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The present issue of the journal contains three articles on several distinct, yet related areas of concern. "American Indians, Stress, and Alcohol," by Mail, reexamines the relationship between stress and alcohol consumption within this special population. She begins by reviewing current definitions and thinking in regard to stress, gradually linking these various views to the role and function of alcohol consumption in Indian and Native communities. This discussion serves as a backdrop for her careful review and update of studies of alcohol abuse/dependence, that suggest a range of causal factors, many of which can be understood in terms of different forms of stress. Mail then shifts the focus to her central question: "Does psychogenic stress -- a physiologic response to a perceived stressor that may in itself induce disease -- contribute to the high risk of alcohol abuse/dependence that is characteristic of many Indian and Native communities?" "Yes," she concludes, based upon her synthesis of results yielded by other lines of inquiry and extrapolation of them to the Indian/Native context. Mail subsequently calls for broadening the research agenda with respect to the interaction among Indian/Native people, stress, and alcoholism to include physiological conditions that may have important implications for the genesis of this illness as well as its prevention and treatment.

As Schacht and her colleagues point out in their article, "Home-based Therapy with American Indian Families," a number of the problems for which home-based therapy may be best indicated include those brought on or exacerbated by stress and alcohol abuse/dependence. The authors open with a brief overview of the therapeutic goals and format of this type of intervention. They next discuss the need for and ecological appropriateness of home-based approaches in working with Indian and Native communities. A detailed review of the components of effective therapy follows, with frequent attempts to illustrate process issues that can arise in the extension of such techniques to Indian clients. Several case examples highlight the types of problems that Schacht, Tafoya, and Mirabla actually encountered in their practice, underscoring the need for non-dogmatic, flexible strategies in applying home-based therapy to complex, dysfunctional family systems. This article enriches the therapeutic literature by providing a thoughtful, concrete discussion of a form of intervention that is often advocated but seldom explicated.

The third and final article, "Abuse and Neglect of American Indian Children: Findings From a Survey of Federal Providers," by Piasecki, Manson, Biernoff, Hiat, Taylor, and Bechtold, considers a phenomenon that is intimately tied to alcohol and stress within Indian families. The authors report a survey conducted by the Indian Health Service that employed key informant interviews to gather information about the emotional and psychological status of Indian children, from birth to 21 years of age, within

two Service Areas. The children in question were selected on the basis of current treatment, need thereof, or history of abuse/neglect. The investigators queried providers about such abuse-/neglect-related factors as living arrangements, handicapping conditions, familial disruption, psychiatric symptoms, substance abuse, and school adjustment. Their findings, though limited by certain aspects of the study's design, are consistent with those reported for the general population, yet differences of magnitude frequently emerge. Histories of abuse and neglect were strongly related to severe levels of family chaos, to increased psychiatric symptoms, greater frequency of running away as well as expulsion from school, and greater involvement in drugs. Hopefully, future studies will be able to move into community settings and address this sensitive topic in a more direct fashion.

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

AMERICAN INDIANS, STRESS, AND ALCOHOL

PATRICIA D. MAIL, M.P.H., M.S.

Abstract: American Indian drinking behavior is often attributed to stress. The causal relationship of stress to Indian drinking and alcohol's role as a stressor is explored. It is likely that some drinking behavior is a response to psychosocial stressors, and that rapid ingestion or large quantity alcohol consumption may also precipitate the psychogenic stress response, thereby exacerbating stress in the individual. Using alcohol to reduce stress increases opportunities for injury and illness.

Research increasingly reveals relationships between psychogenic stress and specific disease states. Because alcoholism is said to be exacerbated by stress, a review was undertaken to determine whether or not a causal relationship could be identified between psychogenic stress and alcohol abuse. Specifically, the focus is on American Indians and Alaska Natives (vs. Indian) because the literature on Indian drinking often cites stress as a precipitating or causal factor in Indian alcoholism.

What Is Stress?

Stress is a word commonly used to refer to a wide range of situations, conditions, states, and circumstances that are presumed to adversely affect people. The unabridged *Random House Dictionary* (Flexner & Hauck, 1987) defines stress variously as:

...physical, mental or emotional strain or tension, or a situation, occurrence, or factor causing this...

and/or

...Physiol. a specific response by the body to a stimulus, as fear or pain, that disturbs or interferes with the normal physiological equilibrium of an organism...

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One of the earliest definitions of stress was promulgated by Hans Selye in 1946 in which he proposed that stress was the nonspecific response of the body to any demand made upon it to adapt whether that demand produced pleasure or pain (Allen, 1983). Allen goes on to note that most stress encountered by individuals in this culture is psychogenic (in which a biologically inappropriate fight or flight response is elicited within the body). This process itself can cause disease. But does this process cause alcohol abuse? And what are the links between alcohol abuse and stress?

Allen (1989) describes three types or subcategories of stress: psychogenic, psychomolletic, and psychosomatic. Psychogenic stress is the physiologic response to a perceived stressor, and is sufficient to cause disease by itself (e.g., such as hypertension or migraines). Psychomolletic stress is that in which the mind is not sufficient to cause a disorder but it can make it more likely for a disease to happen because resistance is weakened (e.g., cancer). Psychosomatic stress is that in which the mind plays a role in the healing process. It is a positive application of stress, and the one with which Indians in the past may have been familiar.

Stress is not apt to be a cause of most clinical disorders, but rather a mediating or exacerbating factor. Recent research in the neuroendocrine physiology of the stress response has demonstrated the extensive damage cause to a variety of organ systems through continued stimulation of the nervous system and prolonged exposure to the catecholamines. An excellent discussion of the physiology of stress can be found in Allen's *Human Stress, Its Nature and Control* (1983).

Where alcohol abuse is concerned, stress of one sort or another is widely attributed to be a factor in clinically-observed illness. An article by Hamburg (1980) noted that stress is viewed as a contributing factor to problem drinking and alcoholism. On the positive side, she suggested that stress points in life are likely to be teachable moments and times when educational interventions would be most likely to contribute to the learning of nondestructive ways of dealing with stress (Hamburg, 1980).

It is proposed that the stress commonly cited as a factor in Indian alcohol use is psychomolletic, with its origins derived from maladaptive psychosocial or sociocultural responses to circumstances of present existence. In the Indian alcohol literature, stress is variously described as both a contributor to as well as a result of alcohol abuse.

Stress Originating In Culture Change

Stress that contributes to abuse is often described as resulting from deviant cultural change, either too rapid acculturation, or to deculturation. Acculturation stress is the result of the demands to integrate into, and identify with, another, more dominant culture. Deculturation stress is that resulting from the loss or devaluation of historical tradition (Brod, 1975).

Examples of culturally derived stress can be found in a variety of studies. Hackenberg and Gallagher (1972), as well as Stull (1973), addressed the costs and negative consequences of modernization among the Papago Indians (now known as the Tohono O'odham), while Topper (1980) addressed the use of alcohol among Navajo male adolescents who were experiencing difficulty in adapting to white culture. Rotman (1969) described how the old, understood, and familiar ways of life for the Navajo were being replaced by something new, different, and often misunderstood. He proposed that alcohol was used to cope with feelings of inadequacy in the face of this rapid acculturation (Rotman, 1969).

Savard (1968) and Topper (1974) suggested that Navajo drinking was a response to the stress of acculturation and the inability of the culture to adapt to economic change. Dubbs (1975) and Graves (1971) reported on the maladaptive use of alcohol that is observed accompanying urban migration. In the case of the Alaskan Eskimo, Dubbs also noted that individuals can bring "preurban" personal experiences that were stressful in the villages with them to the cities, and these, coupled with and compounded by urban stresses, can create a new stress complex for the migrants. Berreman (1964) suggested that 200 years of domination, depopulation, and relocation caused the Aleuts to take refuge in apathy and alcoholism to deal with deculturation.

Berlin (1986) suggested that Indian adolescent males exhibit a greater vulnerability to the stress of culture change. They demonstrate a predisposition to a variety of biological-neurointegrative problems that may ultimately be manifested in psychoses, hyperactivity, or suicide. He also proposed that the forced acculturation on reservations resulting in subsequent loss of traditional family, clan, tribal roles, traditions, customs, and religion contributed to the rise of psychopathologies. And he explored the stress of value systems that pressure individuals to accommodate, compounded by the steady disintegration of both nuclear and extended families (Berlin, 1986).

Phillips and Inui (1986) observed that acculturation is the outcome of processes that are simultaneously occurring at multiple levels within a society, and that the acquisition of alien beliefs and values produces stress which may be alleviated by alcohol use. Savishinsky (1971) reported that acculturative influences were significant sources of stress for semi-nomadic Indians of Northern Canada. They released stress by chronic brewing and drinking, as well as frequent migration back into the bush from the towns and villages that were additional sources of stress.

Fewer authors address deculturative stress. Phillips and Inui (1986) identified high rates of substance abuse, family disruption, criminal behavior, and mental illness as attributes of deculturative stress. They defined deculturation as the loss of traditional beliefs and values. This is consistent with Brod (1975) and Berlin (1986), who suggested that loss/or devaluation of historical tradition is a major source of stress.

The loss of traditional culture and institutions that provided communal discipline and socialization are cited by several authors as significant sources of stress, especially for adolescents (Ackerman, 1971; Maynard, 1969; Whittaker, 1966). Accompanying role-loss for young men is proposed as a significant source of stress (Brod, 1975; Maynard, 1969).

Injuries Related to Stress

Accidental injuries and alcohol abuse have frequently been cited as indicators of the degree of stress and deterioration of mental health within Indian communities. Studies among the Alaska Native populations (Kraus & Buffler, 1979) and the Papago of Arizona (Hackenberg & Gallagher, 1972; Stull, 1973) were conducted to explore the relationship between modernization and stress. Maynard (1969) suggested that there was an Alcohol Adjustment Syndrome which included such characteristics as failure to support one's family and being involved in automobile accidents.

Topper (1973) suggested several diagnostic indicators of social pathology in response to stress that included: 1) higher rates of suicide and homicide; 2) higher incidence of alcoholic cirrhosis; 3) increased automobile accidents; and 4) high rates of arrest for public drunkenness, drunk driving, and drunk and disorderly. Ackerman (1971) postulated that loss of warrior status might be related to the extremely high number of fatal automobile accidents suffered by male Nez Perce.

More recently, life events scales have been administered in Indian communities to try to show relationships between stress, life events, and unintentional injury (Morigeau, 1979). His initial findings were inconclusive. A related scale that has not yet been reported as administered to Indians is the Children of Alcoholics Life Events Schedule (COALES) developed by Roosa and colleagues (Roosa, Sandler, Gehrig, Beals, & Cappel, 1988). With the increasing interest in children of alcoholics and associated therapeutic interventions, this scale might yield valuable planning and evaluative information.

While unintentional injuries are considered diagnostic indicators of alcohol misuse as well as an indicators for stress, Schuckit and Irwin (1988) observed that no single symptom or indicator establishes a diagnosis. However, the presence of one or more indicative factors should alert the clinician to conduct a more thorough history taking. The combination of alcohol and inattention due to stress can prove deadly not only in the operation of a motor vehicle, but for pedestrians or individuals in their homes.

If accidents are indicators of stress, more sensitive tools to assess or rank the influence of life events might be helpful screening instruments for community workers. Additional research will be needed to refine and connect stressful life and environmental events to measurable degrees of psychogenic stress.

Other Stressful Factors

While culture change is often postulated as a major stressor that precipitates or contributes to drinking, several authors have suggested other stressors in Indian life that may also contribute to alcohol abuse. Their observations include: 1) environmental stress due to scarce resources, physically demanding climates, and the need for adequate shelter (Savishinsky, 1971); 2) anger at social inequality between Natives and non-Natives, expressed through drinking and other deviant actions including job instability, sexual promiscuity, and major transgressions against society (Norick, 1970); 3) strife-induced stress within the family unit, some of which has been attributed to the stresses and strains of acculturation, and some attributed to the dissonance between role expectations and role fulfillment (Berlin, 1986; Fischler, 1985; Medicine, 1969; McNickle, 1968); and 4) the absence of natural parents in early life (Hoffman & Noem, 1975).

