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PREVALENCE AND CORRELATES OF DEPRESSIVE SYNDROMES AMONG ADULTS VISITING AN INDIAN HEALTH SERVICE PRIMARY CARE CLINIC

Charlton Wilson, M.D., David Civic, M.D., and Daniel Glass M.S.

Abstract : Depression is common among patients visiting primary care clinics. In order to describe the prevalence of depressive syndromes in an American Indian primary care clinic population and to help define the clinical correlates of depressive syndromes in this setting, a clinic-based research study of depression was undertaken by the Indian Health Service (IHS). One hundred and six patients from an IHS primary care clinic were systematically enlisted for participation in the study. Participants completed the Inventory for Diagnosing Depression (IDD). Twenty-two (20.7%) responded with answers scoring positive for a depressive syndrome. Nine of these 22 (8.9% of the 106 participants) met IDD criteria for a major depressive syndrome. A diagnosis of depression, a past history of depression, use of mental health facilities, unexplained pains, and antidepressant medication use were associated with the presence of a depressive syndrome.

Depression is common among patients visiting primary care clinics (Coyne, Fechner-Bates, & Schwenk, 1994; Depression Guideline Panel, 1993; Zung, Broadhead, & Roth, 1993). Studies in primary care settings show that 6% to 10% of all patients have major depressive disorder and up to 30% of all patients have depressive symptoms (Katon, 1987). For a variety of reasons, depressed patients are frequently not recognized and often inadequately treated (Depression Guideline Panel, 1993). Information that can lead to improved recognition and treatment of depression is needed to avoid the serious social, medical, and economic consequences of failing to make the diagnosis of depression.

Several studies have described the prevalence of depression in American Indian and Alaska Native communities and in Indian Health Service (IHS) mental health clinics (Kinzie et al., 1992; May, 1988; Shore & Manson, 1981; Shore, Manson, Bloom, Keepers, & Neligh, 1988). There is general agreement that depression is at least as common, if not

more so, in American Indian and Alaska Native communities as it is in other communities. Initial studies of the prevalence of mental illness in IHS outpatient populations have been done (Goldwasser & Badger, 1989; Rhodes et al., 1980), but the prevalence of depression in American Indians and Alaska Natives visiting primary care clinics has not been systematically studied. In order to describe the prevalence of depressive syndromes in an American Indian primary care population and to help define the clinical expression of depressive syndromes in this setting, an IHS clinic-based research study of depression was undertaken.

Setting

The study site was a single primary care outpatient clinic at an IHS hospital on a reservation in the southwestern United States. All patients were American Indian and were eligible for care in the IHS system. The facility, a hospital, provides daily primary care clinics as well as 24-hour-a-day emergency care and inpatient services. It is the only IHS facility on or in the vicinity of the reservation and thus provides medical care to the majority of American Indians in the area. The dominant culture on the reservation is that of a southern Athabascan people. Traditional American Indian practices remain very strong in the community. There is also a significant influence from Caucasian cultures in communities near the reservation borders. Approximately 5,000 American Indians receive their care through the hospital. According to the 1990 U.S. Census, 37.3% of the reservation population over age 16 is unemployed and 41.6% of the population over 18 lives below the poverty level. English is the primary language spoken in 64.2% of the homes on the reservation (U.S. Bureau of the Census, 1990).

Methods

During a 1-month period, every fourth adult who signed the registration log for the primary care clinic was recruited for the study. Patients who came for specialty clinics, emergency room care, or afterhours urgent care clinics were excluded. Study enrollment was halted when 100 completed questionnaires were obtained.

Participants completed the Inventory for Diagnosing Depression (IDD) (Zimmerman & Coryell, 1987), a 22-item self-administered multiple choice questionnaire of depressive symptoms. The questions are based on *Diagnostic and Statistical Manual III-R* (*DSM III-R*) criteria for major depressive disorder and scored accordingly. In this study, participants were considered to have a depressive syndrome if they reported a depressed mood and at least four of eight associated neurovegetative symptoms. Participants were considered to have major depressive syndrome if they indicated that the duration of each of these symptoms was greater than 2 weeks. For the purposes of this study, patients who

reported the duration of these symptoms to be less than 2 weeks were considered to have minor depressive syndrome. Participants' charts were reviewed blindly to describe the medical and historical factors present in the study population. A factor was considered to be present if it was written by a physician in a progress note within the year prior to the study, in an admission note at any time, or on the medical record problem list.

Participants gave written informed consent prior to participation. They completed the study questionnaire in private, most participants completed the questionnaire within a 10- to 30-minute period. Approval for the study was obtained from the local tribal leadership, the local IHS administration, and the IHS Area Institutional Review Board.

Statistics were computed using public domain software developed by the Centers for Disease Control and Prevention (Dean, Dean, Burton, & Dicker, 1990). Two-tailed Fisher's Exact test was used for analysis unless otherwise noted in the text (Ware, Mosteller, Delgado, Donnelly, & Ingelfinger, 1992).

Results

Of 204 patients eligible for enlistment, 106 people participated in the study. A comparison between the study participants and the nonparticipating adult clinic population in the same clinic in the same time period is shown in Table 1. The reasons for individuals not participating in the study are shown in Table 2. The most common reason for a clinic visit was "acute self-limited medical problems" (minor colds, gastroenteritis, etc.; 28.3% of visits), followed by "other" (follow-up care, paperwork, questions; 13.2%), "preventive health care" (12.4%), "trauma" care (12.4%), "other infectious illnesses" (10.4%), and "gynecologic/obstetrical care" (8.9%). No other primary complaint constituted more than 5% of visits. The frequencies of the medical and historical events noted in the charts of the participants are shown in Table 3.

Table 1
Participant Characteristics

		Study Participants N=106	Adult Clinic Population N=859
Age	(Mean) years	35.2	40.1
	(Median) years	32.5	34.5
Female		66%	62%
Walk-in (non-appointment)		78%	77%

Of the 106 participants, 22 (20.7%) responded with answers scoring positive for the depressive syndrome. A description and comparison of the clinical characteristics of the 22 participants who had the

Table 2
Enlistment Data

N (% of total)	
198 (100)	Adults potentially enlisted
66 (33)	Not approached
132 (67)	Approached
	Reasons for not enrolling:
	10 refused without specific reason
	3 patients had "no time"
	2 patients "too angry"
	2 patients could not read
	2 patients "too sick"
	1 patient had no glasses
	1 patient "too intoxicated"
111 (52)	Enlisted
5 (3)	Not completed
106 (54)	Study population

Table 3
Chart Notation

Chart Notation (Study Participants)	(%)
Alcohol abuse	42 (40)
Trauma	39 (37)
Assault	21 (20)
Unexplained pain	20 (19)
Hospitalization within last year	17 (16)
Depression	16 (15)
Domestic problem	14 (13)
Low Back Pain	11 (10)
MVA	11 (10)
Headache	7 (7)
Suicide	7 (7)
Anxiety	3 (3)

depressive syndrome and the 84 who did not meet depressive syndrome criteria is shown in Table 4. Patients with the depressive syndrome were

more likely to have had a history of depression noted on the chart (32% vs. 11%, $p = .02$), to have depression noted at the clinic visit by the primary care physician (18% vs. 1%, $p = .006$), and to use the mental health facilities in the month after the clinic visit (18% vs. 0%, $p = .001$). Patients with the depressive syndrome were also more likely to have been prescribed medication in the month preceding the study (60% vs. 32%, $p = .02$ Mantel-Haenszel). However, the difference in prescription drug usage in this study was attributable to a more frequent use of antidepressant medication among the participants with the depressive syndrome. Patients with the depressive syndrome were also more likely to have had a visit within the previous year for the symptom of a pain that was not explained by a specific etiology as indicated by chart review (36% vs. 14%, $p = .02$).

Table 4
Comparison of Patients With and Without a Depressive Syndrome

	Depressive Syndrome Present N = 22 (%)	Depressive Syndrome Absent N = 84 (%)	*p* value
Depression on visit	4 (18)	1 (1)	.006
Hx of depression	7 (32)	9 (11)	.02
Mental health next month	4 (18)	0 (0)	.001
Unexplained pain	8 (36)	12 (14)	.02
Prescribed medication	13 (60)	27 (32)	.02*
Alcohol abuse	11 (50)	31 (37)	.26*
Trauma	8 (36)	31 (37)	.96*
Assault	6 (27)	15 (17)	.37
Hospitalization within last year	5 (22)	12 (14)	.33
Domestic problem	5 (22)	9 (10)	.16
Low back pain	2 (9)	9 (10)	1.00
MVA	2 (9)	9 (10)	1.00
Headache	3 (13)	4 (5)	.15
Suicide	1 (5)	6 (7)	1.00
Anxiety	1 (5)	2 (2)	.51

* (Mantel-Haenszel test)

Of the 22 patients who reported a depressive syndrome, 21 indicated the duration of the symptoms. Nine of the 22 patients with the depressive syndrome (8.9% of the 106 people studied) reported that the duration of each symptom was greater than two weeks. These 9 patients are described as having a major depressive syndrome. Twelve of the 22 participants with the depressive syndrome (11.3% of the 106 patients

studied) reported that the duration of each symptom was less than two weeks. These 12 patients are described as having a minor depressive syndrome. One patient did not report the duration and is not included in any subgroup analysis.

Although the numbers are small, a differentiation of the characteristics of patients with major depressive syndrome, with minor depressive syndrome, and without a depressive syndrome can be made (Tables 5 and

Table 5
Comparison of Patients With and Without Major Depressive Syndrome

	Major Depressive Syndrome Present N = 9 (%)	Major Depressive SyndromeAbsent N = 84 (%)	*p* value
Depression on visit	3 (33)	1 (1)	.002
Hx of depression	5 (55)	9 (11)	.003
Mental health next month	2 (22)	0 (0)	.008
Unexplained pain	4 (44)	12 (14)	.04
Prescribed medication	5 (55)	27 (32)	.26
Alcohol abuse	6 (67)	31 (37)	.14
Trauma	3 (33)	31 (37)	1.00
Assault	2 (22)	15 (17)	.66
Hospitalization within last year	2 (22)	12 (14)	.62
Domestic problem	4 (44)	9 (10)	.02
Low back pain	2 (22)	9 (10)	.23
MVA	1 (11)	9 (10)	1.00
Headache	1 (11)	4 (5)	.40
Suicide	1 (11)	6 (7)	.52
Anxiety	0 (0)	2 (2)	1.00

6). Of the 9 participants with major depressive syndrome, 3 (33%) had depression documented in the clinic visit for that day. A documentation of depression was more common for patients with major depressive syndrome than for patients who did not report a depressive syndrome (33% vs. 1%, $p = .002$). The group with major depressive syndrome also had more frequent documentation of unexplained pains (44% vs. 14%, $p = 0.04$), domestic violence (44% vs. 10%, $p = .02$), history of depression (55% vs. 11%, $p = .003$), and visits to the mental health facility in the month following the study (22% vs. 0%, $p = .008$) than patients without a depressive syndrome. The only differences between patients with minor depressive syndrome and those with no depression were a higher use of mental health facilities in the month following the study (16% vs. 0%, $p = 0.01$) and

Table 6
Comparison of Patients With and Without Minor Depressive Syndrome

	Minor Depressive Syndrome Present N = 12 (%)	Minor Depressive SyndromeAbsent N = 84 (%)	*p* value
Depression on visit	1 (8)	1 (1)	.23
Hx of depression	2 (16)	9 (11)	.62
Mental health next month	2 (16)	0 (0)	.01
Unexplained pain	4 (33)	12 (14)	.11
Prescribed medication	8 (66)	27 (32)	.02
Alcohol abuse	5 (41)	31 (37)	.75
Trauma	5 (41)	31 (37)	.75
Assault	4 (33)	15 (17)	.24
Hospitalization within last year	3 (25)	12 (14)	.39
Domestic problem	1 (8)	9 (10)	1.00
Low back pain	0 (0)	9 (10)	.59
MVA	1 (8)	9 (10)	1.00
Headache	2 (16)	4 (5)	1.00
Suicide	0 (0)	6 (7)	1.00
Anxiety	0 (0)	2 (2)	1.00

a higher frequency of prescription medication use (66% vs. 32%, $p = 0.02$) in the patients with minor depression. Again, the difference in medication use is explained entirely by antidepressant medication.

Discussion

This was a study of self-reported depressive symptoms using *DSM III-R* criteria among adult American Indians attending an IHS primary care clinic. The systematic enlistment of patients, the standardized criteria for depressive syndromes, and the blinded chart review add power to the study's conclusions.

The study does have some potential limitations. One concern lies in the fact that only 54% of patients eligible for enlistment participated in the study. In this clinic, a registration log is signed by patients on their arrival. The order of the registration is based only on order of arrival. Every fourth adult person who signed this log was considered eligible to participate. Approximately 10 adult patients per day could have been enlisted for each of the 20 clinic days during this study period. Sixty-six patients (32%) who should have been solicited for enlistment were not approached. Most of these patients appear to have signed in

late in the day, when time constraints of the clinic interfered with the completion of the study work. These omissions were spread evenly among the study period. Patients approached who did not choose to participate gave a variety of reasons for not enlisting. Because the study's participants had characteristics similar to the nonparticipating clinic patients during the same time period (Table 1) and because no consistent pattern of selection bias was identified (Table 2), we believe that the low rate of participation did not have a major adverse affect on the quality of the results of this study. Another concern in interpreting the results of this study is the potential for cultural differences in the expression of depressive symptoms between American Indian and Alaska Native people and the majority population (Manson, Walker, & Kivlahan, 1987). If significant differences exist, the IDD might not be a valid instrument for defining depressive syndromes despite the fact that it is based on *DSM III-R* criteria. Although the IDD has been highly reliable in testing American Indian adolescents (Ackerson, Dick, Manson, & Baron, 1990), it had not previously been used to test this population. Because the study design did not include a diagnostic interview, a specific diagnosis of a mental disorder cannot be correlated with the responses to the questionnaire. There is a chance, therefore, that the questionnaire results in this study are not a true description of depressive illness in this population. The definition of depressive syndromes in this study is therefore limited to the self-reported quality and duration of depressive symptoms offered by this questionnaire.

In this study, the prevalence of any depressive syndrome was 20.7%. When symptom duration criteria were used, the prevalence of major depressive syndrome was 8.9%. Patients who had a minor depressive syndrome, by our definition, represented 11.3% of the study population. In other studies, estimates of depressive symptoms in primary care settings range from 15% to 50% when using nonspecific instruments. Estimates for major depressive syndrome range from 2% to 9% of patients in studies that use specific criteria and diagnostic interviews as the standard (Katon, 1987). In a recently reported study of primary care practices in Michigan in which the Center for Epidemiologic Studies Depression-Scale (CES-D) followed by a structured clinical interview of a weighted sample and a definition of depression based on *DSM III-R* criteria were used, any form of a depressive disorder was found in 22.6% of all patients and a major depressive disorder was present in 13.5% of all patients (Coyne et al., 1994). Therefore, despite differences in methodology, instrumentation, and populations, the epidemiology of depression in this study appears to be strikingly similar to the epidemiology of depression in other general clinic populations that have been studied.

Also, as in other studies, depression appears to be either underreported or underrecognized by physicians in this IHS clinic. Two previous studies have attempted to describe the prevalence of mental health

disorders in American Indian outpatient clinics. In a review of ambulatory visit diagnoses based on a standardized reporting format, Rhodes et al. (1980) found that mental disorders accounted for 2.1% of all IHS outpatient visits in 1975. Neurosis, which included depressive and anxiety diagnoses, was the most common mental disorder seen (Rhodes et al. 1980). In a review of outpatient visit diagnoses from the study clinic in the year prior to this study, "neurosis," which includes depressive disorders, was found in 2% of ambulatory visits (Wilson, Unpublished Service Unit Data). Goldwasser and Badger in 1988 used the General Health Questionnaire (GHQ) in a nonrandomized sample of volunteers from a different IHS general clinic (Goldwasser & Badger, 1989). They demonstrated a high prevalence of psychiatric symptoms in their volunteer population, with 36% scoring 5 or above on the GHQ, indicating probable psychiatric morbidity. However, only 4.3% scored 5 or above on the depressive subsection. In the present study, physicians in the clinic were not specifically instructed to diagnose or treat depression as a part of the protocol. Therefore, any diagnosis of depression made and recorded in the chart was done only as a part of routine care. The fact that patients with depressive syndromes by IDD criteria were more likely to be diagnosed with depression by the clinic physician suggests that patients with depressive syndromes by IDD criteria are more likely to be depressed by clinical criteria as well. However, because patients answering the questionnaire may have had their clinical presentation altered by the act of answering a questionnaire prior to seeing the physician and because the criteria for diagnosing depression by clinic physicians were not necessarily based on standardized research quality criteria, a direct validation of the questionnaire or of the ability of clinic physicians to diagnose depression cannot be made. It is important to emphasize that even in the study setting, only 18% (4 out of 22) patients with a depressive syndrome by IDD criteria had a chart notation of depression by the physician at the clinic visit. If the results of this study are valid, it and other studies, suggest that depression is as underrecognized and/or underreported in American Indian primary care clinics as it is in other primary care clinic settings.

