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Mental Health and North American Indian/Native Communities: Cultural Transactions, Education, and Regulation[1]

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Critical issues in the delivery of mental health services to North American Indians/Natives residing in rural areas are discussed by (a) describing Indian populations/communities; (b) briefly summarizing available literature concerning the nature of mental health problems within Indian communities; (c) examining Indian belief systems relevant to participation in mental health service delivery processes; (d) exploring community expectations for structuring participatory interactions which may inhibit utilization of mental health services; and (e) describing transactions between Indian consumers and non-Indian professionals which have become typical over time. The rural context was examined as it interacts with individual and community characteristics to affect Indian mental health. Relations between geography and culture, important in understanding the mental health problems of Indian people, are discussed in regard to expanding community healing resources through empowerment, and viewing "education as transformation" as a key concept in enhancing community healing processes.

According to the 1980 U.S. Census, there were 1,418,195 American Indians, Eskimos, and Aleuts in the United States in 1980, a 71% increase since 1970. An estimate in 1981 by the Bureau of Indian Affairs (BIA) indicated that about 735,000 Indians live on or adjacent to Indian reservations, primarily in rural areas. There are about 283 federally recognized Indian tribes holding

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approximately 52 million acres of land, ranging from the Navajo's 14 million acres to groups living on as little as 100 acres. A majority of these tribes have their own languages and cultural systems.

A comprehensive review of the literature published in the past 15 years (McShane, 1985) has detailed the important mental health-related problems and issues faced by American Indian communities, targeted gaps in past and current mental health efforts, and suggested priorities with regards to future research. Many mental health problems have been associated with medical problems, educational difficulties, and/or social issues, for Indian children: As many as 75% of Indian preschoolers experience otitis media (middle-ear infections; McShane, 1982), which result in hearing loss (Paradise, 1980), delays in cognitive and psycholinguistic development (Kaplan et al., 1973; Katz, 1978; Zinkus & Gottleib, 1980), delays in educational achievement (Freeman & Parkins, 1979), delays in grade placement, reading problems, *and emotional difficulties* (Bennett, Ruuska, & Sherman, 1980). Stewart (1975) estimated a reservoir of over 22,000 Indian patients in need of otologic surgery and 13,000 in need of hearing aids. May, Hymbaugh, Aase, and Samet (1983) found very high rates of fetal alcohol syndrome (FAS) in some Indian communities (FAS is believed to be the second most frequent birth defect in the United States and the number one cause of mental retardation). As many as 38% of American Indian children in BIA school are handicapped (Ramirez & Smith, 1978) and neurosensory disorders are manifest in Indian populations at rates 4 to 13 times that of the U.S. population in general (Native American Research Associates, 1979). The 10 states with the highest rates of placement of Indian children in foster care have rates 650% to 2,240% higher than rates for the comparable non-Indian child populations (Study for Congress, 1976). Over 50% of the total Indian population in the U.S. is under 23 years of age (and has a birth rate 2 times that of the general population). Indian children and adolescents make up the single largest subgroup in most reservation and urban communities (U.S. Bureau of the Census, 1984a, 1984b). In states having large Indian populations, 25 to 35% of all Indian children are removed from their families and placed in foster homes (Unger, 1977) and as many as 75% of Indian/Native children in boarding schools experience school-related social or emotional problems (Dlugokinski & Kramer, 1974; Kleinfeld & Bloom, 1977); Indian dropout rates at the high school level tend to exceed 50% (Comptroller General, 1972; Weinberg, 1977) and are double that for other minority groups (*Educational Week,* December 14, 1983). Suicide rates for American Indians are 3 to 10 times the rates for the general population (Peters, 1981) and Indian adolescents abuse drugs at two to three times the rate of non-Indian adolescents across the U.S. (Mail & McDonald, 1980; Oetting & Goldstein, 1978; Trimble 1984). About 50% of all Indian students attend BIA schools or schools bordering

reservations which are also located in rural/remote areas (Havighurst, 1976) and problems in terms of self-concept and identity are serious (Lefley, 1982).

Only three community-wide psychiatric epidemiology surveys have been completed with adult Indians (Roy, Chaudry, & Ivine, 1970; Sampath, 1974; Shore, Kinzie, Hampson, & Pattison, 1973). However, these surveys illustrate the problems of identifying and measuring complexes of culture-specific disorders, developing adequate sampling strategies, using only standard English language, and determining what criterion to use in comparing psychopathology across cultures. Approximately 54 to 63% of subjects in these three study samples were found to be psychiatrically disturbed. Adult males had largely alcohol-related disorders, whereas adult females were more likely to have neurotic and psychophysiologic illnesses (Shore et al., 1973). Among specific tribal groups, depression accounts for 30–40% of all mental health problems (Jilek-Aall, Jilek, & Flynn, 1978; Kahn & Delk, 1973). This is consistent with other reports that the most frequently diagnosed problem for American Indians treated at mental health facilities is depression (American Indian Health Care Association, 1978; Rhoades et al., 1980, Sue, 1977). Such findings include the Indian elderly National Indian Council on Aging, 1981). Mental health professionals and institutions have had difficulty addressing these prevalent and serious mental health problems. This difficulty relates in part to culture-related factors.

