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# AFFECT AND ITS DISORDERS IN A NORTHERN PLAINS INDIAN COMMUNITY: ISSUES IN CROSS-CULTURAL DISCOURSE AND DIAGNOSIS


BY

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A.B., Harvard University, 1992
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THESIS


Submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in Psychology
in the Graduate College of the
University of Illinois at Urbana-Champaign, 2001

Urbana, Illinois


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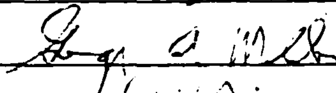

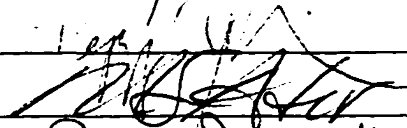

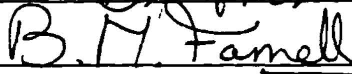

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Abstract

Situated within an NIMH-sponsored study of psychiatric epidemiology in an American Indian community on the Northern Plains, this study examined the cultural patterning of reported experience in the context of standardized diagnostic interviewing. More specifically, analytic attention to the discursive construction of self among Indian respondents promised insight into the unusually low rates of statistical concordance between diagnoses obtained by community members employing the Composite International Diagnostic Interview (CIDI) and a non-resident clinician employing the Structured Clinical Interview for the DSM (SCID). Interviews with 75 tribal members from a single reservation revealed that respondents diagnosed with Posttraumatic Stress Disorder (PTSD) when interviewed by a community member using the CIDI were much more likely to be diagnosed instead with a Depressive disorder when interviewed by an outside clinician using the SCID. It is argued here that the "lay" interviewers found higher rates of PTSD and lower rates of Depressive Disorder because they invoked (and could not circumvent) the local cultural discourse linking trauma and fortitude. As a result, CIDI responses were channeled into culturally appropriate self-representations that primarily associated personal distress in terms of the traumatic social disruptions that respondents had experienced as opposed to the more direct acknowledgment of relatively decontextualized and internalized mood states that the community emphasis upon fortitude precludes in such discursive encounters. In contrast, as a non-tribal interviewer and a trained clinician, I disrupted this local cultural discourse by actively contesting and reorganizing the respondents' own constructions of their distress into established psychiatric categories, thereby facilitating a displacement of CIDI PTSD diagnoses among this sample by the substantial increase in SCID depression diagnoses. Insofar as sustained attention to the sociolinguistic practices of a cultural community may illuminate perplexing epidemiological findings, including the difficult challenges posed by incommensurate ontologies of distress, the implications of this kind of analysis for cross-cultural psychiatric epidemiology are discussed.

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## Introduction

As early as the Community Mental Health Movement of the 1960s, psychologists have recognized that conventional mental health services have failed to reach a significant segment of the American population who might truly benefit from appropriate support and assistance while experiencing profound psychological distress (Albee, 1968). Although this observation continues to characterize service delivery with regard to many troubled persons in today's society, it would be difficult to identify a more underserved group of people than this country's small population of American Indians and Alaskan Natives (Nelson, McCoy, Stetter, & Vanderwagen, 1992). The cultural, political and economic isolation of Native Americans from adequate mental health services is even more remarkable when one considers that the federal government is legally and morally obligated to provide such services, given the unique political status of tribal groups in their historic government-to-government relationship with the United States (LaFromboise, 1988; Pevar, 1992).

The assertion that American Indians are underserved with regard to mental health services is justified on several counts. First, most tribal nations are located in remote areas of the country where the quality and availability of mental health practitioners is especially bleak. Second, even when competent practitioners (usually cultural and community outsiders) are recruited and hired (typically within the Indian Health Service), they are quickly overwhelmed by the unimaginable levels of distress in the everyday lives of most Indian people. Try as they might, such practitioners simply do not have enough hours in the week while using dominant treatment paradigms to begin to reach the number of persons suffering from various kinds of psychological overload and breakdown. Third, the dominant treatment paradigms typically employed by these practitioners are suffused with principles and practices that are culturally alien to most reservation ways of being in the world. That is, these paradigms depend heavily upon particular conceptualizations of emotional experience and expression, communicative norms, the nature of disorder and its treatment, and the meanings of personhood and social relations. Finally, the imported cultural assumptions embodied within these paradigms are not merely interesting ideological alternatives. Instead, they were fashioned in the context of a brutal colonialism. Thus, any single instance of an American Indian client/patient who seeks assistance from an Anglo-American practitioner is inherently shaped by a history of power relationships, the influence of which has been widely unexamined within Indian mental health

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research.

Thus, while there remain many obstacles between suffering American Indian people and adequate mental health services, perhaps the most intimidating (and least researched) problem is how to develop appropriate services that avoid reproducing a colonialist ideological hegemony and further cultural marginalization. So, it would seem that research attention to local conceptualizations of "ordered" and "disordered" experience within Indian communities is an important precursor to the development of truly adequate mental health services (O'Nell, 1989). It is the conviction that Indian people deserve fully accessible, culturally appropriate, demonstrably effective mental health services during times of psychological distress that motivates this exploration of "psychological" disorder within a large reservation community on the Northern Plains.

The SUPERPFP Initiative

The research detailed here was undertaken within the context of a large-scale, NIMH-funded epidemiological study of American Indian mental health conducted by researchers at the National Center for American Indian and Alaska Native Mental Health Research. The National Center, housed at the University of Colorado Health Sciences Center in Denver, Colorado, successfully obtained funding for its American Indian Service Use, Psychiatric Epidemiology, Risk and Protective Factors Project (SUPERPFP [pronounced "super-fip"]) and agreed to support my dissertation research within the structure of this larger project for one year's time (in exchange primarily for my services as a clinical interviewer with the project team). Since my own research is thus situated within and shaped by this larger project, it seems appropriate to briefly review the SUPERPFP design and objectives.

The SUPERPFP was designed to replicate, refine and expand in a cross-cultural setting the methodology of a large-scale epidemiological study known as the National Comorbidity Survey (Kessler, et al., 1994). The major goals of the SUPERPFP include: (a) ascertaining the prevalence within two large tribal groups of several mental disorders classified within the Diagnostic and Statistical Manual of Mental Disorders (third edition, revised [American Psychiatric Association, 1987]; and fourth edition [APA, 1994]) and comparing these findings to data generated by the National Comorbidity Survey (NCS); (b) obtaining utilization rates for both conventional mental health services and alternative healing practices; (c) assessing the cross-cultural reliability and validity of lay- and professionally-administered diagnostic

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instruments; (d) analyzing associated risk and protective factors for psychiatric disorder; and (e) contextualizing these findings within local frameworks of meaning through careful ethnographic analysis.

With regard to the investigation of psychiatric prevalence within these populations, the SUPERPFP designated a stratified, random sample from two large tribal groups ($N$ = 1446 from a "Southwest" Indian population and $N$ = 1660 from a "Northern Plains" Indian population) for participation in a lay-administered diagnostic interview using a slightly modified version of the Composite International Diagnostic Interview (known as the "CIDI"; see Robins, et al., 1988). Official prevalence rates for several psychiatric disorders within these populations were estimated from the results of this lay interview. A clinical subsample (consisting of roughly ten percent of the original sample) was then identified for follow-up participation in a professionally administered diagnostic interview using the Structured Clinical Interview for the DSM-III-R (known as the "SCID"; see Spitzer, Williams, Gibbon, & First, 1992; Williams, et al., 1992). This clinical subsample was selected to specifically represent the three psychiatric disorders thought to be most prevalent in Indian communities (Alcohol Dependence, Major Depression, and Posttraumatic Stress Disorder; in addition, a comparison group with no lifetime history of these disorders was included) and diagnostic concordance between lay and professional interviewers with regard to these disorders was closely examined. As a result, the clinical re-interview afforded project researchers the opportunity to conduct a "validity" check of sorts upon the lay-administered CIDI findings as well as to analyze and discuss patterns of agreement between the two diagnostic interviews.

Finally, an ethnographic subsample of the clinical interview respondents was identified for participation in follow-up ethnographic interviews designed to obtain respondents' perspectives on their experience of these disorders. Thus, a small minority of respondents provided three complementary sources of data (the lay interview, the clinical interview, and the ethnographic interview) that might round out the epidemiological portrait. Since my own research depended heavily upon qualitative analysis, it is worth describing the specific goals of the SUPERPFP ethnographic component here. Essentially, ethnographic substudy sought to investigate the existence of culture-specific syndromes and symptoms among these tribal groups; explore local conceptions and explanatory models of mental illness as they pertain to three prevalent DSM disorders; examine the phenomenological relevance of DSM constructs of these

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disorders; and identify factors relevant to help-seeking and service utilization by members of these communities. As will soon become apparent, however, my own interpretive analyses were more directly tailored to the exploration of diagnostic interviewing practices as the basis for generating psychiatric prevalence rates within a single participating community.

Additional details of the SUPERPFP methodology (including relevant preliminary project findings) will be described in a later section. It will suffice here to observe that my participation in the SUPERPFP shaped my dissertation research in several key ways. First, the unique opportunity to conduct my own research within the context of this larger study afforded me the experience of engaging critically with a groundbreaking, state-of-the-art investigation of psychiatric epidemiology in Indian country. To my knowledge, only three community-wide surveys of psychiatric prevalence among the native peoples of North America have ever been attempted (Roy, Chaudhuri, & Irvine, 1970; Sampath, 1974; Shore, Kinzie, Hampson, & Pattison 1973; see Kinzie, Leung, Boehnlein, Matsunaga, et al., 1992, for a longitudinal follow-up study); none of these, however, begins to approach the SUPERPFP in terms of scope or methodological sophistication. Thus, the occasion to tailor my dissertation research so as to better complement the proposed SUPERPFP analyses represented a mutually beneficial partnership that helps to ensure the relevance and timeliness of my efforts. Second, participation in the project offered several pragmatic benefits, including access to an interesting and remote setting, facilitation of my own research within an established project infrastructure already located in the community, and funding of my research through service to the project. Third, given my substantive project responsibilities, it was clearly in my interest to maximize the relevance of this service for my own data collection and analysis purposes. This consolidation of efforts thus accounts for my particular focus on diagnostic interviewing here, as the preponderance of my energies were devoted to administering SCIDs to respondents in the clinical follow-up subsample. Fourth, my service to the project involved extensive collaboration with a talented research team (including over one hundred project staff) affiliated with the National Center. As a result, my dissertation research benefited substantially from the perspectives, experience, and insights of several researchers with regard to mental health issues and methodologies in these communities. One concrete instance of the significance of this ongoing collaboration pertains to the presentation here of those preliminary SUPERPFP findings with direct relevance for the contextualization of my dissertation analyses. Finally, insofar as my dissertation efforts were explicitly tied to the

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data generated by my service to the project, it must be recognized that project factors beyond my control required revisions in the implementation of my dissertation research. Fortunately, I had planned to rely heavily upon interpretive methods for my research which themselves require a certain amount of flexibility and open-endedness.

Conceptual Introduction and Overview

The broad motivation for my dissertation research was to obtain insight into certain facets of the American Indian experience of "psychological" disorder and its treatment in a northern Plains Indian community. Whereas the SUPERPFP was well positioned to assess several key elements of such culturally-local experiences (including an ethnographic substudy involving a third round of interviews with certain project participants), it is important to note that the project takes as its point of departure the diagnostic categories classified within the DSM-III-R (APA, 1987). Thus, while the ethnographic component of the project undoubtedly obtained information from participants related to a wide range of both "ordered" and "disordered" experiences, a principal focus of the project was to obtain detailed information about the communities' experiences with Substance Abuse/Dependence, Major Depression, and Posttraumatic Stress Disorder. This focus was explicitly reflected in the SUPERPFP's ethnographic substudy, where the majority of the follow-up ethnographic interviews were targeted at individuals (diagnosed respondents and family members) with experience pertaining to these three DSM disorders.

An alternative point of departure for cross-cultural research into the experience and expression of disorder recognizes that local conceptions of "disorder" follow from local conceptions of "order." This recognition implies that the investigation of culturally normative experience precede the exploration of local conceptualizations of psychological disorder. This conceptual strategy thus works from the inside out and ultimately privileges local conceptions of disorder in the analysis of psychological distress and breakdown—it remains an empirical question as to whether the analytically emergent signs and symptoms of locally-defined disorder are likely to map on to traditional DSM categories in any meaningful way, thereby avoiding what Kleinman (1987) refers to as the "category fallacy."

While I have heretofore identified "psychological disorder" as the focus of this dissertation research, it is now appropriate to be more precise. It is my purpose here to attend in some detail to the culturally local construction of disordered affect within a Northern Plains

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Indian community. There is, of course, a rich discourse within psychiatric tradition concerning the "affective" disorders, but I do not propose necessarily to constrain the kind of affective disorder considered here within either the general ideological approach or the specific constructs of psychopathology classified in the DSM. Indeed, I do not even presume that tribal members in this Northern Plains community differentiate (either conceptually or in practice) "affective" disorder from other "kinds" of psychological disorder in this manner, or even distinguish it from disorders of body and spirit. Rather, I am attempting merely to circumscribe a narrow range of disordered experience that retains a focus upon what conventional mental health researchers might loosely recognize as emotional distress and breakdown. It is the precise relationship between these paradigms that merits closer inspection.

There are several reasons for my specific concentration upon emotion and its disorders. First, the SUPERPFP protocol is tailored to the exploration of three particular DSM disorders in which irregular affect is likely to be pronounced. Thus, limiting my study to affective experience and its disorders conveniently demarcates this research in terms of both relevance and manageability. Second, affective experience is generally assumed to be culturally universal among humans and therefore provides a secure point of departure for a culturally local investigation which works its way from normative experience to disordered experience as well as from local concepts of disorder to conventional psychiatric constructs. Finally, the focus upon affect is situated within the interdisciplinary convergence of psychology and anthropology where, as I will describe shortly, a growing body of anthropological research attests to the limitations of conventional psychological approaches to understanding emotional experience.

Of course, such an enterprise requires an appropriate conceptual paradigm to adequately motivate the investigation. I will situate the present research within the conceptual paradigm of cultural psychology.

Cultural Psychology As Conceptual Paradigm

As a (re)emerging academic discipline, cultural psychology provides a reconceptualization of the psychological enterprise (Bruner, 1990; Cole, 1990; Shweder, 1990; Shweder & Sullivan, 1993) which seems better tailored to an investigation of affective experience and disorder as "meaning-full" phenomena in the everyday lives of people. The discipline's central locus of inquiry concerns the semiotic (i.e., symbolically mediated) nature of human experience. Thus, cultural psychology rejects both the one-sided "culture" of traditional

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anthropology and the equally one-sided "individual" of traditional psychology, and instead transcends this conceptual dualism by privileging the exploration of "culturally constituted persons" (See also Cole, 1996; Markus & Kitayama, 1991; Marsella, DeVos & Hsu, 1985; Schwartz, White & Lutz, 1992; Shore, 1996; Shweder, 1991; Shweder & LeVine, 1984; Stigler, Shweder & Herdt, 1990; White & Kirkpatrick, 1985).

For the purposes of this research, culture may be understood to be public, patterned and historically reproduced symbolic practices that are available for human meaning-making (Geertz, 1973). Culture is public because such systems must be shared—there is no culture of one. Culture is patterned because such systems are organized and utilized systematically in order to be intelligible to others—they are not randomly re-created with each usage. Culture is historically reproduced in that subsequent generations are socialized into using the intelligible symbol systems of their communities. This is not to argue, however, that culture is merely "transmitted" from one generation to the next. In fact, culture is constantly reproduced with new modifications as subsequent generations adapt to new circumstances. Finally, cultural practices are symbolic in that they allow for the ascription and communication of meaning or "intelligibility" to others. For example, language is a primary symbol system available to human beings for such purposes.

This is not to argue, however, that such symbolic practices have uniform meaning for all members of a cultural community—cultural psychology recognizes that individuals utilize the symbolic practices available to them for meaning-making in a variety of ways. Cultural psychology regards such individual variation within culture as both interesting and significant. On the other hand, it would be a mistake to assume that individuals can vary within cultures in infinite ways. Rather, it is an essential premise of cultural psychology that individual activity is constrained by culture as much as it is enhanced by it. Thus, cultural psychology is committed to the exploration of "culturally-constituted persons", a designation that reflects the holistic interpenetration and co-constitution of culture and psyche (Shweder, 1990). Culture constrains individual variation, while simultaneously individuals shape, alter and reproduce culture.

Cultural psychology's devotion to accounting for the semiotic nature of human experience implies several fundamental commitments. One of these commitments is the empirical elucidation of human "psychic diversity" across cultures. A second commitment is its focus on human action (or cultural practice) that, in this context, implies situated and meaningful

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human behavior. A third commitment of cultural psychology is the privileging of interpretive methods in an effort to understand cultural meanings inherent to such action. A fourth commitment of cultural psychology is the careful analysis of discourse (or situated communicative practices). The analysis of discursive practice typically focuses upon language usage as fundamental to human experience, where language is seen as the primary symbol system by which human beings construct and communicate meaning (Wertsch, 1985) in embodied action. The centrality of discourse to this analysis of affective experience and its disorders on the Northern Plains is so pronounced that a more detailed discussion of the Ethnography of Communication is in order.

Ethnography of Communication Reviewed

Since the meanings that individuals in different cultures attribute to action are not always apparent to the uninitiated observer, researchers interested in the experiences of culturally constituted persons therefore come to depend upon discourse as a fundamental means of access to and participation in such meanings (Miller & Hoogstra, 1992). Thus, determining the significance of a particular symbol or action for a research participant will in many cases depend upon what the participant actually tells the researcher (via both spoken and gestured channels). This dependence upon discursive practice is even more characteristic of investigations like this study that depends primarily upon communicated reports of affective experience. Thus, the significance of careful attention to sociolinguistic practice in investigating culturally constituted persons would be difficult to overstate.

One important implication of this focus upon discursive practice is that the communication of meaning transcends the grammar, syntax and vocabulary of spoken language. Hymes (1974) has outlined a sociolinguistic agenda that is currently known as the Ethnography of Communication (see also Basso, 1979; Bauman, 1986; Bauman & Briggs, 1990; Bauman & Sherzer, 1989; Briggs, 1986; Carbaugh & Hastings, 1992; Duranti & Goodwin, 1992; Hall, 1992; Katriel, 1991; Philipsen, 1992). This field is dedicated to apprehending the nature of communication with regard to all of its patterned qualities in cultural context (Hymes, 1974): message form, message content, setting, scene, speaker, addressor, audience, addressee, purposes—outcomes, purposes—goals, key, channels, forms of speech, etc. The major contribution of the ethnography of communication has been to recognize that speech (as an embodied human activity) is extremely nuanced and complex—there is far more to

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communication than the referential meanings of the words (or other symbols) employed. In short, it is questionable whether meaning can be properly apprehended in a piece of talk (especially cross-culturally) without attention to the culturally constructed norms and practices of the speaker.

Briggs (1986) has written of many "communicative blunders" during his attempt to understand the meaning systems of his Spanish-speaking residents of Cordova, New Mexico. Most importantly, he notes that the interviewer "stands as a co-participant in the construction of a discourse" (p. 25) and that "contexts are the interpretive frames that are constructed by the participants in the course of the discourse" (p. 12). The implication of this perspective for the interviews to be described here (and to interviewing of every sort) is that the surface meaning of the interview responses first must be understood in light of the meaning of the interview situation itself. Thus, Briggs would assert that the cross-cultural investigator must observe and discern through every step of the research how local norms of interaction, discursive practice, and communicative conduct are shaping the exchange of information so as to maximize the interpretability and cultural validity of participant responses. This is no small task, as each new research encounter necessitates negotiation and re-negotiation of interpersonal relationships within cultural context.

In summary then, this movement within sociolingistics recognizes that communication involves more than the referential meanings of the words employed by participants in discourse, including the interpretive frames—facilitated and constrained by culture—that are constructed and negotiated by participants in discursive interaction. Thus, any meaningful understanding of discursive events depends upon their communicative context. It would be a mistake, however, to ignore or overlook the central role of reference in the analysis of discursive meaning. This seems especially true with regard to this study in which the discursive practices of a distinctive speech community are the subject of inquiry. The majority of these respondents are perhaps a generation or two away from exclusive use of their tribal language. As a result, there was undoubtedly important variation of worldview within the community depending upon facility with the tribal and/or English languages. Furthermore, the usage of English in this community was most assuredly suffused with cultural meanings evident in the tribal language, but often overlooked by exclusive English speakers in their interactions with tribal members. Thus, attention to the subcultural variation in worldview accompanying language use as well as the

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nuances of referential meaning in both the tribal language and English are relevant to properly apprehending discursive meaning in this study.

A primary way, then, that my dissertation research complements the SUPERPFP analyses is to explore in some detail the communicative processes that surround attempts to access disordered experience generally and disordered affective experience in particular. From this perspective, it is recognized that the tribal community sponsoring the SUPERPFP represents a distinctive speech community with complex referential relationships between indigenous terms and related English terms, as well as potentially unique norms governing a wide variety of communicative practices. Systematic attention to these relationships, norms, and practices, especially as they pertain to communication about ordered and disordered affect both generally within community life and specifically within a research context, is essential to a full understanding of such experience.

The emphasis upon situated communicative practices in the investigation of culturally constituted persons is especially relevant for the cultural psychology of affect. More specifically, analytic attention to discursive practices surrounding affective experience within cultural psychology will emphasize the constructive or constitutive power of language and accompanying cultural practices for emotional life.

Emotion in Psychological Research

The study of emotion is, of course, no stranger to psychologists. In a recent summary of psychological research on human emotion that appeared in the Annual Review of Psychology, Oatley and Jenkins (1992) trace the conceptual paradigms that have guided emotion research in psychology back to Darwin (1872/1965) and James (1890). Whereas Darwin emphasized the biological and evolutionary significance of emotional processes and James emphasized the phenomenology of emotional experience, both men conceptualized emotion as primarily intrinsic biological or physiological properties of the organism. The Darwinian tradition in particular inspired research by Ekman (1984) into the cross-cultural prevalence of emotion. Drawing upon the presumed evolutionary significance of facial expression in the communication of internal emotional states to other members of one's species, Ekman discovered that the consistent association by many of the world's cultures of certain facial expressions with supposedly commensurate emotion terminology suggested the universality of at least six basic or core affects. The implication, of course, is that the cultural and linguistic diversity encountered in

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these investigations is trivial insofar as the psychological understanding of emotional experience is concerned.

Oatley and Jenkins (1992) go on to describe the role of cognitive investigations into emotional experience as conducted by psychologists. In response to the early pronouncements by James that emotion was a "feeling of the reaction to an event" (p. 58), the Neo-Jamesian tradition declared that "emotion was perception of a generalized arousal plus an attributional label" (p. 58). Although this idea certainly represents a step beyond the conceptualization of emotion as fundamentally a biological process, it suggests that the cognitive "attributional label" has been overlayed upon the bio-physiological essence of emotion. Focusing upon the cognitive mechanisms involved in emotional experience, then, contemporary psychology tends to emphasize the specificity and function of emotions, including their effects on attention and memory as well as their communicative roles in social interactions. Furthermore, these investigations have allowed for the consideration of emotions in psychology as "mental states," and even recognized that "the conditions that elicit an emotion distinguish it from other emotions" (p. 60). While these relatively recent developments in psychology seem to be conceptual moves in the right direction, the psychological study of emotion still retains a conceptual bias towards the biophysical and intra-psychic character of affect that affords little room for any primary role of social and cultural processes in the constitution of emotional experience. It comes as no surprise, therefore, that Oatley and Jenkins (1992) conclude their "multidisciplinary" review of the psychology of human emotions with a brief consideration of cultural influence: "By conceiving of emotions as certain kinds of states, culture can mould them" (p. 78).

But is culture really so peripheral to the psychology of affective experience? Cultural psychologists think not.

## Cultural Psychology of Emotion

Cultural psychologists and anthropologists have self-critically trained their attention on emotional experience and expression during the past two decades. This attention, grounded in the recognition of the cultural construction of the person, demands a reconceptualization of affect that transcends western notions of emotions as primary physiological essences with secondary cognitive, social or cultural overlays. The result is a new paradigm for emotion research (Abu-Lughod & Lutz, 1990; Armon-Jones, 1986; Harre, 1986; Harre & Gillett, 1994;

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Heelas, 1986; Kitayama & Markus, 1994; Leavitt, 1996; Lutz, 1986, 1988; Lutz & White, 1986; Rosaldo, 1984; Shweder, 1993; Watson-Gegeo & White, 1990; White, 1990, 1993).

The primary challenge facing a new paradigm is to overcome the Cartesian dualism evident in most western academic traditions (Leavitt, 1996). This dualism gives rise to a series of conceptual dichotomies (e.g., natural vs. cultural) that shape academic discourse. Several such dichotomies are profoundly evident in both scientific and western folk discourse about emotions: mind vs. body, cognition vs. affect, thinking vs. feeling, rational vs. irrational, conscious vs. unconscious, intentional vs. unintentional, controlled vs. uncontrolled, etc. (White, 1993). These conceptual oppositions are deeply ingrained in western thinking and have resulted in "two-layer" theories (Lutz & White, 1986) or "dual process" models (White, 1993) of emotion which conceptualize affect as "psychobiological processes that respond to cross-cultural environmental differences but retain a robust essence untouched by the social or cultural" (Abu-Lughod & Lutz, 1990). Thus, with regard to the study of emotions, "any phenomenon acknowledged to be culturally variable (e.g., the language available for talking about emotion) is treated as epiphenomenal to the essence of emotion" (Lutz & White, 1986).

Instead of replicating such dualisms, a cultural psychology with any serious commitment to examining the holistic person as an embodied agent in a socio-cultural context must transcend such thinking. Leavitt (1996) describes an appropriate outcome with regard to the study of affect:

> We would have to see emotions as primarily neither [cultural] meanings nor [psychobiological] feelings, but as experiences learned and expressed in the body in social interactions though the mediation of systems of signs, verbal and nonverbal. We would have to see them as fundamentally social rather than simply as individual in nature; as generally expressed, rather than as generally ineffable; and as both cultural and situational. But we would equally recognize in theory what we all assume in our everyday lives: that emotions are _felt_ in bodily experience, not just known or thought or appraised. (p. 526)

Thus, the dominant characterizations of affective experience as fundamentally biological, individual and private must be counterbalanced with appropriate scholarly attention to their cultural, social and expressive aspects as well.

What concretely, then, does all of this imply for the study of affective experience? First,

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emotion as a research construct must be understood to include these biological, psychological, linguistic, social, and cultural "essences" which are unified in the embodied person engaged in situated and meaningful action. Although few research investigations will be able to analyze all of these constituents simultaneously, a reflexive awareness of the complexity of the domain of inquiry as well as self-control in tendering research claims should be paramount. Second, claims regarding the uniformity of emotional experience (in this richer sense) across cultures seem insupportable. An affective experience that is constituted in part by its semiotic context cannot possibly be universal (i.e., mean the same thing) across all cultures of the world. It is the documentation of such psychic diversity that interests cultural psychologists.

Third, linguistic practices, as principal semiotic systems, take on an essential role in the study of affective diversity. Most researchers within this paradigm emphasize a "discourse-centered" methodological approach (Abu-Lughod & Lutz, 1990; Harre, 1986; Lutz, 1988; Shweder, 1993; White, 1993) that recognizes (beyond the mere referentiality that cross-cultural studies of emotion in psychology typically emphasize) the constitutive power of discourse in the construction of emotional experience. Thus, our enculturation into shared language practices and related social contexts furnishes the ability to participate in the (necessarily shared) emotional life of a community. Fourth, the meanings of emotional experience, as facilitated and constrained by linguistic practices, are situated within wider conceptual webs of cultural meaning regarding personhood, social relations, spirituality, the moral order, etc. (Harre, 1986; Lutz & White, 1986; Shweder, 1993; White, 1993). Of particular interest here is how such local conceptual webs of meaning inform and construct emotional experience for the person. Thus, a systematic exploration of the local ethnopsychology is often warranted in studies of emotional experience across cultures.

Fifth, the translation of cross-cultural affective experience into the culture of the ethnographer seems central to the construction of scholarly knowledge (Leavitt, 1996; Lutz, 1988). According to Leavitt (1996), such translation can be much more than semantic:

> The translation of emotions can seek to convey something of the feeling-tones as well as the meanings of emotions.... This means that ethnographers of affect must work on their own feelings, modifying them to model the emotional experiences of people of another society, and must recast this experience in language that can have a parallel effect on others in their home societies. (p. 530)

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Here Leavitt points to the significance of the ethnographer's experience in the context of research for purposes of the construction of knowledge. Finally then, reflexive attention by the ethnographer to one's own positioning during the research process is essential. With regard to cross-cultural research on emotional experience, then, Lutz and White (1986) suggest four relevant domains for such reflexive scrutiny: (a) the ethnographer's anxieties as signals of potential observer distortion; (b) the distancing techniques necessary to the research process; (c) the ethnographer's personal and cultural assumptions about emotion; and (d) the complex characteristics of the relationships formed during research.

These conceptual commitments to the cross-cultural study of affect have informed the research to be reported here. Of central importance is the discourse-centered methodology that, drawing upon tenets of the ethnography of communication described previously, suggests a concerted focus upon the complex relationship between researcher and respondent in the negotiation of affective meaning. Attention to issues of reference, conceptual translation, worldview, and researcher reflexivity in this study is clearly both necessary and desirable.

Conceptual Summary and Research Questions

Given the foregoing introductory material, including a broad conceptual overview, allow me now to clarify that the goal of this research is to explore certain facets of the local construction of affective experience and its disorders in the specific context of formal psychiatric interviewing on an American Indian reservation on the Northern Plains (the pseudonymously-identified "Black River" Indian Community). This investigation privileges a discourse-centered methodology—highlighting the central role of communicative practices as they pertain to the construction and communication of normative and disordered affective experience—while examining cultural connections between such experience and relevant aspects of the local ethnopsychology. Research conclusions will then be evaluated for their psychiatric significance with regard to two DSM disorders as well as for mental health research and service delivery in native communities more generally.

The specific focus of this dissertation concerns the complex relationship between psychiatric diagnoses obtained across two distinct diagnostic interviews for Black River respondents. In an ideal world, agreement between diagnoses obtained by lay interviewers using the CIDI (which form the basis for estimated prevalence rates) and the diagnoses obtained by clinicians using the SCID would be reasonably high. If so, then project researchers might

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confidently conclude that they had in fact obtained accurate prevalence rates for the disorders in question. Unfortunately for the SUPERPFP researchers, concordance rates for the CIDI and SCID diagnoses at Black River were exceptionally low.

In light of these startling findings, my dissertation seeks to answer one primary question and two subsidiary questions. First, how might local cultural practice account for marked discordance between lay and clinical interviewers with regard to two prevalent psychiatric disorders (Major Depressive Episodes and Posttraumatic Stress Disorder) in a community sample of American Indian respondents? Second, what are the implications of such an account for (a) the cross-cultural assessment of mental illness, and (b) the cross-cultural validation of "established" diagnostic categories? Prior to proceeding to a detailed description of the research method, however, it seems appropriate to provide a cursory overview of the research setting.

## The Research Setting

The research described here was undertaken on a northern Plains Indian reservation. Following appropriate negotiations between the National Center and the local tribal governments of four participating reservations across two large tribal groups, it was agreed that all reports pertaining to the SUPERPFP in these settings would refrain from identifying the particular tribal communities in question. My research focused principally upon just one of these reservation communities that I will designate fictitiously as the Black River Indian Community. Space will not permit a comprehensive review of Black River culture and history. Rather, this overview will briefly describe several facets of life at Black River in order to provide the contextual backdrop for comprehending the analyses to be presented shortly. Fortunately, the available literature concerning the affairs—both historical and contemporary—of this widely celebrated cultural group is one of the most extensive in North American scholarship. For a more thorough ethnographic introduction, interested readers should consult DeMallie and Parks (1987), Grobsmith (1981), Hassrick (1964), Hyde (1961), and Walker (1980, 1982, 1983). Owing to the relatively contemporary focus of Grobsmith's ethnography, the bulk of the material summarized here draws heavily upon her excellent review.

### A Resume of Black River Culture and History

It will be worthwhile here to review as briefly as possible several historical and cultural features that should help to locate the Black River tribe in relation to other North American Indian peoples. Contemporary Black River tribal members are descendants primarily of one of seven bands

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of the westernmost of seven divisions (or "council fires") of a populous Plains tribal culture. All of the various "camps" comprising this large cultural group have been categorized as part of the Siouan language family. The westernmost bands of this tribal group are alleged to have migrated onto the high Plains sometime during the seventeenth century, although tribal experts insist that their creation as a people occurred in the mountains at the heart of their present territory. Insofar as the population distribution of the horse penetrated this part of the country throughout the early eighteenth century, this culture was dramatically transformed by the advantages of a mounted lifestyle around this time period. Trade relations with the French and English shaped intertribal affairs on the northern plains during the eighteenth and nineteenth centuries in particular, where tribal imbalances in the stock of horses obtained from the south and west (which afforded increased success in hunting, warfare and general mobility of people and property) and guns obtained from the east (which afforded increased success in hunting and warfare) mediated power and politics within the region.

Once mounted, the western bands commenced a lifestyle that has come to prototypically represent a generic "American Indian culture" in the popular mind around the world. The bands were organized around extended family groups (or tiospayes; see Appendix A for a glossary of tribal terms employed in this study) that lived in proximal contact with each other over an expansive hunting territory. The tiospaye was based upon a fairly elaborate kinship system involving polygyny, with complicated norms about proper "respect" (i.e., strict codes governing interaction such as proximity, gaze, verbal address and topics of conversation). The bands apparently came together each summer for collective hunting and important ceremonies. Buffalo was the main resource for tribal life, providing food, shelter, clothing and various household implements as well as robes for trade with Euro-Americans. Success in hunting buffalo required fast horses. Thus, ownership of horses became the measure of wealth, and the means to increased wealth and status (the latter was obtained primarily through generosity and valor). An abundance of horses allowed the owner to hunt effectively, move large tipis and abundant property when following the buffalo, loan extras to tribal members in need (thereby gaining a following), give them away extravagantly (again increasing status), and ultimately raid other tribes successfully for more horses.

Leadership, predominantly a male opportunity, was earned through evidence of valor, reputation, and generosity. These qualities inspired confidence in others to trust, honor, and follow such a person. Accomplishments in war, including ferocity in the face of life-threatening odds, merited the highest regard, and every young man aspired to bravery in battle. Political and

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economic influence for both men and women might also be earned through obtaining supernatural power for healing (although such powers were often designated to one by the spirits rather than voluntarily pursued as such). Band society was structured so as to afford a great deal of flexibility for band members (especially men) to make their own decisions and follow their own paths. If an individual wished to strike out on his own, following no leader in particular, that was his prerogative, although one's choices were cast in the context of personal and familial reputation and were always subject to public scrutiny and the attending gossip. Band leaders made decisions on important matters primarily through discussion and consensus among themselves, but the force of their decisions depended upon coercion by the Akicita warrior societies only upon rare occasions.

The tribal cosmology is exceedingly complex (see DeMallie and Parks, 1987; Walker, 1982, 1983, 1987), but centers upon personal and collective recognition of Wakan Tanka, the "Great Mystery." Wakan Tanka is understood to be evident throughout the universe and manifests sacred power in the world through a pantheon of spiritual forces or beings (four of which include, for example, Inyan or Rock, Maka or Earth, Skan or Sky, and Wi or Sun). Supplication of spiritual beings is often mediated through the ritual smoking of a pipe, following the significant mythic-historical presentation of the original sacred Pipe to the tribal community by the White Buffalo Calf Woman. Thus, pipe ceremonies featured prominently in several of the original seven sacred rites maintained by the community, although contemporary tribal members are typically familiar with just a few of these ceremonies. The inipi ceremony, or sweatlodge rite, involves prayer and purification in a shelter constructed of willows and hides or blankets where participants are exposed to heat and steam throughout the ritual. The hanbleceya ceremony, or vision quest, involves the pursuit of supernatural power through isolated deprivation in the mountains. The wiwanyank wacipi, or Sundance, involves the collective renewal of the world and may provide opportunity for the fulfillment of a personal vow in exchange for supernatural favor. The key to many of these rituals was the petition for supernatural favor based upon pity. Thus, the Sundance, for example, involves acts of voluntary self-torture designed to evoke pity from Wakan Tanka, and thus, attention and intervention in human affairs. Furthermore, all spiritual affairs represent the possibility of danger owing to the nature of the sacred power encountered in such settings—ritual malfeasance is just one way in which disastrous effects may result from ceremonial supplication of supernatural forces. Finally, it is worth noting that loanpi and yuwipi ceremonies (not considered part of the seven sacred rites as such) involve the petition for healing or other kinds of supernatural aid mediated by

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medicine persons with ceremonial expertise in calling upon spirits for assistance in helping petitioners.

