American Indian and Alaska Native Mental Health Research

The Journal of the National Center

Volume 4, Number 1, Fall 1990

Published by the National Center

University of Colorado Health Sciences Center
Department of Psychiatry
4200 East Ninth Avenue, Campus Box C249
Denver, Colorado 80262

ISSN 0893-5394

Subscription rates are $35 (US currency) per volume year--including 3 issues plus an annual monograph. Make checks payable to: UCHSC/National Center/Journal. Mail to National Center for American Indian and Alaska Native Mental Health Research, Campus Box C249, 4200 East Ninth Avenue, Denver, Colorado 80262, Attn: Journal Manager.

ISSN 0893-5394

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EDITORIAL

This issue presents four articles on quite different mental health topics. "The Persistence of Traditional Medicine in Urban Areas: The Case of Canada's Indians," by Waldram, sheds additional light on several elements of the ongoing debate about the vitality of indigenous systems of healing in the face of increasing sociocultural change. The author reports data which indicate that Indian people continue to practice and to utilize traditional forms of medicine while living in the city. Moreover, such practices seem to be unrelated to the existence of western, biomedical services or to problems in accessing said services. Waldram persuasively argues that the meaning and importance of traditional Indian responses to illness are tied to cultural identity, as reflected by native language primacy and fluency. However, he also illustrates that these beliefs do not preclude utilizing western, biomedical services. Instead, one observes successive as well as simultaneous hierarchies of resort.

"Locus of Control and Drinking Behavior in American Indian Alcoholics and Non-alcoholics," by Jumper-Thurman, Jones-Saumty, and Parsons, extends an intriguing line of inquiry that has, over the last two decades, engendered considerable interest with respect to American Indians. Beliefs about the control of rewards or penalties -- specifically, whether they are the consequence of one's own behavior or of independent forces -- have been examined in terms of school dropout, cultural values, health behaviors, social adjustment, and life satisfaction. A recurrent thesis has been that American Indians, by virtue of primary socialization processes, are more "externally" oriented and, thus, attribute the course of certain events to forces beyond their personal control. Jumper-Thurman, Jones-Saumty, and Parsons explore this assumption in the context of potential differences between Indian alcoholics and non-alcoholics and their non-Indian counterparts. By and large, they find significant gender and cultural effects that warrant further investigation of the potential utility of this construct for theoretical as well as programmatic purposes.

"Psychiatric Function and Roles in an Indian Health Program Context," by Smith, chronicles the experiences of a young psychiatrist in the course of becoming a staff member and an important mental health resource at an urban Indian health clinic. The author describes this process in terms of various stages that marked the evolving definition of her contribution to the program. The complexity of this process and the multidimensional nature of a psychiatrist's role in such settings are vividly illustrated by several case examples. Being flexible, able to take the perspectives of others, and open to managing non-psychiatric aspects of patients' problems proved to be critical to her success. Smith calls special attention to matters which her prior training had not anticipated, and suggests ways in which others who may find themselves in similar circumstances might respond.

Finally, "Ojibway Adolescent Time Spent with Parents/Elders as Related to Delinquency and Court Adjudication Experiences," returns us to a theme that Zitzow raised in an earlier volume of this journal. In this instance, however, the author has taken the next step in depicting the consequences of significant reductions in the amount of time that Indian youth spend with family. Both the quantity and quality of such involvement bear strong relationships to self-reports of delinquent behaviors (e.g., smoking cigarettes, skipping school, running away from home) and actual court encounters that lead to legal dispositions. This work provides the clearest evidence to date for a series of concerns that have been the subject of considerable discussion throughout Indian communities. Zitzow, in turn, offers suggestions for special emphasis in the development of local, family-oriented resources to redress the observed imbalances in present day parent-child relationships within many Indian homes.

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

THE PERSISTENCE OF TRADITIONAL MEDICINE IN URBAN AREAS: THE CASE OF CANADA'S INDIANS

JAMES B. WALDRAM, Ph.D.

Abstract: The persistence of the traditional medical systems[1] among Canadian Native peoples has been fairly well documented, and some commentators have suggested that a resurgence in these systems is currently underway (Gregory, 1988). Although there have been very few studies of the utilization of these medical systems by contemporary Native peoples, there has been some suggestion that dual utilization is indeed practiced. Virtually nothing is known about the specific patterns of utilization, and the relationship, if any, between the utilization of traditional and western medical services. Similarly, few aspects of health care utilization by Native peoples in urban areas have been researched. The purpose of this paper is to explore this relationship through the examination of data obtained in a recent study of Native and non-Native medical service utilization patterns in the city of Saskatoon, Saskatchewan.

Current Perspectives on the Persistence of Traditional Medical Systems

A review of the literature suggests that there are a variety of explanations offered for the persistence of traditional medical systems in both rural and urban settings in the face of newly introduced or expanded western services. A common explanation refers to the availability of western medical facilities. This perspective argues that there is, in effect, a relationship between the adequacy of western medical facilities and the utilization of traditional medical resources. Simply put, it is argued that where access to western health services is limited, traditional services are utilized. Lasker (1981) warns of the need to maintain a broad definition of "accessibility," arguing that the simple presence of a service is an insufficient measure of accessibility. Press (1978) argues that in urban areas (particularly poor, marginal neighborhoods), there may be few western services, leading to the persistence of "folk" medicine to fill in the gaps. The same argument has been utilized to explain the persistence of traditional medical systems in rural areas, where access to western services is even more likely to be restricted. Indeed, the World Health Organization (WHO) has implicitly adhered to this explanation in its Alma-Ata Declaration on primary health care and in its promotion of traditional health systems in third world countries where western services are inadequate (WHO, 1978).

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WHO's position has been criticized by some authors who argue, as does Laguerre (1987), that "the poor, like everyone else, want access to better health care facilities." The problem with this critique is that it is both a-cultural and ethnocentric; it is not grounded in the reality of health care delivery on a global scale. The greatest refutation of such criticism can be found in the few studies of medical care utilization in urban areas, particularly those areas where western services are available. Research demonstrates quite clearly that under such circumstances, indigenous and other peoples will continue to utilize traditional or other folk medical services in conjunction with western services (Asuni, 1979; Bhatia, et al., 1975; Finkler, 1981, 1985; Nchinda, 1976). Furthermore, critics seem unwilling to consider that: 1) traditional medical services may be viewed by these populations as more efficacious than western medicine, at least for certain problems; and 2) that traditional services may in fact be more efficacious than western medicine from a scientific perspective.

Some researchers have argued, at least in part, that certain socio-economic variables can explain the utilization of traditional medical services. For instance, Press (1969) argues that dual use in Bogota was greatest among people with the lowest socio-economic standing, which he related to a low level of acculturation (or, by corollary, a high degree of adherence to traditional ways). In contrast, both Asuni (1979) and Nchinda (1976) have argued that traditional medical services may be utilized by those with varying levels of formal education, including the highly educated who, one might surmise, would be the most acculturated. Finkler (1981) has cautioned against assuming that all members of any particular socio-cultural or socio-economic group "share the same non-medical orientation" and "avail themselves similarly of competing systems of health care."

The concept of culture is well-represented in the literature on the utilization of medical systems. In general, it is argued that the elements of the traditional culture relevant to utilization behavior remain intact even when western services are introduced (Woods, 1977). Welsch (1983) has argued that the Ningerum of Papua New Guinea have simply incorporated western medical services into their existing medical system and use traditional and western services in a complementary manner. Camazine (1980) has also demonstrated how the Zuni of New Mexico use western and traditional medicine in a complementary fashion, in this case because they not only treat somewhat different types of illnesses, but also because the traditional systems are better at dealing with the psychological and social aspects of illness in general. Press (1978) even argues that the persistence of traditional medical services in urban areas eases acculturation pressures for migrants by maintaining a link with the old ways while facing the new. Nyamwaya (1987) indicates that, for the Pokot of Kenya, complimentarily has also developed, with some individuals utilizing western services even where an indigenous cause is suspected. Of particular relevance to this research, he states: "It is thus clear that belief in inter-personal and spiritual forces in the causation of illness need not be

a hindrance to the utilization of western medicine because western medicine is actually used when available but for the biological aspects of illness, which it is thought to be capable of dealing with" (Nyamwaya, 1987). The North American case par excellence is that of the Navajo, whose strong adherence to traditional medical beliefs has forced the western system to adapt to them on the reservation (Adair, 1963; Kunitz, 1983).

It is clear from the literature that generalizing about the utilization of traditional and western medical systems is all but impossible. If anything, a variety of factors may explain the continued use of traditional systems in an era of ever-expanding western services. The persistence of traditional cultural beliefs and the availability of western services are obviously important, although other socio-economic factors operating at a more individual level cannot be discounted. Overall, the literature suggests that dual utilization is a common adaptation to the existence of two different medical systems, and that the existence of one system does not necessarily affect the utilization of the other.

North American Urban Studies

There is a dearth of studies on the persistence and utilization of traditional medicine by urban North American Indian peoples. Almost exclusively, this topic has been researched in the context of the Canadian Indian reserve or the American Indian reservation.

Only one study exists on the use of traditional medical services by an urban Native population in North America that is comparable to the study to be discussed in this paper. In a study of 277 Indian families in San Francisco in the early 1970s, Fuchs and Bashshur (1975) examined four hypotheses. The two hypotheses of relevance to this research were that "The use of traditional Indian medicine will be maintained in addition to, rather than instead of, Anglo medicine," and that "The use of traditional medicine will not vary with income, education, and other socioeconomic factors." The researchers determined that their data supported both hypotheses. Specifically, they found that having a family physician, the utilization of physician services, and infant immunizations did not differentiate the users of traditional from western medicine. Their data did demonstrate that the existence of a serious illness requiring hospitalization was an important factor determining the use of traditional medicine. Of particular significance, however, was their finding that families who experienced difficulty obtaining medical care tended to utilize traditional medicine more than those not experiencing these problems. Levels of education and income were not useful in predicting traditional medicine use, although their data did suggest that persons with a higher level of education tended to use traditional medicine more than those with lower levels.

In contrast, those speaking an Indian language demonstrated greater use of traditional medicine. Length of residence in the city was somewhat important: those in the city the shortest time tended to use

traditional medicine more than long-term residents, but utilization of traditional medicine remained extensive even among the latter. Finally, the authors argued that many individuals returned to the reservation to utilize traditional medicine. Overall, they concluded that cultural factors are more important for predicting the utilization of traditional medicine than socio-economic factors, and that utilization is not concentrated in the lower socio-economic group.

A study of the Puyallup Indians of Washington provides even less direction than the Fuchs-Bashshur study (Guilmet, 1984). The study examined a variety of health-seeking strategies of this Indian group which, although reservation-based, was surrounded by the city of Tacoma and was very urbanized as a result. A striking similarity existed between the Puyallup study and the one presented in this paper in that most medical services were provided free, and hence financial constraints were relatively insignificant. However, the Washington data demonstrated virtually no utilization of traditional medicine or healers, a fact which Guilmet attributes to years of acculturative pressures and legislative actions outlawing the practice of Indian medicine. The author does suggest that more Indian medicine may be utilized than his study uncovered, but is unable to offer much concrete data on this.

In Canada, only one other study has addressed, in part, the question of utilization of traditional Indian medicine in the city. A study of the "skid row" population in Vancouver by Mears, et al. (1981) uncovered relatively little use of traditional healers or medicine. The authors concluded that lack of access to traditional medicine in the city was one reason for this.

The Saskatoon Study

In 1987, the author commenced a comparative study of the utilization of medical care services among the urban poor in the core area of Saskatoon, a prairie city of some 170,000 people. The overall results of this study have been published elsewhere (Waldram & Layman, 1989). With an estimated city Native[2] population of between 11,000 and 20,000 people, Native presence in the core area is significant. The study sought to understand their utilization patterns in comparison with those of similarly disadvantaged non-Natives.

A total of 226 interviews were conducted with Natives and non-Natives. Two research sites were utilized: one was a medical clinic established in the core area primarily to provide services to disadvantaged persons, and the other was a social service agency located adjacent to the clinic which provides meals, and recreational and social services to the same population. An availability sample was utilized because there exists no comprehensive listing of Natives in this area. Potential adult respondents were simply approached and asked to participate in the study; there were very few refusals. Although the availability sampling technique

was the logical choice, under the circumstances, its limitations are apparent: generalizations beyond the sample can be made only with extreme caution.