ADJUSTING TO CULTURE AND DIVERGENT BELIEF SYSTEMS

There have been at least five major efforts by mental health professionals to take cultural factors into account in delivering mental health services to Indian consumers, but these initiatives have not been entirely successful.

Homogeneity Myth

There have been efforts to alter and change assessment instruments so that they do not disadvantage (e.g., misdiagnose) American Indian clients. However, because of the diversity of tribal groups, it is costly to develop instruments specific to each group. For example, to develop an adequate screening instrument for depression in different tribal communities the researcher must take into account differing cultural-specific conceptualizations of "sorrow," "deep worry," or "sadness." Conceptions of depression vary greatly between groups of Indians. Manson and Shore (in press) found five categories of illness that occurred regularly among Hopi informants: *wuwan tu tu*

ya/wuni wu (deep worry), *kahalai* (loss of mind), *eenung mooki ohta* (spiritual death), *hun noq tutu ya* (drunken-like craziness in the absence of alcohol), and *govisti* (willful suicide).

Measurement and identification tools select highly valued areas of function; however, behaviors are evaluated differently in each tribal society. On one reservation public drunkenness is socially permissible, making alcoholism a significant public psychosocial problem; on another reservation of a different tribal group, drinking to excess occurs expressly in private. Public drunkenness is socially unacceptable.

Conceptions about the nature of how things operate vary among cultures: In Anishinabe (Ojibwa) belief, a major cause of illness was believed to be "bad conduct" *(Madjiijiwe baziquin).* Because a person behaved badly, sickness *(akwazinin)* started. In other words, a person might become ill because of some wrong he committed in the past. An individual might also become ill because of the bad conduct of his parents. Illness of this sort was termed *odjineauwaso.* State-of-the-art Western psychological instruments do not reflect this cultural variation in conceptualization of illness and its behavioral expression.

Content and Process Alterations

There are also efforts to alter and change procedures so that they do not disadvantage Indian clients. For example, flexible psychotherapy scheduling has been attempted—whenever the client shows up the session starts (perhaps with some family members who come along unexpectedly) and ends when the client feels done—which results in a longer session than is typical with non-Indian clients. The largest problem with such process adjustments is that socioeconomic, educational, and cultural differences between the white, upper middle class, college-educated mental health providers and poor, little-educated Indian clients, foster ineffective efforts due to ignorance, insensitivity, and/or miscommunication. Participants who have differing belief systems and participant structure expectations may adjust in maladaptive ways and these maladaptions may stabilize over time and become expected or "normal." Whether adaptive or maladaptive, recurring transactions can be observed in the contexts of education, health care, work and welfare, law, and mental health. The following case study illustrates the point.

A second-grade Indian boy was being recommended for residential mental health treatment at a local agency. The boy had been seen by a psychiatrist who gave him a standard battery of tests and concluded that the boy had lost touch with reality. With a moderate term of residential treatment the psychiatrist was confident that the boy could be cured. The boy's parents had been informed of the diagnosis and attempts were being made to con-

vince them to commit their son. During the same time period, this boy had been referred to diagnostic specialists at his school because of learning, behavioral, and emotional problems. School personnel had often observed him staring vacantly off into space. He was very slow completing his work, and he told "wild" stories at times, saying they were true. Subsequently, he was assessed by the school psychologist and various special educators as having an emotional disability and/or behavior disorder. Consequently, it was recommended that he be placed in a special class with others who had the same type of problem.

The boy was frequently absent from school for days at a time and thus came to the attention of a social worker aide who happened to be Indian. The reason for these absences, as it turned out, was that he would be sent to stay with his grandfather in Canada every once in a while. The Indian social worker aide became concerned when she learned of the various assessments and diagnoses as well as the special placement recommendations made for the boy, because she knew that the boy had a special relationship with his grandfather. His grandfather, a traditional Ojibwa, encouraged his dreaming, whether it occurred by day or night, and often discussed the nature of dreams with him. The social worker aide, also an Ojibwa, was comfortable with the boy's daydreaming and at ease with the boy relating his dreams to her every so often. However, as one can see, there were a number of people (at first a teacher and then other special professionals) who were not at all comfortable with the boy's perception of reality.

Philips (1983) and Greenbaum and Greenbaum (1983) discussed the difficulties of communication between people from different cultures, especially in terms of sociolinguistic differences that interfere with verbal and nonverbal communication between Indians and non-Indians, differing expectations for participant structures (e.g., securing and conveying attention), mutual antagonism, and diminished motivation in terms of cross-cultural interaction, and stabilized transactions that facilitate misunderstanding. In addition to more general belief systems, there are participant structures or "the rules of the game that the players follow" which vary depending upon the level at which (individual, family, group, institution/agency/organization, community, culture/society) interaction takes place.

For example, Philips (1983) observed that Indians interpret the gaze direction of a listener differently than do Anglos; the area around the eyes is for Indian speakers and hearers a behaviorally expressive region. Talk seems to be modified by widening and crinkling of the skin around the eyes. Attentiveness is partially conveyed by changes in facial expression that involve movement in the area around the eyes, but hearers and speakers' do not look into each other's faces as much as in interacting among Anglos. This suggests a pattern of information exchange in which the most expressive region of the face is the least attended to, at least at an obvious observable level. According to Philips, when Indians interpret reactions and responses to ongo-

ing events, the information from the eyes is treated as definitive and as indicative of true feelings, so that one hears accounts such as, "And when he heard that, his eyes opened real wide," and, "He just looked at her," and, "They were snapping eyes," each typically accompanied by a demonstration of the eye movements described by the teller.

