STRESS, DEPRESSION, SUBSTANCE ABUSE, AND RACISM

DONALD JOHNSON, Ph.D.

Abstract: Many studies have focused on the special needs of American Indian populations. Some of these studies have special impact on Indian veterans. These can be grouped for consideration around cultural and personal identity problems. These problems are multifaceted and interacting. They bear directly on the community and individual self-esteem. The four major points of these problems are stress, depression, alcohol/drug dependence, and racism.

Stress

For some American Indians today stress begins before birth. Fetal alcohol syndrome is more prevalent in Indian populations than any other identified racial group by a factor of four to one. Infant mortality in reservation populations is greater than 300 per 10,000 births, higher than any Third World country (Indian Health Service report to the Surgeon General, 1988). Poverty, unemployment, dietary deficiencies, broken families, and substandard housing, sanitation, and education are compound stressors that the individual has faced before entering the military and that greet him or her on return.

Depression

Acute depressive reactions, including suicide attempts, are common Indian mental health problems. Many acting-out behaviors such as drinking, reckless driving, and family conflicts can be seen as symptoms of widespread and underlying depression. Similarly, anxiety, fatigue, physical illness and pain, school and job failures, low self-esteem, low productivity, and feelings of inevitable, personal doom also may be manifestations of the hopelessness and helplessness syndrome of chronic depression.

Years of poverty, prejudice, and cultural breakdown often lead to a loss of sense of meaning and belonging and are therefore contributing factors in depression. Not all individuals in tribal communities are depressed clinically; most people are, to a greater or lesser degree, personally affected

by the historical and current traumas that complicate Indian life. Multiple losses on a personal, tribal, and cultural level all combine into unresolved grief and anger and ultimately into a deeply embedded depression. Unexpressed anger may be stored up and turned against the self, causing guilt and depression. This type of depression also may be associated with an emotional numbing, making it difficult to fully respond to either problems or opportunities as they present themselves (Debruyn, Hymbaugh, & Valdez, 1988). Since they are unable to imagine how things could really be different, depressed people tend to accept negative life circumstances as inevitable.

Suicide is an unfortunately common mental health problem in the Indian community, generally estimated at twice the national average (Debruyn, Hymbaugh, & Valdez, 1988). Indian men under age 40 seem to be particularly at risk for suicide, both because of their frequent lack of satisfying roles in the modern Indian community and because of their tendency to use more violent and deadly methods of attempting to kill themselves, such as hanging or shooting. Some authorities think that a high proportion of fatal car accidents and alcohol-related deaths in general also may be unrecognized suicides.

While in many respects what we know about suicide also generally applies to Indian suicides, counselors should be aware of certain differences, including the following:

1. The involvement of alcohol in over 90% of Indian suicides.
2. The much greater vulnerability of younger Indian men to suicide, in contrast to the greater vulnerability of older men in non-Indian society.
3. The greatly increased risk of an impulsive suicide attempt following a rejection or disappointment.
4. The fact that talking about wanting to join dead relatives, or having an experience of being visited by the dead, may be a clue to an impending suicide attempt. As in non-Indian society, a history of suicides in the family as well as a personal history of previous suicide attempts greatly increases the risk of a completed suicide.

Many suicide attempts are impulsive acts. Most people surviving a suicide attempt do not go on to kill themselves. Therefore, it is extremely important to develop community systems for responding to suicide threats and attempts. Because suicide attempts are impulsive and often occur outside office hours, there is a need to have basic information about suicide and about resources for crisis intervention.