With the advent of U.S. treaty-making with the western bands, a rather vast expanse of territory was reserved by them for their exclusive use through the Fort Laramie Treaty of 1851 and the Treaty of 1868. The latter established a Great Nation for the bands that was legally off-limits to white exploration or settlement. Characteristic violation of these treaties by the United States resulted in political tensions during the latter half of the nineteenth century as white incursion into their territory led to warfare with the United States (as well as with westward tribes whose territory contained more game). The military encounters between these bands and the United States erupted onto the national scene periodically from the 1860s through the 1880s. As a result, the tribal presence and participation in the annihilation of Custer at the Greasy Grass in 1876, as well as the vengeance wrought by the U.S. Seventh Cavalry against one of the bands at Wounded Knee in 1890, still resounds in the contemporary cultural consciousness of tribal members. In the end, of course, land holdings of the bands shrunk considerably, with each band (or group of bands) residing on a separate reservation. Even the tribe's most sacred mountains were annexed by the United States during this period. With military confinement to these reservations (especially after the complete demise of the buffalo in the mid-1880s), intertribal warfare and horse raiding declined rapidly and almost complete dependence upon government rations followed.

It is important to note, however, that the Black River band was generally successful in protecting its interests and achieving its goals vis-à-vis the United States government without recourse to warfare, owing to the gifted leadership of its most famous headman, Sinte Gleska. This leader's many accomplishments included persuading the U.S. government to relocate the Black River reservation half way across the state to more fertile territory in 1877. Thus, the Black River band became known for the conciliatory stance of its headman in sharp contrast to some of the other band chiefs that advocated war and resistance throughout this period. Unfortunately, after more than two decades of shrewd leadership, Sinte Gleska was assassinated by a medicine man from his own band in August of 1881. The reverberations of this astonishing act still divide families at Black River to this day.

The twin pressures of federal Indian policy and Christian missionaries have substantially altered the ways of tribal members at Black River. An Episcopalian mission was established in one of the reservation communities in 1874, and still operates a boarding school there today. More

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influential during the past century, however, has been the historically powerful Catholic Mission that was established (complete with its own boarding school) in a different reservation community in 1885. During my time on the reservation, I must have met as many as ten different Jesuit priests presently associated with this mission. As a result of the "civilization" process, nearly all contemporary residents of Black River are fluent in English, although a good majority from the more traditional communities continue to speak their tribal language in everyday social settings. As with most of the bands, aboriginal ceremonial life at Black River was widely disrupted, going underground for several decades, but a vital public renewal in ceremonial practice has occurred on the reservation since the Indian rights era of the 1970s.

The Black River Context Today

The Black River Indian reservation lies in the heart of the northern plains and is the homeland to between twenty and thirty thousand enrolled tribal members comprising the descendants of the original Black River band. Sibling bands sharing a relatively common language, culture, and history occupy a reasonably large number of additional reservations throughout the Northern Plains (with a total tribal population exceeding 100,000 individuals). The reservation, consisting of less than one million acres (mostly Indian-owned), is rectangular in shape and roughly sixty miles across (north-south) and one hundred and thirty-five miles wide (east-west). A river marks the northern boundary of the reservation, while the state line delineates the southern border. Between the river and the state line stretches a sea of rolling prairie, punctuated occasionally by creeks and ravines that intrude upon the omnipresent grasslands. Present reservation boundaries are contiguous with county boundaries, and the county seat (a non-Indian township surrounded by reservation trust land where tribal jurisdiction prevails) is situated in the north central portion of the reservation. Black River is comprised of twenty communities originally established as settlements of the various tiospayes. Some of these historic communities lie outside of present-day reservation boundaries and represent remote pockets of Indian trust land located as distantly as a hundred miles from the tribal headquarters. The principal tribal and federal government offices, however, are situated centrally in a community lying at the heart of the reservation.

According to the 1990 U.S. census, less than 10,000 people occupied tribal lands on or adjacent to the reservation—most of these (83 percent or about 8,000 persons) were Indian, although it seems likely that a small but significant minority of these Indian residents were enrolled members of Black River's sibling bands that have married in or inherited lands at Black River (and are,

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therefore, technically not Black River tribal members). The resident tribal population is exceedingly young. The 1990 U.S. census indicates that roughly 4,000 of the 8,000 Indian residents of the reservation were less than 18 years of age, and Black River had the youngest median age of the ten most populous American Indian tribes in the country. Of note during my time in residence was the relatively large (by Northern Plains standards) proportion of non-Indians living and working on the reservation. This is reflected in householder statistics in the 1990 U.S. census in which the Black River Indian reservation had the largest percentage of non-Indian householders of any of the ten largest tribes in the country. The Black River tribe maintains its own membership records, but the exact numbers regarding total membership are somewhat elusive. Tribal membership is signified by "enrollment" based upon degree of tribal ancestry. Enrollment currently requires that an individual prove at least one-fourth or more degree of tribal "blood" (meaning descendancy from original band members) and forego membership in any other tribal nation. Enrollment affords the member the benefits and privileges of citizenship in the "domestic dependent nation" known as the Black River Indian Community: health care, educational resources, favored employment status, voting rights, etc. (for more information regarding the rights of Indians and tribes, see Pevar, 1992).

Tribal government at Black River is dictated by the Constitution and By-laws of the Black River Indian Community, as well as its Corporate Charter. All of these documents were ratified by Black River tribal members in the mid-1930s in response to the "reform" in Indian affairs known as the Indian Reorganization Act (or Wheeler-Howard Act). The Black River Tribal Council consists of twenty tribal members elected from thirteen districts (encompassing the twenty communities) by enrolled members of voting age (some districts select more than one representative depending on their population). In addition, the offices of president and vice-president are elected by the tribal membership at large. These elected officials are responsible for all of the administrative, legislative and financial affairs of the reservation, maintaining a government-to-government relationship with the United States. The Tribal Council oversees hundreds of employees in a number of programs managed for the benefit of tribal members. In addition, the council must continually negotiate with the Bureau of Indian Affairs and the Indian Health Service in the interest of tribal well-being. These indomitable federal bureaucracies, historically known for their waste and mismanagement, control most of the resources that are presumably intended for tribal benefit.

The fact that the majority of tribal members live away from the reservation (frequently returning, however, to take up residency at various times in their lives) is necessitated in part by an

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enduring depressed reservation economy. The residents of Black River have depended primarily upon agriculture and livestock for their livelihood. There are limited tracts of fertile lands where irrigation is feasible and some residents make a living from dry-farming on other parts of the reservation. Viable crops include alfalfa and wheat. Still others maintain livestock that they graze on their own land. Several lease their land to outside cattle owners for grazing purposes. Nevertheless, the challenges inherent to making a financial success of any of these enterprises are difficult to surmount. As a result, unemployment is high at Black River (local estimates are as high as eighty percent in the off-season). The primary sources of stable income today are the federally funded programs designated by Congress in fulfillment of its Trust Responsibility to the tribal nations. Thus, the Bureau of Indian Affairs, Indian Health Service and Tribal Council together employ hundreds of people, although not all of the employees are members of the Black River Indian Community. In addition, the county school district and a few private businesses, primarily located in the non-Indian county seat, also provide limited employment opportunities for Black River tribal members. More and more, the council is exploring fruitful business ventures. One such controversial venture under discussion during my time on the reservation in late 1997 and early 1998 was a large-scale hog farm, although many tribal members worried about resultant damage from the enterprise to the local environment. In addition, a renowned tribal college has been growing steadily since the early 1970's, offering hundreds of residents renewed ambitions and upward mobility. About a decade ago, the college began offering Master's degrees, making it the first tribally controlled university in the country. Still, census figures for 1990 indicate that the median household income for Black River tribal members (on and off-reservation residents were lumped together) was $11,703, with 52 percent of tribal members living below the poverty level. Residents of Black River are therefore somewhat more susceptible to the usual social correlates of poverty: a slightly lower life expectancy with higher rates of substance abuse, crime, health and mental health problems and demoralization.

A more detailed review of band history and culture would reveal the development and maintenance of the cultural "ethos" that has prevailed in tribal life. These behavioral ideals have found continuity despite the various and dramatic transformations that have permeated life at Black River. Hassrick (1964) writes:

> Bravery, fortitude, generosity and wisdom—these were the virtues which all men were expected to seek. While it was understood that no man could achieve excellence in all of

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> these qualities, it was believed that every man should endeavor to attain something of each.... Yet each moral quality constituted a remarkable challenge; each was a goal worthy of accomplishment. Nor were they separate, but rather interdependent. In order to exhibit generosity, for example, bravery and fortitude—conceivably even wisdom—were contributing factors.... The ideal female virtues were also four in number and included, as for men, bravery and generosity. But the significant difference in the expected behavior for females was expressed in the last two feminine virtues: truthfulness and childbearing. Bravery for women was closely equated with fortitude for men. (p. 32, 39)

The contemporary significance of these ideals with regard to the research presented here will be described in more detail later.

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# Method

Because the analyses reported here occurred in the context of the SUPERPFP, it is necessary first to describe several methodological facets of the larger epidemiological study for adequate comprehension prior to reviewing the details most relevant to my own analyses. One primary goal of the SUPERPFP was, of course, to obtain accurate prevalence rates of several DSM-III-R disorders in two large tribal populations. Since my own research was confined to just one of two participating tribal entities on the Northern Plains, I will limit any further discussion of SUPERPFP (when possible) to the particulars most relevant for this single reservation that I refer to fictitiously throughout this study as the Black River Indian Community.

## Black River CIDI Administration

### CIDI Participants

The sampling strategy for SUPERPFP started with simply defining the population of interest as the entire enrolled membership at Black River between the ages of 15 and 55 as of June of 1997. The age parameters of this definition would allow for direct comparisons with the National Comorbidity Survey (Kessler, et al., 1994). In addition, identifying tribal membership as the primary criterion proved useful pragmatically because all tribal enrollment records were made available at the local Bureau of Indian Affairs (BIA) agency office for official project purposes. SUPERPFP staff utilized these tribal records in order to first generate their sample and then locate and recruit respondents for participation. Thus, computerized records of the Black River membership served as the basis for designating a stratified, random, and representative sample of tribal members between the ages of 15 and 55 who were currently residing on or near the reservation (defined as within 20 miles of reservation boundaries).

It should be noted that current reservation residency was difficult to predict, and many of the respondents designated as part of the sample were discovered to have moved away from the reservation since last updating their addresses with the BIA enrollment office. As a result, only about one-third of identified sample respondents were actually deemed eligible to participate in the study once their current residency was determined. This potential threat to the representative nature of the sample was controlled for, however, by the sophisticated use of sampling by replicates. Although the precise nuances of this sampling strategy are beyond the focus of this review, it is perhaps helpful to explain that the entire population (i.e., tribal memberships) of

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both Northern Plains reservations (including Black River and its sibling reservation) was divided into eight categories (four age groups by two genders) prior to random assignment to replicates (consisting of 200 respondents per replicate), each of which was designed to retain the stratified and representative character across the eight categories of the study population. Overall, 50 such replicates were designated for possible inclusion in the study, although project researchers understood that they would most likely obtain a large enough participation rate for purposes of their analyses using only a subset of these replicates. The point here is simply that cohorts of randomly selected and representative respondents were successively released for participation until an adequate overall participation rate had been obtained. Furthermore, all respondents within every released replicate had to be recruited for participation before the overall sample was considered complete. This sampling strategy thus protected against the potentially biasing effects of high sample ineligibility rates, etc., thereby preserving the representative nature of the total sample (although derivative statistics obviously required appropriate weighting to ensure generalization back to the population of interest).

With a population of over 20,000 enrolled tribal members (the majority of whom resided off-reservation and were thus ineligible for participation), nearly five percent of the Black River tribal membership (N = 898) participated in the project. Although several demographic indicators specific to the Black River sample were not readily available for this study, the demographics for the entire Northern Plains sample (including both Black River and its sibling reservation [N = 1660]) indicated that about 52 percent of the sample was female, 26 percent of respondents were currently married (with 51 percent reporting that they had never been married), 57 percent of the sample had graduated from high school, 55 percent of respondents had some form of employment, and 66 percent of the sample earned less than $20,000 in the previous calendar year.

CIDI Instrument

Recall that the SUPERPFP design involved the administration of two distinct diagnostic interviews. In the first phase of the project, "lay" interviewers (i.e., community members employed by the project) administered a computerized protocol that included an adapted version of the Composite International Diagnostic Interview (known as the "CIDI"; Robins, et al., 1988), a fully structured assessment tool developed in conjunction with the World Health Organization that weds questions from the Diagnostic Interview Schedule (known as the "DIS"; see Robins,

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Helzer, Croughan, & Ratcliffe, 1981; Robins, Helzer, Ratcliff, & Seyfried, 1982) with items derived from the Present State Examination (known as the "PSE"; see Wing, Cooper, & Sartorius, 1974). The CIDI was specifically designed to enable non-clinicians to reliably obtain diagnostic information with regard to DSM mental disorders (see Appendix B for representative items). More specifically, information regarding psychiatric symptoms is gathered through a series of carefully worded questions that are read verbatim to respondents. Respondents typically answer dozens of these standardized questions either in the affirmative or the negative, or sometimes by choosing one of several authorized responses. Respondents are required to answer these questions in the format prescribed by the instrument, and interviewers are not allowed to explain, interpret, or influence the respondent's answers beyond merely repeating the question or choosing among a limited array of stock phrases. Lay interviewers immediately code respondent information by entering answers on the computer before proceeding to the next question. The data coded for each respondent are then analyzed by computer algorithm and psychiatric diagnoses based upon particular constellations of coded responses are generated for each individual.

The specific sections of the CIDI adapted for use in the SUPERPFP lay interviews enabled assessments of the lifetime and twelve-month prevalence of the following DSM-III-R mental disorders: Alcohol Abuse (AAB) and Dependence (ALC), several kinds of additional Psychoactive Substance Abuse (DAB) and Dependence (DRUG), Major Depressive Episodes (MDEs), Posttraumatic Stress Disorder (PTSD), Panic Disorder (PAN), and Antisocial Personality Disorder (ASPD). In addition, the SUPERPFP CIDI allowed for the designation of a current diagnosis of Dysthymic Disorder (DYS) and Generalized Anxiety Disorder (GAD). I should add that the lay interviews administered in the SUPERPFP incorporated several other sets of standardized questions beyond the CIDI in order to obtain information related to demographics, health attitudes and behaviors, service utilization, etc.

CIDI Procedure

During my year with the SUPERPFP, just over ten tribal members were hired and trained by project staff to administer the lay interviews at Black River. Lay interviewers were recruited by a SUPERPFP field office director (also a tribal member) who advertised employment through the usual tribal mechanisms (e.g., local media, flyers, word of mouth, etc.). Once hired, lay interviewers received a five-day training seminar covering such topics as an introduction to

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project staff, an overview of the project, respondent recruitment and location strategies, an orientation to project documentation, instructions on operating the computer, a review of interviewing conventions, a presentation of emergency procedures, and the completion of mock interviews with feedback. Once the trainees had demonstrated proficiency through the mock interviews, they were provided with several Interviewer Contact Forms (ICFs) containing respondent information and expected to locate and interview such respondents.

Location of respondents was an especially difficult task for the lay interviewers, given the extensive distances involved between the various reservation communities, the absence of telephones in many homes, and the high mobility of the population. Nevertheless, lay interviewers were expected to track down every respondent, either recruiting eligible respondents for the interview or certifying that they were ineligible for participation. If in fact the respondent was determined to live beyond 20 miles of the reservation boundaries, then lay interviewers were required to verify from multiple sources that the respondent had in fact moved away before "closing out" the ICF.

Interviews could be conducted at any time of the day depending upon the scheduling by the interviewer and the participants. Whether conducted at the reservation field office or in respondent homes, lay interviewers were expected to follow the same procedure for every respondent, including: explaining the purpose of the interview, assuring the respondent of the confidentiality of their information, obtaining signed consent for participation, recording the interview on audio cassette (unless the respondent refused consent for this), administering the interview using a laptop computer, saving respondent information to a floppy disc, compensating the respondent for participating, and submitting the disc, cassette tape, and accompanying paperwork to field office staff. On average, the lay interviews required four hours to complete, with a significant minority requiring as long as six hours. All respondents who completed the lay interview were paid $40 for their participation.

Lay interviewers traveled extensively throughout their tenure with the project, sometimes driving over 200 miles round trip to complete a single interview. Lay interviewers were compensated on a per-interview basis, along with additional remuneration for closing out the ICFs of respondents deemed ineligible for participation. In addition, lay interviewers were reimbursed for their automobile mileage. Once the lay interviewers met a certain quota of interviews per month in consecutive months, however, they became "salaried," thereby

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protecting them from the seasonal vicissitudes of completing interviews in this context. Without exception, the lay interviewers resided in various communities on the reservation, and were thus recognized and often acquainted with a substantial number of their respondents. This familiarity between lay interviewers and their respondents represented one salient distinction between the SUPERPFP and NCS methodologies, since NCS lay interviewers were "not allowed to interview anyone they know personally" (R. Kessler, personal communication, September 29, 2000). Official SUPERPFP policy did discourage the administration of the lay interview to a relative, but the kinship networks that prevail on the reservation (combined with the institutional and economic pressures of completing interviews as efficiently as possible) resulted in intermittent (but potentially significant) instances of interviews conducted with second-degree relatives.

Finally, I should note that turnover at Black River was modest compared with other project sites, and a fully staffed cadre included up to seven interviewers at any one time. Three "veteran" interviewers endured throughout the entire year and a half of the data-gathering phase of the project.

## Black River CIDI Prevalence in Context

### Black River Prevalence Rates

Prevalence rates of the various SUPERPFP DSM disorders were calculated by statistical estimation for the entire population based upon CIDI sample findings. The exact prevalence rates for this study are still being finalized by project researchers, but preliminary weighted prevalence rates were very generously provided by project staff for this study (L. Davis, personal communication, March 2000; J. Beals, personal communication, July 2000). Even though they are preliminary statistics, these prevalence rates are not expected to change substantially in response to additional considerations such as weighting the data somewhat differently, etc. For the purposes of this investigation, only lifetime prevalence rates are of interest (see Table 1). Thus, the lifetime prevalence rates for the three target mental disorders most central to the SUPERPFP were as follows (see Appendix C for DSM-III-R diagnostic criteria for select disorders): (a) Alcohol Dependence (ALC) was estimated to occur in 20.6 percent of the Black River population between the ages of 15 and 55; (b) Major Depressive Episodes (MDEs) were estimated to occur in 4.5 percent of the population; and (c) Posttraumatic Stress Disorder (PTSD) was estimated to occur in 21.6 percent of the population. The prevalence rate for any of these three lifetime disorders occurring for members of the Black River reservation population

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was estimated to be about 34 percent. Finally, 53 percent of the Black River population was estimated never to have suffered from any of the CIDI disorders explored in the SUPERPFP. Thus, something like 13 percent of the population was estimated to have suffered from a DSM-III-R disorder other than these three target disorders (e.g., AAB, DAB, DRUG, DYS, GAD, PAN, or ASPD).

For reasons that will become apparent in later analyses, it will be instructive here to report estimated prevalence rates for three additional categories of disorder. First, an overall Depressive disorder (DEP) category, comprising estimated lifetime rates for Major Depressive Episodes (MDEs) and/or current Dysthymic Disorder (DYS), was estimated to include 8.1 percent of the Black River population. Second, a more inclusive category of Alcohol Disorders (ADS), comprising estimated lifetime rates for Alcohol Abuse (AAB) or Alcohol Dependence (ALC), was estimated to include 32.2 percent of the Black River population. Finally, an overall Substance Dependence (SUB) category, comprising estimated lifetime rates for Alcohol Dependence (ALC) and/or other Drug Dependence (DRUG), was estimated to include 22.1 percent of the Black River population. Reference to these more inclusive prevalence rates for Depressive Disorders (DEP), Alcohol Disorders (ADS) and Substance Dependence (SUB) will occasionally provide a more useful statistic for the comparisons to be described later.

Comparison with U.S. Prevalence Rates

These various DSM-III-R lifetime prevalence statistics for resident Black River tribal members are difficult to interpret apart from some sense of the normative rates for these disorders in the general U.S. population. In fact, one reason why the SUPERPFP was designed as a replication of the National Comorbidity Survey (NCS; see Kessler, et al., 1994; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) was in order to afford direct epidemiological comparisons. In the interests of adequate contextualization, it seems appropriate here to provide several relevant results from the NCS (see Table 1): (a) Alcohol Dependence (ALC) was estimated to occur in 14.1 percent of the U.S. population between the ages of 15 and 55; (b) Major Depressive Episodes (MDEs) were estimated to occur in 17.1 percent of the population; and (c) Posttraumatic Stress Disorder (PTSD) was estimated to occur in 7.8 percent of the population. Other prevalence estimates, while not directly comparable to the Black River statistics offered previously, remain enlightening. For example, the lifetime prevalence of any Affective disorder (including MDEs, DYS, and Manic Episodes) was estimated to be 19.3

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percent in the U.S. population. Furthermore, the lifetime prevalence of any Substance Abuse or Dependence was 26.6 percent of the U.S. population. Finally, 52.0 percent of the U.S. population was estimated never to have suffered from any of the CIDI diagnoses explored in the NCS.

In summary, comparisons of the prevalence rates for several DSM-III-R mental disorders for residents of the Black River Indian reservation and the general U.S. population are revealing. I should note first, however, that the SUPERPFP methodology departed significantly from the design employed in the NCS with regard to the exploration of PTSD prevalence in particular. For the purposes of a more accurate comparison statistic, SUPERPFP researchers intend to disseminate the prevalence rates for PTSD at Black River using the CIDI results for just the first of up to three traumatic experiences reported by Black River respondents. Thus, instead of a PTSD prevalence of 21.6 percent (based upon multiple traumas reported in the SUPERPFP), project researchers instead intend to report a lifetime PTSD prevalence of 15.7 percent so as to be more directly comparable to NCS rates as well as other epidemiological studies that have investigated PTSD (J. Beals, personal communication, August 2, 2000). With this caveat in mind, comparisons of psychiatric prevalence suggest that the Black River population experiences half again as much Alcohol Dependence as the general U.S. population, double the instances of PTSD, but just one-fourth the rate of MDEs (or perhaps two-fifths the rate of the more inclusive Depressive Disorders [DEP]).

Black River Prevalence Rates Assessed

I asserted earlier that the SUPERPFP represents the most ambitious and sophisticated effort to obtain accurate prevalence rates for psychiatric disorders among American Indian populations in the history of the U.S. Great care has been taken by project researchers to negotiate the very tricky methodological terrain of several contemporary reservation communities in order to generate the most accurate statistics possible. And although the SUPERPFP research team fully anticipated elevated rates of Alcohol Dependence or PTSD at Black River, none actually believes that the prevalence of Major Depression in this community is truly less than five percent. In fact, near the conclusion of SUPERPFP's data gathering phase, project researchers announced plans for an additional substudy to re-examine the actual prevalence of depression in their samples (J. Beals, personal communication, April 30, 1999). Likewise, the thrust of the analyses presented here will be to explore and explain this

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conundrum, albeit from a different methodological framework.

## Black River SCID Administration

### SCID Sample

While the first phase of the SUPERPFP involved the administration of the CIDI by lay interviewers to a random, representative sample of Black River respondents, the second phase of the project involved the administration of a clinician-administered diagnostic interview to a subsample of these Black River respondents. This clinical subsample consisted of individuals selected from the original Northern Plains sample (including both Black River and its sibling reservation [N = 1660]) using a strategy designed to identify approximately fifty respondents for each of the three target lifetime DSM-III-R disorders (ALC, DEP [MDE and/or DYS], and PTSD), plus an additional fifty respondents to serve as comparison subjects (i.e., no diagnosis of any of these disorders).

Recall that the original CIDI sample was derived from 50 replicates, each containing 200 respondents, selected so as to preserve the stratified, representational character of the Northern Plains population within each replicate. In order to designate the clinical subsample, project researchers estimated the prevalence rates for each of the three target disorders following several months of data gathering and the release of some 14 replicates for CIDI interviewing (the interview completion rate was sufficiently large that it did not matter that the majority of these replicates were not yet completely "closed out" [with all respondents in the replicate either completing the interview, refusing to participate, or deemed ineligible for participation]). These very early prevalence rates were multiplied by the average number of completed interviews per replicate (at that time, n = 48 for every 200 respondents) in order to arrive at an estimate for the number of respondents per replicate that would likely warrant the diagnosis of interest. Given that the ultimate goal was to obtain 50 respondents per diagnosis across both Northern Plains reservations, SUPERPFP methodologists assumed an 80 percent completion rate for clinical follow-up interviews and then projected the number of replicates required in order to obtain the requisite number of interviews per diagnosis. So, for example, the preliminary rate for PTSD was 17 percent, multiplied by an average of 48 completed CIDI interviews per replicate, resulting in an estimated 8.2 respondents diagnosed with PTSD per replicate. Since clinical follow-up interviews for 50 respondents with this diagnosis across both reservations were ultimately desired, 63 respondents needed to be selected for clinical follow-up assuming a

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response rate of 80 percent for these second interviews. In order to sample for these 63 respondents then, 7.7 replicates were required, given the yield of 8.2 respondents per replicate. Project researchers thus determined that eight replicates (rounded off, of course) would be required in order to obtain the desired fifty respondents with PTSD that might actually complete the follow-up clinical interview. Once the requisite number of replicates was determined in this manner for each of the three target disorders, the actual designated replicates were selected randomly from a block of twenty total replicates. All respondents from the designated replicates with the target diagnosis across both reservations were then recruited for clinical follow-up interviews.

The comparison respondents were designated using the same strategy except that the goal was to interview 50 respondents across three comparison categories: a "No Symptoms" category consisting of 12 respondents, a "Low Symptoms" category consisting of 13 respondents, and a "High Symptoms" category consisting of 25 respondents. The precise details of the algorithms used to define these categories is beyond the scope of this discussion, but it should suffice here to observe that the criteria for category assignment depended upon the respondent exhibiting (a) no lifetime diagnosis of any of the three target disorders (although other lifetime disorders might be present), and (b) a particular pattern of respondent endorsement of some seventy current psychological symptoms in a version of the Symptom Checklist (a non-CIDI section of the lay interview).

It is perhaps evident from this relatively protracted description of the clinical interview sampling strategy that comorbidity among the various DSM-III-R disorders was ignored in the generation of the clinical subsample. Thus, a given replicate may have been designated for clinical follow-up with regard to several target disorders; a given respondent may thereby have been selected for clinical follow-up due to more than one target disorder if his replicate was designated for follow-up for more than one target disorder; or a given respondent may have been selected for clinical follow-up on the basis of one disorder while warranting a CIDI diagnosis for a second target disorder for which he was not technically selected because his particular replicate was not designated for follow-up interviews with regard to the second disorder. The point here is simply that the clinical follow-up sampling strategy across both Northern Plains reservations was designed to obtain at least fifty instances of each of the three target disorders, plus fifty comparison respondents, but the exact diagnostic portrait of the subsample was not precisely

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known until after the clinical follow-up interviews were completed.

Utilizing the complex sampling strategy just described, the clinical subsample at Black River consisted of 153 respondents. As part of my project responsibilities during my year with the SUPERPFP team, I conducted clinical follow-up interviews with nearly half of these individuals (n = 75). Since this smaller subset of the Black River clinical subsample forms the basis for the analyses to be presented here, the remainder of this study will refer to these 75 respondents as the "SCID sample". The SCID sample included 33 male and 42 female respondents between the ages of 16 and 55 across 13 replicates. Total counts by CIDI diagnosis for the 75 respondents were as follows (see Table 2): AAB = 0; ALC = 38; DAB = 3; DRUG = 8; SUB (comprising ALC and/or DRUG) = 39; MDE = 9; DYS = 10; DEP (comprising MDE and/or DYS) = 15; PTSD = 37; PAN = 2; GAD = 2; ASPD = 16; and No CIDI diagnosis = 21 (due to extensive comorbidity, these numbers do not sum to 75). With regard to inclusion in the clinical subsample, 53 respondents were selected for clinical follow-up interviews based upon one or more of the three target disorders: 26 were selected for participation based upon a CIDI diagnosis of ALC (12 additional respondents who were selected for other diagnoses also had comorbid ALC, bringing the total to 38 of 75 respondents with the disorder as above); 15 were selected for participation based upon a CIDI diagnosis of DEP; and 32 were selected for participation based upon a CIDI diagnosis of PTSD (where five additional respondents who were selected for other diagnoses also had comorbid PTSD). The remaining 22 SCID respondents were selected as comparison subjects: seven of these were selected for No Symptoms, 11 were selected for Low Symptoms, and four were selected for High Symptoms (with one respondent carrying a CIDI diagnosis of DRUG, which was not a target disorder).

SCID Instrument

In the second phase of the project, trained clinicians (i.e., psychologists and psychiatrists) engaged the Black River clinical subsample in a follow-up diagnostic interview using the Structured Clinical Interview for the DSM-III-R (Spitzer, Williams, Gibbon, & First, 1992; Williams, et al., 1992), a semi-structured assessment tool designed to facilitate the systematic evaluation of DSM diagnostic criteria. The SCID was specifically designed to enable trained clinicians to employ seasoned clinical judgment in the diagnostic process (see Appendix D for representative items). The SCID is thus much different than the CIDI in that clinicians read standardized prompts verbatim by way of initial inquiry into relevant symptoms, but then

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proceed to ask as many unscripted follow-up questions as are judged necessary to confidently rate the various DSM diagnostic criteria. In other words, rather than simply recording a respondent's reply to a particular question, the clinician is engaged in the fluid negotiation of understanding with regard to possible psychiatric symptoms. In this manner the clinician follows the written protocol criterion by criterion, disorder by disorder, rating whether each criterion has been met along the way. At the conclusion of the interview, ratings of the diagnostic criteria are reviewed by the clinician and psychiatric diagnoses are assigned. SUPERPFP clinicians submitted completed SCID protocols to data analysts who coded each criterion rating for computer analysis. Computer algorithms were developed that allowed clinician SCID diagnoses to be confirmed based upon ratings of the diagnostic criteria.

The specific sections of the SCID adapted for use in the SUPERPFP clinical interviews enabled assessments of the lifetime and twelve-month occurrence of the following DSM-III-R mental disorders: Alcohol Abuse (AAB) and Dependence (ALC), several kinds of additional Psychoactive Substance Abuse (DAB) and Dependence (DRUG), Major Depressive Episodes (MDEs), Posttraumatic Stress Disorder (PTSD), Panic Disorder (PAN), and Antisocial Personality Disorder (ASPD). In addition, the SUPERPFP SCID allowed for the designation of a current diagnosis of Dysthymic Disorder (DYS) and Generalized Anxiety Disorder (GAD). I should add that the clinical interviews administered in the SUPERPFP incorporated a few additional items that allowed for the exploration of comorbidity issues as well as respondent comprehension of several terms or phrases used in the interview. I should perhaps clarify that official prevalence rates were not affected by SCID data because the sampling strategy for generating the clinical subsample did not allow for this kind of generalization. Rather, these clinical follow-up interviews afforded project researchers the opportunity to investigate the relationship between lay- and clinician-administered diagnostic interviews. Furthermore, SCID results served as "validity" checks under the common (but frequently overstated) assumption that trained clinicians are able to assign diagnoses more accurately than lay people using an inflexible protocol.

SCID Procedure

Clinicians were recruited through the National Center's central office in Denver, Colorado, and three were hired and trained by SUPERPFP project staff to administer clinical interviews at Black River. Although two of these clinicians were Native Americans, none of the

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clinical interviewers were especially familiar with Black River prior to their tenure with the project. Once hired, clinical interviewers completed a two-day training seminar covering such topics as an introduction to project staff, an overview of the project, a review of the respondent recruitment process, an orientation to project documentation, instructions on administering the SCID, a presentation of emergency procedures, and the observation of an actual SCID administration. Clinicians were then required to observe three videotaped SCIDs and complete their own SCID ratings based upon the recorded interactions of the on-screen clinician and respondent. Excellent agreement between the videotaped results and the trained clinicians was required (as measured by a kappa statistic greater than .80) before clinicians were authorized to conduct SCIDs with Black River respondents. Upon completion of training, clinicians typically scheduled week-long visits to Black River. Clinicians then arrived on site at the appointed time and were provided with a schedule of respondent appointments and the accompanying Interviewer Contact Forms by field office staff (scheduling and transportation of respondents was typically managed by the lay interviewers). Clinicians conducted up to three SCIDs per day for the duration of their visit.

In my capacity as a SUPERPFP clinical interviewer at Black River, my activities were shaped by my unusual status as a full-time staff member with the project while residing in the Black River community. A more thorough description of these activities will be summarized later, but with regard to the administration of SCIDs to Black River respondents, my procedure for conducting clinical interviews involved several sequential steps. First, computer algorithms employing the sampling strategy described previously identified respondents selected for clinical re-interview at the central office in Denver. Next, the appropriate respondent information was forwarded to me at the reservation field office, where I contacted the respondents and scheduled the interview. Most interviews were conducted at the local field office, but it was not uncommon for me to travel to administer the interview in the respondent's community. At the appointed time, I oriented respondents to the interview and assured them of the confidentiality of their responses. Respondents then provided their written consent to participate, completed the interview, and received $40 compensation for their participation (plus appropriate mileage). Median duration of my SCIDs was 2.0 hours. All 75 SCID interviews were recorded for later analysis. In addition, I prepared clinical case summaries for each interview and copied the cassette recordings for every SCID respondent. Interview protocols, including diagnostic

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conclusions and the original cassettes, were then packaged and shipped to the central office for analysis and storage. Upon receipt of these materials by the central office, I obtained the original CIDI diagnoses for each respondent for use in the analyses to be presented here. More specifically, categorical data from these interviews (generally in the form of diagnostic assignments) were analyzed using Chi-squared tests, Odds ratios, and Kappa statistics. Interesting patterns in these statistics were then systematically explored through interpretive inquiry. Thus, a more specific description of the interpretive methods employed is now in order.

## Black River Ethnographic Investigation

### Ethnographic Participants and Procedure

In addition to the formal diagnostic interviews described above, several Black River respondents were selected for a third round of loosely structured interviews oriented towards the ethnographic contextualization of diagnostic findings. Respondents who had already completed both the CIDI and SCID phases of the project were selected for ethnographic follow-up interviews by a SUPERPFP ethnographic research team employing several broad criteria (e.g., complex diagnostic issues, culturally-salient response style, significance of traditional knowledge or practice related to symptoms, etc.). Interviews were thus tailored to the specific issues of interest for each individual respondent. I conducted seven "Ethnographic Interviews" with Black River respondents for the analyses presented here. Once again, respondents were contacted and scheduled, oriented, interviewed, and paid $10 per hour for their participation. All ethnographic interviews were recorded for later analysis—relevant material was transcribed as appropriate.

As an adjunct to the interviews formally associated with the SUPERPFP, I also conducted a series of "Healer Interviews" with two self-identified healers at Black River. One healer identified himself as a "full-blood" tribal member and served as a deacon in the local Catholic parish. This Full-blood Deacon understood his healing gift within the context of both Black River sacred tradition and charismatic Catholicism. A second healer identified himself as a "mixed-blood" tribal member who spent many years living away from the reservation in urban settings. This Mixed-blood Healer understood his healing power within the context of the inipi (sweatlodge) ceremonies that he performed regularly. Multiple interviews with each healer were recorded, transcribed, and analyzed for this study.

In addition to this series of Healer Interviews, I also obtained important ethnographic

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insights through loosely structured interviews with five lay interviewers, including three of the veteran CIDI interviewers with the most seniority and experience at Black River with the SUPERPFP. Criteria for participation in this series of interviews included the prior completion of over 20 CIDI interviews by the lay interviewer in question. These interviews tended to follow an open-ended series of questions that I developed for the purposes of exploring several aspects of diagnostic interviewing at Black River (see Appendix E). These "Interviewer Interviews" were also recorded, transcribed, and analyzed for this study.

