of professionals. For the past three years I have conducted a cross-cultural training institute for mental health professionals. We've worked out a way to evaluate its impact on the trainees and also on their home agencies. I've found some interesting reactions, especially among minority professionals. There is a tremendous questioning: "What am I doing in this profession? What am I doing to my people? To what extent have I been desocialized?" That is something that has to be taken into consideration and built into any training program.

Spero Manson: To this point in our discussion we've talked about undergraduate-graduate level education in universities. Norm, Joe, and I have written about the notion of controlled collaboration between Indian Health Service professionals and traditional healers in Indian communities. I view this as a form of training which is particularly relevant to prevention. I'd like to push us to think about prevention training in a broader sense, to push it past the notion that it just happens among a particular group of people in a university setting.

Norm Dinges: Joe, I didn't hear you mention mental health consultation as practiced in its own right, which, if placed within a collaborative model, could be a very potent form of training. It may be presumed to be something that one does after having achieved the full credentials of professional training. But why can't one learn mental health consultation at other levels, in other forms?

Jerry Mohatt: I'm puzzled by one thing about your paper. You're saying that there is already an indigenous system which is effective. It's working well and training people. Are you arguing for us to stay away? Or are you saying that we should look at the indigenous system, at how its services are provided, at how training is provided, and at how outcomes are measured or are perceived, apply these concepts of training in academic settings?

Joe Trimble: I think we should look at such systems, use them, and integrate their concepts for the betterment of the community, perhaps by "controlled collaboration" between the two entities, as Spero suggested. There will be tremendous resistance; there is tremendous resistance.

Norm Dinges: Where's the resistance from? The community or the educational institutions?

Joe Trimble: On the part of the both.

Jim Shore: I'm not as concerned as you are or as you indicate in the paper that the academic model is totally blank. I think it is an issue of the content, not the form of the model. We use a very strict academic model to train both formal transcultural concepts and community psychiatric skills. We've had a good deal of success in placing our trainees and graduates in transcultural settings with a lot of acceptance: they haven't created riots, they haven't been fired or kicked out. We've used a formal educational model to train these skills, but it has to do with the content and the way in which the curriculum is taught. One of my problems is that NIMH will totally withdraw all of these funds within the next 12 months; I have to pay people a salary, people who are tied to services in the hospital, clinic, or emergency room. I won't have the freedom to protect the kind of curriculum that I've developed. There are other curricula

developed in part (with) support from NIMH that we also need to preserve.

Thus there is an available body of knowledge, a science that grows out of perspectives in public health. The other dimension in education is to develop some momentum so that Indian and non-Indian students who will work in the field can learn this body of science in formal curriculum. That's not happening. We've gone through a period of developing special training programs. Some of the people here direct and are in Indian study programs. Some are more health related than others. I have had the opportunity to review proposals for several different, very good Indian-related mental health programs. But the concepts of prevention don't stand as being clearly taught. One of the general issues that I would raise is, do we feel that there is a body of knowledge specific to prevention? If there is such a body of knowledge, should there be special emphasis on encouraging people who design and direct training programs to get that body of knowledge in the curriculum? Are there special concepts that need to be a part of this process?

Bernard Bloom: My impression about training in psychology is that doctoral candidates are uninterested in prevention. There appear to be very important reasons for that. The first is that they really want to "lay on hands." They get into clinical psychology, as I suspect most people get into medicine, not to prevent illness, but to cure it. They want to find somebody who is sick and to help that person get well. I don't say this with any negative spirit at all because when any of us is ill the last person we want to talk to is someone who is interested in prevention.

The second thing is that there are relatively few employment opportunities for people in the prevention business. Again, I'm speaking from my own experience. We're trying to provide education for the wrong audience. The audience ought not to be doctoral candidates in clinical psychology. They ought to be Indians who have their PhD's in psychology, who have worked for ten years and now understand the limitations of mental health practice.

Spero Manson: Another related point has to do with institutional structures. So we train people to prevent, presuming we have an adequate knowledge base and sensitive format. As I see the nature of formal health care in the present delivery structure, all of one's energy goes into justifying your existence as it is presently constituted in the health services. Many tribal health programs, for example, are predicated on the basis of illness encounters or exposures. How do we break this cycle? How do we take this into account when one is asked to provide inservice education for nurses in a reservation? Adequate curriculum and adequate motivation for providing preventive services need to be reinforced by being seen as legitimate, as valued.

Harriet Lefley: There are barriers it seems to me in the mental health service delivery system itself apart from training considerations. One is the financial issue. Mental health facilities are under increasing pressure to generate reimbursable services and by and large a lot of prevention is not chargeable. There has to be some kind of move to generate third party reimbursement for preventative activities.

Jerry Mohatt: I don't know of any professional role models for providing preventive services on reservations in South Dakota. It's not psychologists, it's para-professionals. . . people who are in face-to-face settings, people with limited training. They have associate degrees at best, few have bachelor degrees. We've been training mental health workers for two years at the bachelor level and these people are crying for good western models of prevention. . . We have to feel a sense of responsiblity for getting good models of prevention to these kinds of people.

A CULTURAL NETWORK MODEL: PERSPECTIVES FOR ADOLESCENT SERVICES AND PARA-PROFESSIONAL TRAINING

Yvonne Red Horse

This paper outlines the problems of Indian adolescents and provides an alternative approach to preventive services in working with Indian youth. The discussion is organized in three sections. The first examines adolescent behavior, experiences and expectations. The second provides an outline of WIDO-AKO-DA-DE-WIN, a project designed to use the natural support network as a preventive model for services to Indian adolescents. The third section discusses the use of this model in preparing para-professionals to work with Indian families. The conclusion offers a future perspective for examining the roles of natural support networks in providing support services to Indian adolescents.

ADOLESCENCE: A TIME OF CRISIS, OF LEARNING, AND RELEARNING

Adolescence is a time for development of self, strengthening of values, and a move toward independence (Watson & Lingren, 1968). For Indian adolescents it is often a time for redefinition, re-evaluation, and re-examination of one's self as an Indian in a non-Indian environment.

Adolescent psychology has postulated a number of tasks for "normal" growth and development (Watson & Lingren, 1968). These tasks outline a presumably natural progression to adulthood. The initial tasks entail acceptance of gender roles and development of relationship skills with the opposite sex. These responsibilities are to be developed early in a child's life. Indian children are taught at a young age to be individualists in preparation for responsibilities to and for other family members as they grow into adolescence (Saslow & Harrover, 1968). For example, most Indian children are taught to be responsible for younger brothers and sisters at a very early age. This preparation sets the stage for a natural helping network which is characterized by family support and nurturance.

Subsequent developmental tasks include the achievement of emo-

tional and economic independence. However, the observed relationships among Indian adolescents are often at odds with those that professional opinion lead one to expect. According to mainstream behavioral science, adolescent growth and development procedes in a linear fashion with regard to age and independence. As the child grows older, he or she is expected to break certain relationships and establish an independent family unit. Within extended family systems, however, relationships are enacted and maintained through a context of mutual interdependence, actually increasing one's dependence upon family. Indian adolescents develop stronger interpersonal bonds during this period of growth and development. Rather than becoming more independent of the family, their obligations and responsibilities to and dependence on family increase, as illustrated by the following case:

> Sara was a twenty-two year old Chippewa mother with a six year old son. She was bright and did well in high school, but dropped out during her junior year to marry the son's father.
>
> Sara, her husband, and son lived with a grandmother off and on for a period of three years prior to their divorce. Sara, during this time, worked full time and finished her GED. Her general preference was to live with the grandmother who provided child care as well as emotional support for her during the problem periods of her marriage.
>
> Upon her divorce, Sara decided to enter college so that she could develop a career and support the family. Sara discussed these plans with the grandmother and a counselor who had worked with the family for the past six years. Sara informed the grandmother and counselor that she had rented an apartment and would be independent from the grandmother who had been part of her support network since she was three years of age. When asked to where she had moved, Sara replied, "Why upstairs in the apartment above my grandmother."

Sara's sense of independence illustrates the importance of maintaining family support. Her responsibility to family and to self is manifested through this extended network.

Still other developmental tasks are described as preparatory to the acquisition of intellectual skills and selection of an occupation. Indian students from birth through third grade develop intellectually at the the same rate as children on the national average. However, from fourth to seventh grade, Indian children decline academically (Bryde, 1970). There are several factors which may contribute to this decline. At the onset of early adolescence children begin to identify with their significant group. The majority of Indian adolescents view their Indianness as the most significant element in the evolution of their self-identity. During this developmental period there is a move to examine the negative definitions of Indians that have been set

forth by the majority culture. Role models often fit the stereotype of the drunken, lazy Indian. A sense of hopelessness and despair occurs as they experience and witness the personal turmoil of parents, peers, and other family members (Fuchs & Havighurst, 1973). The adolescent crisis for Indians coincides with a decrease in self-concept, school attendance, and achievements and poor social relationships. The school drop-out rate for Indian students (60%) is nearly triple that of the nation's youth in general (23%).[1] Indian adolescent suicide is four times greater than the national average (Saslow and Harrover, 1968). These suicide rates are closely related to family dysfunction, alcohol and drug abuse, loss of a friend, or death in the family (Saslow & Harrover, 1968). The successful completion of the above developmental tasks under such circumstances is unrealistic; it is a period of redefinition and reaffirmation.

