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 model 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:

[1]Pursuant 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.

[2]Items 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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