The interview schedule utilized consisted of 123 closed- and open-ended questions, and was administered in English by non-Native researchers. In general, respondents appeared willing to openly discuss the issues raised in the interviews, and a great deal of qualitative data was accumulated through these voluntary offerings. The existence of language problems appeared to hamper only one interview. It is likely that use of Indian medicine in the study is under-represented for a variety of reasons; nonetheless, we were surprised at the extent to which many respondents were willing to discuss this issue with a non-Native.

While the overall study involved both Natives and non-Natives, my concern in this paper is with a sub-group of the overall Native population. This sub-group consists of two categories: status Indians, or those recognized by the Canadian government as "Indians" for purposes of program administration, and non-status Indians, or those not so recognized by the federal government. Elsewhere it has been suggested that there are few cultural differences between the two groups (Waldram, 1987). The current research also demonstrated that the two groups were indistinguishable in terms of specific cultural criteria, especially Indian language utilization. Hence, for this paper I have grouped them together, and refer to them collectively as "Indians." Overall, 119 respondents were so identified, representing five different Indian cultural groups (in order, Plains Cree, Northern Cree, Saulteaux, Dakota, and Dene).

The Indian sample exhibited a mean age of 30.6 years, with 57% female and 43% male. Some 64% were single, separated, divorced or widowed, and 52.8% had dependent children. The mean educational level was 8.7 years, with 92.9% unemployed at the time of the interview.

In Canada, medical care costs for status Indians are the responsibility of the federal government, which either administers services directly (usually in clinics on reserves) or else reimburses specific provinces for services rendered. Non-status Indians do not receive federal medical care services. However, in the Province of Saskatchewan, most medical services are available free of charge to all provincial residents, including non-status Indians. Hence, financial restrictions in the use of most services are minimal and consistent for both the status and non-status Indian populations. There are a few areas in which the non-status Indians are disadvantaged, such as in paying for prescription drugs and glasses. In Saskatchewan, residents pay the full cost of prescription drugs up to a pre-established limit, after which they pay only a fraction. All prescription drug costs for status Indians are covered by the federal government. The federal government will also pay up to a limit for the cost of prescription glasses for status Indians; the non-status Indians are responsible for their own expenses in this area.

Hypotheses

Guided by the existing literature, including the work of Fuchs and Bashshur (1975), the present research tested the following related hypotheses:

1. The utilization of traditional medical services will not detract from the utilization of western medical services among the urban Indian population.

2. Those demonstrating difficulty in utilizing western medicine will demonstrate a greater utilization of traditional medicine.

3. Language variables will be useful in predicting utilization of traditional medicine.

4. Those with the lowest socio-economic standing are more likely than those with higher standing to utilize traditional medicine in the city.

Traditional medical services were defined narrowly in this study to allow for the use of various statistical techniques. In specific, the following variables were selected to measure the utilization of traditional medical services: a) consultation with a traditional healer at some time in the past, and in the year previous to interview; b) utilization of Indian herbal medicines, including sweetgrass, in the past year; and c) undertaking a sweat-lodge ceremony in the past year.

In addition, two beliefs were included to measure attitudes toward traditional Indian medicine: a) belief that Indian medicine could handle some medical problems better than western medicine; and b) desire to have traditional medical services available in a western medical facility, such as a clinic.

The utilization of western medical services was measured by the following variables: a) existence of a regular or family physician; b) last visit to the regular or family physician; c) last physical examination; d) visits to hospital emergency departments; e) existence of a regular dentist; f) last dental examination; g) last eye examination; and h) existence of a regular pharmacy.

Difficulty in utilizing western medical services was measured through a variety of declatory questions, wherein the respondent indicated whether or not they experienced a particular problem. Potential problems included difficulties: a) explaining their health problem to a physician or nurse; b) understanding the physician; c) finding a physician; d) making appointments; and e) paying for non-prescription medications.

The language variables utilized in this analysis were: a) first language spoken; b) ability to speak an Indian language today; and c) frequency of current Indian language utilization.

Results

Hypothesis One: The utilization of traditional medical services would not detract from the utilization of western medical services among the urban Indian population.

Overall, the data suggest an acceptance of this hypothesis. As Table 1 demonstrates, there appears to be little relationship between the utilization of traditional medicine and the utilization of western medicine for the respondents. Indeed, although not statistically significant, a higher percentage of those having consulted a healer in the past actually reported a regular or family physician, a more recent contact with that physician, a more recent eye examination, and a visit to a hospital emergency department. Interestingly, a significantly higher percentage of respondents who had seen a healer at some time in the past reported having a regular dentist, although there was little difference in terms of contact with a dentist.

The data regarding the utilization of Indian medicine was similar, as Table 2 demonstrates. While not statistically significant, it is interesting that almost 87% of those who had used herbal medicines and 76.6% of those who had used sweetgrass reported having a regular physician, in comparison to 75.9% of those not using any Indian medicines (χ^2=0.823, *df*=2, *p*=0.66). Similarly, 75% of those who had used herbal medicines had seen their physician within the previous month, compared to 59% of those not using such medicines (χ^2=6.46, *df*=6, *p*=0.37), and 73.3% had reported having a physical examination within the last year, compared to only 52.7% of those not using any Indian medicines (χ^2=4.83, *df*=6, *p*=0.57).

Although past utilization of traditional medical services was fairly extensive, actual utilization within the year prior to the research was not, with the exception of the use of self-administered herbal medicines. For instance, only six respondents had actually seen a healer in the previous year, and in every case this was in a locale outside the city. Elsewhere (Waldram, 1990a), I have discussed the problem of access to traditional medicine in Saskatoon, noting that while many people desire such access, very few actually know of a healer in the city and only about half believe they could find one.

Of the respondents interviewed in the clinic, three had gone to a healer concerning the specific problem they were experiencing, and another three individuals indicated their plans to do so.

Overall, only a handful (n=6) of respondents had undertaken a sweat in the previous year; three of these six also reported having seen a healer for their current health problem, as reported above, and the sweat may have been a component of that consultation. While all six of these individuals reported having a regular or family physician, in comparison to

75% of those not having undertaken a sweat, the low cell frequency makes data analysis essentially meaningless for this variable.

The attitudinal variables were similar to the others so far discussed in that they failed largely to produce statistically significant results. For instance, whereas 72.6% of those believing Indian healers could handle some medical problems better than western doctors reported having a regular or family physician, so did 82.5% of those not agreeing with this view (χ^2=1.33, *df*=1, *p*=0.25). Some 60% of those believing in the efficacy of Indian medicine reported having seen their physician within the last month, compared to 42.9% of the non-believers (χ^2=3.83, *df=3, p*=0.28); and 48.4% of the believers, reported a physical examination within the last year compared to 57.5% of the non-believers (χ^2=1.67, *df*=3, *p*=0.64). Of respondents believing in Indian medicine, 47.5% reported a regular dentist, compared to 30.0% of the non-believers (χ^2=3.08, *df=1, p*=0.08).

Those willing to consult an Indian healer in a western medical setting tended to differ little from those unwilling to do so in terms of their utilization of western medicine. For instance, 76.9% of those so willing also reported having a regular physician, in comparison to 74.2% of those unwilling (χ^2=0.091, *df*=1, *p*=0.76); similarly, none of the other variables were statistically significant.

The data clearly support the hypothesis that the utilization of traditional medical services does not detract from the utilization of western medical services. Indeed, although few of the differences were statistically significant, there is a pattern which at least suggests that those who utilize traditional medicine demonstrate a greater utilization of western medical services.

Table 1
Past Consultation with Indian Healer by Various Measures of Utilization of Western Medicine

	Past Consultation with Indian Healer YES	NO
Existence Of Regular Physician (χ^2=1.43, *df*=1, *p*=0.23)		
Yes	31 (83.8%)	56 (73.7%)
No	6 (16.2%)	20 (26.3%)
Last Visit To Regular Physician (Mann-Whitney U=624, *p*=0.09)		
In The Last Month	21 (65.6%)	24 (49.0%)
In The Last Three Months	7 (21.9%)	12 (24.5%)
In The Last Year	3 (9.4%)	6 (12.2%)
More Than A Year Ago	1 (3.1%)	7 (14.3%)

Table 1 (Continued)
Past Consultation with Indian Healer by Various Measures of Utilization of Western Medicine

	Past Consultation with Indian Healer YES	NO
Last Physical Examination (χ^2=2.34, *df*=3, *p*=0.51)		
In Last Year	23 (60.5%)	39 (51.3%)
In Last Three Years	8 (21.1%)	17 (22.4%)
More Than Three Years Ago	2 (5.3%)	11 (14.5%)
Can't Remember/never	5 (13.2%)	9 (11.8%)
Existence Of Regular Dentist (χ^2=8.45, *df*=1, *p*=0.00)		
Yes	23 (60.5%)	24 (32.0%)
No	15 (39.5%)	51 (68.0%)
Last Visit To Dentist (χ^2=0.223, *df*=2, *p*=0.90)		
In Last Year	16 (42.1%)	35 (46.1%)
More Than Year Ago	20 (52.6%)	38 (50.0%)
Can't Remember/Never	2 (5.3%)	3 (3.9%)
Visit To Hospital Emergency Department (χ^2=1.46, *df*=1, *p*=0.23)		
Yes	22 (59.5%)	36 (47.4%)
No	15 (40.5%)	40 (52.6%)
Last Eye Examination (χ^2=1.08, *df*=2, p=0.58)		
In Last Two Years	23 (60.5%)	44 (57.9%)
More Than Two Years Ago	12 (31.6%)	29 (38.2%)
Can't Remember/Never	3 (7.9%)	3 (3.9%)
Existence Of Regular Pharmacy (χ^2=0.348, *df*=1, *p*=0.56)		
Yes	26 (68.4%)	56 (73.7%)
No	12 (31.6%)	20 (26.3%)

Table 2
Utilization of Indian Medicines by Various Measures of Utilization of Western Medicine

	Utilization of Indian Medicines		
	Herbal Medicines	Sweetgrass	None
Existence of Regular Physician (χ^2=0.823, *df*=2, *p*=0.66)			
Yes	13 (86.7%)	36 (76.6%)	41 (75.9%)
No	2 (13.3%)	11 (23.4%)	13 (24.1%)
Last Visit to Regular Physician (χ^2=3.3253, *p*=0.20; Kruskal-Wallis one-way analysis of variance)			
In The Last Month	9 (75.0%)	15 (45.5%)	23 (59.0%)
In The Last Three Months	1 (8.3%)	9 (27.3%)	10 (25.6%)
In The Last Year	2 (16.7%)	5 (15.2%)	2 (5.1%)
More Than A Year Ago	- - - -	4 (12.1%)	4 (10.3%)
Last Physical Examination (χ^2=3.349, *p*=0.18; Kruskal-Wallis one-way analysis of variance)			
In Last Year	11 (73.3%)	24 (51.1%)	29 (52.7%)
In Last Three Years	3 (20.0%)	9 (19.1%)	14 (25.2%)
More Than Three Years Ago	1 (6.7%)	7 (14.9%)	5 (9.1%)
Can't Remember/Never	- - - -	7 (14.9%)	7 (12.7%)
Existence of Regular Dentist (χ^2=2.25, *df*=2, *p*=0.33)			
Yes	9 (60.0%)	19 (40.4%)	21 (38.9%)
No	6 (40.0%)	28 (59.6%)	33 (61.1%)
Last Visit to Dentist (χ^2=2.19, *df*=4, *p*=0.70)			
In Last Year	8 (53.3%)	21 (44.7%)	21 (38.2%)
More Than Year Ago	7 (46.7%)	24 (51.1%)	30 (54.5%)
Can't Remember/Never	- - - -	2 (4.3%)	4 (7.3%)
Visit to Hospital Emergency Department (χ^2=0.224, *df*=2, *p*=0.89)			
Yes	8 (53.3%)	22 (46.8%)	27 (50.0%)
No	7 (46.7%)	25 (53.2%)	27 (50.0%)

Table 2 (Continued)
Utilization of Indian Medicines by Various Measures
of Utilization of Western Medicine

	Utilization of Indian Medicines		
	Herbal Medicines	Sweetgrass	None
Last Eye Examination (χ^2=4.89, *df*=4, *p*=0.30)			
In Last Two Years	12 (80.0%)	23 (48.9%)	33 (60.0%)
More Than Two Years Ago	3 (20.0%)	21 (44.7%)	19 (34.5%)
Can't Remember/Never	- - - -	3 (6.4%)	3 (5.5%)
Existence of Regular Pharmacy (χ^2=0.819, *df*=2, *p*=0.66)			
Yes	12 (80.0%)	32 (68.1%)	38 (69.1%)
No	3 (20.0%)	15 (31.9%)	17 (30.9%)

Hypothesis Two: Those demonstrating difficulty in utilizing western medicine will demonstrate a greater utilization of traditional medicine.