The remaining developmental tasks pertain to socially responsible behavior. Indian adolescents often struggle with social service and mental health professionals who encourage separation, independence from family, and an understanding of self separate from significant others. Indian adolescents perceive this advice as a threat to their value of family which has become a primary unit for socialization. The family as a support network is critical to the development of social responsibility among Indian adolescents. The following case example depicts the importance of such a support network:

> Linda was a fifteen year old sophomore in high school. She was an honor student who rarely skipped class and was not a behavior problem in school.
>
> Linda chose not to live with either natural parent when she was fourteen years old. She related to them well but chose to do so on her own terms. The parents accepted this self-direction and self-reliance by their daughter since family alcoholism appeared as a recurrent problem in on-going relationships between parents and child. Actually, Linda had been in and out of foster care since the age of seven because of the alcohol problem which had destroyed and continued to destroy personal relationships.
>
> Linda's county social worker allowed her to decide upon foster placements. Linda thrived under this responsibility, but it contributed to some concerns on the part of the social worker. Linda chose to live with nearby aunts and uncles. In three years she lived with five different households of the extended family; all were within eight blocks of her mother's home.
>
> The case worker was extremely concerned with this apparent pattern of irresponsibility, especially since it contributed to agency tracking problems and appeared to have some influence upon three other children in the family who were also in foster care. An explanation that family represented the best placement and that availability of space in family households varied with different times of the year

did not really soothe the caseworker who thought such behavior nurtured a cycle of dependency.

At seventeen Linda requested support to find a place of her own. Her decision resulted from increased school work that made frequent moving unsatisfactory. The caseworker resisted this attempt and based the decision upon Linda's previous record of inappropriate foster placement conduct. The desired move would leave Linda without any adult supervision to curb her apparent instability.

Indian professionals acted on Linda's behalf. Three compelling arguments about her behavior and resources were presented. First, Linda had demonstrated responsible, self-reliant behavior in school obligations. She was a B+ student who received endorsements from all faculty approached for behavioral appraisals. Second, though Linda would have maintained an independent household, she would remain interdependent with family. She not only had parents, but also significant numbers of aunts, uncles, and cousins within an eight block radius of her apartment. Her family support network that had been nurtured through normal extended family behavior over the years would remain undisturbed. Third, Linda had developed resources external to family: peer group supports, school counselors, and local Indian professionals.

Professionals and para-professionals working with Indian adolescents must examine closely the teachings of human services in areas of behavior, diagnosis, and treatment as well as standards for clinical behavior. Indian values regarding growth and development should be reviewed and studied before developing a plan for service.

WIDO-AKO-DA-DE-WIN: A MODEL FOR ADOLESCENT SERVICES

The Setting

The Minneapolis Public Schools' Indian enrollment is about 3,000, representing approximately 3% of the total school population. South High School, where the pilot and program were implemented, is an inner-city school at which 13% of the school's 1150 students are identified as Indian. South High, as other secondary schools, is striving to make its curriculum and ambience attractive to a diverse student body. Much of what is created at South rarely is fully appreciated by Indian students partially, perhaps, because they are culturally different, e.g., they may learn differently, have different values, and behaviors.

Historically, the integrity of the Indian family has been undermined by a number of social pressures, with direct impact on the Indian students at South High School. The parents of these students were born and raised on reservations when economic self-sufficiency was waning and the Bureau of Indian Affairs control-

led their lives. Parents were taught that they could not adequately care financially and emotionally for their children. Moreover, children were separated (and to remain separate) from families through boarding schools, foster home placement and adoption. Indian values of parenting consequently have been seriously disrupted by early childhood experiences in which family separation served as a life model. These experiences, then, describe the parents of the Indian adolescents at South High. The hardships of urban survival have not permitted them to reconstruct their families nor recapture the extended family relationships which underpin the natural support network.

Overview of the Problem

In Minneapolis schools, for example, some Indian adolescents act out relational frustrations. Observations by a number of Indian professionals suggest that drug and alcohol misuse and abuse may affect 70% of the adolescent population. Truancy is estimated in the 45% range. Incomplete school assignments and high drop-out rates prevail as consequences of inappropriate behavior. Pregnancy among adolescent Indian girls represents a particularly compelling statistic often related to family problems. In the Minneapolis senior high school with the highest proportion of Indian students, 40% of all school pregnancies are among Indian girls. Table 1 represents a three-year tracking of school pregnancies. The numbers may appear small; however, they represent a large proportion of Indian girls remaining in school. The data in Table 1 does not indicate girls who dropped from school because of pregnancy.

Table 1

Three Year Tracking of Pregnant Adolescents at a Selected Minneapolis Senior High School*

Year	Pregnant Students All Races	Pregnant Students Indian		Pregnant Students Non-Indian	
		Number	%	Number	%
1975—76	18	8	44	10	56
1976—77	24	6	25	18	75
1977—78	17	8	47	9	53

* Source: Minneapolis, Minnesota: Minneapolis Public Schools, 1978

The need to design a cultural network model of support services for Indian adolescents is apparent given the above data. A cultural network approach does not follow traditional teachings of adolescent growth and development. However, it is appropriate for teaching effective behaviors according to tribal and family value orientations. A cultural network model builds support for developing interdependent relationships and at the same time recognizes personal achievement. Group work concepts are appropriate since the group serves as a natural support mechanism for personal experiences in sharing, developing mutual respect, responsibility, and caring for self and others. Interdependent responsibility in a group setting teaches personal involvement and obligation to others in the network. A cultural network model incorporates traditional methods of group counseling. The peer group, extended family systems and Indian organizations become integral parts of the natural helping support network. The section below highlights the pilot project at South High which provided the basis to develop WIDO-AKO-DA-DE-WIN.[2]

Pilot Effort

Initial efforts identified adolescents experiencing life difficulties that are receptive to social services designed within a cultural framework. Nine Indian girls between the ages of 15 and 17 years chose to participate. Seven remained active for one full year. The girls accepted a commitment to meet as a group once a week for three hours during non-school periods. They participated without benefit of school credit or monetary compensation. Problems and home situations varied dramatically. Some common features of membership, however, were that each experienced family crises through drug and alcohol misuse and abuse by family members and through personal misuse of drugs and alcohol by each girl. Moreover, each was sexually active. Three were pregnant; one used birth control pills; three relied on "faith" methods of birth control. Male-female relational problems were common and stemmed largely from miscommunication of feelings and values. The girls were not wantonly mischievous. They were, however, significantly misinformed regarding birth control, personal health, nutrition, alcohol and drugs, male-female relationships, parent relationships, and parenting.

Three features were common to each girl's extended family system: 1) severe poverty conditions and high unemployment; 2) inadequate housing; and 3) a strong extended family structural fabric which could serve as a foundation for a cultural network model of services. This structural integrity was beneficial because the extended family spanned both urban and reservation areas. Living situations did differ irrespective of common features. One lived in a household with both parents. Two lived in households with

single parents. One lived with an aunt. One lived with a grandmother. Two had independent households. All of the girls lived within a mile of one another, went to the same high school, and knew each other on a casual basis.

Major goals for the cultural network model of services were for participants, including social workers serving as group leaders, to form a cohesive support group and to laterally integrate into the fabric of existing extended family systems. A mutually positive regard had to be developed. The girls had never experienced positive relationships with professional social workers; therefore, an air of professional distance was abandoned. Social activities were designed to build affective bonds within the group. Some activities, such as feasts, pow-wows, and other selected cultural events characteristic of the group's tribal background, served as continuing threads throughout the groups process. Culture, therefore, served as an integrating component for clinical practice. Recognition of culture as a clinical variable proved essential to the eventual success of the group process.

Predictability of behavior proved crucial in developing trust. All group members, including the leaders, had to be approachable on a consistent basis. Meeting times were scheduled regularly and rotated among group members' homes. Group welfare served as an absolute priority with each person committed to unqualified mutual acceptance of the others. Individual rights became a delicate issue in this initial stage because of the types of personal information shared. Eventually, the issue of confidentiality of information did not overwhelm the group. The initial clinical period allowed members to test each other and to overcome fearful reluctance to share information that potentially may be misconveyed to family and close friends through rumors.

The group process simply exemplified formation of trust in any situation in which dependency and testing are common elements. Motives for group meetings were often questioned. Communication content was sensitive and emotional. Group members often accused the social worker leaders of deliberately using authority to hurt individual members. A heuristic teaching process unfolded that allowed the girls to explore ways of expressing feelings on matters that caused considerable pain. Communication blockages most often centered around personal and parental relationships. Group support proved essential to individual growth and provided reassurance to explore self-acceptance of painful feelings and to translate such feelings effectively to family members and significant others.

The culture network model was guided by natural problem-solving tasks. Group members were required to develop personal competence in translating feelings into behavioral resolutions. This was ac-

complished through linkages with extended family systems which were incorporated as the major problem-solving milieu. Group members shared feelings and information with parents, grandparents, aunts, uncles, cousins, and siblings. This strengthened communication within the group and among family systems. Whenever crises or joyful situations arose, family participation was encouraged. Group members learned to use family as a helping and supportive network and learned that family provided available outlets for both positive and negative experiences.

Elders served a critical function in the transition from group to extended family systems. Elders introduced a wisdom valued and sought by all group members. Cultural wisdom as related through an elder's experience offered a continuity of world view necessary for adolescents struggling to recapture value orientations and searching for meaning in their lives. Indeed, group members rapidly became self-assured young Indian women who no longer experienced urban life as a personal dilemma, but as an opportunity for growth.

A typical final stage, termination, never really took place. The group stopped meeting on a formal basis; support through extended family systems, however, continues to date. The group members, moreover, informally gather during special occasions. In essence, group members experienced a phenomenon quite similar to an extended family system as characterized in Linda's case: members are independent through interdependence and therefore never alone.[3]

WIDO-AKO-DA-DE-WIN

The success of using the natural support network in this fashion led to WIDO-AKO-DA-DE-WIN. The program operated from 1979 to 1980, was funded by the Minnesota Council on Quality Education, employed full-time personnel and integrated curriculum within the school's course offerings. The pilot group was only part of the network, which lacked formal curriculum, but provided individual and family counseling outside of the school setting. For the network to be effective it needed to be expanded, integrated and to place full-time personnel within the school system; these, then, were the structural aims of WIDO-AKO-DA-DE-WIN. WIDO-AKO-DA-DE-WIN provided a supportive atmosphere at South High for Indian students. It also provided the necessary linkage between the reservation and the urban area. Many of the students who were served by this program were products of urban families. Indian students spend much of their day in school or in the community searching for broader family support. The program offered a link to the students' family networks by either establishing new networks or reworking dysfunctional family networks.