Family disruption and stress may also result in increased child abuse and neglect. Fischler (1985) surmised that the most common precipitating cause of abuse and neglect is the extreme social stress experienced by parents who lack effective supports and coping mechanisms. In one study of Indian child abuse and neglect, 50% of abuse cases and 50 to 80% of neglect cases were alcohol-related, compared to 17% among non-Indians. Observed patterns of maltreatment among Indians resulted from such factors as sibling caretaking, poverty, culture change, a generation of unparented parents, alcoholism, and situational stress with ineffective social support (Fischler, 1985). Social environments unable to provide adequate support mechanisms tend to foster feelings of powerlessness/helplessness and lack of personal control. Schinke and colleagues (Schinke, Moncher, Palleja, Zayas, & Schilling, 1988b) hypothesized a relatively strong link between substance use and emotional self-regulation, and developed coping skills training programs for Indian youth to build and improve survival skills (Schinke, Botvin, Trimble, Orlandi, Gilchrist, & Locklear, 1988a).

McKirman and Peterson (1988), while not writing about Indians, developed a hypothesis that would fit Indian circumstances. They maintained that stress induces substance abuse among populations made vulnerable by specific attitudes or expectancies. Their stress vulnerability theory incorporated various sociocultural stressors as contributing to substance abuse. Chief among these were: discrimination, including stigmatization, employment difficulties, verbal harassment or even assault; and negative affectivity, an integrative construct characterized by moderate depression, low self-esteem, alienation, and trait anxiety. They hypothesized that discrimination and negative affectivity can result in substance abuse. Certainly these are conditions familiar to Indian populations, especially those residing in the border towns or on the smaller reservations surrounded by non-Indians.

Alcohol Abuse As A Response to Anxiety

The publication of the Health Field Concept in 1974 (Lalonde) raised public and professional awareness that lifestyle was a significant contributor to health and illness. The style and manner in which an individual eats, sleeps, plays, reproduces, works and socializes, combined with the influence of perceptions and resulting neuroendocrine responses, may account for much of the physical illness and psychic trauma in one's lifetime. Totman (1979) suggested that approaches to studying the social causes of illness could be divided into three main categories: 1) life events or circumstances that precede the onset or worsening of an illness; 2) personality traits linked to susceptibility; and 3) emotional states preceding to and concurrent with disease.

Totman (1979) identified a variety of circumstances in which research has demonstrated a link with disease onset. These include, but are not limited to: bereavement and loss; adjustment to a new job or role; social and geographic mobility; status incongruity; immigration; rapidly changing social environment; and social support.

For Indian populations, all of these sociocultural and psychosocial factors have been identified at one time or another as stressors contributing to alcohol abuse. An additional factor that has appeared in the Indian alcohol literature suggests that anger, anxiety, and feelings of stress that cannot be adequately expressed under normal social and cultural conditions, can be given vent when an individual becomes drunk enough to overcome culturally-mandated repression of such expression. Here, liquor serves as the reliever of tension, frustration, and anxiety.

May (1982) suggested that individual as well as community susceptibility to substance abuse might be predicted by determining the degree of sociocultural integration, the level of acculturative stress, and the level of individual acculturation and integration. Reviewing life events in the context of culture and assessing the degree to which that culture's level of social integration either mitigates or exacerbates individual and community stress, one begins to appreciate the complexity of designing appropriate interventions for different Indian communities.

One of the first psychosocial elements to be nominated as a contributing factor in alcohol abuse was anxiety. In 1943, Horton proposed drinking as a cultural means of reducing anxiety, and postulated that the primary function of alcoholic beverages in all societies was for the reduction of anxiety.

Twenty-five years later, Ferguson (1968) classified Navajo drinkers into two types: the recreational drinker and the anxiety drinker. These styles of drinking were related to lifestyle and the degree of individual social integration, or what Ferguson identified as a "stake" in society (1968). Several authors have explored the role of heavy drinking as a means of reducing anxiety, relieving stress, and overcoming the cultural mandates for proper behavior (Dubbs, 1975; Geertz, 1951; Savard, 1968;

Savishinsky, 1971; Savishinsky & Frimmer, 1973; Whittaker, 1966). Drinking that provided relief from the expectations and proscriptions of a culture has been identified as taking "time out" from the culture's usual behavioral expectations (MacAndrew & Edgerton, 1969). This style of drinking may actually serve as a stabilizing factor for some individuals and communities.

Geertz (1951) described young Zunis as using alcohol to both identify with the white man as well as an expression of hostility against him. This theme is echoed by Lurie (1971) in her discussion of Indian alcohol use as a form of protest movement. Whittaker (1966) noted that anxiety induced by the basic insecurities of life, coupled with contact with other more powerful groups, produced high degrees of insobriety among the Sioux. Drew (1988) identified several acculturative stressors that could precipitate drinking to escape the anxiety and discomfort of stress among urban migrants to Toronto. She classified these as extrapersonal stressors (e.g., financial management, transportation, employment, housing, etc.); intrapersonal stressors (e.g., concern about being on time, amount of sleep, religious practices, etc.); and interpersonal stressors (e.g., non-native understanding of natives, family size, etc.).

The relationship of drinking to spiritual experiences and the manipulation of power within Indian societies is less well understood. Carpenter (1959) proposed a changing role over time for alcohol among Iroquoian peoples, in which alcohol initially served as a means of seeking a higher spiritual experience, such as in a vision quest or search, or discovery of self. In the 17th Century, alcohol was believed to be a dream-maker, while in the 18th Century, alcohol came to be understood as the releaser of tension and aggression. In the 19th Century, during the messianic revitalization of Handsome Lake, alcohol was defined as an evil and destroyer of culture (Carpenter, 1959). It was left for the 20th Century to define alcoholism as a disease entity, although for many Indian peoples, alcohol still has the moralistic overtones of evil and violence (Mail, 1985). One hypothesis suggested that alcohol use permitted expression of hostility as a substitute for witchcraft and ghost belief (Geertz, 1951). Another is that alcohol and drug abuse have become more culturally acceptable as outlets for aggression and frustration as the practice of witchcraft retreats before non-Indian skepticism and the onslaught of acculturation (Mail, McKay, & Katz, 1989).

Proposed causal factors contributing to the use and abuse of alcohol within Indian communities are many and varied. Misuse of alcohol may derive from one or more elements within the individual's universe, from internal community discordance to external pressures. The major studies cited are summarized in Table 1.

Table 1

**Alcohol and Stress in Indian Populations:
Major Hypotheses Regarding Use of Alcohol**

Author	Year	Stress Observation or Hypothesis
Ackerman	1971	Stress from loss of traditional institutions
Berreman	1964	Seeking refuge from stress due to culture conflict
Brod	1975	Response to sociocultural stress
Carpenter	1959	Vision-seeking as refuge from change
Drew	1988	Response to acculturation stress in urban settings
Dubbs	1975	Response to acculturation stress in urban settings
Ferguson	1968	Recreational vs. anxiety drinkers
Fischler	1985	Response to stress contributes to child abuse & neglect
Geertz	1951	Alcohol highlights and relieves stress
Graves	1971	Drinking to relieve stress in urban settings
Hackenberg & Gallagher	1972	Drinking & accidents as indicators of stress
Hoffman & Noem	1975	Absence of natural parents early in life causes stress relieved by drinking
Horton	1943	Drinking as response to anxiety
Kraus & Boffler	1979	Response to sociocultural change
Kunitz & Levy	1986	Hypertension as indicator of acculturative stress

Table 1
(Continued)

Author	Year	Stress Observation or Hypothesis
Lurie	1971	Drinking as a form of protest demonstration
MacAndrew & Edgerton	1969	Drinking for "time out" from institutional expectations
McNickle	1968	Reaction to stress
Mail & Palmer	1985	Availability of stress management programs
May	1982	Loosely integrated tribes have higher risk for stress & substance abuse
Maynard	1969	Drinking as a means of coping with intolerable stress
Medicine	1969	Changes in the family that contribute to excessive drinking
Morigeau	1979	Life stress contributes to unintentional injury
Norick	1970	Response to culture conflict
Phillips & Inui	1986	Reflection of maladaptive adjustment exacerbated by alcohol
Rotman	1969	Response to culture change
Savard	1968	Response to culture change
Savishinsky	1971	To relieve stress and express anger in response to culture change
Savishinsky & Frimmer	1973	To release stress due to culture change
Shore & Stone	1973	High prevalence of psychophysiological disorders including peptic ulcer

Table 1
(Continued)

Author	Year	Stress Observation or Hypothesis
Stull	1973	Accidental injury & alcoholism as social indicators of psychological stress
Topper	1973/1974	Drinking as a response to stress because culture cannot adapt rapidly enough
Whittaker	1966	Drinking due to high stress and deculturation

The Role of Psychogenic Stress

Thus far, all of the reports cited have discussed stress as having sociocultural or psychosocial origins. Stress has been widely used to explain why and under what circumstances Indians use and abuse alcohol. But none of these studies have considered stress in its physiological context. In asking "what is stress" at the beginning of this paper, two definitions were presented: one psychological, one physiological. The vast majority of the Indian alcohol literature addresses psychological, or psychosomatic stressors.

Is it important then to consider psychogenic stress as it relates to Indians? Definitely yes. With an increasing life expectancy (U.S. Indian Health Service, 1984) and culture change inevitable medical care providers for Indian people should increasingly anticipate diseases that can result from psychogenic stress. Only a few studies to date appear to have explored this area either directly or indirectly. Kunitz and Levy (1986), exploring the prevalence of hypertension among elderly Navajo who had been subjected to acculturative stressors, reported a slight but significant trend for blood pressure to increase with age, weight, and alcohol use in men. Shore and Stone (1973) looked at prevalence of peptic ulcer among the Makah, but found no direct relationship between peptic ulcer, alcoholism, and psychiatric impairment.

No studies of Indians have been reported that look at the specific relationship between stressful life events and alcoholism, although many studies infer this. One study (Morigeau, 1979) investigated the relationship between stressful life events and injury, but the results were inconclusive. Alcohol use was not a variable in the study design, but one could infer its potential impact as an underlying factor because the general risk exposure

scale asked about the number of celebrations attended as one measure of risk.

High mean blood pressure among young men, the same age group experiencing high accident, homicide, suicide, and cirrhosis mortality rates, may be an indicator of a population that is especially vulnerable to acculturation stressors that result in chronic stress.

Indians, Stress, and Alcohol

Many authors have postulated a series of events within the social and psychological environment of Indians that cause stress. And while these stressors are believed to contribute to or promote alcohol abuse, there are also individuals in the population who--when subjected to the same stressors--do not drink. Nowhere does the Indian alcohol literature report that when exposed to one or more stressors, 100% of the population at risk proceeded to use alcohol. While the current research does not provide strong evidence for a real association between stress and drinking, an association could be inferred from the social integration model postulated by May (1982). Cohesive and well-integrated communities provide mitigating influences on stress, while poorly-integrated communities tend to demonstrate high levels of stress and concomitant substance abuse.

Evidence of disease in those who use alcohol is well established for non-Indians. There are fewer reports of research in the Indian literature where rigorous research methodology, such as quantity, frequency, and dosage over time, have been applied. Exceptions include research among the Apache, Hopi, and Navajo conducted by Kunitz and associates (Kunitz, Levy, Odoroff, & Bollinger, 1971; Kunitz, Levy, & Everrett, 1969; Levy & Kunitz, 1974; Whittaker, 1962), and the Fetal Alcohol Syndrome (FAS) survey conducted by May and associates (May, Hymbaugh, Aase, & Samet, 1983). It has been well established that chronic alcohol ingestion will, in many individuals, result in the development of cirrhosis of the liver, greater susceptibility to cancers and degenerative conditions. However, the majority of research on Indians consists of self-reports and retrospective data drawn from clinical, psychological, and law enforcement records.

Do difficult circumstances of living create stress and cause Indians to drink? For long-term and complex disorders, this is often difficult to demonstrate, particularly for behavioral or emotional problems.

The Indian alcohol literature discusses both a variety of things which are presumed to cause drinking, as well as drinking behavior that is cited as the cause of problems following drinking bouts. The causes are multiple and complex, and culturally-appropriate screening methodologies for assessment of individual risk are not yet well developed. McKimman and Peterson (1988) observed that so-called objective stressors such as unemployment have substantially different meanings to different people, so that what is stressful to one individual is not to another. The various

components of these complex stressors have not been completely identified and ranked by degree of ability to invoke the stress response.

An additional confounding factor is the recent evidence for biological susceptibility for alcoholism (Cloninger, Bohman, & Sigvardsson, 1981; National Institute on Alcohol Abuse and Alcoholism, 1987; Schuckit, 1987). While repeated ingestion of alcohol can cause addiction, there is evidence that, there is also a genetic susceptibility to alcoholism for some individuals. When susceptible individuals are exposed to alcohol, they will develop the disease of alcoholism. These findings have not been linked to studies of stress, nor have there been studies reporting levels of perceived stress in susceptible vs. non-susceptible individuals. Research should consider whether or not high stress environments might contribute to the acceleration of the disease process in susceptible individuals.