The clinical and historical determinants in patients who reported a depressive syndrome covered a broad range of situations and presentations. Age, sex, and other common demographic information were not different between patients with and without depressive symptoms. However, more frequent use of mental health facilities, a diagnosis of depression, antidepressant medication use, and a history of unexplainable pains did correlate with the depressive syndrome. These characteristics have been correlated with depressive symptoms in several studies of depression in primary care settings (Smith, 1992). Alcohol use, anxiety, headache, and low back pain have been associated with depression in some other studies but were not significant in this study (Chung & Hraybill, 1990; Coyne et al., 1994; Depression Guideline Panel, 1993). It is important to remember

ber that the relatively small size of the present study may have limited the ability to determine differences between the syndrome groups.

Dividing the patients with any depressive symptoms into those with major depressive syndrome and those with minor depressive syndrome may have some important clinical implications. The only symptom difference given by these groups was the duration of their depressive syndrome. However, the minor depressive syndrome group differed from the nondepressed group only in the use of mental health facilities and antidepressant medication. Patients with the major depressive syndrome differed from the nondepressed group in several additional ways, including history of depression, depression on the visit, unexplained pains, and domestic problems. Differences in the quality of depressive syndromes are important because several studies have shown that up to 30% of patients with depression in primary care clinics will improve in several weeks without specific depression treatment (Depression Guideline Panel, 1993). Patients with so-called minor depression are particularly less likely to show benefit from antidepressant medication treatment than are patients with full-blown major depression (Elkin, Shea, & Watkins, 1989). It is possible that patients with time-limited depressive symptoms should be treated differently than patients with full-blown major depressive syndrome. Before specific recommendations can be made, however, further research is needed to determine the natural history of depressive syndromes in this setting.

Even though a screening device such as the IDD cannot diagnose depression, in this study it did identify a group of people with important emotional and physical complaints. Identifying such individuals might help in delivering the appropriate mental health, social service, and compassionate medical intervention to those most in need. Goldwasser's study suggests that the information offered in the GHQ improved clinical recognition of these problems by the primary care physicians in their IHS clinic (Goldwasser & Badger, 1989). Continued investigations into the development of appropriate questionnaires and optimal screening strategies in a variety of IHS clinical settings, however, are needed to better describe the role for depression symptom screening in American Indian primary care populations.

Because of the wide variety of cultures and situations in the American Indian primary care populations, replication studies are needed to determine the epidemiology and characteristics of depression in other IHS primary care settings. Future research should focus on validating and improving the results of self-report questionnaires among people with varying cultures and medical conditions. Future research should also focus on the effect of treatment strategies and service delivery on the quality of life, medical service use, and the economic impact of depression in American Indians and Alaska Natives.

On the basis of this study, health care providers in IHS primary care clinics should recognize that depressive symptoms are common among adult patients. Potentially important clues when evaluating individual patients about depressive symptoms might include a history of depression, visits for unexplainable pains, antidepressant prescription medication use, use of mental health facilities, and a history of domestic violence. Based on this study and on other research, symptom duration may have clinical importance and may help define populations of patients who have different depressive syndromes. Combined with an increased awareness of depression, this type of information might lead to improved clinical recognition of this common and treatable condition.

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THE DILEMMA OF MENTAL HEALTH PARAPROFESSIONALS AT HOME

Bruce G. Miller, Ph.D., and Jen Pylypa

Abstract: The use of community member paraprofessionals in the delivery of mental health services is complicated by the changing nature of the paraprofessional's social relationships within the community. We use an anthropological model of Coast Salish social organization and data from a current delivery system, the Swinomish (Washington) Tribal Mental Health Project, to suggest ways to conceptualize and account for such complications.

Health care administrators serving Indian communities are increasingly aware of the value of employing community members as health providers in order to make their services culturally sensitive and relevant. There is now a general recognition that Indian peoples are frequently alienated from non-Indian health care institutions, practices, and practitioners. And there is a growing academic literature advocating the integration of native caregivers in the form of community paraprofessionals and indigenous healers into health care programs, particularly mental health care, as a means of overcoming this alienation (for example, Dinges, Trimble, Manson, & Pasquale, 1981; Guilmet & Whited, 1989; Jilek, 1982; Jilek & Jilek-Aall, 1973; Minton & Soule, 1991; Runion & Gregory, 1983; Trimble & Hayes, 1984). Although the existing literature shows an appreciation for the difficulties of such collaborative efforts, there is little attention given to understanding how the changing relationship between the caregiver (and the caregiver's family) and the client (and the client's family) may influence access to services. The purpose of this article is to examine several related issues: (a) how Coast Salish health providers are socially situated in their communities, in particular within the family network structure that frames community relationships; (b) the ways changes in relationships within the community affect the providers' placement over time; and (c) the implications for mental health care delivery.

These issues are addressed by the application of an anthropological model of Coast Salish community dynamics to an existing clinical model of service delivery, the Swinomish Tribal Mental Health Project.

Interviews with a paraprofessional collaborator who was formerly a tribal support counselor (using the pseudonym Mrs. Johnson) provide insight into family network relationships and difficulties associated with counseling clients across family boundaries. In addition, our observations are sharpened by collaboration with a former Indian Health Service public health nurse who employed family network concepts in facilitating the delivery of health services, including mental health services, to her Coast Salish clients.[1] We approach this research from an ethnographic and historic perspective, and our nurse collaborator has provided information that helps in applying the ethnographic lens to the process of providing health services. We argue that our approach provides a systematic way to view one significant set of problems faced by mental health programs that employ community members as service providers.

Health Care Delivery and the Role of the Native Caregiver

Generally, two solutions have been proposed to overcome the problems of service delivery to Indian people by mainstream institutions: one is to train practitioners in cultural sensitivity; a second and perhaps more important approach is to employ Indian caregivers who can combine Western and indigenous practices and who are aware of community members' needs, beliefs, and attitudes. The advantages of native caregivers over Western health professionals are numerous. Indian health providers are said to generally be trusted and to occupy a position of respect and positive regard in the community, whereas Western practitioners are frequently distrusted (Guilmet & Whited, 1989; Trimble & Hayes, 1984). As members of the communities they serve, native caregivers are more familiar with local community dynamics, kinship patterns, religion and spiritual needs, values, attitudes, the native language, communication styles, and client expectations (Dinges et al., 1981; Guilmet & Whited, 1989; Runion & Gregory, 1983; Trimble & Hayes, 1984). Whereas Western practitioners are outsiders who are sometimes only temporarily employed by the clinic, native health providers (if they are local) are personally tied to the community and provide continuity in care. They may also be able to reinforce cultural values, pride, and identity, which are important elements in maintaining mental health (Guilmet & Whited, 1989).[2]

Although collaboration between mainstream service providers, community paraprofessionals, and traditional healers can be a successful means of reducing cultural and social distance between caregiver and patient, many authors have recognized problems associated with such collaborative efforts. Dinges et al. (1981) note that relationships of trust in which mutual credibility is recognized can be difficult to establish between Western practitioners and native healers. Nonnative (Western) practitioners may reject traditional healing methods and be unwilling to make referrals to native curers. Western health professionals may be unaware of

patient expectations and not know when referrals are appropriate. Sufficient and culturally appropriate compensation for native healers often does not occur (Dinges et al., 1981). Community members sometimes oppose integration of native and Western medicine, preferring to keep their practices private or at a distance from health agencies (Attneave & Beiser, 1974). Dinges et al. (1981, p. 266) raised the problem of frequent differences in values between community paraprofessionals and patients because of different degrees of assimilation: "There is a prevalent but unwarranted assumption that indigenous paraprofessionals will automatically identify with and have empathy for the community of which they are a part." They observe that some Western-trained paraprofessionals adhere to Western psychological models and therefore do not represent a middle ground between Western and Indian perspectives.

Once the obstacles to collaboration with indigenous healers are removed and culturally sympathetic paraprofessionals are found, it is frequently assumed that social barriers between caregiver and client will disappear. Whereas the Western practitioners are socially distant from the community, native health providers may be socially extremely proximate; they are normally active, participating members of the community. This social proximity give the native provider a significant advantage over the Western practitioner. However, it may also complicate the client–health provider relationship. Coast Salish communities are made up of integrated kin-based social networks that influence the relationships between individuals (Amoss, 1978; Miller, 1992b; Mooney, 1976; Suttles, 1963). Both the native caregiver and the potential client occupy particular social statuses and carry out roles in this family network complex, a fact that may influence the likelihood of an individual seeking the provider's care or finding such assistance socially appropriate. As family composition changes (a phenomenon discussed later in this article) and as interfamily alliances and tensions build and diffuse, the native caregiver's relationship to potential and existing clients may also change.

We present here a preliminary model of the social placement of native caregivers and show the implications for health care delivery of that placement. While the specifics of the model apply particularly to Coast Salish communities, the consistently central role of the extended family in native Indian communities suggests that, with local revisions to account for social organizational differences, these ideas have relevance on a wider scale.

Applying Family Network Theory to Health Care Issues

The origin of the concept of a "social network" is often attributed to Barnes, who imagined "a net of points, some of which are joined by lines. The points of the image are people, or sometimes groups, and the lines indicate which people interact with each other" (Barnes, 1954,

p. 43). Network models are sometimes used to emphasize what Wellman and Berkowitz (1988, p. 4) call the "ties" that represent "flows of resources, symmetrical friendships, transfers, or structural relationships" between social system members. Such models of social structure stress the relationship among members of the social system and the exchange of resources — including goods, services, money, information, love, and support — between them.

Health care studies employing these network ideas are concerned principally with the exchange of one resource within the network, that of psychosocial support, and how the presence or absence of support networks affects mental health (e.g., Llamas, Pattison, & Hurd, 1981). The principal application of such studies is to develop "network intervention strategies" in an attempt to strengthen impoverished social support networks as a means of treating mental health problems (e.g., Pattison & Hurd, 1984). Thus, the present literature is primarily concerned with social support within the network and its direct effects on mental health. We wish to consider other aspects of network relationships, especially how these relationships influence access to health services and the ability of service providers to engage their clients.

LaFargue's (1983) analysis of middle-class African-American family networks is suggestive for the study of the Coast Salish because her work shows the value for health care delivery of understanding changes in family networks over time. LaFargue combined exchange theory and network analysis and found that the patterns of interaction and exchange among family members affected their use of health services, particularly when nurses were unaware of these patterns and misunderstandings ensued. In Indian communities, the family network is equally important as a realm of influence and resource exchange. Family heads and elders control the allocation of resources and only certain family members are seen as appropriate to fulfill particular roles, such as teaching and disciplining children (Miller, 1989; 1992a). As with the families LaFargue studied, Coast Salish family networks possess and exchange private information that is not to be indiscriminately spread (Amoss, 1977; Suttles, 1958).[3]

The work of LaFargue and others (Murdock & Schwartz, 1978) recognizes that a client–health provider relationship is not defined by these two actors alone — the attitudes, beliefs, and social roles of the client's family network can be equally or even more important. When the caregiver is also a member of the complex of family networks that make up the community, he or she has a particular social role and relationship to both the client and the client's family. The success of a client–health provider relationship may depend on whether or not they are both of the same family network, the nature of the relationship between their networks if they are not the same, the degree of access the caregiver has to the client's family head and to private information about that family, and so on. These relationships may change over time as family composition

changes and as relationships between families change. All of these factors affect the appropriateness of care and the possibility of accessing services by a particular caregiver.

Coast Salish Family Networks

Coast Salish Indians lived aboriginally in large, extended family households, and the extended family, in a somewhat altered form, remains the core socio-organizational unit today. A family network, or "family" as it is referred to locally, is a corporate unit in which members operate collectively to carry out such activities as running fish camps, organizing ceremonies, and sponsoring family members in ceremonial life; family members interact and carry out generalized reciprocity on a regular basis, may pool resources, and assist one another in the care of the elderly and children.[4] Family networks composed of linked households are the central unit through which resource exchange and mutual aid occurs (Mooney, 1976). Family members provide one another such essential services and goods as employment advice, transportation, financial assistance, food, equipment, and information. Modern reservation communities are composed of a number of such family networks that compete for the resources available to the tribal community.

Family membership is flexible; it is not based simply on descent, and individuals may choose to affiliate themselves with any one of a number of family networks to which they can show common descent with members or other relationship (such as adoption or marriage). As such, family network composition changes over time; new members are recruited, old members may decide to disaffiliate themselves, new families form around a leader or leaders, and old families lose their cohesion and cease to exist as units. A new family frequently is formed around one or more influential leaders and includes an adult sibling set of brothers, sisters, and cousins. New members are incorporated and recruited as children are born and adults marry into the family or when individuals activate latent kin ties in order to affiliate themselves with the family. Leaders compete with other families' heads to acquire resources for the family and are responsible for allocating them. The quality of leadership influences the composition of the family; followers are attracted and cohesion is maintained by the leader's ability to do such things as speak for the family in public, represent its interests on the tribal council, get jobs for family members, bring them prestige in the Coast Salish regional system, and contribute directly to members' material and spiritual well-being. Members defer to specialists within the family, such as ceremonial leaders, on appropriate occasions.

Because individuals can potentially belong to several different family networks by activating different kin ties, they can attempt to strategically choose which network to affiliate with based on the resources it

can provide. As Amoss (1978, p. 36) observed concerning the Nooksack, a Coast Salish tribe: "Very few people really know who all their relatives are, so it is fairly easy for a person to affirm or ignore distant relationships as it suits his or her social needs." Although there is pressure to belong to only one family network at any given time, members may relinquish ties to a network in which leadership is weak and affiliate themselves with another family in which their life chances will be improved.

The negotiability of membership is one factor prompting changes in family network composition. In addition, family networks appear to follow a somewhat predictable cycle of growth, maturation, and collapse. This is not to suggest a unilineal pattern; variation occurs. This cycle may be divided for convenience into four phases in order to show the implications for service delivery. In the "incipient phase," a leader or group of leaders, ordinarily consisting of one generation of siblings or cousins and their spouses and children, begin to establish a basis for group action. Reciprocity is established within the group, and the group begins to acquire heritable resources (such as fish camp sites useful in commercial fisheries), compete for tribal resources, and attract followers.

As time passes (the "early phase"), the children of the family network members grow to maturity and the network grows as more followers affiliate themselves. Family network leaders become better connected in the information chain of the reservation and are more successful in gaining political office and providing jobs for family members. As second-generation members marry and have children, the family sometimes enlarges to 80 members or more.

By the time the third generation reaches adulthood, the network has attained the height of its size and political influence; this is the "mature phase." Despite the strength and influence of the family, problems of group cohesion arise. As families grow, members find themselves associated with distantly related fellow members. As genealogical and social distance between members increases, the likelihood of social friction and disputes within the network also increases. There may be too many members for all to use the family fish camp (if they have one), conflict over resources occurs, and reciprocity begins to break down. The leadership may no longer be able to provide resources and assistance to all of the members because of the size of the group. Leadership may also break down as family heads die or become aged or incapacitated; such a collapse, combined with the problems of maintaining cohesion, leads to the "fissioning phase," or breakdown of the network. The family network may remain intact by eventually reconstituting under a new head; otherwise, the network disintegrates and individual members may reaffiliate themselves with other networks to which they have latent kin ties or be left without a network of ties and either leave the community or become marginalized in it.[5]

A Model of the Family Network and Health Service Use

The nature of family power relationships within the community and of the significance of the patterned linkage of powerful families to community institutions can be incorporated in the model of network cycling in order to better understand the factors affecting the individual's access to health facilities. The material, financial, emotional, and labor resources available to individuals, as well as their links to sources of community power, fluctuate with changes in network phase. These fluctuations affect health care in two ways: first, the size of a network affects the availability of kin to provide resources such as care, transportation to facilities, and emotional support. Second, the size and power of a network affect the individual's relationship to and identification with tribal institutions that provide services; individuals who are not part of a coherent network or whose family networks are small may feel isolated from sources of community power and be less likely to use services than those from better-placed families.