Finally, additional ethnographic contextualization of my data was secured through a year's participant-observation within the reservation community. A more detailed description of these activities will be summarized shortly, but I should note that such experiences formed the basis for a circumscribed set of fieldnotes as well as more general information about the regularities of community life. All ethnographic interview and field data were analyzed qualitatively in accordance with routine ethnographic practices. Such analyses include the careful scrutiny (and micro-analytic review) of interview transcripts in the effort to identify important features of finely nuanced communication patterns. Insofar as interpretive methods may be foreign to some readers, I will briefly review the logic of such methods as they will be employed in this study.

Theory of Interpretive Inquiry Reviewed

The interpretive methods referenced here depend upon a systematic analysis of the data that uses "as a basic validity criterion the immediate and local meanings of actions as defined from the actors' point of view" (Erickson, 1986, p. 119). The reference is to action rather than behavior because the former implies the latter when attached to the meaning interpretations of the actor herself. This understanding will necessarily draw upon the resources for meaning-making that are generally available in the cultural community of which the actor is a participant.

This methodological overview builds upon the discussion of interpretive study by Gaskins, Miller and Corsaro (1992). More specifically, the following premises are assumed (some of which have been previously discussed in greater detail):

1. Meaning creation as a process can be understood only by attending to the cultural contexts in which persons are situated. The guiding criterion of interpretive methods is cultural validity.
2. Participation in collective cultural practices and routines facilitates the active creation of meaning. Cultural meanings are not merely transmitted in the process of socialization, but

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selectively constructed, altered and rejected.

3. Language is central to understanding meaning since it is humanity's primary tool for constructing shared realities and negotiating divergent perspectives. The constitutive power of language is fundamental to interpretive study.

4. The research question must include and account for the complex relationship between the researcher and that which is being researched. All interpretations are partial and therefore must situate the investigator to allow the results to be evaluated from an appropriate perspective.

5. Ethnographic methods are privileged due to their suitability for the investigation of meaning. These methods are sustained and engaged, microscopic and holistic, and flexible and self-corrective.

This latter point requires further elucidation.

Ethnographic Methods Reviewed

Ethnographic methods typically refer to long-term participant-observation in communities whose roles, relationships, norms, rituals, etc., are largely unfamiliar to the investigator. Although the scope of an ethnography of communication may be more limited than a general and wide-ranging cultural description, the salient qualities of ethnographic inquiry still apply. The goal of ethnographic research is to account for the variety of meanings attributed to these various phenomena. According to Erickson (1986), ethnographic work is "an attempt to be empirical without being positivist; to be rigorous and systematic in investigating the slippery phenomena of everyday interaction and its connectedness through the medium of subjective meaning, with the wider social world" (p. 120). In short, the good ethnographer ultimately hopes to provide compelling evidence for her explication of the meaning-systems of those being investigated. I shall refer to this compelling evidence as grounded interpretation.

Erickson (1986) describes this form of methodological rigor as follows:

> In conducting such analysis and reporting it, the researcher's aim is not proof, in a causal sense, but the demonstration of plausibility, which as Campbell argues is the appropriate aim for most social research. The aim is to persuade the audience that an adequate evidentiary warrant exists for the assertions made, that patterns of generalization within the data set are indeed as the researcher claims they are. (p. 149)

The process of grounding interpretations relies upon several components of traditional ethnography combined with the more tailored concerns of the emergent discipline described

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earlier as the ethnography of communication. The process is fairly straightforward. It begins with common-sense attempts to characterize the meanings laden within the data obtained. Some of these meanings will seem obvious and others may seem opaque. All must be closely scrutinized in an effort to identify "key linkages" among various parts of the data. Erickson (1986) describes these as being "of central significance for the major assertions the researcher wants to make" and allowing for the connection of "many items of data as analogous instances of the same phenomenon" (pp. 147-48). Thus, the task of discovering key linkages is to identify generalizations within the case at hand.

Ultimately, the process of grounding interpretation requires that the following kinds of evidentiary inadequacy be eschewed (Erickson, 1986): (a) inadequate amounts of evidence (i.e., too little evidence to warrant certain key assertions), (b) inadequate variety in kinds of evidence (i.e., triangulation is not possible for key assertions), (c) faulty interpretive status of evidence (i.e., misunderstandings of respondent meanings or inappropriate or unreliable communicative exchange), (d) inadequate disconfirming evidence (i.e., lack of evidence that a deliberate search was made for data which might disconfirm the key assertions), and (e) inadequate discrepant case analysis (i.e., lack of scrutiny of disconfirming instances in order to determine implications for key assertions). In the current task of interpreting the interview data from a limited set of interactions, these "threats to validity" must be assessed across the somewhat constricted range of available information. It is ultimately my responsibility, however, to ground any interpretations of the data in such a manner that the reader can be a co-analyst of these data.

Project Involvement and Community Participation

My employment as a "research associate" with the SUPERPFP commenced on September 1, 1997, and ended on August 31, 1998. As I have already stated, my principal responsibility was the administration of SCIDs to community respondents selected for participation in the clinical substudy. It is important to note, however, that project timetables were necessarily fluid depending upon the course of current research activities. As a result, the clinical substudy did not in fact get underway until February of 1998. Thus, for the first five months of my tenure with the project, I assumed responsibility for a variety of project-related tasks that were conveniently facilitated by my actual residency at Black River. Insofar as the SUPERPFP employed nearly one hundred staff at the National Center and across four field sites, I was the only staff member who was not technically a resident of these communities to live on-

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site throughout my employment with the project.

Following my project SCID training and certification as a clinical interviewer in September, I became a member of the SUPERPFP "clinical team" (consisting additionally of a non-Indian psychiatrist who directed the team as well as a Native Alaskan psychologist). As a member of the clinical team, I shared responsibility for training lay interviewers regarding the intricacies of mandated reporting and emergency intervention procedures with potentially distressed respondents; investigating tribal and state laws, policies, and practices regarding such mandated reporting and emergency interventions in order to assist the National Center in developing project policy; reviewing diagnostic criteria and related items from various diagnostic instruments to help finalize the project version of the SCID; dialoguing with the project's ethnographic team to develop and implement criteria for selecting SCID respondents for ethnographic follow-up; and facilitating an informal "clinical support" group on a regular basis for lay interviewers facing potential distress related to their interviews on each of the two Northern Plains reservations. Although these responsibilities also required fairly extensive travel between the two Northern Plains reservations (105 miles between tribal sites) and Denver, I retained more than adequate time for my own exploration of relevant local cultural practice.

Given adequate time for my investigations, I found that obtaining access to people's lives for research purposes was the principal barrier to my arriving at a more sophisticated understanding of the local discourse regarding emotional experience and expression. I should note that this period of "field work" represented my own first attempt to formally engage people regarding the regularities of their lives in a tribal setting where I personally held no claim to an established community identity. I learned very quickly, however, that Black River tribal members were exceptionally skilled at essentially ignoring "outsiders" of all kinds who routinely live and work at the fringes of community life (perhaps owing to the high proportion of non-Indians who live in their midst). As a result, I consider myself very fortunate to have cultivated a set of relationships with a particular family as a result of my pre-existing friendship with one of their relatives (who himself has never resided at Black River). It was owing to these relationships that I was offered a temporary place to live during my first month on the reservation until I could make alternate living arrangements (which was quite difficult in a setting where notable housing shortages prevail). Furthermore, my "local family" provided a home away from home during my year on the reservation and consistently (and generously)

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offered their support and hospitality throughout my stay. Naturally, these relationships (indirectly) taught me a great deal about social life in this community as well.

And yet, a subtle but pervasive anxiety colored these relationships owing to the nature of my work. It was remarkable during my stay how many times various individuals from the community repeatedly asked me to clarify and explain the scope and objectives of the SUPERPFP as well as my own role in the project. It quickly became clear that my association with the project, billed as an investigation of "mental health" on the reservation, triggered typically unspoken concerns by many of the everyday people I encountered as to whether my formal assessments of people's psychiatric status in my job might also imply an automatic, informal assessment of their own psychological status as well. Thus, one drawback to my formal affiliation with the National Center in this setting was the resultant difficulty I encountered in getting to know community members who became potentially anxious or suspicious about the very reason I had come to live among them for a time. Furthermore, my supposition (because such things are really never discussed directly) about the low-level anxiety I detected in my relationships with my local family was that there were concerns about whether their sharing their lives with me might not also invoke an assessment of their personal and collective "mental" functioning. My awareness of this concern resulted in my exercising great care to avoid anything resembling a "formal" study of their lives, although the boundary between active study and passive learning is certainly artificial. One result of this tension that remained unresolved throughout my time at Black River is that the details of my relationships with this family remain relatively tangential to the research reported here. Given the significance of my being positioned as someone concerned with people's mental health, who then (outside of this family) did I get to know during my time at Black River? The individuals with whom I interacted most closely fell primarily into two categories: people involved with the SUPERPFP and people involved in the ritual life of the community.

My routine interactions with project staff occurred in the context of my role as a member of the clinical team assigned to the Black River field office ultimately to conduct clinical interviews. Since these interviews did not get underway until February, my relationships with field office staff were negotiated in the context of my trying to get oriented to project routines as well as life on the reservation more generally, and my providing "clinical support" for the lay interviewers. The field office staff was fairly reserved in their interactions with me throughout

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my tenure with the project, although as people became more familiar with my presence and personality they seemed to relax into their reserve. I learned a great deal from several of the lay interviewers (especially the three "veteran" lay interviewers) through our casual conversations (and finally in more formal interviews regarding their work). These relationships were fashioned out of our weekly (and later biweekly) clinical support meetings. The clinical support meetings were envisioned by staff at the National Center as a regular forum wherein lay interviewers could turn to a staff clinician to discuss difficulties encountered through their interviews, whether psychological or technical (but with a focus on maintaining morale and well-being). Prior to my arrival, these meetings were conducted via telephone conference call with the team psychiatrist in Denver. Within a few meetings it became clear that a less appropriate forum in which to facilitate personal disclosure, sharing, and support among the lay interviewers would have been difficult to imagine, and my assuming responsibility for on-site clinical support represented only minimal improvement. In fact, the communicative norms regarding emotional expression that prevail in the community essentially rendered the clinical support meeting (at least as originally imagined) absurd. For example, lay interviewers were unlikely to disclose personal feelings in a group setting in which people they did not know well (e.g., other lay interviewers and [initially] me) were present. They were unlikely to view the credentials of a "clinician" as very important in determining whether such a person was to be considered a trustworthy confidant (vis-à-vis gender, age, familiarity, personal reputation, etc.). And they were unlikely to wait until the scheduled weekly meeting to share personal matters if they were in fact troubled by something during the week. In the end, our collective efforts to re-imagine the clinical support meetings fizzled and the weekly "support" meetings gradually became biweekly "procedures" meetings, and finally ceased to exist.

Additional significant relationships developed with other administrative staff in the project field office. A female elder hired by the project to facilitate project research with an elderly subsample was exceptionally generous with her time and attention. In fact, she offered to rent her trailerhouse to me for the duration of my time at Black River. Thus, I lived on her land across the road from her own place beginning in October of 1997. This relationship was significantly instructive for me in many ways about life at Black River, but once again there was some discomfort about my role in the project (although I suspect that age and gender roles were more constraining in this particular relationship). Another relationship that was more influential

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still involved a devout, middle-aged Catholic woman who served an administrative support role on the project staff. Upon my arrival, this person (whom I will call Emma) viewed me with both amusement and skepticism, but through regular casual conversation (as she was really the only staff member to remain in the office throughout the business day), we gradually became friends. Since the age and gender norms that prevail on the reservation do not really allow for non-romantic friendships between a middle-aged mother and a younger man (regardless of marital status), the context for our friendship from the beginning became the activities and commitments of Black River's vibrant but declining Roman Catholic spiritual community. Thus, Emma frequently invited me to Mass at the stunningly beautiful mission church and introduced me to her many friends at the mission, most of whom were Jesuit priests.

It was truly quite remarkable during that year that so many of my new relationships quickly placed me in various ceremonial contexts. In Emma's case (as well as in the case of my local family), that context was Catholic Mass (which led, incidentally, to my relationship with a local deacon who practiced a healing ministry in the context of the Mass). But in other relationships, such as with my elderly landlady and the local tourism office director (to whom I was referred by a project staff member), the context for introducing me to people and facilitating an even wider relational network centered upon inipi ceremonies. In fact, one of my acquaintances explained that there really was no "social life" at Black River, only "sweats." This account of life at Black River omits, of course, the role that drinking plays in the community, but the significant minority of serious ritual participants on the reservation generally avoid drinking parties. Nevertheless, the salience of ritual referral in my experience at Black River led me to end one early fieldnote with the question: "Why does everybody immediately arrange for me to sweat with them?" As a result, I sweated regularly at Black River and met several quite interesting people as a result, including one of the healers I was able to interview on several occasions. Sweating with people, however, only provided a context in which to be introduced to someone—it did not guarantee that any of those fledgling relationships would actually take root. Few of them did for me, and apart from the perennial effects of my mental health research identity, I believe that age and gender factored in heavily as well. That is, it was exceedingly difficult for me to find young men with whom to spend time at Black River. Some suggested that this was because many of them had left for work or school; others referred to the high prevalence of drinking among this age cohort. Either way, in all of my time at Black River,

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it was only at one particular sweat that I regularly encountered men my own age. It turned out that it was among this group that I felt most comfortable and thus participated more frequently there than elsewhere. Participation with them involved perhaps a dozen inipi ceremonies before culminating in my invitation to a yuwipi ceremony as well.

A final point of access to people's lives in the community was the clinical interviewing I commenced beginning in February of 1998. These interviews lent themselves to a certain amount of intimacy owing to the many personal experiences that I routinely asked respondents to recount. Furthermore, built into the project itself was the opportunity (with resources allocated for compensation) for ethnographic follow-up interviews with an especially interesting subset of these respondents. I completed several of these ethnographic follow-up interviews during the latter part of my tenure at Black River. In fact, I developed perhaps the most potentially fruitful relationship of my stay with a respondent whom I will call Ben that I interviewed first using the SCID and then for ethnographic follow-up. Unfortunately, the general timing of my SCID interviews (following another administrative hiatus between February and April) left little room for outside activities in the final months of my tenure at Black River. Thus, just as Ben was beginning to introduce me to the bona fide medicine men on the reservation (for which I required a translator like Ben in order to communicate with some of them), it was time to wrap things up and depart Black River. Ultimately, then, my association with the project opened some doors and closed others, but the timing of my interviewing responsibilities so late during my stay actually constrained some of the most striking opportunities to emerge from the interviews to a significant degree.

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# Results

## Part I: Diagnostic Findings

### Comparison of CIDI and SCID Findings

The focus of the present study concerns the relationship between diagnoses obtained by lay interviewers using the CIDI and clinical interviewers employing the SCID for the Black River clinical subsample. Before proceeding to comparisons across interviews, however, simple counts of the various DSM-III-R disorders diagnosed through my clinical interviews with Black River respondents are in order (see Table 3). Total counts by SCID diagnosis for the 75 respondents were as follows: AAB = 2; ALC = 58 (with one additional ALC diagnosis likely but unconfirmed); DAB = 3; DRUG = 32; SUB (comprising ALC and/or DRUG) = 60; MDE = 31; DYS = 1; DEP (comprising MDE and/or DYS) = 32; PTSD = 20; PAN = 3; GAD = 0; ASPD = 11; and No SCID diagnosis = 11 (due to extensive comorbidity, these numbers do not sum to 75).

SCID diagnoses for my 75 respondents indicated substantial discrepancies with their initial CIDI diagnoses. The overall diagnostic portrait is illuminated by broad comparisons of sample respondents (see Table 4) using the simple counts of disorders experienced in their lifetimes as just presented (possible range was thus 0-8 [i.e., No diagnosis, AAB/ALC, DAB/DRUG, MDE, DYS, PTSD, PAN, GAD, or ASPD]). Whereas the lay interviews had resulted in the classification of 21 sample respondents as disorder-free, I found only 11 respondents without any SCID diagnoses. In comparison with the 18 respondents diagnosed through the CIDI with just one of these disorders, I also found 18 respondents warranting a single diagnosis as the result of my SCIDs. But in contrast to the 36 respondents carrying comorbid CIDI diagnoses (two or more disorders throughout their lifetime), I determined that 46 respondents merited comorbid SCID diagnoses. More specific examination of the disorder counts for the three SUPERPFP target disorders (possible range was 0-3 [i.e., No disorder, ALC, DEP, or PTSD]) reveals a similar pattern (also represented in Table 4). Whereas the lay interviews had resulted in the classification of 22 sample respondents as comparison subjects (carrying none of the three target disorders), I found only seven of these same comparison subjects (with a total of just 12 respondents out of the entire sample of 75) to warrant a disorder-free classification. In comparison with the 25 respondents diagnosed through the CIDI with just one of the target disorders, I found 28 instances of respondents carrying a diagnosis of one target

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disorder as a result of my SCID interviews. And in comparison with 28 respondents diagnosed with comorbid CIDI diagnoses (two or more target disorders throughout their lifetime), I determined that 35 respondents merited comorbid SCID diagnoses. The evidence here is clear: in the process of conducting clinical interviews with the Black River SCID sample, I assigned psychiatric diagnoses to a good number of additional respondents that had appeared to be disorder-free following the lay interview. It remains, however, to describe the particular patterning of this interesting diagnostic trend.

Based upon SCID data, the remainder of the analyses for this study will involve four basic diagnostic categories for several reasons. The first three of these are closely related to the three target disorders in the SUPERPFP. First, Substance Dependence (SUB), consisting of respondents diagnosed either with lifetime ALC, lifetime DRUG, or both, was considered primarily because (a) SCID Substance Abuse (as opposed to Dependence) was rare in this sample and can be diagnosed with very little evidence of distress or functional impairment, and (b) the number of respondents diagnosed with SCID DRUG in the absence of the target disorder ALC was extremely small ($n = 2$) and thus did not seem to warrant inclusion as a separate variable for analysis. Second, the combined Depressive disorders category (DEP) will be discussed primarily because (a) both MDEs and DYS were considered target disorders, and (b) only one respondent was diagnosed with SCID DYS and thus did not seem to warrant the inclusion of a separate variable. Third, Posttraumatic Stress Disorder (PTSD) was included in straightforward fashion owing to its status as a target disorder. Finally, Antisocial Personality Disorder (ASPD) was included very occasionally due to its relative presence in the SCID sample ($n = 11$). All other disorders were omitted from analyses owing to their low frequency in the SCID sample.

Given these clarifications, it is now appropriate to present more detailed diagnostic comparisons across interviews with reference to the variables representing the three target disorders (see Table 5). Whereas the CIDI had resulted in the diagnosis of 39 of these respondents with SUB, I diagnosed 60 with SUB; whereas the CIDI had resulted in the diagnosis of 15 of these respondents with DEP, I diagnosed 32 with DEP; and whereas the CIDI had resulted in the diagnosis of 37 of these respondents with PTSD, I diagnosed 20 with PTSD. Thus, diagnostic discordance between the two interviews would appear to be significant here, given that I found half again as much SUB within this sample, double the cases with lifetime

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DEP, but just half the instances of lifetime PTSD. Nevertheless, a more formal statistical assessment of the concordance (or agreement) of the diagnoses obtained between the two interviews for this sample seems warranted.

Assessing Statistical Agreement

A conventional statistic for assessing concordance in classification between multiple raters while suitably controlling for chance agreement is the coefficient of agreement developed by Cohen (1960), represented by the Greek letter kappa ($k$). Because this statistic may be unknown to researchers unfamiliar with epidemiological studies, I will briefly review it here. With regard to psychiatric disorders in this study, for example, frequency data representing the independent assessments of two diagnostic interviews with regard to the categorical presence or absence of a given disorder may be arranged in a two-way contingency table for sample respondents:

| | | SCID Interview | | |
|---|---|---|---|---|
| | | Presence | Absence | Total |
| CIDI | Presence | a | b | a + b |
| Interview | Absence | c | d | c + d |
| | Total | a + c | b + d | n |

The measure of concordance is then derived using the following equation (Shrout, 1995, p. 225):

$$k = \frac{ad - bc}{ad - bc + n(b + c)/2}, \text{ where } -1 \leq k \leq 1$$

The resulting statistic is interpreted such that $k = 1$ indicates perfect agreement, $k = -1$ indicates perfect disagreement, and $k = 0$ indicates chance agreement only. Although the coefficient of agreement is base-rate dependent and becomes distorted for low frequency occurrences (Spitznagel & Helzer, 1985), the prevalence of psychiatric disorder referenced in this sample is sufficiently high to circumvent any distortion. Although conventions for interpretation differ slightly in the literature, this study will observe the following rules of thumb (see Fleiss, 1981): $k \geq .80$ indicates excellent agreement, $.60 \leq k < .80$ indicates good agreement, $.40 \leq k < .60$ indicates fair agreement, and $k < .40$ indicates poor agreement.

Kappa statistics for the sample of 75 SCID respondents with regard to each of the modified categories of targeted lifetime disorders across the lay and clinical interviews indicated

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poor agreement in every case (see Table 6): for SUB, k = .17; for DEP, k = .27; and for PTSD, k = .33. If one collapses each of these categories into one larger Target Disorder (TAR) category that represents the presence of either lifetime SUB, DEP, PTSD, or some combination of the three, agreement is still poor: k = .28. Only the assessment of the non-targeted ASPD demonstrated appreciable agreement: k = .51.

One obvious explanation for these low levels of agreement is that I am an especially poor diagnostician. I should thus note here that my facility with the SCID predated the brief training provided by the SUPERPFP staff, as the administration of relevant portions of the SCID was a key aspect of my graduate clinical training. Nevertheless, in order to compare the reliability of SCID diagnoses assigned by me with that of other clinicians conducting SCIDs at Black River, I requested and obtained from the SUPERPFP staff the appropriate kappa statistics for my two colleagues at Black River (L. Davis, personal communication, February 3, 2000). Overall agreement between interviews by target disorder across all clinicians was typically poor: for TAR, k = .44; for ALC, k = .24; for MDE, k = .19; and for PTSD, k = .37. Inspection of the coefficients of agreement for each clinician by targeted disorder (see Table 7) indicates generally poor agreement as well (but with occasional exceptions). It is worth noting, however, that kappa statistics reported from my interviews tend to be marginally lower than for my colleagues. Casual examination of the various contingency tables in question reveals that this is principally due to my diagnosing disorders for respondents that they did not obtain through their lay interviews. The exception here involves PTSD, where I diagnosed substantially fewer cases than resulted from the lay interviews. In any event, it will be important throughout this study to remember that agreement across all interviewers and disorders was generally low (with 15 of 20 kappas reviewed falling short of .40 and three of the better kappas corresponding to the collapsed "Any Disorder" category). In addition, any SCID diagnoses assigned by me are available to a limited degree of scrutiny owing to the fact that cassette recordings for all of my interviews are in my possession and many were partially transcribed for this study (and are available to researchers upon request). Finally, quality control procedures for the SUPERPFP resulted in my obtaining reviewer feedback on approximately 10 of my SCIDs—in no case was there clear evidence of my assigning a diagnosis that was not warranted by the information provided by the respondent.

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Contextualizing Diagnostic Discordance

Unfortunately, low rates of agreement between lay-administered and clinically-administered diagnostic interviews are not uncommon in the psychiatric epidemiology literature. In fact, serious conceptual and methodological challenges—especially with regard to diagnostic assessment—continue to confront the field (Dohrenwend, 1995; Regier, et al., 1998; Robins, 1985), including how to identify a "gold standard" to which the inherently fallible results of diagnostic interviews may be compared. In the absence of concrete diagnostic validators, it has been common practice for such research to utilize the expert judgments of trained clinicians as those approximating such a standard. And yet, as Robins (1985) has acknowledged, the practice of privileging clinician diagnoses in this way is problematic. In any case, both the CIDI (Robins, et al., 1988) and the SCID (Williams, et al., 1992) have demonstrated solid test-retest reliability (i.e., diagnostic agreement was good) in their developmental phases when each instrument was re-administered blindly to the same respondents after a brief lapse in time. The more interesting comparisons, however, are between diagnostic instruments or procedures. These studies are relatively rare, which is one reason the SUPERPFP purposefully included the opportunity to compare the CIDI and SCID (another apparent divergence from the NCS methodology). It is important to note at the outset, however, that I have been unable to identify any additional research that specifically compared CIDI results with SCID results across a spectrum of psychological disorders.

Two early comparisons both involved the administration of the Diagnostic Interview Schedule (a predecessor of the CIDI) by lay interviewers using DSM-III (APA, 1980) diagnostic criteria. In the first study (Anthony, et al., 1985), one-month DIS diagnoses were compared to one-month diagnoses obtained by psychiatrists using the Present State Examination (PSE) as a means to structure their own diagnostic interviews. Although this comparison concerns the resultant one-month DSM-III diagnoses instead of lifetime DSM-III-R diagnoses, the results are illuminating: kappa statistics for an "alcohol use disorder" and a MDE respectively were just .35 and .25—PTSD was not assessed in this study. In the second early study (Helzer, et al., 1985), lifetime DIS diagnoses were compared to lifetime diagnoses obtained by physicians who re-administered the DIS and supplemented those results with their own completion of a DSM-III checklist. Although this comparison concerns the resultant lifetime DSM-III diagnoses instead of lifetime DSM-III-R diagnoses and involves a simple second administration of the same fully

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structured instrument by physicians instead of affording actual psychiatrists an opportunity to employ expert clinical judgments, here too the results are enlightening: kappa statistics for an alcohol disorder and a MDE respectively were .68 and .33—again, PTSD was not assessed in this study. Results comparing the DIS diagnoses to the physician DSM-III checklists in this latter study indicated slightly lower agreement than when the physicians simply used the DIS.

It has only been a recent phenomenon (i.e., since my participation in the SUPERPFP) that comparisons between (portions of) the DIS and semi-structured clinical interviews for various DSM-III-R disorders have found their way into the literature. The two studies most pertinent here both examined diagnostic concordance between the measures for MDEs in particular. Eaton, Neufeld, Chen, & Cai (2000) compared DIS results for lifetime DSM-III-R Major Depressive Disorder to results obtained by psychiatrists employing the Schedules for Clinical Assessment in Neuropsychiatry (also known as the "SCAN"; see Wing, et al., 1990), an instrument that incorporates the most recent version of the PSE. Results were unimpressive, with a kappa statistic for the disorder of only .31. The bulk of this discordance was attributed to the tendency of the psychiatrists to assign substantially more depression diagnoses than the DIS. Finally, in the only study to date that directly compares lifetime lay-administered DIS diagnoses of MDE to lifetime clinician-administered SCID diagnoses of MDE, Murphy, Monson, Laird, Sobol, and Leighton (2000) found that agreement was only marginal with a kappa of .45. Again, these results indicated that clinicians were diagnosing a substantial number of additional cases of lifetime MDE among their respondents. In fact, the authors report that clinicians were diagnosing about twice the number of cases of MDE in the sample.

These relatively sparse findings help to demonstrate the methodological complexity and diversity that prevail in investigations of psychiatric epidemiology. In fact, the panoply of potential diagnostic instruments as they evolve over time alone seems rather dizzying. Nevertheless, based upon a rather limited body of research, it seems clear that less than excellent agreement typically characterizes the results of lay-administered diagnostic interviews when compared to the results of clinicians rendering diagnostic judgments. Furthermore, the most recent (and pertinent) data suggest that clinicians are more likely to diagnose lifetime depression in their respondents than lay interviewers using fully structured diagnostic protocols. In the end, psychiatric epidemiologists emphasize the importance of standardizing assessment methods across studies in order to evaluate comparable data rather than examining divergent findings

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across research methodologies (Regier, et al., 1998). So, for example, comparison of SUPERPFP prevalence rates with NCS prevalence rates will be more fruitful, given the effort by SUPERPFP to replicate the NSC design, than comparing such rates to, say, the prevalence results determined by the NIMH Epidemiological Catchment Area program (Regier, et al., 1984) that employed a different research design. This approach seems less than satisfying, however, in that it remains agnostic regarding the question of actual prevalence rates in favor of generating comparable prevalence statistics across communities, all of which might deviate from true population prevalences in systematic but unspecified ways.

Elucidation of SCID Findings

The results of such comparisons thus far across diagnostic interviews for the Black River sample are elucidated as follows. First, as I observed earlier, lifetime psychiatric prevalences in this community as determined by the CIDI are markedly different than the national statistics reported in the NCS (Kessler, et al., 1994). More specifically, I noted that the Black River population appears to experience half again as much Alcohol Dependence as the general U.S. population, double the instances of PTSD, but just around two-fifths the rate of Depressive Disorders. Second, I will presume that my clinical interviews call into question the validity of these CIDI prevalences for Black River because of the very low rates of agreement between interviews combined with the common (and fairly reasonable) assumption that a semi-structured clinical interview allows for a more valid (but certainly not dispositive) assignment of psychiatric diagnoses than the lay administered CIDI. Third, it is particularly interesting to note that in my sample of Black River respondents I found over half again as many instances of ALC and over twice the number of Depressive Disorders, but just half the number of respondents with PTSD. This pattern of discrepancy, especially when compared to the Black River prevalence rates for Depressive Disorders and PTSD vis-à-vis the general U.S. prevalence statistics, suggests an intriguing proposition. More specifically, the diagnostic trend evident in my SCID interviews with specific regard to Depressive Disorders and PTSD could yield rates of these disorders that are more comparable to national statistics were they to generalize back to the Black River CIDI prevalence figures. Such generalization would do much to alleviate the trepidations of project researchers who are truly incredulous in the face of such low prevalence rates for Depressive Disorders and such high rates for PTSD (although higher PTSD rates already accord with SUPERPFP researcher expectations, as do higher SUB rates).

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I should quickly add that the methodological limitations of the SUPERPFP design preclude any definitive analysis of this possibility. Moreover, I have just reviewed recent (but not especially extensive) evidence that suggests it may be typical for clinicians to diagnose double the cases of depression in similar studies (in which case most researchers would conclude that lay interviews underestimate the true prevalence of clinical depression), although the trends for diagnosing PTSD in these scenarios has to my knowledge not yet been reported. So, for example, it is hypothetically possible that if clinicians had re-assessed NCS respondents using the SCID, they too might have found double the cases of depression, thereby leaving the comparability of (probably) underestimated prevalence rates as determined by the lay interviews in both studies intact. Either way, underestimated prevalence rates (whether methodologically comparable or not) for Depressive Disorders at Black River in comparison to U.S. rates as determined by the NCS require explanation. Furthermore, the complete absence in the psychiatric literature of any discussion of trends in diagnostic agreement between lay interviewers and clinicians for PTSD renders the present study an opportune context in which to explore such trends. In contrast, there is at least some previous evidence (Helzer, et al., 1985) of solid agreement between diagnostic interviews for Alcohol problems, leading to the speculation that SUPERPFP researchers have indeed identified higher actual rates of ALC at Black River (although such rates would be higher still if my diagnostic results were to generalize back to the CIDI results).

In any case, since an unassailable position that designates any of these as either actual or artificial prevalence rates is impossible in this (and perhaps every previously reported) survey of psychiatric epidemiology, allow me to utilize this intriguing proposition regarding the potential for Black River discordance to generalize back to more palatable prevalence rates (especially with regard to DEP and PTSD) as a point of departure for the analyses that remain in this study. Thus, a subsequent analytic step is simply an investigation of what the data in my sample suggest regarding the complex associations between these DSM-III-R disorders in particular.

## Part II: Relevant Ethnographic Findings

In my previous description of the Black River Indian reservation, I made reference to the widespread influence of one of the community's most celebrated institutions. Black River's tribally controlled university is renowned throughout Indian country as one of the few accredited tribal colleges in the nation to offer graduate training in a select number of disciplines. Of

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particular interest here is the Black River college logo that incorporates the medicine wheel into a university "shield" featuring a buffalo skull and four eagle feathers. Surrounding the medicine wheel at places in between the four sacred directions are written the community's "four virtues": Woksape (translated in college publications as "wisdom"), Woohitika ("bravery"), Wowacintanka ("fortitude"), and Wacantognaka ("generosity"). These four virtues obviously hold tremendous cultural significance with regard to the local ethnopsychology. The virtue with the greatest relevance for this study of diagnostic interviewing is wowacintanka or "fortitude."

According to the locally regarded dictionary of the tribal language compiled by the Jesuit missionary Eugene Buechel (1983), wowacintanka literally translates into "great confidence" (the noun wowacin meaning faith or confidence, and the adjective tanka meaning large or great). Buechel records the more common meaning of the word as "patience" or "perseverance." My informants at Black River amplified upon this definition by explaining that wowacintanka means "being of strong mind." One individual described the virtue as referring to "self will," that is "how strong you can stand in a given situation." Thus, an obvious implication of wowacintanka for personhood in this tribal community is the routine importance of the restrained management of affect in everyday interpersonal interactions. Hassrick (1964) elaborates:

> Fortitude implied two things: the endurance of physical discomfort and pain, and the ability to show reserve during periods of emotional stress. Although the quality might be described as stoical, stoicism is not an entirely correct definition for this virtue.... Men on war missions or hunting expeditions were noted for their ability to suffer wounds unflinchingly, to experience long periods of hunger and exposure.... These dramatic expressions of fortitude had their counterparts in day-to-day behavior. Here fortitude might well be equated with reserve, might well be described as the quality of dignity.... For example, when old friends met after a long separation. . . their greetings would be. . . non-committal. . ., but this would be the extent of the salutation. There was no further sign of endearment.... Exuberance at such a reunion would be considered giddy and unbecoming, an infraction of decorum.... It was this totally unemotional side of [tribal] behavior which made the term "stoical" appear so very fitting. (pp. 34-35)

Thus, this normative emotional restraint seems especially significant with regard to the communication of emotional distress in the context of psychiatric interviews. In order to grasp the nuanced particulars of wowacintanka, however, it seems necessary to examine its place within the

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broader cultural discourse (i.e., characteristic ways of thinking, explaining, and behaving), especially those that are implicated in the breakdown of normative emotional experience and expression.

My informants described a holistic and integrated experience of distress (involving the spirits, minds, emotions and bodies of afflicted individuals without distinguishing between these the way we do in the West) by invoking a local discourse that implicates "trauma" as a primary etiology of disorder. These traumas were understood to involve a "wounding of the spirit" by the Full-blood Deacon, who identified the most devastating forms of trauma as severe social disruptions such as death of a loved one or divorce from a spouse (interview transcripts are available upon request from the author). He explained that: "In a spiritual sense, our woundedness manifests itself through our physical being. Among [tribal members] I can speak of that.... There's arthritis, high blood pressure, there's diabetes, there's heart trouble, cancer, that develops from wounded spirits." The Full-blood Deacon went on to link healing or recovery to the grieving process. In fact, he indexed the four stages of the grieving process (i.e., denial, anger, grief, and acceptance) that figure prominently in the conventional wisdom of many mental health providers. According to this particular community healer, then, healing involves the emotional grieving of trauma or loss, especially (but not exclusively) interpersonal loss, in order to arrest or prevent an illness process that might otherwise result in eventual physical disability. Spiritual practices involving the manipulation of sacred power (wakan), cast here in both traditional and charismatic Catholic terms, were viewed by the Full-blood Deacon as absolutely central to the healing process.

Although embodied in a very different ceremonial context, the Mixed-blood Healer also recognized a key relationship between trauma and illness in his explanation of healing (interview transcripts are available upon request from the author). His account is sufficiently illuminating to warrant extensive quotation:

> I started looking at the reason some people were healed and the reason that some people weren't being healed seemed to relate to emotional- The sickness itself relates to emotional causes. Some people are willing to look at their emotional traumas and some people are not. And there seemed to be a relationship between people who were not and their inability to get well, and people who were willing to look at those things and their ability to get well. There's, you know, several theorists I guess you could call them that say that wherever sickness occurs in the body relates to the form of trauma, whether it be emotional or physical, but it usually is, you know, in conjunction with the emotions. You

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know, say if a child is abandoned and not nurtured and not given love, you know, there's a number of different kinds of illnesses or conditions that they might be affected by in life. You know, you'll see sometimes- And I can't say this happens in every single case and I'd be a fool to say that, but a lot of women with breast cancer (because that's in the area of the heart and chest) seem to be from a lack of proper nourishment- of emotional nourishment. And the nurturing that they either couldn't get or couldn't give seems to block or create some kind of conflict in that area. A lot of abuse victims, sexual abuse victims, have chronic yeast infections, a lot of chronic urinary bladder infections, a lot of reproductive illnesses, precancerous dysplacias, and so you- I mean what I see is that there is a correlation between an illness, a physical illness, and the emotional cause.