Indigenous Worker-Centralized Service Delivery

A third adjustment strategy commonly used by non-Indian mental health professionals is to place (use) an indigenous Indian worker in a facility based upon the Protestant work ethic and medical model and have him or her adjust to this alien system over an extended period of time. It is hoped that he or she will function as a bridge between more traditional and more disadvantaged Indians (who are less able to cope with an alien system within a short period of time) and persons in the non-Indian system.

There are a number of problems with this approach. The cost is high in human terms for Indian workers who cannot adapt. Turnover rates are very high, and "alienation of the marginal man" occurs: For those who adjust to non-Indian ways, there is of necessity a certain withdrawal from Indian ways. The person can end up isolated from his own community to a degree. One well-run Indian service delivery unit installed a time clock to reduce the tardiness and "inefficiency" of some Indian workers. Some adapted well, but others eventually left. Adaptation to non-Indian ways can be a very painful process. Indians who do adapt often use well-established reliable methods and procedures that are widely accepted by the professional community (e.g., individual "talk therapy" vs. action-oriented network therapy). The acceptance of well-ingrained methods and procedures may facilitate easier coping by the Indian worker; however, it is uncommon for new and innovative techniques to be tried that might be more effective with Indian clients. Underskilled, undertrained Indian workers are not infrequent and find themselves under much stress.

Natural Support Systems

A fourth adjustment is based on the natural support systems in most communities. Allowing these helping networks to function (or actively supporting and reinforcing them) can be beneficial. However, certain forces (i.e., alcoholism, death due to illness and accident, migration and back-migration contributing to acculturation) have caused some deterioration in positive family and social systems so they are less effective. These systems are discussed in more detail in terms of the rural context.

Culturally Sanctioned Healers

And finally, there are culturally specific roles that function in the areas of mental health. One may allow or reinforce traditional helpers such as medicine men and healers—having them relate to Indian people in more or less traditional ways. The basic problem with utilizing such a resource on any scale is that there are few such people in most settings; by definition they have strong cultural ties and these ties are maintained through ongoing activity within culturally defined environments and settings. As intact cultural systems disintegrate these healing roles become disentangled from the fabric of the community. Traditional healers may approach the healing process differently than non-Indian service providers. Particularly with respect to differing approaches to reality, the desire to obtain objective knowledge may be contrasted with the significance of subjective perception for Indian/Native people. An elder and healer (in a personal communication) described an Ojibwa perspective on these two ways of knowing as follows:

> We can contrast the Western and Ojibwa approaches by examining a distinction basic to Western Science, the objective/subjective distinction. In Western thought, the philosophical tradition underlying medical science, objective knowledge, is based on reality, factual observation or observable phenomena. There is a comparable concept in Ojibwa thought and language, ga-na-wa-bun-daw-ming, which means "seeing without feeling." In Ojibwa thought this does not carry a higher value than its complementary concept. In Western thought, objective ideas or observations do carry a higher value than subjective ones; they are more "real," they are "better," and they are more acceptable socially.
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> Subjective knowledge in Western thought is not knowledge at all, it is "merely in the mind," personal to one person, and generally influenced by desire or emotion, or by "unreality" (fantasy). In Western thought subjective knowledge is "less real" and "not so good" as objective knowledge. In Ojibwa thought the corresponding concept is mu-zhi-tum-ing, meaning "to feel what you do not see"—that which does not come from sense perception of the world, but from intuitive, direct connection with other sources of being than can be perceived through the limited human senses.
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> There is thus a major cultural difference between the basic foundations of Western "scientific" and Ojibwa attitudes toward knowledge. This difference can perhaps best be described in terms of 'where reality is located, conceptually'. In Western culture, "reality" is "located" in a feelingless, dead world of objects, and the feelings or perceptions of human beings are merely subjective responses or impositions on this bleak universe. In the Ojibwa way of thinking the whole world is alive with power and spirit; it is like a whole organism, we are only parts of it. What we feel without seeing—in dreams, visions, intuitive perceptions, emotional responses—may be as real, or more real, than that which is seen with the eyes only. Thus the Ojibwa attitudes and methods of healing are based upon feelings and perceptions which are not objective, for they draw upon this real world, which, as with all living beings, is approached with respect.

The participants or actors in the healing process or delivery of mental health services are many and diverse. In consistent ways, North American Indian/Native children, adults, and communities differ from one another as much as individual human service providers, disciplines, and organizations vary in their characteristics. However, although Ojibwa, Navajo, and

Innuit differ in certain ways, each group has had to cope with similar situations (i.e., adapting to the same larger societal norms) and often in a similar manner, just as social workers, psychologists, and psychiatrists vary in purpose and orientation but often practice in remarkably analogous fashion, having to face similar problems. Belief systems are of primary importance with respect to these similarities and differences within and between groups. How knowledge is characterized, conceptions of health and disease, where the locus of action (person, situation, person × situation) is concentrated, what the critical (causal, interactional) nature of operating mechanisms is thought to be, and how change is believed to happen, are all dimensions of perceived reality which participants bring with them and which are crucial to understand in order to begin to make sense of this situation. Belief systems of Indian and non-Indian individuals diverge most signficantly in more traditional communities, which typically happen to be reservation communities located in rural/remote areas.

