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EDITORIAL

This issue of the journal contains three articles. "A Pilot Study of Depression Among American Indian Patients", by Shore, Manson, Bloom, Keepers, and Neligh, reports the results of the first phase of a multi-stage study of depression that employs convergent diagnostic procedures with patient and matched community samples drawn from three distinctly different culture areas: the Plains, Plateau, and Southwest. In the paper at hand, the authors describe and compare symptom patterns generated by the administration of the Schedule for Affective Disorders and Schizophrenia (SADS-L) to index patients (N=86) recruited from local mental health programs. This effort represents the first systematic application of DSM-III diagnostic criteria to this special population. It seems clear that diagnostic tools of this nature can be used in a reliable fashion, but not without close attention to the cultural factors that may affect the patients' interpretation of the questions asked of them. A number of clinically meaningful insights also emerge, particularly in regard to the cross-currents of depression and related disorders among American Indians. Further inquiry along these lines is needed in order to assess the psychometric properties of diagnostic protocols such as the SADS-L, which mark the current state-of-the-art, and to move the field past a historical reliance on non-criteria based measures of psychiatric status.

"Urban Indian Psychiatric Patients in Community Care", by Peters, examines the characteristics, problems, and service utilization patterns of Indian psychiatric patients under care through an extensive community program for the chronically mentally ill in Vancouver, Canada. Drawing upon a recent survey of the primary therapists of all active patients, the author contrasts the resultant sample of Canadian Indian patients (N=25) with a subset of Anglo patients (N=100) who have been matched with the former on the basis of sex, age, educational level, and employment status. His results clearly demonstrate that Indian psychiatric patients experience greater socioeconomic deficits, are more prone to suffer from substance abuse, act violently significantly more often, move more frequently, but in tightly circumscribed areas, and present greater difficulties for community placement than their Anglo counterparts. Peters offers several suggestions for adapting community psychiatric programs to the unique characteristics of this patient population. Hopefully, more thought now will be given to these individuals, who are so visible on the streets of our major cities, yet about whom the literature has, until now, remained virtually silent.

The third article, "Cultural Lessons for Clinical Mental Health Practice: The Puyallup Tribal Community", by Guilmet and Whited, represents a departure, in terms of length as well as narrative style, from the pieces which typically appear in this journal. The authors highlight, through examples drawn from the tribe's

Kwawachee Mental Health Counseling Center (KMHCC), the importance of a cultural perspective on an array of issues that frequently emerges in the context of Indian and Native treatment programs. These issues revolve around such matters as cultural maps, family structure, ritual and ceremonialism, value conflicts, and interactional styles. Guilmet and Whited illustrate, by frequent reference to program experience, how KMHCC staff apply local knowledge in enhancing the acceptability of care offered, in facilitating access to alternative treatment resources in the broader community, in accommodating cultural restrictions on reporting dysfunctional behavior, and in negotiating a fine line, therapeutically, between assistance and interference. Though lacking the empirical weight of quantitative studies, this article nevertheless quickly moves the reader into the emotional and cognitive fabric that characterizes clinical work in these settings.

Spero M. Manson, Ph.D.
Editor-in-Chief

Call For Papers

American Indian and Alaska Native Mental Health Research

The editors of the Journal of the National Center invite the submission of papers, articles, reports, and other unpublished material that focus upon the psychological well-being and functioning of American Indians and Alaska Natives. This scientific refereed journal, published three times annually, contains articles which make a significant contribution to basic and applied research in any field of the behavioral and social sciences which relate to this special population. Interested authors should refer to "Guidelines for Contributors" at the back of this issue for further information.

A PILOT STUDY OF DEPRESSION AMONG AMERICAN INDIAN PATIENTS WITH RESEARCH DIAGNOSTIC CRITERIA

JAMES H. SHORE, M.D., SPERO M. MANSON, PH.D., JOSEPH D. BLOOM, M.D., GEORGE KEEPERS, M.D., GORDON NELIGH, M.D.

ABSTRACT. In a pilot study of depression among American Indians, 86 patients from three different tribal cultures were evaluated utilizing systematic diagnostic criteria. Similarity of symptom patterns was greater than differences between those patient groups drawn from the tribes and in comparison to non-Indian patterns of depression. Among the Indian patients major depression occurred in three distinct subgroups: an uncomplicated pattern, a secondary depression in association with a past history of alcoholism, and a complicated depression superimposed upon an underlying chronic depression or personality disorder. Each of these three disorders requires a distinctive diagnostic approach and each disorder may be influenced by cultural factors.

High rates of depression among American Indians have been widely reported by treating clinicians (Shore & Manson, 1981). In addition, increased suicide rates among certain Indian tribes have been confirmed by various investigators (Shore, 1975; Kraus & Buffler, 1979; Levy & Kunitz, 1971). These findings have been attributed to rapid cultural change, epidemic patterns of alcohol abuse, increased rates of physical illness, accidents and deaths, and demoralization secondary to enforced dependency. This paper reports the first phase of a research project on major depression in three American Indian tribes. The study was designed to explore the relationship of depression to several of the above conditions.

Many examples of cultural influence on major mental disorders, including depression, have been reported among American Indian tribes (Shore & Manson, 1981). For example, Miller and Schoenfeld (1973) described an increased incidence of depression among the Navajo which they attributed to unresolved grief reactions that are more prevalent among the Navajo than other populations. Navajo culture was hypothesized to predispose the individual to unresolved grief by limiting mourning to four days, a prohibition which may stem from a sanction against the expression of anger and a general fear of the dead. Miller and Schoenfeld (1973) speculated that the limited mourning period leads to an exaggeration of normal grief which contributes to depression in Navajo patients different from other Indian and non-Indian patients. Another example involving cultural dynamics of a slightly different nature has been reported by Jilek (1974) as anomic depression among Coastal Salish Indians of the Pacific Northwest. In

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this condition overwhelming stress from rapid acculturation and loss of traditional identity leads to a state of chronic depression.

Regardless of etiology, mental health practitioners, both Indian and non-Indian, have observed a high prevalence of depression and suicidal behavior in Indian patients. One-third to one-half of all patients visiting IHS mental health outpatient clinics have been treated for symptoms of depression (Shore & Manson, 1981). The majority of depressed patients, like those in the dominant culture, are females between 20 and 40 years of age.

These studies suggest that the pattern of depression is influenced by cultural factors specific to American Indians and contemporary pressures of rapid social change. In order to further explore the diagnosis and treatment of this condition, a valid method of identifying depression within this special population is required. This need defined the major goal of the present study.

Methods

Study Purpose and Design

A multi-stage study was conducted to develop a culturally sensitive diagnostic instrument to be used for community-based psychiatric case-finding and treatment evaluation. In the first stage the Schedule for Affective Disorders and Schizophrenia-Lifetime Version (SADS-L) (Endicott & Spitzer, 1978) was utilized to identify index cases of depression. The initial results of the SADS-L interviews are reported herein. This represents the first attempt to assess and compare systematically patients from different American Indian tribes using established research diagnostic criteria.

Study Sites

The overall design of the study was intended to allow intertribal comparisons of a diagnostic instrument for depressive disorders. Consequently, three American Indian reservation communities were chosen to contrast diverse social, religious, political, and linguistic backgrounds. Their selection was a function of our desire to compare different cultural areas, of population size, and of community interest in participation. These three communities are referred to as the Plains, Plateau, and Pueblo tribes. This convention is adopted to avoid identifying the study sites which, because of their small size, may be singled out mistakenly as examples of widespread psychiatric problems.

The Plains reservation site is occupied by a single tribe with distinct bands situated in the northern Midwest. The reservation covers a large land mass of rolling prairies, interrupted by numerous rivers, valleys, and hills. About 6,200 tribal members and slightly more than half this number of non-Indians live on

the reservation. The bulk of the health and mental health services are delivered through the Indian Health Service (IHS) hospital and clinic located in the main reservation town. Part-time satellite clinics extend services to the outlying areas. Long standing social and cultural change have eroded traditional subsistence patterns, language, and religion. Nevertheless, some indigenous healing practices and ceremonies such as the Sun Dance quietly continue.

The Plateau reservation site is located in the Pacific Northwest on a large tract of land that extends from the Cascade Mountains to the arroyos of a semi-arid central plateau. The reservation is comprised of several tribes with a total population of 4,000 people. Health and mental health services on the reservation are delivered through a combination of tribally-operated and IHS outpatient services. The nearest hospital is located off-reservation in a rural town. Even though tribes of the Plateau study site have been subjected to a long history of acculturative pressure, some aspects of the traditional ceremonial life have remained intact and are undergoing revitalization.

The Pueblo reservation site is situated in the Southwest on land dominated by large mesas. The reservation is relatively small, when compared to the Plains and Plateau sites. There are 8,000 tribal members living on the reservation. An on-reservation IHS hospital and outpatient clinic provide medical and mental health care. Like the Plains site, part-time satellite clinics offer limited services to residents living at some distance from the hospital. This tribe is very traditional, having long resisted social and cultural change. Traditional healing thrives, along with an active ceremonial life.

At each reservation a local site coordinator was selected from the tribal mental health program. Tribal and IHS permission were sought and obtained. A procedure to protect human subjects was approved at the sponsoring institution. The local coordinator, together with physicians and other mental health workers, identified cases who were suspected to have depressive disorders and who recently had been in treatment. These patients were approached and more than 90% of them on each site agreed to participate. The initial design called for an equal number of male and female patients to be drawn from each tribe. Since Indian men significantly underutilized mental health services, this sampling strategy proved unrealistic, and the design was modified to permit a larger number of female patients to be interviewed.

Inter-Rater Reliability

The SADS-L was selected as the standard for establishing criterion validity. Since the study required diagnostic assessments by multiple interviewers across different sites, an inter-rater reliability test of the SADS-L was conducted involving the four research psychiatrists (Shore, Bloom, Keepers, and Neligh). All were members of the Department of Psychiatry at the Oregon Health Scien-

ces University, were involved actively in service and research with American Indian communities, and had extensive transcultural experience in this regard. For the inter-rater reliability test, 10 subjects were drawn from the patient population of a local urban Indian mental health program. Each psychiatrist interviewed two or three randomly assigned patients. These interviews were taped and subsequently viewed and rated by the other three psychiatrists.

The degree of agreement among the raters for primary diagnosis was assessed with the kappa statistic. The kappa coefficients of these comparisons ranged between .94 and .79, generally acknowledged as excellent. Kappa coefficients also were calculated for each rater compared with the consensus of the majority for each diagnosis. In addition, an overall kappa coefficient was calculated for each diagnosis. Again, degree of agreement ranged from good (.62) to excellent (1.0) among the comparisons of rater pairs. The overall kappa coefficients for major depressive disorder (.89) and alcoholism (1.00) were excellent. Given the tribal heterogeneity of the 10 patients (six different tribes were represented), these levels of inter-rater reliability proved remarkable and constitute a much more demanding test than if conducted at each culturally homogenous field site.

Results

Between 1982 and 1984 diagnostic interviews were conducted at each site by one of the four research psychiatrists. A total of 104 SADS-L interviews yielded 86 cases of major depression (Table I). There was an equal number of patients from each tribe. In two instances females outnumbered males by almost 2 to 1. This proportion paralleled the predominance of female patients in the mental health clinics. The Plateau patient group showed a reversal of this trend with a larger number of men; referrals were from the predominantly male tribal alcohol treatment program. The average age of all patients was 38; fifty-nine percent had a high school education; fifty percent were married. A higher per-

TABLE I
CONFIRMED CASES OF MAJOR DEPRESSION AMONG THREE TRIBES

	Male	Female	Total
Pueblo	7(24)	22(76)	29
Plateau	17(61)	11(39)	28
Plains	8(28)	21(72)	29
	32(37)	54(63)	86

( ) indicates percentage of rows

centage of males was married (59 versus 44 percent) and a higher number of females widowed or divorced (34 versus 12 percent).