Program objectives. The program had four primary goals and objectives. One goal was to develop a family support network for Indian students at South High. The specific objective was to offer three accredited daily classes, for up to ten students each for three tri-semesters, the structure of which was group-based and provided individual and family counseling sessions for the students. This combination of individual, group and family counseling was intended to enable students and family members to feel better about personal and school relationships.

The second goal was to develop an intensive curriculum covering the subject of self and family. These courses were offered in the school for elective credit. The objective was to offer a curriculum that covered personal assessment, communication skills, values, mores, norms, and Indian traditions, chemical dependency, family systems, male-female relationships, human anatomy/physiology, parenting, nutrition/health/personal and total health care, and school support networks. Since the family traditionally serves to educate, the program's network system continued this process.

The third goal was to clarify and to enable the participants to understand and retain Indian values and identity as urban residents and as urban high school students. An Indian elder provided grandparenting skills in at least four subject areas for each of the three classes, bringing to the network traditional Indian philosophy, expertise, and experience about life and education. Trips to reservations enhanced their educational growth by permitting the students to talk to elders and youth about their networks, values and identities. The use of elders was significant in the development of the support network process. The elders' expertise strengthened the natural development of family-like groups in an educational setting.

The fourth goal was to effect a decrease in the pregnancy rate of Indian adolescents at South High. Students were provided with information on values, health and personal relationships that would enable each student to consciously plan or prevent a pregnancy. This goal served a primary preventive function for children raising children.

WIDO-AKO-DA-DE-WIN offered an innovative approach to working with Indian adolescents because it created a concept of family-as-treatment model. Programs providing support services to Indian students have, in the past, adopted individual-oriented treatment approaches. The argument that group methods are not appropriate when working with Indian adolescents was disproved by the pilot effort. WIDO-AKO-DA-DE-WIN was unique in that its cultural qualities were enhanced by the wisdom of elders. The program was not just beadwork and slogans, but rather established behavioral expectations in the network, exemplified by respect for fellow stu-

dents and staff. Responsibility for positive outcomes of one's own independent development and sharing was evident in the cohesion and mutual actions taken by members of this network at South High School. The school attendance, performance, and family relationships of the participants improved over the course of their involvement in the program; the frequency of their encounters with the juvenile justice system decreased markedly.

IMPLICATIONS FOR PARA-PROFESSIONAL TRAINING

Training models for para-professionals have, in the past, focused primarily on clinical methods of providing counseling services to Indian families. With respect to preventive interventions for adolescents, counselors must be culturally sensitive to the unique situations that confront Indian families in an urban environment. The pilot group and WIDO-AKO-DA-DE-WIN identified four broad areas in which para-professionals require training to effectively counsel and to work preventitively with Indian adolescents. The four areas are: family, community, culture and behavioral health problems.

Family

Helping professionals have failed to recognize the strength that can be derived from the natural support networks which exist in Indian families. Service providers need to understand the network systems that are used in family therapy to positively impact family choice in seeking and receiving help. It is critical that the counselor obtain from the family a "picture" of themselves. This can occur by "joining" the family and observing behavioral and relationship patterns among its members: "In using joining operations to restructure, the counselor uses the family's own movement to propel it in the direction of specific counseling goals" (Minuchin, 1974). By joining the family, a counselor develops an understanding of the family and support system important to the helping process. A major misconception of family therapy is that a family will trust immediately and become open to the counselor. Experienced counselors in the Indian community understand that the first step in the helping process is to establish trust through a joining process. During this period both the counselor and family offer and experience a period of sharing, mutual caring and respect of each other's boundaries. Training in family network therapy, systems theory, and problem-solving processes can provide the necessary skills to apply the natural support network model that was employed here to provide preventive services to Indian youth and families.

Community

The second area should focus on understanding the community

and the system that impacts the delivery of services to Indian families. Training must emphasize the importance of community politics and credibility and consistency in service delivery.

A major problem in the delivery of services to Indian communities is the lack of understanding of the importance of local political structures. The counselor's educational degree and experience are not the critical elements in service utilization, but rather one's parents, aunts, uncles and political standing in the community. Teaching counselors to disattend to Indian politics interferes with the delivery of service to adolescents.

Para-professional credibility can be established through the understanding of community politics of the organizations and relationships that impact service delivery. Indian families' relationships to the helping professions are tenuous. The grandparents and parents of today's adolescents learned to distrust professionals; the credibility of the latter is tarnished by the former's past experiences. Training must focus on teaching consistency and reestablishing credibility, for example, by emphasizing accommodation skills in therapy settings.

Cultural Values

The third area, and possibly the most important, is knowledge about and understanding of Indian culture and cultural values. Counselors who provide services without an understanding of cultural norms can not fully assist a family to grow through therapy.

Devere East Man, a Sioux medicine man, stated that "culture is like a tree, a tree that does not have roots is going to die (1981, p. 172). Para-professional training must provide an understanding of the relationship between family and cultural strengths which can be used to enable the individual to seek and receive help. The following example illustrates the importance and role of understanding cultural values and norms in teaching decision-making to adolescents in the pilot effort:

> Maria's grandmother came to a group session to discuss traditional family planning methods and help the girls have a better understanding of the natural way used in Chippewa families. The elder talked about respect for one's self and the importance of caring for the children through using family networks. She voiced her concerns about those who were sexually active and when asked what kind of birth control methods she used, she smiled and said, "Why we abstained for at least a year after the child was born." The girls laughed but silence came over the group as she continued to speak of the reasons for the abstinence. She discussed her decision was based on concern for the baby's and her health as well as maintaining respect for other family members. It was more important to show respect than to have sexual relationships.

The use of culture in teaching Indian adolescents to understand themselves and their families is critical to personal, social and family development.

Behavioral Health

The fourth area of emphasis in training is the current health and behavior problems which face American Indian adolescents and their families.

At the White House Conference on Families in 1980, alcohol was identified as the second national health problem in the United States. An understanding of the nature and dynamics of alcohol and substance abuse is critical to effective intervention with regard to the major health problems among American Indians. Of the adolescents attending South High School, 70% had personal and family problems related to alcohol and drug abuse. Adolescent pregnancy had reached near epidemic proportions. Counselors must be prepared to teach parenting and relationship skills; the adolescents who participated in the pilot effort clearly lacked them. Delinquency and court involvement is another problem area in which para-professionals will need specific training. Courses in legal policies and procedures are especially appropriate, providing the advocacy skills which are an important part of delivering services to the Indian community.

CONCLUSION

This paper discussed specific needs of Indian adolescents and stressed the importance of family and family-like networks in problem-solving. The life circumstances of Indian adolescents provided a basis for the development of a program that can meet their changing support service requirements.

A cultural network model was introduced which employed concepts from social work practice to integrate cultural values and norms in the delivery of preventive services. The model is predicated on trust, realistic expectations, and non-judgmental behavior. The pilot project and WIDO-AKO-DE-DA-WIN represent innovative approaches to the use of the natural helping support networks which are an intrinsic part of Indian family systems. Such networks can provide educational programs with a new, culturally appropriate avenue for working with Indian adolescents.

Para-professional training with regard to the special needs of Indian adolescents is requisite to the provision of quality care. A cultural network model offers a readily applicable framework for teaching preventive intervention with this special population.

NOTES

1. Minneapolis Public Schools, Title IV Program, Annual Report, 1977–78.
2. WIDO-AKO-DA-DE-WIN is a Chippewa word that means "networking".
3. This section is derived from previous work by Red Horse et al., 1981.

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DISCUSSION

Damian McShane: I worked in the same setting that Yvonne described and I found the paper very interesting. Some of the things that we talked about before, she dealt with very explicitly: pathology, competence, and trying to see how they are related. . . The major theme is the family as a primary unit for socialization, traditionality, and certain structural characteristics. The family is extended in nature. It provides guidelines for training, emphasizing the impor-

tance of family members to successful intervention. It provides the major personal setting or environment in which interdependence is intensified, solidified, and formalized over time. These are very different assertions, especially for the systems within which this preventive intervention operated. Moreover, the paper focused on developmental competencies: how Indians develop, the kinds of tasks required of younger children, the various ways in which these skills are reinforced and examples of how specific competencies evolve.

On the other hand, Yvonne noted a number of problems that the family faces. There are factors that have reduced the educational support and protective function of the traditional family system. These factors include the contamination of traditional values of the parents through early childhood experiences, specifically boarding schools. Though the focus of the project was upon adolescent females, very much is taken into consideration in a historical way of the situations that the parents experienced, which may in turn affect their children's lives. . .

Urban transition and economic hardship prevented the reconstruction of many families and precluded the movement of extended family networks to the city, creating a distance among family members that is extremely difficult to bridge. . .

Lastly, Yvonne offered a critical look at the linear model of development, that children are progressively becoming more independent, that by the time one reaches adolescence, the individual separates him or herself from the family. Conversely, traditionally, Indian family life emphasizes increasing interdependence within the family, a growing of ties, responsibilities, and activities in relationship to the family.

The intervention seemed to operate at different levels. It certainly was tertiary in that it dealt with dysfunction. It can also be considered secondary as well as primary since the staff worked with pregnant adolescents who will also have children who will be parents. They were aided in this regard by construction of viable and functional networks, sometimes new networks comprised of available adolescents and adults. These new or augmented networks were laterally integrated or joined to the existing extended family networks. This not a mild intervention. It's very major reconstruction or replacement. . .

There are some unanswered questions: Were there consistent areas of traditonal family system dysfunction that you noticed in the cases that you dealt with? Was there consistency among some of the individual questions that seemed to surface? Finally, with respect to being a member of a community and professional or para-professional status, what were the advantages or disadvantages of being close to or being distant from the individuals who were the targets of intervention.

Yvonne Red Horse: I'd just like to clarify one area, particularly. We really did not replace networks. We tried to become part of the total network: we didn't remove an adolescent from a dysfunctional family and then give her a new network. We worked with the existing family system, including parents, grandparents, aunts, and uncles. It was more of a joining, of bringing all significant people together. .