Tables 3 and 4 present a variety of data related to this hypothesis. In no cases were the data statistically significant. For example, while 28.9% of those having difficulty explaining their health problem to a physician had used Indian medicine in the past; 26.3% of those expressing such a difficulty had not used Indian medicine. Likewise, while 36.8% of those having difficulties paying for non-prescription medications had a past consultation with a healer, 31.6% of those not experiencing these problems had also seen a healer. The data for the utilization of Indian medicines is very similar. Therefore we must reject this hypothesis. There is no support for the idea that Indians who are alienated from western medicine due to various utilization problems are using Indian medicine as an alternative.

Table 3
Past Consultation with Indian Healer by Various Measures
of Difficulty in Utilizing Western Medicine

	Past Consultation with Indian Healer	
	YES	NO
Difficulty Explaining Health Problem (χ^2=0.0887, *df*=1, *p*=0.77)		
Yes	11 (28.9%)	20 (26.3%)
No	27 (71.1%)	56 (73.7%)

Table 3 (Continued)
Past Consultation with Indian Healer by Various Measures of Difficulty in Utilizing Western Medicine

	Past Consultation with Indian Healer YES	NO
Difficulty Understanding Physician's Language (χ^2=0.283, *df*=1, *p*=0.60)		
Yes	16 (42.1%)	36 (47.4%)
No	22 (57.9%)	40 (52.6%)
Difficulty Finding a Physician When Needed (χ^2=0.035, *df*=1, *p*=0.85)		
Yes	6 (15.8%)	11 (14.5%)
No	32 (84.2%)	65 (85.5%)
Difficulty Making Appointments (χ^2=0.055, *df*=1, *p*=0.82)		
Yes	8 (21.6%)	15 (19.7%)
No	29 (78.4%)	61 (80.3%)
Difficulties Paying For Non-prescription Medications (χ^2=0.316, *df*=1, *p*=0.57)		
Yes	14 (36.8%)	24 (31.6%)
No	24 (63.2%)	52 (68.4%)

Table 4
Utilization of Indian Medicines by Various Measures of Difficulty Utilizing Western Medicine

	Utilization of Indian Medicines		
	Herbal Medicines	Sweetgrass	None
Difficulty Explaining Health Problem (χ^2=1.33, *df*=2, *p*=0.515)			
Yes	4 (26.7%)	15 (31.9%)	12 (21.8%)
No	11 (73.3%)	32 (68.1%)	43 (78.2%)
Difficulty Understanding Physicians Language (χ^2=1.166, *df*=2, *p*=0.558)			
Yes	5 (33.3%)	23 (48.9%)	26 (47.3%)
No	10 (66.7%)	24 (51.1%)	29 (52.7%)

Table 4 (Continued)
Utilization of Indian Medicines by Various Measures of Difficulty Utilizing Western Medicine

	Utilization of Indian Medicines		
	Herbal Medicines	Sweetgrass	None
Difficulty Finding Physician When Needed (χ^2=0.022, *df*=2, *p*-0.989)			
Yes	2 (13.3%)	7 (14.9%)	8 (14.5%)
No	13 (86.7%)	40 (85.1%)	47 (85.5%)
Difficulty Making Appointments (χ^2=0.470, *df*=2, *p*=0.791)			
Yes	2 (13.3%)	10 (21.3%)	11 (20.4%)
No	13 (86.7%)	37 (78.7%)	43 (79.6%)
Difficulty Paying For Non-Prescription Medications (χ^2=2.00, *df*=2, *p*=0.368)			
Yes	4 (28.6%)	17 (37.0%)	10 (23.3%)
No	10 (71.4%)	29 (63.0%)	33 (76.7%)

Hypothesis Three: Language variables will be useful in predicting utilization of traditional medicine.

The three language variables were based on the assumption that Indian individuals with the strongest ties to their Indian language would be most likely to also retain traditional cultural beliefs, including beliefs in the efficacy of Indian medicine. Tables 5 and 6 present the data from this analysis.

As the data demonstrate, language is very significant in understanding the utilization of traditional medicine. Of particular importance is the fact that 34.7% of those who currently speak an Indian language (i.e., they are bilingual in English and an Indian language) have sought the services of an Indian healer in the past, compared to only 12.5% of current monolingual English-speakers. In terms of utilization of Indian medicine in the past year, the data demonstrate that all of those who had undertaken a sweat (n=6) spoke an Indian language as their first language (these data not shown). Although not statistically significant, a higher percentage of those with an Indian language as their first language (61.9%) versus those whose first language was non-Indian (52.6%), had utilized some form of Indian medicine (either herbs or sweetgrass) in the previous year. The picture is not completely clear, however, since statistically significant differences were not achieved for some of these analyses.

The attitudinal questions present a much clearer picture of the persistence of traditional medical beliefs among urban Indians. For instance, 68.5% of those with an Indian language as a first language, and 67.6% of the current Indian language speakers believed in the superiority of Indian medicine for some medical problems. In contrast, only 50.0% of the non-Indian first language speakers and 35.3% of those currently unable to speak an Indian language believed the same. A similar pattern is evident in the tables for those who would and would not consult with a healer in a western medical clinic.

Overall, then, the data allow only a tentative acceptance of hypothesis three.

Table 5
Utilization of Traditional Medicine by First Spoken Language

	First Spoken Language	
	INDIAN	NON-INDIAN
Past Consultation With Healer (χ^2=0.099, *df*=1, *p*=0.75)		
Yes	18 (30.0%)	10 (27.0%)
No	42 (70.0%)	27 (73.0%)
Had Sweat in Last Year (χ^2=2.38, *df*=1, *p*=0.12)		
Yes	6 (9.7%)	- - - -
No	56 (90.3%)	38 (100.0%)
Utilization of Indian Medicines (χ^2=1.06, *df*=2, *p*=0.59)		
Herbal Medicines	10 (15.9%)	4 (10.5%)
Sweetgrass	29 (46.0%)	16 (42.1%)
None	24 (38.1%)	18 (47.4%)
Would Consult Healer in Clinic (χ^2=4.09, *df*=1, *p*=0.04)		
Yes	47 (82.5%)	23 (63.9%)
No	10 (17.5%)	13 (36.1%)
Belief in Superiority of Indian Healers for Some Medical Problems (χ^2=2.91, *df*=1, *p*=0.09)		
Yes	37 (68.5%)	16 (50.0%)
No	17 (31.5%)	16 (50.0%)

Table 6
Utilization of Traditional Medicine by Current Ability to Speak an Indian Language

	Current Ability to Speak Indian Language YES	NO
Past Consultation With Healer (χ^2=4.31, *df*=1, *p*=0.38)		
Yes	26 (34.7%)	3 (12.5%)
No	49 (65.3%)	21 (87.5%)
Utilization of Indian Medicines (χ^2=0.83, *df*=2, *p*=0.66)		
Herbal Medicines	12 (15.4%)	2 (8.3%)
Sweetgrass	34 (43.6%)	12 (50.0%)
None	32 (41.0%)	10 (41.7%)
Would Consult Healer in Clinic (χ^2=2.57, *df*=1, *p*=0.11)		
Yes	56 (77.8%)	14 (60.9%)
No	16 (22.2%)	9 (39.1%)
Belief in Superiority of Indian Healers for Some Medical Problems (χ^2=6.04, *df*=1, *p*=0.01)		
Yes	48 (67.6%)	6 (35.3%)
No	23 (32.4%)	11 (64.7%)

Hypothesis Four: Those with lower socio-economic standing are more likely than those with higher standing to utilize traditional medicine in the city.

Although some of the literature cited earlier suggests that socio-economic status was not particularly important in understanding the use of traditional medicine, the question is far from settled.

Elsewhere, in comparing overall Native and non-Native patterns of utilization of urban western medical services, I have demonstrated broad similarities between the two populations and argued that their comparable status as disadvantaged core-dwellers explains their respective utilization patterns more than differences in culture (Waldram, 1990b). The Indian sub-sample likewise demonstrated certain uniformity in this area. Nevertheless, data analysis demonstrated some very interesting differences. These data are presented in Table 7.

As the data demonstrate, there were no statistically significant differences in terms of age, education, or income for those utilizing Indian medicines in the previous year. In contrast, those stating that they believed in the efficacy of Indian medicine for certain medical problems tended to be slightly younger and have slightly higher education and incomes; the same was true of those who stated they would consult with a healer in a clinic were one available. Those reporting a past consultation with a healer tended to be older with higher incomes.

Other data analyses, not presented here, demonstrated no significant differences for any utilization and attitudinal variables in terms of sex, marital status, existence of dependent children, or the receipt of government social assistance payments (made to both unemployed and unemployable individuals).

It is interesting to note that, while respondents reporting a previous consultation with a healer were slightly older than those not reporting a consultation, those believing in the superiority of Indian healers for some medical problems and willing to consult with a healer in a clinic tended to be younger. It is possible that the older respondents were more pragmatic in their assessment of the efficacy of Indian medicine, in part due to greater knowledge of it, which in turn resulted in them viewing Indian medicine in a clinic as culturally inappropriate or simply not feasible. The data do not allow us to definitively address this issue, however.

Overall, the data suggests that we reject hypothesis four. Indeed, urban Indian respondents most likely to utilize or believe in Indian medicine tended to have a slightly higher socio-economic standing than their peers. These data must be viewed with some caution, however, since a full range of socio-economic variability was unavailable from this sample. It is not possible to state that more affluent, middle-class urban Indians would demonstrate similar beliefs and utilization patterns.

Table 7
Utilization of Traditional Medicine by
Various Socio-Economic Variables

	Past Consultation with Healer	
	YES	NO
Age (years) (t=1.75, df=112, p=0.08)		
Mean	32.8	29.3
Education (grades completed) (t=0.20, df=54.7, p=0.84)		
Mean	8.6	8.5

Table 7 (Continued)
Utilization of Traditional Medicine by
Various Socio-Economic Variables

	Past Consultation with Healer	
	YES	NO
Annual Income ($) ($t$=1.96, df=105, p=0.05)		
Mean	8270	6596
	Utilization of Indian Medicines	
	Herbal Medicines/ Sweetgrass	None
Age (years) (t=-0.82, df=115, p=0.41)		
Mean	29.9	31.4
Education (grades completed) (t=0.39, df=115, p=0.70)		
Mean	8.7	8.5
Annual Income ($) ($t$=-0.07, df=107, p=0.95)		
Mean	7263	7319
	Belief in Superiority of Indian Healers for Some Medical Problems	
	YES	NO
Age (years) (t=-2.34, df=56.9, p=0.02)		
Mean	28.3	33.4
Education (grades completed) (t=2.43, df=100, p=0.02)		
Mean	8.9	7.9
Annual Income ($) ($t$=1.42, df=96, p=0.16)		
Mean	7839	6565

Table 7 (Continued)
Utilization of Traditional Medicine by
Various Socio-Economic Variables

	Would Consult Healer in Clinic YES	NO
Age (years) (t=-2.06, df=44.4, p=0.05)		
Mean	28.7	33.6
Education (grades completed) (t=0.90, df=45.0, p=0.37)		
Mean	8.8	8.4
Annual Income ($) ($t$=1.04, df=100, p=0.30)		
Mean	7333	6402

Discussion

In accepting the first and third hypotheses and rejecting the second and fourth, we are led to the conclusion that individuals continue to utilize traditional medical services while living in the city for reasons largely unrelated to the existence of western medical services or problems in utilizing these services, including financial problems. Clearly, the utilization of traditional services does not detract from the utilization of western services.