The ecology of participants, belief systems, participant structures, and stereotyped transactions can be described at individual, interpersonal, and intercommunity levels. However, little systematic exploration of how rural and urban communities transact in relation to these cross-cultural domains has occurred.

The Rural Context for Transcultural Interactions

In discussing the mental health of some of the most isolated Native peoples, groups living in the Alaskan and Canadian Arctic, Boag (1970) criticized early research, such as that by Novakovsky (1924), which attempted to explain various forms of hysteria and other psychopathologies in terms of a direct relationship between climatic stress (long periods of darkness, severe winter, and isolation) and psychological strain. He argued that such factors only indirectly affected mental health, primarily through how they affected the social-cultural adaptation necessary to cope with them. Boag (1970) additionally observed that the problems of social isolation and of crowding bear looking at, for example, the effects of moving from camp life in a small family group to the crowded conditions of a sizable community. He also remarked upon the effects on mental health of a high proportion of native inhabitants of isolated areas who undergo long separations from their family for purposes of medical treatment or education as another area in need of exploration. An extreme example of the potential effects of separation is found in migration to urban areas and then back-migration to the original rural communities.

Mohatt and Blue (1982) described a 3-years project, on a Lakota Sioux reservation in the Northern Plains, which sought to (a) measure the *tiospaye* (traditional communal society) community as a way of life; (b) discover if social and psychological distress were related to the tiospaye way of life; and (c) implement a form of intervention that built upon the tiospaye way of life and reduced or forestalled social/psychological distress. The authors summarized some of their research, finding that a form urban/back-migration from urban areas occurring on the reservation was responsible for the decreasing traditionality of rural areas and was associated closely with increases in legal and medical indices of community pathology. They reported that clustered communities were characterized by unemployment and unstable social institutions, a finding at odds with the philosophy of planners who assume better access to roads, jobs in small factories, and manpower training programs—more efficiently accomplished by clustering people's homes—achieves full employment. On the Rosebud reservation, concentrating people in small areas decreased the likelihood of employment, and Mohatt and Blue indicated that physical crowding (in dispersed as well as clustered communities) may increase rates of pathology as a function of changes in residence among a group of people who are related by blood or marriage:

> This is not true for those who live in the recently developed clustered communities and who often have no history of a relationship with their neighbors. Relationships take time; "time" in Lakota means place, letu, which is here and also now. The old ways of dealing with interpersonal conflict are not available in this setting. Nor does language mean what it once did. As Albert White Hat, a local leader, told us: "to say 'tahansni' (cousin) in this new setting is more an invitation to drink than to say 'cousin' with its many responsibilities. To say 'blihichiyayo' (take courage) can mean to 'handle a hangover'" instead of resonating with one's deeply held belief in the need to develop wowacin tanka or strength of mind. (pp. 113-114)

On the other hand, Chadwick and Stauss (1975) studied migration and adaptation of reservation Indians to the urban setting. From the vast literature on assimilation and acculturation (cf. reviews: Barnett, Brown, Siegal, Vogt, & Watson, 1954; Simpson, 1968; Spicer, 1968) the authors chose to work with Gordon's (1964) model which contended that as groups come into contact, cultural patterns are changed, particularly by the minority group.

Overall, Chadwick and Stauss (1975) found the level of assimilation of urban Indians was fairly low; Indians living in the city who belonged to white primary groups had not intermarried, retained an Indian self-identity, were the objects of prejudice and discrimination, and engaged in conflict with representatives of the dominant group. The authors concluded that those Indians who lived many years in the city were as traditional as those who had left the reservation only recently; the major effect of relocation was simply to relocate the problems faced by Indian people to a setting where those

problems were not as visible. Moreover, the researchers suggested that the strong sense of peoplehood expressed by the Indian sample, in concert with a high level of active discrimination in the urban society practiced against Indians in the economic and personal relationship areas, served as deterrents to assimilation.

A model incorporating geographical proximity of populations of differing cultures is needed in order to explicate the role that geography uniquely plays in the interplay between transcultural accommodation and mental health; a clearer understanding of the relationships between assimilation, stress, and mental health in rural and urban contexts is needed.

Berry, Mawhinney, Wintrob, and Sintell (1981) proposed a model for considering how people, both collectively and individually, view and deal with culture change, and what the consequences are for their present and future life, particularly in relation to the common theme in the literature that there is resistance to change and (perhaps as a result) a host of negative effects in terms of sociocultural disorganization and personal disintegration. The authors suggested that if adaptation is viewed as the reduction of conflict, then the group and individual options taken to lessen acculturative conflict may be used to examine possible variations in group and individual behavior.

Trying to understand culture change and acculturation among the Cree and the relationships between change phenomena and psychological adaptations, Berry and his colleagues hypothesized on the basis of developing Cree political control over the major changes affecting them, that stress phenomena would be on the decline over the course of the longitudinal study. They also expected those individuals with greater control (both in terms of actual personal resources or a sense of cognitive control) would exhibit less stress. Finally, those individuals with positive attitudes toward the larger society (such as in the integration mode) would exhibit less stress than those rejecting it (in the rejection mode) or those who are marginalized.