TABLE II
FREQUENCY OF SYMPTOMS IN DEPRESSED PATIENTS

Symptom	Non-Indian	Total Indian	Pueblo	Plateau	Plains
Change in appetite/weight	(90)	74(86)	25(86)	22(79)	27(93)
Sleep change	(95)	79(92)	27(93)	26(93)	26(90)
Psychchomotor agitation or retardation	(80)	78(91)	24(89)	25(89)	29(100)
Loss of interest or pleasure	(100)	78(91)	25(86)	25(89)	28(97)
Loss of energy; fatigue	(97)	65(76)	20(69)	20(71)	25(86)
Feeling of worthlessness/guilt	(90)	74(85)	25(86)	20(71)	28(97)
Difficulty concentrating	(95)	62(72)	22(76)	14(50)	26(90)
Thoughts of death	(73)	72(84)	26(90)	19(68)	27(93)

( ) indicates percentage of symptoms present

TABLE III
PATTERN OF DEPRESSION

	Male	Female	Total
Mean number of depressions	4.1	2.9	3.3
Currently depressed	16(50)	34(63)	50(58)
Average duration in weeks	40	32	35
Hospitalized	11(34)	21(39)	32(37)
ECT	0(0)	0(0)	0(0)
Medication	13(41)	33(61)	46(54)
Delusions	2(6)	2(4)	4(5)
Hallucinations	9(28)	18(33)	27(31)
Voices or visions	2(6)	1(2)	3(4)
Suicidal	11(34)	22(41)	33(38)
Pregnancy		9(17)	
Menopause		5(10)	
Somatic treatment preceded depression	1(3)	4(7)	5(6)
Physical illness preced depression	3(9)	3(6)	6(7)
Subject attributed depression to a loss:			
Family death	4(14)	16(32)	20(26)
Other	1(4)	0(0)	1(1)

( ) indicates percentage among all males, females, and total sample

The frequency of the eight major symptoms of depression elicited by the SADS-L protocol is presented for Indian patients in Table II. These symptoms can be compared in turn to those of a non-Indian cohort reported by Kupfer (1983). Table III depicts the pattern of depression for Indian males and Indian females. Indian females evidenced a greater change in appetite or weight and psychomotor agitation or retardation while Indian males experienced greater loss of energy or fatigue. These symptoms were commonly present and occurred in both sexes for 69 percent or greater of subjects. For the Indian sample as a whole, few differences were evident between tribes, the interpretation of which is limited by the sampling method, and, therefore, are not reported.

Sixty-four percent of all cases had more than 1 depression with an average of 3.3 episodes. The age at first depression (mean 29 years) was equally distributed across age groups. Fifty-eight percent of the patients had a current major depressive disorder at the time of interview. The mean duration of all depressions was 35 weeks with a range from 2 weeks to 4 years. Fifty-four percent of the cases had received antidepressant medication and 37 percent had been hospitalized. No case received electroconvulsive treatment (ECT). Hallucinations were present in one-third of the patients. Thirty-eight percent had a past history of suicidal behavior. Eighty-seven percent of the patients had dysphoria for 2 weeks or more. A greater number of patients were treated by medication and hospitalization in the Plains group.

Eighty-three percent of all cases had more than one psychiatric disorder. Table IV presents the diagnoses that occurred in association with major depressive disorder. Males exhibited more alcoholism and drug use, while females had a higher percentage of anxiety, phobic, cyclothymic, panic, antisocial, bipolar, and somatization disorders. In this sample, the Plateau patients -- as expected -- evidenced a higher proportion of substance use disorder, while the Plains patients showed a more frequent occurrence of generalized anxiety, cyclothymia, panic, antisocial, and bipolar with hypomania.

Table V illustrates the association of alcoholism and drug use disorder with secondary depression. Considering life-time diagnoses, 34 of 36 secondary depressions were associated with a diagnosis of substance abuse. Only two secondary major depressive disorders occurred independent of substance abuse. Males had a higher rate of substance abuse than females (75 versus 39 percent).

The occurrence of chronic intermittent and/or chronic minor depression with major depressive disorder has been defined as double depression (Keller &

TABLE IV
DIAGNOSIS OCCURRING WITH MAJOR DEPRESSION

Diagnosis	Male	Female	Total
Alcoholism	24(75)	19(35)	43(50)
Generalized Anxiety	4(12)	13(24)	17(20)
Intermittent	8(25)	8(15)	16(19)
Drug use	7(22)	8(15)	15(17)
Phobic	2(6)	13(24)	15(17)
Cyclothymic	2(6)	9(17)	11(13)
Labile	3(9)	7(13)	10(12)
Hypomanic	1(3)	8(15)	9(10)
Panic	2(6)	7(13)	9(10)
Obsessive-Compulsive	1(3)	6(11)	7(8)
Antisocial	1(3)	5(9)	6(7)
Bipolar with mania	2(6)	1(2)	3(4)
Bipolar with hypomania	0(0)	3(6)	3(4)
Briquet's disorder	0(0)	2(4)	2(2)
Manic	1(3)	1(2)	2(2)
Minor depression	0(0)	1(2)	1(1)

( ) indicates percentage among all males, females, and total sample.

TABLE V
SUBSTANCE ABUSE IN PRIMARY AND SECONDARY DEPRESSION

	Primary Depression	Secondary Depression	Total
Substance Abuse	11(24)	34(76)	45
None	39(95)	2(5)	41
Total	50(58)	36(42)	86

( ) indicates percentage of rows

Shapiro, 1982). Twenty percent of the patients exhibited double depression with no major difference by sex or tribe. The definition of double depression was expanded to include labile and cyclothymic personality, labeling this pattern "complicated depression." This broader definition was based upon observations of the four research psychiatrists across the three sites. They noted that patients generally had difficulty in distinguishing between subtle differences in probe questions of the SADS-L for affective symptoms associated with the personality

disorders. For example, a criteria for intermittent depressive disorder requires frequent intermittent periods of normal mood of a few hours, days, or weeks. A probe question for cyclothymic personality asks if one has had "a few days when you feel down or depressed and then at other times a few days when you feel even better than normal or high." Patients tended to confuse the distinction between normal and high mood in these questions, making the subtyping of SADS-L categories difficult. Applying this broader definition, forty-four percent of the patients were diagnosed as having "complicated depression" with a higher frequency among the Plains cases.

Discussion

This is the first study of depression among American Indian patients that has involved the application of systematic diagnostic criteria by experienced psychiatric clinicians. We were impressed that the SADS-L can be applied in these transcultural settings with confidence if certain limitations are considered. All SADS-L interviews were done in English, even with elderly individuals who spoke English as their second language. The high level of transcultural experience among the four research psychiatrists was essential to judge accurately patients' responses. Two aspects of the SADS-L presented particular problems that required interviewer attention. As mentioned above, patients generally had difficulty in distinguishing between subtle differences in SADS-L probe questions, especially for affective symptoms associated with the personality disorders. In addition, we remain uncertain about the reliability of Indian patients' recall of symptom duration since time perception may be significantly affected by cultural experience. Nevertheless, inter-rater reliability was high among the research psychiatrists. These observations suggest certain modifications of the SADS-L that should improve its administration to American Indian patient populations.

There are few differences either by tribe or sex in the symptoms profiles between patients. The findings suggest a core depressive syndrome among patients who have been in treatment. This is supported further by comparison to the non-Indian pattern of depressive symptoms highlighted in Table II. These findings are reminiscent of the conclusion by Jablensky, Sartorius, Gulbinat, and Ernberg (1981) in the World Health Organization (WHO) collaborative study on the assessment of depressive disorders that "the results point to a considerable degree of similarity in depressive symptomatology across the cultures if particular selection criteria are applied." Mezzich and Raab (1980) compared depressive symptomatology between North and South American patient groups, and also demonstrated a commonality of core depressive symptoms and signs.

In our opinion the present findings indicate the common occurrence of major depressive disorder among American Indian patients from different tribal cultures and that sociodemographic as well as cultural differences may modify the content, but not necessarily the form of the primary syndrome. Marsella (1978) observed that in certain non-Western cultures there appears to be no semantic equivalent for the word "depression", and consequently argued that the syndrome of major depression may not exist in these populations. Based on our findings, an assumption that equates the lack of a semantic equivalent to depression with its absence in a given culture is too simplistic. None of the tribes in this study reported semantic equivalents for depression in their respective languages; yet the psychiatric disorder of major depression was observed in a consistent fashion across all three patient populations. Admittedly, this pilot study is limited by its emphasis on patient samples. Therefore, no definitive conclusions can be drawn concerning the community patterns of depression. However, the data certainly demonstrate that there exists groups of American Indian patients who experience similar depressive symptomatology. In fact, all of our patients had by diagnostic criteria (Schedule for Affective Disorders and Schizophrenia - SADS and Research Diagnostic Criteria - RDC) been assigned the same diagnosis based on their symptomatology.

In a separate publication, Manson, Shore, and Bloom (1985) described the unique concepts of depressive behaviors that co-exist with major depressive disorders in one of these tribes. For the Pueblo tribe the common association of a hallucinatory experience, especially for Indian women associated with major depression, has been previously reported (Matchett, 1972). In the current study hallucinations were common among all patients from the three tribes. They most often were explained by patients as hearing the voices of deceased relatives. In addition, many patients attributed their depression to the stress of a family member's death, inspite of our exclusion of cases of normal bereavement. Periods of dysphoric mood were considered as bereavement if they followed the loss of a loved one within a twelve-month period.

There was a common co-occurrence of alcoholism with major depressive disorder, especially among male patients. Although we searched diligently in each community, it was difficult to identify cases of major depression among Indian males without a history of an alcoholic disorder. In an earlier epidemiological survey of an American Indian tribe, Shore, Kinzie, Hampson and Pattison (1973) reported a 27 percent prevalence of alcoholism, a rate significantly above the prevalence of 4.5 to 5.7 percent in the recent ECA study reports (Myers, Weissman, Tishler, Holzer, Leaf, Orvaschel, Anthony, Boyd, Burke, Kramer, & Stoltzman, 1984). Brod (1975) and Westermeyer (1979) also have written about alcoholism as an extensive mental health problem among

American Indians. Its common occurrence among this patient sample of American Indian males may suggest that symptoms of primary depression frequently are masked by acute and chronic alcoholism. Behar, Winokur, and Berg (1984) studied non-Indian alcoholic patients and concluded that 15 percent had serious, debilitating depressive symptoms which began after 35 months of sobriety. In our study no diagnosis of major depression was made in association with alcoholism unless there was at least a prior three month period of sobriety. The period of sobriety among the depressed Indian male patients with a history of alcoholism ranged from 3 to 48 months. This high rate of alcoholic history with a subsequent depression among Indian males highlights the association of these two disorders and underscores the distinction of secondary depression as a particularly important diagnostic problem.