It can also be argued that for this Indian population, the continued utilization of traditional medicine in the city represents a transference of traditional medical beliefs, especially the beliefs concerning the efficacy of Indian medicine, to the urban context. Traditional medicine remains important to these individuals precisely because they have retained basic elements of their culture, measured in this research by language variables. This retention may, indeed, be fostered by contact with rural or reserve-based Indian cultures, where Indian medical practices are still strong, and by contact with newly arrived migrants. Nevertheless, the data suggest a persistence in beliefs in the urban, multicultural context. And while the sample as a whole was economically disadvantaged, the data suggest that socio-economic standing is likely less important here than the persistence of traditional culture.

The data also demonstrate that western medical services are being utilized extensively, and that the use of traditional services in general are as an adjunct to, rather than a substitution for, western services. Although a few cases occasionally emerged in the research where a patient was forced to decide between contradictory treatments prescribed by a physician and a healer, these were rare. The folklore in the medical community contains anecdotes regarding Indian patients who discontinued medications (such as insulin in diabetics) at the insistence of a traditional healer and suffered medically as a result. Again, however, these seem to be rare instances, and may be no different from cases of patients from a variety of cultural backgrounds who alter medications on their own, discontinue treatments, or fail to present for specialist treatments. There were some cases in which an indigenous etiology was expressed, resulting in a consultation with a healer only, but these were few in number. In most cases where a healer was contacted for a health problem, this was *after* consultation with a physician. Individuals who reported simultaneous utilization of western and traditional medical services invariably consulted a physician first, then a healer.

The nature of the study, particularly the use of an availability sample in a province with universal medical insurance, makes inferences beyond the research setting fraught with difficulty. It is not possible to say that similar results would be retained in a study of urban middle-class Natives in Saskatoon, or that the patterns demonstrated here would reflect those in rural or remote areas.

The persistence of traditional Indian medicine in the city (and in rural areas) does not appear to present a threat to the utilization of western medical services; there is no contradiction in serial or simultaneous utilization by patients. Indeed, the data suggest that those most likely to use one are also most likely to use the other, and there may exist a sub-population of the urban Native population that avoids both western and traditional services. The implications are that practitioners in the traditional and western medical systems should be, at the very least, informed of the activities of the other with regard to specific patients. Whether this means more formal collaboration is certainly an issue for discussion.

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Notes

1. I refer in this paper to traditional Indian medical systems in the plural. Among aboriginal North Americans there existed a wide variety of medical techniques and an array of etiological, anatomical, surgical, and diagnostic knowledge. Despite this fact, there has been a tendency to refer to the traditional medical system in the singular, as if there was only one system or as if they were so similar as to effectively

represent one system. There have been very few attempts to survey the variety of medical knowledge and techniques of aboriginal North Americans, and as far as I know there have been no attempts at surveying this knowledge in a contemporary sense. Therefore, given the lack of data, I feel it is most appropriate to address the question of Indian medicine from the perspective that each culturally-defined group had its own, somewhat unique, medical system (acknowledging, however, that there were and still are similarities, the result of both borrowing and independent but parallel innovation).

2. In this paper, "Native" refers collectively to all status or registered Indians, non-status Indians and Metis.

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LOCUS OF CONTROL AND DRINKING BEHAVIOR IN AMERICAN INDIAN ALCOHOLICS AND NON-ALCOHOLICS

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Abstract: Many investigators have attempted to determine whether alcoholics differ from non-alcoholics in their perceived locus of control. The present study examined the responses of alcoholic and non-alcoholic American Indian males and females on Levenson's Multidimensional Locus of Control Scale. Subjects were 80 American Indian males and 40 American Indian females. All subjects were members of either an eastern (Cherokee) or western (Cheyenne) Oklahoma tribe. Results indicate no significant differences between the Cherokee male alcoholic and non-alcoholic group. Cheyenne male alcoholics reported significantly lower internal control scores than did Cheyenne male non-alcoholics. Within the female sample, alcohol use and tribal membership showed a significant interaction with locus of control. These findings suggest that locus of control may be a potentially useful clinical construct in the development of treatment plans and therapeutic issues for American Indian patients who are alcoholics.

Numerous studies have been conducted on locus of control orientation in alcoholics but the results have been inconsistent; some studies found alcoholics to be more internally than externally oriented, while others have found just the opposite (Hinrichsen, 1976). Vuchinich and associates (Vuchinich, Tucker, Bordini, & Sullwold, 1981) have found that both alcoholic and non-alcoholic males tend to attribute their own drinking behavior to external factors. A study of alcoholic and non-alcoholic females has indicated that women assign major responsibility for problem drinking to the person doing the drinking (Beckman, 1979). Clinical evidence suggests that alcoholics deny personal responsibility for their drinking and attribute causation to external factors (Beckman, 1980). These findings suggest that locus of control may be a potentially useful clinical tool in the development of treatment plans and the prediction of treatment outcome for alcoholic patients.

Since the introduction of a locus of control concept in the early 1960s (Rotter, 1966), there has been an abundance of research investigating the internal-external dimension. On the basis of these studies, perceived control seems to be a significant behavioral determinant of a person's response to life events. Rotter defined the concept of internal

control as representative of a person's belief that rewards are contingent upon one's own behavior. Conversely, external control represents the belief that rewards are controlled by forces outside oneself and may occur independently of one's own actions (Rotter, 1966). Using this dual construct, extensive research has been devoted to utilizing locus of control as a predictor of various behaviors and a variety of research directions have been pursued.

Lefcourt (1976) suggested that the internal-external dimension of locus of control did not possess complete generality. Situational changes could affect the amount and locus of control exhibited. Therefore, the internal-external dimensions might successfully predict behavior in general, but fail in a specific situation. Contemporary trends in the locus of control research have indicated that the internal-external construct is not unidimensional but multidimensional in character (Lefcourt, 1981; Lefcourt, 1976; Lefcourt & Ladwig, 1965; Phares, 1976). Subsequent work by Rotter indicated that locus of control scales measuring expectancies in specific areas of functioning within the broader internal-external dimensions might have greater predictive power than general unidimensional scales (Rotter, 1975). Several of these goal-specific locus of control instruments have now been developed (Lefcourt, 1981).

Levenson (1973) examined the utility of investigating diverse agents of control. She created a three-factor measure of locus of control that consisted of "internality," "control by powerful others," and "control by chance." This division of external control into chance and powerful others might permit more predictive utility and allow for better clarification of external control (Ozolins, Caldwell, & Jaynes, 1983). In a study of alcoholic inpatients using Levenson's scale, Caster and Parsons (1977a, 1977b) found that alcoholics who scored highest on the chance dimension (external control) also had the least successful treatment outcome.

The present study examined the response of alcoholic and non-alcoholic American Indian males and females on Levenson's multidimensional locus of control scale. In view of the findings of Vuchinich et al. (1981) and Beckman (1980), we expected that both male and female alcoholics would report more belief in external control than their non-alcoholic counterparts.

Method

Subjects

Eighty American Indian males and 40 American Indian females were tested with Levenson's multidimensional locus of control scale (Levenson, 1973). In each group, half of the subjects were alcoholic and half were non-alcoholic. Alcoholic subjects were either current inpatients in an alcohol treatment program or had recently (within six months) completed inpatient treatment and were receiving outpatient aftercare

services. The non-alcoholic subjects (social drinkers and abstainers) were recruited from the same geographical area as the alcoholic subjects. Non-alcoholic subjects had no history of treatment for alcoholism, and had had no drinking-related arrests or vehicular accidents due to alcohol usage. Many of the non-alcoholic subjects were family members of alcoholic subjects and/or medical outpatients at an Indian Health Service facility.

All subjects were members of either an eastern (Cherokee) or western (Cheyenne) Oklahoma tribe who were at least half Indian (preference was given to full-bloods in screening subjects for eligibility), who could produce proof of degree of Indian blood or a roll number that could be verified with tribal or Bureau of Indian Affairs records. Subjects were matched for age, education, and drinking history across all groups. Subjects gave informed consent and were paid for their participation.

The age range of the male group was 19 to 65 years. The Cheyenne male alcoholics had a mean age of 32.90 ± 9.38 years, and an average of 11.20 ± 1.15 years of education, while the non-alcoholic Cheyenne males averaged 31.80 ± 9.56 years of age and had a mean of 11.65 ± 1.49 years of education. The Cherokee male alcoholic group had a mean age of 32.00 ± 6.79 years and an average of 11.00 ± 1.62 years of education; and the Cherokee male non-alcoholic group had a mean age of 31.90 ± years and 11.30 ± 1.13 years of education.

The age range of the female group was 21 to 59 years. The Cheyenne female alcoholics had a mean age of 38.30 ± 10.47 years and an average of 11.00 ± 1.49 years of education, while non-alcoholic Cheyenne females averaged 34.00 ± 11.52 years of age and had a mean of 11.30 ± years of education. The Cherokee female alcoholic group had a mean age of 32.50 ± 10.19 years and 11.60 ± 2.01 years of education, and the non-alcoholic Cherokee females had a mean age of 36.00 ± 9.54 years and 12.10 ± 1.28 years of education.

Procedure

Subjects took a series of paper-and-pencil tests in group settings as part of a large research project. The informed consent process was explained first, and then subjects were given instructions for completing the self-report questionnaires. All test protocols were identified only with research numbers. Consent forms and other identifying information were removed from research folders. Subjects were paid for their participation in the study. All tests were administered and scored (blindly) by two female American Indian psychologists.

The test battery included Levenson's multidimensional locus of control scale (Levenson, 1973). This scale is a widely used clinical instrument that assesses belief in control by self (internal control), control by chance and control by powerful others (external control). The scale contains 24 items, with eight items for each of the three locus of control dimensions. The subject indicates strong, moderate, or mild agreement or

disagreement with each statement. Responses to each item are summed, with a higher score signifying strong agreement and a lower score signifying strong disagreement, yielding a separate score between 8 and 48 for each dimension. According to Levenson, the highest score of the three scales is indicative of the individual's locus of control orientation.

Results

Locus of control for male and female groups were subjected to a 2 x 2 analysis of variance using the variables of tribal membership, and alcohol usage. There were no interaction of main effects in the male sample and only one interaction on the locus of control external variable in the female sample.

Independent group-tests were performed to determine the degree of difference of mean locus of control scores between Cherokee alcoholic and non-alcoholic groups and between Cheyenne alcoholic and non-alcoholic groups. These tests indicated no significant differences within the Cherokee groups, while the Cheyenne male alcoholics reported significantly lower internal control scores than non-alcoholics (t=2.27, p<.01).

Alcohol use and tribal membership produced interaction effects in the female sample (F=6.34, p<.01). T-tests on female locus of control scores indicated significant differences between Cherokee alcoholics and non-alcoholics on the external locus of control scales (t=3.08, p<.01), with alcoholic women scoring in the direction of externality more often than non-alcoholic women. There were no significant differences between female Cheyenne alcoholics and non-alcoholics.

Comparison of mean scores are presented for males in Table 1 and for the females in Table 2.