Thus, in the words of this Mixed-blood Healer I again obtained evidence of a local cultural discourse that recognizes that trauma (again viewed primarily as social disruption) may lead to physical illness unless disturbing emotional reactions are "faced," so to speak. According to this informant, healing thus involves the confrontation of troubling emotions, often related to social disruption, especially in the ritual context (e.g., through the inipi or yuwipi ceremonies) of communicating such difficulties to spiritual Beings who are empowered to render requisite supernatural assistance.

Neither of my Healer Interviews was conducted with a prototypical wicasa wakan, and neither informant would presume to identify as a medicine person in the hotly contested ritual context of contemporary Black River. Thus, it would be informative to obtain additional evidence that the significant links between social disruption, illness, and grief were observed among the cultural practices of other more prototypical sources. A tremendous resource in this regard is the vast ethnographic literature that spans over a century of anthropological investigation among this particular tribal group. One close and very accessible study of tribal ritual healing is Powers' Yuwipi (1982), in which he offers an extended account of the ceremonial participation of a tribal family in need of healing. More specifically, an elderly man experiences a recurrence of terrible back pain and so his son approaches the local yuwipi man to ask for help in obtaining relief for his father. The elderly healer states that his father can be helped, but that the son will need to sacrifice on behalf of his father's healing by undergoing the quite demanding ritual of the vision quest. Although much of the account is interesting from the perspective of understanding local healing practices, Powers recorded at least one detail that is tied directly to the aspects of the local cultural

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discourse under discussion here. In the account, as a result of his son's undertaking the vision quest, the boy's elderly father participates in a yuwipi ceremony after having neglecting such affairs throughout most of his adult life. At one point during the ritual, while expressing gratitude to the spirits for his son's efforts, Runs Again speaks of the back pain that has afflicted him chronically. In his discussion of the affliction, he refers to a tunkan, a sacred stone that is wrapped in a pouch and hung around one's neck for spiritual guidance and protection. Runs Again implicates such a stone in the onset of his back pain:

> And also, I would like to say something—truthfully. My father used to have these meetings, long ago. When I was small I was sick and I suffered. He wanted me to grow up to be strong, so he took one of these stones, these sacred stones, like the one I have here, and he wrapped it up in a pouch and hung it around my neck. And he instructed my mother not to be hard on me. But then one day she didn't heed what he had said to her, and she began to treat me badly. Then all of a sudden the stone disappeared, and only the leather pouch remained hanging around my neck. And that is what happened to the stone.... It just disappeared because of the way my mother behaved toward me. And now it seems as if that stone were inside my back causing all this pain I have. (p. 58)

In this very brief account, then, we find an important (albeit fleeting) reference to the etiology of illness. And, once again, interpersonal disruption or trauma (a mother's mistreatment) is seen ultimately to result in physical disability (chronic back pain) as mediated by spiritual (the disappearance of the tunkan) and emotional (unspoken, naturally, owing to wowacintanka) processes. I want to emphasize here that Runs Again never directly discussed or described the emotional distress he experienced at his mother's alleged mistreatment. In fact, one particular function of the local trauma discourse seems to be that it affords the communication of distress while simultaneously preserving wowacintanka—that is, since members of this cultural community share an understanding of appropriate interpersonal relations, any description of severe social disruption necessarily implies the experience of troubling emotions that need never be named, labeled, or described. In any case, Runs Again's participation in the yuwipi, during which he seeks spiritual help, is understood as a reasonable course of action in his bid for physical renewal and restoration.

The point of the foregoing discussion is simply to identify four facets of the local cultural discourse with direct relevance to the assessment of psychopathology in this tribal community. First, there are strong proscriptions against the routine and explicit communication of psychological

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distress or emotional hardship exemplified in the cultural celebration of the virtue known as wowacintanka. Second, the local cultural discourse regarding the etiology of dysfunction in this community identifies trauma—primarily understood as serious interpersonal loss or social disruption—as the catalyst of an illness process that frequently requires appropriate emotional expression in order to prevent disability. Thus, grieving is understood to be the healthy response to such trauma, while dysfunction, breakdown, or illness is seen to be the consequence of trauma that results from the avoidance of appropriate emotional expression related to such disruptions. Interestingly, both healers that I interviewed agreed upon these basic etiological processes of illness despite the apparently discordant healing contexts in which their gifts are practiced. Third, this trauma discourse is invoked in personal descriptions of social disruption and facilitates the local communication of distress without direct reference to its emotional constituents, thus preserving wowacintanka in the face of reportedly difficult experiences. Finally, it bears noting that the emotional restraint epitomized in wowacintanka is seen to actively threaten the possibility for proper emotional expression, were it not for the appropriate ceremonial contexts where such expression is ritually marked as acceptable and necessary. As a result, healing may be understood as the ceremonial supplication of spiritual beings (e.g., through inipi or yuwipi ceremonies, or charismatic Catholic masses) that facilitate and empower transformative emotional expression. In fact, I witnessed such expression on regular occasions during my participation in local inipi ceremonies, where it was not uncommon for either men or women to cry while offering their prayers. And yet, perhaps even a majority of the members of the Black River cultural community do not regularly participate in such ritual contexts where they might access this culturally sanctioned means to emotional transformation. Herein lies a promising line of future inquiry, namely the role that drinking behavior plays as a "profane" mode of emotional expression in opposition to ceremonial practice as a "sacred" mode of such expression. Unfortunately, this provocative thesis is well beyond the scope of the research reported here (but see O'Nell [1999] for a similar elucidation of trauma discourse among war veterans on one of Black River's sibling reservations).

In the end, I have argued that there are significant cultural precedents that associate fortitude, trauma, illness, and grief at Black River. It is important to underscore that this local cultural discourse does not necessarily imply that tribal members routinely talk about traumatic experiences and grief—in fact, the particulars of this discourse (as will become evident) work to

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ensure that they typically do not. How then should we understand this cultural discourse vis-à-vis the diagnosis of Depressive Disorders and PTSD for Black River respondents in the SUPERPFP?

Part III: Additional Diagnostic Findings

Psychiatry too recognizes complex relationships between trauma, illness, and grief, but obviously they are constructed quite differently in the DSM. Within the context of very low diagnostic agreement, I sought to uncover the relationships or associations between these disorders as diagnosed through the lay and clinical interviews at Black River. I employed three basic kinds of statistical analysis to do so.

Chi-Squared Analyses

One straightforward method to identify a systematic statistical association between categorical variables employs the family of Chi-squared tests. Such tests are reviewed in most introductory statistical texts in the field and will not be described in detail here (see Wickens [1989] for detailed treatment). Instead, it should suffice to explain that the Chi-squared tests applied to these data were used to assess the hypotheses that various psychiatric diagnoses were assigned to Black River respondents independently of one another (at $p < .05$ significance). This hypothesis seems sensible in some instances (e.g., a CIDI diagnosis of Alcohol Dependence may indeed be unrelated to a SCID diagnosis of Generalized Anxiety Disorder), but clearly many such comparisons should instead require the rejection of this hypothesis of independence (e.g., a CIDI diagnosis of PTSD should theoretically not be irrelevant to a SCID diagnosis of PTSD). Thus a series of similar comparisons were examined by selectively pairing all possible combinations of the four basic diagnostic categories reviewed earlier. Because comorbidity among psychiatric diagnoses is generally quite prevalent (Widiger & Trull, 1991), I have applied Yates' correction for continuity (Yates, 1934) to all subsequent Chi-squared analyses in order to retain a conservative estimation of independence for what are relatively small sample sizes.

The first set of tests simply explored whether systematic associations existed among the various CIDI diagnoses (i.e., C-SUB, C-DEP, C-PTSD, and C-ASPD) and SCID diagnoses (i.e., S-SUB, S-DEP, S-PTSD, and S-ASPD) respectively (enabling six comparisons for each diagnostic interview; see Table 8). Among the CIDI disorders, the hypothesis of independence was rejected and associations were thus determined for three comparisons: C-SUB was systematically related to C-ASPD ($p = .000$), C-DEP was related to C-PTSD ($p = .018$), and C-SUB was related to C-DEP ($p = .043$). The hypothesis of independence could not be rejected for

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the remaining CIDI diagnoses. In similar fashion, systematic associations were determined for two comparisons among the SCID disorders: S-DEP was systematically related to S-PTSD (p = .002), and S-SUB was related to S-DEP (p = .004). The hypothesis of independence could not be rejected for the remaining SCID diagnoses. The conclusions to be drawn from these comparisons are that patterns of comorbidity exist between DEP and PTSD and between SUB and DEP in the diagnostic results of both interviews, but not between SUB and PTSD, for example.

The second set of tests sought to examine the relationships between CIDI diagnoses and later SCID results, thus involving the comparison of diagnoses across CIDI and SCID interviews (yielding 16 comparisons between CIDI and SCID variables; see Table 9). The hypothesis of independence was rejected for six of these comparisons: C-PTSD was systematically related to S-DEP (p = .000), C-DEP was related to S-PTSD (p = .000), C-ASPD was related to S-ASPD (p = .000), C-SUB was related to S-ASPD (p = .002), C-PTSD was related to S-PTSD (p = .003), and C-DEP was related to S-DEP (p = .017). The hypothesis of independence could not be rejected for the remaining 10 comparisons between CIDI and SCID diagnoses. The conclusions to be drawn from these analyses are that there is a notable pattern of association between DEP and PTSD across interviews that is not the case for other disorders (with the relatively unremarkable exception of C-SUB and S-ASPD). Otherwise, it is interesting to observe that diagnoses of SUB for the CIDI and the SCID were not associated, a result that seems counterintuitive. In addition, I might add that the simple comparison between the two interviews for the all-inclusive Target Disorder category (TAR) resulted in the rejection of the hypothesis of independence (p = .028) as one would expect.

Finally, it is perhaps worth noting that the hypothesis of independence could not be rejected for any comparison involving target diagnosis (whether CIDI or SCID) and gender. That is, gender was apparently unrelated to diagnosis in this sample of Black River respondents.

Odds Ratio Analyses

One of the limitations of the Chi-squared results is that such tests only reveal whether variables are associated without revealing the magnitude of that association. This is because the Chi-squared distributions are responsive to sample size. In order to adequately gauge the degree of association, one requires a different measure of effect size that is not dependent upon sample size, such as the odds ratio (Hillis & Woolson, 1995; Wickens, 1989). The odds ratio allows for

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the estimation of whether—and to what extent—a certain condition will hold, given a previous condition. For example, how likely are people diagnosed with ASPD in the lay interview to be diagnosed with ASPD in the clinical interview? The conclusion from these data is that a Black River respondent who obtained a CIDI diagnosis of ASPD is 18.7 times more likely to obtain a SCID diagnosis of ASPD than a respondent who did not receive the CIDI diagnosis in the first place.

Because this statistic may be unfamiliar to readers, I will briefly review it here. With regard to the psychiatric disorders in this study, frequency data representing the independent assessments of two diagnostic interviews may be arranged once again in a two-way contingency table for sample respondents:

| | | SCID Interview | | |
|---|---|---|---|---|
| | | Presence | Absence | Total |
| CIDI | Presence | a | b | a + b |
| Interview | Absence | c | d | c + d |
| | Total | a + c | b + d | n |

The ratio of the probability that a given condition holds to the probability that it does not hold is known as the odds, and can be interpreted simply as the number of times a condition holds for each time that it does not. The odds are calculated as follows:

$$\text{Odds} = \frac{a}{b} \text{ and } \frac{c}{d}$$

The measure of effect size used here is thus the ratio of the two odds:

$$\text{Odds ratio} = \frac{a/b}{c/d} = \frac{ad}{cb}, \text{ where } 0 \leq \text{odds ratio} < \text{infinity}$$

Positive associations thus have odds ratios greater than 1, while negative associations have odds ratios less than 1, although the magnitudes of these deviations in opposite directions are not comparable (i.e., they are not additively symmetric). When the odds for both conditions are equal, the odds ratio equals 1. To determine whether the odds ratio differs significantly from 1, a 95% confidence interval can be constructed (but the details are complex and beyond the scope of the discussion here; see Hillis & Woolson, 1995). To reject the hypothesis that the odds are equal (i.e., that the odds ratio actually equals 1), the confidence interval must not include 1.0.

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In an effort to further explore the associations among diagnostic categories, four additional variables were developed prior to conducting odds ratio analyses that collapsed across three of the four basic disorders in order to yield sequentially more inclusive categories. One instance was reviewed previously for the category referred to as Target Disorder (TAR) representing the presence of either lifetime SUB, DEP, PTSD, or some combination of the three. The additional categorical variables introduced here involve collapsing across Black River respondents diagnosed with other combinations of these three Target disorders: SUB and/or DEP (referred to as "SorD"), SUB and/or PTSD ("SorP"), and DEP and/or PTSD ("DorP"). Thus, odds ratios comparing CIDI diagnoses and SCID diagnoses were analyzed for every possible pairing among these eight variables (i.e., SUB, DEP, PTSD, ASPD, SorD, SorP, DorP, TAR), yielding 64 total comparisons. Ninety-five percent confidence intervals were constructed for each comparison to determine significance.

Of 64 comparisons (see Table 10), 30 yielded significant odds ratios, 22 yielded non-significant odds ratios (i.e., the null hypothesis that the odds were equal could not be rejected), and 12 odds ratios could not be computed due to empty cells (generally indexing quite obvious associations). The odds ratio presented by way of introduction to this section was the strongest of all examined associations, indicating that a Black River respondent diagnosed with ASPD in the lay interview was 18.7 times more likely to be diagnosed with ASPD in the clinical interview than respondents not diagnosed with CIDI ASPD. The relationships between DEP and PTSD evident in these comparisons, however, comprise the most revealing results of these analyses. More specifically, I found that respondents diagnosed with PTSD in the lay interview were 9.2 times more likely to be diagnosed with DEP in the clinical interview than respondents not diagnosed with CIDI PTSD. In addition, respondents diagnosed with DEP in the lay interview were 10.0 times more likely to be diagnosed with PTSD in the clinical interview than respondents not diagnosed with CIDI DEP. But even more striking are the results for the new collapsed category that treats DEP and PTSD as a single diagnostic entity (DorP). Of the eight strongest associations (arranged by magnitude of association) between the ASPD comparison (representing the single strongest diagnostic association of the 64 comparisons) and the DEP and PTSD comparisons just reported, seven contained the DorP category (see Table 10).

Once again, then, a notable pattern of association between DEP and PTSD across interviews is evident in these statistics, and the magnitude of such associations confirms the

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particular significance of this relationship vis-à-vis all other diagnostic categories (again with the unremarkable exception of ASPD). More important still is the fact that the collapsed category DorP evidences stronger associations than either diagnosis taken separately and thus presents compelling evidence for a systematic confounding of these two disorders across interviews.

Further Concordance Analyses

Recall that the coefficient of agreement (or Cohen's [1960] kappa statistic) measures diagnostic concordance while controlling for chance agreement. I previously reported poor agreement for each of the target disorders across diagnostic interviews (SUB $k = .17$; DEP $k = .27$; PTSD $k = .33$; TAR $k = .28$). Given the inclusion of new variables representing collapsed diagnostic categories, allow me to revisit the kappa analyses in order to further explore systematic agreement between diagnostic interviews (see Table 6). Kappa statistics were computed for each of the three new collapsed categories (SorD, SorP, DorP). The results are revealing: for SorD, $k = .18$; for SorP, $k = .25$; and for DorP, $k = .55$. Thus, the single strongest instance of diagnostic agreement for the Black River sample was obtained for the category that treats DEP and PTSD as a single diagnostic entity. Once more, the strength of an association between DEP and PTSD across interviews was affirmed in statistical terms, with particular evidence that DEP and PTSD diagnoses were confounded across interviews.

Summary of Statistical Results

All three types of statistical tests employed in this study evidenced a strong and consistent relationship between DEP and PTSD for this sample of Black River respondents (in contrast to similar comparisons between these and other disorders or among other disorders). Moreover, these analyses indicate in unequivocal terms the systematic confounding of DEP and PTSD diagnoses across interviews. More specifically, while the lay interviewers employing the CIDI were much more likely to diagnose respondents with PTSD ($n = 37$) instead of DEP ($n = 15$), I was much more likely using the SCID to diagnose respondents with DEP ($n = 32$) instead of PTSD ($n = 20$). It remains simply to account for this systematic skewing of diagnostic results.

Part IV: Sociolinguistic Findings

Prior to embarking upon the preceding statistical analyses, I inquired as to the significance of several pertinent facets of the local cultural discourse at Black River for observed patterns of diagnostic discordance. Based upon the variety of results already presented, it is time now to suggest an explanation for the confounding of DEP and PTSD diagnoses across

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interviews. I will propose here that the lay interviewers found relatively high rates of PTSD and relatively low rates of DEP because Black River respondents disrupted the particular diagnostic logic inherent in the CIDI, effectively displacing this dominant psychiatric discourse with the local cultural discourse previously described. More specifically, Black River respondents expressed their distress to other community members engaged in the administration of the CIDI primarily in terms of the socially disruptive traumatic life events they had experienced as opposed to more directly acknowledging problematic instances of painful mood that the community emphasis upon wowacintanka might preclude in such communicative encounters. In contrast, as a non-tribal interviewer and a trained clinician, I alternatively disrupted this local cultural discourse by actively contesting and reorganizing the respondents' own constructions of their distress into established psychiatric categories, thereby facilitating the displacement of PTSD diagnoses among this sample by increased numbers of DEP diagnoses. That is, the more flexible and demanding qualities of the SCID facilitated my displacement of the local cultural discourse with the dominant discourse of psychiatry in regard to the reported experiences of Black River respondents.

In order to convincingly establish the plausibility of this proposal, a tidy collection of interrelated assertions must be examined:

1. Lay interviewers must have directly inquired about DEP (MDE and Current Dysthymic Disorder) mood symptoms (especially dysphoria and anhedonia) during the CIDI and found that respondents actively denied experiencing such symptoms in their lives.
2. Lay interviewers must have directly inquired about personally traumatic experiences (in accordance with the PTSD stressor criterion) during the CIDI and found that respondents were willing to detail the nature and extent of such traumatic lifetime experiences (without necessarily directly expressing emotional distress relate to these incidents).
3. Ideally, relatively clear evidence pointing to the significance of the local trauma discourse (including the accompanying preservation of wowacintanka) for the negotiated disruption of the dominant psychiatric discourse (as instantiated in the CIDI) would emerge from my conversations with the lay interviewers in the patterning of reported experience by respondents.
4. In my interviews with these same respondents, I must have directly inquired about DEP mood symptoms (especially dysphoria and anhedonia) and found that a substantial number of respondents who actively denied experiencing such symptoms in their lay interviews could instead be characterized as in fact having experienced such symptoms in their lives following a more flexible

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and demanding SCID exploration. The proposal would seem especially supported if such symptoms were reported as the sequelae of (locally-understood) "traumatic" experiences.

5. In my interviews with these same respondents, I too must have elicited details regarding the nature and extent of personally traumatic experiences, but found instead that a substantial number of the same respondents who were diagnosed with PTSD through their lay interviews did not necessarily meet diagnostic criteria for PTSD as determined by a more flexible and demanding SCID exploration.

6. Ideally, relatively clear evidence pointing to the significance of a negotiated disruption of the local trauma discourse (by which wowacintanka was effectively traversed) in this patterning of reported experience would emerge from my clinical interviews, resulting in the displacement of a significant number of C-PTSD diagnoses by S-DEP diagnoses among Black River respondents.

Each of these assertions—three of which are concerned with the lay interviews and three of which are concerned with the clinical interviews—will be considered in turn. As intriguing as this proposal might seem, however, an important caveat is in order: the data simply do not exist for an utterly comprehensive and ultimately dispositive account with regard to such an explanation. For example, the paucity of recorded CIDI interviews—another prevalent communicative convention that I disrupted—prevents the kinds of direct and thorough comparisons across interviews that could speak most persuasively to these issues. Nevertheless, I believe that I can bring non-trivial evidence to bear on each of these assertions. I will begin with the first set of assertions associated with the lay interviews and conclude with the remaining set associated with my clinical interviews.

Relevant Discourse in the Lay Interview

I have already stated that no audio records exist for the majority of the CIDIs conducted at Black River. There are undoubtedly several reasons for this, including the pervasive concern with confidentiality among community members as well as lay interviewer sensitivity to the discomfort that recording the interviews would cause respondents. Fortunately, several of the lay interviewers were gracious enough to sit with me during my time at Black River and reflect upon their work in the context of community life more generally. Thus, the evaluation of the first three assertions presented above will necessarily require indirect evidence drawn from the testimony of the lay interviewers themselves (interview transcripts are available upon request from the author). It is therefore indeed fortuitous that these testimonies include the reflections of

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the three veteran lay interviewers with demonstrated efficacy and experience in administering the CIDI to community respondents at Black River.

Inspection of the relevant transcripts reveals a fascinating array of sociolinguistic issues pertinent to the valid assessment of psychiatric distress among respondents at Black River. Most remarkable to me was the degree of consensus evidenced among lay interviewers regarding the majority of issues I raised with them during our conversations. In fact, only one lay interviewer (LM) contributed observations that occasionally contradicted the assertions of the other four. Indeed, this lay interviewer was unique in several respects among the cadre of interviewers. As the last lay interviewer to be hired by the project at Black River, she reported less truthfulness from her respondents than the other lay interviewers; managed to record all of her interviews (which probably resulted in less frank responses); interviewed individuals with whom she had close personal relationships (e.g., her husband); described intermittent malfunctions in the computer protocol that impaired several of her interviews; and expressed a significant amount of quite personal information with me during our conversation. Nevertheless, even this lay interviewer agreed with the rest regarding several important facets of conducting these interviews.

For example, there was utter consensus among all five lay interviewers that: (a) participant concerns regarding the confidentiality of responses to sensitive personal questions about their "mental health" was perhaps the single most salient issue in recruiting respondents for participation; (b) the necessary qualifications for an effective lay interviewer to convincingly address these concerns included personal maturity and especially a relatively upstanding reputation in the community; (c) proper attention to communicative norms pertaining to age and especially gender often facilitated a more fluid assignment of interviewers to respondents; (d) a white person conducting lay interviews would simply be unable to obtain valid responses from respondents owing to ongoing racial tensions on and around the reservation; (e) interviews with first-degree relatives (and, for most lay interviewers, close friends) were thought to be inappropriate and uncomfortable and were avoided; (f) very few respondents explicitly refused to participate in the study, although a handful indicated their unwillingness to participate indirectly by missing appointments, refusing to answer the door when a lay interviewer arrived to discuss participation, etc.; (g) two sets of questions in the lay interview pertaining to sexual satisfaction and ritual involvement elicited occasional consternation from respondents, a few of

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whom refused to answer these questions; (h) several of the CIDI questions regarding psychiatric symptoms were difficult for respondents to understand and not uncommonly resulted in confusion and frustration during the interview (I will further elaborate upon this shortly); (i) the stigma of being identified in the community as mentally disabled, deficient, or crazy involves fear and avoidance (and sometimes blatant mistreatment) by other community members (including members of one's own family); (j) the experience of completing the lay interview seemed genuinely therapeutic for many of the respondents; and (k) each of the lay interviewers expected that having worked for the project and having conducted these interviews would likely improve their own personal status in the community as well as expand their social networks in a positive way. Furthermore, I should perhaps add that consensus among four of the five lay interviewers prevailed in the matter of recording their interviews: the majority did not record their interviews out of respect for their respondents' privacy and comfort—several noted that recording the interviews would probably undermine their respondents' openness to answering such personal questions. Finally, four of the five lay interviewers seemed especially struck by the degree of honesty with which their respondents answered the interview questions—even the fairly unique lay interviewer reporting a higher rate of potentially inaccurate responses estimated that 75 percent of her respondents were being truthful in their interviews. It is worth noting, however, that the low number of respondents who were clearly less than truthful in their interviews also seemed to stand out in the lay interviewers' minds, owing perhaps to the premium placed upon honesty in the community. Additional descriptions of the lay interviewer experience pertaining to the sociolinguistic facets of diagnostic interviewing will be detailed below as seems warranted. Insofar as they pertain to the lay interviews, I will now consider each of the above assertions in turn.

Assertion One. With regard then to the first assertion proffered above, there is solid (albeit somewhat indirect) evidence that (a) lay interviewers directly inquired about DEP symptoms, and (b) respondents denied experiencing them. First, the computer protocol required that lay interviewers read standardized CIDI prompts related to a clearly-delineated timeframe of dysphoria and/or anhedonia (see Appendix B for sample items) using a range of words and phrases designed to capture local labels for dysphoria in particular. Lay interviewers were required to record a response before moving on to the remainder of the interview. Furthermore, quality control procedures at the National Center reviewed randomly selected interview

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materials on a routine basis for each interviewer to ensure adherence to the scripted protocol and the proper coding of data (in fact, this procedure successfully identified a small corpus of falsified interview data from a lay interviewer who does not feature in this study). Thus, I am quite confident in asserting that lay interviewers did in fact closely adhere to scripted protocol by directly inquiring as to the respondents' experiences of dysphoria and anhedonia—if these symptoms were in fact endorsed by respondents, then additional DEP symptoms were certainly assessed as well. Second, respondents obviously denied ever experiencing several of the DEP symptoms in a single timeframe or else the CIDI computer algorithms would have diagnosed them with a lifetime DEP. And, as I reported earlier, the data suggest an exceptionally low prevalence of DEP at Black River. The question here thus concerns the patterning of DEP symptom endorsement that ultimately yielded these low prevalence rates. For example, while it seems obvious that respondents denied experiencing five coterminous MDE symptoms for at least a two-week period during their lifetimes, it remains unclear which criteria respondents may have actually endorsed that nevertheless fell short of this diagnostic threshold. For example, it is hypothetically possible (however unlikely) that respondents in fact endorsed all nine MDE symptoms, but denied that they experienced such symptoms within the same timeframe, thus precluding a diagnosis of MDE. (Fortunately, statisticians at the National Center have investigated a range of these more obvious possibilities in an effort to understand the low prevalence of DEP, but so far remain mystified.)

To complicate matters further, there was utter consensus among the lay interviewers that certain CIDI items were difficult for respondents to understand, resulting in occasional confusion and frustration for the respondent. Some of this confusion was attributed directly to the CIDI DEP prompts. For example:

[JG = author, XY = Lay Interviewer Initials, (   ) = inaudible or barely audible words]

JG: How well do respondents seem to understand the questions in the mental health portion of the interview?

MR: Real good, except for the part where you've got to stress the time: within the last two days, within the last two weeks, within the last month, within the last two years. You've got to take a- What do you call it? Put a comma in there after the time period. So like, for example, In the last two years, [pause] have you felt this way? You've got to put a kind of a pause-comma after that time period. At first I

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was having problems, I was just kind of reading it, and some of the answers would be wrong.... So, see, you've got to stop and pause after those time periods. That's really a main factor there. I've stressed that to the other interviewers too, because we've all had that kind of problem. So we go so slow, and pause a lot.

Another interviewer took the tactic of repeating the questions to be sure that respondents understood them:

HT: So I'd read the question over to them again, and they'd say, Oh. So then they'd give me their answer. But yeah, usually I had to repeat. I know that in that section there I would have to repeat a question at least twice. Or I'd say, In the past year? Or the past two weeks? You know, I'd have to repeat that part over again, because they just didn't listen. Or maybe I said the beginning part too fast or- I'm not sure.

A third concurred that respondents seemed to overlook key information solicited by these questions:

YS: Yes. So it goes pretty fast, because- I've never had one that ever hesitated on answering questions. When I say the question right away they answer. But sometimes I notice that the emotional well-being part of the interview is confusing because of the timeframe. Some people don't listen very well. And they're listening for very simple questions. But sometimes these are pretty hard, and especially for the time: beginning and end and several years, or several weeks, or several days. They miss wording in there, you know. That's one of my biggest concerns in my interviews. And so when I come up to that part, I just really- You know, it says read slowly anyway, and I do read slowly. And then I really try to explain it to them: You have to really listen to this, you know. Some of them just think about worry, you know. They just listen to just a few words out of there, and some they kind of leave out.

This seemingly pervasive confusion regarding the CIDI diagnostic prompts, especially as it applies to the DEP items, raises the possibility that low rates of DEP were obtained among this sample primarily because respondents were simply unclear as to the meanings of particular symptoms and thus conveniently (as opposed to deliberatively) denied experiencing them, resulting in a high rate of false negative diagnostic attributions in this sample.

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Indeed, these competing explanations present formidable analytic hurdles to establishing that Black River respondents meaningfully denied experiencing symptomatic dysphoria and anhedonia in their lay interviews, especially given the fact that direct records of the interviewer-respondent exchange are unavailable. Given such intimidating analytic constraints, I take limited solace in the fact that the lay interviewers once again evidenced consensus in their explanations of such confusion by providing salient examples of the mistaken positive endorsement of these items by their respondents:

MR: At first I was having problems, I was just kind of reading it, and some of the answers would be wrong. You know, and you'd get down and ask the question, say, For the last two years have you felt depressed nearly every day? And they'd say yes, and then you'd get down about five or six questions, and Wait, wait, now what was that one? For two years? No, I ain't been depressed that long. So, see, you've got to stop and pause after those time periods. That's really a main factor there.

Another lay interviewer commented likewise:

LM: So I don't think they understood it the very first time. And they don't word them right, because I've had a lot of that. I've had a lot of that happen, you know. Or where I'll say Two years or more where you felt depressed or sad most days and still feeling OK sometimes. And they'll be like, Yeah. And then later when I say, Did this two years last without being- And they'll say, Two years?! It wasn't that long! So, Well, you didn't hear the first question when I said Two years or more. Or I'll say Two weeks or more- I try to say, Two weeks or more. I try to make them understand the time period. But sometimes they still don't catch it. And then later on when I say it, they say, Well, it wasn't that long, it was only like an hour. Or only like just for a moment.

A third observed the following:

HT: And some people would have problems with those, because then I would have to go back and say, In the past two weeks? Oh, in the past two weeks, no. So because sometimes it wouldn't make sense to me, because I know they just got through telling me that they tried committing suicide in the past year, then—this is just an example, because I don't know what the questions were—but then I

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would go to another question, and say something like, In the past two weeks did you attempt suicide? And they'd say, Oh yeah. In the past two weeks, did you...? Oh, no. . . . I think a lot of people didn't pay attention enough to what I asked, because sometimes they wouldn't- they would give me a different answer, and it wouldn't make sense to me. And I would question them about it, and then they would think about it, and then they would give me another answer.

Still another concurred:

DM: And so it's hard because you have to say- You start reading the question, like I did yesterday, and she'll say, Yes, uh-huh. And I'll say, let me read the question again: Have you ever in your life had a time of two years or more- And read it like that, and she'll say, Oh, no, not for two years. Because when you just read it like that, then, you know, they're, Yeah, oh yeah. And then after you really think about it and you read it back to them, Oh no, but not for two years!

And finally:

YS: They just listen to just a few words out of there, and some they kind of leave out. And then when it really gets into the heaviness, you know, it gets on into it if you answer Yes, you know. And sometimes they're frustrated.

Thus, in every instance where lay interviewers described the confusion attending these items among their respondents, they elaborated in enough detail to clarify that respondents were mistakenly endorsing these symptoms in their confusion as opposed to conveniently denying such symptoms. Furthermore, there is not one instance among these conversations with lay interviewers where convenient denial of misunderstood DEP prompts (e.g., where a respondent was noted to have previously referred to a difficult period of time that resulted in a suicide attempt, but then denied experiencing DEP symptoms) was noted (although several did reference a handful of cases where convenient denial was utilized by a minority of respondents throughout the majority of the interview in order to limit its duration). Finally, in three of the concrete examples cited by lay interviewers (and presented above), respondents were portrayed as quickly denying that dysphoria had bothered them for the timeframe in question as soon as the miscommunication became clear to them. Taken together, then, I conclude from these data that there is solid (even if incomplete and indirect) evidence to support the assertion that lay interviewers directly inquired about DEP symptoms and that substantial numbers of

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respondents—who may have allowed that they had perhaps experienced such emotions on fleeting occasions—meaningfully denied ever experiencing actual mood symptoms (i.e., persistent and potentially disabling distress) during their lives.

Assertion Two. With regard then to the second assertion enumerated above, there is also solid (albeit again indirect) evidence that (a) lay interviewers directly inquired about personally traumatic experiences, and (b) respondents were willing to discuss such experiences in the interview context. Once again (and for many of the same reasons elucidated above), there can be little doubt that the lay interviewers followed CIDI protocol and directly inquired about potentially traumatic events that respondents may have experienced in their lives. In fact, the CIDI protocol required respondents to rank-order up to three of the most distressing of these experiences so that the item set designed to assess PTSD symptoms could be completed for each reported traumatic event. Moreover, it seems obvious that respondents were capable of and willing to discuss these experiences and their effects in enough detail such that a relatively high proportion of them were ultimately diagnosed with PTSD based upon their CIDI responses. Thus, there would seem to be little need to justify this claim beyond these obvious details. Since the general proposal being developed here will ultimately depend upon the suggestion that CIDI responses resulted in a diagnostic skew towards PTSD diagnoses, allow me to simply remind the reader that such diagnoses depended upon the rather simplistic Yes-No responses to a fairly extensive set of items assessing the full range of PTSD symptoms—the significance of this point should become apparent somewhat later in my argument.

Assertion Three. Finally, with regard to the third assertion listed above, there is good (indirect) evidence that the local trauma discourse (affording the preservation of wowacintanka) shaped the construction of respondent experience in the lay interviews—especially in regard to both DEP symptoms and discussions of trauma—that effectively disrupted the psychiatric discourse evident in the CIDI. By way of introduction to the topic, I will quote one lay interviewer rather extensively in order to provide a more concrete illustration of how wowacintanka might figure in the diagnostic interview vis-à-vis the community:

JG: Have you ever felt like you were helpful to a respondent...?

HT: Yeah.

JG: In what ways?

HT: Well, I feel like I sat there and I listened to them. And like people said, they were

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> glad to be able to talk to somebody. And then knowing that I'm keeping it confidential and I'm not running around telling people about, Well, so-and-so said this, and so-and-so said that. And I did help him to get- because they would break down crying. So they did get to show some emotion, because it's good to do that. It's good to break down and cry sometimes. And if they didn't do that before, and they did it in the interview, then yeah, I think I've helped them. Because it's helped relieve them for a little bit, helped make them feel good for a little bit, to know that somebody was listening to them.

This interviewer thus observed that therapeutic benefits may have accrued to a subset of respondents owing to at least three factors: (a) confidential talk in which somebody "listened", (b) a collapse of wowacintanka (i.e., a "break down") evidenced by clear manifestations of grief (i.e., crying); and (c) resultant relief (or restoration to "feeling good"). Furthermore, the interviewer allowed that some respondents may not have done this before (at least in relation to certain experiences), which raises the question of how routinely tribal members express such grief:

JG: Do you think that's unusual for people around here to break down and cry?

HT: I think so, because people around here are just taught to be real strong. I always hear this. I hear it in stores. I hear it everywhere it seems like. Don't be crying. You're a boy. You're not supposed to be crying. I hear that everywhere wherever I'm at. And that's what it seems like, you know. And even my dad has told me: I was taught when I was growing up, that I'm a man. I'm supposed to be strong. I'm not supposed to cry. I'm not supposed to show any emotions. And that's how it is around here. I hear that a lot, that people—especially men—are not supposed to show their emotions. And I think people around here are raised so they're not supposed to show emotions or personal problems. Or to show that they've got a lot of problems going on. I think you're supposed to show that you're strong, and that you don't have no problems.

JG: What's that about? Where does that come from?

HT: I think it probably comes from- I know it's probably an old idea, because I know there's a lot of older people that tell people that. I just have this feeling that it's an old idea, that you're not supposed to cry, and you're supposed to be strong.