The occurrence of "double" or "complicated depression" among Indian patients is another important dimension to their pattern of depressive illness. Keller and Shapiro (1982) described "double depression" as a major depressive disorder superimposed on an underlying chronic depression and have shown (Keller, Lavori, Endicott, et al., 1983) that it is associated with a guarded prognosis. Among our patients this pattern is common but may be more difficult to diagnose reliably. There is a tribal difference in the occurrence of "complicated depression" with a higher rate in the patients from the Plains tribe (Plains 50%, Pueblo 32%, Plateau 18%) but nearly equal rates among male and female patients (41% and 46%). This intertribal difference in the pattern of complicated depression may not be explained by sampling limitation alone. The mental health clinic of the Plains tribe was the most medically oriented of the three and included the highest percentage of depressed patients who received antidepressant medication and hospitalization. It is possible, however, that the higher rate of "complicated depression" among the Plains group is a true difference and might be attributed to unique cultural and genetic factors. This interpretation is supported by clinical observations (Neligh, personal communication, 1985) that cyclothymia, anxiety, and panic reactions are more common among the Plains tribes in the northern United States and that this pattern occurs more frequently among specific tribal communities.

Conclusion

The occurrence of major depression, alcoholism, and complicated depression presents a triad of depressive disorders among the Indian patients studied. Major depression exists in three distinct constellations among these patients: as an uncomplicated pattern, as a secondary depression in association with a past history of alcoholism, and as a complicated depression superimposed upon an

underlying chronic depression or personality disorder. Each of these requires a distinct diagnostic approach and may be influenced by cultural factors. In summary, our preliminary findings indicate that a common pattern of depression can be distinguished among American Indian patients, that a core depressive syndrome exists among patients across different tribal groups, and that variations are evident which may have clinically meaningful implications.

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URBAN INDIAN PSYCHIATRIC PATIENTS IN COMMUNITY CARE

RON PETERS, B.A.

ABSTRACT. This study examines characteristics and problems of, and services received by Indian psychiatric patients in an urban community care setting in Canada. A census of patients of a community mental health service showed 25 Canadian Indian patients out of 2,652 patients in care, or 0.9%; whereas Canadian Indians are estimated to comprise somewhere between 1.6% and 4.8% of the general population. A comparison group of 100 Anglo Canadian patients was matched four-to-one with the group of 25 Canadian Indian patients in terms of sex, age, educational level, and employment status to render the groups sociodemographically comparable. The Canadian Indian and Anglo groups are compared in terms of related socioeconomic factors, accommodations and transiency, selected clinical characteristics, social networks and social support, prior psychiatric service utilization, and psychiatric services currently received.

In 1966 less than 16% of registered Canadian Indians was living off-reserve. By 1980 this figure rose to nearly 30%, and some 80% of off-reserve Canadian Indians now live in cities. Further, of the more than 100,000 off-reserve Canadian Indians in 1978, more than one-quarter lived in the province of British Columbia. Numbers are readily available for registered Indians only; no one knows in total how many persons of Indian descent live in Canada's urban centers. Indian Affairs figures for 1980 give estimates for the city of Vancouver, British Columbia ranging between 6,500 and 20,000, or, from 1.6% to 4.8% of the general Vancouver population (Frideres, 1983).

Little is known about the utilization by Canadian Indians of urban community mental health services. Fritz & D'Arcy (1982) and Rhoades et al. (1980) find that Canadian Indians under-utilize these services in relation to their numbers in the population, and find an over-representation of substance abuse problems among those who seek treatment.

The purpose of this study was to look at characteristics and problems of, as well as patterns of service utilization among, Canadian Indian psychiatric patients in community care. The hope was that such analyses can offer a guide to the ways in which services can be made more accessible and acceptable to a major group of potential recipients of service.

The study was conducted at the Community Mental Health Teams of the Greater Vancouver Mental Health Service Society (GVMHSS). Operating under a mandate to care for the seriously and chronically mentally ill, the GVMHSS maintains an active caseload of around 3,100 patients, more than half of whom carry diagnoses involving psychotic conditions. Eight multidiscipli-

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nary community teams provide services to geographically defined catchment areas with populations ranging from 15,000 to 120,000. Each patient's principal link with a team is a mental health worker who may provide therapy, who acts as a patient advocate and community services broker, and who will attempt to tailor an individual management plan that may include elements such as housing placement and supervision, social and recreational enhancement, and programs designed to develop vocational skills. Physicians provide assessment and medical supervision. The GVMHSS also operates short-term residential services for patients in crisis, a suicide attempt counseling service, a 24-hour psychiatric emergency service, and offers consultation to various community agencies. In most regards, the GVMHSS fulfills the criteria of a model program for the chronically mentally ill (Bachrach, 1980; Cumming et al., 1976).

Methods

A questionnaire was administered to the primary therapist of every patient actively in care at a Community Mental Health Team during an index week. Of the 2,652 patients included in the study, 25 (0.9%) were identified as Canadian Indian.

To create sociodemographically equivalent groups for comparison on clinical and other characteristics, each Canadian Indian patient was matched with four Anglo patients on several characteristics. Table I first compares Canadian Indian patients with Anglo Canadian patients and all other non-Anglo patients in terms of sex, age, educational level, and employment status prior to matching, and then compares the Canadian Indian and Anglo Canadian matched samples.

There was no significant difference among these ethnic groups by sex (χ^2 = 3.21, df = 2, p = .20). But since sex correlates highly with age, diagnosis, and the presence of violent versus suicidal acts in our caseload, it was thought important to control for this variable.

There were significant age differences, with other non-Anglos (mostly Asians and Central Europeans) being oldest, and Indians youngest (χ^2 = 48.70, df = 6, p = .0001). Canadian Indians are a youthful population; the median age of Indians in British Columbia is sixteen. This distribution depends partly on high fertility rates and equally on a comparatively low life-expectancy. At the same time, proportionately more Indians in their twenties and thirties move to cities (often bringing young children), and Indians over 65 move to cities less often, further skewing the age distribution of urban Canadian Indians (Frideres, 1983).

As is commonly found, the educational level of the Canadian Indian group was low compared with Anglo Canadians and other non-Anglos (χ^2 = 90.27, df = 2, p .001). This finding distinguishes Canadian Indians from non-Canadian In-

TABLE I

SOCIODEMOGRAPHIC CHARACTERISTICS OF: A) INDIAN PATIENTS VERSUS ANGLO AND ALL OTHER NON-ANGLO PATIENTS PRIOR TO MATCHING, AND B) INDIAN VERSUS ANGLO PATIENTS AFTER MATCHING.

	Patients With Characteristic					
	Canadian Indian		Anglo Canadian		Other NonAnglo	
Characteristic	N	%	N	%	N	%
A. Prior to Matching						
Sex						
Male	13	52	926	43	233	48
Female	12	48	1210	57	257	52
Age (years)						
Under 30	5	20	546	25	84	17
30 - 34	5	20	311	15	63	13
35 - 39	8	32	221	10	32	7
40 and Over	7	28	1058	50	311	63
Educational Level						
Grades 0 - 8	15	60	539	25	220	45
Grades 9+	10	40	1595	75	265	55
Employment Status						
Employed	5	20	555	26	150	31
Unemployed	16	64	1257	59	285	58
Out of the Labour Force	4	16	319	15	55	11
B. After Matching						
Sex						
Male	13	52	51	51		
Female	12	48	49	49		
Age (years)						
Under 30	5	20	21	21		
30 - 34	5	20	22	22		
35 - 39	8	32	24	24		
40 and Over	7	28	33	33		
Educational Level						
Grades 0 - 8	15	60	62	62		
Grades 9+	10	40	95	75		
Employment Status						
Employed	5	20	20	20		
Unemployed	16	64	64	64		
Out of the Labour Force	4	16	16	16		

dians, but does not differentiate urban Canadian Indians from rural Canadian Indians (Stanbury & Siegel, 1975).

Finally, patients from all three groups were unemployed at levels five times higher than in the general population. With an unemployment rate of 72%, however, Canadian Indian patients had higher rates than Anglo Canadian (69%) or other non-Anglo patients (65%) ($\chi^2 = 7.83$, $df = 4$, $p = .09$).

After one-to-one matching, the differences by sex, education, and employment status between the Canadian Indian group and the Anglo comparison sample were non-significant ($p = 1.00$). The mean age (and s.d.) in the Canadian In-

dian sample was 36.0 years (11.8), as against 36.1 years (12.3) in the Anglo sample (t, df = -0.04, p = .97).

Given this group of 25 Canadian Indians and a sociodemographically comparable sample of 100 Anglo patients, we set out to see what might be different about Canadian Indian psychiatric patients in community care. Because of the small number of patients involved and the exploratory nature of the study, no great emphasis can be placed on the statistical significance of the results. Some of the findings attain statistical significance, but most do not. Many of the comparisons would be statistically significant, with the same pattern and strength of association, given a larger sample.

Results and Discussion

Related Socioeconomic Factors

Despite matching, only 8% of the Canadian Indian patients derived their income primarily from wages or savings, in contrast to 22% of the Anglo Canadian patients (see Table II). Since the patients were matched for employment status, this indicates that more of the unemployed Anglo patients pre-

TABLE II
RELATED SOCIOECONOMIC CHARACTERISTICS OF INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS

	Patients with Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Principal Source of Income[1]				
Wages and/or Savings	2	8	21	22
Welfare	13	52	42	43
Handicapped Pension	6	24	20	21
Other	4	16	14	14
Employability Ratings[2]				
Competitive Employment	6	24	34	34
Sheltered Emplolyment	8	32	37	37
Unemployable	11	44	29	29
Recombined Employability Ratings[3]				
Part-time Competitive, Full-time Sheltered, or Vocational Training	9	36	26	26
Full-time Competitive, Part-time Sheltered	5	20	45	45
Unemployable	11	44	29	29

1. χ^2 (df = 3) = 2.44, p = .49
2. χ^2 (df = 2) = 2.17, p = .34
3. χ^2 (df = @) =5.25, p = .07

viously worked in jobs where they could accumulate savings. This is understandable since Canadian Indians as a group in British Columbia are over-represented in seasonal, unskilled, and low-prestige occupations (Frideres, 1983).

The combination of under-education, low participation in the work force, lower-class and less-secure jobs, and high rates of unemployment naturally means less disposable income and increased poverty. Thus, Stanbury and Siegel (1975) found that 54% of off-reserve Canadian Indians in British Columbia made less than $2,000 per year, compared with 24% of the general population.

The Canadian Indian patients were rated as unemployable more often by their therapists and were less often rated as ready for regular employment, or for work rehabilitation programs. Among the Canadian Indians who were rated as employable, the majority were deemed ready for part-time competitive employment, full-time employment under supervision, or for work rehabilitation programs. These levels denote an intermediate work readiness, and such patients could be expected to benefit from special training directed at increasing their work readiness.

Accommodations and Transiency

Roughly 55-60% of both Anglo and Canadian Indian patients were living in private independent residences, but the accommodations for the remaining 40-45% were markedly different. More than 30% of Canadian Indians as opposed to 12% of Anglos lived in residential hotels, emergency short-stay facilities, or had no fixed address. Among Anglo patients, about 32% live in some form of supervised housing, as against 9% of Canadian Indians.

Another item on the questionnaire asked, "If in your judgement the client's current housing is not appropriate, indicate which type of housing would best meet the client's needs". The results show that the therapists believed Canadian Indian patients were more often inappropriately housed. The kinds of housing that therapists thought the Canadian Indian group ought to be in were just the types they were absent from: programs for the hard-to-house, supervised group homes, family care homes, and other residential care facilities.

When combined with data, below, on substance abuse and violent acting-out, the general picture is that about two-thirds of both Canadian Indians and Anglo patients do well in unsupervised settings. But when the behavior of the Canadian Indians becomes problematic, they are much more likely to be simply cut adrift.