Alcohol As A Stressor

In addition to the stress-alcoholism equation, is there evidence for alcohol abuse as a cause of stress? Here, evidence is beginning to accumulate. Blum and Trachtenberg (1988) report brain receptor sites for the metabolic products of alcohol (e.g., tetrahydroisoquinolines). A craving for alcohol may be related to a deficiency of the naturally-occurring opiate-like substance, as well as other neurotransmitters. This deficiency can occur genetically or as a result of prolonged stress or long-term heavy drinking. These researchers proposed that by treating the imbalance chemically, it might be possible to alleviate the craving for alcohol. A therapeutic intervention of this nature, coupled with strong counseling and aftercare programs, might yield sobriety maintenance rates considerably higher than current levels. Certainly this is an area that health care providers to Indian people might wish to explore, as many clients of Indian alcohol programs seem to experience frequent relapses, and the counseling staff is spread thinly in high-prevalence communities.

Other evidence is being published suggesting that alcohol ingestion may induce psychogenic stress. A recent report in the *New England Journal of Medicine* reaffirms that excessive ethanol consumption is probably responsible for most of the medical disorders associated with alcohol abuse, and that malnutrition potentiates the adverse effects of ethanol (Diamond, 1989). Thus, such problems as alcoholic cardiomyopathy may be the result of malnutrition, ethanol ingestion, and chemicals released within the body as a response to the stressors of inadequate diet and drinking. As cardiomyopathy has been observed in individuals who were not malnourished but alcoholic, ethanol is implicated as a major cause for this condition.

Schuckit and colleagues (Schuckit, Gold, & Risch, 1987) used the pattern of change in plasma cortisol levels following ethanol challenges to help characterize differences in response to alcohol in sons of alcoholics and controls. While these researchers were looking for neuropsychological

attributes to distinguish individuals at risk from normal, non-risk controls, they were also assessing a product of the stress response: cortisol.

Allen (1983) identifies cortisol as one of the most potent hormones of the entire stress process. Schuckit and colleagues (1987) report that with rare exceptions, human and animal studies indicate that cortisol level increases after ethanol ingestion if the dose is high enough and/or the rise in blood alcohol concentrations is rapid enough. This strongly suggests that ingestion of ethanol in and of itself is a stressor. High ethanol consumption triggers the stress response as well as increasing the risk of addiction. Equally important from a clinical standpoint, it contributes to immunosuppression (Jerrells, Marietta, Bone, Weight, & Eckhardt, 1988). As components of the stress response also contribute to impairment of the immune system, the combination of alcohol ingestion and neuroendocrine response to stress can leave an individual extremely vulnerable to infection.

Allen (1983) attributes the risk to the immune system as a result of elevated levels of cortisol. Cortisol is one of the glucocorticoids released from the adrenal cortex as a part of the stress response. Cortisol's main action is to accelerate gluconeogenesis, the creation (genesis) of new (neo) somatic fuel (gluco). Protein-based gluconeogenesis can draw on muscle tissue for fuel if there is insufficient supply of fatty acids available. The drawing down of the body's protein supply means that protein is not available to manufacture and replace cells that die. Muscular atrophy and cellular immunity are the result. Allen (1983) notes that the white blood cells or lymphocytes, are particularly affected. By mobilizing proteins, cortisol decreases the production of lymphocytes, decreasing the ability of the body to generate an immune response.

Additional evidence is reported by Swartz and colleagues (Swartz, Drews, & Cadoret, 1987). Their research sought to validate the stress-reduction theory (Powers & Kutash, 1985; Stockwell, 1985). They set out to determine if alcohol would diminish the stress-induced release of epinephrine, presumably through disinhibition or sedation. When subjects were given alcohol and stressed, a pattern of epinephrine, but not norepinephrine elevation, was observed. This suggests that alcohol is not just a central nervous system depressant, but creates stimulant effects like elevation of blood pressure. Swartz, Drews, and Cadoret (1987) postulate that central nervous system stimulation might contribute to alcoholic behavior and strongly suggests that alcohol ingestion is, by itself, able to produce a stress reaction.

Other evidence for alcohol as a stressor is observed in the alcohol withdrawal syndrome. This is characterized by increased anxiety, tremulousness, paroxysmal sweats, increased diastolic and systolic blood pressures, increased heart rate, and reduced sleep. Linnoila (1987) reports that most of these are symptoms of sympathetic nervous system over activity, and may be alleviated by pharmacological manipulation. Linnoila suggests that enhanced norepinephrine turnover that is causally associated

with the severity of the withdrawal symptoms. This stress-related reaction is also a result of having ingested alcohol.

Implications for Health Care Workers

This paper started with the hypothesis that Indian alcoholism is caused by stress. The Indian alcohol literature presents a number of suggestions about the types of stress that might initiate or contribute to alcohol abuse. But no studies actually discuss stress from a physiological frame of reference. Stresses identified have all been perceived as external to the individual, or have been described in terms of psychological and emotional reactions rather than a physiological stress response. Several studies have suggested that rather than drinking in response to stress, some Indians drink for recreation or religious reasons, with the resulting drunken behavior producing stress.

In looking at alcohol ingestion itself as a cause of stress, there is some evidence that rapid or copious ingestion does trigger the body's stress response system. And the provocative report by Peris and Cunningham (1986) suggests that consumption of alcohol under stressful conditions (e.g., those that trigger the stress response in the body) may actually reinforce alcohol's perceived euphoric properties.

If Indian people exist under circumstances that are stressful, as many authors postulate, and these conditions in one way or another repeatedly trigger the body's stress response, then the ethnographic observations that stress causes the alcohol abuse may actually have physiological validity.

The elements underlying Indian drinking are complex, but fall into three major categories: biological, psychological, and sociocultural. Biologically, some individuals may have a degree of genetic susceptibility. Psychologically, failure to master good coping skills or to exhibit behaviors consistent with community norms may lead to abusive drinking. Finally, an association may be observed between the degree to which the society is integrated and structured, and the degree to which its members misuse alcohol. Many factors in reservation and urban environments have been identified that, to a greater or lesser degree, contribute to or reinforce destructive drinking patterns. The challenge lies in developing ways to counter, avoid, intervene, and protect against the negative elements, while reinforcing the positive attributes existant within Indian communities.

For the providers of medical care to Indian people, it is clear that research to clarify the nature of alcohol abuse and addiction will help in improving and refining prevention, treatment, and rehabilitation approaches and programs. The contribution of psychogenic stress to illness and lowered immune levels has implications for counseling and patient education.

If stress is a factor, then what resources are available to ameliorate stress in Indian communities? A national survey conducted in 1985 found

that 59.9% of Indian reservations had access to some form of stress management class. The availability varied greatly from area to area, with the lowest availability being in the Billings Area (38.4%) and the highest availability in the Alaska Area (81.8%) (Mail & Palmer, 1985). However, it was not possible to assess the quality of these programs, and one suspects that none of them actually established a physiological baseline against which to evaluate mastery of stress-reducing techniques. Throughout the U.S., there is no standard or qualifying certification for instructors, no quality assurance guidelines for courses, and no assurance of the consistency or cultural appropriateness of stress management approaches. If stress does contribute to alcohol abuse, then one can construct strong arguments for increasing the availability and maintenance of stress reduction and training in coping skills. Models for coping skills to reduce and manage stressors in life are being adapted to various ethnic groups to help prevent drug and alcohol abuse (Schinke et al., 1988b). This type of work needs to be encouraged, expanded, replicated, and evaluated. These approaches should be coupled with physical exercise programs, as there is evidence that exercise has both preventive and rehabilitative contributions toward recovery (Palmer, Vacc, & Epstein, 1988).

Conclusion

Environmental, sociocultural and psychosocial factors may serve as stressors and/or coping strategies for American Indians. Research suggests that the physiological stress response evoked by complex, multiple stressors may, in fact, exacerbate alcohol abuse. Although there is no clearly demonstrated cause and effect relationship between the current alcohol abuse and psychosocial stress, there is evidence that the physiological stress response itself may enhance the effects of the alcohol, contribute to the development of tolerance, exacerbate abusive use of alcohol, and impair the immune response. Alcohol use may have become the primary coping response for some individuals and communities. A drinking peer group may be as powerful an influence as a genetic susceptibility.

Better understanding of the human stress response and personal skill in coping with stress may determine whether an individual becomes ill or is able to live a whole, well and productive life as a member of a traditional or modern community. Continued efforts at prevention, intervention, treatment, and rehabilitation need to be developed, with increased emphasis on stress reduction and bicultural coping skills. Directions suggested by recent research should be incorporated into therapeutic program planning and implementation. Primary prevention of alcohol abuse is simple: don't start. Secondary prevention is far more complex, but answers from the disciplines of education, psychology, biology, anthropology, and medicine are coming together to provide a better understanding of the complex disease known as alcoholism.

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HOME-BASED THERAPY WITH AMERICAN INDIAN FAMILIES

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Abstract: Home-based therapy can provide an essential service to American Indian families who would not otherwise receive treatment. The theoretical, cultural, historical, and institutional contexts and their impacts on home-based therapy are examined. Some common case profiles and means of intervention are discussed, with recommendations.

Home-based family therapy provides a crucial mental health service for families who are not able or willing to utilize traditional (e.g., clinic) mental health services (Bryce & Lloyd, 1981; Cautley, 1980; Clark, Zalis, & Sacco, 1982; Maybanks & Bryce, 1979; Sherman, Neuman, & Shyne, 1973; Stroul, 1988). This is particularly important in rural Indian communities for several reasons. First, mental health clinics are often not available to these communities. Second, even if these services are available, they are often underutilized because of their distance from the homes, transportation problems, Indian discomfort in settings foreign to the culture, the stigma attached to use of the services (in small communities it is hard to keep visits to these clinics a secret), and the difficulty some Indians may have with speaking of their problems to strangers at specific appointment times. Further, the staff at mental health clinics are most often from cultures other than the Indian community they serve. Even when these services are utilized, they may be ineffective due to the greater likelihood that Indian clients, because of discomfort in this foreign setting, may be less honest or self-disclosing than they would be in their own homes.

The Need for Home-Based Therapy

Home-based therapy offers the advantages of reducing the above problems, providing a service where the client is more likely to be comfortable and honest, viewing first-hand the client's living situation and/or the context of the problem. This would include such factors as who lives there, their relationships, what resources are available, the family and physical boundaries or lack of them, the extent of the stress of poverty, and the degree of family chaos or order. For families or individuals who otherwise would not participate in therapy or do not understand what it is, home-based therapy provides a way of establishing the therapeutic relationship, which eventually could be transferred to a clinic setting. It also provides clients

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with some sense of security and control, which may be particularly important for those who feel powerless, vulnerable, and victimized. With families that are particularly dysfunctional and/or chaotic, there are often insufficient resources and/or organization to attend a weekly scheduled session at a clinic some distance away. In many cases, the choice is simply home-based therapy or no therapy, since the individuals would not otherwise seek or accept mental health services.

Home-based programs in non-Indian communities have been developed over the last 15 years with a particular focus on intervening in families where there is a high risk of a child being placed outside the home (Bryce et al., 1981; Cautley, 1980; Kinney, Madsen, Fleming, & Haapala, 1977; Sherman et al., 1973; Stroul, 1988). The Homebuilders Program, begun in 1974 in Tacoma, Washington, demonstrated a high success rate in keeping children from placement outside the home, and was more cost-effective than out-of-home placement and treatment (Kinney et al., 1977; Stroul, 1988). The National Resource Center on Family-Based Services of Oakdale, Iowa, now provides information regarding home-based programs nation-wide, as well as training for home-based therapists. These programs are oriented toward empowering the family and parents, and utilize various interventions including immediate crisis intervention, easy accessibility of services, linkage and advocacy with other community programs, and training in specific skills such as parenting. They vary in length from short, intensive intervention (e.g., in the Homebuilders Program, 30 days' service with roughly 20 hours per week during these 30 days) to mid-range, brief treatment programs, to long-term intervention programs (such as that described by Clark et al., 1982; Stroul, 1988). Some involve a highly-structured approach involving team assessment and intervention (e.g., Cautley, 1980), while others are very informal with little structure, provided by one therapist (e.g., Clark et al., 1982). (See Stroul, 1988 for a comprehensive review of these services.) Some of these models are applicable to home-based services in Indian communities, while others are less likely to be successful, as will be discussed below.