There is a relationship, then, between network phase, the availability of kin to provide care and assistance, and the degree of identification with community services. Given the nature of family network cycling, the changes that will likely occur in the individual's access to health care over time can be anticipated to a degree. In the incipient phase, there are a limited number of family members available to provide care for the sick, children, and the elderly, transportation to health services, and emotional support. This problem is compounded by a lack of power in community institutions and associated alienation from community services.

In the early phase, more familial assistance is available, and members become more involved in community institutions. The family is better able to sponsor members in religious ceremonies, such as winter spirit dancing and the Shaker Church, which promote strong Indian identity and, indirectly, mental health (see Miller, 1990).

In the mature phase, the family network is large and able to provide more extensive care for its members. The network has power and influence in community-directed institutions, such as health facilities, and members therefore can more easily identify with them. Use of services in Coast Salish communities depends in large measure on personal ties to health care providers and service staff, and it is in the mature phase that people are most likely to have family members occupying tribal service positions.

When family networks fission, the regular pattern of reciprocity breaks down and the number of family members available to provide assistance is once again limited. Members typically lose their power to influence institutions and may become alienated from community services and institutions. Some people move away from the reservation and are too geographically distant from tribal services and programs to make effective use of them. Those who remain may be unwilling to trust and reveal personal

information to caregivers and service staff who are members of other families, given the strong cultural emphasis on private family knowledge.

This analysis reveals the importance of knowing a client's place in the family network complex and where the family network stands in its natural history in order to understand issues of access to health facilities. We wish to extend the analysis to consider an additional factor that appears when community members are employed as health providers: what the social position is of the community health provider in this same family network complex and how the relative placement of client and caregiver influences the likelihood of the former effectively accessing the latter's care.

Applying the Model

The Project

The Swinomish Tribal Mental Health Project, which employs native paraprofessionals on Coast Salish reservations, provides an ideal context in which to explore these issues.[6] The program was established in 1984 through a cooperative effort between the Skagit Community Mental Health Center and the Swinomish and Upper Skagit Tribes. Two tribal support counselors at each reservation deal with such problems as suicide attempts, domestic violence, social withdrawal, family crisis related to substance abuse, child abuse, runaway teens, unresolved grief, conduct disorders, somatoform disorders, and spiritual problems (Swinomish, 1991, p. 207). Aspects of the program include:

1. Employing and training tribal members who are seen in the tribal community as natural helpers.
2. Cooperating with traditional Indian healing systems.
3. Developing a culture-specific model of service delivery.
4. Serving traditionally oriented and "hard to reach" Indian clients.
5. Increasing linkages with other mental health and social services programs available in both tribal and mainstream communities. (Swinomish, 1991, p. 206)

The success of the Swinomish Tribal Mental Health Project team in incorporating native health providers, knowledge of community social structure, and the active involvement of community members makes their approach worthy of careful consideration. We wish to add our model of family network cycling in order to reconsider the implications for health care accessibility of the native caregiver's social placement in the community.

The Social Placement of the Paraprofessional

Structural analysts point out that the relationship between two individuals can be understood only if it is considered in the context of the social networks in which it is embedded (for example, Wellman, 1988). This is especially true in Coast Salish communities, where members of an individual's family network guide one's relationships and behavior both directly through influence and pressure and indirectly through the links that they create between the individual and other community members. The Swinomish project team emphasized the importance of this issue, noting:

> Almost all tribal members are influenced by subtle and not so subtle family loyalties, obligations and conflicts. Political and social ties, as well as spiritual and career choices are often determined by which extended family a person belongs to. (Swinomish, 1991, p. 174)

The individual's social place in the community and relationships to others are determined, to a significant degree, along family lines:

> The importance of the Indian person's extended family cannot be overestimated. An Indian person is carefully trained in family relationships and traditions, and his/her social place is largely determined by family connections. (Swinomish, 1991, p. 227)

The nature of an interpersonal relationship is therefore not defined purely by two individuals. Furthermore, particular community members are regarded as appropriate to offer assistance to any given individual. One of the goals of the Swinomish project is to employ tribal members who are seen by the community as "natural helpers," someone who is already recognized as having a helping role and who is a well-known, knowledgeable member of the community.

The client's family must know the counselor's ancestry because it establishes the context for the relationship. The counselor must be recognized as "one of us," in the sense of being of the community. However, to be seen as "one of us," a person may need to be more than just an Indian or even a community member; he or she may also need to be family:

> Family membership can be an important way of defining who is "in" and who is "out" of one[']s social group. . . . it can be difficult to become really close to anyone who is not in some sense a part of one[']s family. As one of our Tribal Support Counselors puts it, it is rather like being on a team: "you're either in or you're out." (Swinomish, 1991, p. 147)

Although being an appropriate helper may not always require that the counselor belong to one's own family network, being a member of a distant or rival family network may classify the counselor as "one of them"

and therefore unacceptable as a helper. Many factors affect whether or not two families have personal ties and a positive relationship, including:

1. The relative social status of each family.
2. Whether the families are related through marriage.
3. The religious affiliations of the two families.
4. The degree of traditionalism of both families.
5. Their history of friendly or unfriendly relations. (Swinomish, 1991, p. 175)

These factors affect the possibility of a successful interfamily, client–health provider relationship. If a counselor is from a distant, rival, or powerful family, he or she may not be a "natural" helper to that individual. No one individual can be a "natural" helper to the entire community; any given counselor will be an appropriate helper to some families but not to others.

The problem of gaining the trust of community members is repeatedly cited in the Swinomish project's publication (1991) as an issue in mental health care delivery. This theme is echoed elsewhere, and Lewis (1970) noted, somewhat cynically, that among Coast Salish peoples there is a prevalent distrust of all who are not close kin. Collins observed in the 1940s that distrust of Coast Salish community members who are not family affected the choice of practitioner to heal a supernaturally inflicted illness:

> A victim's family calling in a local shaman, who is not a relative, can never know for certain that he is favorably disposed toward them. It might even have been he who caused the illness in the first place. . . . This doubt of the good interest of members of one's own community sometimes leads to the precautionary measure of calling doctors from distant villages, men who will be less likely to be involved emotionally in the success or failure of the cure. (Collins, 1974a, p. 38)

It may even be preferable to be treated by a stranger than by nonfamily community members who could potentially have interest in exploiting the relationship for their own gain. Mrs. Johnson noted that it is sometimes easier to help people she doesn't know than community members who are not part of her family.

A related reason for the unwillingness to take problems to members of other families is a cultural emphasis on family "advice," the privately held knowledge, noted earlier, that should not go outside the family. This practice of restraint is extended to apply to information about health, finances, and other family affairs (Miller, 1992a). Mental health care often requires clients to reveal information not only about themselves but also about their families, especially when dealing with many of

the issues that the Swinomish Tribal Mental Health Project identifies as motives for seeking care, such as domestic violence, family crisis, child abuse, runaway teens, and conduct disorders (Swinomish, 1991, p. 207). A person will likely not seek help from someone to whom it is not appropriate to reveal such information. This is a significant impediment to a counselor's ability to assist someone from a family network other than his or her own. The Swinomish project's literature recognizes the importance of personal links between the support counselor and the client as a criterion for acceptance of the counselor's services: "People are accepted as helpers not primarily on the basis of their training, experience or job role, but on the basis of their personal connection in the tribal community" (Swinomish, 1991, p. 143).

Mrs. Johnson believes that every family has "someone like her" whom family members go to for help with personal problems. Thus, each intact family network normally contains a "natural helper" who is viewed as an appropriate person to counsel family members. When problems are too difficult for this person to solve, or if an individual has no such family member to ask for assistance — as in the case of a fissioned family network — the individual or his or her family may seek help from Mrs. Johnson. When a client is not from Mrs. Johnson's own family, she asks the client about family and ancestry in order to establish a relationship and build trust between the client and herself. This enables her to gain the client's confidence and provides a basis for their relationship. Familiarity with the client's family is used to bring her closer to the client so that she will not be perceived as a stranger. The importance of establishing trust before a therapeutic relationship when dealing with nonfamily members is evident. However, the amount of information about a family that can acceptably be revealed to an outsider is limited; although Mrs. Johnson uses the family context as a basis for establishing a therapeutic relationship, there are limits to the degree to which she can get "inside" a family other than her own.

Mrs. Johnson noted that the quality of the relationship she is able to have with a client depends on how she thinks of the client's family. If she regards the client's family as "good people." she believes this helps her have a positive relationship with the client. If she has a negative relationship to the client's family, she will have difficulty communicating with and helping the client, especially at first. She stated that once an individual relationship was established between herself and the client, her perception of the family, as well as their opinion of her, becomes less important. Mrs. Johnson believes that her own relationship to the client's family, independent of the client's personality, influences her initial ability to establish a positive rapport.

Personal links are important not only as the basis of acceptance of a counselor's services but also as a channel through which they are accessed. Mrs. Johnson observed that most client-counselor relationships

are initiated when a person seeks care on behalf of a family member by approaching the counselor socially, outside of the clinic setting. This requires that a family member know the counselor personally and be comfortable asking for assistance. Thus, personal links are necessary not only for a client-counselor relationship to be seen as appropriate but also as the principal channel through which care is sought. Such personal ties are often based on family connections.

Whether or not a particular client-counselor relationship is viewed as appropriate is an issue for not only the client and the client's family but the counselor as well. Indian health providers may feel less comfortable dealing with the personal life of a member of another family, since "Indian people usually try not to intrude on each other's business, and are particularly reluctant to interfere with other families" (Swinomish, 1991, p. 179). Individuals who are winter spirit dancers have powers that are frequently unknown, and because powers can be dangerous, community members intrude into another's affairs with caution. A certain social distance and respect for privacy may need to be maintained when dealing with clients from other families, and open communication may be more difficult, especially when the personal lives of the client's family members are involved.

Frequently, successful mental health care requires not only the tacit approval of the client's family but also their active involvement in the form of consultation and support. The family leader must be consulted and their approval obtained before decisions can be made and action taken. The Swinomish project team recognized that should such permission fail to be granted, treatment might be impossible: "In Indian culture, important decisions require the approval of spouses and senior relatives, particularly grandparents. Without the support of key extended family members, mental health treatment is likely to be ineffective or even sabotaged" (Swinomish, 1991, p. 228). If family leaders feel that a therapeutic relationship between a particular counselor and a member of their family is inappropriate, permission may not be granted and treatment may not occur even if the client approves of the relationship.

Mrs. Johnson considers consulting family members about important problems affecting a client essential. Before making decisions concerning the treatment process, she goes to family members whom she sees as "important to that person" to establish a relationship and discuss the client's problem. She would not make significant decisions concerning a health problem without first consulting at least one member of that person's family, even if the client did not request such consultation. For example, she stated that if a young woman were pregnant and considering an abortion, she would not help the woman to make a decision or take her to have an abortion without first consulting and gaining the support of the woman's family. She feels that the health clinic's confidentiality rules are an impediment to her ability to help people; it is difficult to operate effectively as a counselor without violating these rules by consulting family

members about clients' problems.[7] Even if a client were willing to take action without consulting family members, the support counselor, obliged to comply with community values, may feel ethically bound to consult family authorities before taking action to provide treatment. This is in conflict with Western concepts of confidentiality and causes a dilemma for the counselor. On the one hand, the Swinomish Tribal Mental Health Project's "Confidentiality Guidelines for Tribal Support Counselors" state, "Never repeat things you are told by clients, even to members of your family or of the client's family" (Swinomish, 1991, p. 293). On the other hand, counselors risk losing their already precarious position of trust if they do not violate individual confidentiality by consulting family leaders. Such a loss of trust could jeopardize not only the present client-counselor relationship but future ones as well. The Swinomish project's literature suggests that "workers must find the appropriate balance between maintaining strict individual confidentiality and involving family members" (Swinomish, 1991, p. 255), however, Mrs. Johnson indicated that this issue is far from resolved.

The counselor often relies on the supportive presence of family members in the treatment process: "Extended family may need to be called upon for support, discipline, teaching, or for spiritual activities" (Swinomish, 1991, p. 355). Active family involvement is an essential element of the Swinomish project: "Our Tribal Mental Health services rely heavily on family involvement. Even when 'family therapy' is not specifically used, extended family are often involved as consultants and helpers in the treatment process" (Swinomish, 1991, p. 227). In such cases, a relationship of trust and approval between the client's family and the counselor is all the more critical, because treatment relies on the family's active involvement. The Swinomish project literature recognizes that gaining family support is "a sensitive task that must be approached in a culturally 'right' way," and that "utilizing 'inside' family connections is a key in this process" (Swinomish, 1991, p. 228). Where inside family connections do not exist or interfamily tension and distrust prevent them from being used effectively, the counselor's power to mobilize the important therapeutic resource of family presence and guidance is significantly reduced. Family members are actively involved in determining access to a support counselor's care in one further respect: the most common means by which a client-counselor relationship is initiated is through a person seeking assistance on behalf of a family member. As Mrs. Johnson noted, family members must commonly persuade an individual to seek help. Given the general disinclination to trust health services, this requires a strong trust in the support counselor on the part of the client's family members.

Interfamily conflicts were cited as a significant impediment to effective client-counselor relationships across family boundaries. Mrs. Johnson stated that if another family and her own were "fighting" (on bad terms), it would be impossible for her to help individuals from the other family with whom she had not already established a client-counselor

relationship. If a strong relationship had already been established, she would be willing to continue counseling the client; however, the client's family would be angry and disapproving. Despite Mrs. Johnson's willingness to continue helping a client, she believes that interfamily disputes could prevent the family support necessary to make a therapeutic relationship successful, and she (or any counselor) would be unable to obtain vital permission for treatment from a disapproving family or consult with them and involve them in the treatment process.

Changing Relationships I: Interfamily Conflict

We have shown how the state of interfamily relationships at any given time can affect an individual's access to the care of native health providers. These relationships are not static; a client-counselor relationship is therefore susceptible to change. One factor that may alter these relationships is changing interfamily alliances and rivalries. New alliances between previously distant families may make links between a counselor and certain individuals possible. Conversely, rising tensions and disputes between previously cooperative family networks may jeopardize existing client-counselor relationships or prevent new ones from forming.

Just as an individual's relationships to others are influenced by family membership, interfamily relationships are affected by individual ones. A dispute between two individuals often results in animosity between the members of their respective families. Such family feuds may persist for years, as noted in the recent studies by the Northwest Intertribal Court System (1991) and the Swinomish mental health project:

> Inter-family rivalries, once begun, can be difficult to end. Tension between two people may involve their entire extended family groups in an ongoing series of unpleasant exchanges. . . . After a period of time, it may no longer be clear to anyone just why these two families don't get along. However, a pattern of suspicion and dislike may be perpetuated for quite a long time, possibly for generations. (Swinomish, 1991, pp. 174–175)

In the instance of interfamily conflict, new client-counselor relationships may not form and existing ones may be jeopardized because of the client's own sense of family loyalty, pressure from the family to sever a relationship, or the difficulty of providing effective care in the absence of family involvement in the treatment process.

Because relationships between family networks can change abruptly for a variety of reasons, ranging from political tension to personal conflict, the degree of access a support counselor will have to different families in the future is not entirely predictable at the time of hiring. A counselor who is presently well situated to serve a large proportion of the

community may be unable to do so successfully in the future as a result of a conflict that has little to do with him or her personally.

Changing Relationships II: Family Network Cycling

The likelihood that a native counselor will be an effective helper for a given family also changes over time as a consequence of the cyclical process of formation, growth, and collapse of family networks. Members of mature family networks are more likely to have ties that make a therapeutic relationship to an Indian counselor feasible than are individuals from families in the incipient, early, and fissioning phases. In the mature phase, an individual is more apt to have a family member who is a counselor, simply because the mature network makes up a large proportion of the community's population. If there is no family member who is a counselor, it is possible that the family will still have a personal link to a counselor's family because the large number of external ties, such as marriage ties, that a mature network maintains. Smaller and fissioned families are less likely to have a family member who is a counselor and have fewer personal links to other families that could help to establish interfamily, client-counselor relationships. Members of small and fissioned families and of unaffiliated households may be unwilling to confide in members of large families or use tribal institutions, as noted.