Among other findings, Berry et al., (1982) concluded that the integration mode was related to cognitive measures in the Cree sample and both stood in opposition to acculturative stress. Independent of acculturation, the preferred mode of intergroup relations (integration) was also the most healthy (low stress). Stress and marginality were generally related to indicators of acculturation.

Such results as those in Mohatt and Blue (1982), Chadwick and Stauss (1975), and Berry et al. (1982) reinforce the role of geography in the relation between acculturation, stress, and mental health. It may be that the actual physical distances involved between reservation and city, reservation and proximal rural towns, and the movement of residents between, have systematic and consistent effects upon these relations and should be explored. An illustration of these elements and their relation occurs in rural Alaskan Native com-

munities, which are extremely isolated, where access is very limited (only by air or water during limited times of the year) and where traditional culture and language may be very strong. In such communities contact with the distant larger society is limited and non-Native sojourners are considered visitor-guests during their short stays, and an atmosphere of openness, generosity, and mutual respect is normative. In reservation communities that are located very close to urban or larger town centers of the larger society, access is easy, contact and intermarriage more frequent, language and traditional culture often maintained with less integrity by fewer individuals. An overall atmosphere of defense and an attempt at psychological isolation may be manifest as assimilation and alienation are experienced as detrimental consequences of acculturative stress in the close contact situation. There is, as well, a middle group wherein reservation communities, that are moderately distant from communities of the dominant culture, may adjust to more typical rural problems and tend to have a relative balance of nearness–distance that facilitates integration rather than the other extremes (assimilation or maintenance of traditional culture and language). The relationships affected by the proximity of different communities, affected by movement of community members back and forth, need to be examined and explored in terms of the transactions that are thus inhibited and facilitated with regard to differing belief systems, participant structures, and stabilized transactions, especially as these distance and interactional relationships affect the mental health and delivery of mental health services in Indian communities.

Indeed, the delivery of mental health services by agencies and individual professionals from without the native community may be viewed as a transcultural contact situation producing its own amount of stress. Brett (1971) characterized mental health service deliverers who journeyed to isolated northern native communities as young, enterprising people in need of money, who go in for the short haul to obtain a stake for the future back in civilization; individuals with a lesser or greater degree of missionary zeal and spirit; those who see the north as a place of escape; and the short-term visitors.

It is clear that there is an important distinction between viewing this situation from a reference point internal to one's own cultural and from an external viewpoint. This distinction is a crucial one from the standpoint of Indian experience, as expressed by Martin (1979):

> In pursuing our "promotional" view of prevention, our first concern was to begin to view Indian communities as being healthy and functional. Although pathology does exist, we began to examine the nature of much of the external stress placed upon communities by various agencies and providers. It was decided that much of this "foreign" intervention was, in itself, pathogenic. Thus, it appeared feasible that a first step in the "promotional" model would be to reinforce community strengths while, simultaneously, seeking to "treat" pathology existing within these interfering external systems. Therefore, alteration or modification of external systems impacting the community would become a primary objective. As Indian people for too long, we

> have used inappropriate standards and have succumbed to other people, allowing them to "muddle" in our lives. Now we will promote and strengthen those elements of our culture, tradition, and community that have prevailed throughout the years, and even more so today, to our advantage.
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> In this this process, we must begin to look at elements within external systems that are dysfunctional and generate negative outcomes in the community. Interventions within these systems should realign them so that they would be more acceptable and amendable to both the community and the system in question. Furthermore, the development of the strengths of both the external systems and of the community would result in a more stable interface.
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> The key point here is that we must alter external pathogenic systems so that they begin to generate positive outcomes within the community. (pp. 3-4).

Katz (1983–1984) has identified a particularly relevant aspect of Western thinking (often applied to rural situations) that may be dysfunctional as applied to the mental health needs of Indian people. He suggested that the "scarcity paradigm" dominates Western thinking about distributing resources: scarcity determines value, communities must compete for access to resources, accumulate their own supply, and resist pressure to share. In terms of generating and distributing human resources, helping is in scare supply, value (expressed in fee schedules) becomes entrained to scarcity, people must compete for their share of helping and trust "marketplace" mechanisms which continue to distribute inequitably.

Katz (1981) described the particular contrast between two indigenous systems of becoming healers and the Western approach to training and utilizing healers, in relation to this sort of thinking:

> The process of transformation, a concept deduced from the ethnographic material that follows, characterizes the education of healers in these two non-industrial, non-Western societies. Briefly, healers' education involves a transformation of consciousness in which potential healers experience a sense of connectedness, joining a spiritual healing power, themselves, and their community. This transformation establishes the possibility of healing but does not remove healers from the context of daily life. Healing involves the healers' struggle to serve as a vehicle to channel healing to the community, without accummulating power for personal use. That effort affects the inner quality of their lives, transforming them. (p. 57)

Katz suggested that while non-Western approaches may have similarities to the community mental health movement (goals are to help distribute resources fairly throughout communities, to emphasize prevention more than treatment, and to make use of extensive community support networks), "education or transformation" suggests features lacking in the education of community mental health workers. For instance, the education of community psychiatrists does not emphasize a new experience of reality or require restructuring of self. The psychiatrist learns a new set of values and attitudes, learns a "scientific" approach to behavior that stresses mastery over a body of concepts and techniques and does not draw upon transpersonal knowledge (he or she is dependent upon what can be conceptualized and controlled).