The Communities

This paper refers to the experience of three mental health professionals in providing home-based family therapy to Indian communities in northern New Mexico. The families seen were typically those whose problems had not been effectively addressed by the traditional community resources (e.g., the extended family, clans, societies, or tribal government). Reasons for the breakdown of the helping system for these families included: families with chronic, intergenerational problems (including alcoholism); families where one or both spouses were from a different tribe or were of a different religion than the prevalent religion; families where a family member or ancestor had committed a "sin" in the eyes of the community (which then was hesitant to help them); families where the

woman had children by several different fathers; and families which had not been initiated into any of the traditional clans or societies. This context, as well as the presenting problems, then influenced the types of interventions needed and possible, as will be discussed in the examples below.

The Historical Context

Home-based therapy in Indian communities requires an integration of knowledge of the literature on family therapy, with an understanding of the historical and cultural context of the Indian family. Clearly each of these areas encompasses a vast area of knowledge beyond the scope of this paper. However, there are two important historical factors that have profoundly influenced the functioning of the Indian family.

The first is the change in the economic base of the Indian communities. This was affected by both the forced migration of many Indian communities from their homeland (the foundation of their culture and economics), as well as the impact of modern technology on the Indian culture, economics, and expectations. The way these factors impacted each community affects the extent to which the adults can be economically productive in a way consistent with the values of the community. For Indian cultures that view life holistically, with each aspect of life affecting and interacting with the other, it puts a tremendous strain on the adults responsible for the economic well-being of the family (typically the man) if the only means of providing for the family are inconsistent with the cultural values. Examples are nomadic tribes being forced to live on small family plots with the expectation that they will be farmers, and peace-loving agricultural communities (such as those providing the context for this paper) who must rely on employment with military agencies responsible for developing nuclear weapons. The communities in which the authors worked are among the fortunate tribes who still live on their ancestral land. However their communities are dramatically impacted by the non-Indian communities surrounding them.

More subtly, there is the conflict between the expectations of most jobs of the Anglo community (e.g., to work regular hours, 40 hours a week, 50 weeks a year), and the religious and cultural demands of the Indian community. Deaths in the community often require that adults spend up to seven days in special ceremonies at short notice. Feast days and other religious events of the community also require extensive time commitments. Many jobs cannot accommodate these sudden and frequent absences from the workplace. This often places the family breadwinner in the position of choosing between violating cultural values but providing economically for the family, versus staying true to the culture but dependent on family and government financial support. In either case, they risk losing the respect of the community, family, and self.

The second factor profoundly influencing the Indian family is the history of the boarding schools. Many who are now the grandparents of Indian families were abruptly taken or sent from their families to live for years at boarding schools at some distance from their homes and communities. Often punished for speaking their native language, they were prevented from seeing their families for most of the year. Raised away from their own parents and communities during their formative years, they were psychologically traumatized and robbed of education in parenting consistent with cultural values. Those who returned to their native communities as young adults likely had unresolved issues of grief and dependency, and were sometimes ill-prepared to be young parents or spouses. Many had lost their language and had little knowledge of their history or their culture, or the values or the beliefs which provided the context and direction for being a spouse and a parent. This paper cannot do justice to their story, or fully address the implications of their tragic history.

Today, there are more choices for schooling (including on-reservation bilingual day schools in some communities). However, in many communities once the child reaches high school age, the choice is public school in non-Indian towns (often characterized by inter-racial tension and harassment) or boarding school at some distance. Parents may face the difficult choice of sending their children to a local school where they face harassment and conflict (the drop-out rate of Indian children in these schools is often high), or to a boarding school with other Indian children at some distance from home. For these reasons, many American Indian parents and children today have spent much of their formative years away from their family and community, raised in a peer culture with a confusion of tribal and Anglo values and world-views.

These factors, then, are part of the complex context of the families in crisis who are brought to the attention of the home-based therapist.

Components of Effective Therapy

Frank (1973) provided a descriptive analysis of the common features of healing practices across cultures, based on numerous sources of information regarding "healing in primitive societies, miracle cures, religious revivalism, Communist thought reform, the so-called placebo effect in medical practice, and experimental studies of persuasion" (p. xix). These common features of healing include aspects of the relationship between the client and helper, locales designated as places of healing, rationales or myths to explain the problem, and tasks or procedures prescribed by the rationale to effect the healing. There are particular difficulties in maximizing the effectiveness of both home-based and clinic-based therapy in regard to these factors, as will now be discussed.

Regarding the relationship between the client and therapist, effectiveness is maximized if the client has confidence in the therapist's competence and desire to be of help, and if the therapist believes that the client

can master the problem. This becomes problematic when the therapist is from another culture, particularly operating in the western clinic-style therapy mode. The credentials of the therapist may not be valued or respected by the Indian client, who may be more likely to value age, life-experience consistent with his or her culture and values, and traditional methods of thinking and healing. Men may also have more credibility and status in some Indian communities than do females, although the reverse may be true in other communities. Because of a long history of betrayal and mistreatment by those outside the tribe (particularly Anglos), the client may also doubt the therapist's desire to be of help. And the therapist, perhaps burned-out and discouraged by large caseloads of people with chronic problems, may doubt that the client can master the problems.

The therapist can address some of these barriers by sharing common cultural experiences (e.g., attending ceremonies in the community, offering help or cooperation in the community in informal ways), by talking about applicable lessons learned from his or her own experience, by establishing positive relationships with more well-adjusted members of the tribe, and by attending to symptoms of burnout. Going to the home (as in home-based therapy), because it involves more work and more risk to the therapist, also demonstrates to the client the therapist's desire to be of help.

Before discussing intimate details of the family's functioning, spending time in casual conversation, sharing meals, helping with chores, or providing a useful service (such as transportation) also helps the family feel more comfortable talking honestly with the therapist and more willing to consider the therapist's feedback. Indians are often accustomed to non-Indians coming into their community seeking information (which is often used in unwelcome ways) or making suggestions to change the community or individuals (often based on limited or distorted information and a differing value system), and typically leaving after a few years before ever really understanding the community or people. Individuals from outside the community often have little credibility until they have been integrated into the community for many years. On an individual basis, therapists from outside the community will have little credibility until they have spent time both in the community and with the Indian family in informal contact. For this reason, the brief, intensive intervention model (such as described by Kinney et al., 1977; Cautley, 1980) is less likely to be effective in Indian communities. Because of the length of time required to establish a working relationship, as well as the lack of availability of other resources for follow-up referral, home-based services in American Indian communities are more likely to require long-term involvement--sometimes over several years.

Flexibility regarding appointment times and greater availability to respond to crises can also demonstrate the therapist's helpfulness and desire to be of help. Many home-based services, such as the Homebuilders Program, include 24-hour crisis service as an essential component (Kinney et al., 1977; Stroul, 1988). When home-based therapists live in and

integrated into the Indian community, they are often effectively "on-call" 24 hours a day, since clients may often come by the home unannounced when crises arise. While this may be optimal for service delivery (although there may be risks of fostering dependency), it also is extremely stressful for the therapist, who may need to establish some limits to availability in order to avoid burnout. This can be particularly demanding when the therapist is the only professional available, as is often the case in Indian communities.

Frank (1973) found that effective healing involved designating certain locales as places of healing. This raises expectations that while in the locale where healing ceremonies are held, the client is safe from harm and not held accountable in daily life for what is done there. When ceremonies are held in the home, purification rituals are often performed. Collaboration, or at least respect for these rituals can help define the home as a place of healing.

It is clear that the clinic has the advantage of being an identified place of healing, which is not always the case in the home. Those who do home-based therapy are often well-aware that it often does not feel "safe," due to unexpected intrusions of visitors, phone calls, and being in the same environment where abuse (such as domestic violence) may occur. Families have more control and opportunities to dilute the influence of the therapist, e.g., by refusing to turn off the T.V., walking out of the room, welcoming visitors, etc. The therapist can address some of these issues by establishing an agreement with the family over intrusions, or can use the initial home visits to establish a relationship that is then transferred to the office setting. The family's willingness to cooperate with the therapist in being home at scheduled times, reducing distractions, and abiding by the agreement, is an indicator of the degree of their commitment to therapeutic assistance.

Although initial resistance can be anticipated and worked with in the ways noted above, if it continues over an extended period of time despite the therapist's efforts to establish a working relationship, the therapist and supervisor need to evaluate the costs and benefits of pursuing the therapeutic relationship. With some highly resistant and dysfunctional families, it is necessary for a major crisis or the threat of court intervention to occur before they are willing to cooperate even marginally with therapeutic efforts.

Frank (1973) notes that the rationale or myth used to explain the problem must be compatible with the culture or belief system of the client. This again is often problematic when the therapist is from a different culture and is trained in western-style therapeutic interventions and theories. Analytic-style interpretations, particularly in the context of the unfamiliar clinic environment, may seem bizarre and not helpful to the client. Similarly, a rapid, highly-structured assessment procedure based on non-Indian therapeutic assumptions (such as those described by Cautley, 1980) might be perceived as foreign and intrusive, and risks losing valuable information about the family and cultural context that would be less likely volunteered

in such a situation. Advice, analogies, or an appropriate example from the therapist's own life experience, particularly in the informal context of the home setting, may be more understandable and acceptable (and therefore helpful) to the Indian client. At the least, this offers an opportunity to determine whether the therapist's way of thinking makes sense in the client's own context.

Finally, Frank (1973) also indicates that the task or procedure prescribed by the rationale must be compatible with the client's culture and belief system. Western-style therapy by appointment one hour a week in a clinic setting is especially problematic in this regard for many Indians. Similarly, purely reflective, nondirective, and/or interpretive therapeutic styles may be regarded as strange and a waste of time. Visiting clients in their homes and eating with them are more likely to give the therapist opportunities to offer advice and examples consistent with the family's culture and values. Particularly when a family is in crisis, it is often important to make specific suggestions or interventions during or even before the first meeting. This is both to address the crisis effectively (Kinney et al., 1977; Stroul, 1988) as well as to demonstrate the therapist's usefulness to Indian clients who may often be doubtful as to the helpfulness of therapy, and want quick results.

As Nelsen (1980) notes, directives, advice, limit-setting, and advocacy are important ways of protecting and providing support for clients when they are unable to take essential effective action. If those are not provided at the time they are needed (such as during a crisis), the client may conclude that the therapist is not likely to be helpful to them, and may not follow through with treatment. On the other hand, it is important for the therapist to accurately assess the client's needs, so that advice and directives are not provided when the client is able to make his or her own decisions; doing so would disempower and disrespect the client. Indian families may need specific assistance in understanding and obtaining available resources and help from the less familiar non-Indian community. However, it is important that the agencies and individuals providing services to Indian families work to empower these families to be able to return resources themselves, rather than fostering dependency.

The Institutional Context

Financial Considerations

Who pays the salaries of the home-based therapist, and how does that impact his or her work? Although this may vary in different locations, some of the possible employers and the impact of the institutional context will be discussed next. In the experience of the authors, potential funding comes from four different sources: the Indian Health Service (IHS), Bureau of Indian Affairs (BIA), grant projects coordinated by tribal agencies, and state-funded mental health programs.

The IHS has taken a major leadership role in establishing a model for community-based series in northern New Mexico. Respecting the importance of leadership and input from the communities, they hired Mental Health Technicians native to and living in each community, who provided home-based therapy and interventions and were liaisons between the community and mental health consultants hired by IHS to provide therapy. The consultants had the option of meeting with families in their offices at a central location, or going to the homes for home-based therapy. Much of the home-based therapy provided in the author's experience was in this context.

Some training and supervision was provided, although it was difficult to find supervisors who understood the particular difficulties of home-based therapy and the specific cultural context. The consultants often found it difficult to apply textbook models of family therapy to the home environment. Feelings of isolation, discouragement when home-based work did not meet the expectations of office-based Western therapy models, and the additional time required in transportation--as well as the difficulties inherent in the home context (as noted above)--make it easier for the consultants to use an office-based model. Whether or not home-based therapy was provided depended on the commitment of the consultant to the home-based model, and on supervisory support and understanding of the unique aspects of the model. In particular, home-based work requires the trust of the supervisor that the consultant is using time appropriately (since no one can monitor this), and the understanding of the need for travel time and compensatory time for evening and weekend hours worked.