However, the relationship of a particular family to a counselor is not necessarily permanent. A mature family network may eventually become too large to maintain cohesion and may fission. Members may reaffiliate or reorganize into smaller groups. One or more of these new groups may contain support counselors or individuals who have ties to these paraprofessionals, whereas others may become distanced from counselors because the individuals who linked them to a counselor's family are no longer part of their network. Other families in the formative stages will grow as they recruit new members and will form links to other families as their members marry. Because of this increase in membership and in external ties, these growing families may become more personally linked to a support counselor, making therapeutic relationships more likely.

Families in the mature phase at the time counselors are initially appointed are more likely to have their family members hired than are smaller families because of the prominence of their members on tribal councils and committees. Ultimately, the people whom these decision-makers are most likely to perceive as natural helpers are those individuals who already perform this helping role in the decision makers' own families.

No matter the circumstances of the counselor's family network at the time of hiring, his or her relationship to other families will inevitably change. Just as changes in the size and composition of potential clients' family networks affect their relationships to a counselor, so do changes in the counselor's family network. Counselors from small family networks

will become linked to a larger proportion of community members as their networks grow, new members are recruited, and affinal ties are formed to other families. Counselors from families in the mature phase who are well situated to serve the community will become less so when networks fission and family members, including those who represent important marriage links to other families, reaffiliate themselves with other networks or move away. Thus, hiring counselors who are well connected to many individuals and families in the community does not guarantee that they will continue to be well situated in the future. In fact, quite the opposite may be true. However, given the relatively systematic development and collapse of family networks, these changes are somewhat predictable.

The consequences of the fissioning of a counselor's family network are particularly significant. Not only may fissioning diminish the number of families to which the counselor has ties, it may also have personal consequences that decrease the counselor's effectiveness. When the counselor's family fissions, he or she may become marginalized in the community and feel removed from both the community and community leaders with whom the counselor must work, a process Mrs. Johnson has reported in the case of her own family. As family members reaffiliate themselves or move away, counselors may feel socially isolated. Lacking family support, they may experience increased difficulty in dealing with the stress associated with the complex role demands and emotional strain of a counseling job. They may even decide to leave the community and affiliate with kin who live elsewhere. Loss of counseling staff is particularly detrimental in an Indian community because it takes a long time for new counselors to become accepted and changes in staff can be disruptive to client services (Swinomish, 1991, p. 257).

Conclusion

The need to employ native paraprofessionals as health providers in Indian communities is becoming widely recognized. To make these individuals effective, health agency staff must understand the implications of paraprofessionals' social relationships to different segments of their communities. It should not be assumed that all individuals have equal access to a native health provider's care; the present study of Coast Salish family networks reveals that the social placement of paraprofessionals results in differential access for members of different families. Nor should it be assumed that a native health provider's social position in the community is fixed; as family networks grow and fission and as interfamily relationships change, so does the access of family groups to the paraprofessional's care. A knowledge of family network relationships is useful in understanding how individuals access care, who will and will not be likely to use services effectively, and how access patterns will change over time. The Swinomish Tribal Mental Health Project's publication recommends that

"provider and client should be socially related such that therapeutic rapport is possible" (Swinomish, 1991, p. 118). If that advice is to be taken seriously, then interfamily relationships must be taken into account.

Knowledge of family network relationships has helped nonnatives working in various social service sectors to provide more culturally sensitive services. However, there are other factors of varying importance that similarly affect client–health provider relationships in Indian communities. Runion and Gregory (1983), in designing paraprofessional programs in four Louisiana tribes, observed that factions, kin-based groups, and age-sex groups all create community biases. These and other group loyalties are seen as the source of ongoing problems in most previous programs employing paraprofessionals. The relationships affecting the social placement of the paraprofessional discussed in this paper could be adapted to help understand similar problems associated with other forms of group affiliations. Other, individual circumstances not related to group memberships affect the individual's use of health services, of course; however, behavior patterns associated with family network and, possibly, other group affiliations have significant and predictable influence on health care access patterns.

Family network relationships are complex, and incorporating knowledge of them into health care programs can be equally complicated. Careful selection of community members to be trained as paraprofessionals and an awareness of the viewpoints of those involved in the selection process could help ensure that health providers have access to different groups. However, we argue for the importance of an awareness of the changing circumstances. Initial client interviews can be designed to chart a community's family networks and their relationships to one another in order to identify the families to which the paraprofessional's ties are weakest. Individual clients can be located within the family network complex in order to understand how they are connected to significant others, including the paraprofessional, the family head, and other individuals who represent important resources, such as native healers, to whom referrals may need to be made. Family network charts can be updated regularly to account for changes in family composition and interfamily relationships. The patterned nature of family network cycling means that significant changes in family composition can be anticipated. Potential problems for client-provider relationships associated with the fissioning of networks and changes in the health provider's social placement in the community can therefore be foreseen and provided for.

Although network relationships present some barriers to the paraprofessional's effectiveness, they can also be used as a positive resource to increase health service accessibility. By actively attempting to forge links to key individuals from families who fulfill important roles as advisors and caregivers — such as family heads, elders, and various types of natural helpers — the health clinic staff may be able to establish

trustful relationships and include themselves in the network of resources utilized by these families. The Swinomish program staff found that the employment of a 78-year-old tribal elder as a cultural consultant was "a significant element in [their] ability to mobilize family involvement" (Swinomish, 1991, p. 228). Once links are formed, the clinic staff can encourage family authority figures to consult directly with paraprofessionals about problems concerning family members, thereby acknowledging their authority and decision-making power and gaining their trust while strengthening the clinic staff's relationship to that family network.

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Notes

1. Laraine Michalson, our collaborator on this study and an officer in the United States Public Health Service, presented some of her views to the 45th Annual Northwest Anthropology Conference,

Burnaby, BC, April 1992, in a paper titled "The Nursing Approach: Family, Community, and Service Delivery to Native Americans."

2. We believe that these generalizations do not always pertain; some community members are ineffective, just as some outsiders are effective and sensitive. Non-Indian personnel are frequently knowledgeable and represent a largely untapped resource for the study of Indian communities and in the creation of effective mental health planning.

3. In the contact period, "private knowledge" included such family-held information as knowledge of magic, etiquette, and how to prepare in order to acquire spirit powers. Today the categories of private knowledge are slightly different, but the concept is equally relevant.

4. The natural history of the family network in Coast Salish communities is considered in more detail and in other contexts in Miller, 1989, 1990, 1992a, 1992b.

5. The biomedical and mental health implications for the process of fissioning are most onerous for elders, who are sometimes left with little help and a sense of alienation from the community. See Amoss, n.d., Miller, n.d.

6. We wish to thank Jennifer Clarke, the first director of the Swinomish Tribal Mental Health Project, for her contribution to our understanding of the project. Errors in interpretation are, of course, our own.

7. Mrs. Johnson believes that in many ways she is able to help people more effectively now that she is no longer employed as a counselor because she is free of the legal obligation to maintain secrecy. We have used the present tense in writing about Mrs. Johnson and her views because she presented them in this way. She is still a "natural helper," and her counseling experiences are important and vivid to her.

GROUP THERAPY OF ABORIGINAL[1] OFFENDERS IN A CANADIAN FORENSIC PSYCHIATRIC FACILITY

James B. Waldram, Ph.D. and Stephen Wong, Ph.D.

Abstract: In recent years, the use of group therapy approaches with Aboriginal or Native Canadians/American Indians has become widely accepted. However, many advocates of this approach rarely consider the implications of group therapy for culturally heterogeneous groups, such as when non-Aboriginal peoples are involved or when there are Aboriginal peoples from different cultures and/or with different degrees of orientation to Euro-Canadian culture. This article documents the use of one form of group therapy for Aboriginal offenders in a forensic psychiatric facility, where this degree of cultural heterogeneity exists. The article concludes that, at least within a forensic psychiatric setting, group therapies that mirror the social, cultural, racial, and class structures of Euro-Canadian society are problematic in the treatment of traditional Aboriginal offenders but much less so for acculturated Aboriginal offenders.

Introduction

Group therapy is an important element in a variety of psychotherapeutic treatment programs in North America. There was a time when group therapy approaches were deemed to be too culturally biased to be useful in the treatment of Aboriginal peoples. In more recent years, group therapy has become more accepted in specific circumstances. The purpose of this article is to demonstrate one arena in which cultural misunderstandings and insensitivity and the differing social, class, and racial structures of group therapy affect the involvement of some Aboriginal peoples. The case in point in this article pertains to a forensic treatment program in which Aboriginal offenders are combined with non-Aboriginal offenders in a psychiatric facility.

Group Therapy and Aboriginal Peoples

Edwards and Edwards (1984, p. 7) have argued that, for treatment of alcohol abuse, group approaches have become "the treatment of

choice for a number of agencies with programs serving American Indians." Similarly, Neligh (1988, p. 145), in his discussion of group therapy for mental illness, has challenged the idea that Indian patients do not do well in structured group therapy settings. However, Neligh (1990, p. 156) also stated that "it was long taught that for whatever reason Indian people became so uncomfortable in groups that (group) psychotherapy should not be attempted." Although he has not discussed in detail the reasons for such an assertion, Neligh notes that his belief stems from the experiences of mental health professionals associated with the U.S. Indian Health Service. These mental health professionals were involved in the delivery of services through single-issue groups, such as one in Montana for American Indians suffering from panic disorders and agoraphobia. His views are supported by Wolman (1970), in her discussion of a Navajo group therapy exercise emphasizing "problem" drinking, and by McDonald (1975), concerning a multicultural all-female Aboriginal group in San Diego that handles problems unique to single, urban American Indian mothers (e.g., dealing with physical and sexual abuse). In both cases some cross-cultural problems were noted.

Similarly, Manson, Walker, and Kivlahan (1987, p. 170) described a "new movement" toward increasing use of group therapy for American Indians that "contrasts sharply with prior assertions that group psychotherapy is inapplicable" for these peoples. Alcohol treatment programs seem particularly well suited for such group approaches. Manson et al. (1987, p. 170) explain that such a negative view of the applicability of group psychotherapy was based on three assertions:

> First, Indians have been stereotyped as being stoic and silent. Second, it was presumed that an unspoken solidarity among Indians would preclude the involvement of non-Indians as either fellow patients or group leaders. Third, it was believed that the Indians' social norms, which disapprove of setting oneself apart from others, would repress the therapeutic expression of fear, weaknesses, or problems.

The increasing use of group therapy approaches in alcohol and drug abuse programs is particularly noteworthy.

The observations of those in favor of group therapy differ from those of Archibald (1974, p. 43). He has suggested that because of the "unique communication characteristics" of American Indians, some alterations in the traditional group therapy process are needed to make group therapy useful for American Indians. These characteristics included a "comfort with protracted silence, an extreme sense of personal privacy coupled with a guardedness for fear that cultural secrets may be revealed and lost, and the acceptance of individual difference being a right." In his interviews with psychotherapists, Archibald determined that those who could claim to be making progress with Aboriginal clients were those who supported the Indians' desire to discuss the persecution of their people or

who encouraged discussion about the standards of the "dominant culture." However, Archibald refers to both of these attitudes of psychotherapists as "traps." noting in particular that the first is "a defense which has been found very hard to shift from once established" (1974, p. 44). The groups under discussion were heterogeneous, not only representing 32 tribes but also including non-Aboriginals in many cases. The heterogeneity of the groups led Archibald (1974, p. 44) to observe that "no one claimed to have a successful psychotherapy group with more than a 50% Indian composition." Part of the problem, apparently, was the Indians' use of silence as a defense and retreats into assertions that non-Indians would not understand them anyway. Furthermore, admissions by individuals of "greater strength or . . . weakness" violated Indian norms that disapproved of such boasting behavior.

The difficulty in understanding the group therapy experiences of Aboriginal peoples is the result of the lack of clarity in the sparse literature that addresses this topic. Significant variables, such as the objectives and cultural constitutions of groups, the political-legal context (e.g., whether patients are mandated to undergo treatment), the racial and cultural backgrounds of the therapists, and the values being communicated, are not afforded the attention they deserve. Implicit assumptions that the Aboriginal participants are culturally homogeneous or that cultural differences are not relevant are apparent though rarely detailed. Not only are possible cultural differences (e.g., Cree vs. Chipewyan) ignored or glossed over, but so, too, are the differing degrees to which Aboriginal people are oriented toward a Euro–North American (or African–American, Hispanic–American, etc.) culture versus an Aboriginal culture.

The work of French (1981, 1989), Trimble and Fleming (1989), and Renfrey (1992) has brought these questions of cultural diversity more into focus. All explicitly recognize that cultural heterogeneity is a fact that must be addressed in assessing and treating Aboriginal peoples. French (1989) and Renfrey (1992) identify three basic groups of Aboriginal peoples: (a) traditional, (b) middle class, and (c) marginal. The "traditional" Indians are those whose "psychological perspective . . . comes closest to representing the Aboriginal tradition" (French, 1989, p. 159). These are the least acculturated of the American Indians. The "middle-class" Indians are those who have effectively acculturated to the non-Indian, American culture; that is, they "subscribe to the norms of the majority society and [are] openly rewarded for this loyalty" (French 1989, p. 160). Finally, "marginal" Indians "are those American Indians torn between their traditional cultural heritage and the dictates of the larger majority society." The principle behind such designations — that there are different types of adaptation to colonialism — is sound. However, these authors mix concepts of culture and class and ignore the existence of "upper class" and "working class" Indians, culturally rooted middle-class Indians, or Indians who are functionally bicultural. French further states that "any viable transcultural

counseling model must have as its primary focus . . . the facilitation of a positive 'self-image' — one rooted in their cultural tradition" (French 1989, p. 161). According to French (1981, pp. 145–146), therapeutic interventions must critically assess the client's cultural and class biases before they can be effective:

> Attempting to make an Indian learn white ways at the expense of his "Indianism" leads to increased turmoil which is often internalized and concealed through alcohol, tension and the like. . . . [F]or most Native Americans, the end result is massive self-aggression [alcoholism, mental and physical health problems and suicide] or other-aggression [assault and homicide]. There is little doubt that the most well-adjusted Native Americans are those who are proud of being Indians. . . . Clearly, any viable Native American therapeutic model must encourage Indian clients to become more responsible, with "responsibility" defined in culturally-relevant terms. Native American behavioral patterns, like those of most groups, seem to be dictated by certain cultural factors. In order to ascertain the nature of an Indian behavioral problem, the therapist must first understand the cultural circumstance surrounding the client's marginality.

Trimble and Fleming (1989) specifically discussed the issue of the extent of acculturation and treatment success. They note the existence of "successfully acculturated," "marginally acculturated" and "moderately traditional" American Indian clients. They argue:

> Although no empirical evidence supports the contention, there is a strong likelihood that Indians raised in a very traditional, native-oriented manner, especially in reservation communities, pueblos, or villages, are not familiar with the conventional counseling process. Consequently, they are not likely to make "good" clients, largely because they are not accustomed to talking out their problems with strangers or, most certainly, non-Indian counselors. Furthermore, the traditional, native-oriented Indian is more likely to receive assistance from kin, friends, and traditional healers or shamans. In contrast, highly acculturated Indians, particularly those raised in urban settings, are more likely to respond to counseling. . . . [It] would appear that the acculturation of the client is a potent contributor to a client's receptivity to counseling in a conventional sense. (1989, pp. 195–196)

It is our contention that a hybrid of the ideas of French (1989) and Trimble and Fleming (1989) on the counseling of individual Aboriginal people can be extended to provide a framework for analyzing group therapy experiences for Aboriginal peoples and American Indians, a framework that incorporates cultural, racial, and class variables in the analyses. Based on the previous assumptions, there are a number of logical prerequisites for group therapy to work. First, the therapists must understand the cultural and life circumstances of the Aboriginal clients; this may well mean that some of the therapists should be Aboriginal peoples themselves. Second, there must be some degree of social and cultural homogeneity within the

group. Third, the values that underpin the group therapy exercise must be relevant to the clients.

But what of circumstances in which the treatment model is inherently based on Euro-Canadian/American norms, the group membership includes non-Aboriginal as well as Aboriginal peoples (including those with little or no knowledge of their heritage or culture), and the therapists have little practical knowledge of the life circumstances of the Aboriginal clients? These situations are frequently formed among treatment programs for Aboriginal peoples in a variety of settings. Can the therapist make the experience applicable to the various cultural and class backgrounds of such a diverse group? These questions are not answered when we examine the literature that supports group therapy among American Indians, primarily because it does not address these more complex group therapy situations.