One of the things that we tried to do in developing the support network was to work around politics. One of the ways in which we did that was to develop consistency and to establish trusting relationships with the families that we worked with. They may not have liked our political stance, but they sure liked what we did with their kids. As an example, I had a woman who really did not like me at all and verbally expressed it at every community event. But when her kid got into trouble she utilized the service: "Okay, I don't like what your political stance is, but I'll work with you in terms of my kid." That's what I'm talking about, working around the political system and trying to disallow for what happens in the community.

In terms of information and confidentiality? One of the important objectives in developing the system with family members was to work with the parents, grandparents, aunts and uncles to enable them to utilize their own networks so that once the group ended they didn't need to rely on the group itself. They could begin to rely on other family members for help: we actually re-taught a network system that has been in existence for years. Rather than getting high, the adolescents learned to call an aunt or uncle to help them. Everybody knew that we didn't keep things secret, because that was part of developing the network system. We retaught the adolescents (and others) that one needs to trust family members again.

The reason we used the school system is because that was where a lot of para-professionals worked in the community in terms of dropout prevention, upward bound, and support services. We had immediate access to services, plus a lot of other agencies which could provide services. Most of the other agencies that we plugged into were right there in the community within a three mile area so that a student lived in the community, went to school in the community, and also got services within the existing community.

Harriet Lefley: I think this is a beautiful example of what should be done: feedback in the academic training system. What you did was to involve families as co-therapists, not to treat them as dysfunctional and as unidentified patients, but to involve them in the community venture. This is one area that we really lack in academic training. . . The other thing that also should be imparted is what you have mentioned about interdependence. I've been very much interested in the issue of dependency in recent years, especially with

regard to our theraputic orientations and how often our emphasis on independence can be maladaptive, particularly with respect to traditional cultures. I think these are two areas that could well be fed back into the training system.

Yvonne Red Horse: One of the things that became apparent, particularly among the para-professionals, when we got into using the network system to address alcohol, drugs, and communication skills, was that our own inadequacies surfaced: "I don't know how to teach them parenting skills." "I don't know a whole lot about drugs and alcohol." "I don't know how to detect when it's abuse and misuse." It's really important to examine specific problem areas in training because service providers frequently feel inadequate.

NEW ROADS TO COPING — SIOUAN SOBRIETY

Bea Medicine

Alcohol use and abuse among American Indians and Alaskan Natives have been, since the 1960's, the most widely studied aspects of contemporary tribal lifestyles. However, systematic interpretation of the results of these studies is both taxing and frustrating, due partly to the many different assumptions that underpin the investigation of such phenomena. Those features which seem amenable to preventive intervention often prove to be illusory targets that are irregularly glimpsed from behind a cloud of interpersonal and psychological problems. Only recently emerging longitudinal studies of specific tribes—several of which pay particular attention to the social contexts of drinking—allow for the kind of information that will ultimately lead to the design of effective alcoholism prevention programs (Kunitz, 1977; Levy & Kunitz, 1974; Waddell & Everett, 1980). Coterminously, studies which concentrate on the cognitive dimensions of alcohol use and abuse within this special population present new data that can be of considerable value to providers in the actual delivery of services. Unfortunately few, if any of our current training programs, whether preventatively oriented or not, have incorporated these fresh insights into their curricula.

The purpose of this paper is to illustrate that ethnographic observation of drinking patterns and an awareness of the various ways in which the underlying cognitive dynamics may be expressed are critical to understanding the experiences of Indian alcoholics, their achievement as well as maintenance of sobriety, and to the formulation of successful strategies for coping with the diverse pressures that initially contribute to alcoholism in Indian people. With this end in mind, then, I delineate the tendencies toward and the maintenance of sobriety among individuals on the Standing Rock reservation who have learned to cope without the use of alcohol. My major concern is to describe the maintenance mechanisms: What are the forces which propel the individual into attempting sobriety? What activities does a "sober individual engage in after attempting sobriety? What are the support systems which are most conducive to maintaining sobriety?

"EVERYONE DRINKS!" — A LAKOTA RATIONALE FOR DRINKING

Most observers of drinking styles among the Lakota have noted that the aim of drinking is to get drunk as soon and as quickly as possible (Kemnitzer, 1972; Maynard, 1969; Mohatt, 1972). Some have described the social setting in which drinking behavior is learned. Kemnitzer, basing his perceptions on Pine Ridge, provided the following synopsis which is relevant to all Sioux reservations:

> Although the main environments for social drinking are homes, cars, parks and bars, in all of these the whole family is included. Small children are present at drinking parties, and infants are taken to bars and there suckled, or beer and wine is mixed in their bottles. Children under twelve play around the drinkers in bars, and by the age of fifteen are in drinking groups of their own, but do not participate in public bar drinking until they are older. Adolescents are also sniffing gasoline and glue as well as drinking alcoholic beverages. The drinking culture is also expressed in the play of younger children:
>
> > Two young boys are playing with toy cars. They pretend to load the cars with people, drive the car to White Clay for wine, get drunk, and wreck the cars on the way home. Little girls playing with dolls make up a situation where the "parents" get drunk and fight.
>
> Young children are also coerced by older children and adolescents to sniff gasoline and to drink. Thus, values and behavior reinforcing traditional drinking patterns are transmitted by example and instruction to children of all ages, and drunken behavior becomes "normal" behavior for a significant segment of the population. (1972, p. 139)

Though the "significant segment of the population" is not specified, the patterns of participation in drinking behavior clearly are well established by the time the child becomes a member of his or her adolescent peer group.

This conditioned propensity for alcohol is carried into the nexus of reservation and "border town." In describing the "culture of excitement" for the Sioux, White (1970) depicted the following "folkway":

> For the Sioux Indian one of the most important is chronic drinking to excess. This is the easiest way to quick elation and excitement, a way to relax and forget the fears and insecurities of one's life. It is also a means for the Sioux, who by tradition is dignified and reserved, to be loud, raucous, and cocky in his repartee. In his elation, he forgets any sense of inferiority and gains a feeling of power and assurance—ready to accept any dare. (p. 189)

In his categorization of the folkways that are said to be characteristic of the "culture of excitement" (which could be well correlated with the "culture of poverty"), White included such "norms" as the "readiness for physical violence," violation of the law or vandalism," and "sex play." He stated that this culture is "shared by men and women of all age groups" (p. 190), and is found in the "Sioux lower-class subgroup which, with its focal point on the line of bars on Rapid City's Main Street tends to be a world apart even from the rest of the Indian community" (1970, p. 189). His description fits a type of urban nomadism (Spradley, 1970), and drinking behavior in urban areas as described by Ablon (1964). A similar picture of drunken behavior and subsequent maladjustment is evident in the behavior of other American Indians (Dosman, 1972; Graves, 1970, 1971; Hackenburg, 1979; Nagler, 1970; Price, 1979).

Hurt and Brown (1965) noted that the patterns of alcohol consumption had become concretized since the Eastern Dakota began using alcohol. Their study of the urban Dakota, an eastern group in South Dakota, indicated that excessive drinking was not typical of drinkers in earlier periods. However, as this group became urbanized, a noticeable increase in consumption was discernible. It appears that intensified contact with White communities has fostered alcohol use among the Eastern and Western Siouan groups. Besides drinking to satiation and stupor as a final stage, most writers agree with Kuttner and Lorincz (1967) that drunkenness allows Sioux individuals, particularly males, to display aggressive comportment which is under control in a state of sobriety.

Women and Drinking

There is little on the drinking styles of Indian women in the literature on alcohol. Maynard (1969) provided these observations of the Pine Ridge reservation:

> In the case of the women, the attitude is quite different. In some situations and among some groups women are also under pressure to drink. In general, however, the woman who does not drink is respected and the woman who drinks is criticized. Especially open to censure are women who neglect their children because of drinking or who hang around bars unescorted. (p. 40)

White (1970) indicated that in his Rapid City group both men and women were "equally ready to fight physically" (1970, p. 189). Moreover, women apparently figured importantly in the subgroup's sexual code, which was not explicated except to point out that "at the bottom of the group (in status as well as the meaning of life) are the women who have become prostitutes and the complete derelicts known on Main Street as the "winos" (p. 192). He observed that men stationed at the air base, cowboys coming into the city, and traveling construction workers often become "friends" who support

some Indian women as long as they are in the area. An important consideration in the relationships between Lakota males and females is the pressure of the peer group for the male to continue in his drinking pattern. This usually leads to a dissolution of the marriage and the woman's dependence on Aid to Dependent Children. It also leads to an isolation from married friends. Very often, single Lakota women, after a marriage failure, gravitate to a life on the "Main Streets" of the northern Plains communities.

Whittaker (1962) noted that, in contrast to their male counterparts, women on the Standing Rock reservation show less of a tendency to drink large amounts of liquor at a single sitting. However, he observed that a larger amount is consumed than by the White sample population in Iowa. Speaking of a time in the 1950's, he delineated a pattern of generational differences among Indian women in which the number of drinkers had increased twice as fast as males and nearly quadrupled over recent generations. He also noted that woman tended to stop drinking when children were born. These trends continued into the present and characterize contemporary (1970-80) drinking patterns on most of the Lakota Sioux reservations (Hurt & Brown, 1965; Kemnitzer, 1972; Maynard, 1969; Medicine, 1969; Mohatt, 1972).

As mentioned, from 1960 onward, drinking by females in the child-bearing age became more frequent. Women's response to their husbands' eternal "boozing," as they say, has been to "join them." This attitude is more usual than one imagines. Many Lakota women say "if you can't lick them, join them." That is, after pleading for years for abstinence or, at least, sporadic drinking on the part of their husbands, they begin to accompany the men to bars and begin to drink. For some this is only a transitory act. They stop when they have convinced their husbands to lessen their alcohol consumption. For other Sioux women drinking becomes a way of life. There are some Sioux women, as with Indian women of other tribes, who are able to go into a bar or restaurant and "drink like whites." In "border towns" off the reservation, this means that they might have a cocktail or beer before a meal, or go to a local bar where live music is featured. Others do not go to bars or drink at all. These often are older women or those who have achieved sobriety.