The BIA is the agency long responsible for meeting the social service needs of Indian communities. In our context, one social worker, a probation officer, and a supervisor were responsible for meeting the social service needs of eight communities with considerable distance between them. Although the small staff and different types and levels of skills (e.g., in therapy) limit the extent of services that can be provided, BIA staff also provide some home-based family interventions. These include talking or problem-solving with the family when a family member is in trouble with the law, and doing home studies or investigations of child abuse and neglect. Since these workers have offices in a central location, most of their interventions in the communities are of necessity home-based.

Although few tribes have funds of their own for social services, some receive grant money to provide social and therapeutic interventions. These grants many provide services targeted at alcohol/drug problems, services for youth, or other social services. Home-based services can be provided in this context, although they are limited by the availability of grant funds and the uncertainties of year-to-year funding.

Finally, state-funded mental health programs (e.g., community mental health centers) also can provide home-based services, which are again limited by the extent of staffing and time available. During years of more adequate staffing, efforts were made to provide outreach into Indian

communities, including some home-based therapy. However, currently limited staffing and waiting lists make it difficult to spend the extra time and energy on home-based work. As a result, mental health services are available primarily to those able and willing to come to the clinics (at some distance from the reservations).

Legal Considerations

An additional important aspect of the institutional context involves child abuse and neglect. Although the federal government passed a law in 1974 declaring child abuse illegal and requiring those suspecting it to report it to state agencies, these laws do not apply on the reservation. In addition to the guidelines provided by the Indian Child Welfare Act, different tribes have different legal responses (or lack of responses) to child abuse. In some tribes it is not against the law or not addressed by the tribal code; in others it is illegal, but there are no clear consequences for it or these consequences may not be implemented. The BIA has jurisdiction on the reservations, but tribes vary in the extent to which there are clearly-developed procedures and trained personnel to respond to reports of abuse. Some tribes have established a working agreement with state agencies to assess and treat child abuse, while others have their own staff and programs to respond to reports of abuse. It is essential for the home-based therapist in Indian communities to know the procedures and consequences of reporting abuse, as well as the limits of confidentiality regarding abuse; this enables the therapist to inform clients at the beginning of the working relationship about the limits of confidentiality. Needless to say, this information can have a powerful impact on the therapeutic alliance and the course of treatment.

Case Examples: Dynamics and Interventions

What follows are examples based on the authors' clinical experience that illustrate the different types of family problems and contexts frequently encountered, and the different modes of intervening. Many of these cases are composite examples of several such cases.

The Children-Never-Grow-Up Family

In this family there is a pattern in which the grown children (now adults and parents) remain in or close to their parents' home, and have difficulty functioning as competent adults. Often they are economically dependent on their parents or on welfare, and may have chronic alcohol and drug problems. Their parents may be over-involved in their lives, rescuing them from the consequences of their self-destructive behavior ("enabling" according to the literature on alcoholic families), and undermining their attempts to live or work independently. Wives of alcoholic sons

may be encouraged to tolerate abuse and irresponsibility, and blamed if they attempt to remove themselves and/or children from being targets of abuse. There may be a strong mutual dependency between these adult children and their parents, where each is extremely dependent on the other to meet their needs, yet never seems to get these needs met. These adult children have great difficulty parenting since they are absorbed in trying to meet their own needs, often in self-destructive ways. Their children may be chronically neglected and/or abused. Underlying these problems may be unresolved dependency and grief issues, difficulty finding suitable employment, and the dynamics which come into play around the disease of alcoholism (see Black, 1981; Wegscheider, 1981).

The referral or presenting problem may be neglect, abuse, or behavior problems of the children. Strategies may involve: interventions to stop the abuse (as elaborated in the Chronic Problem family below); referral for alcoholism treatment including working with the dysfunctional family system (see e.g., Wegscheider, 1981; Bradshaw, 1988b); and structural interventions to strengthen the marital unit and generational boundaries and encourage competent, responsible functioning of the grandparents (Minuchin, 1974). For example, the grandparents may be encouraged to talk about the norms and values for appropriate behavior when they were younger, and the consequences at that time for abusive or irresponsible behavior. Remembering these (typically more strict) norms that often emphasized responsibility, hard work, and respect for elders, can help the grandparents set firmer limits and consequences, and high expectations for their adult children, so they are less likely to tolerate or "enable" abusive and irresponsible behavior. The therapist might also express concern about the adult children's dependency on their parents to care for them, with realistic worries about the adult child's capacity to care for himself once the parents are gone. The grandparents might list the different things they do for their children, and those areas of self-care which they fear their child would at least be competent to provide after they are gone. The grandparents might be encouraged to teach and facilitate the independent functioning of their children, one skill at a time, toward the goal of having peace of mind in their old age.

This case also suggests the difficulties in applying a purely structural mode: without realistic employment opportunities for the parents (particularly the father in cultures which expect him to be the "bread-winner"), it is difficult to provide incentives to stop self-destructive behavior or to realistically strengthen the role and importance of the parental unit. This suggests an additional community intervention: finding ways to provide tribally-based employment that can be consistent with tribal values.

The length and intensity of the therapist's contact with these families varies according to the extent of dysfunction and crisis. Since the grandparents may provide some measure of stability, the families may be less crisis-oriented and more able to respond to two- to four-hour visits every other week over about a six month period. During crises, more frequent

visits are necessary. This of course would vary considerably depending on the family stability and resources.

The Fringe Family

In one such example, a single mother from a dysfunctional family of origin was having significant parenting problems and was not being helped by the traditional community resources. She was isolated from the community both because of her mixed tribal heritage (one parent from the tribe of residence, the other from another tribe), as well as the different tribal and non-tribal identities of the fathers of her four children. There was no consistent male figure in the home, and the fathers of the children were often irresponsible, abusing drugs and/or alcohol, and disapproved of by the community. The woman herself abused alcohol and drugs and had a series of abusive sexual partnerships. Since she had violated both the tribal boundary and ethical taboos, the tribe had limited interest in providing her or her children with help or support.

There were multiple referrals in this case, usually by the school and community health nurse for repeated problems of child neglect, poor hygiene and nutrition, and academic and social delays. Because of the reluctance of the community to provide assistance, these problems had been on-going for years without intervention when they were finally brought to the attention of the mental health consultant. In this case, therapeutic intervention involved providing numerous supports for the mother, including a therapeutic supportive alliance, education regarding parenting skills and health care, and (when possible) financial assistance. Coordination to facilitate the involvement of other community agencies and resources was essential, including involvement of the community health nurse, schools, and tribal social services. Involvement of the mother and children in social activities was facilitated to reduce their isolation and stigmatization. She also needed therapeutic assistance working through issues related to her own dysfunctional family (e.g., see Bradshaw, 1988a) before she could adequately parent her own children. An assessment had to be made as to whether to place her children temporarily in foster care (outside her dysfunctional extended family) while she developed the skills and resources necessary to parent them. This family required long-term support over several years, with contacts ranging from weekly to monthly; intervention on multiple levels was required before the mother developed the skills and resources necessary to adequately parent her children, as well as take care of herself. She did respond positively to these interventions, however, and is currently functioning successfully both at work and at home.

The Chronic-Problem Family

These families had typically been problematic and dysfunctional for generations; often they were labeled as such by their communities, which

had given up attempting to help them and/or were exhausted by the families' constant crises and pleas for help. There were often generations of alcoholism, poverty, unemployment, physical and sexual abuse, and dependency on outside resources (e.g., government or tribal funds). The families often showed patterns characteristic of families of alcoholics, including spouses and other family members who support and enable the alcoholic, and children who are parentified, lost or neglected, or function as the scapegoat of the family and act out family conflicts (Wegscheider, 1981; Black, 1981; Bradshaw, 1988b).

With these families there are often multiple referrals. The children may have significant behavioral problems such as chronic fighting and truancy. The nurse at the school may find evidence of physical abuse and, when the child is asked about this, hears of serious abuse and the child's fear of returning home.

Intervention in these cases involves two aspects: protection of the child, and treatment of the child, dysfunctional parent(s), and family. The means of intervention will depend on the community resources and procedures for reporting and responding to abuse. In one such case encountered, the nurse reported the abuse to the school principal, who notified Child Protective Services (CPS). CPS in turn notified the IHS Mental Health Consultant, who contacted the tribal authority to get police back-up to go with her and the CPS worker to the home. These individuals then reported the allegations to the parents. When the parents confirmed that the allegations were true, they were informed of their rights and responsibilities, and the legal implications. The tribal court then mandated a cessation of the abuse and mandated alcoholism treatment and counseling for the abusive adult.

Family therapy to address the dysfunctional family system (e.g., Wegscheider, 1981; Black, 1981; Bradshaw, 1988b), in addition to individual treatment of the alcoholic(s) and traumatized children and/or spouse, is essential in order to stop the patterns which have perpetuated individual problems. This often requires both education and legal leverage, since families may have difficulty accepting that they as a whole, as well as the individual(s), needs treatment. The home-based therapist needs to work with the more functional members of the extended family or social system (e.g., in some cases the godparents) who may be willing as "insiders" to confront abusive or substance-dependent members and encourage them to get treatment. To give them support and ideas for most effective intervention, family members can be encouraged to think of individuals in their community who stopped drinking and what precipitated their stopping. (Unfortunately, AA and Al-Anon, which are often helpful sources of such support and information, were not effective resources in these communities.)

In cases of chronic problems, it often becomes necessary to have the legal threat of the child's removal from the home and possible charges if family members are to participate in treatment and accept outside help

and intervention. Consequences are necessary because of the high likelihood of poor treatment compliance and repeated abuse. The involvement of other community agencies is also typically required to assist with employment and economic assistance. Frequently, many agencies are involved in helping these families, who may pit one agency against the other, or request the same help from several agencies. It is therefore important for the agencies involved to coordinate efforts to reduce unnecessary conflicts and duplication. Consent to receive information from all agencies involved should be obtained early in treatment. Because of the chronicity of the problems, the low motivation for treatment, and the extent of family pathology, legal leverage and follow-through are essential.

These families are often in perpetual crisis, and can require many hours each week for months. Because of family chaos, it may require several lengthy sessions before the therapist can "figure out what's going on." Distracting and urgent, frequent crises can prolong the process of addressing long-term family patterns and attempting to implement change. These families often require years of interventions (for various dysfunctional members), which hopefully decrease in frequency except for periods of crisis. The long-term goal is to increase the problem-solving skills of family members so they can begin to resolve (and prevent) their own crises with decreasing involvement of the therapist. The therapist must guard against becoming an enabler by always "rescuing" the family from crisis, and must encourage increasing competence and self-sufficiency. The therapist may also work individually with more motivated family members to strengthen their ability to cope with the difficult family situation.

The Two-Worlds Family

In contrast, there are families who can profitably use clinic-based therapy once they are aware of its availability, or once they become comfortable with involvement in therapy through initial home-based intervention. The Two-Worlds Family may be moderately functional and high achieving, with strong parents who have been successful in the Anglo culture. One or both Indian parents may have some college education, and/or may have adopted a religion different from the dominant tribal religion. While originally members of the tribe, they have adopted both tribal and non-tribal values and behaviors. Both the parents and the children, as they reach adolescence and early adulthood, may experience identity issues and confusion, feeling alienated both from their tribe of origin and from the Anglo world as well.

These individuals are most likely to be open to Anglo-style mental health services and interventions, since they are more familiar and comfortable with the cultural context of these services. They are more likely to seek these services themselves, or be open to referral to these services by a home-based therapist, and be motivated to change. Referring problems may have to do with depression; ambivalence and confusion regarding

values, goals and achievement; life transition problems; anxiety; and somatic complaints. Individual therapy can be helpful in providing support and helping family members clarify their own values and identity. These families are less likely to require home-based services, and may readily make the transition to clinic-based therapy.

Conclusion and Recommendations

Home-based therapy provides a crucial service for Indian families who otherwise might not seek or utilize mental health services. However, it is often difficult to obtain and provide home-based services. Toward this end, the following recommendations are made.