Table 1
Mean Locus of Control Scores for Male Alcoholics & Non-alcoholics

	CHEROKEE		CHEYENNE	
	Alcoholic	Non-alcoholic	Alcoholic	Non-alcoholic
AGE	36.20	33.10	34.05	30.35
{SD}	10.85	11.00	9.77	9.31
		(t=0.87)		(t=1.22)
EDUC	11.30	11.15	11.40	11.50
{SD}	1.55	1.45	1.27	1.39
		(t=0.31)		(t=0.24)
LOC-I	38.65	37.05	36.85	41.45
{SD}	6.39	10.05	5.06	5.62
		(t=0.60)		(t=2.72)*

Table 1 (Continued)
Mean Locus of Control Scores for Male Alcoholics & Non-alcoholics

	CHEROKEE		CHEYENNE	
	Alcoholic	Non-alcoholic	Alcoholic	Non-alcoholic
LOC-C	29.30	24.85	28.10	26.35
{SD}	7.62	8.31	8.52	8.22
		(t=1.76)		(t=0.66)
LOC-P	25.65	22.65	24.00	22.95
{SD}	8.88	7.84	6.81	8.11
		(t=1.13)		(t=0.44)
LOC-E	27.20	23.50	25.75	24.20
{SD}	7.33	6.47	6.65	7.32
		(t=1.69)		(t=0.70)

p<.01

Table 2
Mean Locus of Control Scores for Female Alcoholics & Non-alcoholics

	CHEROKEE		CHEYENNE	
	Alcoholic	Non-alcoholic	Alcoholic	Non-alcoholic
AGE	32.50	36.00	38.30	34.00
{SD}	10.19	9.54	10.47	11.52
		(t=0.68)		(t=0.87)
EDUC	11.60	12.10	11.00	11.30
{SD}	2.01	1.28	1.49	1.33
		(t=0.66)		(t=0.47)
LOC-I	36.40	40.30	36.50	38.10
{SD}	2.14	4.00	2.12	4.63
		(t=1.19)		(t=0.99)
LOC-C	29.30	20.90	26.30	29.30
{SD}	5.60	4.43	6.65	7.63
		(t=3.72)*		(t=0.94)
LOC-P	26.70	21.50	23.00	25.80
{SD}	6.67	7.68	8.43	6.86
		(t=1.62)		(t=0.81)
LOC-E	28.20	21.40	24.90	27.60
{SD}	5.69	4.06	6.62	7.04
		(t=3.08)		(t=0.88)

p<.01

Discussion

Both the alcoholic and non-alcoholic males and females were more internally than externally oriented, as expected by the norms (Levenson, 1973). There were no significant mean differences between Cherokee alcoholic and non-alcoholic males. However, a significant difference was found for the internal scale between Cheyenne alcoholic and non-alcoholic males. The non-alcoholic males scored higher than the alcoholic males on this scale as predicted. Given this finding, it could be speculated that American Indian alcoholics may experience a lower level of belief in personal power/control than do non-alcoholics. This may not be purely a function of cultural differences, but probably is a combinative effect of alcohol and cultural beliefs clashing in contemporary society. These findings suggest a consistency with those of Lefcourt (1976), which indicated that situational changes might affect the amount and direction of locus of control. In spite of a significantly lower level of internal control--and contrary to our expectations--the Cheyenne alcoholic males did not report significantly higher levels of external control.

The Cherokee alcoholic women, as expected, scored higher on the combined external scale than did their non-alcoholic counterparts. There were no significant differences between Cheyenne alcoholic and non-alcoholic women. Contrary to our predictions, alcoholic women did not score lower on the internal scale than non-alcoholic women. Perhaps this finding reflects the changing roles of females in contemporary society. Traditionally, most American Indian women accepted very little responsibility outside the home environment; their roles centered around homemaking, child care, and family maintenance. However, within the last two decades, Indian family structures have changed as necessitated by the economic realities of American society. More Indian females have become heads of households and taken on the role of a single parent. Thus, they have been required to enter the work force outside the home. This additional responsibility may be a significant factor in the emergence of the American Indian woman as one with a greater amount of perceived control, as suggested by the findings within the female sample.

To put these results in perspective, it may be useful to look at the data relative to studies using a Caucasian sample reporting on the same instrument. In a study of white alcoholics and non-alcoholics, Shelton and colleagues (Shelton, Parsons, Leber & Yohman, 1982) found that non-alcoholic males scored significantly higher on the internal control dimension than did alcoholic males (t=2.32, p<.05). A comparison of mean scores from our study and those of Shelton, et al. was conducted using z-tests to determine the degree of difference between mean scores. The white alcoholic males were significantly older than both the Cherokee and Cheyenne alcoholic male groups (p<.001), and had a significantly higher level of education than either the Cherokee or Cheyenne alcoholics (p<.05).

Although these comparisons may be considered statistically invalid, they are presented as a major point of interest of their applicability in cross-cultural research.

Internal locus of control scores were similar for white alcoholics and Cherokee male alcoholics. These same groups differed significantly on both external scales. Cherokee male alcoholics attributed control to chance (z=3.75, p<.001) and powerful others (z=2.19, p<.05) significantly more often than white alcoholics. Cheyenne alcoholic males reported belief in internal control significantly less often than did white alcoholics (z=1.98, p<.01). Conversely, these same groups differed significantly on both external scales. Cheyenne male alcoholics attributed control to chance (z=2.86, p<.01) and powerful other (z=1.76, p<.05) significantly more often than did white alcoholics.

We compared the results from the female sample of the current study with those of an earlier study from this laboratory using Caucasian female alcoholics and non-alcoholics (Jones-Saumty, Parsons & Fabian, 1980). Once again z-tests were employed to determine the degree of difference between mean scores. The female Caucasians were definitely older than either of the female Indian groups and significantly older than the Cherokee group (p<.01). Likewise, the Caucasian females had a significantly higher level of education than either the Cherokee (p<.05) or Cheyenne (p<.01). All three groups were similar on overall locus of control orientation. However, both the Cheyenne and Cherokee females indicate a greater tendency toward externality than their Caucasian counterparts. Specifically, the Cheyenne females scored significantly higher on the chance construct (p<.01) than did the white females (groups combined). The Cherokee females reported significantly higher scores on both of the external scales, chance (p<.01) and powerful other (p<.01). It should be noted that scores on the internal scale were similar across the Indian and white groups, and mean differences were statistically not significant.

Further, a Pearson product moment correlation of all subjects (80 males and 40 females) revealed a substantial relationship between the powerful others and chance scales in this American Indian sample (r=0.53, p<.001). This finding suggests the reliability of the scale for measuring external control and provides some further value for the cross-cultural comparisons previously made. Additionally, a relationship was found between the powerful other and internal scales (r=.21, p<.01) that could be indicative of the pervasive level of traditionality within this American Indian sample. Certainly, one of the tenets of that traditionality seems to be the belief in an omnipotent and beneficent guidance influencing their lives. However, this belief seems to be compatible with the belief in internal control, thus lending a sense of balance to a people who must maintain a lifestyle encompassing two distinct cultural identities.

This study examined the response of alcoholic and non-alcoholic American Indian males and females on a multidimensional locus of control scale. Results indicate a similarity of belief in internal control across the

alcoholic versus non-alcoholic dimension as well as the Cherokee versus Cheyenne dimension within the female sample. Conversely, there seems to be a similarity in belief in external control across the alcoholic and tribal dimensions within the male sample.

Although the multidimensional locus of control scale allows greater predictability and extended utility, our results suggest that additional study is indicated to determine the effects of other variables such as depression, anxiety, expectancy of reinforcement, and intellectual functioning on perceived control.

Information regarding locus of control could be used as a salient component in the integration of treatment planning and the determination of therapeutic issues. Such information becomes important in view of the dearth of data on American Indian alcoholism and its concomitants.

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PSYCHIATRIC FUNCTION AND ROLES IN AN INDIAN HEALTH PROGRAM CONTEXT

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Abstract: This paper relates the experience of a non-Indian psychiatrist who successfully functioned in an urban Indian health care setting. It illustrates the process of becoming a part of a mental health team and the complexities of becoming a culturally-sensitive psychotherapist. This is accomplished by relating personal experiences, observations, case examples and self-questioning of therapeutic roles and functions. The author concludes that a psychiatrist should not rigidly define his or her role upon entering a particular setting but instead should allow a multitude of roles to unfold. Psychiatrists are also urged to remain constant students of the culture of the patients and organization, applying that knowledge as dictated by the treatment situation.

Introduction

The literature is virtually silent in regard to the process involved in entering and negotiating the role as a psychiatrist in a setting that is different from the therapist's own culture. The interplay of perceptions between therapist, staff, and client has a substantial impact upon developing relationships and treatment. Within this paper I would like to convey the complexities and nuances of this experience at the Indian Health Program through observations, case examples and persistent questioning of my role and function as a therapist.

The Indian Health Program (IHP) is located in a large urban area, and serves a population of 17,000 American Indians. Components within the facility include medical and dental clinics, Indian Child Welfare (ICW), an alcohol abuse prevention program, health education, administration, and fund raising. The IHP also houses and distributes food and clothing to needy individuals and families.

Negotiating a Role with the IHP

As a resident in psychiatry, I elected to utilize time during my senior year working at a facility providing care to American Indians. One of the most anxiety-producing aspects of accessing such a system was the length of time needed to negotiate my role. My supervisor, as an American Indian, was the primary facilitator during our initial discussions with the IHP staff. His cultural understanding and identity greatly assisted my entry into a

American Indian and Alaska Native Mental Health Research, 4(1), Fall 1990, pp. 41-52

system unknown to me. The mediating process with the health center began four months in advance of my actual placement there; the amount of time was imperative as the process was a slow one which involved numerous levels of exploration and discussion. Because the IHP did not have an organized mental health service, there was no well-circumscribed program area for me. Although this undefined role created much anxiety, it was beneficial in forcing me to learn approaches to a system, utilizing this open-endedness to focus my interests where my services were needed.

Meetings were arranged with the director and several other members of the IHP. An early difficulty was the recurring change of staff, requiring frequent renegotiation with new personnel. In retrospect, it was critical to have multiple key figures present at the meetings so that one need not start anew upon the departure of a major program. For example, during this negotiation phase the director of the program resigned; two of the three staff I eventually worked with were hired shortly before I began my placement. Early discussions focused on staff perspectives of the role they played in the local American Indian community, programs they had initiated, and current policies within the organization. Staff indicated that being Caucasian affected my understanding of their culture, yet they welcomed me in providing care for their people. During this time, it was important that I listen to their perspective, thereby enabling some initial trust to occur between us. Staff soon realized that I was not going to impose my expectations upon them. This approach allowed me to better understand the needs and difficulties of the organization rather than entering with a fixed agenda that could have alienated the staff.

During this time I wanted to set up a meeting with a woman who managed a program of interest to me. I left telephone messages for her to contact me, but received no response. I wondered if this lack of response was due to her personality or perhaps racial exclusion because I was non-Indian. Alternatively, I wondered if it was possible that her program was uncertain of receiving continued funding. I never discovered why my calls were not returned, yet through this experience I realized that one must continue to keep an open mind about disturbing behaviors. Rather than assuming reasons that may potentially compromise perspective and capacity to function in an unfamiliar setting, it is important to remember that there can be numerous explanations as to their cause.

As the negotiation continued, I began to focus more directly on my personal interest of providing psychotherapy for Indian women. ICW worked extensively with women, and could identify and provide referrals. During this phase of negotiation it was important not to promise more than I could fulfill. For example, the staff wondered if I would be able to participate in court hearings. After thinking about this possibility, I decided that this was a service that I would not be able to provide due to time constrictions. Staff wondered if there would be a fee for my services, and I clarified that my time would be without charge to clients. I also clarified the exact time period I would be available and that there could not be a

guarantee that another resident would replace me upon my termination at the clinic. Without this open discussion, expectations could have been raised that potentially could have caused many future problems.

Once a mutual understanding had been arrived at between the IHP and myself, our arrangement was formalized through a letter. In it, I described our agreed upon goals, my time commitment, and my appreciation for being given the opportunity to work with the IHP. I also personalized the letter by telling staff about my background, permitting insight into my non-professional life. This became my unofficial "contract" with the IHP.

Initiation of Clinic and Practice

The next stage of entry was to actually initiate my clinical role at the IHP on a regular basis. I requested an orientation to allow me to tour the various departments, thereby familiarizing myself with the services provided and introducing me to all employees. This also was a period during which the ICW staff became acquainted with me. In turn, I began to familiarize myself with the specifics of their program. We discussed several women the ICW staff had identified as potential clients, reviewing their case histories, needs, and willingness to participate in psychotherapy. Interview times were arranged by the ICW staff for these identified clients.

On my first day of clinic time, none of the scheduled clients kept their appointments. I became apprehensive that there would not be clients to work with despite my long hours of negotiating an area in which to work. In contrast, the following week I was very busy with several scheduled evaluations and an emergency client; contrary to my early apprehension, my services clearly were needed.

As I began seeing clients regularly and therefore became more known, I was aware of staff seeking me out to investigate who had come to work in their program. The program's medicine man repeatedly walked by my door; it seemed he wanted to observe me from a distance for a while. Another staff worker caught me in the hall and asked for an informal consult in assessing the needs of a non-Indian woman who had appeared psychotic. ICW staff began to communicate their concerns, to ask for direction, and to utilize me in a supervisory capacity. I, in turn, began to explore the varied aspects of my role at this program.

Evolution of Varied Roles

Upon entering the IHP, it was beneficial to have some perspective of these potential roles. As I became more familiar with the staff and programs, I became increasingly aware of the variety of functions I performed. My roles did not unfold gradually over time but seemed to occur almost spontaneously, changing quickly from moment to moment with a great deal of overlap. Initially this was quite confusing until I sorted out the

roles with the assistance of my supervisor. It was important for me not to limit myself to the role of therapist. As my roles at the IHP developed, so did the staff's ability to identify what I had to offer.