The data on transiency suggest that Canadian Indians in our caseload tend to stay in one general district, but are quite mobile within that district. Thus, both groups are very likely to have lived within their catchment area for at least a year, but two-thirds of the Canadian Indian group changed addresses within that time, as compared with one-third of the Anglo group.

TABLE III
ACCOMMODATIONS AND TRANSIENCY AMONG INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

	Patients With Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Type of Residence[1]				
Private Independent Housing	14	61	55	56
Hotel, Transitional Housing, or No Fixed Address	7	30	12	12
Other (Supervised) Housing	2	9	31	32
Do the Current Accommodations Meet the Patient's Housing Needs?[2]				
Yes	17	68	87	87
No	8	32	13	13
Patient's Recently Moved into Team Catchment Area?[3]				
Yes	4	17	8	8
No	20	83	88	92
Changed Address in Last Year?[4]				
Yes	15	65	36	37
No	8	35	60	63

1. X^2 (df = 2) = 7.59, p = .02
2. X^2 (df = 1) = 3.90, p = .05
3. X^2 (df = 1) = 0.70, p = .40
4. X^2 (df = 1) = 4.74, p = .03

TABLE IV
SELECTED CLINICAL CHARACTERISTICS OF INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

	Patients With Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Violent Acting-Out in Last Year[1]				
Yes	12	50	16	16
No	12	50	83	84
Suicide Attempts in Last Year[2]				
Yes	3	13	4	4
No	21	87	96	96
Primary Diagnosis[3]				
Schizophrenia, Other Psychosis	12	48	54	54
Drug and/or Alcohol Abuse	5	20	2	2
Personality Disorder	3	12	17	17
Other Psychiatric Disorder	5	20	27	27
Capable Under the Property Act[4]				
Yes	24	100	89	94
No	0	0	6	6
3-Month Hospitalization-Risk[5]				
Yes	11	44	52	53
No	14	56	47	47

1. X^2 (df = 1) = 10.80, p = .001
2. X^2 (df = 1) = 1.27, p = .26
3. X^2 (df = 3) = 12.40, p = .006
4. X^2 (df = 1) = 0.55, p = .46
5. X^2 (df = 1) = 0.29, p = .59

These results are consonant with some data on urban Canadian Indian migration patterns, but not others. Neils (1971, p. 125), for example, comments that "one of the most visible and noted characteristics of Indians living in cities has been their mobility, in a pattern of movement that seems to be peculiarly Indian and demonstrates the ability of Indians to use the urban structure in an Indian way". However, studies of Indians in U.S. cities report that the majority of Indians move out within six months, or move back and forth between the reserve and the city (e.g., Levine, 1968). The pattern is similar to that seen among migrant workers.

Our Canadian Indian patients, though mobile within a given catchment area, do not seem to be "migrants" in the manner described by Levine, but are more like "residents", having spent considerable time in an urban setting. Davis (1968), in another Canadian study, finds a pattern similar to ours: a survey of Indian and Metis households in the Western prairies shows that, while mobile within the region, the majority of respondents had long terms of residence within the city.

Selected Clinical Characteristics

The Canadian Indians at our teams were reported to have acted in a violent fashion significantly more often than matched Anglo patients. A 50% rate of violent acting-out seems high, but in another study conducted at the GVMHSS suicide attempt counseling service, Canadian Indian suicide attempters also were found to be the only ethnic group in which family violence was reported to be present more often than not (Peters, 1982). In both of these studies, "violence" was rated in global terms by non-Canadian Indian service providers. One would feel more comfortable with the reliability of these data if specific behaviors had been rated instead.

The data on suicidal behavior in this sample are equivocal (see Table IV). While we know that the suicide death rate among registered Indians in British Columbia is typically double the general Provincial rate (Termansen & Peters, 1979), virtually nothing systematic is known about either attempted or completed suicide among Canadian Indians in urban settings (Peters, 1981). Finally, too, the importance of inter-tribal differences in suicidal behavior and the need for individualized program approaches is becoming ever clearer in this literature. Consequently, any global notion of "the suicidal Indian" is increasingly viewed as inappropriate.

About half of each group had been assigned a diagnosis of schizophrenia or of other psychoses. Though the course of schizophrenia varies somewhat cross-culturally (Sartorius et al., 1978), agreement on core signs and symptoms is high (World Health Organization, 1973). The differences tend to be related to the content, severity, or frequency of particular symptoms and signs (Jablensky & Sartorius, 1975).

The major diagnostic difference is the high proportion of Canadian Indian patients with primary problems of drug and/or alcohol abuse. The cross-cultural validity of the diagnosis of alcoholism has been supported by Westermyer & Peake (1983), where, on 10-year follow-up, a group of Canadian Indian heavy drinkers showed outcomes similar to alcoholic rather than normal populations. The evidence therefore suggests that this is a "real" problem, rather than simply being a question of a culturally alternate style of dealing with alcohol, as some writers have suggested (cf. Kunitz & Levy, 1974).

The only other diagnosis given often enough to report separately was personality disorder, where Canadian Indians were no more likely to be assigned this diagnosis than matched Anglo patients.

Two other items included in the survey were whether or not the patient was deemed legally capable under the Property Act, and therapists' ratings of the patients' risk of hospitalization. By these measures, the need for actions that imply serious impairments in functioning was no more or less common among Canadian Indians than among the group of matched Anglo patients.

Social Networks and Social Support

Family cohesion, a strong reliance on extended social networks, and the notion of the community as family are important features of traditional Indian culture. Studies of Canadian Indian urbanization also give the overall impression of high levels of social cohesion. McCaskill (1981, p. 85), for example, reports that large households (not necessarily "families" as typically defined) were common among Canadian Indians living in Vancouver, and comments that the informal communal arrangements formed were "particularly striking considering the large number of single parent families and single, divorced, and widowed individuals seen". At the same time, much has been written in recent years about the disintegration of the family unit among Canadian Indians, and the role played by the child welfare system in its demise (Johnston, 1983).

The Canadian Indian patients in our sample were, in fact, seen to more often live alone, and this was balanced by a tendency to not be found in group living situations (see Table V). These group situations are the same supervised housing settings that Canadian Indians were noted to be relatively absent from earlier.

Though Canadian Indian patients in our sample live alone more often than both the matched Anglo group and other Canadian Indians living in Vancouver, our data show that they receive no less support from their social networks (though they also receive no more). This suggests a loose-knit network of friends or relatives that one might not live with, but who are proximate enough to be a source of support. McCaskill (1981) found that 72% of Vancouver Canadian Indians reported having friends or relatives living in the city, and that a significant

minority of urban Indians associate almost exclusively with other Indians, suggesting an extension of the pattern of extended kinship typical of the reserve. McCaskill also reports high levels of membership in formal Canadian Indian organizations and attendance at Indian activities and ceremonies, from which additional support may be derived.

Prior Psychiatric Service Utilization

The findings for prior contacts with community psychiatric services are largely negative; however, a concentric geographic pattern is notable (see Table VI).

TABLE V
SOCIAL NETWORKS AND SOCIAL SUPPORTS AMONG INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

	Patients With Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Living Arrangements[1]				
Lives Alone	12	48	37	37
Lives With Family	6	24	20	20
Group Accomodations	2	8	22	22
Other Arrangements	5	20	21	21
Emotional Support from Family[2]				
Yes	11	44	48	48
No	14	56	52	52
Emotional Support from Spouse[3]				
Yes	5	20	2	12
No	20	80	88	88
Emotional Support from Friends[4]				
Yes	14	56	61	61
No	11	44	39	39
Patient is an Isolate[5]				
Yes	8	32	33	33
No	17	68	67	67

1. x^2 (df = 3) = 2.82, p = .42
2. x^2 (df = 1) = 0.02, p = .89
3. x^2 (df = 1) = 0.51, p = .47
4. x^2 (df = 1) = 0.05, p = .89
5. x^2 (df = 1) = 0.00, p = 1.00

Canadian Indian patients were more likely to have previously utilized community psychiatric services within their local catchment area, equally likely to have utilized these services in the city as a whole, and less likely to have used services outside of the Vancouver area. This matches the pattern of changing

address often within a given area, but less commonly from one area to another. If one looks simply at the number of prior community psychiatric contacts, regardless of geography, the effect disappears.

Services Currently Received

Canadian Indian patients were as likely as Anglo patients to be referred into community psychiatric care by an inpatient service. They were, however, much

TABLE VI.
PRIOR PSYCHIATRIC SERVICE UTILIZATION AMONG INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

	Patients With Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Prior Psychiatric Hospitalizations[1]				
None or One	5	20	34	34
Multiple	20	80	66	66
Prior Service Within the Current GVMHSS Catchment Area[2]				
Yes	11	44	27	27
No	14	56	73	73
Prior Service In a Different GVMHSS Catchment Area[3]				
Yes	8	32	32	32
No	17	68	68	68
Prior Service Outside of the GVMHSS Catchment Region[4]				
Yes	3	12	24	24
No	22	88	76	76
Any Prior Community Psychiatric Contacts[5]				
None or One	19	76	80	80
Multiple	6	24	20	20

1. x^2 (df = 1) = 1.23, p = .27
2. x^2 (df = 1) = 1.99, p = .16
3. x^2 (df = 1) = 0.00, p = 1.00
4. x^2 (df = 1) = 1.07, p = .30
5. x^2 (df = 1) = 0.03, p = .87

less likely to be referred from another community-based psychiatric service. This matches the geographic patterns of mobility and utilization noted previously, and suggests problems in engaging these patients in ongoing outpatient

treatment. Thus, only one Canadian Indian patient was referred to the GVMHSS by another community mental health team, one more by a general practitioner, and no referrals were received from privately practicing psychiatrists or psychiatric outpatient departments.

TABLE VII.
COMMUNITY PSYCHIATRIC SERVICES CURRENTLY RECEIVED AMONG INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

	Patients With Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Source of Current Referral[1]				
Psychiatric Inpatient Facility	8	32	31	31
Community Psychiatric Facility	2	8	31	31
Self, Friends, Relatives	7	28	22	22
Other	8	32	16	16
Years of Case Activation to Date[2]				
Less Than One Year	9	6	33	33
One to Two Years	8	32	33	33
More Than Two Years	8	32	34	34
Services Received *				
Chemotherapy	16	64	72	72
Oral Neuroleptics	7	28	47	47
Depot Neuroleptics	6	24	19	19
Antidepressants	0	0	12	12
Anxiolytics	1	4	9	9
Sedatives	2	8	10	10
Other Medications	7	28	32	32
Individual Psychotherapy	21	84	89	89
Family Therapy	4	16	25	25
Activity Therapy	1	4	15	15
Play Therapy	1	4	3	3
Occupational Therapy	2	8	16	16
Social-Recreational Services				
GVMHSS-Funded	6	24	27	27
Ministry of Health-Funded	8	32	30	30
Community-Funded	12	48	37	37

1. x^2 (df = 3) = 6.99, p = .07
2. x^2 (df = 2) = 0/08, p = .96

* This section shows only the number and percent of patients who were receiving a given service. None of these differences are statistically significant.

Canadian Indian patients were slightly more likely to be referred by themselves or a friend or relative, and much more likely to be referred by "other" means. This last category largely reflects referrals by various forms of community gatekeepers: landlords, operators of other residential facilities, police officers, and welfare workers. There is little to distinguish Canadian Indian from Anglo patients on the basis of length of service given in years.