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Men and women have their different roles.

The proscription against showing emotions is thus understood to be a traditional ethic that continues to prevail in contemporary social life. For this interviewer, there are apparent gender patterns that shape wowacintanka as well, which raises the question of gender differences in its adoption or expression:

JG: Well, is it acceptable for women to show their emotions then?

HT: Not really. Not here on the reservation anyways. Because women are supposed to be strong, too. Everybody's supposed to be strong, not show your emotions, not cry. Even seems like when you're grieving- You know, I've gone to funerals where- I mean, I'm an emotional person. I'll cry at funerals or movies. But I see like at funerals sometimes- Like for instance, I had a cousin passed away in August, and my girl cousins were all there at the funeral. But once we got back to their house, they just broke down and started crying. And I thought, Boy, when they first brought in the body and they let everybody go through and look at it, and they shake hands with the family, and they hug the family- And it seems like that's the time to cry. But they didn't until they got home and no one was around and then they started crying. And I asked my cousin, I said, You know- And I had been bawling that whole time at the funeral, you know, or when they first brought the body in. And I thought, Gee, you know, I looked over and saw the rest of the family. And the girls, you know, that was their brother that had passed away and they just like- They were like being real strong. And I thought that about them, too, when I saw them. And then we got home, and one of my girl cousins- We're real close because we were both raised by my grandma. And I said, how come you guys didn't cry? Because you guys didn't show any emotion there when all the people were present and they were shaking your hands. And she said, Because, she said, Ma probably would have gotten mad at us. So I thought, Well. So I guess I speak from experience, from growing up, being around people, living here on the reservation and being around people that- Being with my girlfriends and then being with my male friends too, you know, that they were taught to not cry. Not to show your emotions in public. And I think that that's why there's so much suicide, too, that goes on on the reservation

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because they don't have anyone to turn to.

And so even in public settings where grief may be understood or expected, wowacintanka would appear to prevail for many tribal members (whether male or female). It would seem that relatively intense displays of distressing affect are reserved for more intimate settings, which raises the question of which settings might be deemed appropriate for such emotional displays.

JG: You mentioned that after the funeral in the home that there- What other opportunities- What are the other kinds of situations where someone is able to kind of break down and cry over something really terrible that happened, and not necessarily be looked down upon?

HT: Let's see. I guess probably maybe a tragic event that happened, you know, if- I'm not sure. I'm just not really sure about that. I think maybe if there had been a real serious or tragic accident, you know. And at the hospital and they're dying, and maybe their family comes to them and maybe you can cry there because all the family's there and they're in the room together. But it seems like when they're in their home and when they're together as a family, or when they're with somebody that's dying, and maybe like that it seems like it's OK if the family's going to cry. But if you're seen by outsiders, that's not OK. I mean I had a friend who even committed suicide when I was in high school, and his girlfriend was really grieving. And she was told Don't cry in front of people. I think that's a lot of- Around here people keep their emotions inside. I think maybe that's where the alcoholism comes in.

What I found interesting here is that even this interviewer, who had lived her entire life in the community, had difficulty identifying a range of situations in which it might be considered appropriate to display intense emotional distress. In the end, she alludes to the role of alcohol. I inquired further:

JG: How so?

HT: ...A lot of people drink to try and- I notice that when- just from all the places that I've worked. And working with coworkers. For them to go out and drink, it helps them to get their worries off their mind. Then after while when they start getting drunk and they start crying about it, you know. And they're gassed and they don't know what they're doing. And they're crying about their problems and

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stuff. Because I have a lot of friends that are single that are about my age that are single, and that's what they do. Go out to get rid of their problems or to ignore them or to suppress them, they'll go out and they'll drink.

JG: If someone who's really drunk is crying about their problems, is that...

HT: That's looked down upon.

JG: That also is?

HT: Mm hm. Like they're weak.

And so the opportunity that alcohol affords for expressing troubling emotions would appear to run afoul of wowacintanka as well (although it is unclear from this testimony precisely why this may be the case). In any case, this lay interviewer suggested that the collapse of wowacintanka evident in her interviews was relatively infrequent:

JG: Well, we were talking about whether you ever felt like you were helpful to your respondents in the course of the interview. What proportion or percentage of your respondents do you think found the interview helpful to them directly in some ways?

HT: I'm not sure I'd really be able to answer that. I think just from like the respondents that did break down and cry, and then when they were leaving they said that this helped them. That is where I would be able to answer you from there. But I'm not sure- I can't remember how many people told me that, but I think it's maybe like four or five. That they got to talk about it.

JG: Do you think that- Did any of them seem worried or embarrassed that they broke down and cried?

HT: No.

JG: But if they were in public, they would have been worried about that then?

HT: I think maybe because I was associated with the University of Colorado that they probably thought of me as a counselor, where it was OK to break down and cry. Plus it was just us two in the room and everything has to be kept confidential, so I can't go out and say so-and-so started bawling around because of this or that, you know. So I think that was probably why they broke down and cried. But if they had gone to their mother or maybe someone in the family and started crying, then the person that they went to probably would have said, Don't be crying, there's

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worse things. Because I hear that a lot, too. You shouldn't be crying. There's worse things that could happen. Or stuff like that.

Finally then, this interviewer suggested that even these relatively rare displays of painful affect occurred following an assessment by the respondent as to the acceptability of "breaking down" in the interview setting. She returned to the role that confidentiality likely played in such an assessment, and concluded by observing that wowacintanka was expected to hold even within very intimate family situations as well. (Interestingly enough, this interviewer described elsewhere in our conversation the relative acceptability of similar emotional displays in ritual contexts, such as the inipi ceremony).

Given this extended introduction to the pragmatic force of wowacintanka within the interview setting, it now seems appropriate to examine the specific influence of wowacintanka on respondent reports of DEP symptoms and trauma (as reconstructed indirectly from my conversations with the lay interviewers). I have already reviewed evidence that some significant portion of respondents mistakenly endorsed CIDI DEP items only to clarify rather quickly that their dysphoria did not trouble them for any significant period of time. What seems interesting here is that respondents were not portrayed by the lay interviewers as necessarily denying any experience of dysphoria, but instead were portrayed as denying that such dysphoria ever involved persistent impairment or distress. Thus, it may be that (under certain conditions) when directly asked about troubling emotions, some respondents at Black River are willing to endorse painful feelings (without necessarily volunteering such information or elaborating upon them) so long as such feelings cannot be construed as actually overwhelming the respondent (after all, in order to demonstrate wowacintanka one would presumably require trying circumstances to effectively withstand).

Nevertheless, there is at least some evidence that even the acknowledgment of dysphoric experience may have threatened to undermine wowacintanka for some respondents:

JG: Do people seem to understand what you mean when you ask about feeling nervous, scared or anxious?

YS: Yeah, they understand that.

JG: What about worried, depressed, sad?

YS: Yeah, they understand. Depressed would kind of- People try to stay away from that question when you talk about depressed. That and low, ( ), or irritable,

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or empty. They try to stay away from those, you know, what I was saying. They answer no.

JG: So you think really they say no without thinking about it too much? Why do they try and stay away from that?

YS: Probably denial. They (don't want anybody)- to tell them about that situation. Because when you talk about depression to a person, they just kind of- ( ) share something of ( ). Because I think when you talk about mental health, I believe the person thinks that you're crazy. And you talk about depression, that you have a mental problem, too. Now I don't know where this started, how long in generations (it comes), but I believe that our forefathers taught us that. I do remember a couple times my mother and dad and grandmother and grandfather would say, If you don't behave, ( ) will send you to the mental health department. They'll send you to [Place] where they send everybody who's crazy. And you know- so I don't know what generation it came from, but there is something out there that- When you talk about depression and mental health, it's-

JG: So the word depression, people connect with mental health, or being sent away, or being crazy?

YS: Yeah. Because I notice a couple of my respondents, when I come to that part, talking about depression ( ). They kind of hang their heads, you know. And it's like, you kind of recognize that Oh, I wish we'd hurry up and get over this part, you know. So that's an interesting part right there. And some I just have go, No, no, no, no. And then there's some that say Yes. And then when we- you know, when they answer Yes, it goes into more detail, you know. And they're like What can I say?, you know. So I think it's kind of confusing, and they-

JG: Do you think you could talk about being sad instead of being depressed, and they would have the same reaction?

YS: Well, there is a part that says sad.

This relatively rich testimony provides a glimpse into the workings of wowacintanka with specific regard to the CIDI DEP items. Here the lay interviewer suggested that the stigma of psychiatric distress directly colors the assessment process owing to the association of "depression" with mental illness (perhaps the ultimate "break down" of strong-mindedness or

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fortitude). Some respondents were portrayed as quickly denying such symptoms, while others admitted to experiencing such symptoms with evident discomfort (e.g., hanging their heads as if to state, "What can I say?"). In either case, the assessment of depressive symptoms was characterized as uncomfortable for respondents and seemed to pose a direct threat to wowacintanka.

The evidence provided by the lay interviewers regarding the influence of the local trauma discourse (especially with regard to the maintenance of wowacintanka) in respondent reports of traumatic experience is even more extensive and elaborate. This was so for three reasons: (a) the experience of significant trauma is relatively prevalent at Black River; (b) the narration of such events by respondents appears to entail for them one of the most difficult challenges to wowacintanka, owing to the typically unspoken emotional distress associated with these traumas; and thus, (c) respondent "break downs" in wowacintanka were most likely to occur in the PTSD section of the CIDI where lay interviewers directly inquired about such experiences. A related reason then for the salience of respondent wowacintanka vis-à-vis reported trauma in my conversations with the lay interviewers involves the angst-ridden struggle of the interviewers to maintain their own wowacintanka in the face of respondent grief. This latter point is relatively evident in the conversation transcripts (although it will not be developed extensively here).

All of the lay interviewers reported occasional struggles by their respondents to control their emotions in the face of discussing traumatic experience. For example, one interviewer observed the following:

JG: Well, what kinds of emotions do people show when talking about upsetting experiences?

LM: I've had a couple- I guess a couple cry. Two or three cry, anyway. I'll stop the tape and take a break.

A second lay interviewer elaborated further:

JG: What kinds of emotions do respondents show when talking about upsetting experiences?

HT: What types of emotions? Crying.

JG: How frequent was that? What percentage of respondents were crying?

HT: Probably about twenty percent. It was real low. And let's see. Either that or they

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> would sit there for a long time and think. That's when I knew that- because you just don't know by looking at a person that they're going to have so much traumatic events. And when I would get onto the first, and they would sit there and they'd go [deep sigh], you know. Or they would start taking deep breaths, or start taking longer to think about things, then I would know, OK, we're going to have a couple of traumatic events coming up. At least two or three because in my interviews there was probably about five people that I interviewed that didn't have any traumatic events. The rest of them had either like- And it seemed to me that the interviews that I did, it wasn't just one traumatic event, it was like three or more traumatic events that happened to the person. If it was none, it was none. Otherwise if it was at least one, there was at least three of them. Because I don't remember ever doing one interview where I just did one traumatic event. I always did at least three or more.

The most remarkable facet, however, of the lay interviewer testimonies regarding the role of wowacintanka in respondent reports of trauma was how effective many respondents were at maintaining emotional control while describing truly horrific experiences. In fact, the successful exercise of wowacintanka among many respondents actually astonished several of the lay interviewers (who then attempted to account for the conspicuous absence of strong emotional expression in the trauma section of the interview):

> LM: I've had a couple- I guess a couple cry. Two or three cry, anyway. I'll stop the tape and take a break. I think that's with females. For the male, he didn't show any expression. He just said, Yeah, I was molested. Were you stabbed or was a knife used on you, you know. Yeah, right here, you know. And he'll show me where he was- I can't believe he's- he could even- he can say it without crying or something. I suppose this is the male macho thing or something, I don't know.

This interviewer thus invoked gender in accounting for the surprising absence of detectable affect from this respondent.

Other lay interviewers commented on similar scenarios:

> JG: What kind of emotions do respondents show in talking about these upsetting experiences?
>
> DM: Some of them, none at all. And some of them, maybe they get teary in the eyes,

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or maybe they'll just sit there for a while, and you know that they're thinking about it, and you know it bothered them. But some of them, nothing at all. Oh yeah, I was in a car accident and my best friend died. Were you there? Oh, yeah, he died right next to me. Like that. But some of them don't even care. But you can tell, if they don't care, it don't bother them. And it probably was in the trauma section and somebody that I know that it bothered them, something ( ), I'll just say Would you like to take a break? And some of them say, yeah, some of them say no, I'm OK. We'll go on.

JG: What proportion or percentage of the respondents you've talked to get visibly upset?

DM: Maybe about thirty percent?

And later:

JG: How many of the people have actually broken down in the trauma section?

DM: Not very many. . . . not very many people break down. I mean, physically break down and cry and stuff. It's happened maybe twice?

Here the lay interviewer implied that a lack of emotional expression on the part of the respondent must have meant that he did not care about the loss of his friend. Later, she offered a different speculation to account for the absence of clear emotion in respondent accounts of traumatic experience:

JG: It's interesting then, because a good part of the interview, especially for the mental health, which is a real important part, is about bad feelings. Are people able to talk about that then, in a real honest way, without showing those feelings? Or how does that work?

DM: I don't think so. ( ) Some of them are OK. When you're talking about bad feelings, you're talking about going through a trauma and how you felt after the trauma. Were you horrified, you know. . . . But then they ask you all of these questions about your feelings after these traumas. And a lot of them say, Yeah, I guess I did- I was fearful. They can say yeah to that. And it don't bother them. Some of them don't (seem that bothered by it). And they tell me shocking things.

JG: How do you know it doesn't bother them?

DM: Because they act like it. They're just like, Yeah, I saw somebody who had raped

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people. I had a woman that was raped and never showed once (any emotion). Oh yeah, that was way back when I was 16 years old. And how did you feel after that happened? Did it make you more concerned about danger? Oh yeah, uh-huh. Or- You know, all those questions that they ask? Because you can tell by looking at the person and asking those questions how they react, if they felt any emotion at all. And some of them it don't really bother. Maybe it happened so far back in their life that they dealt with that in some way where it don't bother them. But they don't show any ( ). So I can't really say that it didn't bother them, but just by looking at them-

We addressed the possible role of wowacintanka in these encounters as follows:

JG: Do you think that maybe they're just being strong?

DM: Mm hm. They hide it. Like I said, ( ) in their families. They don't want anybody to know. And they come in here, they think they have to be strong. They don't want anybody to know. ( ) I would be ( ) something like that, even if it happened 20 years ago. (To begin with,) maybe they've gone to treatment. Maybe they've dealt with some of that too. But then they ask ( ) too. Have you ever received any treatment (for that), and they say no.

Thus, in addition to the possibility that respondents simply did not care about terrible tragedies, this interviewer also speculated that perhaps the respondents in question did not evidence obvious emotion because they had already resolved the difficult emotional issues wrought by such trauma through treatment. She seems somewhat mystified, however, that such respondents deny ever having obtained treatment.

Another lay interviewer tried to account for a seeming lack of feeling on the part of her respondents as well:

JG: But there's more people than those who are actually telling you about stressful things that just don't show any emotions?

LM: Mm hm. Like maybe it was like where they seen a car accident, or been in a car accident, but it wasn't that bad. They'll say, even though they was in one, later on they might say Well, it wasn't that traumatic. But you know, they say Have you ever been in a car accident, or in a situation, like a threatening situation? And I guess I get a lot of that. Or where they were mugged or robbed or

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> something. They don't show any emotion. They can talk about it. I guess it wasn't that bad for them because it doesn't seem like it was that bad. Things happened to them, but I guess it wasn't that traumatic or something.

And so this interviewer speculates that perhaps the traumatic events reported by respondents must not have been experienced as very upsetting after all.

One interviewer allowed that more subtle cues of emotional distress could be detected in her interviews:

JG: What kinds of emotions have respondents shown when talking about some of their traumatic experiences?

YS: That's something that's really hard to identify, because a person will just sit there and tell you about them. And I'm pretty concerned at the end of the interview because somebody has lots of traumas, you know. And I'm always asking them How do you feel, do you feel all right? That's something you always say ( ) happen today ( ) that's already gone. And in there they ask, Did you feel helpless, did you feel intense fear? And then I watch them, and some of them relive that, you know. Because you can tell- they look like they have that scared feeling, like it's happening right then. And when you ask those questions, Did you feel horrified? Yes, you know. And then when you get over that section, then they come back to being themselves again.

JG: Would you say that people generally express a lot of negative emotion when they're talking about those traumas, or do they express less than you would expect?

YS: Both, I would say. Some express a lot of negative emotions, you know. I did one in my respondent's home, and she really smoked a lot. ( ). I could tell that it was ( ). And then the other time, the woman would tell me- she showed less emotions. And to me, to myself in my mind, I was thinking, Boy, this woman's a very strong woman to sit here and not even show emotion.

JG: What proportion or percentage of respondents have shown strong emotions during the interview?

YS: Strong emotions? You mean like crying, and like that? Reacting? Mmm. I would probably say only about five of them. Five out of the (ones) I've done.

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Like I've just explained to you about, you know, they showed- they relived it, you know, in their mind. They were scared or something. And then after we got over that questions about intense fear or intense (  ) After we get over that, they just seemed to come back.

Finally, one interviewer described how he actively manages the interview situation so as to prevent the collapse of wowacintanka among his respondents:

JG: But you've seen other people talk about pretty traumatic things, and not be very emotionally expressive?

MR: Yeah, it's kind of like they've got calluses. Maybe that's why he could talk about it without breaking down or whatever.

JG: Have you seen people break down in these conversations?

MR: One woman almost broke down, but we took a break. So you can see when they- you can tell by their facial expressions and the way they answer things, that (  ). You need to take a break, because they're getting- like some people need to start trying to cuss: That so-and-so, why in the hell did he do this or that? And Oh, why don't we take a break, I'll give you some coffee. That gives them a chance to cool down a little bit.

JG: So you help to kind of regulate those feelings?

MR: Yeah, you have to. You're the regulator, because you'd be surprised what you can bring out in people. You have to be the regulator, and hopefully you regulate it OK, otherwise you might be into trouble yourself with the interviewee. And with (  ) probably. They might get so irate that they'll just say The hell with you, and get up and leave. And then they'll go spread this bad word around, and bad word spreads like wildfire on the reservation.

This interviewer offered detailed glimpses of his strategy for regulating the emotional tenor of the interview:

MR: What I do is I try not letting them elaborate. If they start elaborating, then you're in trouble.

JG: In the trauma section?

MR: Yes. You're in trouble then. You're off track. So I say, Well, wait a minute now. You've answered the question. Let's get back here and do the next

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question. So you've got to regulate it all the time. You've got to be cautious because if you start sitting there and listening, they'll want to get deeper into just one subject. You have to stop that and get back on track, otherwise you ( ).

JG: What do you think would happen if you just let them elaborate?

MR: You'd be there for ten hours. And you wouldn't- You might not even get the interview finished because they might work themselves into such a frenzy that they might just say the hell with it. So it's really cautious- you've got to be cautious all the time. You know, you've got to- In my mind, I say you've got to be callous.

Lay interviewers were encouraged to follow up on particular respondents who seemed distressed in the interview (but who didn't warrant immediate medical intervention):

JG: So, what about in cases where you finished the interview ( ) pretty bad?

MR: Well, I've never had any feeling really that bad. The one I did, I did a follow-up on. I was concerned about her because she was a young girl. And I was concerned about what she might do in the future because of all the family problems. But I checked back on her and she seemed to be doing all right. So she must have a strong mind or something.

JG: So by and large, people have been OK?

MR: Yeah. It brings them- it kind of depresses them a little bit during the trauma section. The ones who have a lot of trauma. But afterwards they pull out of it. They've been doing it for years, you know. All we're doing is pulling the scab off of the wound, but it scabs over again.

The purpose of reviewing the lay interviewer testimony in such detail relates to the assertion that the local trauma discourse, especially with regard to the preservation of wowacintanka, was evident in respondent constructions of their experience and resulted in the denial of CIDI DEP symptoms as well as the acknowledgment of traumatic events in the PTSD section of the interview protocol. I have thus attempted to demonstrate that the strong cultural endorsement of wowacintanka as a salient feature of the local discourse at Black River rendered the lay-administered diagnostic interview a sociolinguistic "proving grounds" for the interpersonal negotiation of fortitude vis-à-vis psychological distress. Given the central role of (locally-defined) traumatic experience in the explanatory models of illness and distress at Black

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River, it is therefore not especially surprising that community respondents elaborated upon traumatic events they had experienced while struggling to maintain their fortitude (which most were successful at doing). Similarly, it is not especially surprising that community respondents quickly contested their mistaken endorsement of persistent and potentially disabling emotional distress once the significance of their errors became apparent.

I should add here that this apparent pattern of response by Black River participants is necessarily dependent upon the specific method of organizing diagnostic inquiry employed by the CIDI. Essentially, the CIDI DEP items confront Black River respondents with the question of whether they have ever suffered persistent and potentially disabling dysphoria and/or anhedonia without explicitly situating such symptoms within a locally meaningful context (e.g., by identifying a "triggering" event). That is, within the typical Yes-No CIDI format these items invite respondents to report what might seem to be "free-floating" mood symptoms that thus tend to become characteristic of persons rather than situations. In effect, then, the CIDI DEP items inquire of respondents whether they have general difficulty maintaining wowacintanka, whether they are in fact weak-minded. This less obvious meaning of the CIDI DEP items would thus predictably skew responses towards a denial that psychological weakness accurately characterizes the participant, potentially resulting in the lower-than-expected prevalence of DEP at Black River. In contrast, the CIDI PTSD items provide Black River respondents with a culturally salient means to discuss distress. Again within the Yes-No format of the CIDI, Black River respondents were invited to report horrific personal experiences, and a great many of them did so. The remaining CIDI items designed to assess the full range of PTSD symptoms (delivered in lockstep fashion with relatively complex wording) could easily have been construed by the respondent as an opportunity to simply ratify how truly terrible the original experience had been. This less obvious meaning of the CIDI PTSD items would thus predictably skew responses towards a more widespread endorsement of the somewhat subtle PTSD items, resulting in the higher-than-expected prevalence of PTSD at Black River.

In the end, a systematic skewing of diagnostic results at Black River could have easily emerged from the manner in which the lay interview assesses psychiatric symptoms vis-à-vis the local trauma discourse in this community. That is, the very ontologies of distress represented in the concepts and categories of western psychiatry (as encoded in the CIDI) on the one hand, and the local trauma discourse that prevails at Black River (even in the context of a fully-structured

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diagnostic interview) on the other hand seem fundamentally incommensurate and should be expected to yield unanticipated results. By priming respondents in the DEP section of the CIDI with reference to non-contextualized mood symptoms, it is not surprising that the prevalence of DEP Disorders at Black River seems astonishingly low. By priming respondents in the PTSD section of the CIDI with reference to culturally salient traumatic events, it is not surprising that the prevalence of PTSD at Black River seems unusually high.

Although the evidence considered here is necessarily limited and indirect, I believe that it lends support to the thesis that the lay interviewers employing the CIDI invoked (and could not circumvent, given their own positioning and the scripted nature of the interview protocol) the prevailing trauma discourse (emphasizing the preservation of wowacintanka) such that the systematic denial of CIDI DEP symptoms (which require the acknowledgment of persistently troubled emotions in the absence of meaningful context) and the systematic endorsement of PTSD symptoms (which are by definition etiologically linked to traumatic experience) is rendered plausible. This pattern seems especially remarkable given the fully-structured nature of the CIDI, which would presumably withstand local disruption by respondents owing to the lockstep method by which it was employed. It remains simply to assess the three remaining assertions pertaining to the clinical interviews.

Relevant Discourse in the Clinical Interview

The evidence in support of the three assertions pertaining to the lay interviews was necessarily indirect owing to the dearth of recorded materials related to these interviews and my (current) inability to access SUPERPFP data that might facilitate the illumination of local response patterns through CIDI item analysis. In contrast, the evidence pertaining to my clinical interviews with Black River respondents was buried in an extensive body of potentially relevant material. For example, I have already noted that I retained cassette recordings of all 75 SCID interviews and prepared written case summaries for each respondent following these interviews. Thus, rather than struggling to indirectly reconstruct evidence by which to adequately support certain assertions, the current task involved the painstaking extrication of clinical interview material that speaks most directly to the issues at hand. The set of assertions that emerge from my proposed explanation for diagnostic discordance at Black River requires that the negotiated disruption of the local trauma discourse adequately account for this discordance between lay interview findings and my clinical interviews. The effort to adequately account for observed

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patterns of diagnostic discordance, then, suggested one obvious strategy for effectively organizing my clinical interview material for more detailed analysis.

I arranged respondents from my SCID sample (as indexed by their Respondent Identification Numbers or RIDs) in a two-way table indicating whether they had been diagnosed with lifetime DEP, PTSD, neither, or both disorders in the lay and clinical diagnostic interviews respectively (see Table 11). The diagonal cells in this table thus represent cases of diagnostic agreement between interviews with regard to these two disorders, while the off-diagonal cells represent instances of diagnostic discordance. Casual inspection of this table confirms that the diagnostic patterning of DEP and PTSD evidenced widespread disagreement between interviews, with no instances of agreement for lifetime DEP only, just two instances of agreement for lifetime PTSD only, and seven instances of agreement for comorbid DEP and PTSD. Thus, the majority of cases for either disorder appear in the off-diagonal cells. Furthermore, the off-diagonal cell containing the greatest number of cases is the C-PTSD x S-DEP cell (n = 10), followed by the C-PTSD x S-Neither cell (n = 7), the C-PTSD x S-Both cell (n = 6), and finally the C-Neither x S-DEP cell (n = 5)—most of the remaining off-diagonal cells contain just one or two cases each and will not be considered further. Thus, it is these four off-diagonal cells that will receive the greatest analytic attention in the discussion to follow. I might note in passing that further subdividing respondents based upon SCID ALC diagnoses was relatively unproductive since only six respondents out of the total of 47 diagnosed with SCID DEP and/or PTSD did not carry a lifetime diagnosis of ALC (suggesting, I think, the relative prominence of alcohol abuse as an "idiom of distress" [see Nichter, 1981] in this community).

One final note is in order regarding my discussion of the analyses to follow. These analyses were based upon the aforementioned case summaries and partial transcripts for clinical interview respondents (which are available upon request from the author). Case summaries retain the format used when I wrote them in 1998, with minor additions or modifications clearly identified. Partial SCID transcripts were comprised of excerpted sections of the interview deemed most relevant for the analyses at hand, including portions of the Overview section (in which relevant demographics and psychiatric history were explored); the introductory portion of the Alcohol Disorder section (in which alcohol use patterns and history were explored); the introductory portion of the MDE and Current Dysthymic Disorder sections (in which symptomatic dysphoria and/or anhedonia were assessed); the introductory portion of the PTSD

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section (in which potentially debilitating traumatic experiences were explored); and finally the post-interview debriefing (in which respondents were asked to reflect upon certain facets of the interview itself). Documented symptoms by disorder for each respondent were listed in each section of the transcript in lieu of actual transcribed discussions for individual diagnostic criteria (owing primarily to resource constraints with regard to transcribing entire interviews). With this clarification in mind, it now seems appropriate to review the evidence at hand.

Assertion Four. There is solid evidence based upon my clinical interview material that I inquired directly about mood symptoms related to DEP and determined that a substantial number of my respondents in fact warranted a DEP diagnosis even though their CIDI responses precluded such a diagnosis. First, even casual inspection of the available interview transcripts confirmed that I adhered to SCID protocol and inquired about respondent experiences of dysphoria and anhedonia. Second, the pattern of S-DEP diagnoses relative to C-DEP diagnoses for these respondents should be evident in Table 11. For example, 21 SCID respondents who emerged from their lay interviews without a DEP diagnosis were in fact judged by me to warrant a SCID diagnosis of DEP (see the C-Neither x S-DEP cell [n = 5], the C-PTSD x S-DEP cell [n = 10], and the C-PTSD x S-Both cell [n = 6] in Table 11). In contrast, only four respondents who emerged from their lay interviews with a positive diagnosis of DEP were instead determined not to qualify for this diagnosis through their clinical interviews (see the C-DEP x S-Neither cell [n = 1], the C-Both x S-Neither cell [n = 2], and the C-Both x S-PTSD cell [n = 1] in Table 11). Finally, agreement with regard to the applicability of DEP diagnoses prevailed for eleven respondents (see the C-DEP x S-Both cell [n = 2], the C-Both x S-DEP cell [n = 2], and the C-Both x S-Both cell [n = 7] in Table 11)—seven of these evidenced profound distress as indicated by marked comorbidity (see the C-Both x S-Both cell in Table 11, in which all respondents also warranted ALC diagnoses and the majority warranted several additional DSM diagnoses as well).

I will seek later, of course, to attribute the identification of these additional cases of DEP to a negotiated disruption of the local trauma discourse (with an attending traversal of wowacintanka) through my clinical interviews (see Assertion six). It will suffice here, however, to examine the influence of the local trauma discourse (wherein fairly extreme social disruptions are locally implicated in the etiology of disorder) with regard to respondent constructions of distress that I ultimately diagnosed as DEP. Recall, then, that I diagnosed a total of 32

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respondents with DEP through my clinical interviews. The vast majority of these described a proximal life event leading to the period of distress characterized by a variety of MDE symptoms (including at least five such symptoms not better accounted for by obvious organic etiologies or Uncomplicated Bereavement). The range of triggering stressors identified by these respondents may be categorized as follows: death of a loved one leading to "dysfunctional" bereavement: ten respondents; divorce or break-up with a romantic partner: ten respondents; disruption of immediate family (including removal of children by social services, children in conflict, or abandonment of family): four respondents; health difficulties: 3 respondents; interpersonal violence: 2 respondents; and imprisonment (including solitary confinement and witnessed violence): 2 respondents. Only one respondent failed to provide a proximal stressor with regard to DEP symptoms, explaining instead that he had contended with dysphoria his entire life. In summary, the vast majority of these respondents reported experiences of fairly serious social disruption immediately prior to the onset of DEP symptoms in their lives.

This trend in respondent reports during the clinical interview (as related to DEP symptoms in particular) lends strong support to the thesis that the local trauma discourse described to me by cultural experts (who described death and divorce as prototypical traumas) figures prominently in respondent constructions of their distress, although I will soon assert that it was the more flexible and demanding character of the SCID that rendered these results possible. This phenomenon in turn provides additional support for the proposal that the local trauma discourse likely disrupted the CIDI discourse as well, possibly rendering PTSD items (which focused upon traumatic events) more personally relevant than DEP items (which focused more directly upon experiences of troubled mood without explicitly eliciting discussion of the proximal or contextual events associated with these symptoms).

Assertion Five. Once more there is strong evidence from my clinical interviews that I effectively accessed a range of personally traumatic experiences from the majority of my respondents, but determined that a substantial number of those diagnosed with PTSD as a result of their lay interviews did not in fact warrant a diagnosis of PTSD based upon their clinical interview responses. This pattern of S-PTSD diagnoses relative to C-PTSD diagnoses for the sample should be evident in Table 11. For example, 21 SCID respondents who emerged from their lay interviews with a PTSD diagnosis were in fact judged by me not to warrant a SCID diagnosis of PTSD (see the C-PTSD x S-Neither cell [n = 7], the C-PTSD x S-DEP cell [n = 10],

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the C-Both x S-Neither cell [n = 2], and the C-Both x S-DEP cell [n = 2] in Table 11). In contrast, only four respondents who emerged from their lay interviews with no diagnosis of PTSD were instead determined to qualify for this diagnosis through their clinical interviews (see the C-Neither x S-PTSD cell [n = 2] and the C-DEP x S-Both cell [n = 2] in Table 11). (As an aside, it is in fact somewhat noteworthy that these numbers stand in exact counterbalance to the frequencies of discordant DEP cases for the Black River sample reported above.) Finally, agreement with regard to the applicability of PTSD diagnoses prevailed for 16 respondents (see the C-PTSD x S-PTSD cell [n = 2], the C-PTSD x S-Both cell [n = 6], C-Both x S-PTSD cell [n = 1], and the C-Both x S-Both cell [n = 7] in Table 11)—the same seven respondents mentioned before evidenced profound distress as indicated by marked comorbidity (see the C-Both x S-Both cell in Table 11).

In order for this particular pattern of diagnostic discordance to actually support my initial proposal, evidence of significant trauma must have been presented by the vast majority of these respondents (even though I eventually determined that such experiences were not accompanied by the necessary constellation of symptoms to warrant a diagnosis of PTSD). That is, in order to demonstrate that the local trauma discourse was truly influential in the communicative processes entailed in diagnostic assessment, respondents diagnosed with PTSD in the lay interview must have been consistently forthcoming during my clinical interviews regarding similar personally distressing traumatic experiences (even if they declined to describe the emotional consequences of such experiences in any detail). An alternative scenario, for example, that could also explain less frequent PTSD within the SCID sample would posit a more general reticence regarding traumatic experiences among respondents in their clinical interviews specifically (e.g., in order to shorten their second interviews or to avoid distressing recollections triggered during the lay interview, etc.). Fortunately, evidence from my clinical interviews suggests that respondents were indeed engaged in the routine report of lifetime trauma during the SCID assessment of PTSD, just as the local trauma discourse would lead one to expect. With regard to the 21 respondents diagnosed with C-PTSD who did not appear to warrant a diagnosis of S-PTSD, the median and modal number of PTSD "criterion A" traumas reported in the PTSD section of the clinical interview was two (range was 1-5+). I should perhaps add that even those clinical interviews within this discordant subset that I judged to be of questionable validity (RID Numbers 04546.0, 05388.1, 10207.1, 11335.1, and 15719.0 in Table 11) still allowed for the

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consideration of appropriate trauma in the assessment of PTSD (although it remains questionable in two cases whether the respondents actually provided a full range of traumatic events for consideration). In summary, all of these respondents reported fairly serious traumatic experiences during their lives. This facet of respondent participation during the clinical interview (as related to PTSD symptoms in particular) lends strong support to the thesis that the local trauma discourse figures prominently in respondent constructions of their distress, although I will shortly argue that it was the more flexible and demanding character of the SCID that actually precluded the assignment of PTSD diagnoses to these particular respondents. Nevertheless, this phenomenon provides additional support for the proposal that the local trauma discourse likely influenced CIDI responses as well, once again rendering PTSD items more personally relevant than DEP items.

Assertion Six. Given the thrust of the preceding assertions related to the clinical interviews, it is finally appropriate to review the evidence in support of the proposed negotiated disruption of the local trauma discourse that could explain the diagnostic patterning of reported experience among SCID respondents at Black River. In the end, I will want to demonstrate that such disruption was facilitated by the flexible and demanding character of the clinical interview and resulted in the displacement of C-PTSD diagnoses in favor of S-DEP diagnoses among Black River respondents. I will first review the evidence supporting the disruption of the local trauma discourse in the DEP sections of the SCID and then move to consider similar evidence related to the PTSD section of the interview.

As I have already suggested, the local trauma discourse at Black River (including the attendant reinforcement of wowacintanka) should have rendered diagnostic access to respondent experiences of persistent or problematic dysphoria and/or anhedonia somewhat difficult. Indeed, the first suggestion that some of my respondents might be reticent to describe their emotions in much detail came in the first few minutes of the interview (during the Overview section), in which I routinely inquired about their moods during the past year. Although somewhat atypical, several respondents were noteworthy for their terse noncommittal. For example:

[JG = author, Re = Respondent, *** = skipped material, ( ) = inaudible or barely audible words]

RID No. 04546.0

JG: How has your mood been in the last year?

Re: Well, I'd say okay.

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JG: Mm hm. How about other feelings in the past year?

Re: Like what?

JG: Anything come to mind?

Re: No.

---

RID No. 15270.0

JG: How has your mood been in the past year?

Re: It hasn't changed that much.

JG: Generally, how have you been feeling?

Re: Average.

JG: Not especially happy, not especially sad?

Re: No.

JG: How about other feelings in the past year?

Re: No.

---

RID No. 11335.1

JG: How about other feelings in the past year?

Re: Other feelings. Nope.

JG: No?

Re: Nothing really.

---

RID No. 05535.0

JG: How about other feelings in the past year?

Re: Like?

JG: Anything come to mind as standing out in your own experience?