First, there is a great need for institutional support for home-based therapy services. This includes not only hiring individuals to provide these services, but also providing training and supervision specific to home-based family therapy and its unique demands and possibilities. As Nelsen (1980) points out, individuals are more able to provide useful support to their clients when they are receiving support themselves in their professional settings. This is particularly important for home-based therapists. As noted by Stroul (1988), "Extensive individual and group supervision also is reported to be an essential factor in the success of home-based programs. It is important for staff to feel that they are "not alone" with the crises and overwhelming problems of families and that back-up and support are available to them at all times" (p. 33). Unfortunately, this is rarely the case for therapists providing home-based therapy with Indian families. Often the therapist is the only therapist available, sometimes for several communities, with supervision provided infrequently by individuals many miles away who have limited understanding of the unique problems of home-based work in Indian communities. On a positive note, there is an increasing data base of home-based services in non-Indian communities that can be tapped and modified by therapists in Indian communities. Sources such as the National Resource Center on Family Based Services in Oakdale, Iowa, can provide information, training, and support, and can decrease the isolation of home-based therapists in Indian communities.

Flexibility regarding hours is also important, since it is often necessary for the therapist to go to the home in the evenings or weekend when the family is available or in crisis. Credit and record-keeping needs to reflect time spent in travel, after-hours work, the length of the contact (e.g., one visit may last several hours), and the number of persons seen. For example, while clinic-based work may involve one or two persons seen for an hour between 8:00 and 5:00 each week, home-based therapy may involve one three-hour session with seven family members on an evening or weekend, every two weeks.

Second, it is important that expectations for results of home-based therapy be realistic. Both the supervisor and the therapist need to consider the chronicity and multiplicity of the problems, the resistance to change, and

the greater difficulty of home-based work in many cases (due to some of the factors noted above). A longer time frame and limited expectations are typically necessary. Families requiring home-based therapy are not the neat textbook cases presented in many family therapy models. These are typically the most difficult and resistant families who, by definition, would not or could not utilize traditional mental health services. In a time of budget shortages, the therapist and supervisor must evaluate the gains in providing services to families in great need, including children who are likely to have increasingly serious problems and possible costly out-of-home placement if there is no intervention, versus the costs in time and energy.

Cost-effectiveness of home-based therapy should be considered relative to the cost of out-of-home placement of children, rather than comparing it with clinic-based outpatient therapy. In the home-based model, the therapist initially carries much of the commitment to treatment and change for the family, may not initially understand or be able to respond to the help available. However, ultimately, for change to occur, the family--or certain members of it--must become invested in change. The therapist and supervisor must make difficult decisions about how long to invest in a family that is not yet invested themselves. These decisions are especially difficult when there are children who are being harmed by abusive parental behavior who cannot otherwise receive help because of their parents' resistance to treatment.

Finally, we have found several characteristics to be helpful in a home-based family therapist. That individual needs to be flexible and adaptable to numerous unexpected crises and changes of plan, as well as to the unpredictable and culturally unique home context. The therapist must be willing to not be in total control, since there are so many variables in home-based work which are out of his or her control. Because of the slowness of change and typically high levels of resistance, patience and a sense of humor are invaluable. Cultural sensitivity is essential: it is helpful for the therapist to either live in or be a part of the community, or to work closely with a liaison person who does. Either the therapist or the liaison person needs to be available in times of crisis, and to have frequent contact with the family. The therapist needs to have an awareness of the community's resources and regulations, as well as the community's values, and must work in harmony with these. It is easier if the therapist has characteristics valued by the community. Finally, it is important for the therapist to have a support system, both professionally and socially, to retain perspective, reduce professional isolation, and prevent burnout in this highly-demanding but important job.

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ABUSE AND NEGLECT OF AMERICAN INDIAN CHILDREN: FINDINGS FROM A SURVEY OF FEDERAL PROVIDERS

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Abstract: Child abuse and neglect is of growing concern in many American Indian and Alaska Native communities. The present paper represents one attempt to add to the existing, albeit sparse, knowledge base concerning the abuse and neglect of American Indian children. It reports the results of a survey of federal human service providers in which the subject of child abuse and neglect in Indian communities figured prominently. The study took place at several locations in Arizona and New Mexico. Data were obtained using the key-informant method from 55 federal service providers who identified 1,155 children, from birth to 21 years for inclusion in the survey. Children were included if they were currently in mental health treatment, if they were in need of mental health treatment, or if they were known to have been abused or neglected. Particular emphasis was given in the data collection to abuse- and neglect-related factors such as living arrangements, familial disruption, psychiatric symptoms, substance abuse, and school adjustment. The patterns evident in this sample closely resemble those trends identified among abused and/or neglected children in the general population. Sixty-seven percent of the sample was described as neglected or abused. The presence of abuse and/or neglect was strongly related to severe levels of chaos in the family. Children who were described as both abused and neglected had more psychiatric symptoms, greater frequency of having run away or been expelled, and greater frequency of drug use.

Child abuse and neglect is of growing concern in many American Indian and Alaska Native communities.¹ Individuals have begun to share openly their personal experiences; tribal codes are being debated; child protection teams are under development. This has not always been true. Until recently, a conspiracy of silence often surrounded this phenomenon.

For a long time, acknowledging the existence of child abuse and neglect in these communities was perceived as tantamount to criticizing the indigenous culture itself. The essence of Indian identity springs from family and community. Consequently, breakdowns in childrearing practices and

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increasing intergenerational conflict were denied. One might even speculate that the political battles that established the Indian Child Welfare Act (ICWA) in 1978 fueled this denial. Criticism ran high--justifiably so--of the unbelievable rates at which Indian children were removed from their homes and placed for foster care or adoption in non-Indian homes and of the inequitable as well as insensitive practices by state social service agencies. Indian families, many proponents of the act argued, possess unrecognized strengths and resources that are critical to their children's psychosocial development. Few dared to correct the overgeneralizations that characterized these times. With the passage of the ICWA, a large degree of control over the welfare of Indian children passed to the tribes, thereby encouraging them to look more closely at and freeing them to speak more candidly about such problems as child abuse and neglect.

This, despite this new candor, much of the available information about the abuse and neglect of Indian children is limited and anecdotal. Less than a half-dozen systematic studies have been published over the last decade that provide any insight into the nature and scope of this problem. The present paper represents one attempt to add to the existing, albeit sparse knowledge base. It reports the results of a survey of federal human service providers in which the subject of child abuse and neglect in Indian communities figured prominently.

The paper begins by summarizing the published literature specific to child abuse and neglect within this special population. The discussion then turns to the survey in question, summarizing its design and administration. The sample is subsequently described as are results that relate directly to child abuse and neglect. Particular emphasis is given to associated factors such as living arrangements, familial disruption, psychiatric symptoms, substance abuse, and school adjustment. The paper concludes by comparing these results to those evidenced in the general population.

Relevant Literature

There appears to be wide variation in the prevalence of child abuse and neglect across different American Indian and Alaska Native communities. Fischler (1985) estimated a rate of 5.7 cases per 1,000 children in off-reservation communities. Among the Navajo, White and Cornely (1981) reported 10.3 cases per 1,000 children under nine years of age. Hauswald (1987) reported a significant increase in this ratio over eight years since White's original work. The prevalence of child abuse and neglect was projected to be even higher among Cheyenne River Sioux, reaching 11.07 cases per 1,000 persons living on the reservation (Wichlacz, Lane, & Kempe, 1978). Jones (1969), referring to a small native village in Alaska, described one-third of the total child population as homeless, neglected, or abused; many subsequently were removed by an area child welfare agency.

Comparable rates for the United States population in general have increased steadily from 10.1 per thousand in 1976 to 30.6 per thousand in

1985 (American Humane Association, 1987). It is unclear if this reflects an actual increase in number of cases or if it is an artifact of increased reporting. Strauss and Gelles (1986) cited recent compulsory child abuse reporting laws and the advent of a new morality regarding how much violence is acceptable in childrearing as two possible influences on the increased reporting of child abuse. They argued that increased reporting may be occurring at the same time that actual incidence is declining.

For the U.S. as a whole, the proportion of cases of neglect to abuse is reported to be 1.5:1 (Scheper-Hughes, 1987). Among Indian communities cases of neglect are far more numerous than those of abuse, with ratios ranging from 2:1 to 6.1:1 (Fischler, 1985; White & Cornely, 1981). This is particularly worrisome when one considers that White's study revealed that just as much if not more severe harm to a Navajo child can occur in instances of neglect as in instances of abuse. The same study also suggests that Indian children may be at greater risk of death as a consequence of abuse than their U.S. counterparts. Hauswald's (1987) experience among the Navajo indicates that the proportion of cases of neglect to abuse may be shifting. By 1985, she had observed a marked increase in physical and sexual abuse, which accounted for 10 to 15 percent of all reported cases. There was a concomitant increase in the number of reports issuing from the community, whereas hospital personnel previously had been responsible for the vast majority of such reports.

Causes of child abuse and neglect in American Indian and Alaska Native communities span the full spectrum of possibilities. Interpersonal conflict, marital disruption, parental alcoholism, inadequate caregiver-child bonding, severe educational deficits, chronic physical illness, unemployment, and violent death are common among the families of abused and neglected Indian children (Fischler, 1985; Ishisaka, 1978; Oakland & Kane, 1973; White & Cornely, 1981; Wichlacz, Lane & Kempe, 1978). In this respect, the dynamics probably mirror those of families in general (Cohen & Densen-Gerber, 1982; Helfer & Kempe, 1987). More unique contributors include stresses resulting from rapid sociocultural change, gender role changes, failed parenting skills, the changing nature of the extended family, and special risks attached to boarding schools (Beiser, 1974; Graburn, 1987; Hauswald, 1987).

Method

Instrumentation

The survey was developed by the Albuquerque Area Indian Health Service Mental Health Programs Office and the Indian Children's Program. It was designed to gather information about the mental health needs of Indian children and adolescents to provide information on which to base requests for increased funding for mental health programs and the design of more appropriate, effective services.

A pilot study was conducted in 1983 in the Albuquerque Area prior to the final drafting of the instrument. Its purpose was to obtain provider input into the design and content of the survey instrument. The survey consisted of eight pages of questions covering demographic, medical, mental health, social service, and educational experiences. Demographic variables included current residence, birthplace, tribe, and living situation as well as date of birth and gender. Medical problems were covered by nine checklist items pertaining to handicapping conditions and two open-ended questions regarding chronic medical problems and current medications.

A large section comprised of 41 items was devoted to emotional and behavioral problems. These items, answered in a yes/no format, tapped symptoms described under various disorders classified in DSM-III. Examples included: "Has this young person appeared to you to be unhappy, blue, depressed, very miserable for long periods of time?" "Is this young person unusually active or speeded up such as in constant motion or inability to sit still?" "Has this young person shown an explosive temper?"

This section also included questions about abuse and neglect, out-of-home placement, drug use, and school-related problems. Examples of these items are: "Has this young person been a victim of emotional, physical, or sexual abuse?" "Does this young person use inhalant substances (such as glue, paint, gasoline sniffing)?" "Has this young person been truant from school?" The remaining ten questions on the survey focused on current treatment (type and adequacy), unmet treatment needs, and resources available to the child.

Data Collection

The survey began in September of 1984, and concluded in February of 1986. It encompassed all 26 reservations in the Albuquerque Indian Health Service Area and seven reservations in the Phoenix Indian Health Service Area. A total of 983 surveys were completed in the Albuquerque Area and 172 surveys were completed in the Phoenix Area. In each of the areas, providers were asked to identify children who, in the provider's opinion, were in need of mental health treatment. The children were to be included in the survey whether or not they were already receiving services. Providers were also asked to include all children known to have been abused or neglected, whether or not those children presently were in treatment.

Every attempt was made to be consistent in the explanation and administration of the survey. That the survey administration was done by the same person in each case (the survey coordinator) insured some consistency in the information gathered. The survey coordinator met with each provider and assisted in the completion of a survey on each identified child. In a few cases when time was very limited, providers finished surveys

on their own after having completed a portion of the surveys for their community with the survey coordinator.

Data collection was limited to federal employees because of Office of Management and Budget restrictions on the use of survey instruments with the general public. This restriction placed certain constraints on the study. In some communities there are few or no federal employees providing mental health related services to Indian children. In other communities, federal employees provide almost all such services. Schools are a major source of information about children's needs, and these proved--with some exceptions--difficult to access, even when staffed by federal employees. This constraint, in addition to those imposed by time and travel, resulted in some communities being more thoroughly canvassed than others.

The 55 providers who identified the Indian children and completed the surveys had widely varying educational and experiential backgrounds. They represented disciplines including social work, psychology, education, and medicine. Their positions ranged from administrators to mental health technicians and included community health nurses, school counselors, psychologists, alcohol counselors, and teachers. Psychologists completed 40.2% of the surveys. Sixteen percent was completed by mental health technicians, 15% by community health nurses, 13% by social workers, and 5% by school personnel. Providers who completed the survey were both Indian and non-Indian, and included members as well as nonmembers of the communities in which they provided services. All were employees of either the Indian Health Service or the Bureau of Indian Affairs.

