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American Indian and Alaskan Native Mental Health

William E. Hartmann and Joseph P. Gone

The topic of American Indian (AI) and Alaska Native (AN) mental health is a vital component of mental health dialogues today. Although AI/AN communities account for less than 1 percent of the U.S. population and raise particularly difficult challenges to popular mental health research and treatment paradigms, they merit the attention of mental health professionals for several reasons. Top among these reasons are the gravity of the mental health disparities these communities continue to face and the unfulfilled legal obligations established in treaties that guarantee the provision of adequate health care. Owing to the complexity of issues surrounding AI/AN mental health, a historical approach serves best to understand the context of AI/AN mental health problems today and the multiple perspectives on causes and potential solutions to their mental health disparities.

Historical and Cultural Overview

Prior to European contact, the territory now claimed by the United States was populated by over 7 million inhabitants speaking over 300 different languages, many as linguistically disparate as modern English and Chinese are today

(U.S. Department of Health and Human Services 2001). These Native inhabitants were organized into complex social networks based on kinship (i.e., genealogical lineage), known as tribes. In contrast to European states that exercised sovereignty over subjects and a geographically bounded region, North American indigenous tribes afforded roles to community members according to kinship networks and a reciprocal relationship with the land in a specific geographic region. Understanding that, as a people, they were created and sustained from their tribal lands, relationships between land and tribe were maintained by following ritual protocols, maintaining good relations with other beings that inhabited the land, and performing ceremonies of renewal (Kidwell, Noley, & Tinker 2001). As a result of North America's immense geographic diversity, the harmony established between land and tribe led to significant variations in lifestyle between regions. Whereas the fertile Southwest supported several corn-based agricultural communities, the Great Plains supported nomadic lifestyles based on game migrations and seasonal change, and the numerous small islands and inlets of the Northwest coast supported communities built around sea travel and fishing. In this way, indigenous tribes adapted their lifestyles to regional climates and strove to exist in harmony with the gradual seasonal change of the land on which they lived.

Despite the adaptive abilities of Native communities, European and Euro-American colonization of North America led to extended periods of violent oppression and jarring cultural change that have taken their toll on the health and welfare of Indigenous peoples. Beginning with the formation of selective alliances and declarations of war between colonizing European forces and indigenous tribes, the establishment of an independent United States of America with ideals of Euro-American cultural superiority quickly led to policies of displacement and containment for Native peoples. As political tactics adapted to shifts in power and societal values across the centuries, racially motivated genocide via massacres and death marches evolved into cultural genocide in the forms of forced sedentarization of tribal communities on reservations, where cultural practices were suppressed by religious organizations, attendance at off-reservation boarding schools aimed at "killing the Indian in the child" were mandated, and other governmental policies designed to make traditional lifestyles untenable were implemented (U.S. Department of Health and Human Services 2001). While these processes were fairly ubiquitous among tribes of the mainland United States, the experiences of Indigenous tribes in modern-day Alaska were somewhat distinct in that they managed to retain larger portions of their traditional lands due to decreased interest of Euro-American colonizers. At the same time, they suffered to a much greater extent from epidemics of tuberculosis, which led to frequent and extended relocations of infected community members to distant sanitariums (U.S. Department of Health and Human Services 2001).

It was in the wake of these and other horrific experiences at the hands of the U.S. government that indigenous communities assumed additional identities as American Indian and Alaska Native, which defined them both as a distinct ethno-racial category sharing similar cultural features and legacies of adversity and a political identity with rights to guarantees made by the U.S. federal government. Although reduced to only 250,000 individuals by the early nineteenth century, AI/AN communities have since flourished following a marked change in governmental policy instigated by the Self-Determination and Education Assistance Act of 1975. After this turning point, policies of active oppression shifted toward acknowledging many AI/AN tribes as sovereign "domestic dependent nations" with rights established by treaty to equal and adequate mental health care, among other entitlements (Gone & Trimble 2011). Although these more favorable conditions have allowed the AI/AN population to demonstrate its resiliency by growing to include nearly 2 million members of federally recognized tribes (U.S. Bureau of Indian Affairs 2011), the damage done to families, communities, and cultural support systems over centuries of violent oppression has left its mark on the mental health of many of these communities.

Key Mental Health Issues

Having evolved as a way of coping with forced abandonment of many traditional ways of life on reservations, widespread alcohol dependence has gradually spread to become a serious concern for many AI/AN communities (Hicks 2007). Despite significant variation in the prevalence between and within communities, the negative impact of alcohol dependence extends far beyond AI/AN individuals through increased family violence, risk-taking behaviors (e.g., drunk driving, unprotected sex), and many other mental and physical problems associated with excessive drinking. Also following from feelings of hopelessness that developed with the advent of reservation life, suicide has become a serious problem for many AI/AN communities facing conditions that promote continued feelings of hopelessness owing to disintegrated community support systems, confused and belittled cultural identities, and meager opportunities for success by either Western or traditional standards. Some communities have managed long stretches without seeing completed suicides (as well as increased positive indicators of physical and mental health) through a strengthening of ethno-cultural identity, community support systems, and political empowerment (Chandler & Londale 1998). Nevertheless, others continue to be plagued by frequent suicide completions.