Re: No. ( ) I was really happy to see my daughter…

---

RID No. 05663.1

JG: How about other feelings during the past year?

Re: Such as?

---

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RID No. 10383.0

JG: How has your mood been in the past year?

Re: Mmm, I don't know. Probably- Kinda- I don't really say much to anybody. Kinda keep to myself.

---

RID No. 04688.0

JG: How has your mood been this past year?

Re: Oh, I thought it- I wasn't too off, but- [Pause] Okay.

JG: How about other feelings in the past year?

Re: Okay.

What stood out from these responses is not that participants were unable or unwilling to acknowledge troubled feelings (especially since all of them ultimately warranted SCID diagnoses of lifetime DEP), but that direct inquiries about emotional states as abstracted from a particular life context seemed slightly perplexing to these respondents and did not elicit much emotional detail.

In contrast, some of these same participants offered (slightly) more descriptive responses to another set of questions in the Overview section of the SCID:

RID No. 04546.0

JG: Well, thinking back over your life, what was the most difficult time for you?

Re: Uuuum, when my dad passed away.

***

JG: And how were you feeling after that happened?

Re: Um. Lost.

---

RID No. 15270.1

JG: Well, thinking back over your life, what was the most difficult time for you?

Re: My car accident.

***

JG: And what about that was especially difficult?

Re: Lost my boyfriend. ( ).

JG: He was in the car with you?

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Re: Yes.

JG: And how were you feeling after that happened?

Re: After ( ) that, then I was in a wheelchair and- gradually getting used to it now and- don't bother me as much now.

JG: You felt pretty upset early on?

Re: Yeah.

---

RID No. 11335.1

JG: Well, thinking back over your life, what was the most difficult time for you?

Re: When my father died, back in eighty- '85. No, '81.

JG: How were you feeling after that?

Re: Ohhhhh, ( ), I don't know. Just- kinda like I kinda went crazy or something. I started doing all kinds of bad stuff. Never hurt nobody, though. Just drinking and taking coke and smoking. Wasn't very old then.

---

RID No. 05535.0

JG: Well thinking back over your life, then, what was the most difficult time for you?

Re: Probably when I was really young, when I was like living out in [Community] with my parents. Cause I was the youngest one and I had a lot of older brothers. And they were like musicians. And they had this band. And my mother spent most of their time with those boys. And I didn't hardly do anything with her or spend time with her....

***

JG: Okay. How were you feeling during those-

Re: Pretty helpless. That was the only time in my life I ever thought about suicide, but then I thought that, you know, I figured out real fast that it's- Nobody would care if I killed myself [laughs] but me. It wouldn't bother or affect anybody but me.

---

RID No. 05663.1

JG: Thinking back over your life, what was the most difficult time for you? [Pause]

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(A difficult time.)

Re: After divorce from my second wife.

JG: Is that when you came back and you were drinking//for a year straight?

Re: [Interrupts] Yes.

JG: What was- Well how were you feeling when you- after that?

Re: Very, very depressed. Destructive.

---

RID No. 10383.0

JG: Well thinking back over your life, what was the most difficult time for you?

Re: When my parents moved to [City]. I was seventeen years old, going through a divorce. And they went to [City]. And I had nobody to turn to here. My uncles and my cousins, but they weren't much help.

JG: Mm hm. Yeah. How were you feeling during that time?

Re: Hurt. Lost. (        ) drank a lot.

---

RID No. 04688.0

JG: Well thinking back over your life, what was the most difficult time for you?

Re: Well, there was- there was several. That time when I was into the alcohol problems- Well I'm still having it, but- Um, let's see. When my parents died. And I had a brother that died. I had two brothers that died, but that first one didn't affect me as much as this- this other one. Those are really difficult times that I can remember.

JG: How were you feeling during those tough times?

Re: Oh, kind of depressed and, you know, thinking like, well maybe it shoulda been me instead of them and that kind of stuff.

The significance of these seven sets of responses (representing fully one-third of non-depressed CIDI participants who were diagnosed with S-DEP) was that in discussing specific "difficult" life experiences, respondents were willing to provide some description of troubling emotions (e.g., lost, helpless, hurt, depressed). And while these descriptions were not especially evocative, they demonstrate that participants were able to offer relevant information regarding painful feelings if pursued in the context of relevant life events. Finally, the life events

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seemingly most relevant for pursuing such emotional descriptions involved serious social disruption in every single instance (e.g., death, divorce, and maternal neglect). I have thus offered these observations by way of introduction to the following discussion in order to highlight the contrast in responses between inquiries framed in the context of the local trauma discourse (i.e., serious social disruption) and those framed simply in reference to more abstract emotional states.

Recall that 21 Black River respondents who were not diagnosed with C-DEP were instead determined by me to warrant diagnoses of S-DEP (see the C-Neither x S-DEP cell [n = 5], the C-PTSD x S-DEP cell [n = 10], and the C-PTSD x S-Both cell [n = 6] in Table 11). I will argue here that the more flexible and demanding character of the SCID permitted a disruption of the local trauma discourse during the clinical interview that can account for the majority of these cases. First, in comparison to the CIDI, the SCID was more flexible because scripted prompts are merely the entrée to a more accommodating communicative exchange during which the clinician attempts to understand the respondent's experience in enough detail to confidently rate specific diagnostic criteria. In principle, the CIDI does not allow for unscripted communications to influence item responses. One seemingly significant aspect of this SCID flexibility was the inclusion of the introductory Overview section during which respondents are encouraged to provide general background information that can be referenced either by the clinician or the respondent in later sections. For example, the clinician-respondent exchanges cited earlier all appeared in the Overview section and provided the background for later discussions of symptomatic periods related to these events. In contrast, the CIDI does not routinely provide opportunities for respondents to review challenging life events that could serve to contextualize later assessment of related symptoms (although the CIDI PTSD section is a clear exception).

Second, in comparison to the CIDI, the SCID was more demanding because participant responses to scripted prompts are typically interrogated in order for the clinician to ensure that reported symptomatic experiences truly coincide with diagnostic criteria—in short, a simple Yes or No is almost never sufficient for the determination of SCID ratings. In principle, the CIDI is only concerned with a limited and certified range of constrained responses (typically, but not always, of the Yes-No variety) to specific items. One seemingly significant aspect of this demanding character of the SCID was the sometimes convoluted give-and-take between clinician and respondent as each struggled to clarify the meanings of particular statements. In the end, it

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was this flexible and demanding character of the SCID to which I thus attribute my disruption of the local trauma discourse, thereby resulting in the marked increase in DEP diagnoses in this sample.

The disruption of the local trauma discourse through my clinical interviews typically involved a complicated traversal of wowacintanka in the DEP sections of the SCID. I describe this traversal as complicated because (most notably) the MDE section of the SCID (especially the initial review, during which symptomatic irritability [an addition of the SUPERPFP to extend potentially significant diagnostic range], dysphoria and anhedonia were assessed) seemed especially challenging in terms of identifying potentially significant periods of dysphoric and/or anhedonic distress for respondents. This is evidenced, I think, by the fact that five of the 21 respondents under discussion (RID Nos. 04546.0, 05663.1, 05839.1, 08966.0, and 10383.0 in Table 11) required multiple passes through this section before I was able to identify an appropriate period of distress and confidently arrive at a diagnostic conclusion. The CIDI, of course, does not provide such built-in flexibility, a detail that again strengthens the present argument.

In any case, the disruption of local discourse evident in the traversal of wowacintanka in the DEP sections of the SCID appeared to result primarily from two related processes. First, there were several instances involving a "breakthrough to DEP" (n = 11; see RID Nos. 04546.0, 05388.1, 05521.0, 05535.0, 05663.1, 05839.1, 07205.0, 10207.1, 10383.0, 11335.1, and 12206.0 in Table 11). Second, there were several instances involving a less difficult identification of symptomatic distress owing to the "convenient referral" (n = 6; see RID Nos. 06306.1, 06919.0, 12004.0, 12725.1, 13474.0 and 16068.0 in Table 11) to previously described distressing events (e.g., during the Overview section of the SCID). These twin processes thus characterize the vast majority of the 21 SCIDs under consideration here, leaving just four respondents who provided evidence of DEP in a relatively straightforward manner (such that the absence of a DEP diagnosis from their lay interviews remains a mystery).

The breakthrough to DEP apparent in eleven of these clinical interviews occurred in at least two ways. The least complex of these involved simple persistence on my part, in which I proceeded to repeatedly inquire about possible symptomatic dysphoria and/or anhedonia until the respondent provided relevant instances that were then determined to meet criteria (see, for example, RID Nos. 04546.0 and 10207.1 in Table 11—since these interviews were identified

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generally as "low validity" interviews, they will not be described in detail). This simple persistence involved the traversal of wowacintanka in the sense that multiple exchanges regarding the experience of troubling mood symptoms were required before acknowledgment of such symptoms prevailed. I should also note that persistence on my part was required in several more of these interviews as well, but alongside this persistence were additional tangible features indicating the traversal of wowacintanka.

Thus, the dominant pattern representing the breakthrough to DEP in these eleven interviews included a literal shift in discourse indicating the traversal of wowacintanka. Several of these were relatively subtle, but indicate a change in discursive stance by the respondent. For example:

RID No. 07205.0

JG: Well, have you ever had a period where you feeling depressed or down most of the day, nearly every day?

Re: Most of the day? Yeah.

JG: What was that like?

Re: Just not feeling good about myself. Wanting to change my- change my- Not my life, but change my goals in my life.

JG: Can you think of a time in your life where for two weeks or more you were down or depressed pretty continuously.

Re: I don't think so. No.

Gee, probably, but I can't remember why or when. I can't remember. Just think it had a lot to do with when I first had health problems.

JG: Like this period// in eighty-six?

Re: [Interrupts] Yeah. Yeah.

---

RID No. 05535.0

JG: Have you ever had another period in your life where you were feeling depressed or down most of the day, nearly every day?

Re: No. Not really.

There were the times when my brother died and my parents died. After I was really young I pretty much learned how to control like feeling bad. I very seldom

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ever get depressed for a long period of time or let myself feel bad.

JG: How about after your divorce? Were you sad or down and depressed after that for//

Re: Yeah. I was highly depressed because (life) just- You know, I left everything with my husband, everything we owned. And I was lucky to get away with my kids. And so we had to like start from scratch... And I just found it just so hard that it was- it was depressing [Laughs].

JG: Yeah. Yeah. Would you say that you were feeling depressed like that most of the day, day in and day out ( )?

Re: Yeah. Mm hm.

JG: How long did that period of day in, day out depression last for you?

Re: Mmm, maybe about six months.

---

RID No. 05663.1

JG: In the last four weeks, so, you know, going back until the end of February, has there been a period of time when you were feeling depressed or down most of the day, nearly every day?

Re: Not at all.

JG: Not at all?

Re: I don't even hardly ever get depressed.

*** [But later...]

JG: Have you ever had a period when you were feeling depressed or down most of the day, nearly every day?

Re: (We don't- ) say ( ) depressed.

JG: Or down?

Re: When I- I was really down when I was coming back from Texas after getting my divorce papers. I think I stayed that way for a year.

JG: For a year. Uh huh. Was that most of the day, nearly every day for//

Re: [Interrupts] Nearly every day.

JG: For the whole year, or for//

Re: [Interrupts] Yeah, cause she was on my mind almost every waking minute,

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seemed like. I even dreamed about her.

---

RID No. 10383.0

JG: Okay. In the last four weeks has there been a period of time when you were feeling depressed or down most of the day, nearly every day?

Re: No.

JG: No? Haven't been sad for a two-week period, then, in the past month?

Re: Yeah. Lost my grandpa.

JG: Uh huh. Mm hm. So in the past month you've been feeling sad still from that?

Re: Yeah.

*** [And later, in regard to a different episode...]

JG: Well has there ever been another time in your whole life when you were depressed or down//most of the day, nearly every day?

Re: [Interrupts] Mm hm.

JG: When was that?

Re: When I was going through my divorce.

JG: Okay. What was that like?

Re: I wasn't really depressed, but I felt- I felt like a failure. Cause I couldn't get my little boy back.

JG: Were you sad or down a lot after that?

Re: Yeah.

The foregoing examples are enlightening in that each of these respondents initially hedged or denied that they had been "depressed or down," only to clarify later that symptomatic dysphoria had in fact troubled them in relation to particular life events. This is precisely the phenomenon that I attempt to capture in the phrase "breakthrough to DEP." Finally, it is worth noting one more time that the majority of these events involved relatively severe social disruption (e.g., death or divorce).

The most dramatic breakthroughs to DEP that emerged from these interviews involved relatively lengthy exchanges that ultimately resulted in the effective traversal of wowacintanka. One prototypic instance merits extended citation (but RID No. 12206.0 was similar as well):

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RID No. 05521.0

JG: In the last four weeks has there been a period when you were feeling depressed or down most of the day nearly, every day?

Re: Uh-uh. I don't let myself feel that way. When I feel like that then I'm- really feel bad. But like I said I pray like that. Then I just pray.

Evident here was the respondent's immediate concern with maintaining wowacintanka in the face of questions about depression. Several questions later the respondent referred back to an earlier account of her aunt's death:

JG: Well have you ever had a period when you were feeling depressed or down most of the day, nearly every day?

Re: Just- probably (ninety-) that I felt bad for maybe- I don't know, probably when she first died. ( ) depressed about her, but- just have to get through it.

The only relevant instance that apparently came to this respondent's mind was the death she described in the Overview section. In order to avoid the potentially confounding role of bereavement, however, I proceeded to inquire about additional periods of dysphoria:

JG: Have you had any other times in your life where you felt depressed or down, again, most of the day, nearly every day ( )?

Re: Maybe when I was going through my divorce I was depressed most of the day.

JG: And how many days in a row would you say that you were depressed like that most of the day?

Re: I would say for a week. That would (make me). I would go out and drink. ( ) so, (do something else).

Here the respondent cast her divorce as a second instance of potentially relevant emotional distress. Once again, this instance had been discussed in the Overview section of the interview. In order to meet the diagnostic criterion for symptomatic dysphoria, however, the episode must have endured for at least two weeks. Since the respondent here maintained that her depression persisted for just one week, I might have moved on to a new line of inquiry. Instead, I remembered from the Overview section that she had reported a suicide attempt via a medication overdose following this divorce:

JG: That's when you took the pills, right?

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Re: [Indicates assent]

JG: How long after your divorce did you take the pills?

Re: When I was going- when I was going through my divorce. (I mean), before it happened.

JG: Before it happened. I gotcha. Were you depressed or down when you took the pills then?

Re: [Indicates assent] Luckily, my cousin's a nurse. She ( ) and rushed me to the hospital.

JG: How long had you been depressed or down before taking the pills?

Re: I think- maybe about a month because we were living in Anchorage, Alaska. And I wanted to go back up there. And he let me know he had somebody else. She was living in our house and all that stuff, so.

JG: So maybe for that month you felt depressed and then took the pills?

Re: Mm hm.

JG: Did you continue to feel depressed after you took the pills?

Re: I- I was, but- there wasn't- there's nothing I could do to get him back or anything. And I just- gave it up. Gave ( ) up.

JG: So for that month, before you took the pills then, were you feeling depressed or down most of the day, nearly every day, during that month?

Re: [Indicates assent]

She then rather suddenly remembered an additional incident of dysphoria related to another break-up, during which she reportedly coped much more effectively:

Re: And then another time, too, was- when I felt like that was- January, from January of ninety-five to- ( ) (June fourth). I'd say about six months, I felt real bad because I- My little girls' dad- from my- Two oldest ones belong to my first husband (there). And I was with another man when I had two kids from him. But he decided he didn't want to be with me anymore, so [Clears throat]. You know, I didn't do nothing drastic then. I didn't take no pills or drink heavily or nothing like that. I was- took it day by day...

JG: Were you depressed or down most of the day, nearly every day during that time?

Re: Mm hm.

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JG: Well, I//

Re: [Interrupts] I don't like my past two relationships. I wish things coulda been better. I'm happy now.

And so the respondent provided the details of another painful social disruption, although she was careful to assure me that she "didn't do nothing drastic then" but instead took it "day by day." She concluded by affirming that she was currently "happy." Perhaps to her chagrin, I returned to the suicide attempt (an incident that probably indexes the utter collapse of wowacintanka) in order to assess for symptomatic anhedonia:

JG: Well, let me ask you again about the time before you took the pills. During that time did you lose interest or pleasure in the things you usually enjoyed, where you couldn't have fun or get into ( )?

Re: Just- ( ). I stayed with my brother who was paralyzed- he got in a car accident. I was ( ). I lived with him and helped him out. But he was always telling me, Forget him, he didn't do no good for you anyway. I put my baby in a stroller and go for walks with him. That would be better if we were separated ( ) back together.

The respondent's reply here was interesting. On its face, it does not seem to address the question I put to her. And yet, one could argue that the local trauma discourse prevailed here, in that my question regarding her internal emotional state was met with the description of how her brother continued to offer emotional support, indicating (indirectly) that she was noticeably distressed during this period.

I tried one more time:

JG: Well during that month when things were pretty tough were you able to have much fun?

Re: [Indicates dissent]

JG: Were you able to, you know, get into things or like watch TV, reading a magazine ( ) whatever you ( )?

Re: No, cause my- my mind would wander back to ( ) what was going on. Where did I go wrong? All those things I thought about.

JG: Was that nearly every day during that month that you couldn't have fun or couldn't keep your interest in anything?

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Re: Mm hm.

I then needed to select one of these instances for further assessment and so returned to the break-up she had just recently reported:

JG: Well it sounds like you- there's been other times in your life when you've been down, though, too. You mentioned in particular this six months after your boyfriend decided he wanted to be with someone else. During that time, was it hard to have fun or keep your interest in things?

Re: No. I was alright.

JG: ( )?

Re: I was- that first couple of months- ( ) it really hurted me, but I hardened my heart and just- (turned) the other way and- I didn't ( ). Put up with him or her or- I'd (go to work). I didn't really- (took) me six months to get over it, but- It just took one month to really feel bad and stuff. And after that I enjoyed myself. I just went and had fun. Go to movies or whatever.

The respondent thus described the maintenance of wowacintanka in the face of this break-up by employing the local term sometimes invoked by woman coping with romantic hardship at Black River: hardening the heart. I, however, remained somewhat unclear about the criterion I was trying to assess:

JG: But during that first month you were able to have fun or able to keep your interest in things?

Re: Yeah.

JG: You were? Okay. But during- when you went through your divorce, before you took the pills, it sounds like you weren't.

Re: Yeah.

JG: Then before you took the pills was that the worst in your life that you ever felt down like that, that way?

Re: [Indicates assent]

I then assessed the respondent for the remaining MDE criteria related to this suicide attempt and determined that she in fact met diagnostic criteria. The point of this extended exercise (along with the more concise presentations appearing initially) was to demonstrate the "breakthrough to

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DEP"—whether through simple persistence by me, an obvious discursive shift by the respondent, or a combination of both—that characterized eleven of the 21 clinical interviews resulting in the positive discordant diagnosis of S-DEP among Black River respondents.

Recall that an additional process evident in the clinical interview likewise resulted in the positive discordant diagnosis of S-DEP, namely the "convenient referral" that I have already introduced. This particular phenomenon depended primarily on the fact that the SCID commences with a general overview of potentially relevant personal history that allowed respondents at Black River to mark distressing experiences for future consideration by both themselves and the clinician. The operative function of this early designation of distressing events (mostly involving social disruption) was to provide specific tangible life contexts that might later facilitate more candid discussions of symptomatic distress since they revolved around previously identified events. In effect, then, the SCID Overview section ironically facilitated the disruption of the local trauma discourse by initially capitalizing upon it. A concrete instance of this process was provided in the extended example reviewed above (but which more prototypically represented the first process). Most such instances, however, required very little negotiation.

In the first example, the respondent had originally described in the Overview section how social services had removed her son from her custody:

RID No. 12004.0

JG: Well now I'm going to ask you some more questions about your mood or how you've been feeling. In the last four weeks, has there been a period of time when you were feeling irritable most of the day, nearly every day?

Re: It was the time when that happened with my boy.

JG: How long did that period of grouchiness last?

Re: Probably about two and a half weeks. And everybody was- well my ex was afraid I was going to do something again. Try something. I wou- I didn't feel that bad, though.

Thus, during the MDE section, the respondent immediately alluded back to this event from the Overview section. The entire MDE section was thus devoted to discussing symptoms related to this event—the evaluation of additional periods of difficulty from her life was simply unnecessary.

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A second respondent also invoked experiences she had described during the Overview section of the SCID (including suicide attempts and the death of her grandmother) when replying to my questions about symptomatic dysphoria:

RID No. 16068.0

JG: Well have you ever had a period when you were feeling depressed or down most of the day, nearly every day?

Re: Uh-uh.

Depressed. Just those last times- last time I- Like I said, I can feel it coming on but I really don't let people know about my feelings.

JG: When's the last time that you were feeling suicidal?

Re: Probably after I lost my grandma. But then I know I had to stick around to help my mom through it. I went in to talk to [my therapist] that time too.

JG: And that's when you were drinking pretty heavily?

Re: Yeah. Then after I stopped pretty much drinking then I needed to go see her.

JG: And after you lost your grandma were you depressed most of the day long?

Re: Yeah. To the point where I would just bust out crying and-

***

JG: After your grandma passed away, how long were you depressed?

Re: Pretty much- about maybe a good three weeks after, two weeks, three weeks after I lost my grandma. But really where nobody could see it. Cause of my mother. I was trying to be strong for my mom.

In this account, the respondent provided relatively straightforward evidence of depressive symptoms related to events that had been previously identified as distressing. As a result, the MDE assessment that proceeded from this point was relatively uncomplicated. And here again there is evidence of wowacintanka at work in the respondent's daily life, although perhaps her extensive experience with an Indian Health Service therapist has enabled her to more freely describe internal emotional states under similar communicative conditions. Finally, these two examples are provided simply to illustrate the "convenient referral" process that characterized the MDE assessment of six Black River respondents who were assigned positive discordant DEP diagnoses in their clinical interviews.

The preceding analyses were detailed in the effort to substantiate the claim that the

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flexible and demanding character of the SCID facilitated the disruption of the local trauma discourse among Black River respondents such that the traversal of wowacintanka became possible in the clinical interviews, ultimately resulting in the assignment of DEP diagnoses to these respondents. This argument remains plausible insofar as the lay interviews involved the assessment of CIDI DEP symptoms in non-contextual fashion (focusing upon problematic internal emotional states in the abstract without grounding such experiences in the socially disruptive events that comprise the local trauma discourse) while following a lockstep Yes-No protocol that renders the communicative traversal of wowacintanka significantly more difficult.

If the clinical interviews allowed for the additional assignment of DEP diagnoses to Black River respondents who did not warrant C-DEP diagnoses, then it remains to demonstrate that the flexible and demanding character of the SCID could likewise have resulted in the displacement of C-PTSD diagnoses from many of these same respondents. Recall that 21 respondents who were diagnosed with PTSD in the lay interview were determined by me not to warrant this diagnosis in their clinical interviews. I have already argued that this could not be attributed to the failure of such respondents to actually report significant experiences of trauma. The interview transcripts for these respondents detail the emotional sensitivity and intensity that characterized these discussions. Furthermore, I have suggested that the CIDI PTSD items invoked the local trauma discourse among respondents in which severe social disruptions remained especially salient as the precursor to distress and eventual (if not properly expressed) disorder. As a result, I have advanced the hypothesis that the various CIDI items designed to assess the full range of PTSD symptoms (delivered in both constrained and complicated fashion) could easily have been construed by respondents as an opportunity to indirectly affirm the significance of their distress relatively independent of the specific and detailed content of the items. Thus, I have stressed that this unusual relationship to the CIDI PTSD items among participants would disrupt the CIDI discourse and predictably skew lay interview responses towards the widespread endorsement of PTSD symptoms, resulting in a higher-than-expected prevalence of PTSD at Black River. Finally, I proposed that the more flexible and demanding character of the SCID actually precluded the assignment of PTSD diagnoses to these respondents by disrupting this kind of interpretive relationship to the CIDI PTSD items (that originally emerged, of course, from the local trauma discourse at Black River) with the dominant alternative.

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What then is the evidence in support of these claims? I should begin by acknowledging once again that such evidence is circumstantial. This is particularly true in this instance because resource constraints prevented the detailed transcription of the criterion-by-criterion exchange in the PTSD section of the clinical interviews wherein the nuances of diagnostic negotiation related to specific symptoms would be most apparent. Nevertheless, I again believe that I can muster non-trivial (but somewhat tentative) corroboration for these proposals. I should note first, however, that the pattern of discordant PTSD diagnoses under consideration is less striking than the pattern of discordant DEP diagnoses previously discussed. For one thing, the frequency of positive concordant S-PTSD diagnoses ($n = 16$) is more equivalent to the frequency of negative discordant S-PTSD diagnoses ($n = 21$) than was the case for DEP (where $n = 11$ and $n = 21$ respectively). That is, the respondents diagnosed with C-PTSD in the absence of C-DEP (see the third row in Table 11) were much more evenly distributed across the SCID PTSD/non-PTSD categories (the various columns in the third row of Table 11)—a good number of respondents primarily diagnosed with C-PTSD were diagnosed with S-PTSD; a good number were diagnosed with S-DEP instead; and still others were diagnosed with neither disorder in their clinical interviews. This diagnostic spread across respondents indicates that the phenomenon of interest suggested by the preceding statistical analyses (i.e., the trend towards C-PTSD diagnoses being displaced by S-DEP diagnoses) was primarily fueled by the ten respondents who appear in the C-PTSD x S-DEP cell in Table 11. The point here is simply that negative S-PTSD discordance is less dramatic than the positive S-DEP discordance, and I would suggest that the resulting explanatory burden is thereby reduced appropriately. Finally, I should also observe that it is perhaps more difficult in the end to account for the unexpected absence of a diagnosis in comparison to evaluating the reasons for its unanticipated assignment given that the positive evaluation of diagnostic criteria offers much more tangible evidence with which to work.

It seems appropriate here to return to the lay interviewers' suggestion that CIDI respondents were not especially attentive to the finer details of many of the CIDI prompts. I previously quoted one lay interviewer regarding this facet of her experience:

YS: Yes. So it goes pretty fast, because- I've never had one that ever hesitated on answering questions. When I say the question right away they answer. But sometimes I notice that the emotional well-being part of the interview is confusing because of the timeframe. Some people don't listen very well. And

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> they're listening for very simple questions. But sometimes these are pretty hard, and especially for the time: beginning and end and several years, or several weeks, or several days. They miss wording in there, you know. That's one of my biggest concerns in my interviews.

The specific context for these reflections was the "emotional well-being" portion of the interview, which most certainly includes the CIDI DEP sections (since the explicit references to relevant timeframes apply most specifically to the DEP, GAD, PAN, etc.). It is less obvious here whether the lay interviewer was also alluding to the PTSD section of the interview with regard to respondent confusion. In any case, it seems reasonable to suppose that respondents who were listening for "very simple questions" in the "emotional well-being" sections of the interview and responded "right away" were just as likely to reply with less attentiveness to the nuances of the PTSD items in the lay interview as well.

Such inattentiveness could conceivably account for the apparent frustration evidenced by respondents (at least according to the lay interviewers) who expressed confusion after repeatedly addressing the exact same CIDI item set for each consecutive trauma that they had initially reported:

> JG: So what is it about the trauma, then, that makes them so challenging?
>
> MR: Extra questions. Seems like- OK, for every trauma there's a set of questions that's being asked, and some of these people get irate because of the depth. It goes in depth more. And you ask more and more questions about each trauma. And what it does is, when they do that, it brings up their feelings from when it actually happened, so-
>
> JG: You said they get irate. What do you mean?
>
> MR: "Didn't I answer that question before?!?!?".... That's what they say to you! See, that's what they do. They say Didn't I answer that question before? And I have to explain to them, Oh, that was on car accident. This one's on personal friend getting killed. See, they're the same question, but they say, Didn't I answer that question twice already? Or something like that, you know.
>
> JG: They start to get a little aggressive.
>
> MR: Yeah.
>
> JG: How do you feel when they do that?

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MR: You say, No no. You've got to explain it to them. They see each- I say, there's 25 or 50 questions about this trauma. Then it's going to ask you the same questions exactly about this trauma see. So that's what- And it takes longer. And to them, they get annoyed to bring this problem back up to the surface. And then to kind of just circling around them asking them all kinds of questions upsets them.

Thus, if inattentiveness did in fact characterize a significant proportion of responses to the CIDI PTSD items, then it seems plausible that the local trauma discourse at Black River would predispose participants to actively endorse such items in the communicative act of affirming the distress that accompanied the serious social disruptions that they endured.

The obligation to demonstrate that the clinical interviews resulted in the disruption of this discourse such that many of the respondents diagnosed with C-PTSD were instead determined not to merit an S-PTSD diagnosis is indeed challenging. Perusal of the clinical interview transcripts for these negative discordant S-PTSD cases suggested that these 21 respondents may be characterized in the following ways. First, there were clinical interviews that I identified as "low validity" based upon the impressions I recorded in the clinical case summaries immediately following the interviews themselves. These respondents offered questionable or inconsistent reports during their interviews and appeared to intentionally misrepresent their personal experiences in a noticeable effort to shorten the interview. This phenomenon (which was also apparent to a limited degree in the lay interviews) essentially rendered the absence of S-PTSD diagnoses uninterpretable in these cases (although the inclusion of these same respondents in the prior discussion of positive discordant S-DEP avoids this problem by the simple fact that false-positive diagnoses [as opposed to false-negative diagnoses] were unlikely to result from this respondent strategy). Five of the 21 respondents (RID Nos. 04546.0, 05388.1, 10207.1, 11335.1, and 15719.0) were in fact identified as having completed low validity clinical interviews in this sense.

In addition, one other respondent (RID No. 05663.1) insisted that the most distressing traumatic event he had experienced was a less prototypic PTSD stressor (involving merely the threat of severe social disruption) despite the fact that he reported additional experiences that seemed more in keeping with the intent of the diagnostic criteria. Nevertheless, because this stressor could not be definitively excluded from consideration based upon a strict reading of the

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diagnostic criteria, the assessment proceeded with regard to this unique event. Such unusual instances were rare and so it makes sense here to exclude this instance from further consideration, again owing to the relatively uninterpretable conclusion that this respondent did not warrant a diagnosis of PTSD related to this markedly non-prototypic event.

The remaining 15 respondents may be sorted into two mutually exclusive categories as determined by my clinical interviews: those with significant (but subthreshold) PTSD symptoms, and those without significant PTSD symptoms. Slightly over half of these remaining respondents (n = 8, see RID Nos. 04688.0, 05366.0, 05535.0, 07763.0, 08966.0, 12004.0, and 12848.1 in Table 11) evidenced significant PTSD symptoms, by which I mean that such respondents fell no more than two symptoms short of the minimal PTSD threshold (see Appendix C for diagnostic criteria) of one re-experience symptom, three avoidance symptoms, and two arousal symptoms (totaling six symptoms across three categories). (For the purposes of this analysis, individual subthreshold PTSD symptoms were tallied as counting for one-half of one symptom each). These eight respondents provided the basis then for arguing that the flexible and demanding character of the SCID effectively disrupted the local trauma discourse that may have originally resulted in the over-assignment of PTSD diagnoses in the CIDI. More specifically, the shift in diagnostic status relevant to PTSD across interviews for these respondents hinged upon the fact that they were in fact judged during the clinical interview to evidence substantial post-traumatic distress—it was simply that such distress did not sufficiently match the specified constellation of signs and symptoms required for a positive PTSD diagnosis.

My determination that such distress in these cases did not meet full PTSD criteria emerged from the interrogation of respondent reports with regard to these symptoms so as to frequently require participants to reflect more precisely about the nature of the experiences they were describing. In the eight cases described here, this interrogation ultimately resulted in a judgment by me that the respondents did not in fact meet some specific diagnostic criterion even though they may have initially replied to a relevant prompt in the affirmative. With regard to parental violence witnessed by one respondent in her childhood, for example, we engaged in the following exchange concerning two of the PTSD avoidance criteria:

RID No. 08966.0

JG: Did you feel distant or cut off from others after seeing your parents fight like that?

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Re: Umm. Yeah, but I try not to be. I- You know, I- Like I said, I really used to hide it.

JG: Did you have trouble connecting with people after seeing this done?

Re: No. No.

JG: You were able to feel close to others and//

Re: [Interrupts] Yeah. Yeah.

JG: Okay. Since witnessing that domestic violence did you feel numb or like you no longer had strong feelings about anything or loving feelings for anyone?

Re: My father.

JG: Okay. Uh huh. Were you still able to love your mother through//

Re: [Interrupts] Oh, yeah.

In this instance, the respondent answered in the affirmative to two consecutive prompts that further elucidation then resolved with regard to the precise meaning of the diagnostic criteria.

The significance of such an exchange for the present argument should be obvious: it was only within the flexible and demanding structure of the SCID that this respondent's initial affirmations could be meaningfully evaluated with regard to the criterion of interest. In the context of the CIDI, such similar responses would have been rejected as too descriptive and the respondent would have been encouraged to answer Yes or No only, without further elaboration, exploration, or discussion. It certainly seems likely in this case that the respondent would simply have replied in the affirmative for each of these prompts. In the context of the SCID, however, it was frequently possible to ensure to a greater degree the mutual understanding of clinician and respondent statements. It turns out that the interrogation of such initial affirmations to SCID prompts resulted in clarification and a reversal of stance (such that a key [and sometimes decisive] diagnostic criterion was deemed not to have been met in spite of these early affirmations) for seven of these eight respondents—the remaining exception (RID No. 05149.0) evidenced a traditional posture so laden with wowacintanka that even I was unable to break through to a more confident judgment about the respondent's experiences. It is interesting to note further that these reversals in stance occurred with regard to the subset of avoidance criteria in particular, such that the implications concerning the influence of wowacintanka in this process are difficult to ignore.

Of course, it is only fair to acknowledge that the SCID prompts are worded somewhat

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differently than the CIDI items, and so it is hypothetically conceivable that respondent affirmations to SCID prompts may have corresponded with denials to the CIDI items. Even a casual inspection of the CIDI items and SCID prompts (see Appendices B and D), however, will indicate a good deal of overlap such that substantial opposition in response valence across interviews seems unlikely. Thus, a careful review of response patterns with regard to the casual affirmations offered in the face of PTSD prompts by participants at Black River provides solid support to the contention that the flexible and demanding character of the SCID facilitated the disruption of the local trauma discourse, resulting in less frequent diagnosis of PTSD in comparison with the lay interview results.

Summary of Sociolinguistic Findings

The sociolinguistic analyses reviewed here followed a series of statistical analyses indicating a systematic confounding of DEP and PTSD diagnoses across the lay and clinical interviews at Black River respectively. That is, whereas the lay interviewers employing the CIDI were much more likely to diagnose respondents with PTSD instead of DEP, I was much more likely using the SCID to diagnose these same respondents with DEP instead of PTSD. The purpose of this section was thus to offer a plausible account for this systematic skewing of diagnostic results in terms of the local cultural discourse. The resultant investigation has explored the empirical viability of six interrelated assertions related to the proposal that the lay interviewers found lower-than-expected rates of DEP and higher-than-expected rates of PTSD because Black River respondents disrupted the particular diagnostic logic inherent to the CIDI, effectively displacing the dominant psychiatric discourse with the local cultural discourse that prevails at Black River. That is, Black River respondents expressed their distress in the communicative context of the lay interview primarily in terms of the socially disruptive traumatic life events they had experienced as opposed to the acknowledgment of relatively decontextualized and internalized mood states that the community emphasis upon wowacintanka precludes in such communicative encounters. In contrast, as a non-tribal interviewer and a trained clinician, I alternatively disrupted this local cultural discourse by actively contesting and reorganizing the respondents' own constructions of their distress into established psychiatric categories, thereby facilitating the displacement of PTSD diagnoses among this sample by increased numbers of DEP diagnoses.