Lakota women have been long aware of the use of alcohol since the days when it became legal to purchase it and even before then. Some who came from families who were *o ki se'* (literally, "halves," or "half-breeds" as they are called in reservation English), often saw their fathers drink liquor. Some of these individuals, lacking the physical features that are stereotypically associated with Indians, could purchase liquor. Others were bootleggers. If one's father was a White man, very often this person purchased liquor for her Indian friends and relatives. Some women made wine from the wild grapes

and wild chokecherries which grew in the Northern Plains.

Many of the young women who grew to adulthood during the early years of the repeal of the ban on alcohol consumption (after 1953), learned to drink as part of their adolescent period. As it is for males, learning to drink became almost a puberty rite for a significant number of young women. Introduction to alcohol thus was (and remains) a part of growing-up for both sexes.

A gradual introduction to alcohol consumption is accomplished by several means. Generally, and at the present time, a female learns drinking behavior in the family setting. This means that in most cases her father and mother are both drinkers and her introduction to drinking is not a problem to them. Indeed, there are many families who actively encourage young daughters to accompany them on drinking bouts. Some families carefully guard their daughters from peer group interaction, but the numbers in this category have steadily declined since the 1950's.

In the families who actually encourage daughters to drink (or who may not discourage their participation), there is a sense of fatalism. The girls will drink no matter what they, as parents, do. This attitude has several latent functions. By allowing the daughter to drink, she may become a form of insurance as a source for alcoholic beverages, especially if she falls into the pattern of "border-town" existence previously described as the "Main Street" syndrome. A young Indian female is often able to recruit White ranchers, farmers, and even police officials to support the drinking habit she acquires. Moreover, her extended kin, if composed of heavy drinkers, also share in this symbiotic relationship. Indian women who fit this description very often form liaisons with bar owners, bartenders, and business men to guarantee a source of liquor. In many cases, this goes beyond the mere supply of liquor, and may become a form of livelihood. Survival strategies of Indian women "winos" and transient single men have not been examined in contemporary tribal life. This type of behavior is not looked down upon by most Lakota people. Derision is not part of the attitude that such persons engender. Statements as "Poor thing! He/she can't help it," are often heard when Lakota people refer to persons ensnared in alcohol addiction.

That these actions are not peculiar to the Standing Rock or Cheyenne River reservations is readily evident from other entries in the literature. Describing a town in eastern South Dakota, Hurt (1967) wrote:

> A further characteristic of the Indian in Yankton is the numerical superiority of women (141 women and 121 men). Since the sexes are almost eaual in number under the age of 18, women are more numerous in the adult group.

> Men are apparently more transient, leaving Yankton for larger industrial areas, moving back to the reservation, or simply wandering along the open highways. The women are less mobile because their responsible sex role involves care of large numbers of children usually found in the urban Indian family. (p. 227)

Referring to the social milieu, he further stated, "Unless an Indian is a mixed-blood, he has little social contact with the white man except for members of the lowest socio-economic class. In particular, contacts between young Indian girls and older white men are fairly frequent in bars and in automobiles" (1967, p. 227).

Traditional mechanisms of social control have not adapted to the new lifeway and are not functional. One remant of traditional male and female "sibling" behavior is illustrative. The institutionalized *hakatakus* (meaning "to follow after them") refers to expected behavior for a Lakota female's "brothers"—biological and sociological. They were expected to serve as her guardians, "watching and protecting her from other men" (Hassrick, 1961, p. 123). This seemingly anachronistic custom is still apparent in some of the more traditional families. It certainly is not as prominent as it was in the early reservation period, lasting until the late 1950's among the majority of "full-blood" *tiospaye* (extended families). This is only one example of the breakdown of social institutions and the resulting demoralization of a people. It also represents an acculturational process in which new norms and values were not realistically represented by the agents of socialization and religious forms that followed the suppression of native belief systems.

In summary, Lakota women fulfill a variety of roles at the intersection of alcohol and everyday living. Some women are willing participants in the drinking game. Others have been compelled to join, hoping to salvage a marriage or to hold her man's attention. Others serve as caretakers: driving drunks home, feeding them, cleaning them, and helping them through their escapades in many ways. Other women act as intercessors or mediators in the interethnic encounters in the "off-reservation" towns bordering the Indian enclaves. Women, wives, mothers, sisters, aunts, and cousins appear with bail money, plead with non-Indian judges, contact lawyers, and maneuver to keep Lakota males out of jail. There have been instances in which sexual favors have been granted by women to law officers. A subtle racism in the judicial system is recognized by all, Indians and Whites. This is reflected in the common request expressed by Lakota males when they plead with the women of their *tiospaye* (extended family) to intercede in their behalf with the legal system: "They listen to you."

Men and Drinking

The most common response to "why do you drink?" by Lakota

males is "Everyone does it." There is a strong impetus to drink, especially among males. Peer pressure is great, and is markedly clear during the adolescent period. However it carries into the adult years in the form of the traditional friendship group (*kola*-hood) which has become a "drinking buddy" sodality. Previously, I referred to the tensions inherent in the marriage or liaison relationship that involve conflicting loyalties to the peer group and to a stable marriage. Acceptance by one's comrades very often is the more potent force. This frequently is a result of frustration and perceived failure on the part of Lakota males to obtain jobs and to provide a livelihood for their families. Self-actualization and meeting the expectations of the larger kin group (the *tiospaye*) are difficult to fulfill in many contemporary Lakota communities. The inability to "pull one's weight," as Lakota say, in a social structure in which the survival of the unit depends upon equitable contributions of time and effort, is a heavy burden. This is especially onerous for male members of the extended family. The inability to provide strikes at the very core of *Bloka*-ness (Lakota masculinity).

The drinking proclivities of Sioux males have been described graphically in the literature. Blakeslee (1955) referred to "several Dakota males of different ages and degrees of acculturation" who engage in "riotous eating and drinking which took place the first two weeks after the arrival of the subsistence check. The end of the month was sober and lean." He noted that although the "older men frowned on drunkenness, all opposition to drinking behavior was passive."

Among Lakota males, drinking alcoholic beverages and participating in the daring exploits which this mandates are thought of as a validation of manhood. This is evoked as *bloka* which is used as a modus operandi for all Lakota males—whether they are fully bilingual or not. Its translation into English is noted as male superiority, but is more accurately equated with the Spanish *macho*—male chauvinism. The behaviors and attitudes of Lakota males are tied to this notion of masculine potency. Male supremicist attitudes are fully ingrained in the socialization process. The "warrior syndrome" has been explicated in several ethnographic monographs (Hassrick, 1961; MacGregor, 1945; Province, 1937). The stress on the value of males continues, yet has not been completely assessed in the continuity of cultural ideals, despite the powerful sanctions which are brought into play. As one example, a Lakota female is not fully recognized as a matured woman until she has produced a son. Similarly, males feel inadequate until they have fathered a son. A very decided male bias is part of the socialization processes for both male and female children.

In discussing the "culture of excitement," White (1970) offered further insight into this androcentric bias when he stated:

> . . within the strictly matriarchal Sioux family the relationship of the mother to the boys is observed to be unusually salient, while in the boys there is frequently a dislike, even contempt, for the absent father or the present but worthless father. (1970, p. 193)

The internalization of the androcentric ideal is a powerful force in the motivation to drink alcohol by young boys entering adolescence. The dare "to prove you're a man!" is a great incentive to action and is commonly invoked in peer relationships during a male's maturational process. It appears to intensify during puberty, but seems to continue throughout a male's lifetime if he is to be accepted as a member of the Lakota male peer group, a *kola* group. The native interrogation "*ni bloka he*," "Are you a male?", is sufficient to thrust a young or old Lakota male into any feat of daring. This is also part of the expected behavior which might provoke a reaction to a dare ranging from reckless driving to self-mutilation such as withstanding cigarette burns on arms or hands while displaying stoicism and *bloka*-ness. A native utterance like, "*Ai! A-tash bloka sni*," "not like a man!", is sufficient to demolish a male Lakota who aspires to membership in the group. Interestingly, a male who resists taunts and dares or who exhibits feminine characteristics is often dismissed by being called *winkte*, "woman-like," or a homosexual. There is an awareness among some Sioux people that the enactment of the latter role was institutionalized in pre-reservation days. Others are as merciless as members of the dominant society. Generally, however, a recognized and accepted *winkte* (true homosexual) is not harassed and tempted to drink. English equivalents for *winkte* are "Sissies" or "Mama's boys": terms of derision for repeated resistors of alcoholic beverages. But as most Lakota males wish to be accepted, this cultural ideal of Lakota masculinity is exceedingly effective in inducing men of all ages to consume alcoholic beverages.

For Sioux men, their involvement in sharing, especially of alcoholic beverages, and continued participation in peer groups can be counterproductive and can undermine marital bonds. This inability to care for their families is not unique to Lakota men, however. Lang (1979) and Westermeyer (1972), writing about the lives of Indian men in general, have indicated that apathy and continual drinking are major factors in marriage discord, which, when combined with discrimination and racism, contribute to the negation of self.

It is possible that these feelings of inadequacy and emasculinity covertly motivate the dependence upon alcohol so evident in the studies of drinking styles among Lakota males. Early socialization to drink in order "to be a man" is constantly exhorted throughout the masculine experience. Drinking conformity is demanded by one's "drinking buddies" or peers and, if one refuses, then one is said to be "too good to drink with us."

Mohatt (1972) attributed the rationale for Lakota male drinking to the concept of "power." The *wakan* or power domain is familiar to most Lakota males. Traditionally, the search for power was a means of self-actualization and self-direction. The *hanbleceya* ("crying for vision" or vision quest) was an institutionalized means of achieving an altered state of consciousness in order to receive a vision which became a mandate for action in one's adult life. By fasting, drinking water, and concentrating upon the *Wakan* (the omnipotent power base), the senses were altered. A visionary "guardian spirit" appeared and became a guide to the future life of the individual male. However, this explanation does not seem plausible given that Lakota males have not actively pursued vision quests since the belief systems were suppressed in 1882. (There have been attempts at *hanbleceya* since 1960, however. These new experiences are cloaked in secrecy by most participants.)