The variety of roles undertaken can be organized into several categories including therapist, consultant, facilitator and information contact. In retrospect, I entered the system perceiving myself primarily as a therapist--a role familiar to me as well as a self-imposed identity. My function as a therapist was to interview patients, assess their problems, and perform appropriate treatment. Yet as my contact time progressed, staff members approached me with different roles in mind. For example, staff began presenting case material to me with subsequent discussion which resulted in my performing in a consultation capacity. This was a role easily accommodated due to years of clinical training. I recognized the expertise I could convey and how to assist staff members with problem-solving.

Staff also searched me out as an information contact. For example, the director approached me regarding how mental health services might best be conducted at the facility over time. Another staff person requested information on referring a patient to an appropriate resource for mental health treatment. Alternatively, I began to develop my role of facilitator to help strengthen the skills and group cohesion of the staff. My initial, self-defined role as therapist greatly expanded.

Dynamic Aspects to the Roles

There are dynamic aspects to these roles that deserve special mention and can be referred to as flexibility, perspective-taking, and case management. More closely defined, flexibility involved a fluid accommodation of staff and program needs. Examples include acknowledging that this facility served a small and circumscribed community in an overlapping manner, with staff and clientele providing services to people they knew socially. I often found myself conducting therapy with a patient one moment and shortly thereafter socializing with the same person in a community meeting room in the facility. Although I had been trained to maintain a therapeutic distance from patients, this would not have been appropriate in this setting, as overlap between service and socialization is not only acceptable but is an important component of being accepted by the community itself.

Perspective-taking is an integral aspect of working as a psychotherapist in that one must be able to take into account the viewpoint of the other person in order to gain understanding and communicate effectively. For several reasons, it is particularly important in entering a specific cultural system. In working with staff and negotiating relationships, it is critical to consider the perspective that another might have adopted in approaching a given issue. An example was my observation that a staff member who initially was quite engaged with me suddenly became withdrawn and unavailable. I could have presumed that I had offended her

in something I said or did. In assessing this new behavior I considered another explanation: this staff member had divulged considerable of personal information in our discussions and as a result felt the need to distance herself. The appropriate response in this case was to give her the needed distance while maintaining an open door for communication, rather than asking if I had done something wrong. She was eventually able to return to a working relationship with me, which might not have been possible if I had been intrusive at an inappropriate time.

A second reason that perspective-taking is so important in this setting is that cultural differences and their implications for treatment must be ascertained. An example involved an Indian woman who was extremely upset with the school system, feeling that it had forced her to cut her son's long hair after allegedly finding lice. She felt the real issue was that school personnel had a difficult time accepting the length of her son's hair and utilized the lice issue to force compliance. It was important for me to know that long hair on an Indian boy is an integral aspect of participating in Native dancing. Without this knowledge, I would have been less able to understand the depth of trauma this woman had experienced. Not only had the school implied that she did not keep her son clean but she personally felt assaulted by the school's disregard of the significance of her boy's long hair to both his identity and hers as American Indians.

In working within a complex system such as the IHP, case management is an important element. There are multiple levels of problems to be assessed and coordinated to maximize treatment intervention. For example, a patient at the IHP more than likely has multidimensional needs. One patient who will be discussed in further detail needed an alcohol treatment program, individual psychotherapy to deal with her depression, foster care for her child while she was in treatment, and financial assistance to find housing and employment. All these were necessary to help her maintain sobriety. Each intervention integrally affected the others in that if only one or two needs had been addressed, treatment would have been likely to fail. In order to provide integrated care, it was important that I work closely with ICW staff. They knew the clients, their families, potential support networks, and the available community resources. The following case examples help to further elucidate the multiple roles and functions I assumed within this complex organization.

Case Examples

Case 1

B is a 25-year-old unmarried Northern Plains woman with a long history of alcohol abuse and mood swings (since 17 years of age). She had entered an inpatient alcohol treatment facility specifically for American Indian, and her 2-year-old son had been placed in foster care while she underwent treatment. B also has a 5-year-old son who lives with her sister

in a different state. She has not seen this older son for several years. Family history includes an alcoholic mother. As a result, B recalls constantly moving from place to place, never being sure where she would be at any given time. Other family members include two sisters from whom she feels alienated and a father she never met. B came to therapy motivated to make her life better.

In working with B, it was important to take into consideration the multidimensional aspects of her problems and needs. To receive optimal care she needed alcohol treatment, individual psychotherapy, foster care for her child, and financial assistance. In order to ensure an integrated approach, a case conference forum was established to exchange information and define treatment goals. Two care providers and I met together on a regular basis with additional phone contact to update information between meetings. For example, at one meeting the social worker shared foster care plans and the results of regular contact between B and her child. The alcohol counselor discussed B's work in the area of assertiveness as opposed to aggression. She also discussed the alcohol treatment program and gave an overall perspective of issues addressed over time. As the psychotherapist, I shared B's work on issues of loss and how that affected her current ability to maintain ties with people. Also discussed were long-term treatment goals and how to continue the support this woman needed after she completed her inpatient alcohol treatment program. We decided to help her widen her support network through additional resources.

At one point the client wished to attend one of these case conferences. On one hand she was curious about our discussions, and on the other hand she wanted to participate in her care. She was invited to a portion of one meeting and given the opportunity to state her concerns and goals. In return, the care providers discussed with her the current phase of treatment and future plans. It was helpful to all involved to have her actively taking an interest and participating.

With so many care providers, issues of confidentially needed to be addressed. Permission was obtained from the client for allowing exchange of information among providers. She had the right to specify any personal information not to be shared. B agreed to this plan because she knew the case conference approach represented her best interests.

When multiple care providers work with a single individual, the question of competition between staff and potential interference with treatment may be raised. This was not an issue with B for several reasons. First of all, this client had so many needs that it was actually beneficial for the staff to share this burden as a way to provide support for one another and to prevent burnout. If one provider had been managing the case, it could have been overwhelming. Secondly, each provider shared her particular area of expertise, enabling the others to learn about this aspect of the treatment and thereby increasing the knowledge and understanding of the complexities of B's case.

Role flexibility was important in working with B. Early in her psychotherapeutic treatment, B would exhibit little affect; yet afterwards she would leave me and cry in the social worker's office. Typically, a psychotherapist works with affect within the session as an important part of the treatment. In this case, it was almost as if there were two co-therapists working separately. Initially, as B was gaining trust with me, she was more comfortable being tearful with the social worker whom she had known longer. At the end of each session, after B's departure, my colleague and I would discuss the case and work on treatment approaches together. This arrangement worked, but required a flexible approach. Eventually B was able deal with affect directly with me. A factor that quickened this process was my colleague's absence one day, forcing B to utilize our therapeutic relationship.

Role fluidity was also integral to working with my "co-therapist" in the case. At times I functioned as a supervisor to my colleague, helping her to maintain objectivity in working with B. At other times, she would function as my supervisor in helping to guide me through cultural aspects of the case with which I was unfamiliar.

In working with B, there were issues that required that she verbalize her anger. I was not sure if and how the expression of anger would be culturally appropriate and recognized that this was an area that needed a perspective of cultural sensitivity. I went to my co-therapist to inquire about this matter. She told me about the symbolism of the peace pipe, how it represents wisdom and goodwill; she told me that unless B's anger was dealt with she would not be able to attain that which the peace pipe stood for. With this knowledge I began working with B on anger from both past and current experiences. As B began to recognize her feelings, she talked about how she would repress her anger and end up drinking to deal with it. In therapy, she learned to talk about her problems and associated feelings, rather than using deeply ingrained self-destructive responses. Over the course of treatment, it became clearer that B's difficulties in dealing with her anger were due to personal issues rather than cultural ones.

It is very important to inquire about potential cultural aspects in dealing with clients, as this knowledge could be an integral part of treatment. Cultural sensitivity is an ongoing process of inquiry and self-instruction with an awareness that specific cultural factors may play an important role.

Case 2

N is a 13 year old girl from the southwest who was removed from her home by social services due to sexual abuse by her stepfather. N was eventually placed with her biological father (Mr. G) and his wife after not having seen him since her parents divorced when she was eight years old. Her mother reportedly had abused drugs for many years during N's childhood and had chosen to continue living with the stepfather despite the abuse allegations. N's father had been alcoholic when living with the family,

but had been sober for the past two years. He also worked at the program where N was treated.

Difficulties with alliance with N and her father were a problem from the onset of therapy. Although weekly appointments were scheduled, N attended sporadically, and Mr. G was resistant to his daughter receiving evaluation and treatment despite social services recommendations that she be in ongoing therapy. Consequently, flexibility and perspective-taking were important aspects of working with this family.

Due to sporadic attendance, it was important to have a set time so N knew she had an appointment every week regardless if she came. When N did not arrive for her appointment, I would leave my office door open and her father would stop by to talk during a break from his work. Initially he said N only needed to see me once or twice, that talking about the incest wasn't going to help her any. I took this opportunity to educate Mr. G about psychotherapy and how it could help his daughter, particularly with her inability to trust adults. At times he was so agitated he refused to discuss anything with me; at other times he shared the frustration he experienced in dealing with his daughter. Although he was never the identified patient, a major portion of treatment was accomplished through this "open door" policy. It would have been unlikely that N's father would have spoken with me via any scheduled appointment. He also had refused several offers of family counseling, which in my opinion would have been optimal in helping them to adjust to each other at home. Slowly over time, Mr. G's trust in me increased to the point that he brought N to the scheduled sessions on a more consistent basis. He seemed to respond to my willingness to disclose information without breaking N's confidentiality. Perspective-taking was important in recognizing the father's ambivalence about having his daughter in treatment. This understanding allowed me to educate and work with him in a comfortable manner. After approximately one month, N's father was able to share important information about his daughter and his relationship with her at home that was central to treatment.

N was distrustful in therapy and frequently angry. She experienced problems in adjusting to a new living situation and had developed maladaptive ways of dealing with people that had been present long before moving into her father's household. She began to share some things about herself, yet wondered if I was working for her father. She knew that he frequently spoke with me and was further confused by the fact that he worked at the IHP. I told her that information she wanted to remain confidential would not be discussed with her father unless it involved harming herself or someone else. Her only request was that I not discuss with her father what she told me about boys. Shortly thereafter she tested me by talking about her sexual activity and her desire for birth control We talked about her concerns in regard to sexuality, noted that saying no was an option, and discussed where she could obtain birth control if needed. Although N continued to distrust me, she initiated some moves to establish a relationship with me. Although she was the identified patient, the therapy

consisted of treating both N and her father in tandem. My flexibility of being available to each, and in a way allowing them to regulate treatment is very different from the standard model of weekly therapy sessions with an individual. Recognizing that my time at the clinic was less than six months, reasonable treatment goals needed to be set for N and her father. It was decided that a viable plan would be to help her to establish a relationship with an adult in which N could begin to learn basic trust. A reasonable goal with her father was to help him understand his daughter, his reactions to her, and how to set limits. He also needed to be educated about the importance of consistent, ongoing therapy for his child.

Two months after beginning treatment, N was placed in a shelter by her social worker after she accused her father of sexually abusing her. The following day she rescinded this claim and agreed to return to live with him. Mr. G was angry and hurt by N's behavior and spoke at length about his feelings during one of our "open door" sessions. Yet, at the same time he began to take steps to understand N's behavior. He wondered if this might indicate that she hoped to return to live with her mother because she had never adjusted to leaving the home she had known for 13 years. It was helpful for him to vent his frustration and to have his feelings validated, as well as to problem-solve ways to deal with his daughter's behavior.

Following this incident, N consistently attended sessions until one month later when she missed a scheduled appointment. The following day she attempted suicide by overdosing on pills and was admitted to an adolescent treatment ward. Her father was angry with her, feeling that she had disregarded all he had done for her and was trying to get attention. He vacillated markedly between wanting to have nothing to do with her and recognizing that she had significant emotional problems.

It was important to help Mr. G recognize that his daughter's suicide attempt was a call for help. We spent several "open door" sessions talking about N, her needs, and his feelings about her refusals to see or speak with him at the hospital. He came to understand that she needed extensive treatment for her emotional problems--an important insight for him.