The diversity of background and experience among the providers/respondents undoubtedly affected the types and severity of problems that were identified as well as needs that were considered appropriate for inclusion in the survey. For example, 26.5% of the surveys completed by a psychologist included a Diagnostic and Statistical Manual, Version Three (DSM-III) psychiatric diagnosis. That figure was 8% for surveys completed by community health nurses and mental health technicians and only 5% for those completed by social workers. Similarly, social workers and school personnel recorded the presence of child abuse on 75% of their surveys. For psychologists and mental health technicians this figure was close to 50%.

A second important influence on the nature of the data collected was the fact that providers completed surveys on some children that they did not necessarily know well. This was most likely to be true when surveys were completed on children known to need treatment or known to have been abused or neglected who were not being seen in treatment by the provider. However, 81% of the surveys were completed by providers working directly with the child. Chi-square analyses comparing children described by providers who knew them with children who did not work directly with the provider demonstrated no differences between these two

groups on frequency of child abuse or neglect, presence of a DSM-III diagnosis, or total number of symptoms reported.

These two factors, diversity of respondent characteristics and characteristics of the survey, most likely impact the ratings of behavioral and emotional problems. Demographic, educational, and treatment status variables are likely to have been more obvious to the providers, given their positions. Therefore, results from the mental health symptom questions should be interpreted with the above limitations in mind. Provider diversity is likely to result in an underestimate of symptoms because not all providers possessed either the training or the familiarity with the child that would be necessary to make these ratings.

Sample Characteristics

The sample was comprised of 1,155 children representing 50 tribes, most with roots in the Arizona/New Mexico area. Their ages ranged from newborn to 21 years. The mean age was 12.7 years; the modal age was 16 years. Table 1 describes the distribution of age and gender in the sample. Girls and boys were equally represented across age groups. Nearly one-half of the sample was adolescents (13-18 years). As can be seen from Table 2, at the time of the survey, the majority of children lived with family members (including step-family). However, approximately 30% resided in foster or adoptive homes and the remaining 12% in boarding schools or institutional settings. History of out-of-home placement revealed that 16.6% of the children had been to boarding school, 19.7% had been in foster placement, and 20% had at some point been placed in group homes, hospitals, or other residential settings.

Table 1
Distribution of Age and Gender

	Female		Male	
	N	%	N	%
Under 2 years	27	2.3	24	2.1
3-6 years	60	5.2	75	6.5
7-12 years	118	10.2	161	13.9
13-18 years	275	23.8	275	23.8
19 years and older	73	6.3	67	5.8

Table 2
Living Situation

	N	%
With parent or stepparents	646	58.5
With foster or adoptive families	325	29.4
Boarding school	55	5.0
Institutional setting	79	7.2

Note: Information on living situation was missing for some children (n = 50)

A significant percentage of the sample was reported to be suffering from chronic physical illnesses (20.5%). Other developmental handicaps included physical disabilities (1%, n = 11) and mental retardation (.4%, n = 5). Eighteen percent of the children were assigned psychiatric diagnoses.

For the present analysis, 37 symptoms of emotional and behavioral problems were combined to calculate a total symptom score. This score ranged from 0 to 35, with a mean of 7.94 and a mode of 0 for the total sample. Twenty-two percent of the sample was rated as abusing alcohol, 10.8% was abusing inhalants, and 15.8% as abusing other drugs. Twenty-nine percent of the sample was rated as abusing one or more of these substances. In addition, 25% of the sample had run away from home (at least once) and 24.8% had been expelled from school.

Data were also collected on five major life stresses. Sixty-six percent of the children had alcoholic parents, 39% had experienced parental divorce, and 18% had experienced the death of a parent. Fifteen percent had, at some point, been a member of a single-parent family. Sixty-seven percent of the children were characterized as having lived in a chaotic family situation.

Results

In this sample of Indian children, 67% were described by providers as neglected or abused (including sexual abuse). For analytic purposes, the sample was divided into four subgroups: children who were neglected but not abused ("neglect only"), children who were abused but not neglected ("abuse only"), children who were thought to be both abused and neglected ("abuse/neglect combined"), and children who were "neither abused nor neglected." Tables 3 and 4 indicate the relative frequency of abuse, neglect, and abuse/neglect (combined) by sex and age. The data show that while a greater percentage of boys than girls was neglected, more girls suffered abuse and abuse/neglect (combined) than boys. The percentage of children abused increased with age, whereas the reverse was observed in regard to neglect (Chi square = 41.74, df=3, p.=001). Abuse only proved to have the lowest frequencies of the three subgroups.

Table 3
Abuse/Neglect by Gender

	Female		Male	
	N	%	N	%
Neither abuse nor neglect	147	12.8	231	20.0
Neglect only	100	8.7	139	12.0
Abuse only	75	6.5	33	2.9
Both abuse and neglect	231	20.0	199	17.2
Total abused/neglected	406	35.0	371	32.0

Table 4
Abuse/Neglect by Age

	Under									
	2 years		3-6 years		7-12 years		13-18 years		19+ years	
	N	%	N	%	N	%	N	%	N	%
Neither abuse nor neglect	6	11.8	36	26.7	100	35.8	180	32.7	56	40.0
Neglect only	21	41.2	38	28.1	48	17.2	107	19.5	25	17.9
Abuse only	2	3.9	10	7.4	27	9.7	55	10.0	14	10.0
Both abuse and neglect	22	43.1	51	37.8	104	37.3	208	37.9	45	32.1
Total children in age group	51		135		279		550		140	

Note: % = Percentage of children within age group

Note: Each category is mutually exclusive

Approximately half of the surveys specified types of abuse or neglect: emotional, physical, and medical neglect, and emotional, physical, and sexual abuse. Table 5 describes the frequencies with which these types of abuse and neglect were reported for this subsample. Emotional abuse and emotional neglect are the most poorly specifiable of these categories (in terms of a common definition) and, therefore, are subject to the greatest interpretation by providers. Consequently, we anticipated that emotional abuse and neglect might be over-reported for children in this sample. This, however, does not appear to be the case. The frequencies of children reported to be emotionally abused or neglected were not disproportionate to the frequencies of those experiencing other forms of abuse and neglect. The presence of emotional abuse or emotional neglect is likely to be highly correlated with the presence of any of the other forms of abuse and neglect.

Table 5
Type of Abuse/Neglect by Gender

	Female		Male	
	N	%	N	%
Emotional neglect	176	31.8	202	33.6
Physical neglect	148	26.8	149	24.8
Medical neglect	105	19.0	98	16.3
Emotional abuse	180	32.5	166	27.6
Physical abuse	101	18.3	87	14.5
Sexual abuse	68	12.3	12	2.0

Note: % = Percentage of females/males in the sample.
Note: These categories are not mutually exclusive.

At the time of the key informant interview, of the children living with parents or step-parents, 61% had a history of abuse or neglect. Approximately 77% of those living in foster or adoptive homes had been abused or neglected at one time. This figure was 73% for those residing in boarding schools or institutional settings (see Table 6). Table 7 displays frequencies of all children ever placed outside of their homes. Children who had been abused had a lower frequency of out-of-home placement than children who were neither abused nor neglected. Those in the abuse/neglect (combined) subgroup had the highest frequency of placement.

Table 6
Current Living Situations by History of Abuse and/or Neglect

	With Parents or Step-parents (n = 646)		Foster or Adoptive Family (n = 325)		Boarding School/ Institutional Setting (n = 134)	
	N	%	N	%	N	%
Neither abuse nor neglect n = 363	252	39.0	75	23.0	36	26.9
Neglect only n = 231	126	19.5	73	22.5	32	23.8
Abuse only n = 107	72	11.6	26	8.0	9	6.7
Both abuse and neglect n = 404	196	30.0	151	46.5	57	42.5

Note: % = Percentage of children in each living situation.
Note: Information on living situation missing for 50 children.

Table 7
History of Out-of-Home Placement by Past Abuse/Neglect

	Boarding School (n = 192)		Foster (n = 227)		Other (n = 230)	
	N	%	N	%	N	%
Neither abuse nor neglect n = 378	52	27.1	13	5.7	48	20.9
Neglect only n = 239	48	25.0	59	26.0	45	19.6
Abuse only n = 108	11	5.7	7	3.1	14	6.1
Both abuse and neglect n = 430	81	42.2	148	65.2	123	53.5

Note: % = Percentage of children in each placement.

Five survey items focused on traumatic events or chaotic situations associated with the child's family. These questions asked about parental alcoholism, divorce, death of a parent, single parenting, and chaotic family situation. A summary score was calculated to reflect the degree of familial disruption that a child had experienced in his or her life. Scores ranged from 0-5. As can be seen in Table 8, there was a clear relationship between abuse/neglect (combined) and degree of familial disruption (Chi square = 253.7, df=15, p.=001). Sixty percent of the children falling into the abuse/neglect (combined) category scored greater than 3 on the index as compared to 48% of the neglected children, 35% of those who were abused, and 18% of those who suffered neither abuse nor neglect. Table 9 lists the percentage of children in each of these abuse/neglect subgroups who experienced the particular events that comprise this index. Children without histories of abuse or neglect were less likely to have experienced each of these events, with the exception of parental death. Children with histories of abuse/neglect (combined) showed a higher frequency of each disruptive event except having a single parent.

Table 8
Degree of Family Disruption by Abuse/Neglect

	Level of Disruption (%)					
	Lowest 0	1	2	3	4	Highest 5
Neither abuse nor neglect n = 378	31.2	25.1	25.7	17.5	0.5	0.0
Neglect only n = 239	10.0	10.0	32.2	41.0	6.7	0.0

Table 8
(Continued)

	Level of Disruption (%)					
	Lowest 0	1	2	3	4	Highest 5
Abuse only n = 108	19.4	14.8	29.6	30.6	3.7	1.9
Both abuse and neglect n = 430	7.4	5.4	26.5	45.1	11.9	3.7

Table 9
Traumatic Event by Abuse/Neglect

	Parental Alcohol Abuse		Divorce of Parents		Death of Parent(s)		Chaotic Family		Single Parent	
	N	%	N	%	N	%	N	%	N	%
Neither abuse nor neglect n = 378	153	40.5	108	28.6	49	13.0	152	40.2	33	8.7
Neglect only N = 108	178	74.5	87	36.4	33	13.8	191	79.9	47	19.7
Abuse only n = 108	67	62.0	48	44.4	12	11.1	66	61.1	12	1.1
Both abuse and neglect n = 430	354	82.3	204	47.4	112	26.0	370	86.0	77	17.9

Note: % = Percentage of children in each category

Table 10 describes the overall psychiatric symptom data. Thirty-seven symptoms were rated. Tukey's Studentized Range Test of the mean number of symptoms revealed significant differences at the .05 level of certainty between the abuse/neglect (combined) subgroup and each of the three other subgroups. There were no other significant differences among the subgroups. Very few children (n = 47) were rated as having more than 20 of 32 symptoms; thus, only the 0-20 range is represented in Table 10. Few children in the abuse only group were rated as having more than 10 symptoms (18.5% vs. 30.3% for the "neglect only" group, 34.7% for the abuse/neglect (combined) and 22.6% for the children who were neither abused nor neglected).

Table 10
Psychiatric Symptoms by Abuse/Neglect

	0-5		6-10		11-15		16-20		Mean
	N	%	N	%	N	%	N	%	
Neither abuse nor neglect	167	44.7	126	33.7	65	17.4	16	4.3	6.83
Neglect only	100	42.7	63	26.9	48	20.5	23	9.8	7.57
Abuse only	59	54.6	29	26.9	13	12.0	7	6.5	6.08
Both abuse and neglect	146	37.2	110	28.1	82	20.9	54	13.8	9.59

Note: Grouped for convenience

The 37 symptoms were categorized by one of the authors (DB), a child psychiatrist, into nine clusters. The clusters reflect depression, anxiety, sleep problems, elimination problems, attention deficit problems, developmental difficulties, conduct disorder, drug use problems, and schizophrenia-like symptoms, respectively. The clusters are comprised of variable numbers of items and were rationally derived. They do not represent diagnoses. An individual symptom may be included in more than one cluster.² A score was calculated for each child on each symptom cluster by dividing the number of symptoms present by the number of symptoms in the cluster.