AI/AN children also feel the effects of community-wide distress and the grim prospects they face growing up in these disadvantaged communities, often expressing their frustration by acting out. At school, these children are more frequently diagnosed with behavioral problems by school clinicians and demonstrate extremely high rates of school dropout.

A final problem area for AI/AN mental health has been the increased prevalence of posttraumatic stress disorder (PTSD). PTSD is a condition in which individuals experience extreme levels of anxiety that cause significant social, occupation, and/or interpersonal distress following a psychologically traumatic event (e.g., near-death experiences, rape, physical abuse). In addition to serving in the U.S. armed forces at the highest rate of any ethnic group in the country, AI/AN individuals are also disproportionately exposed to other traumatic non-war-related events associated with racism among members of the dominant society, various forms of alcohol-related violence, and life in extreme poverty (Gone & Trimble 2011; U.S. Department of Health and Human Services 2001).

Mental Health Services

To the surprise of many mental health professionals, despite experiencing such high levels of distress, very few AI/AN individuals seek help for their mental health problems, and when they do, they drop out of treatment at the highest rate of any cultural group in the United States (Sue, Allen, & Conaway 1978). Many mental health researchers suggest that part of the disconnect between AI/AN need and use (i.e., underutilization) of mental health services has been lack of access. Since its founding as a branch within the Department of Health and Human Services in 1955, the Indian Health Service (IHS) has become the primary provider of subsidized health services for AI/AN individuals. Unfortunately, chronic underfunding by the federal government has restricted the number of clinics IHS can support, and geographic isolation on reservation settings (only 34 urban IHS clinics exist) has severely limited access to the vast majority of today's AI/AN population, which lives in urban settings (Castor et al. 2006). Since poverty and unemployment are equally characteristic of urban Natives as those living on reservations, access to private mental health services is all but out of the question for most AI/AN individuals.

Although lack of access to services seems to play a key role in deterring help seeking among AI/AN communities, it does little to explain why even those who enter into mental health treatment programs drop out at such high rates. Subjective reports point to differences between the culture of the typical Western mental health clinic and that of AI/AN communities (U.S. Commission on Civil Rights 2004). Indeed, an AI/AN individual receiving mental health services must confront cultural discordance at the levels of the service provider and the intervention itself. Because of a shortage of AI/AN mental health practitioners, it is almost always the case that AI/AN individuals that make it through the door of a mental health clinic are presented with a non-Native, usually white counselor or clinician. As such, the development of mutual understandings and supportive client-therapist relationships proves exceedingly challenging and requires traversing vast differences in life experience, cultural norms of interaction, and understandings about how the world works.

In addition to being asked to share intimate life details with someone with whom they struggle to relate, AI/AN individuals can also experience Western mental health interventions as awkward, confusing, or even potentially undermining of their Native culture. Western therapies invariably carry both implicit and explicit assumptions about how a person is defined and how the world works—healing included. Evolving out of Western individualism, or egocentric views of the person as isolated and independently autonomous from their environment, mental health interventions have predominantly focused on problems or disorders of individuals. Whether implemented through one-on-one or small-group therapy sessions, the individualistic self of Western therapy leads to emphasis being placed on getting the client to understand how he or she has developed a problem (e.g., the individual attempts suicide because he or she is unable to see alternatives to feeling hopeless) and what he or she can do to resolve it (e.g., the person might challenge him or herself to take notice of hopeful opportunities). For many AI/AN individuals, on the other hand, selfhood is understood and experienced as a web of relations extending to family members, sacred lands, and other-than-human beings (e.g., spirits) in both the past and the present. As a result, individual-focused Western therapies seem to miss the bigger picture of how the context in which Native people exist heavily influences their behavior (e.g., a person attempts suicide because his or her ancestors suffered violent colonization that still affects living family members, sacred lands, and the tribe itself insofar as AI/AN cultures are constantly delegitimized by Western society). Such therapies also miss how problems experienced by an individual from an AI/AN community can be addressed (e.g., the person might restore harmony to his or her relations by reviving cultural practices).

Identifying Solutions

Solutions to these problems have long been called for but only recently begun to be explored in earnest (U.S. Commission on Civil Rights 2003). Perhaps most straightforward among them is the need for increased funding of mental health initiatives for AI/AN communities, a reasonable request considering that governmental appropriations for these communities equate to less than 40 percent per capita the allocations for the general population (IHS 2011). Increased funding could allow for the training of more AI/AN mental health professionals as well as the establishment of new IHS clinics for expanding AI/AN communities, whose only access to mental health services currently may be through admittance to an emergency room or prison. In addition to improving access to mental health services, funding could also support the development and assessment of solutions aimed at overcoming cultural barriers to mental health treatment.