The next section of this article will detail just such a complex, heterogeneous group therapy situation, in which the issues of history, culture, and class arise.

The Setting

Research was undertaken in 1991 and 1992 at the Regional Psychiatric Centre (RPC) in Saskatoon, Saskatchewan. The RPC is a federally operated, fully accredited forensic psychiatric hospital dedicated to the assessment and treatment of federal offenders (those serving sentences of 2 years or more). It is one of three such regional facilities in Canada. The RPC offers a variety of treatment programs for offenders suffering from psychiatric illnesses, substance abuse problems, personality disorders, and sexual deviancy. The treatment staff generally consists of social workers, addictions counselors, registered nurses and registered psychiatric nurses, occupational and recreational therapists, psychiatrists, and psychologists. Offenders are admitted to the RPC for treatment or assessment and are usually returned to the referring institution on completion of the intervention. Treatment programs vary in length depending upon the program in question and the seriousness of the presenting problems. The average length of stay is about 7 months, but in some instances offenders stay for treatment for a protracted period or they might return for subsequent treatment later in their sentences. Offenders are referred to as "patients" while they reside at the RPC.

The observations reported here were made over a 5-week period on the unit dedicated to the treatment of personality-disordered male offenders, based on the therapeutic community (TC) concept. Most of the participants of the TC had lengthy criminal records, often involving violent offenses such as armed robbery, assault, and homicide. They did not suffer from mental illnesses (e.g., a psychotic or affective illness). No psychotropic medication was used. Some were

serving life sentences that required the offender to serve a minimum of 10 to 25 years before eligibility for parole. Others were serving shorter terms and could be released within a relatively short time. Indeed, for many offenders, treatment at the RPC is considered an essential step toward being granted parole.

The most common diagnosis among this group of offenders is antisocial personality disorder (APD), according to the criteria of the *Diagnostic and Statistical Manual,* Third Edition-Revised, of the American Psychiatric Association (1987). The disorder, applied only to those over 18 years old, is characterized by a pattern of irresponsible and antisocial behavior since the age of 15. There must also be persistent evidence of conduct disorder before the age of 15 (for example, running away from home or fighting). Many of those diagnosed as APD present management problems while incarcerated, typically display antiauthority attitudes, and often present problems in aggression and emotional instability.

The TC concept was developed by Jones (1963, 1982) who stressed that one approach to rehabilitate inmates is to provide them with an environment in which they can learn to take responsibility for their behaviors. To this end, positive peer group influences are mobilized, in addition to therapeutic inputs from staff, to bring about behavioral changes (see also Vorrath & Brentro, 1985). The central method of intervention in the TC program is the daily group meeting, which is mandatory for all patients and includes most available staff. This "large group." which usually lasts for about 2 hours, functions as a major forum for therapy. Personal and other day-to-day living problems that the offender has been experiencing are encouraged to be brought up for discussion. The rationale behind this approach is that the offenders will likely experience similar problems in the community. It is believed that open and honest communication and interactions in the group will foster a level of trust among patients and between patients and staff. Ways to resolve problems are actively solicited from the patient's peers rather than being imposed on the patient unilaterally by staff. Subsequent groups are used to monitor the willingness of the offender to incorporate problem-solving techniques into his behavioral repertoire and his progress toward problem resolution. Open and constructive confrontations among members of the group are strongly encouraged. Peer group influences are actively utilized to obtain compliance from offenders, because some offenders are much more receptive to suggestions and constructive confrontations from fellow offenders than from staff. Democratic decision making is strongly encouraged to engage offenders in practicing conflict resolution skills. The offender's disruptive behaviors are openly confronted by both staff and patients. Staff take on the role of facilitators in the group and serve as models of prosocial behaviors.

A contract is drawn up at the beginning of treatment through the collaborative effort of the staff and each patient. It consists of a set of

objectives that the patient intends to address during treatment. For example, one objective in a treatment contract may read, "I will not threaten others in order to get what I want." Once weekly, in the presence of the whole group, a "ward rounds" is undertaken, in which the staff review the progress of two or three patients based on their treatment contracts.

Noncompliant and unmotivated patients may then be challenged during the large group and during ward rounds. Over time, a group culture develops that serves as a positive socializing influence on inmates.

The program also offers other "small" groups that are optional and focus on specific problems, for example, stress management, substance abuse, and assertiveness training. Offenders are also provided with brief, goal-directed, individual counseling to deal with issues that cannot be handled within the large group. Alcohol and substance abuse programs, such as AA, are available. Some Aboriginal offenders also have recourse to an elder and more traditional treatment approaches, including the use of sweat lodges (see Waldram, 1993). The overall treatment goals emphasize the need for the patient to (a) behave responsibly toward himself and others, (b) increase his level of prosocial interactions with staff and other group members, and (c) behave assertively rather than aggressively or passively (see Ogloff, Wong, & Greenwood, 1990, for a more comprehensive discussion of the program).

The research reported here was part of a larger project to assess the effects of culture on treatment for Aboriginal offenders. One author, Waldram, a medical anthropologist with extensive Aboriginal research and community experience, was afforded the opportunity to interview patients and observe group therapy sessions as part of the research. The other author, Wong, is the psychologist for the 24-bed TC unit and therefore is actively involved in the treatment of Aboriginal and non-Aboriginal patients alike. The observer's presence in the group was explained to the patients, who consented to his presence. At no time did the observer offer comments during the group sessions, although he was offered a seat within the circle (a tacit indication by patients that he was welcome to speak).

Over the period of the research, of the 24 patients in this unit, the number of Aboriginal patients fluctuated between 7 and 9. None of the treatment staff were of Aboriginal ancestry, and most were female. On any given day, four or five staff members would attend the large group, including primarily the psychiatric nurses and social workers (and occasionally a psychiatrist and/or psychologist).

In addition to directly observing the large group, the observer interviewed Aboriginal patients extensively about their group therapy experiences. These interviews were conducted in multiple parts, and most were tape recorded. Ranging from 1 to 3 hours, the first interview with a patient followed a semistructured format and usually dealt with his cultural and family background and prison experiences. The patient's

general views of the group therapy process as it operated were also sought. Subsequently, as each individual was active in the group, follow-up interviews were conducted to obtain the patient's views of these specific events. As a result, observations on the specific group therapy behavior of various patients could be made and compared with their general comments made in the interviews regarding group therapy. This exposure to the group therapy setting, combined with the interviews, provided an orientation to the cultural nature of the treatment approach utilized and the reactions of the Aboriginal patients to it.

In this article, reference is made to the individual's cultural orientation. The specific details of the three broad orientations employed, "traditional." "bicultural" and "acculturated," are discussed at relevant points in the text. These designations were developed as part of the broader research project, utilizing data from the semistructured interviews as a guide.

Patient Experiences

In each session observed, the individual "taking group" loosely followed a theme that was determined in consultation with unit staff. The individual taking group was expected to talk at length but would occasionally be interrupted for questions or comments from staff or other patients. At a certain point in the sessions, the patient would be expected to respond to questions or "feedback" from the others. Hence, the ability to articulate well in English is crucial to a successful large group experience. Furthermore, individuals demonstrating "shy" personalities, that is, those who find it difficult talking about themselves or offering feedback, are at a disadvantage. The quiet, introverted person may be viewed, alternatively, as being unwilling to "open up" as others have done or as hiding behind their shyness to avoid participating. Assertiveness training is an important component of the treatment program.

It is evident that most patients, Aboriginal and other, find the initial large group experience to be difficult. Most inmates in prison are influenced by the "con code," part of the inmate subculture that breeds suspicion and a passively unco-operative attitude toward prison authorities. There is a strong sense of individualism, and inmates often talk of doing "my own time," which by inference means keeping to oneself and not being concerned with other inmates. But with group therapy, one is expected to expose one's past, and those who appear to be "sloughing off" are routinely chastised by other patients. Although patients are taught that personal details that are exposed in group are not to be communicated beyond that setting, patients are acutely aware that they will likely encounter other patients after transfer back to their parent institutions and that there are no guarantees that details of their offenses and personal lives will not be spread. Furthermore, these details may well form part of

their official case management record, which travels with them from institution to institution and is used in various progress reports (including parole assessment). Over time, many adjust to the ritual of large group, learning what types of comments solicit positive feedback, how to avoid negative feedback, and how to offer feedback to other patients that is or appears to be insightful to the treatment staff. Patients are aware that they are always being scrutinized by staff, and their own performance is occasionally raised for discussion in the large group.

Many of the personality characteristics normally associated with traditional Aboriginal peoples are in conflict with the assertiveness that is central to the large group experience.[2] In many Aboriginal cultures it is inappropriate to talk directly about oneself or to criticize others. It is also a sign of disrespect to make sustained eye contact during formal discourse. And many Aboriginal peoples come from small communities where ties of kinship interconnect most residents and where there are few strangers. Hence, those patients who are traditional are triply disadvantaged in the large group experience: they may have a relatively poor grasp of the English language, they may be forced to challenge not just their past behavior but also the cultural basis of that behavior, and they may be less experienced at communicating with large groups of non-kin or strangers, many of whom are "white." Although all Aboriginal patients admitted to the program have learned to some extent the dominant Euro-Canadian cultural context of the correctional system (itself a unique subculture), some of them still find the treatment approach radically different from anything they have known before.

One traditional northern Cree patient discussed the language problems he encountered:

> I don't know, I just sometimes get frustrated. Like I can't really express myself. I would rather talk Cree to these people, but they can't understand. I can't explain, I can't express myself in English like I do in Cree, and sometimes in large groups when they ask me questions, I don't really know what to say in English.

Another traditional patient, an Inuk, was barely able to communicate in English. Indeed, during the two interviews held with this person, it was difficult to communicate even basic questions and answers. Although he represents the extreme in linguistic difficulties likely to be encountered in the program, his situation deserves further elaboration. Despite staff efforts at providing English tutors and translators, this individual remained largely unclear as to what the treatment process was about. It was unlikely that he would improve as a result of treatment:

> No, I get frustrated when I don't understand it so I just sit there, dream, dream that I was out there [out of prison]. . . . I don't nothing. I don't know what they are saying. But I am getting a little bit to know more. No, mostly in group I spit out a few words but I wish I could talk more. But I

> can't do it. Like I go I might say wrong words and I feel that I don't want to get them confused as to what I am saying or get in their way.

It was his decision not to demand translation services, since to do so would, in his eyes, be a bother to the center staff.

The need to discuss one's life and to offer feedback to other participants in the group engenders rather stressful reactions in all participants in the group, in particular Aboriginal offenders who are unfamiliar with the behaviors that underlie the process of group therapy. One traditional northern Cree patient stated:

> First few feedbacks I took they asked me, they asked me what I could think, and one time I just wanted to give feedback on my own without anybody saying, asking me what I think or feel. And after I gave that feedback, then my heart was going fast, it was beating fast, I was nervous, my face went red and I got real nervous. I was nervous for about five minutes and after that it was alright. The second time I gave feedback I was still kind of, I still feel the nervousness. I could feel it, but I wasn't that nervous anymore, and it felt good to be able to talk.

Stated a traditional northern Ojibwa:

> I'm scared [in group]. I don't know, like I know I speak kind of low [normally] but when I go into a large group, everything slows down. I get scared I might say something wrong, that I will offend them. I'm scared.

For some traditional patients, simply talking to large groups of people was difficult:

> So eighteen years, I think I lived half of that in the bush. So there was nobody there, and I got used to that. Now I'm going the other way. I'm trying to get used to people. I used to go to Brotherhood, too, Native Awareness. But I couldn't go to those places because I couldn't get used to being around people, lots of people. So I didn't really mind about three or four guys, eh, but more than that, that was kind of hard for me [northern Cree].
>
> Even in the Pen [penitentiary] I had a hard time with all the interaction, from the different kind of people, that I sometimes have a hard time with. Well here [at RPC] I had a hard time with that, interacting with so many people [northern Cree].
>
> It really hurts for me. I've never been in a group, you know, many guys to talk to. . . . I get nervous, sweat, I can hardly speak [northern Cree].

Finally, it should be noted that some traditional offenders strongly believed that neither the non-Aboriginal staff nor other patients understood or cared to understand the rural/remote/reserve context that shaped their lives:

> Like I said that one time that I sensed that I'm not too comfortable talking about my childhood because I can sense that a lot of people don't understand how it is living on a reserve, and that's what I said in the group one time. Like the way I was brought up, what I seen, the changes in the reserve and all those things that I've seen when I was a kid. A lot of these guys grew up in cities and they don't understand [northern Cree].

That there were cultural differences between Aboriginal patients raised in the reserve context (likely more traditional) and those raised in the city (likely more acculturated) did not escape some patients. Offered one traditional northern Cree patient:

> I know that they are part of the Native, they are Natives. But I see that they missed something in life. When I know people that grew up in cities or down south, down here, they miss a lot of that, that they weren't taught these things [life in the bush culture] and I sort of feel sorry that they are Natives but they are nothing else. . . .

Bicultural Aboriginal offenders are able to function fairly well in both Aboriginal and Euro-Canadian cultures. Typically, they have been raised in Aboriginal communities and speak an Aboriginal language, but they have extensive experience in non-Aboriginal environments, perhaps because of residential schooling experiences or growing up in proximity to non-Aboriginal communities. These individuals also experienced many problems similar to those of the traditional Aboriginal men, including language problems and difficulty speaking in large groups, although in general these were less significant. In contrast to traditional Aboriginal men, bicultural offenders tended to be more critical of the group therapy process, often perceiving racism and discrimination directed toward the Aboriginal offenders by both the staff and other patients. One such patient stated:

> From my experience, you know they [staff] focus more on the white people in my unit anyways. They aren't so hard on them in disclosure groups and stuff like that. . . . They don't ask them [Aboriginal patients] the same questions as they ask white people and stuff, you know. And after the disclosure groups they give them a hug[3] and a pat on the back and everything you know. And that never happened to me [Chipewyan].

And another bicultural patient commented:

> Well, when I first come up here. . . . maybe this is where I am racist. . . . there is this one guy, Caucasian, who was taking group, and nobody said anything to him. And then this Indian guy took group and everybody was on him. Everybody was on him and I got choked at that, eh. All I seen was all these white people on this Indian guy and that got me choked. And I talked to this other Indian guy after and I told him how I saw things and he told me that I have to overcome that, eh. But that's what I saw. . . . and that kind of turned me off. Now when white guys talk, I

> won't say anything. I won't give them any feedback or anything. But if a Native guy is talking, I will help them out [Saulteaux].

Observations of this patient indicated that he did, indeed, participate only when an Aboriginal patient was taking group.

It is quite likely that these perceptions of racism are linked strongly to both previous prison experiences and life "on the street," as one bicultural offender explained:

> Some of these guys here [taking group] and myself, eh, get uncomfortable here because they're [staff] white. They're white and it is not that I am a racist guy, eh, it is nothing like that. But when I was growing up, I came to believe that I could never trust a white man [northern Cree].

Similar to many traditional offenders, the bicultural offenders sometimes felt that their Aboriginal experiences, including living on the reserve, were misunderstood or even ridiculed by staff and other patients. One Chipewyan patient, arguing that the staff did not understand "where I am coming from," noted that "they haven't experienced the lifestyle that I have experienced, and to me sometimes I think they don't understand a thing about the violence that is associated with a lot of reserves in our country." While it is true that the staff have not experienced the lifestyle of any incarcerated offender they treat, this individual is clearly making reference to the Indian reserve lifestyle. Another commented on the problems that some Aboriginal patients experience when discussing such issues as gas sniffing, a major health issue on some reserves. Abusers are often held up to ridicule by non-Aboriginal patients with more glamorous substance abuse problems, such as cocaine addiction. As one patient stated,

> Some reserves are, you know, pretty well known for sniffing or drinking [L]ysol and some reserves are very bad for assaults. And a lot of these staff members don't realize that, eh, and in a lot of these [groups] they don't understand it either. And at first there was one Native guy, he was taking groups and he was talking about his offenses, and assault, eh, and these guys, they were kind of putting him down, in a sense. "Why would you do something like that." eh? And after the group the guy was all freaked out, eh.