In terms of the various therapies and other services currently being received, none of these differences was statistically reliable. But visual inspection of Table VII suggests that Canadian Indian patients consistently receive slightly less of virtually everything. In fact, of the fifteen services listed, Canadian Indian patients received an average of 3.8 different types per patient, compared with 4.5 services per patient among Anglos, which is marginally significant (t = -1.41, df = 123, p = .08).

The only individual differences that approached even marginal significance in this section were the low proportion of Canadian Indians on oral neuroleptics, and their under-representation in activity therapy. Diagnosis provides no basis for predicting fewer Canadian Indians on oral neuroleptics; the slightly higher share of Canadian Indians on depot neuroleptic makes up part of the difference, and suggests medication compliance problems. Under-participation in activity therapy may either be related to the high levels of violent acting-out in this group, which creates a potential for management problems in group settings, or may reflect a lack of perceived relevance of the kinds of activity offered.

Conclusion

Even when matched on sex, age, education, and employment status, Canadian Indian psychiatric patients in community care showed relatively greater socioeconomic deficits -- reflected in their higher dependence on transfer funds, unmet housing needs, and somewhat lower ratings of employability. Shore et al. (1973), studying a Pacific Northwest Indian village, found that degree of psychiatric impairment correlated highly with socioeconomic status, family income, and employment status within the village population. Thus, while Canadian Indians as a group have a lower than average socioeconomic standing, Canadian Indians with psychiatric impairments fare worse than either other Canadian Indians or other non-Canadian Indian psychiatric patients.

Canadian Indian patients in community care were seen to be quite mobile within relatively restricted geographic areas, showed a somewhat greater tendency to live alone, but received levels of social support comparable to the matched controls. This, in connection with the literature reviewed, suggests a transfer to

the city of traditional migratory patterns, and a broad but loosely-knit social network reminiscent of patterns of association seen in villages and reserves.

Canadian Indians in our sample were reported to act violently significantly more often, more commonly carry a diagnosis of substance abuse, and present greater difficulties in community placement. Possibly, they are more prone to suicidal behavior, but not markedly so, and any excess risk of this nature may be associated with the higher levels of substance abuse observed (cf. Berglund, 1984; Moore et al., 1979). We do not, for example, find a greater frequency of depressive diagnoses among Canadian Indian patients.

We do find a suggestion that Canadian Indian patients more commonly have multiple hospitalizations, but more information on the nature and duration of these inpatient stays is desirable. The prior use of community psychiatric services seems similar to that of the matched group of Anglo patients, and the differences that exist seem largely attributable to Canadian Indian mobility patterns.

Various community gatekeepers seem more important as sources of referral into care than are other community-based psychiatric services. It is possible that active public education efforts directed toward enhanced case identification, or greater consultation and liaison work with welfare workers and the police force would prove useful.

Using the best available population data (which are not good), we know that Canadian Indians are certainly not over-represented on our caseload, and may be significantly under-represented. Additional patient census studies will be conducted in the future to monitor progress in this area. For the present, however, community mental health facilities such as ours are mandated to provide accessible, acceptable, and appropriate care to all members of the community. In a strongly multicultural city such as Vancouver, this includes giving due consideration to the problems involved in meeting the mental health needs of a culturally and ethnically diverse population.

Wu & Windle (1980), studying the utilization of community mental health centers by various ethnic groups, found that the presence of minority staff members, in itself, serves to increase minority utilization. Though the relatively small numbers of Canadian Indians seen in many community services may seem too small to warrant additional staff, several points are worth bearing in mind: a) the purpose of such an exercise is, in fact, to increase the number of Canadian Indians being seen; b) Wu & Windle (1980) found that ethnic staff members did not have to be actually be seeing the minority patients themselves for utilization to increase, and c) such positions can be filled through developing employment equity programs without increasing staffing levels.

In addition, resources for staff education in the areas of Canadian Indian cultural differences and communications styles should be explored. Workshops conducted on an annual basis would allow new employees to gain knowledge of Canadian Indian culture and interpersonal styles, and maintain an ongoing level of interest in the issues of multiculturalism. Since clerical and other support staff are often the first persons encountered by patients on arrival, such a staff should be actively encouraged to take advantage of such training opportunities.

Our data also show that Canadian Indians are: a) markedly under-represented in existing community residential programs; b) over-represented among persons of no fixed address, in residential hotels, detoxification centers and other emergency and transitional facilities, and c) more often deemed to be living in unsuitable accommodations by their therapists. The feasibility of psychiatric boarding homes for Canadian Indians, run by Canadian Indian staff, should be explored. Ideally, whole Canadian Indian families should be able to stay in such facilities.

A point that has been made repeatedly by Canadian Indian organizations in relation to residential alcohol and drug treatment programs for Canadian Indians is the direct and deleterious effect this can have on Canadian Indian families. As the Indian Homemakers' Association of British Columbia (1981, p. 1) has stated:

> While the family is said to be the base of any society, the family for Indian people is of still greater importance. It is the very foundation of our culture. In contrast to the individualistic, nuclear family concept of the non-Indian people we are culturally a communal society which functions within the framework of the extended family.

The acceptance of residential treatment programs by Canadian Indians has in the past been low, in part because such approaches are perceived to weaken Canadian Indian families, and so Canadian Indian society as a whole.

Our data also indicate that Canadian Indian patients would stand to benefit, as would non-Indian patients generally, from increased resources and facilities for vocational rehabilitation. Since the Canadian Indian patients studied here are functioning at such low socioeconomic levels, the absolute and relative gains they could accrue would be significant.

Another, more general, set of concerns lie in the area of continuity of care. In terms of both policy and program planning, Canadian Indians and psychiatric patients are best thought of as being members of largely distinct, yet somewhat overlapping populations. Logically, and for the most part appropriately, the kinds of social programs, staff, and skills that have evolved to meet the needs of these populations are equally distinct.

Problems arise when, as in the present case, the focus is on persons at the overlap between groups. Neither persons working in Canadian Indian social and support services nor the community mental health worker are equipped to deal

optimally with persons who are at the intersect of the two populations, who need specialized psychiatric services and culturally appropriate and acceptable counseling in equal measure. Solutions to these problems seem to lie in the areas of developing formal systems-links, and boundary-spanning roles that permit good case-management practices.

Finally, no discussions in these areas should occur in a vacuum without active input from those persons most directly affected. As Shore (1974) suggests, the guiding principles in this area should stress Canadian Indian needs, such as: a) planning, implementation, and evaluation; b) taking cross-cultural differences into account when planning mental health programs and an explicit recognition of the effects of inter-tribal cultural differences on the diversity of Indian mental health care needs, and c) the necessity of matching the philosophy and methods of a treatment facility to the specific needs of the population being served.

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CULTURAL LESSONS FOR CLINICAL MENTAL HEALTH PRACTICE THE PUYALLUP TRIBAL COMMUNITY

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ABSTRACT. This paper discusses some of the implications of a cultural perspective for the delivery of mental health care at the Kwawachee Mental Health Counseling Center of the Puyallup Tribe of Indians. The paper first places Kwawachee in its cultural and socioeconomic context. A series of issues is then chosen as a basis for considering the clinical relevance of this treatment setting. These issues include cultural maps, family structure, ritual and ceremonialism, values and value conflict, communication styles, anger and traditionality. The paper concludes by emphasizing the importance of integrating local cultural perspectives within mental health services.

This paper discusses some of the implications of a cultural perspective and understanding for mental health practice at the Kwawachee Mental Health Counseling Center (KMHCC) of the Puyallup Tribe of Indians in Tacoma, Washington.[2] While the text is concerned primarily with case study materials, the issues may apply to clinical mental health practice among other populations of American Indians and Alaska Natives. The paper first places the KMHCC in its broader cultural and socioeconomic context. Several issues are then chosen as focal points around which to consider cultural lessons for clinical practice. The central issues include: cultural maps, family structure, ritual and ceremonialism, values and value conflict, sense of time and self, communication styles, anger, and traditionality. The paper concludes by discussing the importance of the integrating the local community's cultural perspectives in the provision of mental health service.

Kleinman (1980) argues that an understanding of a medical system must start with the appreciation of health care as a system that is social and cultural in origin, structure, function, and significance. "In the same sense in which we speak of religion or language or kinship as cultural systems, we can view medicine as a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal arrangements" (p. 24). A corollary of this position is that the Puyallup health care system can only be understood in relation to the ongoing cultural values, meanings, and behaviors of the tribal community.

"Cross-cultural therapy implies a situation in which the participants are most likely to evidence discrepancies in their shared assumptions, experiences, beliefs, values, expectations, and goals" (Manson & Trimble, 1982, p. 149). It is

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necessary for the mental health practitioner to understand, respect, and reinforce the dominant cultural values of the client and his/her community in order not to impose the values of one upon the other. Indian and Native standards or values of "good" or "healthy" can be biased unconsciously by the cultural values of the health care worker or counselor (Clark, 1983). American Indian and Alaska Native patients and clients may temporarily abandon their own health care practices and beliefs in order to satisfy the expectations of health care workers and therapists, but ultimately will reject imposed treatment regimes which run counter to internalized cultural values (Leininger, 1978). Positive interventions can only be accomplished in terms of the perceived notion of the "healthy" individual as defined through consensus within his/her reference community.

In our attempt to describe a number of the cultural values, meanings, and behaviors which influence clinical treatment and differentiate the American Indian and Alaska Native population of this area from the general population, there is a clear, persistent danger of stereotyping and generalization. Despite the cultural and inter-cultural diversity characteristic of this population, the following description is necessary and useful in order to better understand the nature of client-practitioner interactions in providing mental health care to the Puyallup tribal community.

The Kwawachee Mental Health Counseling Center and Service Population

The Kwawachee Mental Health Counseling Center is part of a broader health care system managed by the Puyallup Tribal Health Authority. Support services within the Puyallup Tribal Health Authority include outpatient primary medical and laboratory support, a pharmacy, dental clinic, elders program, nutritional support, substance abuse counseling and inpatient treatment, well child clinic, children's services (Indian Child Welfare), community health outreach, limited transportation services, vocational support, low income energy assistance, and an extensive out-reach network to appropriate non-tribal resources.

Between October 1, 1986 and June 30, 1987, KMHCC provided mental health services to an unduplicated count of 174 individuals. Sixty percent of the clients was female, while 40 percent was male. Forty-two (24.1%) of these clients were classified as acute care cases. Seventy-two (41.4%) clients were recorded as chronically mentally ill. Fifty-eight (33.3%) clients were reported to be seriously disturbed. Elders comprised 4.6 percent of Kwawachee's clients; 18.4 percent were children. Nearly all (97.7%) of the individuals seen were underserved minorities and impoverished.

Numerous problems impact the individuals served by KMHCC. Some of these problems are shared with many Indian communities; others are unique to the

Puyallup Tribal catchment area. Kwawachee serves a reservation community around which the city of Tacoma and its suburbs have grown, bringing urban problems without alleviating the traditional problems typical of reservations. Ninety-nine percent of the land within reservation boundaries has passed from Indian ownership. Indeed, the 1980 Census indicated that only about 3.4 percent of the total reservation population was American Indian or Alaska Native.

Client files from the Puyallup Tribal Health Authority Central Admissions Department indicate that, in 1986, the Health and Social Service programs of the Puyallup Tribe served individuals representing in excess of 150 tribes and bands from throughout the United States. During the 1985 fiscal year, the Puyallup Children's Services caseload was comprised of members of the Puyallup Tribe (22.7%), of other Washington tribes (47.7%), and children from other tribes and bands throughout the United States (29.3%). The fact that the service population contains a minority of members of the Puyallup Tribe creates a number of complex service problems which are discussed below.