Several weeks into N's hospitalization, Mr. G refused to speak with me at the clinic. He would not come in to talk when my door was open, and he would walk away when I approached him. This dramatic change in behavior was puzzling. In taking perspective, I recognize that he may have needed this distance for unclear reasons. Perhaps he felt it was of no use to talk with me, since his daughter refused to talk with him. A colleague at the clinic reported that he had come to her several times to discuss his daughter. It seems that it was important for him to talk with someone not as involved as myself. In this manner, he could continue the process he had begun with me.

Once again the therapist should ask if cultural factors played an important role here. It seems more likely that N's case primarily had to do with a troubled adolescent who came from a chaotic childhood and

subsequently had an early developmental deficit in trust. Her response was to develop a way of dealing with it which was not culture-specific.

Case 3

S is a 37-year-old Northern Plains woman who was referred for difficulties in coping. Several months earlier her sister and brother-in-law died in a motor vehicle accident, leaving their nine children homeless. S agreed to take four of these children in addition to five of her own. The ages of the children ranged from 6 months old to 16 years. The eldest niece (D) manifested difficult behavior problems compounded by severe depression with chronic suicide threats. S was overwhelmed and began to exhibit signs of major depression, including decreased appetite with significant weight loss, difficulty sleeping, and feelings of helplessness and hopelessness. The niece's disruptive behavior had affected other family members to the extent that S's son also had become vegetatively depressed. S did not feel that she could cope with the situation and was constantly fearful that her niece would harm herself. She believed that she could manage to handle the other children if it were not for her niece.

The niece began treatment at a local mental health center and her social worker began to look into hospitalization. Phone calls were exchanged between the niece's therapist, the social worker, and myself; we agreed that immediate intervention was necessary to maintain stability within the home. This forum for the providers expedited necessary treatment: D was hospitalized that day.

Several follow-up appointments were arranged with S, but she cancelled each one. She reported by phone that she was feeling much better, that the depression had resolved, and that she was gaining back lost weight. Caring for the eight remaining children was taxing, but she was coping well. Her son was doing better and she thought that his depression was lifting.

In gaining perspective of this case it was important to identify my role as therapist. Initially, I believed that I would need to treat S for a major depression. As it turned out, I helped to facilitate the hospitalization of her niece, thereby alleviating a significant stressor. S did not need further sessions with me as her life and depression dramatically improved, and she could function again as the mother of all the children. Although she acknowledged her grief at the loss of her sister, she was managing these feelings on her own. The extent of intervention that S had needed had been completed.

Termination

My partings with clinic staff were varied. Many of the staff avoided saying goodbye either by not dealing with the issue or by arranging meetings on my last day and being unavailable. Other staff members were

able to acknowledge my leaving in a meaningful way by discussing the experience of my presence in the clinic and their feelings with respect to my leaving. As a token of closure, I left cards with personal notes attached for the people with whom I had worked most closely.

Terminations with patients were difficult. I had come to know B quite well and had seen the progress she had accomplished in therapy. During our last session she was quiet and withdrawn, unable to talk much about what she was experiencing other than feeling abandoned by me. Earlier I had decided to give B a small gift to remind her of our work together. I had heard that giving small gifts was a part of American Indian culture. As a therapist, giving gifts to a patient was something I had been taught to see as inappropriate; therefore this gesture on my part was contrary to my training. Yet I realized that my gift to B had an important bonding effect upon her. She brightened when I presented the small notebook for her to write poetry in and began to deal more directly with our parting. She, in turn, had a self-made gift that she gave to me, after she waited to see if I would give her a gift. I felt as if this exchange of gifts solidified our relationship, emphasizing that we cared enough to remember each other in a special way. Gift-giving in this population was an important cultural factor for me to consider as a therapist.

Alternatively, N said that she did not care that I would no longer be visiting her in the hospital. Yet, on our last day, she became angry and tearful with me. She also had learned that she would be leaving the hospital to enter a residential treatment facility which caused her a great deal of distress. I gave her a special card with a personal message about our relationship, towards which she acted indifferent. However, I noticed that she kept it close to her after running out of the room during our session. She was unable to acknowledge that our limited time together and my consistency had been important to her, but her behavior suggested that I had meant something to her.

Conclusion

I gained several important lessons through my experience in the IHP. A psychiatrist should not rigidly define his or her role upon entering a particular setting, but rather should allow the multitude of roles to unfold. After initial surprise at switching suddenly from one role to another, I soon became more fluid in this area as I acknowledged that it was the essence of my work there. Acceptance and an ability on my part to allow such changes offered the IHP a wider spectrum of my capacities and allowed me to experience the IHP on several levels.

I also learned that to be a culturally-sensitive psychotherapist, one must constantly consider the possibility of cultural influences upon treatment. This is a continual process of questioning, learning, and discovery that occurs when working within a culture different from one's own.

Cultural differences are important, as is a constant awareness of problems that might arise due to these differences. I had expected to find many cultural dimensions to my work at the clinic, yet I actually found that most of the therapeutic issues and conflicts were familiar. I discovered that basic human conflicts out weighed the differences. The universal suffering of human experience underscores that a culturally sensitive therapist can work with people from a different culture.

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OJIBWAY ADOLESCENT TIME SPENT WITH PARENTS/ELDERS AS RELATED TO DELINQUENCY AND COURT ADJUDICATION EXPERIENCES

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Abstract: This study sought to determine whether volume of time spent by adolescents (ages 12-18) with their families (parent/elder present) and the existence of family dysfunctional factors (substance use, domestic abuse, and negative well-being within the family) shared a relationship with adolescent experience in court adjudication and juvenile delinquency behaviors. Results indicated that adolescents experiencing greater volume of family contact tended to have less involvement with both court adjudication and delinquency behaviors (r = -.16 to -.38). Increased frequency of family dysfunctional factors served as a predictor of adolescent involvement with court adjudication and juvenile delinquency (r = .24 to .59).

Introduction

Mental health practitioners within an Ojibway community were concerned about the rapid increase in juvenile involvement with the courts, social service agencies, and professionals providing therapy. Within the recent 10 year period, they observed: 1) a 220% increase in adolescents (ages 12-18) being diagnosed with problematic use of alcohol and drugs (including inhalant abuse); 2) a prorated increase of 280% in the number of youths designated in need of court/county protective services; 3) a 235% increase in the number of adolescents coming before the court systems because of their own criminal involvement; and 4) 60% of self-referred patients to mental health services presenting with concerns focused on conflicts between adults and children.

In addition, the community realized a suicide attempt rate of 40 attempts per 100,000 in the 15-19 year-old age groups as compared to the total U.S. population ratio of 12.8 per 100,000 as measured by the Indian Health Service (1988). Other concerns for the community's American Indian adolescent population focused on increases in teenage pregnancy, school drop-outs, and adolescent involvement in satanic activity.

Agency professionals and community elders focused their problem-solving discussions on concern for the adolescents' family and extended family of origin more specifically, the quality and quantity of time adolescents reported spending with their families with an adult/elder present as a role model. A study of family time comparing the reservation adolescents of the 1930s revealed significant reductions in both the quality

American Indian and Alaska Native Mental Health Research, 4(1), Fall 1990, pp. 53-63

and quantity of family time spent with elders. The 1980s adolescent also reported a substantial increase in family alcohol and drug use, family violence, child abuse, and negative well-being responses (Zitzow, 1990).

Delinquency or adolescent dysfunctional behaviors rooted in family problems is not a new phenomenon. Previous research identified a host of similar causal factors to Indian adolescent suicide such as "instability of family relationships, upheaval in home environment...parental alcohol and substance abuse...and widespread recognition that traditional ways were failing to be maintained over time" (Bechtold, 1989).

Some of the historic observations regarding delinquency still appear to apply today. "Deviant behavior does not necessarily arise from impulses of individuals breaking through social constraints; but it may well come about because of the socially induced deviations--deviations which the culture and social organization conjure to produce" (Merton, 1958). Other summaries regarding the adolescent delinquent in society as a whole suggested "acting out serves as a release valve for unstable, unendurable family tension" (Pollack & Friedman, 1969). MacIver (1966) suggested that delinquents grew up "with a set of expectations and aspirations that are relative both to the indoctrinations and to the situations within which they are bred." James (1969) advised that if we probed beneath the surface behaviors of delinquents, we might find alcoholism, emotional imbalance, violent parents, or other problems. Jesness (1983) measured the correlationships between parental neglect and the child's delinquency. Parsons (1968) saw delinquency as a product of "social disorganization--a lack of agreement on what the important social values were, consequently the juvenile found it difficult to incorporate a coherent set of values to serve as a guide for personal conduct."

Purpose of the Study

The purpose of the study was to examine further the issue of Ojibway adolescent (ages 12-18) quality and quantity of time spent with family (parent or elder present) as it relates specifically to adolescent involvement in delinquency and court adjudication. Delinquency behaviors were defined as: smoking cigarettes, ticketed traffic violations, skipping school, running away from home, using alcohol, smoking marijuana, stealing, intentional property damage, and arrest. Court adjudication was defined as any experience of a juvenile in court resulting from the juvenile's own inappropriate behaviors that caused some decision by court officials.

Method

Ninety-four respondents (ages 12-18) were randomly selected from a 1900-square mile rural reservation that included six separate communities (proportionate by court adjudication experience, school drop out, age, and sex). Court adjudication was determined from court records. The final

sample represented nearly 22% of the total population available within this community. A survey was developed and administered within the respondent schools or within their homes for adolescents who were no longer in school. Respondents were asked to calculate the quantity of time spent with family (adult or elder present) and away from family in the following areas: eating, working, recreation, entertainment, and spiritual activities. Additional Likert-format questions assessed the respondent's quality of family time through items that asked about family alcohol and drug use, family abuse, and negative well-being.

The survey was re-administered to a pilot study population of 18 students to determine test-reliability. The responses remained largely consistent and provided Pearson *r* correlations between test-retest that ranged from .61 to .85. Students off the reservation in boarding schools were not accounted for. The proportion of males and females in the final sample were equivalent. The descriptive characteristics of the sample group closely resembled the general population at large.

Results

Figure 1 provides a summary of the existence of natural parents within the respondent's home.

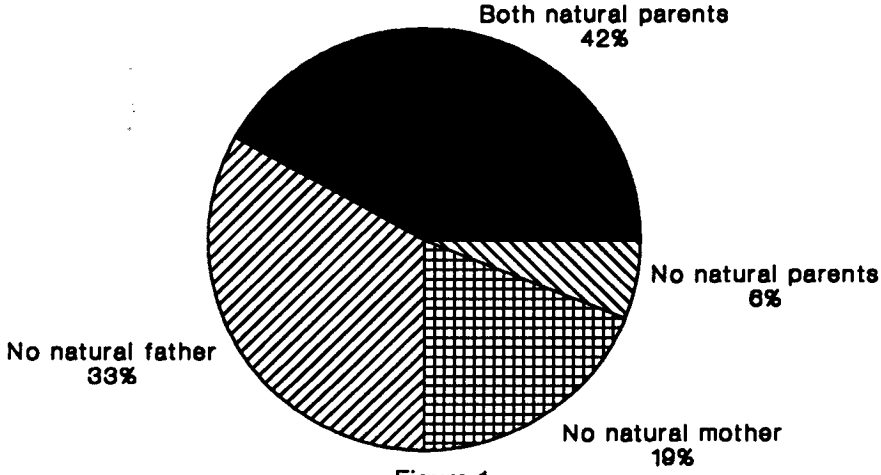

Figure 1

Thirty-three percent of respondents indicated having no natural father present (4% of the total indicated a step-father present) and 19% indicated no natural mother present (3% of the total indicated a step-mother present). Six percent of respondents reported neither a natural mother nor father present.

Forty-two percent reported both natural parents at home and 45% indicated single-parent families without step-parents present. (This group

may include families with a parent's live-in partner who is not regarded by the respondent as a parent figure.) The Ojibway adolescent with both natural parents in the home appears to be in the minority.

Table 1 summarizes adolescent calculations regarding time with and away from family in selected activity areas.