Stages of Drunkenness

There is a definite pattern to drunken Lakota behavior, especially among men. It begins by drinking a great deal of any available alcoholic beverage. This is the "feeling good" stage when talking, joking, and "bragging"—the telling of tales of daring and success—occur, often referred to as a "laughing spell" by some males (Mohatt, 1972, p. 274). It is followed by a period of maudlin reminiscences that can lead to tears; one of the few times when Sioux males resort to tears in public. This phase can be traumatic for young children who may be present. After this comes a stage in which bellicosity and beligerence dominate. Kuttner and Lorincz (1967) suggested that drunkenness allows Sioux individuals to display aggressiveness that is under control when they are sober. This aggressive behavior often results in fights and acts of violence. The final state is complete comatoseness, called "passing out" by Lakota in reservation vernacular. This stage—passing to an ultimate state of stupor—does not exactly correspond to Kemnitzer's states of drunkenness. His documentation of drunken states at Pine Ridge sequences them as follows: "initiating a party," "first animation," "slightly high," "tipsy," "happy," "depression," "indignation," and "fights" (1972, pp. 139-140).

The Lakota themselves do not have such elaborate distinctions, but certain stages of inebriation can be identified. These linguistic categories show the differences in indigenous perceptions of the drunken states. Jules-Rosette (1978, p. 570) posited that descriptive vocabularies "both alter the experience through indexing it and are transformed by the experience." This description is especially apt when the vocabularies of both Lakota and English are juxtaposed to depict stages of inebriation. The emic elements of drunken behavior can be outlined as follows:

STANDARD ENGLISH	VERNACULAR ENGLISH	LAKOTA DIALECT SIOUAN
Non-intoxicated	"Sober"	*Ito mani sni* (Drunk not) *T'an ables ya na un* (Composure having)
Slightly intoxicated	"Getting Tight" "Feeling Good" "Getting High"	*Ag'a* (Wavering, uncertain) *Ki tan la o waste' sni* (Slightly not well, not in good shape)
Intoxicated	"Drunk" "Gone" "Polluted"	*Ito mani*** (A contracted form of *Ito kes kes omani* in an unusual way, walking) Presently, these translations are given: to stagger, reeling, spin, and get dizzy *Tuktel iya ye* (Where gone is unclear) *Ti yes ni* (Not at home)
Comatose	"Passed out" "Dead drunk"	*O t'e* (Dead) *O t'e xpi ya* (Deadly sleep) *O t'e ito mani* (Dead drunk)
Delirium Tremens	"The shakes" "D.T.'s"	*Chan chan un* (Shaking, in state of)
Hallucinations	"Seeing snakes"	*Skan skan wa yanke* (Moving things are seen) *Zu ze cha wa yanke* (Snakes are seen) *Taku t'ok t'okcha wa yanke* (Strange things are seen)

* In the literature on bilingual education, vernacular English is often referred to as "Reservation English," "Indian-English" or "Red English." Native languages are often called "Indian" by native peoples themselves; thus, one hears the phrase "speaking Indian."

** Riggs (1851, p. 96) translates *i-to'-ho-mni-* as an adjective, "dizzy, light-headed, drunk."

It is readily apparent that the Lakota utterances evoke the experiences described. Native referential terminology is different from the White mode when the Lakota discuss drinking among themselves. The gloss "alcoholic" is a term borrowed from the health practitioners on the reservations and is used to describe someone who is habitually drunk. To any other person who drinks occasionally, it is usually stated that "he or she drinks," or in Lakota *yat ka'un* (He, she, it drinks). If a person drinks alcohol frequently, one says in Lakota *ito mani s'a* or "that person gets drunk." The English term "alcoholic" refers to one who purchases alcohol when money is available and then becomes drunk. That this pattern is usual and predictable is given. The median income for males on Standing Rock Reservation for 1970 was $1,861.00 and for females was $1,447.00 (U.S. Department of Commerce, 1970, p. 163). The general lack of money makes continual drinking impossible, and is pertinent to the "binge" drinking syndrome. It is also an adaptive feature. The sporadic nature of drinking at least allows Lakota persons to maintain regular nutrition programs and thus does not foster alcohol-related malnutrition. Cause of death among Lakota persons is often diagnosed as cirrhosis of the liver. The vernacular is simply "cirrhosis" or in Lakota *pxe-shica*, "bad liver."

Social Controls

Among the Lakota, though one's being is bound up in kinship (Deloria, 1945; MacGregor, 1945; Mirsky, 1937; Schusky, 1975), coercion or control by kin is seen as a transgression against the individual. Moreover, alternative forms of social control are weakly developed. These mechanisms, which once took the form of *akicita* (soldier) societies, were formulated to meet certain specific needs, i.e., regulation of the hunt. Some aspects of the ritual cycle were eradicated in the early reservation period, which, together with the disappearance of the hunter and warrior roles, render traditional patterns of male self-actualization almost impotent. The *akicita* societies were replaced by Agent-appointed police who were called *maku maza* (Metal Breasts), and were seen as enemies rather than peace-keepers. The name and attitude still apply to the tribal police of today.

Field's (1962) arguments regarding relationships between social structural features of traditional societies and drinking behavior are relevant. In his critique of Horton's research on anxiety, Field concluded that "drunkenness in primitive societies is determined less by the level of fear in a society than by the absence of corporate kin groups with stability, permanence, formal structure, and well-defined functions" (1962, p. 58). He based his initial hypotheses with regard to sobriety upon assumptions about the role of "solidarity and respect." He speculated that individuals in closely-knit

societies that operate on respect for authority tend to drink moderately and act passively when drunk. The Pueblo societies of native North America are a ready example to contrast with the loosely structured societies of the northern Plains. Yet it seems that Lakota do not currently think of drinking as a problem, whereas recent reports on the Hopi (Levy & Kunitz, 1974) indicate that, at the present time, the Hopi evidence a high incidence of cirrhosis of the liver. The latter appears to be due to solitary and sustained drinking, as opposed to Lakota patterns of imbibing which tend to be sporadic and enthusiastic, without sanctions from the kin group, or community at large. It still is not clear, but one can surmise that the "binge" or "spree" drinking episodes of the Lakota do not result in a flagrantly high rate of cirrhosis of the liver. The fact that drinking periods are tied to availability of funds mitigates a persistent pattern of imbibing. Indeed, economic limitations have also been noted by other researchers (Leland, 1976). Field's speculations are based on coded materials drawn from an analysis of early cross-cultural studies (Field, 1962; McClelland, Davis, Kalin, & Wanner, 1966, 1972; Whiting & Child, 1953), which were in turn derived from the Human Relations Area Files and therefore are subject to the biases of these source documents. However, there is no denying that a loosely-structured, less well-defined social organization, coupled with diffused authority, is more likely to allow drunkenness among its members. Control predicated on kinship relationships is noticeably lacking in such groups as the Lakota (Goldfrank, 1943; MacGregor, 1945; Mirsky, 1937).

Despite the common and unquestioned bit of folk-wisdom that "all Indians are drunks," there have been many persons—males and females—of Lakota ancestry who have not been drinkers. Though the number of teetotalers is declining, they generally range from 35 to 80 years in age. The Lakota women are the largest group in this segment. Some women in their 70's have never tasted liquor, except sacramental wines. These persons fit in the category of total abstainers. There are other women who drank in their youth, but who, upon reaching ages 35 to 40, stopped entirely and voluntarily. There is only one woman, age 55 who was a "heavy drinker" and stopped. She became a Mormon. Of the 10 persons in one community of 90 adults who were converted to Mormonism and became abstainers, following the non-alcoholic code of their new faith, four persons (one married couple) began drinking after two years of achieved sobriety. They explain their lapses as becoming "Jack Mormons."

By what means do the persons who, in reservation parlance, are the "confirmed drunks," "habitual drunkards," "alcoholics," or *ito mani k'tca*—the "supreme or ultimate drunks," achieve a continuous sober state?

When Lakota regard individuals who have previously been drinkers of intoxicants, they state, *wana yat k'e sni*, "Now, that person does not drink." Sobriety is envisioned as a state that a person elects to reach by self-determined action and a very conscious plan. This state is known as *puza* or "dry," which metaphorically means "does not take in any liquid"—the liquid refers to alcoholic beverages. The path through which this sober state is reached is the exercise of *chin ka cha*, which best translates as "personal autonomy" and is often heard in reservation English as "will power." This sober state is appreciated, but is not widely acclaimed—as, for example, being a good "traditionalist," being generous in giving feasts, or being a good war dancer. It appears that being "reformed"—as some Lakota say—has been a part of the maturation process that men have followed. It is not a predictable event. White (1970) mentioned "reformed" friends of the male clique in Rapid City, but did not define this status. Among the Standing Rock Sioux, "reformed" usually means that one has given up the habit of drinking. The prevalent folk view is that being "sober" means "not drunk." Being "reformed" is the complete non-use of intoxicants. The "cured" state is seen as a permanent state reached by persons who heretofore had been heavy drinkers. They are described as "staying sober," or *yat k'e sni.*

Abstinence and Controlled Drinking

Drinking alcohol, simply called "drinking" or *yat kan*, and abstinence, are distinct from the state of sobriety described above. The former means to drink in a social manner initially, but with the possibility of turning into a prolonged bout or "binge." This involvement depends upon the *chin ka cha* configuration of the individuals who might be involved. Abstinence is not drinking at all. Seldom are these Lakota persons participants in the group events of drinking. In some drinking groups, the pressure to imbibe may become intolerable. Statements such as "You think you're too good to drink with us," or "I didn't know you're a *wasichu* (White person)," or "So you're not a Lakota anymore," are examples of pressures to drink which can be unnerving to non-drinkers. In other drinking groups, if one states that he (or she) does not drink, he is seldom pressured to imbibe. This is not a usual pattern, however.