Indian and Native people of Pierce County share a number of features with most reservation populations: a very high unemployment rate, a median family income lower and less stable than that of the non-Indian population, severe housing problems, a high alcohol and drug abuse rate, low educational attainment, and a reservoir of health problems due to the impact of long term poverty. Some residual difficulties in child-rearing may be traced to the boarding school era which deprived parents and grandparents of the present generation of exposure to traditional child-rearing skills. Compounded with re-emerging issues of identity and alienation, the situation for urban Indian families, in general, and those at Puyallup, specifically, is fragile.

Recent Bureau of Indian Affairs Labor Force Reports place the Indian/Native unemployment rate for Pierce County at an alarming 66 percent. Fifty-seven percent of this labor force continues to seek gainful employment. Though the economic conditions within this county will probably not change for them, only nine percent of this labor force has ceased to seek work.

The 1980 Census demonstrated that, for American Indians and Alaska Natives in Pierce County, the economic situation has not improved significantly from 1970. In fact, there is a marked increase in the percentage of Indian families living below poverty level: 27.9% in 1980 compared to 24.6% in 1970. Over twenty percent of Indian families had incomes of less than $5,000, compared with 5.7% of White families, 11.4% of Black families, 12.5% for Asian and Pacific Islander families, and 10.4% for families of Spanish origin.

The Puyallup tribal community not only suffers higher levels of poverty than its neighbors, but does not fare well when compared with American Indian and Alaska Native residents of Washington State as a whole, or with their counter-

parts in the surrounding congressional districts. Slightly less than 16% of all Indian residents of the state reported incomes less than $5,000, median incomes 24.5% greater, and mean incomes of 20.4% greater than for the Puyallup service area.

The 1980 Census assists in identifying some of the stresses faced by Indian and Native households. Nearly 28% of Pierce County's Indian families was headed by females with no husbands present. Almost 45% of the Puyallup families is headed by females with no husbands present. The median income reported for the latter was $5,667, which approaches the minimal support provided by Welfare through Aid to Families with Dependent Children.

Given this extreme disadvantaged status, it is reasonable to expect that this population experiences a very high incidence of health, mental health, and social problems. Disadvantaged minorities experience higher rates of mortality, infant mortality, restricted activity days, bed days, disabilities, and admissions to mental hospitals. There is a high positive correlation between low income and low self-reported health status of disadvantaged minorities (Robert Wood Johnson Foundation, 1987). Given the economic malaise of Indians and Natives in the greater Tacoma area, and the lack of change in this status over the last ten years, the high incidence of domestic and socio-psychological problems are likely to continue.

Cultural Maps

Historically, the Puyallup Tribe has served as a "hub" of Indian culture (Hunt, 1916; Smith, 1940). For centuries people from as far away as Canada and the Columbia River Basin have gathered here in the summer months to trade, to visit relatives, to attend various ceremonial occasions, and, more recently, to attend boarding school, to seek work among the hops fields, and to receive care at the Cushman Indian Hospital. Today, the Puyallup Tribal Health Authority acts as a similar magnet. The large number of social service and other support agencies for low income individuals and families (including state, county, and private agencies, low income housing, food support systems, churches, and the support agencies of the Puyallup Tribe) tend to attract individuals in need of care or support to the Tacoma/Pierce County metropolitan area. The regional alcohol and drug treatment facility, for example, which is managed by the tribe, currently provides services to an inpatient population, 75% of whom are from some other county or state.

Non-Indian agencies and providers, however, may not be aware of the difference in local "reference points." Clients of the Puyallup tribal community do not go to Tacoma, they go to the Puyallup; they do not go to Auburn, they go to

Muckleshoot; they do not go to Everett, they go to Tulalip; they do not go to Shelton, they go to the Skokomish. Additionally, non-Indian providers are generally unfamiliar with the access points for tribal connections and resources specific to American Indian and Alaska Native entitlement.

Internal travel between reference points is guided by current, meaningful "cultural maps". The urban-rural enclave exists within the context of a series of strictly Indian cultural meanings. Many of these seemingly discrete, separated "places" and activities are viewed as a continuous and coherent whole by the tribal community. The interspersed agencies, places, and activities of the majority culture are like the forest: trees to be used or avoided.

KMHCC personnel are aware of these cultural maps and use them to distribute information about and garner support for their clinical services. Beyond simple awareness, KMHCC personnel actively participate in tribal events and demonstrate their membership in the community. For example, a recent and tragic fire killed nine Indian children. KMHCC personnel closed the office and attended the funerals, providing support and counseling on a personal and informal basis free of the institutional setting. Many of the "clients" were not even aware that they were receiving mental health support.

Thus, KMHCC is an important and accepted part of the family-based mental health care referral system in the tribal community. Given this embeddedness in the culturally meaningful cognitive system, stigma about seeking mental health care from professional practitioners is reduced. KMHCC personnel also utilize their knowledge of the cultural system to gain access to ongoing traditional healing ceremonies for clients in need. The ceremonial cycle among Pacific Northwest tribes is not easily accessed by those unfamiliar with the specific cultural meanings of the urban-rural enclave.

Family Structure

The extended family is of paramount importance to most Indian and Native clients. Informal resources such as the extended family are known to provide emotional support, material assistance, physical care, information referral, and mediation in times of emotional need. An Indian or Native client who perceives him/herself as being isolated and without "family" to depend upon and interact with may experience much more difficulty in coping with acute episodes or chronic illness (Bertche, Clark, & Iverson, 1981). "To be really poor in the Indian world is to be without relatives" (Primeaux, 1977, p. 92). Relatives include

a wide variety of extended kin in addition to the immediate family. Sources of referral to professional or traditional practitioners include this extensive network and, consequently, are much more diverse than within the non-Indian community (Guilmet, 1984).

Indian and Native children often have "multiple parents" including those from past marriages or present relationships. Kinship is not necessarily based upon blood lines. Older individuals often are referred to as "grandma", "uncle", or "auntie". This is a modern adaptation of old patterns within subsistence cultures where different extended kin and the network allowed for ease of access to various subsistence goods.

A high degree of autonomy is encouraged among Puyallup children and adolescents. Both are viewed as much more independent, responsible, and capable at an earlier age than among the general population. Independence is encouraged; children are given a wide range of latitude to learn through trial and error and direct observation. Children are rarely told not to do something (Guilmet, 1985a); however, older children may be informed of the possible consequences of behavior, but "left free to make their choice" (Backrup, 1979).

KMHCC personnel report that children frequently serve as a filter system. If care is good, fair, warm, and effective for the children, then when a health problem becomes serious enough to indicate the need for outside consultation or intervention, adults are more likely to seek assistance through the same agency. This "filtering" occurs as well among the extended family or community network and affects peer referrals. If a tribal person has a particularly unpleasant experience with a certain provider, it is highly likely that this information will be shared among family members and friends. This certainly occurs among members of non-Indian communities. Yet, the particular imperatives which lead individuals to perceive an experience as unpleasant or counter-productive are culturally laden and unique within the Puyallup community.

Reluctance to speak openly of familial concerns among strangers continues to evidence itself among the KMHCC service population. KMHCC has attempted several group program elements. In our experience the admixture of the group ultimately is critical to therapeutic success. KMHCC counselors report considerable success with therapies which include only extended family members. Yet group situations have not been found to be appropriate for the chronically depressed who exhibit a great fear of being criticized. The local chronically mentally ill population varies significantly from the general population. Counselors maintain that the chronically mentally ill population contains many depressed, anxiety and panic disorders, post-traumatic stress disorders (which KMHCC counselors claim might be epidemic within the tribal population), and borderline, dependent, and antisocial personality disorders. KMHCC chronic

patients do not include a high percentage of psychotic or schizophrenic individuals. As alcoholism is endemic to the Indian community, and many children grow up within alcoholic households, post-traumatic stress disorder-delayed often is evident.

In spite of the unique strengths of the Indian and Native family, one KMHCC clinician describes the necessity of providing intergenerational counseling, brought on by rapid and massive change in some families:

> I had lots of cases of older generations taking responsibilities for younger generations of extended family members. But without the respect for elders among the youth, as well as modern attitudes towards adults in general, it was all too easy to end up in exploitation situations, the elders exploited by children, but unequipped to handle it, knowing mainly the obligation to family. Meanwhile, the young tend to believe that their elders have an endless supply of money and material goods, without realizing at times the obligations that elders feel towards them--obligations that can lead elders to give away everything they own and end up homeless, under the right circumstances. So it seems to me that there are multiple cultures to juggle: the different cultural experiences of each generation; the traditional and nontraditional Indian cultural experiences; reservation and non-reservation experiences; the culture of poverty and its knocking up against other class values; the youth culture and the world of older people. It ... requires ... careful juggling to figure out what a person's frame of reference primarily is.[3]

The extremely high stress experienced by the local Indian and Native community has contributed to the multiple dysfunctions observed by KMHCC staff, and constantly experienced by individual members of the families at risk. The involvement of extended family members "attempting to assist" or "plainly disrupt" normal family activities and therapeutic support complicates the delivery of in-house services. There also is a high level of involvement of outside agencies such as the legal system, welfare system, Tribal Children's Services, State of Washington Children's Services, parole officers, substance abuse treatment programs, and others because of the multiple dysfunctions experienced by many of these families. Coordination of so many agencies which are essential to and which deeply influence individual family members, cannot be accomplished effectively from an office. Outreach support services often include attending court with clients, treatment programs, schools, and interagency meetings aimed at coordinating services for the client and family.

The KMHCC Children's Specialist reports a substantial level of avoidance by client families with respect to mental health counseling for children and involved family members. "Getting most any Indian family to commit themselves to traveling to an ongoing program of mental health counseling support is difficult. Even the foster families are sometimes noncompliant" (Ruth Currah, Children's Specialist, personal communication). For this reason outreach counseling and support services are necessary to a successful mental health network for dysfunctional American Indian and Alaska Native families.

Healing Rituals and Practices

Tribal ritual and ceremonial practices provide a code for ethical behavior and social organization "which contribute to an understanding of the meaning of life" (Mitchell & Patch, 1986). They also provide means for intervening in individual or social dysfunction.

The Puyallup tribal community is caught between two cultures: attempting to preserve the best of the old, while adapting the best or the necessary of the new. Though there has been significant progress in the control of contagious and biomedically oriented pathologies, there still exists a high rate of death attributed to the stress of biculturalism. This phenomenon has been described elsewhere in the context of the "epidemiological transition" (Broudy & May, 1983).

Much of this high death rate is due to accidents, suicides, substance abuse, and violence--expressions of the emotional stress experienced by individuals who have been stripped of their cultural traditions and forced to live a bicultural existence. The chronic depression displayed by many Indian people can be linked, at least provisionally, with such factors as failing to acquire upward mobility in American society; subjective feelings of rejection and discrimination; guilt stemming from collective and personal denial of their heritage; and moral disorientation due to the fragmentation of traditional cosmological systems (Jilek, 1978, 1982). An increasing body of psychiatric literature suggests that the integration of Indian healing theories and techniques with Western treatment strategies--especially in situations where Western approaches have proven ineffective--can have a positive impact on this type of anomic depression.

KMHCC staff relate that many traditional people are concerned with receiving an "Indian name." The rituals and the giveaways surrounding this practice and traditions are complicated. However, the effect upon KMHCC clients is noticeable, though subtle. For some clients and even staff members, the lack of an Indian name leaves them feeling that their life is "not complete."

