Social Support Systems and Residual Persistence among Urban Indians Utilizing an Urban Indian Agency

by

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CHAPTER 1

Introduction

Mental health problems of American Indians are acknowledged by policymakers, health care providers and consumers as worthy of attention. Most of the leading causes of death in the American Indian population are due to mental health problems, such as suicide, and alcohol-related accidents, homicides and cirrhosis (National Institute on Alcohol Abuse and Alcoholism, 1980). The American Indian suicide rate was 1.7 times that of all Americans and 3.2 times higher for 15-24 year old youths; homicide rates are twice as high for Indians as for all races (U.S. Congress Office of Technology Assessment, 1986). Alcohol intake was reported to be three times higher for Indians than Hispanics and seven times higher for Indians than whites (Graves, 1967). Alcohol-related illnesses accounted for 70% of Indian Health Service (I.H.S.) clinic visits (Task Panel Reports, 1978), and 35% of all American Indian deaths are alcohol-related (National Institute on Alcohol Abuse and Alcoholism, 1980). The National Institute on Drug Abuse (1983) reports that twice as many American Indians as whites were in treatment for drugs in 1982--much higher than the percentage of American Indians in the population. Heckler (1985) reports that 88% of American Indian high school seniors had used marijuana at least once, as compared with 60% of other high school seniors, and 34% of the American Indian youths had experimented with inhalants, as compared with 12% for other high school seniors.

Urban Indians, especially recent migrants, experience many mental

health problems. For example, when Seattle Washington's Indian Health Board listed the twenty most commonly treated problems seen in their clinic, psychiatric disorders ranked among them: Alcohol (2); anxiety with symptoms (12); depression (13); anxiety (18) (Sorkin, 1978). American Indians in Portland, Oregon, identified their three principle health concerns as alcohol abuse, poor teeth and poor vision (City Club, 1975; Grant-Morgan, 1973). Borunda and Shore (1978) noted that the concerns of Portland's American Indians were the low incomes among most urban Indian workers, the extent of alcohol abuse, and the desire to maintain some traditional practices.

Over one-half of the nation's Indians now live in urban settings (Heckler, 1985). This move to urban areas was encouraged by the Bureau of Indian Affairs' Relocation Policies in the 1950's, which provided transportation, training and allowances for American Indians who chose to leave the reservation for the cities. But many returned periodically to the reservations, and some returned permanently due to family ties (Ablon, 1971). The literature cites two major reasons for this transiency: a) American Indians were faced with foreign, conflicting values of the dominant white culture, causing confusion and frustration (Ablon, 1971; Hanson, 1980; LaFromboise, 1979; Westermeyer, 1979); and b) until recently, American Indians who desired free health care from the I.H.S. had to return to the reservations (Aurum et al, 1974). Currently, I.H.S. cares for about 60% of the total Indian population (Heckler, 1985), and 90% of this is provided on reservations (Sorkin, 1978). Hence, urban health services are perceived as inadequate by the

urban Indians and providers (U.S. Congress Office of Technology Assessment, 1986; Sue, Allen & Conaway, 1978). The problem of providing mental health services to urban Indians was serious enough to warrant examination by a task force to the President's Commission on Mental Health (Task Panel Reports, 1978).

Purpose

Mental health care providers and the literature suggest that differences in social support systems and persistence of traditional cultural practices may be two factors that distinguish urban Indians who seek out mental health services from other urban Indians. A functioning social support system affects the adjustment of American Indians to urban areas (Ablon, 1964, 1971; Graves, 1970; Martin, 1964; Red Horse, Lewis, Feit & Decker, 1971). Yet, no studies have been reported that compared social support systems of urban Indians who utilize mental health services and those who do not. Therefore, one purpose of this study is to describe the social support system characteristics of urban Indian clients who utilized the mental health services of an urban Indian clinic and whether they differed on those characteristics from urban Indian clients who used other services at the agency.