Table 1
Table of Adolescent Time (Hours per Week)
Spent With and Away from Family
N=94

Activity	Time With Family	Time Away From Family
Eating	4.15	4.50
Working	1.72	6.09
Recreation	2.85	22.75
Entertainment	3.35	20.60
Spiritual Activity	.40	.76
Total of 5 Activities	12.47 hours	54.70 Hours

The average adolescent respondent appears to spend the majority of his/her time eating with family (adult or elder present). This is slightly less than the time spent eating away from family. Working with family was at a rate of 1-3/4 hours per week. Respondents reported more time in spiritual activities away from their family (.76 hr) as compared to with family (.40 hr). This may be due to the availability of Sunday school and other church-sponsored youth activities. The combination of recreation time (2.85 hrs) and entertainment (3.35 hrs) represents nearly half of the total adolescent time with family of 12.4 hours per week. The ratio of time with family to time away from family is 1:4.5. (Much of the adolescent time away included school attendance and school activities.)

Summary results of adolescent responses to survey of family drug and alcohol use, domestic abuse, and negative well-being data is reported elsewhere (Zitzow, 1990). Fifty percent of the adolescents reported alcohol use by adults "most or some" of the time in their home with 10% reporting illegal drug use "most or some" of the time. Thirty-two percent reported the experience of having adults in their home using money for alcohol or drugs that should have been used for food or clothing for the children. Twenty-six percent reported being left at a young age unattended by an adult or capable adolescent. Eighty-five percent reported "adults yelling at adults" in their home, while 43% reported "adults hitting adults" within their home. Twenty-two percent reported "adults yelling at children" and 6% reported "adults hitting children" most of the time. Thirty percent reported the experience of "feeling the adults at home didn't care about me" most or some of the time, and 20% reported "feeling afraid to go home" most or some of the time. Forty-nine percent reported "feeling like running away"

most or some of the time, and 34% reported "feeling like hurting myself" most or some of the time.

Table 2 summarizes adolescent admission to delinquency behaviors and court adjudication.

Table 2
Summary of Adolescent Behaviors Participated In
N = 94

Item	Yes	No
Smoked cigarettes	79%	21%
Ticketed traffic violation	8%	92%
Skipped school	64%	36%
Ran away from home	32%	68%
Used alcohol	85%	15%
Smoked marijuana	53%	47%
Stole something	70%	30%
Intentional damage to property	45%	55%
Was arrested	29%	71%
Court adjudicated	29%	66%

Use of alcohol, cigarette smoking, stealing something, and skipping school were the most frequent inappropriate behaviors reported by respondents. Eighty-five percent reported using alcohol; 53% reported smoking marijuana and 29% indicated being arrested by law enforcement personnel. (Court records indicated only 25% were arrested. It is possible that court records were incomplete or that some students exaggerated their court involvement.)

Table 3 summarizes survey items that showed significant relationships to the experience of court adjudication and the summary of delinquency experiences for Ojibway adolescents. Levels of significance are listed along with calculated Pearson *r* statistics. Quantity indicators of family time constituted ratio data, therefore the F statistic was used to determine levels of significance while quality indicators (using Likert scale responses) and delinquency participation required chi square as the test of significance.

Having a natural mother or father in the respondent's home yielded significant differences with respect to court adjudication and delinquency involvement among the surveyed population. The correlations ranged from (-.20 to -.29), indicating only low predictive value with the tendency of those who lacked natural parents within their homes to show increases in the experience of court adjudication and delinquency.

Family time quantity indicators yielded low to moderate inverse correlations ranging from -.16 to -.37 with the experience of court adjudication, while the same items yielded higher correlations -.20 to -.38 with total delinquency behaviors. An inverse correlation was measured

between the experience of court adjudication or delinquency and the family time spent with mother or father, total eating time, cleaning up after meals, family discussion, recreational fishing, and Christian religious experiences. Respondents indicating greater volume of family time with these items reported less court adjudication and fewer delinquency involvements.

Table 3
Type of Family Time by Court Adjudiciation and Delinquency
N = 94

Item	Court Adjudicated		Total Delinquent Behaviors	
	p	*r*	*p*	*r*
Mother present in home	.03	-.22	.05	-.20
Father present in home	.03	-.21	.07	-.29
Quantity Indicators				
Help w/cleanup w/family	.01	-.37	.01	-.38
Family discussion after meals	.10	-.17	.26	-.25
Total eating time w/family	.07	-.22	.01	-.32
Help with cleaning house w/family	.10	-.16	.02	-.24
Fun fishing w/family	.01	-.31	.03	-.33
Total recreation w/family	.07	-.16	ns	ns
Partying (drugs or alcohol present)	.01	.30	.10	.23
Listening to the radio alone	.01	.26	.02	.24
Total Christian spiritual exp.	.03	-.23	.08	-.30
Total trad. Indian religion	.01	.29	.08	.23
Quality Indicators				
Adults drinking in home	.02	.29	.05	.27
Adults using drugs in home	.01	.45	.01	.34
Money used for alcohol by adults	.01	.45	.01	.33
Left at home alone at young age	.01	.32	.08	.38
Total substance abuse in family	.01	.54	.05	.43
Adults yelling at adults in home	.01	.40	.03	.38
Adults hitting adults in home	.01	.48	.03	.39
Adults yelling at kids in home	.01	.34	.06	.24
Adults hitting kids in home	.01	.35	.04	.35
Total domestic abuse in home	.01	.45	.02	.39
Felt adults didn't care about me	.01	.26	.01	.43
Felt afraid of going home to family	.01	.36	.02	.36
Felt like running away from home	.01	.41	.01	.54
Total negative well-being factors	.01	.41	.02	.51
Total family dysfunction factor	.01	.59	.06	.59
Felt my parents did a good job raising me	.01	-.34	.01	-.44

Table 3 (Continued)
Type of Family Time by Court Adjudiciation and Delinquency
N = 94

Item	Court Adjudicated		Total Delinquent Behaviors	
	p	*r*	*p*	*r*
Delinquency Behaviors of Respondents				
Skipping school	.01	.35	.01	.65
Ran away from home	.01	.32	.01	.54
Alcohol use	.05	.24	.01	.43
Marijuana use	.01	.40	.01	.60
Stole something	.01	.27	.01	.61
Damage to property	.01	.35	.01	.59
Arrested	.01	.73	.01	.63

"Partying with drugs or alcohol present," "listening alone to the radio," and "traditional Indian preference for religion" exhibited a positive correlationship with court adjudication and delinquency behaviors ranging from .23 to .30. Persons engaging in these behaviors tended toward involvement in adjudication and delinquency. The data regarding traditional Indian religion preference may not be accurate. After further investigation of family history of adolescent respondents, it was found that many adolescents who indicated a preference for traditional Indian religion either participated in no religious experiences or were regarded by others as not practicing true traditional Indian experiences. Of all the items listed, young people who spent more time eating with family and recreational fishing with family tended to be less involved with court adjudication and delinquency. Adolescents who reported less time with their families (parent or elder present) tended to be at higher risk for involvement in court adjudication and delinquency behaviors.

When examining the quality indicators of family time, from substance abuse to family abuse and respondent well-being within the family, moderate correlations were observed ranging from .24 to .59. Court adjudication tended to correlate higher than deliquency with quality indicators of family.

Total substance use within the family correlated with court adjudication at (r=.54) and with total delinquency (r=.39). The total of negative well-being items also strongly correlated with court adjudication at (r=.41) and delinquency at (r=.51).

A total family dysfunctional score was calculated combining all of the items assessed within the quality indicator portion of the assessment. Total family dysfunction is associated with both court adjudication and delinquency (r=.59). These data suggest that the family quality indicators related to substance use, domestic abuse, and negative adolescent well-being more strongly predict adolescent court adjudication and

delinquency than a simpler index of time adolescents spent with their families.

In their response to the Likert-scaled question, "I feel my parents/elders did a good job raising me," moderate inverse correlations of -.34 to -.44 were obtained. As adolescents tended to feel negatively about the parenting they received, they also tended to exhibit more court adjudication and delinquency involvement.

Each of the delinquency behaviors assessed correlate with court adjudication and delinquency (r = .24 to .73).

Conclusions

Quality and quantity of family time Ojibway adolescents spent with their parents or elders were the foci of this study. Data also indicated a substantial number of reservation adolescents experiencing both delinquency and court adjudication.

Spending time with family in activities such as cleaning up, recreational fishing, family discussion, or just eating together appears to reduce the potential for adolescent delinquency. Conversely, the activities that isolate the adolescents or draw them away from family (e.g., listening alone to the radio, partying with drugs or alcohol) appear to be strongly related to court adjudication and delinquency.

Many of the adolescent respondents were frank and critical in their evaluation of their families. Family drug and alcohol use and hitting or yelling (whether at adults or adolescents themselves) predicted court involvement and delinquency for adolescents. Reports of negative well-being related to the family (e.g., feeling like running away, fear of going home, feeling that adults didn't care, or feeling like hurting myself) were moderately associated with court adjudication and delinquency.

Adolescents reporting less time with their families tended to be more involved with both court adjudication and delinquency behaviors (r = .16 to .38). Quality of time with families, patriculatly as reflect in dysfunctional factors like family alcohol and drug use, domestic abuse (verbal and physical violence), and negative well-being, tended to be even more strongly related (r = .24 to .59) to court adjudication and delinquency.

The data reflects support for the myriad of concerns regarding adolescent involvement with their families identified in mental health case consultations, child protection reviews, probation background reports, and even around the kitchen tables of tribal elders. The data for these Ojibway adolescents appear to mirror the adolescent dilemma found in American families generally. Additionally, in times of parent absence or dysfunction, peers, siblings, foster parents, or the state appear to be poor "parental substitutes."

The solutions and recommendations for positive social change are found not in a rejection of the Ojibway family, but with a strength and commitment that once occurred in most families. Attention must be directed

away from the "crisis intervention" mindset that currently exists among mental health practitioners, legal agencies, and to a positive reconstruction of legitimate family support and skill development.

The number of family concerns in a reservation community often, to an exhaustive degree, exceeds the training and resources of helping personnel. For every mental health practitioner within the reservation community, family systems or parenting skill professionals must be availabe to provide both out-patient and in-home family assistance. Their skill development should focus on:

1) Informing parents of the powerful difference they make in the lives of their adolescents (teach specific skills in re-empowerment);

2) Persuading parents not to abandon their power to nurture, teach, and affect their children (teach skills in active, not passive or reactive, parenting);

3) Interpreting new parenting skills in ways that are meaningful (use behavioral reinforcers that parents already have available);

4) Developing prevention strategies for family abuse (teach conflict resolution, anger identification and control, and behavioral-task focusing);

5) Making the family environment more attractive in an effort to increase quantity and quality of family time (provide positive family alternatives, e.g., family recreation, work skill development, effective use of leisure time, family history contacts, and family discussions);

6) Supporting and teaching values to youth that are legitimate, genuine, and persistent. Parents are often so intent on giving their children the things they did not have themselves as children (e.g., three-wheelers, stylish clothing, or video games) that they forget to give their children some of the wonderful things they may have had in their own childhood (e.g., inner strength, life skills, values, goals, or well-being).

Reservation leaders and helping agency personnel should:

1) Develop a pro-family campaign and focus on a philosophy that "Ojibway children are all our children and our investment in the future."

2) Provide more supervised activities to promote socialization skills, effective use of leisure time, and positive adult role-modelling.

3) Develop an "early warning system" (e.g., substance abuse, family abuse, neglect, etc.) before a family gets to "crisis" levels with a follow-up of a legitimate, persistent, and systematic network of parenting intervention, therapy, and monitoring.

4) Erase "turf," legal, or philosophical wedges and unite in promoting non-fragmented support of family effectiveness. (There appears to be more than enough work for everyone.)

5) Confront dysfunctional families, and provide immediate intervention and referral to appropriate resources (e.g., women's shelters, court authorities, psychologists, chemical dependency counseling). Better and healthier reservation family alternatives (foster care personnel or special behavioral management homes) must be developed for families not yet ready for systematic family intervention.

Quality of family time together appears to be a benchmark of family function and success. Quantity of family time appears to be the vehicle by which healthy family function is sustained.

This study was dependent on adolescent self-disclosure and may suffer limitations due to situational reaction of respondents as well as their errors in calculation of time estimates. The sample, both due to its size and lack of representativeness (e.g., in boarding school, treatment or correctional programs) suffers further limitations. The study suggests a willingness of reservation adolescents to offer their frank, albeit critical, perceptions of their families and the adequacy of their interactions with adults. There is value in frank adolescent perception for developing healthier family solutions for reservation communities.

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Special thanks to Julie Heisler, secretary, and to Hollis Littlecreek and Ruglus Mason (Ojibway mentors) for their help in the completion of this study.

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