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## Discussion

Within the next several months, the National Center for American Indian and Alaska Native Mental Health Research will struggle with the decision of whether to release "official" findings that American Indians in the United States are twice as likely to suffer from Posttraumatic Stress Disorder, but only two-fifths as likely to suffer from clinical depression in comparison with the general population of the United States. In addition, these researchers may suggest that, while serious alcohol problems disrupt many native lives, American Indians are no more likely than other Americans to suffer from a debilitating psychiatric disorder during their lifetimes. With continuing sponsorship by the National Institute of Mental Health, any release of such conclusions would no doubt reshape the national conversation—to the extent that such a conversation really exists at the national level—regarding mental health policy and practice in Indian country. It is difficult in advance to predict the manifold ways in which access to "scientifically sound" facts might impact Indian country. Perhaps federal legislators, bureaucrats, and bean counters (who administer the Trust responsibility to federally-recognized Indian tribes) would sound a retreat from the battle against addiction and disorder in native communities since Indians are seemingly no more generally at risk for such difficulties than the general population. Or perhaps instead policy makers would shift resources within existent "behavioral health" clinics in Indian Health Service facilities towards the more widespread treatment of posttraumatic stress. In fact, no one knows the precise implications of "official" statistics for Indian mental health. In the midst of such speculations, however, one thing is sure: the seal of "science" would lend enormous credibility to any numbers generated by the SUPERPFP and such numbers would then be difficult to effectively contest in the public sphere.

The goal of the research presented here was to explore certain facets of the local construction of affective experience in the specific context of formal psychiatric interviewing on an American Indian reservation on the Northern Plains. In contrast to the SUPERPFP, which drew primarily upon state-of-the-art methodological advances in psychiatric epidemiology, this investigation privileged a discourse-centered methodology in the effort to identify the cultural substrates of affective experience and expression (and their disorders) relative to the conventional assessment of psychiatric distress. The immediate context for this research was the local administration of the Composite International Diagnostic Interview to reservation respondents (whereby the prevalence of psychiatric disorder might be determined), followed by

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the expert administration of the Structured Clinical Interview for the DSM-III-R by clinicians (whereby the validity of diagnostic results might be illuminated through comparisons across interviews). I have demonstrated that diagnostic agreement between these two interviews (at least among this particular reservation population) was marginal at best, indicating that any prevalence statistics estimated from the CIDI results are necessarily suspect.

Researchers at the National Center are thus caught in a quandary. On the one hand, they demonstrated tremendous foresight in proposing the SUPERPFP clinical and ethnographic substudies in order to appropriately contextualize their epidemiological findings. On the other hand, the psychiatric establishment, legislators, and Indian leaders eagerly await the numbers—it is the prevalence statistics that stand to become the enduring legacy of the SUPERPFP. And so, researchers at the National Center must now decide whether and how to mitigate the public enthusiasm for their numbers with the additional evidence they currently harbor attesting to the questionable validity of these numbers.

The predictable path to follow in such an instance would be to acknowledge the typical range of methodological limitations on apprehending "true" estimates of psychiatric disorder in the community in order to designate the numbers instead as primarily useful in terms of their comparative value vis-à-vis the findings of the National Comorbidity Survey that served as the methodological template for the SUPERPFP. This epistemic shift (in the face of statistics with questionable validity) towards more readily interpretable numbers via comparisons across replicated designs seemingly describes the favored strategy in psychiatric epidemiology for drawing conclusions in the context of routine diagnostic discordance (Dohrenwend, 1995). And yet, the rationale for this shift utterly depends upon the replication thesis—research in different settings remains relatively incomparable unless certain methodological conventions are standardized. Social scientists across a range of disciplines (and psychiatric epidemiologists are no exception) typically nurture a consensus regarding the conditions under which the thesis of comparability holds. Social psychologists, for example, might initiate a carefully scripted research protocol for groups of respondents around the world in order to identify meaningful differences in local behavior. Of course, such protocols would not be truly identical. For example, the script might require translation into another language prior to implementation across cultures. It is precisely these alterations where disciplinary consensus is required in order to determine which departures from protocol are meaningful and which are trivial.

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The problem for a study such as the SUPERPFP (and possibly for every cross cultural study of psychiatric epidemiology) is that there are obvious grounds for asserting that the replication of the NCS in the Black River Indian Community meaningfully departed from the original protocol in multifaceted ways so as to render the results strictly non-comparable. That is, given the communicative encounters that comprise diagnostic interviewing in particular, the often subtle sociolinguistic norms that govern who speaks with whom about what (and under which conditions) take on paramount significance. This would seem especially true in cultures where mental health and psychological disorder are generally stigmatized. As a result, the NCS and the SUPERPFP may be seen to diverge substantially in terms of the "interpretive frames" routinely constructed by interviewers and respondents in the diagnostic process. For example, whereas the NCS required respondents to meet with lay interviewers with whom they were not acquainted, the lay interviewers at Black River were in fact frequently known to their respondents (and their positive reputations arguably mobilized participation in the interviews). Insofar as this comparability of diagnostic findings across cultural contexts becomes all that researchers might cling to in the face of low-validity statistics, I thus conclude that any sophisticated attention to the nuanced socioliguistic differences across research settings will typically dash their hopes.

But there are even more substantive implications of the analyses presented here with regard to the application of conventional psychiatric investigations across cultures. For beyond the relatively obvious questions about who interviewed whom or which particular diagnostic interview was employed lurks the much larger issue of ontology that I referred to earlier in passing. More specifically, I observed that the ontologies of distress represented in the concepts and categories of western psychiatry (and encoded in the CIDI and SCID items) on the one hand, and the local trauma discourse that prevails at Black River on the other hand are fundamentally incommensurate and should in fact be expected to yield unanticipated results that confront researchers with perplexing interpretive challenges. I noted that, by priming respondents in the DEP section of the CIDI with reference to non-contextualized mood symptoms, it is not surprising that the prevalence of DEP Disorders at Black River seems astonishingly low. By priming respondents in the PTSD section of the CIDI with reference to culturally salient traumatic events, it is not surprising that the prevalence of PTSD at Black River seems unusually high. And given the "flexible and demanding" character of the SCID, by which the dominant

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discourse of western psychiatry was more "effectively" imposed upon respondent experience, it is not surprising that a substantially different constellation of diagnostic findings prevailed in the clinical interviews.

One cannot, of course, breezily identify the nuances of incommensurate ontologies, especially in the context of conducting brief survey research. And yet, in my extended time at Black River, I found numerous instances in which the local ontology erupted in ways that rather obviously ran counter to the ontology presumed by western psychiatry and articulated through its DSM (see Gaines, 1992). Most obviously, it was apparent in my clinical interviews with regard to the relatively challenging task of identifying and understanding distressing emotional experience vis-à-vis DSM diagnostic criteria. Occasionally, there was explicit resistance to my attempts to circumscribe respondent experience in terms of such criteria:

RID No. 05149.0

Re: What is this all about? All this is dealing with depression and- What is it?

JG: This one section is. And then the other one was about alcohol. And there's a section on drugs. This is about mental health stuff. It's about difficulties and challenges that people face. And it's kind of interesting because, in some ways, we're kind of talking past each other. In other words, I hear what you're telling me about in terms of your experience. And how you're- how you've come to think and understand what you've been through. The problem is- is that at least, you know, from my perspective as this interview- is that I have to ask real specific detailed questions that might not really fit that well with how you think about or have made sense about what you've experienced. And so, that's why I keep feeling like I have to interrupt or I have to get us back on track. Or it's kind of odd because I have these real detailed, specific things I have to find out from you. And the way you're telling me things isn't necessarily gonna tell me those things cause those things might not be really important in some ways. But for this interview they are important so it's a little funny.

Re: Yeah. Cause it- You keep repeating yourself over and over. I mean-

JG: That's because I'm not, I'm not getting the information I need to get to get done here today. And so I'm trying to- I keep bringing us back and keep asking again in different ways to make sure I really understand about what I need to get for

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this. So, you know, one thing I think that would make- help us get finished is if you really focused on what I'm asking. And answer as specifically as possible, a question that I ask. We could get done finally. And then// (

)

Re: [Interrupts] Yeah, but- I mean, if you have to experience something that I experience, I mean- that experience that I had to go through don't even pertain to some of this stuff here. You know, I- And the thing is, I didn't have to go to Mental Health. I mean I had to deal with this on my own. I mean- more than likely a lot of people don't do what I do. And of- there are a lot of people who ain't like me. And it- it seems kinda funny and odd for them- for you to be asking me all these kinda questions when I never had to deal with majority of the questions.

JG: Right. Actually most people who come in don't. I mean, it's always a- sometimes almost like a struggle to communicate that, well, I'm asking some things that might not be familiar, might not even relate to your life that much. And that you might not even care about. But, for reasons that have to deal with, you know, getting some statistics to the Tribal Council, for being- Basically talking within, sort of, how Mental Health thinks about things, which is not the way most Indian people think about things. But that's what we have to do here and so this is the kind of interaction where what I have to do is try and get from you some information so that we can describe yours and lots of other people's experiences in this kind of unusual way.

Re: This is really an unusual way to be- I mean, because, I mean. I'm more of a traditional person. I don't even deal with things like this. I deal with things in a different way. I mean, I- For me, when I have a problem, I pray. For me, when I have something that's happening that's not right, then I go and I pray about it. And it comes about by itself. It'll come around. And then somewhere out there it'll- they'll show me. And then I sit back and I look at the- you know, I pay attention to people. I pay attention a lot. You know, it- And a lot of things that you're asking me, I mean, I experience some of the things but not everything. I mean I experience it in my own way.

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JG: Right. That's right.

Re: Not a white man's way.

JG: Exactly.

Re: This is a white man's way of thinking.

JG: Absolutely, it is.

Re: It's not my way.

This communicative interaction reveals that the ontology inscribed in the SCID was readily understood to be discordant with the local ontology to at least some respondents (although most did not object so explicitly or forcefully).

In addition to the communicative breakdowns such as the one just presented, numerous other facets of my experience at Black River suggested an ontology that differed strikingly from that of most American communities (which would presumably accord more closely with that of western psychiatry than the ontology at Black River). For one, the difficulty I experienced in becoming acquainted with a wider range of community members exemplifies the role that tiospayes play in structuring tribal life—without a clear family identity, it was nearly impossible for me to interact with others who routinely ignore outsiders in their daily lives. In addition, that most of the relatively few acquaintances I was fortunate to make initially occurred in the context of ritual or ceremony reflects the local importance of spiritual practice in regard to the concerns of "mental health" with which I was so readily associated. These instances (among others) revealed very fundamental differences in normative experience among Black River tribal members that I was essentially excluded from exploring in any firsthand detail until my tenure with the SUPERPFP had nearly drawn to a close.

What then are the specific contours of this local ontology at Black River and how does it differ from that of middle America? It should be obvious by now that I am unable to provide anything even remotely resembling a rich firsthand account. A brief glimpse into at least some of its more fundamental constituents is available, however, in much of the extensive corpus of ethnographic material about this tribal group and other close linguistic relations. For one thing, the esteemed Father Buechel (1939) explains in his grammar of the tribal language that the form of a verb "by itself does not indicate the time of action or being" (p. 31). In fact, there is no distinction in this language between past and present tense with regard to, say, recounted events, except insofar as adverbs of time (and sometimes context alone) will afford. Thus, it should not

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be surprising that even contemporary community members that are a generation or two removed from their tribal language should encounter some difficulty representing their distress as lasting "two weeks or more" or identifying exactly when certain symptoms of distress occurred relative to other symptoms, etc. In addition, some of the most established ethnographers of this tribal group, including Walker (1982) and Powers (1975), as well as the most widely acclaimed American Indian intellectual of our era, Vine Deloria, Jr. (who happens to be a member of one of Black River's sibling bands), all describe an ontology of time within these communities that differs radically from that of the West. Deloria in particular (1992; but see Walker also) contrasts the relative predominance of spatial orientation as opposed to temporal orientation within native cultures more generally. Thus, at Black River (and within its sibling communities) local experience is much more likely to be expressed in terms of spatial relationships configured through a fine-tuned ecology of spiritual beings, other people, animals, and the places associated with them, all ordered together in an overarching cosmology that emphasizes spatial rather than temporal relationships. Furthermore, this emphasis upon the interconnected relationships of all things is reflected in the customary refrain evident throughout local ritual: Mitakuye Oyasin ("We are all related."). This sense of interconnection or "interdependence" contrasts markedly with the western ideal of "independence" (see Markus and Kitayama, 1991), and is seemingly expressed even in the very basic concept of "mind" (as evident in wowacintanka: "strength of mind"). Farnell (1995), in a study of Plains sign talk among a closely-related tribal group (in linguistic terms), describes how the gesture indexing "mind" involves the movement of a pointed finger away from the center of the body. Following a rather interesting analysis of this phenomenon, Farnell summarizes as follows: "In other words, as the sign language emphasizes, mind is not a place, it is a disposition towards others: a capacity of a whole person, not a place in the head, separate from a body" (p. 255).

This too brief review is presented simply to reinforce the notion that incommensurate ontologies imply somewhat hidden but nevertheless extremely potent and divergent social realities that confront cross-cultural investigations of psychiatric epidemiology with very serious challenges indeed, especially with regard to the meaning of diagnostic interview results and unexpected prevalence findings in cultural contexts that differ markedly in their character from western ones. The sobering lesson here is that my year of residence at Black River was sufficient, not to actually comprehend the nuances of the local ontology, but rather simply to

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recognize that it harbored serious implications for the research we were conducting. And I worry that much cross-cultural research of this nature is undertaken in so transitory a manner as to preclude any sophisticated consideration of these implications.

It is now appropriate to return to the questions that originally motivated this dissertation research. First, I asked how local cultural practice might account for diagnostic discordance between lay and clinical interviewers within a community sample of Black River respondents. I have argued here that the interpretive frames surrounding diagnostic interviews at Black River were constructed from the local cultural discourse—evidencing an incommensurate ontology of distress—that privileges socially disruptive traumatic events as salient in the etiology of disorder. I have suggested that this focus upon experiences of social disruption affords community members a means to communicate distress by virtue of referencing such events without conceding personal wowacintanka (i.e., fortitude, or strength of mind) through explicit descriptions or demonstrations of distressing emotional states. In the context of astonishingly low rates of clinical depression and higher than expected rates of PTSD at Black River (in comparison to U.S. norms) as well as striking diagnostic discordance between lay and clinical interviews, I have proposed that communicative patterns of reinforcement or disruption of this cultural discourse between respective diagnostic interviews can systematically account for these discrepancies.

In this context, it is thus impossible to meaningfully declare that either the contested CIDI diagnoses of PTSD or the SCID diagnoses of DEP are more "accurate" without first describing from which ontology accuracy is sought. In the case of DSM diagnoses, a western psychiatric ontology is obviously invoked. But the very process of psychiatric diagnosis through the CIDI that was explicitly designed to yield prevalence statistics (based upon a western ontology) was itself undermined by diagnosis through the SCID (also based upon a western ontology) which revealed (through careful sociolinguistic analysis) that the local ontology at Black River had in fact disrupted the lay interview process. One might thus argue that the SCID actually afforded a "corrective" disruption of the local ontology in favor of the successful imposition of the ontology of western psychiatry, but since the SCID subsample was not selected to generate prevalence information, researchers are confronted by a serious quandary.

The more interesting question, I suppose, is whether any account within the context of western psychiatric discourse is in fact a preferred explanation for the identification of distress at

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Black River. The difficulty in formulating a response to this question stems from the fact that there remain very few empirical anchors by which to ground the consideration of competing claims. Is there an entity that corresponds roughly to PTSD (as constructed in psychiatric discourse) at Black River (and around the world)? No one knows. If there are in fact such entities as Major Depressive Episodes in the world, are they being "masked" by communicative practices at Black River, or is this population in fact dramatically less prone to episodic melancholia? No one knows. I will observe here that one aspect of my account of diagnostic discordance at Black River participates in the dubious enterprise of reifying research expectations as the means to sustaining an argument. For example, in order for my proposal to remain coherent, I have embraced (principally for rhetorical purposes, I assure you) the assumption of National Center staff that the prevalence of clinical depression at Black River cannot possibly be so low. In reality, of course, no one knows. It is thus in the context of competing guesses (no matter how educated) about these matters that an argument such as the one I have developed here rises to challenge those who would foreclose on these questions and systematically overlook or ignore the variety of negotiated frameworks for theorizing, institutionalizing, and investigating affective distress across cultures. One framework that would almost certainly muster challenges to my own investigation of these matters is concerned with the roles of power and discipline in acts such as psychiatric diagnosis. Such concerns are compounded across cultural settings, particularly when practices of a dominant culture are exported into historically oppressed communities. I have argued here that my "disruption" of the local cultural discourse and the "contesting and reorganizing" of the reported experience of Black River respondents for the purposes of psychiatric diagnosis might render provocative diagnostic results potentially intelligible (from the perspective of the dominant ontology that suffuses western psychiatric concepts and categories, obviously). The larger question is whether such acts represent an irredeemable extension of the (neo)colonialist enterprise—I have yet to personally resolve this question.

Many of these observations are related to the second question that originally motivated this research, namely what are the implications of this account for (a) the cross-cultural assessment of mental illness, and (b) the cross-cultural validation of "established" diagnostic categories? I have already argued that the cross-cultural assessment of mental illness is rendered problematic in the sense that a fine-tuned awareness of local cultural discourse—with its attending

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local ontology of distress—becomes central to a meaningful interpretation of clinical results (especially when assessment is carried out in the tense postcolonial context of Indian country in the U.S.). What then should National Center researchers have done differently? The methodological rigor and complexity that characterized the SUPERPFP design remains impressive and National Center researchers must be commended for the inclusion of substudies that might actually help contextualize the epidemiological results—in fact, this dissertation was supported under the rubric of this commitment. Nevertheless, the project is an exemplary study of cross-cultural psychiatric epidemiology and is therefore prone to the vulnerabilities of such research (several of which have already been described). Naturally, I remain convinced that such research is routinely destined to result in widely-circulated prevalence statistics of questionable validity which, across cultural communities, will not typically remain methodologically comparable. Thus, given that I can see merit in attempting to characterize the frequency of distress in various populations, I would call for the implementation of more intense and concentrated efforts among smaller numbers of respondents in order to arrive at more valid conclusions regarding distress and disorder (perhaps including more broadly defined measures of distress alongside DSM categories of disorder). Finally, I should remind us that the National Center has in fact obtained rather rich data whereby to complicate its own otherwise conventional results. It remains to be seen how researchers there will choose to present their findings in the context of the clamor for prevalence statistics.

With regard to the cross-cultural validation of "established" diagnostic categories, I have already alluded to the difficulties that inhere in such an enterprise since it is not yet clear that any such category as currently conceptualized within conventional neo-Kraepelinian psychiatry rests upon sufficient scientific evidence to withstand the difficult questions posed by the local and variable cultural construction of affect, distress, and disorder. Again, the absence of compelling empirical anchors renders the field an unstable "science" shaped more by theoretical assumptions and methodological commitments than by consensually identified validators for purported disorders. In this state of flux, it may simply be that one's position on the existence "in nature" of various identifiable psychiatric disorders is ultimately determined by a priori conceptual assumptions (as opposed to, say, compelling scientific evidence that speaks beyond its own self-contained language game). As a result, I continue to struggle with the simple implication that I may have ruled out the existence of discrete and universal psychiatric illnesses simply by virtue of adopting cultural psychology (and its assumed heterogeneity in emotional

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experience across cultures) as a conceptual paradigm—I have yet to construct a means by which to arbitrate these competing conceptual frameworks.

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Table 1

Comparison of Black River and General U.S. Lifetime Psychiatric Prevalence Rates

| DSM-III-R Disorder | Black River | NCS |
|---|---|---|
| Alcohol Abuse | 11.6 % | 9.4 % |
| Alcohol Dependence | 20.6 % | 14.1 % |
| Alcohol Disorder | 32.2 % | 23.5 % |
| Other Drug Abuse | 9.9 % | 4.4 % |
| Other Drug Dependence | 6.6 % | 7.5 % |
| Combined Substance Dependence | 22.1 % | ---- |
| Substance Abuse or Dependence | ---- | 26.6 % |
| Major Depressive Episode | 4.5 % | 17.1 % |
| Current Dysthymia | 5.4 % | 2.5 %[a] |
| Combined Depressive Disorders | 8.1 % | ---- |
| Any Affective Disorder | ---- | 19.3 % |
| Posttraumatic Stress Disorder | 21.6 % | 7.8 % |
| Panic Disorder | 2.6 % | 3.5 % |
| Generalized Anxiety Disorder | 1.5 % | 5.1 % |
| Antisocial Personality Disorder | 11.3 % | 3.5 % |
| No Lifetime Disorder | 53.3 % | 52.0 % |

Note. Black River prevalence statistics are preliminary only. DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised); NCS = National Comorbidity Survey (Kessler, et al. 1994; Kessler, et al., 1995).

[a]This statistic reflects the 12-month prevalence for the disorder.

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Table 2

Summary of CIDI Disorders for Black River Sample (N = 75)

| DSM-III-R Disorder | Frequency[a] | No. Selected for[b] |
|---|---|---|
| Alcohol Abuse | 0 | --- |
| Alcohol Dependence | 38 | 26 |
| Other Drug Abuse | 3 | --- |
| Other Drug Dependence | 8 | --- |
| Combined Substance Dependence | 39 | --- |
| Major Depressive Episode | 9 | 9 |
| Current Dysthymia | 10 | 10 |
| Combined Depressive Disorders | 15 | 15 |
| Posttraumatic Stress Disorder | 37 | 32 |
| Panic Disorder | 2 | --- |
| Generalized Anxiety Disorder | 2 | --- |
| Antisocial Personality Disorder | 16 | --- |
| No Target CIDI Disorder | 22 | 22 |
| No Symptoms | 7 | 7 |
| Low Symptoms | 11 | 11 |
| High Symptoms | 4 | 4 |
| No CIDI Disorder | 21 | --- |

Note. CIDI = Composite International Diagnostic Interview; SCID = Structured Clinical Interview for DSM-III-R; DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised).

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(Table 2, cont.)

[a]Frequencies do not sum to 75 due to diagnostic comorbidity. [b]Respondents were selected for participation in the clinical follow-up interview based upon the CIDI diagnoses enumerated below.

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Table 3

Summary of SCID Disorders for Black River Sample (N = 75)

| DSM-III-R Disorder | Frequency[a] |
|---|---|
| Alcohol Abuse | 2 |
| Alcohol Dependence | 58 |
| Other Drug Abuse | 3 |
| Other Drug Dependence | 32 |
| Combined Substance Dependence | 60 |
| Major Depressive Episode | 31 |
| Current Dysthymia | 1 |
| Combined Depressive Disorders | 32 |
| Posttraumatic Stress Disorder | 20 |
| Panic Disorder | 3 |
| Generalized Anxiety Disorder | 0 |
| Antisocial Personality Disorder | 11 |
| No Target SCID Disorder | 12 |
| No SCID Disorder | 11 |

Note. SCID = Structured Clinical Interview for DSM-III-R; DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised).

[a]Frequencies do not sum to 75 due to diagnostic comorbidity.

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Table 4

Diagnostic Comorbidity Within Black River Sample (N = 75)

| | Frequencies | | |
|---|---|---|---|
| Diagnostic Interview | No Disorder | One Disorder | Comorbid Disorders |
| All DSM-III-R Disorders | | | |
| CIDI | 21 | 18 | 36 |
| SCID | 11 | 18 | 46 |
| Target DSM-III-R Disorders | | | |
| CIDI | 22 | 25 | 28 |
| SCID | 12 | 28 | 35 |

Note. All rows sum to N = 75. DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised); CIDI = Composite International Diagnostic Interview; SCID = Structured Clinical Interview for DSM-III-R.

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Table 5

Comparison of Target Disorders Across Diagnostic Interviews for Black River Sample (N = 75)

| | Frequency | | |
|---|---|---|---|
| DSM-III-R Disorder | CIDI Diagnoses | SCID Diagnoses | Trend[a] |
| Combined Substance Dependence | 39 | 60 | More |
| Combined Depressive Disorders | 15 | 32 | More |
| Posttraumatic Stress Disorder | 37 | 20 | Less |

Note. DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised); CIDI = Composite International Diagnostic Interview; SCID = Structured Clinical Interview for DSM-III-R.

[a]Trend refers to the pattern of SCID diagnoses vis-à-vis the original CIDI diagnoses.

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Table 6

Concordance Across Diagnostic Interviews for Black River Sample (N = 75)

| DSM-III-R Disorder | Kappa Statistic | Result[a] |
|---|---|---|
| Combined Substance Dependence | .17 | Poor |
| Combined Depressive Disorders | .27 | Poor |
| Posttraumatic Stress Disorder | .33 | Poor |
| Antisocial Personality Disorder | .51 | Fair |
| Any Target Disorder | .28 | Poor |
| Substance Dependence and/or Posttraumatic Stress Disorder | .25 | Poor |
| Substance Dependence and/or Depressive Disorder | .18 | Poor |
| Depressive Disorder and/or Posttraumatic Stress Disorder | .55 | Fair |

Note. Concordance was assessed using Cohen's (1960) coefficient of agreement (kappa statistic). DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised). [a]Evaluation of concordance was made in accordance with standard conventions (see text for details).

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Table 7

Comparison of Diagnostic Concordance Across Clinical Interviewers at Black River (N = 155).

| | Kappa Statistic | | | |
|---|---|---|---|---|
| DSM-III-R Disorder | Author | Clinician 2 | Clinician 3 | All Clinicians |
| Alcohol Dependence | .19 | .29 | .34 | .24 |
| Other Drug Dependence | .19 | .40 | .19 | .22 |
| Major Depressive Episode | .24 | -.07 | .34 | .19 |
| Posttraumatic Stress Disorder | .29 | .31 | .61 | .37 |
| Any Disorder | .30 | .57 | .71 | .44 |
| N | 91 | 33 | 31 | 155 |

Note. Concordance was assessed using Cohen's (1960) coefficient of agreement (kappa statistic). Statistics were provided by SUPERPFP staff. As a result, the total sample size differs here from references in the text owing to slight changes since these analyses were reported. In addition, the author's sample is more inclusive here than the data analyzed in the text. DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised); SUPERPFP = American Indian Substance Use, Psychiatric Epidemiology, Risk and Protective Factors Project.

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Table 8

Results of Chi-Squared Tests for Diagnostic Comparisons By Interview for Black River Sample (N = 75)

| Diagnostic Comparison | Significance Level[a] |
|---|---|
| CIDI | |
| SUB x DEP | p = .043 |
| SUB x PTSD | ns |
| SUB x ASPD | p = .000 |
| DEP x PTSD | p = .018 |
| DEP x ASPD | ns |
| PTSD x ASPD | ns |
| SCID | |
| SUB x DEP | p = .004 |
| SUB x PTSD | ns |
| SUB x ASPD | ns |
| DEP x PTSD | p = .002 |
| DEP x ASPD | ns |
| PTSD x ASPD | ns |

Note. CIDI = Composite International Diagnostic Interview; SCID = Structured Clinical Interview for DSM-III-R; SUB = Combined Substance Dependence; DEP = Combined Depressive Disorders; PTSD = Posttraumatic Stress Disorder; ASPD = Antisocial Personality Disorder; ns = nonsignificant.

[a]All Chi-squared tests applied Yates' correction for continuity (Yates, 1934) and required $p < .05$ for significance.

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Table 9

Results of Chi-Squared Tests for Diagnostic Comparisons Across Interviews for Black River Sample (N = 75)

| Diagnostic Comparison | Significance Level[a] |
|---|---|
| C-SUB x S-SUB | ns |
| C-SUB x S-DEP | ns |
| C-SUB x S-PTSD | ns |
| C-SUB x S-ASPD | p = .002 |
| C-DEP x S-SUB | ns |
| C-DEP x S-DEP | p = .017 |
| C-DEP x S-PTSD | p = .000 |
| C-DEP x S-ASPD | ns |
| C-PTSD x S-SUB | ns |
| C-PTSD x S-DEP | p = .000 |
| C-PTSD x S-PTSD | p = .003 |
| C-PTSD x S-ASPD | ns |
| C-ASPD x S-SUB | ns |
| C-ASPD x S-DEP | ns |
| C-ASPD x S-PTSD | ns |
| C-ASPD x S-ASPD | p = .000 |
| C-TAR x S-TAR | p = .028 |

Note. C- = CIDI diagnosis; S- = SCID diagnosis; SUB = Combined Substance Dependence; DEP = Combined Depressive Disorders; PTSD = Posttraumatic Stress Disorder; ASPD = Antisocial Personality Disorder; TAR = Any Target Disorder; CIDI = Composite International

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(Table 9, cont.)

Diagnostic Interview; SCID = Structured Clinical Interview for DSM-III-R; ns = nonsignificant.

[a]All Chi-squared tests applied Yates' correction for continuity (Yates, 1934) and required $p < .05$ for significance.

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Table 10

Odds ratios for Comparisons Across Diagnostic Interviews for Black River Sample (N = 75)

| Diagnostic Comparison | Odds Ratio | Diagnostic Comparison | Odds Ratio |
|---|---|---|---|
| C-ASPD x S-ASPD | 18.7 | C-PTSD x S-PTSD | 6.5 |
| C-DorP x S-TAR | 17.9 | C-DorP x S-SorD | 5.7 |
| C-PTSD x S-TAR | 14.7 | C-DEP x S-DorP | 5.6 |
| C-DorP x S-PTSD | 13.5 | C-DEP x S-DEP | 5.1 |
| C-DorP x S-DEP | 12.5 | C-SorP x S-TAR | 4.9 |
| C-DorP x S-DorP | 12.0 | C-TAR x S-TAR | 4.9 |
| C-SorP x S-DorP | 10.2 | C-PTSD x S-SorD | 4.6 |
| C-TAR x S-DorP | 10.2 | C-SorD x S-PTSD | 4.1 |
| C-PTSD x S-DorP | 10.0 | C-DorP x S-SUB | 4.1 |
| C-DEP x S-PTSD | 10.0 | C-SorP x S-SorP | 4.0 |
| C-PTSD x S-DEP | 9.2 | C-TAR x S-SorP | 4.0 |
| C-DorP x S-SorP | 8.7 | C-SorD x S-DorP | 3.7 |
| C-PTSD x S-SorP | 7.1 | C-SorP x S-SorD | 3.4 |
| C-SorP x S-DEP | 7.0 | C-TAR x S-SorD | 3.4 |
| C-TAR x S-DEP | 7.0 | C-SorD x S-DEP | 2.9 |

Note. Of 64 comparisons, 22 were nonsignificant and 12 could not be computed. Only significant odds ratios are shown here. C- = CIDI diagnosis; S- = SCID diagnosis; SUB = Combined Substance Dependence; DEP = Combined Depressive Disorders; PTSD = Posttraumatic Stress Disorder; ASPD = Antisocial Personality Disorder; SorD = Substance Dependence or Depressive Disorder; SorP = Substance Dependence or PTSD; DorP = Depressive Disorder or PTSD; TAR = Any Target Disorder; CIDI = Composite International Diagnostic Interview; SCID = Structured Clinical Interview for DSM-III-R.

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Table 11

Categorization of Black River Respondents by CIDI & SCID Diagnoses (N = 75)

| | SCID Diagnoses | | | | |
|---|---|---|---|---|---|
| CIDI Diagnoses | Neither | DEP | PTSD | Both | Row Count |
| Neither | [n = 28][a] | 05521.0<br>05839.1<br>06306.1<br>06919.0<br>12725.1 | 08597.0<br>13977.1 | | n = 35 |
| DEP | 04548.1 | | | 06942.0<br>13019.0 | n = 3 |
| PTSD | 04646.0<br>04743.1<br>05366.0<br>07763.0<br>12705.0<br>12848.1<br>15164.1 | 04546.0<br>04688.0<br>05388.1<br>05535.0<br>05663.1<br>08966.0<br>10207.1<br>10383.0<br>11335.1<br>12004.0 | 07399.0<br>10617.0 | 07205.0<br>12206.0<br>12347.1<br>13474.0<br>15270.0<br>16068.0 | n = 25 |
| Both | 15092.0<br>15719.0 | 05149.0<br>14561.1 | 05796.0 | 04659.0<br>04782.1<br>05643.1<br>06110.0<br>08253.0<br>12697.1<br>13192.1 | n = 12 |
| Column Count | n = 38 | n = 17 | n = 5 | n = 15 | N = 75 |

Note. Categorized respondents are represented by their six-digit Respondent Identification Number. CIDI = Composite International Diagnostic Interview; SCID = Structured Clinical Interview for DSM-III-R; DEP = Combined Depressive Disorders; PTSD = Posttraumatic Stress Disorder.

[a]Respondent Identification Numbers were omitted in this cell to conserve space.

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# Appendix A

## Glossary of Tribal Terms

Akicita: warrior society

Hanbleceya: vision quest rite

Inipi: sweatlodge rite

Inyan: rock spirit

Loanpi: various healing ceremonies

Maka: earth spirit

Mitakuye Oyasin: "We are all related."

Skan: sky spirit

Tiospaye: band or extended family

Tunkan: sacred stone worn around the neck

Wacatognaka: generosity

Wakan: sacred power

Wakan Tanka: The Great Mystery

Wi: sun spirit

Wicasa Wakan: medicine man

Wiwanyank Wacipi: sundance rite

Woksape: wisdom

Woohitika: bravery

Wowacintanka: fortitude

Yuwipi: a specific kind of healing ceremony in which spirits are summoned to help

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# Appendix B

## Sample CIDI Items

### Introduction

This part of the interview asks about your emotional well-being.

In the next questions I will sometimes say things differently from the way most people would talk about them. For example, many questions use the word "period" to talk about a time that has a definite beginning and end, such as "a period of at least two days when you felt nervous." If I use a word that is unfamiliar to you, please ask me about it.

The first group of questions will be about a lot of different ways of feeling. It's like a checklist of different emotions. Some of them ask about different time periods, so if it gets confusing, let me know.

### Sample Major Depressive Episode Items

In your lifetime, have you ever had two weeks or more when nearly every day you felt sad, blue or depressed? [Yes or No]
Have you ever had two weeks or more when nearly every day you felt down in the dumps, low, or gloomy? [Yes or No]

Has there ever been two weeks or more when you lost interest in most things like work, school, hobbies, or things you usually liked to do for fun? [Yes or No]

> *If yes*: Did you ever **completely** lose interest in things like work, or school, or hobbies, or things you usually like to do for fun? [Yes or No]

Has there ever been a period of 2 weeks or longer when you lost your appetite? [Yes or No]

> *If yes*: During any of these periods did you **completely** lose your appetite? [Yes or No]
>
> [Includes 5 other questions for criterion related to appetite disturbance.]

Have you ever had two weeks or more when nearly every night you had trouble falling asleep? [Yes or No]

> [Includes 6 other questions for criterion related to sleep disturbance.]

Has there ever been a period lasting 2 weeks or more when you lacked energy, or felt tired out all the time, even when you had not been working very hard? [Yes or No]

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[Includes 2 other questions for criterion related to energy disturbance.]

Has there ever been 2 weeks or more when nearly every day you talked or moved more slowly than is normal for you? [Yes or No]

[Includes 1 other question related to psychomotor retardation.]

Has there ever been two weeks or more when nearly every day you had to be moving all the time – that is, you could not sit still and paced up and down? [Yes or No]

[Additional questions pertaining to remaining diagnostic criteria follow. Then, much later…]

Did any of these periods of feeling [KEY PHRASE] occur just after someone close to you died? [Yes or No]

*If yes:* Did you ever have a period of feeling [KEY PHRASE] along with some of these other problems circled on [handout] at times when it was not just after a death? [Yes or No]

Could any of these problems circled on [handout] have been due **entirely** to medications, drugs, alcohol, physical illness or injury? [Yes or No]

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Sample Dysthymic Disorder Items

Have you ever had a continuous period lasting two years or more when you felt depressed or sad most days (PAUSE), even if you felt O.K. sometimes? [Yes or No]

> *If yes:* Did a period like that ever last two years without being interrupted by your feeling O.K. for two months in a row? [Yes or No]

Have you ever felt low or gloomy for two years or more, even if you felt O.K. sometimes? [Yes or No]

Think now about all the times in your life when you felt depressed or sad most days for two years or more, even if you felt O.K. sometimes. During one of those times...

... were you often in tears?
... did you often feel like crying?
... did you frequently feel hopeless?
... did you often feel that you could not cope with your everyday life and responsibilities?
... did you feel that your life had always been bad and was not going to get any better?