After this incident, the subject in question opened his next group with a discussion of the reserve and put his criminal activity into focus. As a result, according to the patient's memory, the staff and other patients were much more understanding. It is not that the patient was trying to minimize his own criminal behavior by blaming it on the violence in his community. Most offenders, Aboriginal offenders included, have come from disruptive and often violent environments. Some Aboriginal patients perceived that the staff and other patients were simply unable to understand the extent of social pathology and prevalence of crimes in some Aboriginal communities. It becomes relatively easy for some patients to

feel that they are not understood and never will be understood by non-Aboriginal offenders or staff. This in turn affects the performance of Aboriginal offenders in group therapy.

Acculturated Aboriginal offenders are those whose cultural orientations are most similar to the Euro-Canadian, non-Aboriginal patients. Many of these individuals were raised in Euro-Canadian foster or adoptive homes, usually in urban areas. Typically, they lack knowledge of their heritage, language, and culture (although some begin to learn about their culture while in prison). We would not suggest that their cultural orientations are identical to those of Euro-Canadians, however, since issues of race and Aboriginality are nevertheless part of such a cultural formulation. However, in general, there was a significant lack of culture-specific problems associated with the large group experience for these individuals. It is quite likely that these individuals share essentially the same group experiences as non-Aboriginal offenders. There is one exception to this, however. Since most of these offenders identify themselves as Native or Aboriginal in one way or another, they share with their bicultural counterparts some perceptions of racism within Canadian society as a whole as well as within the forensic treatment program.

Observations of Group Therapy Sessions

In an effort to substantiate some of the observations made by respondents, as well as to learn more about the programming they were experiencing, one of the authors, Waldram, attended most of the daily large group therapy sessions for 5 weeks in 1991. The other author, Wong, routinely attends these sessions as part of the therapeutic team.

Patients voluntarily offer to take group, although in practice there appears to be a variety of pressures that are brought to bear on certain individuals, both by staff and by other patients, to take group when it is felt that there is a need for them to do so. Similarly, the topic for discussion is usually decided by the patient, though often in consultation with the staff. The first group that any patient takes after arrival to the unit normally involves a description and an analysis of his criminal activities and, in particular, his current offense.

The atmosphere within the group is at times very controlled and supportive and at other times confrontational and somewhat volatile. Both the other patients and the staff participate in questioning the patient and offering him feedback. Whereas the feedback offered by the staff is usually couched in professional language, the other patients tend to be more direct in their use of language. Self-disclosure in group entails talking about one's feelings, thoughts, weaknesses, and vulnerabilities, among other things. There is no doubt that self-disclosure is quite threatening to most people, and in particular to many offenders who have had very little experience with this type of exercise. It is not surprising, then, that many

patients are apprehensive of the idea of taking group; it is a time of great tension for most. Many recounted how they spent numerous prior nights awake, worrying about it. During the course of this research, one non-Aboriginal patient attempted suicide minutes before he was to take group, but such a reaction is extremely rare.

In a typical group session, the patient taking group is effectively in charge. He begins when he is ready, concludes when he finishes what he has to say, then opens up for questions and feedback. Although there is normally a 1 1/2-hour time limit, in some cases this may be exceeded, or the patient may call the session to an early close. Throughout the session, the patient taking group is the subject of intense attention and commentary. The others listen, question, offer support, or criticize. Very clearly, the ability to articulate and verbally defend oneself is essential to achieving an acceptable outcome as defined by the patients.

The large group experience, like other aspects of forensic programming, is laden with Euro-Canadian cultural meaning. In many ways, the groups demonstrate a certain tension between the professional "helping" culture of the staff, complete with its own concepts of deviancy and therapy, and the culture of the patients, including the con code and other subcultural behaviors that develop within the prison system. The patients' discourse tends to be earthy, with the occasional use of profanity, and seems to fall in line with the adage "You can't con a con." But overall, for both staff and patients, the rules of group therapy are based on the conceptualization of criminal behavior with Euro-Canadian cultural rules as the background. The problems experienced by some Aboriginal offenders in this setting are due, in part, to their differing cultural backgrounds. A few examples will illustrate.

The first is a traditional Aboriginal offender. This Ojibwa man from a relatively remote area indicated that his topic was "communicating." He spoke very softly, so softly in fact that he was barely audible. While he seemed to want to discuss his inability to communicate with people and to be assertive in interpersonal contexts, the staff tended to concentrate mostly on his soft-spokenness (admittedly a component of "communication"). On numerous occasions he was asked to speak up, and some staff even chastised him for this. He was told that he had important things to say but that he could not be heard.

At one point, he was asked if he could communicate better in his own language. Although he responded in the affirmative, there was no subsequent mention by staff of his Aboriginal status and linguistic duality. There was no exploration of the possibility that his quietness was a product of his Ojibwa culture and upbringing. The staff once again challenged him to speak up. Subsequent discussion with him indicated that these challenges were extremely disconcerting, as he did not see his quietness per se to be a problem. He felt that he was not permitted to talk about his communication problems as he understood them.

During this session, there was fairly active participation by some of the other Aboriginal patients in the group, offering mostly supportive comments. This was in sharp contrast to their relative quietness when a Euro-Canadian patient was taking group.

While others, including Aboriginal patients, also spoke very quietly from time to time, this was the only case witnessed in which the auditory level was made an issue by the staff. Ironically, from the researcher's vantage point in the group circle, there was one staff member whose voice was every bit as quiet and inaudible as that of the patient. No mention was made of this by anyone. Only a few days later, a Euro-Canadian taking group also spoke softly but was asked to speak up only a couple of times. Unlike the Aboriginal patient referred to previously, this Euro-Canadian patient's quiet demeanor was not made the central focus of the session, despite the fact that his voice was equally inaudible.

A second traditional patient, a Slavey from the far north, was discussed during ward rounds. He was challenged by the staff for doing little to fulfill the terms of his treatment contract. He replied rather bluntly that he did not trust the staff. He related that he had once confessed to a priest who turned over the confession to a local newspaper. As a result, he had problems trusting the "white" staff and believing that "opening up" would not bring him harm.

This patient was then challenged for frequently wearing a baseball cap during the group, although on this particular day he was not. The rules for group prohibit the wearing of hats, although the rule is not uniformly enforced. When asked why he always wore the hat, the patient replied simply that he just liked to wear it. He was then confronted by one staff member who suggested that he wore the hat because he was "hiding behind it." Although not explained further, the implication was that the hat was a tool that he used to assist in his nonparticipation and uncooperative behavior regarding his treatment program. He replied once again that he wore it only because he liked to. For the rest of the observed time period, this patient never wore his cap again in group, although he was always observed wearing it in other situations. Throughout this exchange regarding the cap, the patient spoke in a quiet voice and rarely looked up from the floor.

In a subsequent interview with the patient, the cap incident was raised. The patient stated that, in his remote northern Indian community, virtually every adult male wore a cap and that he had worn one his entire adult life. He stated that he did not like to make eye contact with people but that the hat was not an eye shield; indeed, he continued to stare at the floor when he spoke without the hat. For him, the hat was an integral part of his apparel, and he felt more comfortable with it on.

These two cases illustrate a number of points. The quiet, shy demeanor that is often characteristic of traditional Aboriginal people in unfamiliar situations is the product of both their cultural upbringing and

their relative lack of experience in a Euro-Canadian cultural milieu. The lack of eye contact in many Aboriginal cultures is considered a sign of respect. Speaking in a passive or a nonassertive, quiet voice is also typical, and loud, assertive behavior is considered rude. The wearing of baseball caps has become a common trait in northern communities.[4] Although there is considerable intracultural variability, all of these examples represent cultural behaviors that are very typical. These behaviors were, however, interpreted by the staff as signs of evasiveness or uncooperativeness or simply regarded as problematic. In challenging these behaviors, the staff were inadvertently challenging the Ojibwa and Slavey cultures. Unlike the Euro-Canadian patients, these Aboriginal patients were being challenged to surmount not only their own personality traits but also those traits imbued in them as cultural beings.

Bicultural patients tended to be considerably more assertive in group, maintaining strong eye contact and articulating well in English. Unlike the traditional patients, these patients expressed an acute understanding of the plight of Aboriginal peoples and often placed their own predicament within a historic context of what had happened to their "people."

One bicultural Plains Cree patient took group on the topic of self-esteem. For him, the question of self-esteem revolved around his experiences as an Indian and the problems he encountered when he began to attend a predominantly "white" high school in a nearby city. Seeing the occasional drunken Indian on the streets of the city made him feel ashamed of his culture. He explained that he lost pride in his people, and the racism he experienced in the city as he attended school resulted in numerous acts of violence and left him feeling bitter about "white" society.

This patient articulated well and spoke at an adequate volume. He was able to maintain eye contact easily throughout.

The patient received very little feedback at first. Eventually, another bicultural patient, a Saulteaux, raised the question of racism and the role of government in oppressing the Aboriginal peoples. In general, the Euro-Canadian patients remained fairly quiet until a staff member directed the conversation to the subject of drug abuse and the nature of the criminal activity involved.

Interestingly, both a Euro-Canadian patient and a Euro-Canadian staff member tried to equate the patient's experiences with racism to their own. The Euro-Canadian patient, of Eastern European descent, suggested that he, too, had experienced racism at the hands of other "white" kids in his neighborhood, including racial taunts and namecalling, and indicated that the Aboriginal patient seemed to want to blame all his problems on the "white man." which was denied. The staff member suggested that the patient's problems in the city high school were really no different from those she and other rural peoples experienced in Saskatchewan when transported to urban schools. Although the patient responded by

emphasizing that his situation was different because he was a member of a minority, this issue was not pursued by staff.

At a later ward round when this patient was addressed, he suggested that he had not received much feedback from the time he took group and also noted that he was still a little uncomfortable speaking in group. A Euro-Canadian patient confronted him, stating that it was "bullshit" when some patients said they were uncomfortable when talking in group, and that he was just hiding behind this excuse to avoid participating. No one challenged this interpretation.

At another ward round, a different bicultural patient was discussed. Mention was made that this Saulteaux man appeared to be dozing in group and that he tended to talk quietly into his hand. He replied, "I don't listen with my eyes. I listen with my ears," which evoked some laughter. He was informed by staff that it was impolite to listen with his eyes closed, and he agreed to try to keep them open.

This individual's overall participation in group was relatively minimal. He spoke quietly and often looked downward as he did. He tended to speak more when another Aboriginal patient was the subject. The interview with him and other observations indicated he was not really a shy individual, and thus his behavior in group seemed to be somewhat unique and situation-specific. He had a deep mistrust and resentment of Euro-Canadian peoples.

These two bicultural patients, on various occasions, expressed the viewpoint that historical processes and contemporary problems such as racism were important factors in understanding their own criminality. This attitude seemed somewhat contrary to one objective of the staff, which was to make the patients take personal responsibility for their actions. Indeed, the staff obviously have no control over the sociohistoric factors that have led to Aboriginal oppression in Canada. However, in our view, these are not incompatible. The demonstration of an understanding by staff of the historic issues pertinent to Aboriginal peoples would likely facilitate a positive working alliance between staff and patients; ignoring these issues may have the opposite effect. Indeed, these patients were expressing their own identity and difficulties in cultural and historic terms, but they received little feedback as such and generally found the staff uninterested in pursuing these avenues of inquiry. This only further worked to convince some patients that staff did not care about their backgrounds. The lack of empathy expressed on the question of racism was particularly noteworthy. At some point in the treatment process, but not necessarily in the large group, these issues needed to be addressed.

While these bicultural patients have had considerably more exposure to Anglo-Canadian culture, there was still more evidence of discomfort regarding speaking in large group.

The acculturated patients who took group during the period of research were largely indistinguishable from the Euro-Canadians. Issues

regarding their Aboriginal heritages were not raised, and they appeared to be able to handle the pressures of group therapy fairly well, at least as well as the Euro-Canadian patients. As noted earlier, these Aboriginal offenders appear as distinctly different from the others; they may have problems in the large group, but these are not differentiated from those of the non-Aboriginal offenders for the most part. However, the acculturated offenders did express some problems in self-identity related to their Aboriginal heritage but lack of knowledge of Aboriginal language and culture. They also suggested that experiences with racism were important in shaping their lives both on the street and in prison. But these topics were not generally raised in group therapy. We would suggest that, of all the Aboriginal offenders, they were the most able to adopt the rules of behavior expected of the patients in the group.

Conclusion

Group therapy is an unnerving experience for most Aboriginal offenders, as it is for their Euro-Canadian counterparts. However, many Aboriginal offenders do appear to be at a greater disadvantage. Topics of relevance to them, such as racism and the reserve context, appear to be minimized in treatment. Indeed, it may be difficult for non-Aboriginal staff and patients to truly understand the legacy of colonialism as it has affected and continues to affect Aboriginal peoples. Traditional and bicultural offenders may have difficulties expressing themselves in English, and traditional offenders in particular may exhibit culture-specific behaviors that are counterproductive to performance in the large group setting.

Success, as defined by the patients[5] in the large group is determined in part by the degree to which they accept the norms of the group, at least superficially. These norms are inherently based on Euro-Canadian, middle-class culture. Patients are expected to speak directly, openly, and honestly, to offer feedback to others, and to present themselves as interested, active participants. Maintaining eye contact and an audible voice level are inherent elements of this. In effect, for all patients, success is predicated on their ability and/or desire to comply with the objectives of the group. While the traditional patients seem to have great difficulty doing this for cultural reasons (and they do appear to try), the bicultural patients may be more resentful of the Euro-Canadian domination of the group and seem to select not to cooperate any more than is necessary. These individuals encounter much more hostility from other, non-Aboriginal patients and staff and are not afraid to return the sentiment.

To understand the utility of group therapy, it is essential to separate the process of the group from the content or lessons to be communicated. For the traditional Aboriginal offenders, and many of the bicultural offenders as well, the confrontational nature of the large group is culturally inappropriate, and renders them at a distinct disadvantage. Though

we cannot provide many details here (see Waldram, 1993), it is interesting to note that all-Aboriginal groups such as the Native Brotherhood meetings, sweat lodge, and sweetgrass ceremonies often involve confession and taking responsibility for one's actions but without direct confrontation of any kind. In terms of content, then, some elements, such as taking responsibility, seem appropriate for all offenders, but others, such as assertiveness training, are not appropriate for the traditional people. It is essential at the outset of the treatment program to identify the cultural orientation and the degree of acculturation of the patient. The staff should also determine whether, upon completion of the sentence, the patient intends to return to a small Aboriginal community, a large urban center, or other types of community living. It makes little sense to adopt a therapeutic approach that, if successful (i.e., the patient adopts a new attitude and changes his behavior to be more law-abiding), actually renders the patient a cultural misfit in his home community. Such a problem is particularly acute for the traditional patients.

The type of group therapy described in this paper adds a new dimension to our understanding of this mode of treatment. The participation of Aboriginal offenders is conditioned by their own cultural orientations, the cultural makeup of the group, the cultural underpinnings of the group therapy model, and the unique setting of the institution. These data support the assertions of French (1981, 1989), Trimble and Fleming (1989), and Renfrey (1992) that culture does matter and must be taken into account when offering group therapy to Aboriginal offenders. Furthermore, the dynamics of Aboriginal history and resistance to colonialism also explain their participation and working relationship with the staff. Although commentators such as Manson et al. (1987) and Neligh (1988) are able to support group therapy as a successful treatment modality, attention must be paid to the contexts in which it is useful. From the perspective of many Aboriginal offenders, the group therapy approach described in this article is little more than a re-creation of the larger Canadian society and history, wherein non-Aboriginal or "white" people have complete control over the Aboriginal peoples and the "white" people overtly state that they know what is best for the Aboriginal peoples and make the rules and assess behavior.[6] The Aboriginal peoples are numerically in the minority among the other offenders, and perceptions of racism condition interaction between "white" and Aboriginal peoples. The fact that the group therapy occurs among an offender population in a prison setting suggests that the offender subculture and prison environment also are important.

This article argues that multicultural settings in which non-Aboriginals are combined with Aboriginal peoples who have differing degrees of orientation to or familiarity with Euro-Canadian culture, and in which the treatment approach and the therapists are Euro-Canadian may be too

complex to allow the Aboriginal participants to experience an outcome as successful as that of non-Aboriginal participants.