Treatment of suicidal clients also must address underlying problems such as cultural identity confusion, alcoholism, and depression. Since suicidal clients frequently are angry, alienated from mainstream society, and hard to reach, it is particularly important that culturally acceptable methods of treatment are offered.[1]

Alcohol and Other Drugs

That alcohol is a major problem in American Indian communities is a truism. Alcohol is a primary social, economic, health, and spiritual problem for many contemporary reservation and urban American Indians. As mentioned above, alcohol is a factor in 90% of all Indian suicides. For some subgroups alcohol is involved in all social interactions. Veterans served in the military where an abundance of relatively inexpensive alcohol is found along with a permissive if not mandatory attitude toward its use. The trap became irresistible. Two brief case histories illustrate this point:

1. John was born on a remote reservation. His father had abandoned the family when the fifth child was born. John, the eldest, was 7 years old and already had spent most of his time with his maternal grandparents. His mother chronically abused alcohol but would periodically sober up and lecture the children on the evils of "firewater." Until he was 14 years old, John would binge drink with some of the older boys. At 14 John was sent to Jesuit boarding school "because there wasn't enough food for everyone." On all his trips back to the reservation he would "get drunk at least once to be with the guys." At 17 years old he "enlisted to get away from the Jesuits" and found Marine boot camp easy by comparison. He completed two tours in Vietnam, was wounded twice, was awarded two Purple Hearts, three Bronze Stars (two with "V" devices for valor), and spent as much time as possible drunk. On his return to "the world" he got a job in a sawmill, was fired for poor attendance, moved to a city on the West Coast, and lived on the street for 12 years. He began recovery in 1986 and now does outreach for an Indian Health Service alcohol treatment program.

2. Will was born on a reservation but was adopted by an Anglo family before he was 1 year old, after his mother was killed in an auto accident. His adoptive father was a Protestant minister and Will says, "I didn't drink, but was preached at as though I did." When he finished high school he returned to his reservation and immediately began using alcohol "Just like everyone — I had to become Indian some way." At 18 years old he enlisted to avoid prosecution on an alcohol-related charge. He was disinherited by his adoptive family, volunteered for airborne training, volunteered for Vietnam, was wounded at the beginning of his second tour, and is paraplegic from the gunshot wound. He now drinks as much of his compensation check as his guardian will give him. When asked by strangers how he became paralyzed he most frequently replies, "Fell off a bar stool in Southeast Asia."

Racism

The most destructive form of racism is institutional and has two forces. The first distorts or destroys the anvil on which all personality is shaped: the traditions, rituals, and ceremonies that give culture its definition. The second deflects the hammer of everyday experience through negative stereotypes and expectations. That there has been a historical, systematic, deliberate attack on American Indian culture is beyond dispute. All American Indian religious practices were outlawed until passage of the Indian Religious Freedom Act of 1978. This author remembers the last time some missionaries gathered up all the drums, feathers, and pipes they could find. They burned the drums and feathers, then broke the pipes, throwing the pieces out on a gravel road.

The examples used in this section, while personal, are not atypical and are, I believe, necessary for the clinical counselor to begin to understand the disabling effects of the special needs of Indian veterans. The above mentioned negative influences impede achievement in school, block acquiring of and advancement in work, limit potential in social and family relationships, and pass on to each succeeding generation the "sins" of the parents.

In the military, institutional racism is expressed by calling Indian soldiers "Chief, Tonto, or Scout." In readjustment, it is more subtle and is expressed by counselors' expectations that Indian veterans come from a "line of natural warriors" and therefore only need to quit drinking, go to pow-wows and the sweat lodge, and get on with his or her traditions. That the recent tradition consists of alcohol, unemployment, poverty, broken homes, and a sense of personal doom is overlooked. In truth, the American Indian combat veteran needs all of the services offered other veterans with special attention to his recent and remote traditions, ceremonies, rituals, and unique needs. Counselors need an awareness that Indian veterans' culture is radically different than mainstream veterans. Access is needed to find appropriate consultants from the ranks of practicing American Indian contemporary professionals and traditional healers.

Donald Johnson, Ph.D.
Vet Center Team Leader
2230 Eighth Avenue
Seattle, Washington 98121

References

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Note

1. The foregoing section was adapted with permission from *Overview of the Mental Health Status of Indian Communities, Needs and Barriers*, edited by Jennifer Clark, Ph.D., and published by the Swinomish Tribal Mental Health Project, LaConner, Washington, 1991.