Gustafson (1976), exploring the group matrix of individual therapy with Indian people of the plains, described one of the elements of Katz's proposition. Gustafson observed Indian patients presenting problems common to mental health practice—anxiety over performance, depression after loss, loss of self-esteem from failure—but also found that whereas an empathetic understanding of the therapist would draw forth increased gratitude and commitment from the patient in settings he had experienced previously, this did not happen with Indian patients. He attempted to explain this failure by suggesting that the patient-therapist boundary, in these situations with Indian patients, was influenced primarily by the need of the patient to have a powerful group to which to belong. The patient's literal adherence to the beliefs of his culture and religion and his perception of the therapist in this light often made the therapist appear to be wrong or incomprehensible. If the patient's wish to belong was currently unmet, he or she would often exert considerable pressure on the therapist to become involved in the patient's life. The patient's need for the protection of a literal guardian, or a new, powerful group matrix for his life, could make the offering of empathic understanding seem quite insubstantial.

> My secretary, who was an Indian woman, once presented me with a cartoon showing an Indian, lying out of sight of the analyst on the analytic couch, saying, "I have a fear of vanishing." The irony is in the real threat. . . [to] the Indian. . . . The holding power of the reservation is in doubt. As the group weakens its ritual power and its numbers feel more lost on the sparse Montana plains, we are surely apt to see what we clinically would call narcissistic personality disorders—where the primary wish is to regain lost omnipotence. The customary solutions, as I have argued, are those of the group, the religious group or pair, rather than the consultation. The magic of understanding and being understood are only satisfying enough for the most independent of persons in these bleak surroundings. Perhaps we all need the narcissistic protection of a vital group life. Our interest in Indian people, who at one time had such a life, may tell us something about our own needs. (p. 238)

In summary, adjustment efforts which originate primarily from outside Indian families and communities have many problems associated with them that need detailed exploration. However, these difficulties seem to arise from the differences between the individuals and communities of differing cultures.

Differences in *culture* result in a lack of cultural understanding by non-Indian providers, lack of trust, and rapport between Indians and non-Indians, lack of contact and relationship with the Indian community by professionals, difficulties because of changes in Indian leadership, and other problems. *Differences in socioeconomic status* result in the inability of Indian consumers to cover the cost of mental health services, insufficient funds for adequate mental health programs, not enough finances to deal with problems like child care, and in general, reduce the accessbility of mental health service for Indian persons. Differences in *geography* (residence, location) result in prob-

lems of transportation and distance, lessened familiarity with available resources (less felt input and ownership) by Indian people, fewer and less available trained staff on the reservation, scheduling difficulties, child care difficulties, and other problems which again tend to decrease accessibility and effectiveness. Differences in *language* impede communication, as does the lack of understanding of mental health terminology, jargon, and the language of therapy. This may be perceived at times by providers as a lack of client openness (reticence, shyness). Differences in *educational level* result in a lack of knowledge about the concept of mental health by Indian consumers, lack of information (awareness) about specific functions of existing resources and processes, lack of trained Indian personnel, and a distancing effect coming out of the educational levels of providers.

Besides culture, economics, geography, language, and education, there are two other areas of importance. Historical relationship is one and the state of technical resources another. Because of the *history* of past relationships with non-Indian social services and legal systems, potential Indian consumers may be realistically afraid of losing rights as free individuals and as guardians of their children. The state-of-the-art in professional areas of mental health seems to have the following characteristics in relation to the *technical resources* applicable to the situations of the Indian people: There is a lack of adequate understanding of the development and prevalence (etiology, epidemiology) of Indian mental health problems; there is a lack of trained Indian personnel; there is a rigidity of fixed responsibilities of existing provider roles, flowing partially from limited resources; and there are few preventive efforts.

But how are these difficulties corrected or avoided? Clearly, the training of competent professionals, both Indian and non-Indian, as well as sanctioning and monitoring these professionals in relation to the delivery of services to Indian communities is central to any sort of resolution.

The functioning of mental health professionals in transcultural settings has been problematic, to the say the least. Separate literatures have focused upon detailing specific transcultural difficulties in relation to training, preventive intervention, service delivery (i.e., psychotherapy), and research—each with its own approaches to resolving issues of educating, sanctioning, monitoring, and regulating providers. Exploration of existing regulatory mechanisms of the larger society, especially in terms of education as a form of regulation, professional organization regulation (ethical codes, practice guidelines), and legal and quasi-legal sanctions (licensure and certification, registration, competency tests) as they relate to, and operate within, transcultural situations from the perspective of the ethnic community and/or consumer has been minimal. A rather unique model with potential for greater input, power, and control is proposed with respect to American Indian reser-

vation communities as a way of exploring the need to look for alternative forms of resolution of these long-standing problems.