To be effective in providing services to Aboriginal offenders, it is imperative to assess the degree of acculturation of the client. Unfortunately, there is no valid and reliable instrument available to assess acculturation. However, a thorough assessment of the client's proficiency in the relevant Aboriginal and English languages, the duration of urban versus reserve residency, the educational and occupational experiences, and the client's comfort level with the intervention would be very useful. The process and the content of intervention, be it group or individual counseling, should be explained clearly to the client, preferably by someone sensitive to their cultural needs.

The personal agenda of the client, especially his future release plan, should direct the intervention. The client who wishes to go back to the reserve and live among other Aboriginal people would have little use for predominantly Euro-Canadian interpersonal skills, for example. On the other hand, if he wishes to leave the reserve and start a new life in the mainstream society, mainstream interpersonal skills would be quite essential to his work and living. Service providers should further explore such personal plans and wishes prior to the intervention. As such, Euro-Canadian based interventions may or may not be appropriate, depending on the Aboriginal person's personal agenda.

Training should be provided to sensitize staff to Aboriginal history and issues. Knowledge and awareness of the prevailing culture and other forces in and around the client's area of residency, which could shape the client's future behaviors, antisocial or otherwise, would also be very useful in preventing future relapses.

Finally, having a forum, separate from the ongoing interventions, for the discussion of racism and Aboriginal history between clients and staff may be useful in bridging the gap of mistrust.

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Notes

1. The term "Aboriginal" is used in this article to collectively identify all peoples recognized in the Canadian constitution as "aboriginal"; this includes the "Indian, Inuit and Metis" peoples. The uppercase is used for Aboriginal in keeping with current Canadian usage.

2. It is important to emphasize to readers who lack detailed knowledge of the Canadian scene that there are still many isolated Aboriginal communities. Some of these lack permanent road access, and many people still speak their Aboriginal languages as their first language (and the elderly may be unilingual). For many, life in the bush or on the tundra defines their cultural and social existence.

3. The patient's comment here should be interpreted figuratively, since staff never actually hug patients.

4. The wearing of baseball-style caps is extensive among northern Aboriginal peoples. It is more a "cultural behavior" than an individual habit because it is so widespread and is considered the norm for adult males. It is rare to see such men in public without their hats.

5. "Success" includes various elements, including receiving positive feedback from the staff and support from the other patients. It also includes a subjective assessment of the degree to which the patient was criticized or made to feel anxious or uncomfortable during the session.

6. It is true that many non-Aboriginal offenders also react negatively to the idea that the treatment staff know what is best for them and have significant control over their lives while at the psychiatric center. However, these feelings are not conditioned by more than 130 years of oppressive, paternalistic policies directed specifically at them through the use of legislative action and military force, as is the case for Aboriginal peoples. This, we would argue, makes the Aboriginal case unique.

MENTAL HEALTH AND AMERICAN INDIAN WOMEN'S MULTIPLE ROLES

Linda Napholz R.N., Ph.D.

Abstract: The author's purpose in conducting this study was to identify the relationship of sex role orientation to indices of psychological well-being among 148 American Indian working women from the Midwest. Analyses revealed that the sex-typed group had significantly higher depression scores, higher role conflict scores, lower self-esteem scores and lower life satisfaction scores when compared with the cross-typed and androgynous groups. The undifferentiated group had significantly lower self-esteem scores when compared with the androgynous group. Further research is needed to understand how different sex role orientations support different roles that American Indian women occupy.

Two of the most salient issues in the United States today are the changing work and family roles of U.S. women and a concern with the promotion of health in the country's population. The ways in which time pressures, role conflicts, and other stressors affect the mental health of employed women have clearly become important national issues (Reifman, Biernat, & Lang, 1991). In 1987 the National Institute of Mental Health identified the mental health effects of women's multiple roles as a priority research area. The need for systematic research of factors related to both positive and negative mental health outcomes of multiple-role women was emphasized (Eichler & Parron, 1987). As greater numbers of women enter the workforce, it has become increasingly important to understand not only what impact the working woman has on U.S. family life but how working, in turn, affects the lives of women. The fact remains that most women are concentrated in relatively few, relatively low-status occupations, especially a minority group such as American Indian women.

It has been asserted that American Indian women are among the least studied groups in U.S. society (Snipp, 1990). The few studies that are available have focused on the stressful life circumstances of this group and the strain that these circumstances put on their capacity to cope (Pearlin & Schooler, 1978; Silver & Wortman, 1980). Compared with

other women, the health and mental health status of American Indian women is generally worse (McGrath, Keita, Strickland, & Russo, 1990). The U.S. Department of Health and Human Services (1988) reported that compared with other American women, the death rate for American Indian women is 6 times higher for alcoholism (10 times higher for ages 25 to 45), 5 times higher for cirrhosis/liver disease, 3 times higher for homicide, 3 times higher for accidental death (for ages 15 to 54), and 3 times higher for motor vehicle accidents. Moreover, suicide is twice as high among both American Indian women and men than among the general American population (May, 1987).

There are other significant stressful life circumstances that occur for American Indian working women. In comparison to Euro-American women, American Indian women are hindered by lower average earnings, by overrepresentation in low-status occupations, and by an average low level of education (Gordon-Bradshaw, 1987; Kopasci & Faulkner, 1988; Lin Fu, 1987). The poverty rate of American Indian women is more than double that of Euro-American women (Wilson, 1987). Therefore, American Indian women are more likely than Euro-American women to suffer from poor or no housing, insufficient food and clothing, and inadequate access to health and mental health services (Gordon-Bradshaw, 1987).

American Indian women are at risk for many factors associated with depression, including poverty, lack of education, and larger numbers of children (McGrath et al., 1990). In addition, the cultural background of American Indian women may vary in cultural role prescriptions that contribute to depression in a variety of ways. Some American Indian tribes have norms of passivity, deference, and courtesy for both sexes that reinforce gender stereotypes for American Indian women. These women may experience particular problems and conflicts in asserting themselves, especially around issues of power (McGrath et al., 1990). Culturally sanctioned subordinate gender roles among certain tribal groups may contribute to depressive symptomatology among those American Indian women.

There is little information about how differences in sex role stereotypes and expectations might influence psychological well-being among different tribes of American Indian women (McGrath et al., 1990). A study by Shore and Stone (1973) identified the pressures on Indian women who lived in a minority group poverty-level community from a Pacific Northwest coastal tribe. It identified a higher prevalence rate of duodenal ulcers related to the pressure these women experienced being part of a matrilineal culture and the stresses of acculturation. The culturally sanctioned sex role for some American Indian women seems to support more interpersonally oriented expressive qualities. Sex role research on Euro-American women and men indicates that masculinity (instrumentality), as measured by the Personal Attributes Questionnaire (PAQ), correlates more strongly than femininity (expressiveness) with higher levels of self-esteem and lower levels of anxiety, depression, and other indices

of emotional distress (Sharpe & Heppner, 1991; Spence, Helmreich, & Stapp, 1974).

A multitude of bicultural, conflicting pressures and expectations exist for urban American Indian working women. With a central focus on the family (Green, 1983; Medicine, 1983), urban American Indian women are more likely to experience bicultural stress if they are committed to a profession (Welch, 1987). Welch (1987) noted that these working women are isolated from the social support and cultural framework of the tribe to help resolve conflicts. In addition to the stress of employment outside the tribal community, more highly educated American Indian women find that adapting to the majority culture provides greater economic and political opportunities but can also be a major source of conflict and stress (LaFromboise, 1988) and can increase their psychological problems (Kemnitzer, 1973).

Increased psychological problems among urban American Indians (in the Portland area) was supported by a 1972–1973 survey conducted by Borunda and Shore (1978). It was hypothesized that urban American Indian enclaves would continue to show an increase in population growth and that certain segments of this population would be in a high morbidity category for specific emotional and physical illnesses and accidents. In addition to lack of support in the tribal context, services of the U.S. Public Health Service are unavailable to an urban population. The American Indian residents in the Portland-area study identified the need for mental health education and for direct services for alcoholism, drug addiction, anxiety, depression, and maladjustment. Shore, Manson, Bloom, Keepers, and Neligh (1987) evaluated 86 adult American Indian patients from three tribal cultures and found that depressed Indian females evidenced a greater change in appetite or weight and psychomotor agitation or retardation. The researchers hypothesized that psychological well-being is influenced by cultural factors specific to American Indians and contemporary pressures of rapid social change.

Contemporary pressures on urban American Indian working women may contribute to role conflict. The idea that traditional, socialized sex roles may result in negative mental health consequences received a great deal of attention in the 1970s during the women's movement. The construct sex role, derived from sex role theory, is defined as "behaviors, expectations, and role sets defined by society as masculine or feminine which are embodied in the behavior of the individual man or woman and culturally regarded as appropriate to males or females" (O'Neil, 1990, p. 203). The women's movement prompted an increased awareness of the unreasonable restrictions placed on women through enactment of the traditional female role. Docility, submissiveness, low self-esteem, and passivity are some of the characteristics that seem to be brought about by the feminine socialization process (Mander & Rush, 1974). "Whether these behaviors reflect internal psychological characteristics or pervasive

gender role expectancies and norms continues to be debated" (McGrath et al., 1990, p. 22). In their review of the literature on feminine development, Baruch and Barnett (1975) also found a high degree of sex role socialization in females to be related negatively to autonomy, self-esteem, and adjustment.

Bem (1974) has identified sex role theory in which some individuals might be androgynous, that is, "both masculine and feminine, both assertive and yielding, both instrumental and expressive — depending upon the situational appropriateness of these various behaviors" (p. 155). Thus, one might suggest that women who are psychologically androgynous would not be as limited in their behavior as women whose behavior is governed by sex roles. A study by Cristall and Dean (1976) supports this conclusion. They found that individuals who are highly self-actualized are also free from strong sex role stereotypes. In contrast, Spence and Helmreich (1978) suggest that sex role behaviors and preferences are often only minimally related to instrumental and expressive trait dimensions. They suggest that many other variables, such as attitudes, values, interests, abilities, and external pressures, may be more of a determining factor in the individual's sex role preferences and behaviors. Androgynous individuals were also found to be higher in self-esteem (Bem, 1977) and higher in role consistency, suggesting better adjustment and achievement of "ego identity" than sex-typed individuals (Heilbrun, 1976). Whiteley (1985) found a positive association between mental health and androgyny. This association was primarily due to "instrumentality," which is a "masculine" trait that reflects a sense of agency or mastery (Whiteley, 1985).

Psychological well-being has also been linked to sex role orientation. Long (1989) noted that high levels of psychological adjustment and low levels of distress have a strong relationship to masculine sex role orientation as measured by the Bem Sex Role Inventory (BSRI). Masculine sex role orientation is associated with instrumental behavior and with values such as competence, rationality, and assertiveness, in contrast with feminine sex role orientation, which is associated with warmth and expressiveness. Long found that among working women, high-masculine women reported significantly lower scores on measures of anxiety and strain, greater problem-focused coping, and higher self-efficacy. Flett, Vredenburg, and Pliner (1985) studied the influence that depression may have on instrumentality (masculinity). Their study, which examined changes in the PAQ and the Beck Depression Inventory (BDI) scores after a period of 3 months, suggested that depressive symptomatology preceded a decrease in instrumentality scores. In summary, in a comprehensive review of the androgyny research, Sharpe and Heppner (1991) concluded that masculinity, as measured by the BSRI and the PAQ, has consistently been shown to positively correlate more strongly than femininity with self-esteem, healthy ego identity, and global measures of psychological adjustment. In a comprehensive review of the androgyny

literature, Cook (1987) found that despite femininity's positive relationship with a range of variables, masculinity is more strongly related to various indices of psychological health. This consistently stronger relationship is one of the most stable results to emerge from androgyny research, holding across a variety of androgyny measures and dependent variables.

In summary, American Indian women, especially those living in an urban area, are in the process of redefining their own cultural identities. Despite erosion of their traditional spiritual base and traditional social and economic roles because of acculturation, American Indian women have maintained their responsibilities to family, tribe, and nation. These demands often place Indian women in a position of having to fulfill multiple and conflicting social roles (LaFromboise, Heyle, & Ozer, 1990). According to Green (1983), traditional psychological well-being is impossible if integration and balance of these roles are not achieved.

The purpose in conducting this study is to describe sex role theory's current applicability to a sample of urban American Indian working women in regards to indices of psychological well-being. Research on the American Indian female experience is needed that takes into account the varied roles and commitments that make up the experience of their lives. It is essential that delineation of differential sex role and status categories for American Indian women be achieved, as bicultural demands often place Indian women in a position of having to fulfill multiple and conflicting social roles (LaFromboise et al., 1990; Medicine, 1988). Additionally, there has been a breakdown of the complementary nature of male-female relations and a general increase in American Indian male dominance and control over American Indian women. According to Green (1983), psychological well-being is impossible if integration and balance of these roles is not achieved. Based on the extremely limited research available on American Indian women's psychological well-being (LaFromboise et al., 1990) and the lack of cultural norms available on the study instruments, the intent of this study is descriptive. Psychological well-being is not a unitary construct, and studies of well-being have focused on varying aspects, such as self-esteem, life satisfaction, or depressive symptomatology, both singly and in combination (Baruch & Barnett, 1986). This study will compare four sex types on indices of psychological well-being: depression, life satisfaction, role conflict, and self-esteem. Based on sex role theory (Bem, Martyna, & Watson, 1976) and adjustment, it is expected that the androgynous and cross-typed groups would have lower depression and role conflict scores and higher levels of life satisfaction and self-esteem than the sex-type and undifferentiated groups.

Method

Sample

This study was conducted in a large, Midwestern, metropolitan county that has a population in excess of 1 million. The convenience sample included American Indian women, ranging in age from 18 to 65. The researcher and an assistant collected data at an urban-based Indian festival from which many urban American Indians from Wisconsin attend. Participants were also drawn from employees of an urban American Indian health center. There are 11 American Indian reservations in Wisconsin: Red Cliff Chippewa, Bad River Chippewa, St. Croix Chippewa, Lac du Flambeau Chippewa, Forest County Potawatomi, Mole Lake Sokaogan, Menominee, Stockbridge-Munsee, Oneida, Lac Courte Oreilles Chippewa, and the Wisconsin Winnebago Communities and Trust Land. Participants could fill out the questionnaire immediately or send it back to the researcher in an addressed stamped envelope.

Participants identified themselves as American Indian (100%, N = 148), with a mean age of 37 (SD = 10.3) (Table 1). Although the majority of participants were single (33.8%, n = 50), 43 (29.1%) lived with husband or lover and children (29.1%, n = 43), whereas most of the participants did not have children (67.6%, n = 100). Most of the participants had 13 to 16 (52%, n = 77) years of education and were employed full-time (75%, n = 111). Participants reported individual and median family income within ranges of $10,000 increments. The median individual income group was in the range of $10,000 to $19,999 (33.8%, n = 50), and the median family income group was in the range of $10,000 to $19,999 (23.0%, n = 34). Most of the participants considered themselves middle class and most indicated "other" as their religious preference (40.5%, n = 60). Their religious preferences included pagan, metaphysical, Earth-centered, traditional Indian, Medicine Lodge, traditional Tubatulable, Big Drum, and traditional Longhouse.