The major orientation of individuals to sharing and toward immediate gratification may override the consideration for control of drinking. Periodic "falling off the wagon," as the Sioux label a "slip," occurs. It is usually coincident with the first of the month, or the payment of leases within a kinship group, usually in December. For most persons, the resumption of drinking indicates that

periods of non-drinking are of a temporary nature. These periods are also difficult to distinguish from times when money is lacking.

Abstinence is seen as "never drinking," as in the Siouan *yat k'an sni.* Thus, the Lakota notion of abstinence indicates that a person has never indulged in alcoholic beverages and maintains this stance. Abstinence can cost dearly. Consider the following for another Native group:

> However, except for a number of women, there are few abstainers among the Naskapi. In fact I knew of only one adult male (sixty-five years old) who claims never to drink and whose claim is substantiated by others. Furthermore, he is a virtual recluse whose most frequent interactions are with some older Montagnais who, as far as I could gather, do not drink either. (Robbins, 1973, p. 109)

Quitting Drinking and Pressures

Women tend to stop drinking by the time they are 35 or 40 years old. This is explained simply by saying that they are *winyan tanka* ("women, big") which has connotations of "maturity" in Lakota. When pressed, they indicate that they are "too old to drink" or that "their children are grown, now." Some mothers say that when they attempted to reprimand their children about drinking, their past drinking days were used to negate their admonitions. Therefore, they feel that if they are to control their children, they should set an example. Maintenance of sobriety is not a difficult task for the majority of them.

As for the Lakota males, some of them also begin to "level off" in their drinking by age 40 onward. Some become complete non-imbibers. The most common response to the question, "why did you quit drinking?" from the men who have achieved complete sobriety is, "I was tired of drinking and carousing." Many of them indicate that sobriety is not an easy road to follow. They specifically mention the taunts by the drinkers who urge them to drink with them, the lack of support groups, the loneliness initially encountered and the "lack of friends." Many of them report that the ridicule and disbelief in their new status is equally onerous from the White people in the towns. One informed me that when he went into the trading center, he was most often greeted with, "Well, chief! I remember when you used to drink!" He responded, "Yes, and I was a better drunk than you were!"

Folk beliefs and sobriety. Few folk beliefs exist about the onset of uncontrolled drinking among the Lakota today. A major deterrent used by the "full-bloods" invokes the concept of *wacunza* or "to cause harm." Grobsmith (1974) interpreted this concept as "immanent justice." A native interpretation is that an implicit and always unspoken consequence of an untoward act is to bring misfor-

tune upon someone by one's action. Thus, if children cry needlessly or for no obvious reason, they are told that they are going to *wacunza* someone in their family. When one who has not been drinking (in a sober state for some time) begins to imbibe alcohol, or if one who has never drunk liquor begins to drink excessively, the person is told that *wacunza* will result. This uncontrolled behavior is also thought to result in the injury or death of a closely related member of the *tiospaye*. A segment of the population also believes that excessive drinking after the death of a loved one can result in the habit of constant drinking. This is called *ah' yah*—"to make habit-forming." Most traditional Lakota will not drink for a year, or at least six months, after the death of closely related kin.

Some women believe that excessive drinking can cause miscarriages or stillbirths; however, a majority of women do not drink during a pregnancy. For some, this may be a time when they give up drinking entirely. A few young women in their 20's who were carrying illegitimate children, often drank excessively but did not state a reason for this.

Dimensions of sobriety. Dimensions of sobriety and abstinence from intoxicants are seldom mentioned in studies on Siouan drinking. Therefore, Whittaker's work is extremely pertinent. Religious beliefs or ethical considerations have often been stated as reasons for non-drinking by many people. Among the Standing Rock Sioux in 1961, only 9% of the abstainers indicated these reasons (Whittaker, 1963, p. 81). Some respondents offered health or efficiency as a reason for sobriety. However, 47% of the Sioux sample could not offer an explanation for **not** drinking. In his report to the tribe, Whittaker noted:

> Forty-seven per cent of the Indian group either could not, or would not give a reason for abstaining. Discussions with Indian leaders concerning this and the large numbers of drinkers who did not give a reason for drinking revealed the general concensus that these people had very likely never given the matter much thought. (Note 2, p. 29)

His study group consisted of formerly heavy drinkers: 26% of the Indian abstainers had previously indulged in drinking four or more times a week. Forty-three percent of those who later abstained reported having stopped drinking between the ages of 20 and 40 years old.

In answer to the question, "How can an alcoholic stop drinking?" 73% of Wittaker's respondents answered that it simply took will power; 21% thought the drinker would require help, and 6% thought religion would be the answer (p. 83). The emphasis on "will power" is striking. It is the closest English vernacular term for the Lakota concept of *chin ka cha*, which, as noted previously, is best understood as self-actualization or exercise of personal autonomy.

Whittaker was struck by the lack of social controls to mitigate excessive drinking. He stated that the drinker was not punished; any deviant or unusual behavior that happened while drinking was excused, and the drunk was incorporated immediately into the group. In reference to an earlier description of male superiority in Siouan society, he noted that women were expected to remain with a drinking spouse. Moreover, "beating a wife when drunk was not disapproved by over a third of the respondents" (Whittaker, 1963, p. 85).

The following observation by Whittaker is also important to this discussion:

> Questioned about attitudes toward abstainers, 58 per cent said they thought a person who refrains or refuses to take a drink is "commendable," 14 per cent did not care one way or the other, 17 per cent either did not know or expressed no opinion, 3 per cent were hostile to such a person, 5 per cent thought this must be a person of great will power, and 3 per cent said they had never seen anyone refuse a drink and hence could not answer the question. (Whittaker, 1963, p. 86)

Not caring or not knowing, which suggests non-interference, hostility, and reference to "will power" are reflective of Sioux attitudes toward alcohol consumption.

"I GOT TIRED OF DRINKING. . . "—INTERPRETATIONS OF INTENTS AND CONTINUITIES OF SIOUAN SOBER STATES

"I got tired of drinking" is a recurrent theme throughout many of the explanations given by Lakota persons as to why they stopped drinking alcohol. This phrase in English is a direct translation from the Lakota term *ta watl yesni*, which was elicited by two psychologists on Standing Rock Reservation (Johnson & Johnson, 1965). They interpreted it as signifying: to be "totally discouraged." The native term is more appropriately transcribed as "tiredness" of an obnoxious situation or as "approaching with dread." Placed in the context of alcohol use, it can be interpreted either in Lakota or in reservation English as simply deploring the life of drinking alcohol. Rejecting a life of dissonance and dissipation due to drinking and attempting to assume a more productive life is at the heart of this process. A major question is: how do Sioux Indians restructure a defensible self-image after a long period of alcohol use and abuse?

Braroe (1975), writing about the Cree of Canada, observed that:

> Feeling guilty for transgressing a moral rule is not the same as being guilty. One feels guilty when one's action is felt as a blemish on the inner self, when one has violated standards that are accepted as part of one's identity and are used to evaluate one's own moral worth. Obviously, Indians do not experience the guilt that Whites associate with their own

> drinking and readily use to evaluate Indians' drinking. There is one very revealing exception to this pattern. During the Sun Dance liquor is forbidden, and no one present in the circle of tents around the sacred lodge may possess or consume it. This rule is observed and enforced by the majority of the band; and the few who break it are scolded, a sanction apparently strong enough to dissuade infractions by most of the community. This is the sole occasion on which drinking appears to be a source of guilt on the reserve. When I asked why alcohol was forbidden at this time and at no other, an Indian man replied positively: 'Because the Sun Dance is an Indian thing and drinking is a White thing' (p. 141)

This passage illustrates the compartmentalization that allows Indians to co-exist with non-Indians in separate socioeconomic and ritual spheres.

It is apparent that guilt or shame are not effective means to discourage Lakota drinkers; a period of self-assessment and a re-evaluation of directions in one's life is necessary. Although Levy and Kunitz (1974) attributed a lack of introspection to the Navajo male drinker, they nevertheless indicated that many Navajo men stop drinking at middle age and do it without apparent external coercion or difficulties on their part. Levy and Kunitz wrote: "Aging itself causes a cutting down of drinking" among the Navajo. Further, they stated, "In any event, the high proportion of Navajo males who have quit after years of heavy drinking leads us to question the chronic addictive nature of 'Indian alcoholism'" (1974, p. 137).

Aging does not seem to be as important a variable in Siouan sobriety, although it has some relevance. In fact, there are a few women (three) who began to drink for the first time in their lives in their late fifties and early sixties. This was unusual, however, and was tied with the loss of close kinpersons. As for Lakota males, many continue drinking to the very end of their lives. No great censure is directed at these aged drinkers. Some community members say, "Well, they have nothing to look forward to."

Therefore, the assumption of a sober state as a new way of life is a highly idiosyncratic act for Lakota individuals. Withdrawing from the world of drink on all Lakota reservations and social groups is a very painful process. Peer pressure is extremely intense. Social isolation is a price one must pay by selecting this alternative way in order to insure the continuance of abstinence. Extreme pressure is applied to force persons to begin drinking again. A reformed drinker mentioned that the "hardest part of being sober is the loss of friends." Courage and a certain self-isolation seem in order for the maintenance of sobriety.