[All questions are answered Yes or No]

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Posttraumatic Stress Disorder Items

Now I'd like to talk about unusual events that are extremely stressful or disturbing—things that do not happen to most people but when they do can be frightening, upsetting, or distressing to almost everyone. By that I mean things like being in a war or heavy combat, being physically assaulted or raped, being in a major earthquake, flood or range fire, or a very serious accident or fire, seeing other people killed or dead, or some other type of disastrous event. During your life, have any of the following types of things happened to you or have you seen any of these things happen? We are interested in whether these events have happened ever in your life:

[Thirteen questions follow assessing kinds of traumatic events, all answered with Yes or No. In addition, three questions are asked about terrible things happening to loved ones.]

You said you were in some life-threatening accidents. Now I'd like you to think back for a moment to the worst time. The rest of the questions will be about that time. Do you have it in your mind? Thinking back on the worst time:

What kind of accident was it? [Select among 5 categories of accidents]

How old were you when this happened? [Record age]

At the time, did you believe that you or someone else could be killed or seriously harmed? [Yes or No]

At the time, were you seriously harmed or was anyone else killed or seriously harmed? [Yes or No]

When this happened, did you experience feelings of intense helplessness? [Yes or No]

Did you experience intense fear? [Yes or No]

At the time, did you feel horrified? [Yes or No]

We've talked a lot about different kinds of extremely stressful or upsetting events, and you told me that some of them happened to you. Now I would like to ask you about the time after the stressful things happened.

You told me you had been in several extremely stressful situations. I'll repeat the situations you told me about. I'd like you to think about the three times that were the worst. The next questions will be just about those times.

Here are the things you mentioned earlier. [Presents list] Which of these experiences were the three worst ones?

[Identify three worst and repeat harm/horror/helpless questions from above.]

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The next questions will be about how you felt after [EVENT] happened:

Did you keep remembering [EVENT] even when you didn't want to? [Yes or No]

After it did you keep having bad dreams or nightmares about it? [Yes or No]

Did you suddenly act or feel as though [EVENT] was happening again even though it wasn't? [Yes or No]

Did you get very upset when you were reminded of it? [Yes or No]

Did you sweat or did your heart beat fast or did you tremble when you were reminded of [EVENT]? [Yes or No]

After [EVENT] did you have trouble sleeping? [Yes or No]

After it did you feel unusually irritable or lose your temper a lot more than is usual for you? [Yes or No]

After it did you have difficulty concentrating? [Yes or No]

After [EVENT] did you become very much more concerned about danger or very much more careful? [Yes or No]

After [EVENT] did you become jumpy or easily startled by ordinary noises or movement? [Yes or No]

Did you deliberately try not to think or talk about [EVENT]? [Yes or No]

Did you avoid places or people or activities that might have reminded you of it? [Yes or No]

After [EVENT] was your memory blank for all or part of it? [Yes or No]

After [EVENT] did you lose interest in doing things that were once important or enjoyable for you? [Yes or No]

After [EVENT] did you feel more isolated or distant from other people? [Yes or No]

After [EVENT] did you have difficulty experiencing normal feelings such as love or affection towards other people? [Yes or No]

After [EVENT] did you begin to feel that there was no point in thinking about the future anymore? [Yes or No]

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Appendix C

DSM-III-R Diagnostic Criteria for Select Disorders

**DSM-III-R Dx Criteria for Major Depressive Episode (MDE)**

A. At least five of the following sx's have been present during the same two-week period and represent a change in previous fx'ing; at least one of the sx's is either (1) depressed mood, or (2) loss of interest or pleasure. (Do not include sx's that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations.)

(1) depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time)
(3) significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains)
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness of being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. (1) It cannot be established that an organic factor initiated and maintained the disturbance
(2) The disturbance is not a normal reaction to the death of a loved one (Uncomplicated Bereavement)

**Note:** Morbid preoccupation with worthlessness, suicidal ideation, marked fx'al impairment or psychomotor retardation, or prolonged duration suggest bereavement complicated by Major Depression.

C. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood sx's (i.e., before the mood sx's developed or after they have remitted).

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D. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.

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## DSM-III-R Dx Criteria for Dysthymic Disorder (DYS)

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. **Note:** In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

(1) poor appetite or overeating
(2) insomnia or hypersomnia
(3) low energy or fatigue
(4) low self-esteem
(5) poor concentration or difficulty making decisions
(6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.

Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

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## DSM-III-R Dx Criteria for Posttraumatic Stress Disorder (PTSD)

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:

(1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
(2) recurrent distressing dreams of the event
(3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)
(4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

(1) efforts to avoid thoughts or feelings associated with the trauma
(2) efforts to avoid activities or situations that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma (psychogenic amnesia)
(4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
(5) feeling of detachment or estrangement from others
(6) restricted range of affect, e.g., unable to have loving feelings
(7) sense of foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts or anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response
(6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

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E. Duration of the disturbance (symptoms in B, C, and D) of at least one month.

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# Appendix D

## Sample SCID Prompts

NOTE: All prompts are followed up with additional questions as necessary in order to confidently rate diagnostic criteria.

### Sample Major Depressive Episode Prompts

Have you ever had a period when you were feeling depressed or down most of the day, nearly every day? (What was that like?)

> *If yes*: When was that? How long did it last? (As long as two weeks?)

During that time, did you lose interest or pleasure in things you usually enjoyed? (What was that like?)

> *If yes*: When was that? Was it nearly every day? How long did it last? (As long as two weeks?)

During that time…

> … did you lose or gain any weight? (How much?) (Were you trying to lose weight?)
>
> > *If no*: How was your appetite? (What about compared to your usual appetite?) (Did you have to force yourself to eat?) (Eat [less/more] than usual?) (Was that nearly every day?)
>
> … how were you sleeping? (trouble falling asleep, waking frequently, trouble staying asleep, waking too early, OR sleeping too much? How many hours a night compared to usual? Was that nearly every night?)
>
> … were you so fidgety or restless that you were unable to sit still? (Was it so bad that other people noticed it? What did they notice? Was that nearly every day?)
>
> > *If no:* What about the opposite—talking or moving more slowly than is normal for you? (Was it so bad that other people noticed it? What did they notice? Was that nearly every day?)
>
> … what was your energy like? (Tired all the time? Nearly every day?)
>
> … how did you feel about yourself? (Worthless?) (Nearly every day?)

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*If no:* What about feeling guilty about things you had done or not done? (Nearly every day?

... did you have trouble thinking or concentrating? (What kinds of things did it interfere with?) (Nearly every day?)

*If no:* Was it hard to make decisions about everyday things? (Nearly every day?)

During that time...

... were things so bad that you were thinking a lot about death or that you would be better off dead? What about thinking about hurting yourself?

*If yes:* Did you do anything to hurt yourself?

Just before this began, were you physically ill? (What did the doctor say?)

Were you taking any medicines or street drugs? (Any change in the amounts you were taking?)

(Did this begin soon after someone close to you died?)

*If yes:* How long did these problems last after the loss?

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Sample Dysthymic Disorder Prompts

For the past couple of years, have you been bothered by depressed mood most of the day, more days than not? (More than half the time?)

*If yes:* What was that like?

During these periods of (OWN EQUIVALENT FOR CHRONIC DPERESSION), do you often...

... lose your appetite? (What about overeating?)
... have trouble sleeping or sleep too much?
... have little energy to do things or feel tired a lot?
... feel down on yourself? (Feel worthless, or a failure?)
... have trouble concentrating or making decisions?
... feel hopeless?

[Further prompts are presented in order to confirm adequate timeframes and to rule out organicity.]

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<u>Sample Posttraumatic Stress Disorder Prompts</u>

Sometimes things happen to people that are very stressful or disturbing—things that do not happen to most people and are so bad that they would be distressing, upsetting, or frightening to almost everyone. By that I mean things like major earthquakes or floods, very serious accidents or fires, physical assault or rape, seeing other people killed or dead, being in a war or heavy combat, or some other type of disaster. At any time during your life have any of these kinds of things happened to you?

[Record events]

Sometimes these things keep coming back in nightmares, flashbacks, or thoughts you can't get rid of? Has that ever happened to you?

> *If yes:* Related to which event(s)?
>
> IF RELATED TO MORE THAN ONE EVENT:
> Which of these upset or affected you the most?

What about being very upset when you were in a situation that reminded you of one of these terrible things?

> *If yes:* Related to which event(s)?
>
> IF RELATED TO MORE THAN ONE EVENT:
> Which of these upset or affected you the most?
>
> IF NO AND MORE THAN ONE EVENT LISTED:
> Which of these upset or affected you the most in general?

[Identify the trauma to evaluate in the remainder of the section.]

IF UNCLEAR: How did you react when (TRAUMA) happened? (Were you very afraid or did you feel terrified or helpless?)

Now I'd like to ask a few questions about specific ways that (EVENT) may have affected you. Did (EVENT) keep coming back to you in some way? For example...

> ... did you think about (EVENT) when you didn't want to or did it come to you suddenly and vividly when you didn't want it to, perhaps even when there was nothing there to remind you of it?
>
> > *If yes:* Can you tell me more about that?
>
> ... what about having dreams about it?

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*If yes:* Can you tell me more about that?

... what about finding yourself acting or feeling as though you were back at that time?

*If yes:* Can you tell me more about that?

... did you feel a lot worse when you were in a situation that reminded you of (EVENT)?

*If yes:* Can you tell me more about that?

Since the (TRAUMA)...

... have you made a special effort to avoid thinking or talking about what happened?

... have you stayed away from things or people that reminded of (TRAUMA)?

... did you have trouble remembering some important part of what happened?

... have you been much less interested in doing things that used to be important to you, like seeing friends, reading books, or watching TV?

... did you feel distant or cut off from others?

... have you felt "numb," or like you no longer had strong feelings about anything or loving feelings for anyone?

... did you notice a change in the way you think about or plan for the future?

Since the (TRAUMA)...

... did you have trouble sleeping? (What kind of trouble?)

... were you unusually irritable? What about outbursts of anger?

... did you have trouble concentrating?

... were you watchful or on guard even when there was no reason to be?

... were you jumpy or easily startled, like by sudden noises?

... have you ever found yourself reacting physically to things that reminded you of (EVENT)—like breaking out in a sweat, breathing heavily or irregularly, or your heart pounding or racing?

About how long did these problems—(CITE POSITIVE PTSD SX'S)—last?

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# Appendix E

## Lay Interviewer Experience Questions
December 1997

### Introduction

As you know, I am interested in learning more about how Lakota people experience distress in this community. There are several ways that I plan to deepen my understanding of these issues, but one way is to turn to community members who already routinely talk with people about their problems. I wanted to talk with you because your role as a lay interviewer for the project requires you to ask people about distressing experiences they may have had. As a result, you have probably developed an expertise about several issues which I would like to better understand. So, in sum, the purpose of our interview today is for me to benefit from the considerable experience you have gained as an interviewer with this project.

I have already mentioned that the things you say in this interview will be kept confidential--that is, no one will have access to the specifics of what we talk about in this conversation except me. Since I am working on a dissertation, I may write about some of the things we speak of today. If so, I will do this in a way that mentions no names. The reason that I am recording the interview is so that I can be as accurate as possible in thinking about the things you tell me. No one will have access to this recording except me. In addition, if you would like a copy of the tapes we make here today, I will be happy to make a copy of them for you.

Finally, given the commitment we have to maintaining the confidentiality of project participants, please do not mention any names or other identifying information if you decide to discuss particular interactions you have had with respondents.

Do you have any questions before we get started?

### Interview Questions

1. As an interviewer for the project, you have had to approach members of your own tribal community and ask them very detailed questions about their personal lives. How comfortable have you felt in doing this? Which kinds of interviews are the most comfortable for you? Which are the least comfortable? Can you briefly describe the most comfortable interview that comes to mind? What about the most *un*comfortable? What would you change about the interviewing process if you could to make it more comfortable?

2. As you know, the interviews we are conducting were developed for use with white people in research settings. How well do you think they translate for Lakota people in this community? What does the average respondent think this project is all about? What do you see as some of the major cultural factors influencing the interview process? How much faith do you have in the accuracy of peoples' responses to interview questions?

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3. When you first approach respondents and try to recruit them for an interview, what kinds of concerns do they have about participating? What kinds of things do you say to convince them that they should participate? What proportion (percentage) of potential respondents which you have contacted have refused to be interviewed? What were their reasons? Given that you know in great detail what these interviews are about, would you participate in one if you were asked to?

4. What proportion (percentage) of the interviews you have conducted were smooth? Difficult? What strategies have you learned to make the interview go more smoothly?

5. My guess is that answering these kinds of questions in an interview setting is pretty unusual for your respondents. Do you sense that it is difficult for them to talk about their feelings in response to interview questions? Why or why not?

6. How do you think your respondents feel about the personal nature of many of the questions you ask? Are there particular questions that you dislike asking? Which ones? Why? Are there particular questions that respondents have refused to answer? Which ones? Why? How open and honest do you think your respondents have been? Why do you think they respond in that way?

7. How well do respondents seem to understand the questions in the mental health portion (Section E) of the interview? Are there any questions in this section that people have trouble with? Do people seem to understand what you mean when you ask about feeling nervous, scared, or anxious? How about worried, depressed or sad?

8. It seems like the section of the interview which asks about traumatic events could be an especially difficult part of the interview. What has it been like to ask people about their experiences of trauma? What kinds of emotions do respondents show when talking about upsetting experiences? What proportion (percentage) of your respondents have shown such emotions during the interview?

9. What has been the strangest interview you have conducted? Have you ever wondered if any of your respondents were truly crazy? How did/would you feel interviewing a crazy person? How do people in the community generally feel and act toward crazy people?

10. Do you prefer to interview someone you know or would you rather interview a stranger? Why? Do you think most respondents would rather be interviewed by someone they know or a stranger? Why? Have you ever interviewed a family member? What was that like? Would you recommend in general that interviewers go ahead and interview their family members?

11. What impact has your being young/middle aged and male/female had on the interviews you have conducted? Do you think it is generally helpful in the interviewing process that you are a member of this community? How do you think people would respond in this process if you were not Indian?

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12. In conducting these interviews, you hear about many disturbing experiences that your respondents have had. Does hearing about these things ever bother you? What is that like for you? Can you remember an example of an interview that was especially upsetting to you? How do you cope with hearing distressing things like that? Have the clinical support meetings been at all helpful for you in times like these? What would you do differently in these meetings to make them more helpful?

13. One aspect of the research task we are involved in is that we are not really in a position to directly help the people we talk with. What are your thoughts about this aspect of the interviews you conduct? Have you ever felt like you were helpful to a respondent anyway? What proportion (percentage) of your respondents do you think found the interview directly helpful in some way?

14. Have you ever interviewed a respondent where you felt that he or she was worse off because of the interview? What proportion (percentage) of your respondents do you think were worse off in some way because of the interview? How would you improve the interview process to ensure that your respondents were most likely to be helped by the interview instead of hurt by it?

15. Does it bother you much that the project is not in a position to be more directly helpful to respondents? How useful is the resource list to the respondents? Do you think many of your respondents have taken advantage of these resources? Why or why not?

16. As a member of this community, what do you value the most about the interviews you conduct? What do you value least? Can you think of any especially satisfying interviews you may have conducted? What made the interview so satisfying to you?

17. How do you think your participation as an interviewer in this project will affect your long-term relationships with people in the community?

18. Do you have any additional comments or observations about the interviewing process?

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Curriculum Vitae

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## CURRENT POSITION

Assistant Professor — 7/00-
Committee on Human Development
The University of Chicago, Chicago, IL

## EDUCATION

Ph.D. Department of Psychology, University of Illinois, Champaign, IL. — 1/01

Major: Clinical and Community Psychology
Minor: Quantitative and Qualitative Methods

Dissertation: *Affect and Its Disorders in a Northern Plains Indian Community: Issues in Cross-Cultural Discourse and Diagnosis*

Dissertation Chair: Julian Rappaport (Psych)
Dissertation Committee: Peggy J. Miller (Psych & Speech Comm), Gregory A. Miller (Psych), Brenda Farnell (Anthro), Mark Aber (Psych)

---- Intern in Psychology & Clinical Fellow, Dept. of Psychiatry — 1999-00
McLean Hospital/Harvard Medical School, Belmont, MA

Rotations: Bipolar & Psychotic Disorders Partial Hospital Program
Mood & Anxiety Disorders Partial Hospital Program

Training Director: Philip G. Levendusky, Ph.D., ABPP

A.M. Department of Psychology, University of Illinois, Champaign, IL. — 1/96

Major: Clinical and Community Psychology

Thesis: *Gros Ventre Cultural Identity As Normative Self: A Case Study*

Thesis Chair: Peggy J. Miller
Second Reader: Julian Rappaport

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A.B. Cum Laude in General Studies, Harvard University, Cambridge, MA. 6/92

Major: Psychology

---- United States Military Academy, West Point, NY. 1988-90

## HONORS AND AWARDS

Charles A. Eastman Dissertation Fellowship, Native American Studies, Dartmouth College, Hanover, NH. 1998-99

Graduate Fellowship, American Indian Graduate Center, Albuquerque, NM 1997-98

CIC Minority Predoctoral Fellowship in the Social Sciences, Committee on Institutional Cooperation, Bloomington, IN: tuition and stipend for 4 yrs graduate study at member institutions. 1993-97

Ed Scheiderer Memorial Award for Outstanding Research or Scholarship by Clinical Student, Department of Psychology, University of Illinois, Champaign, IL: for Master's thesis. 1996

Robert P. Larson Human Development Award, Counseling Center, Student Affairs, University of Illinois, Champaign, IL: for the "enhancement of student development" via advocacy on behalf of Native American student concerns. 1995

American Indian Ambassadors Program, Americans for Indian Opportunity/Kellogg National Foundation, Bernalillo, NM: Year-long tribal leadership development initiative. 1994

Carl and Lily Pforzheimer Foundation Public Service Fellowship, Harvard College, Cambridge, MA: for assisting the Fort Belknap Indian reservation's Constitutional Review Committee in efforts to restructure the tribe's political system. 1992

Leo F. Daley and Richard T. Flood Scholarship, Harvard College, Cambridge, MA: in recognition of achievement at Harvard. 1991-92

A.T. Anderson Memorial Scholarship, American Indian Science and Engineering Society, Boulder, CO. 1991-92

American Indian Scholarship, National Society of the Daughters of the American Revolution, Tahlequah, OK. 1991-92

Lamont Public Service Fellowship, Harvard College, Cambridge, MA; 1991
Education-For-Action Social Action Grant, Radcliffe College, Cambridge, MA;
Educational Exchange Foundation Fellowship, New York, NY;
J. W. Saxe Memorial Prize, Washington, DC:
for organizing and cataloging tribal archive materials on Fort Belknap Indian reservation.

Distinguished cadet, United States Military Academy, West Point, NY: Ranked in top one percent of class. 1988-90

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## CLINICAL & RESEARCH EXPERIENCE

1999-00 **Pre-doctoral Internship in Psychology**, McLean Hospital, & **Clinical Fellowship in Psychology**, Department of Psychiatry, Harvard Medical School, Belmont, MA. Provide individual and group psychotherapy, cognitive behavioral consultations, and case administration foı patients in partial hospital programs with severe psychopathology (including psychotic disorders, major affective disorders, anxiety disorders, substance use disorders, and personality disorders). Participate in multidisciplinary rounds, training seminars, case conferences and intensive supervision. Supervised by Philip Levendusky (Ph.D.), Edmund Neuhaus (Ph.D.), Robin Goldstein (Ph.D.), Francesca Antognini (Ph.D.), Andrea O'Rourke (LICSW), Laura Ferrer (Ph.D.), and Robert Dello Russo (Ph.D.).

1997-99 **Substance Use, Psychiatric Epidemiology, Risk & Protective Factors Project (SUPERPFP)**, National Center for American Indian and Alaska Native Mental Health Research, University of Colorado Health Sciences Center, Denver, CO. As a research intern and consultant, I assisted Spero Manson (Ph.D.), Janette Beals (Ph.D.), and Theresa O'Nell (Ph.D.) in an NIMH-sponsored study by conducting over 100 clinical interviews using the Structured Clinical Interview for the DSM-III-R (SCID) and 10 ethnographic follow-up interviews with community members on northern Plains and southwestern Indian reservations; preparing written reports summarizing demographic information, symptoms, and psychiatric diagnoses following each interview; providing clinical support for lay interviewers working for the project; and coordinating with community institutions and agencies on behalf of the project.

1996-97 **Individual Psychotherapy Practicum**, Department of Psychology, University of Illinois, Champaign, IL. Conducted 60 sessions of individual psychotherapy with one male and one female client. Supervised intensively by Gregory A. Miller (Ph.D.).

Spr. 1996 **Fort Belknap Indian Community Action Practicum**, Department of Psychology, University of Illinois, Champaign, IL. Explored multiple opportunities for community action/intervention while in residence on Fort Belknap Indian reservation. Co-founded and supported grass-roots cultural society dedicated to Gros Ventre cultural preservation, tribal advocacy, and the establishment of pro-social opportunities for reservation youth. Taught undergraduate courses at Fort Belknap College. Consulted for tribal anti-violence initiative funded by U.S. Department of Justice. Appointed Chief Administrative Officer by tribal government. Supervised by Julian Rappaport (Ph.D.).

Fall 1995 **Psychotic Experiences & Psychopathology Project**, Department of Psychology, University of Illinois, Champaign, IL. As a research assistant, I aided Gregory A. Miller (Ph.D.) in an NIMH-sponsored study by conducting 15 diagnostic interviews with undergraduates; assigning RDC, DSM-III, DSM-III-R, and DSM-IV diagnoses; assessing Family History (using FH-RDC) and psychotic experiences (using Chapman scales); and attending weekly meetings to discuss unique and challenging diagnostic issues.

Fall 1995 **Paraprofessional Training Practicum**, Department of Psychology, University of Illinois, Champaign, IL. Adapted cognitive-behavioral assertiveness training program for use by local paraprofessionals in nearby African-American community. Consulted with local community leaders to recruit paraprofessionals, explain structure and goals of the intervention, solicit feedback, and ensure cultural sensitivity. Attended weekly supervision meetings. Supervised by Howard Berenbaum (Ph.D.).

Summ 1995 **Longitudinal Effects of State Mental Health Center Closure Upon Discharged Patients Project**, Department of Psychology, University of Illinois, Champaign, IL. As a research assistant, I aided Julian Rappaport (Ph.D.) and Howard Berenbaum (Ph.D.) in a state-sponsored study by conducting quality of life and diagnostic interviews (including components of Structured Clinical Interview for DSM-III-R, Brief Psychiatric Rating Scale, Quality of Life Inventory, Satisfaction With Life Scale, Illinois Pleasure Scale, etc.) with 15 hospital residents prior to discharge and attending weekly administrative meetings to monitor progress, determine policy, and resolve research dilemmas.

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1994-95 **Diagnostic Interviewing Practicum**, Department of Psychology, University of Illinois, Champaign, IL. Conducted 28 clinical interviews using Structured Clinical Interview for the DSM-III-R (SCID) with psychiatric inpatients in a community hospital setting. Prepared written reports summarizing demographic information, symptoms, and psychiatric diagnoses following each interview. Reviewed patient charts and consulted with hospital staff to exchange relevant information. Supervised by Gregory A. Miller (Ph.D.) and Howard Berenbaum (Ph.D.).

1994-95 **Columbia School Practicum**, Department of Psychology, University of Illinois, Champaign, IL. Mobilized university and community resources in an effort to empower parents and children associated with a primarily African-American elementary school. Attended weekly group meetings to theorize relevant approaches, develop appropriate interventions, plan future activities, examine the results of investigations and interventions, and discuss pathways to more effective social change. Supervised by Julian Rappaport (Ph.D.) and Thom Moore (Ph.D.).

Summ 1994 **Gros Ventre Cultural Identity Project**, Fort Belknap Indian Community, Harlem, MT. As a primary investigator, I conducted ethnographic interviews with tribal elders exploring the construction of personal and cultural identity for original Master's thesis research under the direction of Peggy Miller (Ph.D.) and Julian Rappaport (Ph.D.).

Summ 1993 **Voice of Indian Teens Project**, American Indian Summer Research Program, University of Colorado Alcohol Research Center, and National Center for American Indian and Alaska Native Mental Health Research, University of Colorado Health Sciences Center, Denver, CO. As a research intern, I assisted Candace Fleming (Ph.D.) and Jim Moran (Ph.D.) in NIAAA-sponsored research by examining ethnic identity and its relationship to substance abuse among American Indian adolescents and preparing a written review of the scientific literature pertaining to this construct.

1991-92 **American Indian Sacred Objects Repatriation Program**, Peabody Museum of Archaeology and Ethnology, Harvard University, Cambridge, MA. As a curatorial assistant, I researched and organized archival and ethnographic collections from Plains areas; assisted with storage of sacred materials; and hosted tribal elders and historians.

1990-92 **Fetal Dysmaturity & Attention-Deficit Disorder Project**, Eunice Kennedy Shriver Center and Harvard Medical School, Waltham, MA. As a research assistant, I aided Curtis Deutsch (Ph.D.) in a March of Dimes study by administering, scoring, and encoding psychological tests for over 40 parents and their children, including the DISC, DICA, Vineland, ADHD Symptoms Checklist, Connors, WISC-R, WRAT-R, PPVT, Boston Naming Test, Edinburgh, and Denckla. Additional responsibilities included recruiting subjects to participate in the study.

Summ 1990 **Peer Counselor**, Cadet Counseling Unit, West Point, NY. Provided crisis intervention and routine counseling as peer counselor for Cadet Basic Training Company (100 new Cadets) over 6-week period. Advised Chain of Command regarding referred personnel. Provided classroom instruction in stress management. Participated in daily business meetings to discuss cases, review counseling approaches, and resolve professional and ethical dilemmas. Supervised by CPT Mike Jameson (Ph.D.).

## TEACHING EXPERIENCE

Fall 1996 **Primary Instructor**, Abnormal Psychology, University of Illinois, Champaign, IL. Supervisor: Louise F. Fitzgerald. Full responsibility for class of 40 undergraduates.

Spr. 1997 **Co-Instructor**, Community Psychology, University of Illinois, Champaign, IL. Supervisor: Julian Rappaport. Shared responsibility with another graduate student for class of 100 undergraduates.

Wint 1996 **Primary Instructor**, Developmental Psychology, Fort Belknap College, Fort Belknap Agency, MT. Supervisor: Majel Dominguez. Full responsibility for class of 10 undergraduates at tribally-controlled community college.

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Wint 1996 **Primary Instructor**, Counseling Pharmacology, Fort Belknap College, Fort Belknap Agency, MT. Supervisor: Majel Dominguez. Full responsibility for class of 5 undergraduates at tribally-controlled community college.

## PUBLICATIONS, PRESENTATIONS, & WORKS IN PROGRESS

**Publications**

Gone, J. P. (1999). "We were through as Keepers of it": The "Missing Pipe" narrative and Gros Ventre cultural identity. Ethos, 27(4), 415-440.

Gone, J. P., Miller, P. J., & Rappaport, J. (1999). Conceptual self as normatively oriented: The suitability of past personal narrative for the study of cultural identity. Culture & Psychology, 5(4), 371-398.

**Formal Presentations**

Gone, J. P. (2000, November). Tracking illness in Indian country: Self, culture, and the postcolonial predicaments of psychodiagnosis. In C. Willging & T. D. O'Nell (Co-Chairs), American Indian mental health research in the 21st century: Culture, history, and colonial realities. Session conducted at the 2000 Annual Meeting of the American Anthropological Association, San Francisco, CA.

Gone, J. P. (2000, August). Caught in the conceptual quagmire: Constructing culture for clinical science. In W. Heller (Chair), Constructing mental health: The embodiment of culture, emotion, and language. Symposium sponsored by the Society for a Science of Clinical Psychology at the 108th Annual Convention of the American Psychological Association, Washington, DC.

Gone, J. P. (2000, March). Wounding "Warriors Without Weapons": The postcolonial predicament of psychodiagnosis in Sioux country. In J. Rappaport (Chair), Individual and collective resistance to dominant narratives in the diagnosis and treatment of mental illness and alcoholism. Session conducted for the 2000 Annual Meeting of the Society for Applied Anthropology (co-sponsored by the Society for Medical Anthropology and the Society for Community Research and Action), San Francisco, CA.

Gone, J. P. (1999, August). Interpreting the intersubjective: An alternative "way of knowing" for psychology. In A. Jenkins (Chair), Epistemology and ontology--Beyond traditional conceptions. Session conducted at the 107th Annual Convention of the American Psychological Association, Boston, MA.

Gone, J. P. (1999, August). New approaches to fighting alcohol problems in Indian country: Lessons from community psychology. In J. L. Chin (Chair), New voices to old problems: Culturally relevant community research and clinical practice. Session conducted at the 107th Annual Convention of the American Psychological Association, Boston, MA.

Gone, J. P. (1999, June). Confronting the curricular conundrum: Is doctoral training in psychology really relevant for American Indian communities? Presentation at the Twelfth Annual Convention of American Indian Psychologists, Logan, UT.

Gone, J. P. (1998, December). "We were through as Keepers of it": The "Missing Pipe" narrative and Gros Ventre cultural identity. In S. E. Wortham (Chair), The narrative construction of self in cultural contexts: Formal-functional approaches. Invited session conducted at the 97th Annual Meeting of the American Anthropological Association, Philadelphia, PA.

Gone, J. P. (1998, November). "We were through as Keepers of it": Narrative, history, and Gros Ventre cultural identity. In P. Iverson (Chair), Identity and community in Native North America, part II. Session conducted at the annual meeting of the American Society for Ethnohistory, Minneapolis, MN.

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Gone, J. P. (1998, September). Rethinking Indian mental health for the 21st century. Invited presentation through Native American Speakers Program, Department of Psychology, Northern Arizona University, Flagstaff, AZ.

Gone, J. P. (1998, June). The anthro's revenge: Cultural psychology and the future of social research in Indian country. Presentation at the Eleventh Annual Convention of American Indian Psychologists, Logan, UT.

Gone, J. P. (1997, June). Rethinking Indian mental health for the 21st century. Presentation at the Tenth Annual Convention of American Indian Psychologists, Logan, UT.

Gone, J. P., & Rappaport, J. (1996, May). Community as intersubjectivity: Why interpretive methods must be privileged in community psychology. Presentation by J. Rappaport (in my unexpected absence) at the Midwestern ECO-Community Conference, Chicago, IL.

Gone, J. P. (1995, June). Community psychology: Overlooked opportunities for Indian country. Presentation at the Eighth Annual Convention of American Indian Psychologists, Logan, UT.

**Informal Presentations**

Vasquez, M. J. T., Wyatt, G. E., Sue, D. W., & Gone, J. P. (1999, August). On becoming a psychologist--Tips for ethnic minority students. Symposium conducted at the 107th Annual Convention of the American Psychological Association, Boston, MA. [Invited by J. E. Trimble to speak in his unexpected absence.]

Comas-Diaz, L., Bernal, G., Franklin, A. J., Nagayama Hall, G. C., Gone, J. P., LaFromboise, T. D., Murguia, A., Trimble, J. E., Root, M. P. P., Vasquez, M. J. T., & Wyatt, G. E. (1999, August). Presidential Miniconvention on Ethnic Minorities--Scaling the summit: Want to publish? Advice from Division 45 editorial board. Symposium conducted at the 107th Annual Convention of the American Psychological Association, Boston, MA.

Gone, J. P. (1999, May). Rethinking mental health services for Indian country: Part III—A Lakota case study. Colloquium presentation through Native American Studies Program, Dartmouth College, Hanover, NH.

Gone, J. P. (1999, March). Rethinking mental health services for Indian country: Part II—Concepts and contexts. Colloquium presentation through Native American Studies Program, Dartmouth College, Hanover, NH.

Gone, J. P. (1999, January). Rethinking mental health services in Indian country. Presentation to Psychiatry Interest Group, Dartmouth Medical School, Hanover, NH.

Gone, J. P. (1998, November). Rethinking mental health services for Indian country: Part I—Perspectives and paradigms. Colloquium presentation through Native American Studies Program, Dartmouth College, Hanover, NH.

Gone, J. P. (1998, April). The significance of Native American student activists in the struggle for progressive change in American higher education. In Dialogue on the Elimination of Racist Mascots. Panel discussion conducted at the First Annual Conference on the Elimination of Racist Mascots, University of Illinois, Champaign, IL.

Carrier, H. J., Gone, J. P., Perkins, O., Rankin, H. E., Rodriguez, A. L., Strong, W. C., Teters, C., & Tibbetts, D. W. (1995, June). Offensive university mascots: The stolen images of Native American people--A case study. Major Workshop Session conducted at the 8th Annual National Conference on Race and Ethnicity in American Higher Education, Santa Fe, NM.

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## TRIBAL PROGRAMS EXPERIENCE

**Chief Administrative Officer**, Fort Belknap Indian Community, Harlem, MT. Feb.-Aug. 1996. Appointed by tribal government to manage over fifty tribal programs employing over 200 personnel. Resigned position to return to doctoral program.

**Personnel Policies Consultant**, Fort Belknap Community Council, Harlem, MT. April-June 1993. Reviewed, developed, prepared, and distributed comprehensive tribal policies and procedures in close consultation with Fort Belknap Tribal Administrator.

**Administrative Consultant**, Fort Belknap Chemical Dependency Program, Harlem, MT. Feb.-April 1993. Assisted Program Director during organizational restructuring to surpass minimum standards for compliance with Indian Health Service contract. Provided expertise in all program requirements as set by contract and Indian Health Manual, Part 3, Chapter 18. Reviewed, developed, and distributed comprehensive written policies and procedures in close consultation with program staff. Assisted in preparation of proposals for initial, supplemental, and continuation funding for program.

**Vocational Education Project Counselor**, Fort Belknap Education Department, Harlem, MT. Oct. 1992-Feb. 1993. Provided personal, academic, career, and higher education guidance to select students pursuing two-year college degrees. Identified and utilized existing community organizations, agencies, and human service representatives to meet educational needs of Indian adults. Devised individual plans for students receiving services through Project. Assisted Project graduates in finding part-time and full-time employment.

**Special Assistant to Constitution Review Committee**, Fort Belknap Indian Community, Harlem, MT. June-Oct. 1992. Assisted Committee with public relations, community education, research, and other administrative tasks in efforts to restructure the tribe's political system.

**Tribal Archives Coordinator**, Fort Belknap Indian Community College, Harlem, MT. Summer 1991. Conceived and implemented classification system for archival materials. Created comprehensive directory of materials available. Accessed and organized tribal council minutes for public use in archives. Advised President Margarett C. Perez concerning archival policy.

## MILITARY SERVICE

1986-88 **U.S. Army**, 2nd Armored Cavalry Regiment, Amberg, West Germany. Rank: Specialist. M1 Abrams Tank Crewman. Selected for Operations Team ("secret" clearance) to monitor sensitive West German/Czechoslovakian border security. Awarded: Army Achievement Medal (twice); Army Good Conduct Medal; and Certificate of Achievement (twice). Completed Emergency Medical Technician-Ambulance Course. Detached seasonally to Regimental Band. Discharged honorably to enter U.S.M.A. as cadet.

## OTHER PROFESSIONAL ACTIVITIES AND AFFILIATIONS

Journal Review and Referee Work

- Cultural Diversity and Ethnic Minority Psychology: The Official Journal of Division 45 (APA), student editor
- Culture, Medicine, and Psychiatry: An International Journal of Comparative Cross-Cultural Research

University Service

- Creator & Co-Founder, Native Community Leadership Development Program, Dartmouth College, Hanover, NH

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- Graduate Student Representative, Society of Indian Psychologists, USA
- President, Native American Student Organization, University of Illinois at Urbana-Champaign
- Admissions Committee, Division of Clinical and Community Psychology, University of Illinois at Urbana-Champaign
- Council of Native American Students at Harvard, Harvard University, Cambridge, MA

Professional Affiliations

- American Psychological Society
- American Psychological Association
- Society for a Science of Clinical Psychology, Div. 12 (Sec. III), APA
- The Clinical Psychology of Ethnic Minorities, Div. 12 (Sec. VI), APA
- Society for Community Research and Action, Div. 27, APA
- Society for the Psych. Study of Ethnic Minority Issues, Div. 45, APA
- Society of Indian Psychologists
- American Anthropological Association
- Society for Psychological Anthropology, AAA

## REFERENCES

Available upon request.

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