Means were then obtained for each cluster for each subgroup of abuse/neglect. These means are presented in Table 11. As can be seen from this table, the abuse/neglect (combined) subgroup exhibited the highest means for all symptom clusters. Using Tukey's Studentized Range Test at the .05 level of significance, differences between the abuse/neglect (combined) subgroup and one or more of the other subgroups were significant for all symptom clusters except attention deficit and elimination problems. The lowest means on all clusters were reported for the "abuse only" subgroup. This subgroup differed significantly from the other three subgroups only on the attention deficit cluster. The "neglect only" subgroup did not appear to differ from those who experienced neither abuse nor neglect.

Table 11
Symptom Cluster Means by Abuse/Neglect

	Abuse/Neglect Status			
	Neither	Neglect Only	Abuse Only	Both
Depression	.22	.24	.20	.30
Sleep	.09	.12	.05	.16
Elimination	.10	.07	.03	.10
Anxiety	.38	.41	.33	.46

Table 11
(Continued)

	Abuse/Neglect Status			
	Neither	Neglect Only	Abuse Only	Both
Attention deficit	.24	.25	.15	.27
Developmental disability	.21	.23	.16	.28
Conduct disorder	.17	.19	.15	.25
Drug use problems	.14	.17	.12	.21
Schizotypal	.12	.15	.12	.19

Table 12
Drug Problems by Abuse/Neglect

	None		Alcohol		Inhalants		Other Drugs		Alcohol + Other Drugs	
	N	%	N	%	N	%	N	%	N	%
Neither abuse nor neglect n = 394	278	78.8	36	10.2	9	2.5	11	3.1	19	5.4
Neglect only n = 216	170	78.7	15	6.9	4	1.9	10	4.6	17	7.9
Abuse only n = 104	82	78.9	13	12.5	1	1.0	2	2.0	6	4.9
Both abuse and neglect n = 353	283	71.8	41	10.4	16	4.1	34	8.6	20	5.1

Note: % = Percentage of children in each abuse/neglect category.

Ratings were also obtained for types of drug problems. Substance use problems were divided into "none," "alcohol only," "inhalants only," "other, non-alcohol drugs," and "alcohol plus other drugs." Table 12 summarizes the frequencies for each of these categories by abuse/neglect status. Children in the abuse/neglect (combined) subgroup exhibited the highest frequencies of inhalant and other, non-alcohol drug problems. Children in the "neglect only" subgroup were reported to have a lower frequency of alcohol problems and a higher frequency of polydrug problems (Chi square = 24.35, df=12, p=.02).

Finally, frequencies of school expulsion and running away were calculated for the four subgroups (see Table 13). Again, children falling into the abuse/neglect (combined) subgroup demonstrated the highest frequency of both expulsion and running away (Chi-square for runaway = 34.985, df=3, p=.0001, Chi-square for expelled = 7.958, df=3, p=.047). The abuse only group had a low rate of school expulsion. The children who were neither abused nor neglected had the lowest rate of running away.

Table 13
School Expulsion and Runaway by Abuse/Neglect

	Expelled		Runaway	
	N	%	N	%
Neither abuse nor neglect n = 378	84	22.2	61	16.1
Neglect only n = 239	57	23.9	54	22.6
Abuse only n = 108	20	18.5	28	25.9
Both abuse and neglect n = 430	125	29.1	146	34.0

Note: % = Percentage of children in category.

Discussion

We have repeatedly acknowledged the limitations of such an indirect means of studying child abuse and neglect among American Indian children. Despite readily apparent biases, key informant approaches can yield valuable insights, as demonstrated by the present study. Its significance also derives from the need to balance personal testimony with empirical data, of which there is little in regard to this special population.

The results of this study follow trends noted in the literature with respect to the U.S. population, though differences of magnitude frequently emerge. For comparative purposes, the study sample is best likened to a treatment population rather than to the children of a community in general: providers selected subjects on the basis of need for treatment, past or current histories of mental health treatment, or presence of abuse and/or neglect.

Significant percentages of children in mental health treatment are said to have experienced abuse and/or neglect, ranging from 30% to 42% (McDanal & Bolman, 1979; Monane, Leichter & Lewis, 1984; Rogeness, Amrung, Macedo, Harris & Fisher, 1986). Yet, even these estimates fall far below those reported for the Indian children in this survey, which was two-thirds of the sample. The observed sex differences in the relative frequencies of abuse and/or neglect were consistent with those of the general population (American Humane Association, 1987; U.S. Department of Health & Human Services, 1982). In this sample, a slightly greater proportion of Indian girls than Indian boys had a history of neglect and/or abuse. The Indian boys, however, more commonly suffered neglect; the Indian girls were more prone to being abused. This result may reflect the preponderance of adolescents in the sample. In the general population, boys are more likely than girls to be physically abused as young children.

As adolescents, however, girls are more likely than boys to be physically abused (Pagelow, 1984).

The mean age for the abused and/or neglected children in this sample was 12.8 years, which is older than the mean age of 7.1 years for abused and/or neglected children in the general population. This difference may be attributable to the fact that older children are more likely to be seen in mental health and school settings, from which much of this sample was identified. A high percentage (8%) of children under two years of age in this sample reportedly was neglected and/or abused. This result may be a function of the narrower range of mental health problems that providers perceive as experienced by infants, rather than a substantive difference across various age groups.

A considerable amount of missing data tempers the strength of any conclusions that can be drawn from the discrimination of types of abuse and neglect sought by this study. With this caveat in mind, the results indicate that emotional neglect and emotional abuse ranked as the most common, and physical and sexual abuse the least common types of abuse among these Indian children. Clearly, however, emotional abuse and neglect co-occur with the other forms of abuse and neglect, and the categorizations were not mutually exclusive. Significant sex differences are apparent with respect to all three types of abuse. Greater percentages of Indian girls than Indian boys are reported to have histories of emotional, physical, and, particularly, sexual abuse.

It is not surprising that, in this study, Indian children residing with foster or adoptive families exhibit more frequent histories of abuse and/or neglect than their counterparts who lived either with parents or in such institutional settings as boarding schools. In both Indian as well as non-Indian communities, child abuse and neglect are common reasons for the suspension of parental rights and out-of-home placement. The troublesome aspect of these findings lies in the observation that, at the time of the survey, 61% of the children with histories of abuse and/or neglect resided within the familial households that likely gave rise to these conditions. Several recent, highly publicized cases of sexual abuse in Bureau of Indian Affairs schools alert us to the fact that the home is not the only arena in which these children are at risk. Unfortunately, the present study cannot speak to whether such patterns continue in the current place of residence.

High levels of family disruption and family stress have been associated with child abuse and neglect both in the general population and in American Indian communities (Black & Mayer, 1980; Fischler, 1985; Gelles, 1987; Kaplan & Pelcovitz, 1982; Straus, 1980; Watkins & Bradbard, 1982; White & Cornely, 1981). Life stresses such as single parenting, alcoholism, unemployment, low socioeconomic status, and social isolation are among those identified as risk factors for abuse and neglect. Although the present study included only five specific stressors, the data are consistent with documented patterns. Children who suffered abuse and/or neglect were represented more frequently at the higher levels of the overall family

disruption index than those who were neither abused nor neglected. The abuse/neglect (combined) group scored highest at the most severe end of the six-point index. Similarly, children who had been abused, neglected, or both had greater frequencies of each of the five disruptive events.

Children who have been abused and/or neglected exhibit behavioral, social, developmental, and cognitive deficits when compared to children who have not experienced abuse or neglect (Browne & Finkelhor, 1986; Egeland, Sroufe & Erickson, 1983; Green, 1978; Lamphear, 1985; Martin, Beezley, Conway & Kempe, 1974; Toro, 1982). Results from studies using clinical samples of abused/neglected children are mixed, however, with respect to whether or not these children differ psychiatrically from other non-abused, but emotionally disturbed children (Carmen, Rieker, & Mills, 1984; Kazdin, Moser, Colbus, & Bell, 1985; Monane et al., 1984; Rogeness et al., 1982). Monane et al. (1984) indicated that abused and/or neglected children did not differ diagnostically from other emotionally disturbed children, although the former were more violent. Similarly, a study by Carmen et al. (1984) including both adolescents and adults evidenced no differences between the diagnoses assigned those psychiatric inpatients with and those without abuse histories. Symptomatically, however, female patients who had been abused were more self-destructive than nonabused females. Abused males were more aggressive than nonabused males. Kazdin and colleagues (1985) found that physically abused subjects (ages 6-13) showed greater depression and hopelessness than the non-abused controls, but only on the self-report measures. Rogeness et al. (1986) reported increased frequency of conduct disorder in abused or neglected boys and in abused girls. They also found that abused or neglected children had more borderline, conduct, and concentration symptoms than did non-abused, non-neglected children.

In the present study, the abuse/neglect combined group had the highest mean scores across all symptom categories. In fact, with the exception of the attention deficit cluster, the only statistically significant differences occurred between the abuse/neglect combined group and one or more of the other three groups. The "abuse only" group had the lowest mean scores of any of the groups, including the neither abused nor neglected group. However, the only significant difference between the "abuse only" group and any of the other three groups was on the attention deficit symptom cluster.

Data from the present study do not permit comment on diagnostic differences among the four subgroups. The results are consistent, however, with previous findings that children who have experienced abuse only or neglect only do not differ psychiatrically from those who have experienced neither abuse nor neglect. Interestingly, in this sample, those children who suffered both abuse and neglect did evidence greater frequencies of psychiatric symptoms than any of the other children. Other studies have not specifically addressed the psychiatric status of children with histories of both abuse and neglect.

These data offer important insights into the problems of abuse and neglect of American Indian children. While the patterns evident in this sample closely resemble those trends identified among abused and/or neglected children in the general population, differences in magnitude are apparent. Of this sample of children, seventy-seven percent of whom were reported to have unmet mental health treatment needs, two-thirds had a history of abuse or neglect. This finding has several implications. First, the need for preventive and intervention efforts is clear. The consequences of child abuse and neglect represent serious short-term and long-term mental health problems for American Indian children and youth. Despite recent strong recommendations for increased services to American Indian children and youth, mental health treatment and prevention programs for this population are rare. However, efforts are currently underway to establish local Child Protection Teams and crisis intervention services to American Indian victims of family violence.

The second, related, implication is that child abuse and neglect are embedded in a context that must also be addressed through the provision of adequate mental health services. Namely, abuse and neglect are strongly interrelated (as both cause and effect) to chaotic family situations and to other mental health problems such as alcoholism and depression. Among American Indians, these problems are likely related to a constellation of factors including poverty, lack of employment and other meaningful activities, racial discrimination, geographical isolation, inadequate education, and cultural identity issues.

Finally, a reduction in child abuse and neglect through the effective provision of preventive and intervention programs would be associated with a lower risk to children and adults, and a further reduction in child abuse and neglect in future generations. Almost one-half of all American Indians are under age 18. This fact, combined with the historical significance of children in American Indian cultures, indicates that the importance of programs aimed at the reduction of child abuse and neglect in this population cannot be underestimated.

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Reference Notes:

¹Pursuant to a 1975 joint resolution of the National Congress of American Indians and The National Tribal Chairman's Association, the population described in this article, in the absence of specific tribal designation, is referred to as American Indian and/or Alaska Native.

²Items included in each symptom cluster are as follows:

Depression (10 items): unhappiness, withdrawal, eating problems, sleeping problems, concentration, mood changes, psychomotor retardation, suicidal ideation, suicide attempt, excessive physical complaints.

Elimination (1 item): enuresis or encopresis.

Sleep (1 item): sleeping problems.

Anxiety (2 items): concentration, worrying.

Attention (3 items): concentration, unusually active or speeded up, frequent accidents or injuries.

Developmental (5 items): in a "dream world", difficulty coping with change, psychomotor retardation, frequent accidents or injuries, learning problems.

Conduct (20 items): frequent accidents or injuries, suicide ideation, suicide attempt, explosive temper, violent, vandalism, excessive alcohol use, inhalant use, other drug use, school problems related to drug use, legal problems related to drug use, legal problems, lying, firesetting or cruelty to animals, interpersonal difficulty, disobedient in school, inappropriate sexual behavior, runaway, truancy, pregnant, expulsion.

Substance use (7 items): frequent accidents or injuries, excessive alcohol use, inhalant use, other drug use, school problems related to drug use, legal problems related to drug use, expulsion.

Schizophreniform (7 items): worrying, in a "dream world", difficulty coping with change, hallucinations, delusions, confused thinking, bizarre behavior.

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