DISCUSSION

Gardner (1980) nicely outlined many of the problems related to transcultural service delivery, both in terms of psychotherapy and broader community interventions. He observed the socialization of Western European and American professionals toward individualistic patterns, with values bound up in the protestant ethnic. Examples of this socialization include concern with individual rather than some larger organism of which the individual is a part; emphasis on self-protection, self-assertion, and self-expansion...along with manifestation of isolation, alienation, and aloneness as opposed to contact, openness, and union; repression of thought, feeling, and impulse. Such values led professionals to make ethnocentric attribution concerning ethnic individuals who deviated from these norms. Thought processes of ethnic individuals were seen to reflect an absence of a conception of general facts, an inability to anticipate future events, the absence of abstract ideas, and the absence of the idea of casuality. Criteria applied generally to psychotherapy resulted in the exclusion of the poor and minorities who were considered traditionally as action-oriented rather than verbal, more extrospective than introspective, inclined to see their problems as physical rather than psychological, impulsive, and unreflective. Psychotherapists and community workers added descriptions of poor and minority individuals as hostile and suspicious, resistive to efforts at establishing rapport, untreatable and unreachable, and incapable of insights. Consequently, nontraditional patients received the most severe diagnoses and the poorest quality care. Seldom were they referred for either individual or group treatment, and when treated were treated by the least experienced members of staffs. A consensus, based on such experience, was reached that disadvantaged populations were unsuitable for dynamic therapy. However, new formulations of the inappropriateness of traditional psychotherapy for the problems of nontraditional patients reinforced the bifurcation of service delivery along the lines of social class and ethnicity with the establishment of the community mental health movement. While earlier literature had found disadvantaged populations unsuitable for dynamic therapy, the new, more progressive literature found dynamic psychotherapy unsuited to the needs of the disadvantaged. The affluent receive dynamic psychotherapy, and the disadvantaged receive short-term, crisis-oriented treatment or maintenance-oriented after care. A further paradigm shift elaborated psychotherapy as not suited to the needs of the poor because it requires of the patient expectations, values, and verbal skills

which the poor do not possess. The language style of the poor is seen as restricted and associated with an inability or unwillingness to defer gratification, apathy and hopelessness, hostility toward the greater society, and a tendency to retreat into primitive life-styles.

Gardner (1980) cited Lorian's (1978) summary of major negative attitudes reported by therapists in relation to work with disadvantaged patients as including: (a) a felt lack of rapport, (b) a conviction that these patients were too hostile and suspicious to enter a working alliance with them, (c) difficulty with being empathic or genuinely concerned with these patients, (d) disapproval of their sexual and aggressive behavior, crude language, violent outbursts, and apparent apathetic response to treatment, and (e) the greater amount of dysphoric affect experiences while treating this class of patients compared to more traditional ones. Everett (1977) reported that disadvantaged patients frequently perceive therapists, particularly those with a psychodynamic orientation, as cold, distant, rejecting, paternalistic, condescending, and insensitive. Peck (1974) added that such patients frequently leave treatment after less than five sessions. This relates to the fact that lower class patients failed to receive practical advice on how to solve their problems, lacked confidence in taking treatment, and did not find realized in the therapeutic relationship their expectations of an active, warm, and sympathetic professional.

Gardner (1980) criticized adopting the difference paradigm to account for difficulties and failures in the application of traditional psychotherapies to the problems of disadvantaged patients. Mental health professionals argued that the demands of expressive psychotherapy ran counter to both the expectations and the typical modes of problem solving found in lower-class, unsophisticated patients. As evidence they cited data indicating that the poor often reject psychotherapy as irrelevant to their expectations and needs (Korchin, 1976), that they are likely to drop out of therapy prematurely (Poussaint, 1975; Heitler, 1976; Korchin, 1976), that they tend to seek rapid relief of symptoms with minimal commitment to the therapeutic situation (Korchin, 1976), and that they prefer medication and occasional advice to regularly scheduled talks about their problems (Hornstra, Lubin, Lewis, & Willis, 1972).

These observations led some therapists to suggest alternative ways of solving these problems so that more effective treatment services might be provided for the poor and minorities. Korchin (1976) proposed the alternatives of (a) abandoning individual psychotherapy in favor of community-oriented interventions, (b) abandoning verbal therapy in favor of behavioral methods which the poor can better comprehend and respond to, and (c) adapting psychotherapy so that it is more responsive to the psychosocial skills and needs of the poor. To this list Gardner added a fourth alternative: modify-

ing therapist thought and behavior so that bias, misunderstanding, and unnecessary technical rigidity are overcome and disadvantaged patients can seek assistance in a truly therapeutic atmosphere. Essentially, the approaches suggested by authors such as those listed reflect the following alternatives:

1. Modification of psychotherapist cognitive and emotional orientation;
2. Modification of traditional treatment approaches;
3. Modification of patient expectation and knowledge;
4. Negotiating/facilitating/inducing shared role-relationship expectations.

In terms of affecting these modifications and approaches, two vehicles immediately present themselves: education and professional organization regulation.