KMHCC staff express the need for more information regarding the Plains traditions, since a large population of Plains people have migrated to the Tacoma-Pierce County catchment area and seek care through Puyallup tribal programs. As a result of the ongoing expansion of pan-Indian traditions, especially within urban areas, many community members find themselves participating in the healing and spiritual traditions of other tribal entities. At least one member of the Puyallup Tribe has participated in the Sun Dance, is a Pipe Holder, and holds Pipe ceremonies. The Sun Dance and the Pipe Ceremony are both Plains traditions. This is not as unusual as one might expect since tribal peoples with traditions of exogamous marriage often accept, appreciate, and

honor the traditions of the tribal groups with which they associate. Increased transportation and communication technologies have reinforced this basic integrative pattern.

A deep and abiding faith in the old forms of Indian medicine is present among some KMHCC clients. For example, individuals report the lingering appearances of deceased relatives in the form of owls or other presences, a traditional Puget Sound Salish belief (Guilmet & Whited, in press). Also, the traditional healing aspects of the Shaker Religion which incorporate old forms of treatment and diagnostics, pit the healers against a well-defined evil influence, either devilish in Christian terms, or the negative powers existing within the traditional ceremonial complex (Gunther, 1949).

Current practice among KMHCC staff and within the programs involves the spiritual cleansing of areas, offices, and individuals with sweet grass, sage, or cedar smoke--these plants being variously important either east or west of the Cascade Mountains. The smoke is power and a prayer. Traditional treatments derive predominantly from the local Coastal Salish smokehouse tradition. Additionally, traditional sweats, Shaker healings and cleansing, talking circles with eagle feathers, the Pipe Ceremony from the Plains tradition, and Southwest shamanistic healings are employed within the existing treatment regimen.

When a person does something while under the influence of alcohol and/or drugs, it is commonly accepted that the "power" of the alcohol or drugs is responsible for any aberrant behavior during the power's possession and influence (Jilek, 1982). This seems a direct descendent of the spirit power network and spirit dancing (Amoss, 1978) which may allow or encourage the avoidance of individual responsibility for actions during "possession." In the traditional context, the power of the spirit would reject many of these behaviors or activities. The powers of traditional healers, an individual's personal power, the Shaker healers, or the higher power within Alcoholics Anonymous must be stronger than the power of alcohol or drugs to effect long-term abstinence or control.

The city lacks access to culturally appropriate and meaningful "things to do." Several KMHCC clients from local tribal groups relate that since they came to the city they are unhappy: there is "nothing to do." Things to do may be defined as "rural and woodsy." One cannot hunt in Wrights Park. Burnings (destruction of possessions) or give-aways (potlatches) seldom occur within the urban environment. There is less ceremonialism, such as name givings, which provide basic cultural support to the urban Indian. Unfortunately, similar complaints also are echoed by recent migrants from rural and isolated reservations, who desire access to the stimuli of urban living. This "lack of things to do" in both environments demonstrates the dilemma of participating in two distinctly dif-

ferent and at times conflicting cultural milieus. A KMHCC staff member describes the urban situation in the following way: "It is really a trade off; individuals may come to the city for the chance at a job and economic independence [non-Indian culturally defined success] and instead find unemployment and the lack of the networked emotional and spiritual support system which is 'necessary' to keep oneself in balance with the world and in good health."

Kwawachee staff recognize the need to provide clients with access to individuals knowledgeable in Indian and Native bereavement practices, ceremony, and symbols to assist them in coping with the stress of death in the community. A fatalistic approach to "tragedies" and death may be symptomatic of the extent to which death pervades the tribal community. Pierce County vital statistics indicate that the Puyallup tribal community experiences at least two deaths per month. Although traditionally viewed as the natural way of things, as "these things happen" the high rate of mortality among the contemporary Puyallup community is disturbing. Separation from the ritualized or ceremonial systems of the reservation complicates the grieving process and mitigates against psychological closure.

Ethnic Identity and Conflict

KMHCC personnel recognize the need to address the difficulties that a client faces in coping with the cognitive dissonance typical of biculturalism and rapid culture change. Internal value conflicts are discussed openly to help the client realize that he/she is not alone in possessing attitudes contrary to those of mainstream American society.

Mental health therapies which build upon success models and achievement orientations typical of mainstream American society have limited utility among KMHCC clients. For example, rewards built into the token economy approach in behavioral psychology, which accentuate the personal acquisition of wealth, may not be effective in motivating compliance to a behavioral regimen. However, culturally sensitive rewards featuring the acquisition of items to be redistributed at a "give-away" can be expected to be more appropriate to the value set of the community. Indian and Native people of the Northwest generally had redistributive economies such that prestige was maintained through the redistribution of wealth both in public ceremonies and in localized community contexts. This traditional orientation still exists to an important extent among many of the members of the Puyallup tribal community. For those participating in the redistributive economy, sometimes called the "give-away life", a sig-

nificant portion of the economic resources of the household and the extended family network may be consumed in order to gain prestige.[4]

Indians and Natives may not define long-term goals in the same manner as the general population. The population tends to respond in a survival mode to the "concrete realities of the present" (Spindler & Spindler, 1957). Success is defined in terms of survival instead of accrual of property and wealth. Individuals are more inclined to accept things as "just the way they are". Hence, individuals under stress often present in extreme crisis, especially if self-referred, or triaged by tribal and non-tribal service providers. Consequently, goal-oriented therapies built around the expectation of long-term future gain and change may not be as culturally sensitive as therapies that are contextual and experimental in nature.

Within the KMHCC environment "appointment" and "on time" may mean to the client, "sometime today" and to the counselor, "Tuesday at 8:30." Clinical personnel must be able to take a flexible middle ground approach to meeting with clients. Clinicians can not be rigid in their expectations of schedules, but must expect responsibility from clients in meeting agreed appointments so as not to interfere with the clinical opportunities of others. Sometimes clients simply can not find personal transportation or afford busses. Outreach to individuals who regularly miss appointments may not be a universally satisfactory solution because outreach does little to foster individual responsibility. Outreach itself has a danger of fostering dependence, and, at KMHCC, is tailored to individual situations and client needs.

Personality temperaments influenced by seasons and seasonal consciousness may be evident. Many traditional illnesses and spirit sickness arrive only during the winter (at least amongst the local Coast Salish Longhouse community). Self-concept may be based upon fishing and hunting professions even though these activities are only part-time or seasonal. Seasonal work can cause economic hardship on households with concomitant stress through periodic lack of money or job loss due to time taken off from nontraditional work to pursue subsistence tasks.

Traditional activities are valued and exercised. This may not be limited to self-concept, but can extend into family structures, gender identity, and social organization. Traditional segregation of gender roles often is expressed in the modern context in a slightly altered fashion. Women may still take care of things immediately at hand: earning a steady income, caring for children and the household. Men may wait for the cyclical return of the big chance: either the fish or the symbolism of the fish or the big kill in the hunt. It is the "big" job, the large catch, the heroic act which define the male role. The social responsibility of the male, even in the modern context, frequently is to maintain his

political and or social power through hosting parties, drumming and dancing, and sharing his "wealth" in order to gain prestige.

Males usually find it more difficult to secure steady employment, leaving many women as the primary sources of household income. Emotional problems can arise in families because of this subsequent loss of power among males. KMHCC clinicians aid the client in learning how to express this anger in socially acceptable ways so that it is not directed towards family members.

KMHCC personnel bear a unique burden because of the multicultural, urban nature of the Puyallup tribal community. Building individual identities based on ethnicity requires the development of a pan-Indian and Native ethos capable of bridging diverse cultures. Once developed, however, nurturing this multicultural perspective becomes an important means of promoting mental health. Many members of the Puyallup community already display this ethos and serve as role models to individuals in crisis.

Client-Practitioner Interaction

American Indians and Alaska Natives generally are more reserved and less demonstrative than the general population. Small talk is not popular. Words are important and powerful, used carefully, sparingly. Nonverbal communications and small group interactions are extremely important. Silence is acceptable, respected, and sometimes expected. In response to one researcher's inquiry as to the nature of Indian quietness, a perturbed Navajo father responded with some emotion: "Next time you should study on those people who talk too much" (Guilmet, 1976).

Silence is also the safest response to unpredictable, uncontrollable, or unfamiliar situations. For example, Basso (1970) stated that the Western Apache refrain from speaking when meeting strangers. The Western Apache do not feel compelled to "introduce" persons who are unknown to each other. Eventually, it is assumed, they will begin to speak. However, this is a decision that is properly left to the individuals involved, and no attempt is made to hasten it. Outside help in the form of introductions or other verbal routines is viewed as presumptuous and unnecessary. Strangers who are quick to launch into conversation are frequently eyed with undisguised suspicion. Keeping silent among the Western Apache is a response to uncertainty and unpredictability in social relations.

It seems clear that the strained, foreign interactions typical of client-mental health practitioner interactions will elicit silence from some Indians and Natives. This raises questions regarding the applicability of Western "talk therapies" among this population. An important question for clinical research is the

relationship between traditionality and the display of silence in clinical contexts. A second question is the extent to which silence influences the amount of attention clients receive from practitioners, and thus the comprehensiveness and effectiveness of subsequent interventions.

Individuals may display a deeply held belief that another's problems and foibles are that person's own, and not to be mentioned or noticed publicly. This behavior reflects the general value of non-interference in the autonomy of another individual (Spindler & Spindler, 1957). Even though the entire community may know something about someone, it usually is not talked about or spoken of openly. "That sounds like a personal problem to me," may often be articulated in the face of open questioning, complaining, or gossip.

At KMHCC Indian and Native individuals may sit together for hours without saying anything to each other. The need to fill silence is not as apparent (Guilmet, 1978). Eye contact may be perceived as a sign of disrespect, so that lack of it seems disconcerting to some non-Indian counselors. Respect may be shown by not staring or looking at others (Hall, 1969; Lewis, 1975). Individuals often understate actions or past accomplishments, activities, or events; and when recounting the past, may offer sparse descriptions in informal interpersonal groups (Weiringa & McColl 1987).

KMHCC "client intakes" are handled differently than among other populations. The initial impressions of the client of the mental health clinic can send away a person in need (and potential client). Important considerations, especially for the receptionist or person answering the telephone, and not just therapists, include eye contact or lack of it, interactions which make the individual feel supported, welcomed, respected, and valued as an individual.

Instead of asking direct questions, the intake may take longer and involve personally supportive conversations centered around client needs. During intake, KMHCC staff explore the "generational history" of a client in order to determine traditional background and to define the support network. Intake personnel have commented that they were not even aware of the many "traditional hangovers" which are a normal and accepted part of their own lives.

When pressed for explanations, KMHCC clients often present problems in the form of a "story." Counselors are expected to listen quietly until the story is completed and then seek clarification. A pattern of question-answer, question-answer, is not necessarily appropriate, and may in fact lead to silence. Questions that ask "why" contain a judgemental component and should be avoided (Spradley, 1979). "They {why questions} indicate to the informant that they have not been clear, have not provided the right answer, or that their actions were not understood or condoned by the interviewer" (Lange, 1987, p. 16).