Currently, the momentum among mental health researchers concerned with cultural barriers to treatment has coalesced behind adapting Western therapies to

better fit AI/AN cultures, and "cultural competency" training for counselors and clinicians. These two strategies suggest that Western therapies can be adapted for use in AI/AN communities, often by incorporating Native cultural symbols (e.g., the medicine wheel) or by providing additional culturally salient components to therapy (e.g., an optional sweat lodge after a group therapy session). They also suggest that therapists can be educated to better understand and communicate with their AI/AN clients. Although some support has been found for improved outcomes as a result of cultural adaptations of therapy for AI/ANs (and other minority groups), and training in cultural competence would almost certainly improve counselor-minority client relationships, it is far from clear how such practices would apply to multicultural settings in which most AI/AN individuals now live. (One may ask, for example, for how many cultural groups would it be feasible to adapt therapies and train therapists to serve competently?) Furthermore, without additional funding, such changes are unlikely to help administrators of reservation-based clinics recruit and retain quality mental health professionals, a chronic problem in these isolated settings. Finally, concerns have also been raised among some researchers and AI/AN cultural leaders that many of the discordant beliefs and values embedded in Western therapies will not be addressed by simply adjusting their presentation or by teaching therapists more culturally appropriate ways of conveying their messages.

Those raising this final concern offer an alternative path to restoring AI/AN wellness that remains to be assessed of its potential effectiveness. Developed from the understanding gained through collaborative exchanges between mental health professionals and respected AI/AN community members, this approach adopts local worldviews by relying on community stakeholders such as AI/AN health center administrators, service providers, and respected leaders to develop local visions for overcoming barriers to their community's wellness. As such, it recognizes Euro-American colonization as the origin of AI/AN mental health disparities and promotes cultural revitalization according to local community healing traditions as the best means of returning to health. Such traditional healing practices might likely include performing various ceremonies, sharing traditional teachings, and/or increasing involvement in community activities. In focusing on cultural revitalization, this approach champions "culture as cure" for what is often described as a "cultural wound" inflicted over centuries of historical oppression (Gone & Trimble 2011).

Conclusion

Although elevated levels of distress among many AI/AN communities is evident, what is less clear are the best means by which the U.S. federal government can fulfill its treaty obligations to ameliorate such mental health disparities. The modestly improved outcomes from efforts to adapt Western therapies according

to AI/AN cultural norms, and from training clinicians to be better versed in AI/AN cultures, suggest that this strategy of developing cultural variations within the Western mental health community is one potential route forward. Following this path will likely help to meet the needs of those AI/AN individuals interested in Western interventions but not comfortable negotiating the explicitly Western ecologies of mental health treatments. At the same time, the promise of empowering local AI/AN communities to develop and evaluate their own interventions involving traditional means of healing is heartening. The potential yield of this alternative route via healing and empowerment at the community level makes the thorough exploration of this option an imperative, in the eyes of many. Finally, increasing financial resources to remove barriers to accessing mental health services, to train members of AI/AN communities to become mental health professionals themselves, and to fund research that will propel forward efforts to adapt established interventions and support local strategies is essential. In light of the U.S. government's primary role in creating and sustaining these AI/AN mental health disparities over centuries of oppression, the obligation to meet AI/AN mental health needs is both a legal and ethical one.

See also Alcohol Abuse, Alcoholism, and Mental Health; Culturally Competent Mental Health Care; Posttraumatic Stress Disorder; Poverty, Unemployment, Economic Inequality, and Mental Health; Rural Mental Health Services; Suicide and Suicide Prevention

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Anger and Aggression

Kathleen E. Darbor and Heather C. Lench

Burt and Linda Pugach appear to have the perfect marriage, but their romance did not start out so happily in the late 1950s. When they started dating, Burt was married to another woman. He refused to divorce his wife, and Linda finally left him and became engaged to another man. Burt did not take this well. In 1959, he hired someone to throw acid in Linda's face when she answered her door. The attack left Linda blind and disfigured, a condition that Burt regrets to this day. Burt describes himself as simply overcome with anger. While it is incredible that Linda would then marry Burt in 1973 after he was released from prison for this crime, the more critical issue is the anger that motivated Burt to hurt her, and how his actions might have been prevented. Although this may be an extreme (though true) case, many other people also experience problems in their daily lives as a result of anger. A man might become physically violent whenever he perceives a slight to his honor or might refuse to speak to his children when they do not accept his advice. A woman might throw objects during disputes with her husband or spread malicious rumors about a talented colleague. In each case, actions that resulted from anger can cause social or professional problems.

Anger is a normal and common emotional experience. In some cases, however, anger can become dysfunctional because its intensity or duration impairs people's ability to function at work or home. There has been a dramatic upsurge in the number of people referred for anger management treatment in the last few decades. Despite recognition that many people suffer from problems related to anger that require therapy, there are no guidelines for diagnosis or treatment because anger is not currently recognized as a disorder by the mental health field.

What Is Anger?

Anger is experienced when someone or something blocks the attainment of an important goal. For example, a spouse may prevent one from feeling valued by

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