Education as a Regulatory Mechanism

Paige and Martin (1983) found that there are excellent materials on specific training techniques and activities available to those concerned with transcultural training (see Althen, 1981; Batchelder & Warner, 1977; Casse, 1979; Hoopes & Ventura, 1979; Pusch, 1981; Weeks, Pedersen, & Brislin, 1977). However, they made the point that "cross-cultural" training as a field is vulnerable to abuse as a function of its newness, the demand for cross-cultural trainers, its eclecticism, its semiprofessional status, and its lack of professional standards and ethics. Unsatisfactory experiences with predominately cognitive and experiential models led cross-cultural trainers to search for a synthesis of approaches that would promote the behavioral, self-awareness, and socioemotional learning of the experiential approach along with the conceptual and information learning of the cognitive model. A particular focus upon cross-cultural sensitivity, intercultural competence, and multiculturalism resulted in attempts to operationally define these concepts in terms of acquiring new patterns of behavior, cognition, and belief. Paige and Martin (1983) summarized:

> The most frequently posited personal qualities associated with authentic intercultural competence are: the ability to tolerate ambiguity, empathy, the ability to withhold judgment, reduction of ethnocentrism, a culturally relativistic world view, an appreciation of other value and belief systems, personal flexibility, a willingness to acquire new patternn of behavior and belief (Adler, 1974; Bochner, 1973; Hammer, Gudykunst, & Wideman, 1978; Ruben, Askling, & Kealey, 1977; and Porter & Samovar, 1976). (p. 44)

If these factors are associated with effective performance within an unfamiliar setting, then training designed to promote these personal qualities is inherently oriented to effecting personal transformations among trainees. This is what can be referred to as the "person-transformation" imperative

which characterizes much of contemporary cross-cultural training. Self-identity or sense of personhood is anchored in those belief systems, world views, behavioral repertoires, and cognitive classification systems that are acquired through one's upbringing and socialization. Not only do these come to represent reality and truth (Berger & Luchmann, 1967) but they become highly valued and preferred ways of thinking and behaving. Moreover, they become internalized and unconscious; at the deepest level they define one's view of oneself as a person. Geertz (1963) pointed out that learned orientations toward one's kinfolk, religion, ethnic group, and community become deeply rooted "primordial attachments" and serve as powerful motivating forces in the individual's life.

Therefore, cross-cultural training may be potentially threatening, even damaging, because it challenges existing and preferred beliefs, ways of thinking, and ways of behaving. This line of reasoning argues for training directed at promoting personal change, cognitive restructuring, or what Kuhn (1962) referred to as a "paradigm shift." Indeed, Mestenhauser (1981) pointed out that culture learning cannot occur without the acquisition of a new world view. Acquiring a restructured world view necessarily needs to involve community members holding the different beliefs to be understood.

This perspective of education and regulation needs to be viewed from the perspective of Indian communities. From a legal viewpoint an Indian reservation is a separate legal jurisdiction related in many ways to the state(s) surrounding it and to the federal government. Indian reservations have been called "domestic dependent sovereignties" existing within the federal system. As semiindependent entities these reservations operate under specific tribal codes usually through an executive branch of government, the tribal chairman, a legislative branch, the tribal council, and a judicial branch, the tribal court. These branches are not as clearly separate as in other federal and state jurisdictions but the basic governmental structures are in place.

In 1975 Congress passed the Indian Self-Determination and Education Assistance Act (25 U.S.C.S. #450a-450n). This Act gives authority to the Secretaries of HEW and Interior to contract with specific tribes and other Indian organizations for the delivery of federal services. To date, a number of tribes have taken over the provision of mental health and social service programs.

The Indian Self-Determination Act understood in the context of tribal governmental authority provides tribal mental health programs with a potential model for the development of a tribal regulatory authority charged with either licensure or certification of nontribal mental health professionals in the employ of the tribe. There is nothing to prevent a tribal entity that has control of its mental health program, having exercised its option under the Self-Determination Act, from setting its own criteria for practice within the boundaries of the reservation. Presumably the tribal government will try its

best to recruit a mental health professional who meets the highest available standards for the particular mental health discipline in question, a person who is eligible for licensure or registration in the surrounding jurisdictions and who could move freely in the professional circles in the surrounding reservation society.

The tribe, however, need not stop there. In order to be eligible to practice within the reservation the tribe could consider specific competencies relevant to local tribal practice. This could include requirements at the time of hiring which might include prior training and experience in transcultural mental health delivery. More important however, are the requirements placed on the individual once employment is arranged. These requirements might include a program of on-the-job education which would familiarize the person with the available literature regarding specific mental health needs and problems of that particular tribal group plus any literature of more general nature thought important by the tribal licensing body. In addition, this body could require a period of on-the-job training which needed to be completed prior to final hiring. This training could be guided by the principles of training the outside professional in local health and mental health practices which would include some period of mutual exchange of concepts and ideas with local healers. Once permanent hiring and/or licensure were established, continuing education could be tied to continued licensure. Ethical and professional practices could be spelled out and means of challenging continued licensure could be spelled out in tribal law.

This model provides the tribal government with control of professional practice within the jurisdiction of that reservation community. Models of such professional practice already exist in several reservation communities which regulate who can practice law within the jurisdiction of the particular reservation. Practical problems exist in relation to recruitment and retention of mental health professionals in rural reservation communities. The proposed model may not alter these difficult problems. However, such activist approaches by trial government migh help professionals move in the direction of such job opportunities, given a demonstration of firm guidance for the new professional by the tribal government.

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