STEREOTYPING IN AMERICAN INDIAN MENTAL HEALTH

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INTRODUCTION

It is widely accepted within the social sciences that culture plays an important role in socialization and personality development. Values, attitudes, and behaviors are shaped by the dominant culture of the larger societal system as well as by the individual's immediate cultural community and family system. It has been suggested by Norton that assessment of the degree of incongruence between these systems is a critical consideration when working with minority clients (Norton, 1978). Research that examines the relationship of system incongruence to the labeling of mental illness is scarce, and it is only recently that researchers have even begun to investigate the relationship between cultural variations and mental illness.

While there are very few studies on the incidence of mental illness among American Indians, those that do exist tend to be examinations of particular cultural adaptions or lack of them, among a given tribe, as viewed from a psychiatric perspective (Bahr, et al., 1972). Psychiatry, it should be noted, reflects and enforces the values and norms of the dominant culture and, through its use of diagnostic categories, is the arbiter as to what constitutes mental illness. This raises an important issue in cross-cultural psychiatry: the psychiatric diagnostic system is based on symptoms of patients from one general cultural background - Western European. When a culture bound diagnostic system is applied in both cross-cultural research and in multi-cultural clinical settings, it is likely that errors of classification and distortions will occur when comparing patients from different cultural backgrounds (Enright & Jaeckle, 1963).

Additionally, in clinical settings where there is high consensus about the perceived cultural differences in the patient population, diagnosis may reflect distortion and errors of classification which closely approximate stereotypical views of these differences. As there is a serious lack of information about the extent to which Indian people have accepted and conform to the values and norms of American society, it is presumable that the popular stereotypes of the Indian that persist among the public at large also prevail among clinicians.

This is an exploratory study of treatment of Indian and non-Indian adolescents that focuses on group differences in problem identification as incorporated into psychiatric treatment plans.

METHOD

This study was conducted on an adolescent treatment unit of a community hospital in urban Minnesota. The subjects consist of 80 patients who represent all of the identified Native American (40 patients) and an equal number of randomly selected non-Indian patients admitted to the unit over a period of three years. The non-Indian sample includes not only white patients, but minorities as well.

The data come from hospital records and charts and focus on information concerning treatment, as interpreted through problem identification in the patients' care plans. A care plan, as utilized on this unit, is the most tangible form of what is meant by "treatment" for each patient. Care plans were read by this investigator and every identified problem behavior or characteristic was noted; categories of problems were induced from the data and each individual statement of problems was assigned to a category.

Formal statistical analyses (Chi Square or Fisher's test of significance) were applied to each category separately to determine whether the proportion of Indian and non-Indian patients in the category was significantly different than what would be expected if there was no relationship between the identified problems and ethinic group membership. Also included is a qualitative analysis of trends that are not readily apparent by statistical test.

THE SAMPLE

The youth in this sample ranged in age from 12-18 years. There was no available information regarding tribal affiliation for the Indian patients, although the two principal tribes residing in this area of Minnesota are the Chippewa and the Sioux. Of the non-Indians, there were

6 Blacks, 3 Hispanics, and 31 Caucasians. Both groups included almost equal numbers of males and females.

As no standardized information concerning family income or parental employment was available in the charts, a very rough measure of socio-economic class was determined by whether or not the hospitalization was being paid for by public assistance; this was used simply to separate the "haves" from the "have-nots". A clear difference between the two populations exists, with 90 percent of the Indian patients receiving public assistance and only 32.5 percent of the non-Indians receiving these benefits. While similar percentages of Indians and non-Indians were discharged to their homes (63% & 73%, respectively) the Indian youths were hospitalized an average of 40.6 days while non-Indian youths were kept an average of 25.8 days.

FINDINGS

The perception of Indian "differentness" may have little to do with actual differences in cultural socialization but, rather, be a sterotyped notion of what an "Indian" is. As diagnosis clearly dictates treatment, the identification of problems and diagnostic labels assigned to patients indicate not only categories of psychiatric symptoms, but also imply a certain modes of corresponding therapeutic intervention.

Table 1 summarizes the problem categories in which significant differences were found in the identification of problem characteristics between the Indian and non-Indian patients. Taking these categories of Table 1 in order, we find that:

1 While stealing was the only behavior significantly identified as being characteristic of Indian youths, all three categories of "disturbing" behaviors are somewhat more frequently identified in Indian than non-Indian care plans.

2 Both populations were seen as verbally and physically hostile. Although not statistically significant, the Indian youths were identified twice as often as the non-Indians as being physically agressive.

3 A large portion of both groups was labeled uncooperative. The tendency to be isolative and seclusive was a trait more frequently ascribed to the Indians.