Lakota Self-Analysis

A period of introspection or an increased awareness of self occurs

in the move to sobriety. One native term which is used to describe this phase—*ah wa bleza ki*, to examine one's self—means to cogitate or to become introspective. This term involves a type of "self-analysis" within the indigenous frame. It has great implications for a change in behavior and is based upon the psychotherapeutic beliefs of the Lakota people. When one seeks advice from a native practitioner *wa pi ya* (curer), *wi cha sa wakan* (holy man) or *winyan wakan* (holy or sacred woman), and asks for aid—for either physical or mental disturbances—the supplicant is asked to *ah bleza* (examine) one's actions. The underlying premise here is that unless one is able to cogitate upon one's actions, and place some perspective upon these acts, one is unable to deal with problems that are believed to be based in interpersonal relationships. If one is perturbed by the actions of another in a stressful situation, one might describe this for the practitioner, who very frequently states, "*Tok'sha, he ah bleza ki,*" or "Eventually, the person who is causing distress may examine his/her acts and will rectify the situation." This, admittedly, is a very diffuse modality. The process places the burden of remedial behavior upon self-actualization and the character of the person who causes the dissonance. This is the ultimate focus upon individual autonomy (*chin ka cha*), which is characteristic of the Lakota Sioux. There is no force outside the individual, such as *wakan* (sacred, omnipotent power) or slight feelings of guilt, via the Christian ethic, that places the responsibility upon the individual to change. The attempt to effect change resides entirely within the individual. This, then, may offer an explanation as to why many Sioux relate an achievement of sobriety to "will power." The great emphasis on individualism, or at least individual decision-making, as to one's life and behavior are tied to these concepts of personhood. This may also explain the lack of controls that exist beyond the individual and why kinfolk elect to remain apart from the control apparatus when it comes to drinking and non-drinking behaviors. The entire decision is placed upon the individual. The person is also allowed an unstructured freedom of choice by the equally significant term, *chin ka cha*, which has connotations of "he/she prefers to be that way." When these terms are used, they signify that no force outside the individual is able to intervene and effect significant change in the person's behavior. This is a delicate issue, for the Lakota person might at any time *wa chin ko* (most commonly translated as "to pout") and withdraw. This concept has been developed more explicitly elsewhere (Note 1; Lewis, 1975).

It appears, then, that intervention and behavior modification, which is the crux of sobriety, are self-induced and constructed in such a manner as to withstand the pervasive, calculated and continuous pressure of a peer group, beginning with adolescents and continuing with age-sets that are like the *kola*-ships (friendship or clique

groups) that continue in contemporary Lakota life.

Ceremonies and Abstinence

There are specific times when Lakota people do not imbibe. Religous events, whether native or Christian, are times when sobriety prevails. Other times are during certain rites such as naming ceremonies, birthing times, or funerals. Any untoward drinking is certain to bring censure upon the offenders by the *tiospaye* members and gossip from the community. Men never drink when hunting. Many of the more traditional men utilize charms and certain roots during this event and liquor is forbidden. The prevailing pattern of White behavior is assumed by the more acculturated when fishing: men, and sometimes women, drink beer at this time. Utilization of alcohol is exceedingly prevalent at rodeos where Whites and Indians interact. This appears to be a pattern cross the Northern Plains (Braroe, 1975). Drinking, though often officially banned, is common at pow wows. These are largely social events on the reservations and in urban areas. As is common in the larger society, alcoholic beverages are now assuming importance at birthdays for adults, weddings and divorces.

The Sun Dance ritual and other older ceremonies, as the *Uwi pi*, which is a curing ceremony, forbid the presence of anyone who has used alcohol. The smoking of anything (specifically *pezi*—which translates as "grass", i.e., marijuana) except the sacred tobacco is also proscribed. These rules are strictly enforced and anyone with a suspicious odor—even of perfume—is usually turned away from the ceremony. Participants in these ceremonies are not supposed to drink alcohol. But this is not rigidly enforced—nor can it be—in their daily lives away from the ritual cycle. There are instances (outside of the ritual cycle) in which many of the newly-emerging "medicine men" have been intoxicated on their speaking tours to universities or in their lives on reservations.

It is obvious, however, that some persons participate in the Sun Dance for therapeutic reasons, as those persons of Lakota heritage do, to seek a transformation of the individual. The search for supernatural aid to eliminate dependence upon an intrusive and abusive item—alcohol—is a new departure in the ritual. This is a variant from the previous function, which was the preservation of the social order and participation primarily for the welfare of the group. This buttresses Jorgenson's (1972) analysis of the Sun Dance of the Ute and Shoshone, which is seen by the participants of many tribes as an alternative to drinking and a means of possibly achieving rigorous temperance.

Besides serving other functions—prestige and honor in participating, status in scarification marks, compassion for the people by offering prayers, enhanced Indian identity—for the contemporary

Indian male, "sun-dancing" is a means of controlling excessive use of alcohol. A revitalized ritual, the Sun Dance is not completely integrated into the symbolic belief structure of the Sioux. As a repressed religion, with the underlying structure of native language and value systems also suppressed, complete integration and manifestation of belief are still being formulated—especially on an individual level. Increasingly, it is becoming a Pan-Indian or inter-tribal phenomenon, with other tribes—Shoshone, Cree, Micmac, and others—also seeking enlightenment in a native faith. Moreover, the Sun Dance is a regularized event performed on an annual basis. It may, however, occur in various places on the Sioux reservations during the summer months. Though an intense rite, and evocative of deep religious feelings, it is not of sufficient duration to have lasting effects as a mechanism of alcohol control. Participants come from different Sioux reservations and there is little *esprit de corps* or continual intensification. There is no sustained support system that might function throughout the year in isolated Lakota communities or in urban areas.

Some Lakota persons, again, most often males, attend the *Yuwipi* ceremony as a means of obtaining help for their drinking problems. Though this is primarily a curing and/or clairvoyance ceremony, depending upon the wishes of the initiator or patient, there are reasons for its performance. Participants in the ritual, besides the patient, ask for help by supplicating and imploring the *Wakan Tanka* (Great Spirit) and supernatural spirits. Kemnitzer (1978), in reference to the Oglala Sioux, indicated:

> Others also ask for help; people who had lost things, people giving thanks for previous help, men worried about a wife's illness, and women worried about their husband's drinking. (p. 3)

A *Yuwipi* ceremony may be held specifically for a person who has a drinking problem. This is usually activated by his parents or members of his kin group. All persons present meditate on his problem and pray for him. However, if the ceremony is held for drinking control or anything else, any person present may ask the supernatural spirits for aid to curb his drinking problem. There is no evidence that anyone was cured through this rite. It is, nonetheless, the only indigenous support system besides the Sun Dance. Many persons attend the *Yuwipi* to call attention to the fact that they are cognizant of their drinking problems. The religious practitioner does not assume an active role in the treatment of the person who publicly acknowledges his affinity for alcohol. He merely requests supernatural aid.

When individuals of either sex seek aid from a religious practitioner or native counselor, the person does not receive stringent di-

rections for change. He or she is simply asked to *ah bleza* one's actions and implement change. There is strong emphasis on *chinka cha* (individual autonomy) and reason and will to change. The therapist listens, and may give advice in a non-threatening non-judgmental manner.

PURSUING THE SOBRIETY CAUSE

Since the 1970's, governmental agencies and tribal governments and Indian associations, such as the National Congress of American Indians, have expressed concern over the "problems" of alcohol use. Major emphasis has been on intervention strategies.

The states of abstinence and sobriety in contemporary native societies have not been examined. However, patterns of abstinence have been historically evident. This fact has been outweighed by attributions of anomie or blurred by noting only a disadvantaged position in the social structure of a superimposed society. Concerned native peoples seem to have subscribed to the "problem" orientation and have not looked to non-indulgence. As seen from the Lakota Sioux data, native beliefs of expected behavior based upon gender considerations, i.e., male superiority and female subservience, are powerful forces at play in contemporary indigenous social systems.

Sobriety as an achievement seems based upon an enhanced awareness of self and society and certain introspective processes. Age, sex, status and economic state are important considerations.

But the social climate is also significant. Social movements and positive nativistic orientations may create a means to control drinking and assert abstinence patterns. After generations of cultural suppression and forced acculturation to the dominant society, it is only since the 1960's that a conscious revitalization movement has assumed ascendancy in most Sioux reservations and urban Indian enclaves. Allied to this resurgence is the belief that alcohol is an introduced evil that was part of the genocide and ethnocide policies of the conquerors. This is a subtle orientation, verbalized in other contexts such as the American Indian Movement and other protest organizations. The ideologies of these new movements are important in current Indian life. Voluntary organizations such as the National Congress of American Indians and the recently formed North American Indian Women's Association have also delineated the problem of alcoholism among their constituencies. They often manifest their concern by giving workshops on the problem. Of significance is an increasing native awareness of the alcohol problem in Indian communities. This heightened consciousness and spirit of self-determination may be positive forces in sobriety maintenance.

NOTES

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DISCUSSION

Maxine Robbins: I'm impressed with the paper in terms of content. This would be extremely useful, valuable as a means for sharing, particularly with alcoholism workers and mental health counselors. . . Fortunately or unfortunately, as Bea points out in the paper, there's a tendency to believe that only alcoholics, recovered alcoholics, or sober alcoholics can help non-sober alcoholics. . . I'm most impressed with the notion of exploring sobriety either from the standpoint of people who have never drunk or people who are recovered alcoholics. In this sense, this is promotion of good mental health; we tend to do just the opposite. We talk about the number of alcoholics that we know and we don't talk about, define, or describe the people who don't drink or who drink a little, in control.

Spero Manson: The kind of material that Bea presents, in terms of perspective as well as specific content, is sadly lacking in many if not all mental health training programs, regardless of discipline. She describes the **context** of alcohol use and abuse within a particular Indian community. Bea traces the ethnohistorical antecedents to the introduction of alcohol in Indian and Native societies. She points out, and most of us would agree, that reference to "the" American Indian, and an accompanying disregard of tribal heterogeniety, has obscured intra-tribal differences in the social and cultural matrices in which alcohol is embedded. In this respect, Bea outlines the linguistic and cultural frames for alcohol consumption among the Lakota, illustrating its special meaning for this group. She briefly reviews the wide variety of theories and research methods that have characterized the study of Indian drinking and convincingly argues that little has been contributed to our understanding of the meanings of tribal-specific patterns of imbibing. The last, and, from my point of view, most important aspect of her paper concerns the Lakota individuals who have achieved and maintained sobriety after years of heavy drinking. Here Bea gives us a rare glimpse at the social dynamics and personal dilemmas involved in continued sobriety in Indian communities. Moreover, she focuses on **sobriety**, not alcoholism per se, and describes how Lakota people develop certain competencies with regard to managing this area of their lives. This is the "stuff" of which prevention training should be made.