The use of a professional vocabulary, in most cases, detracts from the therapeutic relationship because of the inability of the client to understand the therapist in culturally meaningful terms. Pioneering research in the field of cross-cultural psychiatry (Bergman, 1973a, 1973b, 1974) has shown the difficulty of "...moving rapidly back and forth between two cultures and the systems of healing proper to each and trying to find appropriate roles for mental health people, in a receptive but wisely skeptical community." (Bergman, 1973b, p. 10)

Anger and Traditionaltity

KMHCC personnel constantly deal with anger and resentment on the part of their clients. Indians and Natives often view themselves as members of conquered, occupied nations. This deep bitterness is based upon historical realities. KMHCC counselors report that many times clients are unaware of the source of their anger. Clinicians seek to help the individual to express anger in socially acceptable ways. Some clients do not feel that it is acceptable to express anger. Thus, frustrations build and can become expressed dangerously while drinking. Unfortunately, this anger may be directed towards those from whom the individual would otherwise receive the most care, support, and affection.

KMHCC clinicians often try to convince young clients that there is power in, significant levels of success that can be accomplished through, and potential influence that can be exerted upon the "system" by the continued expression of traditional values. In this way, the Indian or Native child can assert faith in their family and their community. Children must, perhaps, be convinced that they will not lose this "membership" and value orientation through continued exposure and participation in the dominant society's "conflicting value system." Many Puyallup children still, unfortunately, do not believe that one can and should be proud to be an American Indian or Alaska Native.

KMHCC counselors walk a fine line between assistance and interference. Clients will not accept callous intrusions into personal or familial situations, but will respond if, in the client's judgement, the counselor is sincere, sensitive, and worthy of personal trust. One KMHCC counselor stated simply "know the client; know the situation; trust your intuition and judgement". Counselors who are identified as having heavy investment in the values, attitudes, and behaviors typical of mainstream society find great difficulty establishing an effective client-practitioner relationship. Non-Indian counselors must demonstrate exceptional sensitivity in order to break through this resistance.

Given the noninterference orientation of Indians and Natives, counselors also should anticipate that many individuals will not want to recognize or accept the constraints of traditional values, sentiments, beliefs, or practices of their elders.

It may be counter-productive to encourage involvement in traditional activities and behaviors when the return to traditionality is not perceived as a valuable activity by a client. Traditionality is not a universal panacea to the multiple ills of Indian country. In the KMHCC experience there is no easy, linear, progressive "fix".

Conclusion

As an agency under the direct control of the Puyallup Tribal Council, the Kwawachee Mental Health Counseling Center provides mental health counseling services with sensitivity to the needs and desires of the local Indian and Native community. The cultural lessons described above for clinical mental health practice stem from direct experience and involvement in the tribal community.

KMHCC counselors are either members of the Puyallup community, or State certified minority (American Indian and Alaskan Native) specialists experienced in the local context. Consequently, the level of trust between therapists and clients as well as their families is significantly improved. As Puyallup tribal community members raised within and/or sensitized to Indian and Native culture, KMHCC professionals are intimately familiar with local ways and are able to communicate and understand their clients' problems. Counselors are familiar with the economic necessities which often force stable, capable Indian families to move frequently or to live with extended family members. The traditional and responsible use of extended family members as caretakers is viewed as a normal part of community life.

KMHCC's therapists are familiar with the common practice of encouraging and recognizing competence, responsibility, and pride in children at an earlier age than the non-Indian community. As members of the local tribal community, KMHCC staff are familiar with cultural differences between tribes, as well as intercultural and interfamily patterns. Members of the larger Indian health and social support network managed by the Puyallup Tribal Health Authority, KMHCC professionals have immediate access to various tribal resources.

Because KMHCC's goals are to prevent family breakups, support Indian families in crisis, and to provide mental health services to individuals in a culturally aware manner, the staff and program are viewed by the community as less threatening, less disruptive, and more sensitive than those of the State of Washington or private non-Indian providers. Recent research has verified that because of this trust, the rates of referral from households to providers associated with the Puyallup Tribal Health Authority are extremely high (Guilmet, 1984).

When interviewing or counseling community members, tribally employed therapists are not judgmental of their low income and housing situations, common law marriages, and other life styles often stigmatized by the majority culture. Within the tribal community of which KMHCC is a part, cases are judged on individual merit and not upon conformity to the dominant society's values. As an integral part of the local tribal community, the Kwawachee Mental Health Counseling Center has access to and utilizes traditional strengths and practices not available to, or perhaps even known, in the non-Indian community. Counseling services are sensitive, holistic, and integrated within the broader medical and social support network managed by the Puyallup Tribal Health Authority. They are American Indian and Alaska Native resources.

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Notes

1.We understand that it is technologically impossible to present coauthorship in an American Indian and Alaskan Native spirit of mutual cooperation without individual aggrandizement given the implicit interpretation of order. However, we simply wish to comment that, on our part, there is no difference between authorship and coauthorship. We regret that we have had to acquiesce to a linear progressive format. Such alien and non-oral format does not allow for the mutual hermeneutic exchange of ideas and considerations in an egalitarian context. We have decided through much trepidation to submit to an alphabetic solution.

2.The authors would like to thank those who have commented on various drafts of this paper. We would especially like to thank the mental health professional staff at Kwawachee (Aleicia Charles, Steve Fenwick, Dr. Robert Houck, and Marsha Fulton) for their involvement in the generation of clinical information and their comments during all stages of this research. Further, the authors wish to thank Ruth Currah (Children's Mental Health Specialist who works closely with the Tribal School, Tribal Children's Services and Kwawachee) for her observations. However, the authors accept sole responsibility for any problems that might exist with this paper or our interpretation of their comments and responses.

3.Written comments by John Crumbley, a former Kwawachee counselor and currently a doctoral candidate in counseling at the University of Oregon, Eugene, Oregon. August 8, 1987.

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Announcing the Ninth National Indian/Native Health Conference

The Ninth National Indian/Alaska Native Health Conference, will be held in Seattle, Washington at the Red Lion Seatac Inn, November 9-12, 1987. The conference is sponsored by the National Indian Health Board (NIHB) and hosted by the Northwest Portland Area Indian Health Board.

As suggested by the conference theme, "Indian Health--Consumer Challenges," the meeting will focus on the major medical problems and policy issues affecting the delivery of health services to this country's 1.4 million Native Americans. As explained by NIHB Chairman Melvin Sampson, "our theme for this year's conference was selected to emphasize the continuing need for Indian People to have an active, meaningful role in determining the future of their health care programs."

According to NIHB Executive Director Jake Whitecrow, a number of presentations and workshops should be of interest to professionals in mental health disciplines. "In planning this conference we have selected four broad areas of interest, and within these areas are selected topics dealing with the mental and emotional health of Indian people."

Among the topics that may be of particular interest to mental health professionals, says Whitecrow, are domestic violence, AIDS, Indian child welfare, services for Indians with handicaps, alcohol and substance abuse, traditional Indian medicine and culture, chronic diseases, and health promotion. Other subject areas include current legislation affecting Indian health programs, the Federal budget process, physical fitness, nutrition, and environmental health.

In addition to the presentations and workshop sessions conducted during the four-day event, conferees will be able to participate in a host of other activities, including a health fair (screening, testing, and counseling), health run, aerobics classes, substance abuse seminars, exhibits, a banquet and awards ceremony, and a pow wow.

The meeting is open to the public. Conference fees are $40 pre-registration; $50 on site registration, and $30 for seniors and students. For those able to attend only one day, a special $20 daily fee will be available. A separate fee of $18 is required for those interested in attending the banquet.

Additional information--including registration forms, a tentative agenda, and conference poster--can be obtained by contacting the National Indian Health Board; 50 South Steele, Suite 500; Denver, Colorado 80209 Phone: (303) 394-3500.

From the Society of Indian Psychologists

The Society of Indian Psychologists (SIP) convened in New York City in August, 1987 to become an official sub-division of the American Psychological Association (APA). SIP is a charitable, non-profit organization which represents an increasing number of professional psychologists who work with American Indian and Alaska Native people. The National Center looks forward to establishing a supportive relationship and to encouraging the promotion of mental health research within the Society and in the individual communities of its members. Toward this end, Dr. Teresa LaFromboise, President of SIP, has been invited to describe the functions and activities of her organization.--The Managing Editor

In conjunction with the American Psychological Association's annual convention, the members of SIP held a brief, but important, business meeting to establish and issue a statement of our purpose, to adopt objectives for the 1987-88 year, to announce the selection of this year's American Indian APA Minority Fellows, to elect new officers, and to address other issues and topics presented for discussion.

We additionally were pleased with the selection of topics presented at the APA convention addressing American Indian issues. Joseph Trimble, Ph.D., Department of Psychology, Western Washington University, presented two papers entitled "Stereotypic Images, American Indians, and Prejudices" and "Psychological Diversity Among American Indians: Methods and Concepts". Candace Fleming, Ph.D., Puget Sound Indian Health Service, presented a paper on "Family Therapy with American Indians". Arthur Blue, Ph.D., Brandon University, discussed "Problems and Issues in Self-Identity Development: A Clinical Perspective"; Robert Annis and Barry Cornblum, also faculty members at Brandon University, addressed the issue of "Self-Identity of Indian Children: A Cognitive Perspective".

An announcement of the 1987-88 American Indian APA Minority Fellows included: Dolores Big Foot, University of Oklahoma; Connie Cowles, University of Vermont; Deborah Jones-Saumty, Oklahoma State University; Justin McDonald, University of South Dakota; Annette Miles, Oklahoma State University, and Avie Rainwater III, Oklahoma State University. Drs. Arthur Blue and Damian McShane are the American Indian representatives on the Minority Fellowship Advisory Board. In addition to the Clinical and Research awards, it

also was announced that fellowships in the field of Neuroscience are now available. Deadline for applications is January 15, 1988. Interested applicants can call (202) 955-7761 for further information.

The statement of purpose adopted by the Society is as follows:

1. To operate a national organization for non-profit, charitable, and professional purposes which include a commitment to the improvement of quality psychological services for American Indian/Native people; to address the unique cultural backgrounds, heritage, and traditions of Indian tribal communities, and to increase the SIP membership.

2. To establish an organization for American Indians and Alaska Natives who are vitally concerned about the improvement of the mental health status of this special population; to invite the solicitation of clinical and research solutions; to continue with the publication of a newsletter and to promote further involvement of members in the APA and other professional associations.

3. To create, through an exchange of skills, expertise, and experience, opportunities for career development, positive inter- and intra-personal relationships, the enhancement of Indian peoples; to sponsor conference presentations for the benefit of Indian people, to publish the findings of successful programs and distribute this information to SIP members and the newsletter audience.

4. To stimulate and promote research development on counseling and psychology intervention for publication to enlighten students, faculty, clients, and others concerned about the development and welfare of Indian and Native people.

5. To encourage Indian people to become more actively involved in the improvement of the quality of their health and to encourage SIP members to serve as facilitators within Indian and Native communities in an effort to promote the relevance of psychology.

6. To recommend to federal, state, and local government possible legislation which would improve the educational, counseling, and leadership involvement of American Indian people.

The following objectives were adopted for the 1987-88 year:

1. To build the membership of SIP;
2. To assist in the recruitment of American Indians to state and national psychological associations;
3. To publish a newsletter;
4. To become more involved in networking among our members;
5. To provide educational technical assistance to universities and legislative and accrediting offices.

The next annual meeting of SIP will be held in conjunction with the annual convention of the APA in Atlanta, Georgia from August 12-16, 1988. The themes of the convention are "Issues of the Black Male in Society and Adjustment of Refugees and Immigrants to the United States".

Teresa LaFromboise, President

Comments and/or inquiries can be directed to Teresa LaFromboise, Ph.D., School of Education, Department of Educational Psychology, Stanford University, Stanford, California 94305.