4 Both groups show similar problems relating to generalized authority and accepting limits.

5 Indian youths were significantly identified as having problems in expressing themselves and being verbal.

6 While there is no significant difference in

TABLE 1: COMPARISON OF INDIAN & NON-INDIAN PROBLEM CHARACTERISTICS

Frequency. Chi^2, p: * .10; ** .01)

Classification	*Indian*	*Other*
1. Disturbing behavior		
1.1 Stealing	5*	1
1.2 Lying, being sneaky	8	3
1.3 Cursing	4	1
2. Hostility		
2.1 Handle anger, no sign of direct hostile action	13	8
2.2 Aggressive physical acts: push, kick etc.	10	5
3. Withdrawl from activity		
3.1 Partake, cooperate in structured unit activity	21	18
3.2 Withdrawn seclusive	10*	2
4. Generalized authority limits	11	14
5. Verbalness, expressiveness	27**	9
6. Drug or alcohol abuse	7	3
7. Genralized low self concept	2	19**
8. Thinking disturbance. hallucinate, fantasy	0	7**
9. Paranoid feelings	0	3
10. Anxiety	1	4
11. Depressed	0	4*
12. Personal hygiene	8	3
Total care plans (11 missing, N = 69)	36	33

the labeling of drug/alcohol problems, the content of these problems seems strongly related to economic access. Indian care plans most often mentioned paint and glue sniffing and abuse of alcohol while non-Indian care plans cited marijuana, heroin and alcohol abuse.

7 Non-Indian youths were most often, and significantly, described in terms of low self-concept.

8 In categories 8 through 12, non-Indians are seen as significantly different in all categories except anxiety.

There are also general trends which do not measure as statistically significant, but should be mentioned. In reviewing the overall content of problem identification, *specific* behaviors are more often attributed to Indians than non-Indians. The notion of "low self-concept" suggests an intra-psychic or psychological level of problems which are not attributed to Indians. Likewise, the more classic psychiatric diagnoses pertaining to thought disturbances, depression, anxiety, and paranoid feelings are not only more signifcantly assigned to non-Indians, but are *almost totally absent* in Indian diagnosis.

DISCUSSION

Indian patients, who are recognized as being culturally different from non-Indian patients, are analyzed, labeled, and treated on the basis of this conceptualization of "differentness" which can clearly be seen in the problem identification by staff. The assessment of a patient's self concept is largely dependent on verbal interaction. Indian youth, who are seen as non-verbal, pose a special problem for staff whose diagnoses rely heavily on the expressiveness of their patients. Further, the reluctance of staff to assign a label of "hallucination" or "delusion" to *any* Indian experience may, in fact, be a result of unfamiliarity with the actual religious beliefs on their Indian patients. If a non-Indian sees God it is called a delusion; if an Indian sees God it is assumed to be a religious experience.

While the data presented here account for a numerically small sample and include only one treatment setting, it nevertheless seems logical that the findings can be generalized as being fairly representative of similar treatment settings in urban Minnesota. Although we know relatively little about the Indian population, the focus in this study is not on the patient but, rather, on the labels assigned to patients by staff members.

As there are a disproportionate number of poor Indians on the unit, this disparity in economic status may also contribute to the perception of the Indian patients as being different (Pine, 1972). Within the context of culture there are serious questions raised here about the interpretation of behavior. It is necessary to distinguish between that which is economically effectuated and that which is culturally created.

The cultural ignorance and bias that is reflected in the care plans correspond closely with stereotyped characteristics and behaviors which are attributed to, and perceived of Indians by non-Indians (Houts & Bahr, 1972). These stereotypes would include the view of the Indian as being reserved and non-demonstrative, war-like, nomadic, irresponsible, stoic, non-emotional, and non-expressive.

Any real cultural differences that exist between basic perspectives of the two groups may initally clash in a most fundamental interaction between the two — communication. Wax and Thomas point out that social discourse is one of the areas where Indians and Whites most easily misunderstand each other (Wax and Thomas, 1961). These problems are amplified in situations in which there is an atmosphere of power and authority, as is the case in psychiatric treatment. As the definition of mental illness relates to norm violation in a society, we must begin to closely examine *whose* norms are being infringed upon in multicultural psychiatric settings.

Moreover, the sterotypes of the Native American as non-verbal, and physically aggressive, are *not* only a benign form of white middle class ignorance, but are stereotypes which reinforce the idea of cultural inferiority — not simply a neutral cultural difference. These differences are viewed as negative attributes, cultural in origin, which those in positions of power and authority seek to change through "treatment." Further, issues dealing with the consequences of poverty and continued denial of Indian access to opportunity are not acknowledged as relevant to therapeutic intervention. The notion of pathology is placed within the context of the Native American culture, and not within the broader context of

American society. Farris (1976:501) criticizes "The arbitrary attempt to transfer this rigid clinical approach to the unique problems of the American Indian" as being a "grave professional error."

Endemic to this problem is the scarcity of Indian mental health professionals and the reluctance of urban Indians to speak up and demand their rights (Locklear, 1972). There has been minimal involvement, at best, by American Indians in the development and implementation of programs affecting them. The absolute necessity for Indian participation in progams which "treat" Indians is clearly evident.

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