Instruments

The PAQ (Spence & Helmreich, 1978) consists of 24 abstract trait dimensions (i.e., descriptions of dispositional properties that make no reference to overt behavior or to the situations in which these dispositions are manifested). The PAQ is a self-report trait measure containing separate masculinity (M) and femininity (F) scales that measure desirable instrumental and expressive trait dimensions (Spence, 1991). Four subgroups that assess sex role orientation may be distinguished by the use of the male-valued and female-valued scales. These subgroups are undifferentiated, sex-typed (also referred to as feminine); cross sex-typed (also referred to as masculine); and androgynous. Participants were asked to

Table 1
Characteristics of the Sample

Variable Category		*n*	%
Age	Range 18–65	148	100
	Mean 37.5		
	SD 10.3		
Marital Status		148	
	Single	50	33.8
	Married	34	23.0
	Remarried	15	10.1
	Divorced	44	29.7
	Widowed	5	3.4
Living Arrangement		148	
	Alone	25	16.9
	Husband or Lover	26	17.6
	Husband or Lover & Children	43	29.1
	Children Only	27	18.2
	Roommate	17	11.5
	Parents	10	6.8
Children		148	
	Yes	48	32.4
	No	100	67.6
Education (years)		147	
	Less than 12	48	32.4
	13–16	77	52.0
	More than 17	22	14.9
	Missing	1	0.7
Hours Worked		144	
	Part-Time	33	22.3
	Full-Time	111	75.0
	Missing	4	2.7

Table 1 (Continued)
Characteristics of the Sample

Variable Category		*n*	%
Income		147	
	$ 0–9,999	23	15.5
	$ 10,000–19,999	50	33.8
	$ 20,000–29,999	41	27.7
	$ 30,000–39,999	22	14.9
	$ 40,000–49,999	7	4.7
	$ 50,000–99,999	4	2.7
	Missing	1	0.7
Family Income		143	
	$ 0–9,999	7	4.7
	$ 10,000–19,999	34	23.0
	$ 20,000–29,999	24	16.2
	$ 30,000–39,999	31	20.9
	$ 40,000–49,999	19	12.8
	$ 50,000–99,999	27	18.2
	$ 100,000+	1	.7
	Missing	5	3.4
Social Class		148	
	Upper Middle	11	7.4
	Middle Class	77	52.0
	Lower Middle	37	25.0
	Working Class	23	15.5
Religion		144	
	Protestant	29	19.6
	Catholic	51	34.5
	Mormon	1	.7
	Athiest-Agnostic	3	2.0
	Other	60	40.5
	Missing	4	2.7

rate themselves on bipolar items by circling the number on a 5-point scale (0–4) that describes where they fit on the continuum. Total scores are obtained on each scale by adding the scores on the eight items. The range of possible values is 0 to 32 for each scale. Norms of 20 and 21 for the M

scale and 23 for the F scale were established by Spence and Helmreich (1978) from samples of high school and college students. A second set of norms was established using data from 715 college students.

Since the PAQ attributes are socially desirable, one threat to the instrument's validity is the possibility that scores might be distorted by respondents' bias toward selecting socially desirable answers. Spence et al. (1974) explored the index of social desirability using the Marlow-Crowne Social Desirability (SD) scale. The correlations between the SD scale and the PAQ scales ranged between .08 and .36 (Spence et al., 1974). The construct validity of the PAQ M and F scales as measures of instrumentality and expressiveness has been demonstrated (e.g., Bem, 1977; Bem et al., 1976; Spence & Helmreich, 1978). The Cronbach alpha obtained for this study was .74.

The BDI (Beck & Steer, 1987) is a 21-item measure of the presence and degree of depression. Each item assesses an attitude or symptom of depression. Depression is defined as (a) a mood disturbance that is characterized by pervasive feelings and complaints of being depressed, sad, downhearted, and tearful; (b) physiological symptoms that include diurnal variation, disturbances in sleep, decreased appetite, decreased weight, decreased libido, constipation, tachycardia, and unexplainable fatigue; (c) psychomotor disturbances, which are those of either retardation or agitation; (d) psychological disturbances that include confusion, emptiness, hopelessness, indecisiveness, irritability, dissatisfaction, personal devaluation, and suicidal rumination (Beck & Steer, 1987). For a nonclinical population, dysphoria may be a more appropriate qualifier when measuring depression. More than one response can be given per item, but only the highest weighted response is scored. Total scores can range from 0 to 63. Scores between 0 and 9 are considered within the normal range or asymptomatic; scores of 10 to 63 indicate depression, with higher scores signifying greater severity of depression (Beck & Steer, 1987). The utility of employing different cutoff scores must take into consideration the administration sample and purpose. If the purpose is to detect the maximum number of depressed persons, cutoff scores should be lowered to minimize false negatives. Although the number of false positives will increase, this method may be useful when screening for possible cases of depression (Beck & Steer, 1987). For the purposes of this study, the original scoring procedure and cut-off scores for nondepressed were utilized so that comparisons with other research studies would be possible. Beck (1970) reported an internal consistency reliability for the BDI of .86 on the basis of responses of 38 psychiatric patients. The Cronbach alpha obtained for this study was .86. In a review of the instrument, Stehouwer (1985) reported correlations of .66 between the BDI and the Depression Adjective Checklist and .75 between the BDI and the Minnesota Multiphasic Personality Inventory Depression scale.

The Role Conflict Questionnaire for Women (RCQW) was developed by Nevill and Damico (1974). It is a nine-item scale used to delineate

the areas of role conflict for women. Gender role conflict is defined as a psychological state in which gender roles have negative consequences or impact on the individual or on others (O'Neil, 1990). Total scores range from 0 to 63, with higher scores indicating greater role conflict. The items were developed on the basis of 252 problem statements from 30 women. These statements were classified by three independent judges with 87% agreement into nine categories. Riesch (1981) administered the RCQW to two groups of women (N = 79 and N = 50) and found coefficient alphas of .73 and .70. Riesch piloted the instrument on 20 college-educated and married women, and the Cronbach alpha for reliability was .69. The Cronbach alpha obtained for this study was .73.

The Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965) is a 10-item scale designed to measure self-approval or self-acceptance. Respondents indicate their degree of agreement with each item on a 4-point Likert scale, ranging from strongly agree (1) to strongly disagree (4). The instrument was originally designed as a Guttman scale; however, the scale can also be scored with simple additive scoring. The researcher used the latter method in this study. Scores determined on the basis of this method can range from 10 to 40, with higher scores indicating higher degrees of self-esteem. Internal consistency for the scale is indicated by a coefficient of reproducibility of 92% (Rosenberg, 1979). Silber and Tippett (1965) reported test-retest reliability of .88 over a 2-week period for a sample of college students. The scale has been found to correlate significantly (r = .59) with scores on the Coopersmith Self-Esteem Inventory. The Cronbach alpha obtained for this study was .88.

The Satisfaction With Life Scale (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985) is a five-item scale designed to measure global life satisfaction as a cognitive-judgmental process. Total scores can range from 5 (low satisfaction) to 35 (high satisfaction). A 2-month test-retest correlation coefficient was .82, and coefficient alpha was .87, based on the responses of 176 undergraduates. The Cronbach alpha obtained for this study was .89. Scores on the SWLS correlate moderately to highly with other measures of subjective well-being and correlate predictably with specific personality characteristics.

Procedure

The administrators of two organizations, one that employs American Indian women and one that was the head administrator for an American Indian festival, were contacted. The investigator worked with a single contact person from each organization. Authorization to administer the questionnaire at the institution and festival was granted to the investigator. Approval from the University of Wisconsin-Milwaukee Institutional Review Board for the Protection of Human Subjects was obtained prior to individual data collection. The questionnaires were made available to

individuals by the investigator. A large standing poster was utilized at the festival to invite working American Indian women to participate in the study. Participants were informed that they could withdraw at any time without penalty and that their participation in the study was completely voluntary and anonymous. Envelopes and a drop-off box were provided for the participants. Participants requesting to fill out the questionnaire at a later time were provided with stamped, addressed envelopes to return the questionnaire to the investigator.

Results

There were 201 text packets distributed and 148 returned. Therefore, a 73% response rate was realized. In these questionnaires each participant had no more than 5% missing data. Missing data were managed by a mean substitution method. Descriptive statistics for the instruments and their Cronbach coefficient alphas are listed in Table 2.

Table 2
Description of Mean Scores, Standard Deviations, and Alpha Levels of Study Instruments in American Indian Women

Instruments	Mean	Standard Deviation	Cronbach Coefficient Alpha
Role Conflict	32.52	10.82	.8374
Satisfaction With Life	21.66	7.02	.8295
Self-Esteem	31.93	4.31	.8286
Beck Depression	6.59	6.30	.8670
Femininity	23.60	4.18	.7039
Masculinity	20.77	4.38	.6565

A one-way analysis of variance was used to analyze the difference among the four sex types — androgynous, undifferentiated, cross-typed, and sex-typed — on hours worked per week, age, role conflict, satisfaction with life, and self-esteem. Results of the one-way analysis of variance are shown in Table 3. The Fischer's LSD technique was used to identify where the statistically significant differences between groups occurred, using a .05 alpha level.

There was a significant difference between the androgynous- and undifferentiated-typed women on hours worked per week ($p < .05$). Androgynous women worked significantly more hours per week than the undifferentiated and also more hours than the other two sex role–typed women, although the difference was not significant.

Sex-typed women experienced significantly more role conflict than the other sex role types and they had significantly lower life satisfaction

Table 3
Hours Worked, Age, Role Conflict, Satisfaction With Life, Self-Esteem, and Depression for Sex Role Orientation Categories

Variables	Androgynous $n = 63$ × (SD)	Undifferentiated $n = 23$ × (SD)	Cross-typed $n = 25$ × (SD)	Sex-typed $n = 32$ × (SD)	F	p
HRWK	42.44	34.38	39.50	38.71	3.1	.03
	(10.78)	(11.09)	(12.65)	(11.48)		
AGE	37.02	36.71	39.69	36.47	.5	.62
	(9.52)	(12.98)	(9.25)	(9.93)		
ROLE CONF	31.05	30.08	30.46	37.47	3.3	.02
	(10.49)	(11.11)	(10.70)	(11.23)		
SAT W LIFE	22.92	21.21	22.73	18.81	2.8	.04
	(6.81)	(6.32)	(6.31)	(7.72)		
SELF-ESTEEM	33.49	30.42	32.42	29.53	8.3	.00
	(3.94)	(3.76)	(4.56)	(3.84)		

scores than the cross-typed and androgynous women. Sex-typed women also had significantly lower self-esteem scores when compared with the cross-typed and androgynous women. The undifferentiated women experienced significantly lower levels of self-esteem when compared with the androgynous women. A one-way analysis of variance did not produce a significant F ratio with age.

Beck and Steer (1987) classify participants scoring above 9 as in the depressed category. In the total sample, 39 (28%) of the participants scored in the depressed range. The depression scores were dichotomized into a normal nondepressed category (score range 0 to 9, $n = 99$) and a depressed category (score range 10 to 63, $n = 39$). There was a significant difference in the number of participants falling in the depressed range among the four sex role orientations ($\chi^2 = 8.38$, $df = 3$, $p = .038$). Of the sex-typed participants, 48.4% ($n = 15$) fell into the depressed range, as compared with 26.9% ($n = 7$) of the cross-typed, 21.7% ($n = 13$) of the androgynous, and 19% ($n = 4$) of the undifferentiated group.

In summary, the sex-typed group had significantly higher depression scores, higher role conflict scores, lower self-esteem scores, and lower life satisfaction scores when compared with the cross-typed and androgynous groups. The undifferentiated group had significantly lower self-esteem scores when compared with the androgynous group. The androgynous group worked significantly more hours per week than the undifferentiated group. All four sex role orientations had high levels of depression.

Discussion

There were significant relationships between sex role orientation, depression, role conflict, life satisfaction, and self-esteem scores. The congruencies with positively valued traits of one's own sex (sex-typed) appear to have an impact on role conflict, life satisfaction, self-esteem, and depression. Perhaps for American Indian working women who are sex-typed in sex role orientation, there is more conflict leaving the feminine role and adjusting to multiple role demands. Having an androgynous or cross-typed role orientation may facilitate flexibility with multiple roles. Since the androgynous-typed women worked significantly more hours and had lower levels of role conflict and higher levels of life satisfaction and self-esteem, further exploration is indicated of the work variable as well as sex role orientation in regard to its influence on the psychological well-being among American Indian women. The PAQ classifies independence, being active, competing, decision making, self-confidence, and dealing with pressure as being masculine (instrumental) trait dimensions. These attributes may be necessary for today's American Indian working woman to help her buffer the effects of bicultural stress and multiple role demands. These results support previous research conducted on Euro-American women identifying a positive association between mental health measures of self-esteem and lower levels of depression mainly due to the masculinity (instrumentality) variable (Bassoff & Glass, 1982; Sharpe & Heppner, 1991; Spence et al., 1974; Whiteley, 1985). Higher levels of role conflict among sex-typed American Indian women also concurs with Negy and Woods' (1992) findings of increased role conflict among sex-typed Euro-American women.

The sample of urban American Indian women in this study was well educated, with an average of 13 to 16 years of education. Educational attainment has been found to be inversely related to feminine sex role orientation and positively related to assertiveness. The 1986 U.S. Census report indicates that 54% of American Indian women finish high school and only 6% finish college (Taeuber & Baldisera, 1986). The study sample was mainly middle class. This is in contrast to Hurtado (1989), who identified American Indian women as predominantly working class (Hurtado, 1989). Female-dominated single-parent families constitute 23% of American Indian women (Taeuber & Baldisera, 1986), compared with 18.2% in the study sample. The sample in this study appeared more advantaged than the American Indian women in the 1986 U.S. Census report, in that they were more educated, considered themselves middle class, and had less single-parent families. LaFromboise (1988) suggested that American Indian women who are more highly educated would find that adjusting to the majority culture could provide greater economic and political opportunities but could also be a major source of conflict and stress.

In the current study, role conflict occurred at a significantly higher level for the sex-typed group regardless of educational attainment and

income. This is in contrast to Moyerman and Forman's (1992) meta-analytic study that identified higher socioeconomic status samples as evidencing the greatest increases in psychological adjustment. Possibly, sex-typed American Indian women have more difficulty shifting roles between the majority culture and the tribal community than do androgynous or cross-typed American Indian women. This idea is supported by a review of research studies by Negy and Woods (1992), who found that adjustment was negatively related to sex role differentiation. An American Indian woman who is androgynous may be able to be assertive when needed and nurturing when called upon. Bicultural stress may be a factor indicating that the androgynous and cross-typed American Indian women in the sample have worked out a balance in the minority and majority culture.

The depression rate for the androgynous, cross-typed, and undifferentiated American Indian women approximated that found among professional women, which is thought to be about 20% to 25% (Kaplan & Sadock, 1988; McGrath et al., 1990). The sex-typed group had a depression rate double that (48%). Perhaps for these sex-typed American Indian women, changes in the role of women, changing family patterns, shifts in occupational patterns, increased drug use, and urbanization may be factors contributing to a much higher rate of depression.

The results of this study provide information influenced by the disease-oriented, clinical categories and paradigms of conventional psychology looking at levels of dysphoria. Whereas empirical studies are critical, especially in determining intervention needs, cultural assumptions must be recognized (LaFromboise et al., 1990). In this study 10 participants chose not to complete the BDI, which may indicate the need for the development of more culturally sensitive instruments for American Indian women. Because of missing data (14.8%) on the BDI, the degree of depression among the study participants may actually be underestimated. The structuring of culturally appropriate psychological interventions, especially in light of the high percentage of dysphoria among the sex-typed American Indian women, may be indicated. Further research is needed to evaluate the cultural appropriateness of the study instruments and to develop cultural norms. For example, the BDI tends to measure dysphoria in nonclinical populations. A greater understanding of indigenous concepts of a depression-like syndrome may help in the task of designing an instrument that will accurately identify depression among nonclinical American Indian women. What is needed is a series of cross-cultural cross-validation studies with the study instruments that document empirically the measured similarities and differences of the study findings as a function of culture.

Those who provide psychological care for American Indian women in acute care settings, clinics, and occupational settings are in key positions to identify psychological symptomatology related to negative mental health responses associated with multiple role occupancy.

Because of the community-based definition of self, many traditional therapeutic interventions emphasizing individual volition and responsibility (internal locus of control) may prove inappropriate without a cultural translation (McGrath et al., 1990). Culturally sensitive intervention strategies incorporating gender, racial, cultural, and societal realities are first steps toward facilitating Native American women's growth toward an optimal level of psychological well-being. The more information that is available about the effects of the female socialization process, the more information practitioners will have to guide them. Since sex-typed American Indian working women are at a greater risk for depression, providing support for androgynous and cross-typed sex role orientations may help mediate American Indian women's responses to stressful life events (Baucom & Danker-Brown, 1984).

The fact that the study population was from a convenience sample in one geographical area limits generalizability. The majority of women in this study were not from reservations. The data collected in this study are based on self-report measures collected at a single point in time. Further research is needed that examines how relationships among work- and family-related variables both increase and reduce risk for psychological problems among American Indian women. The associated issues of acculturation, assimilation, passing, and culture denial are important considerations for further research on American Indian women. Longitudinal developmental research employing quantitative and qualitative methods may provide more sensitivity and insight in assessing differences in American Indian working women across the life span with regard to depression, self-esteem, life satisfaction, role conflict, and sex role orientation.

Research on the American Indian female experience needs to be placed in a framework that takes into account the varied contexts, roles, and commitments that make up the experience of their lives. American Indian women's complexity and cultural contexts are finally being supplemented by American Indian women's own reflections and research.

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