A second factor that may affect urban Indians' ability to adapt to urban areas is the degree of residual persistence, that is, the use of traditional cultural practices. Some American Indians have values that differ from and/or are incongruent with values of the white dominant society (Hanson, 1980; LaFromboise, 1979), while others do not. Thus, another purpose of this study is to describe the degree of residual

persistence existing in the urban Indians who utilized the mental health services of the urban Indian health clinic compared with those who used other services at the agency.

The goal of this study is to add to the knowledge-base assisting nurses and other mental health professionals in providing meaningful mental health services to urban American Indians. For instance, it is important to recognize traditional beliefs in diagnosing and treating American Indians in order to enhance rapport and perhaps compliance, and to utilize the strengths inherent in each individual (Hanson, 1978; LaFromboise, 1979; Liberman & Knigge, 1979; Lockhart, 1981). Recognizing traditional practices assists with health teaching and community program planning. Further, strengthening social support systems may offer an alternative to handling problems (Froland, 1978). For example, extensive social support systems are being utilized in doing therapy with urban Indians in some locales (Attneave, 1969, 1982). Thus, the limited literature available suggests that awareness of the social support systems of American Indians and degree of residual persistence will assist health care providers in determining the need for and nature of interventions.

Definitions

The following definitions are used to clarify the subjects and variables examined in this study:

"American Indian" refers to any person considering himself to be a "descendent of a tribe of pre-Columbian natives of the Western Hemisphere" (White Cloud Journal, 1978, p.2). The American Indians in

this study can come from continental United States, Alaska, Canada, but not from the Pacific Islands and Hawaii. "American Indians" refers to persons who consider themselves to be Indian, Native American, Aleuts, Eskimos, regardless of blood quantum.

"Urban Indian" refers to any American Indian who has resided in a major city in the United States with population over 50,000 for at least six months (L.M. Ryan, personal communication, November 9, 1981).

"Mental health subjects" refers to urban Indian clients who have utilized the services of the urban Indian mental health center; these clients may also have utilized other services offered by the urban Indian agency.

"Comparison group subjects" refers to urban Indian clients who utilized services offered by the urban Indian agency, such as, day labor, social services, primary health care, dental services. These subjects had neither utilized nor were currently using the mental health services offered by the urban Indian clinic or any other mental health agency in the city.

"Social support system" refers to "an enduring pattern of continuous or intermittent ties that play a significant part in maintaining the psychological and physical integrity of the individual over time" (Caplan, 1974, p.7).

"Extended family" refers to a family which includes more members than a nuclear family of parents and their children; it may include several generations, and other kin, such as cousins.

"White", when used as a noun, or adjective with the noun "men",

refers to the members of the Caucasian race; when used as an adjective with the noun "culture", it refers to the cultural practices of the dominant culture in the United States (L.M. Ryan, personal communication, November 9, 1981).

"Pre-contact" refers to the period in American Indian history before the coming of white men.

"Residual persistence" refers to the continued practices of traditional cultural exercises and valuing of traditional beliefs, as preserved through the oral histories of the elders (Hanson, 1980). These customs date back to pre-contact times. Extreme residual persistence implies total rejection of the dominant white culture's beliefs, values and practices, and is the opposite of assimilation.

"Assimilation" refers to the outcome after a minority culture is totally engulfed into the dominant culture; it occurs in stages but without any fixed order (Chadwick & Strauss, 1975).

"Acculturation" refers to the process of adopting some of the dominant society's traits; various degrees of assimilation is the potential outcome (Gordon, 1964; Jacoby, 1956).

Limitations

One limitation of this study is that the urban Indian agency used in this study attracted people of lower income. Because volunteers were paid $5 to complete the survey interview, this non-probability convenience sample may have characteristics unlike other urban Indians.

There is the possibility of interviewer bias. Some clients had already established a rapport with their interviewer through previous

contacts; others had a stranger for an interviewer. The race, age and sex of the interviewer may have affected the subjects' rapport. This study relied heavily on subjects' honesty, and the degree of rapport may have affected honesty.

Summary

The purpose of this study was to examine the extent of social support systems and degree of residual persistence present in urban Indian mental health clients and a comparison group of urban Indians not utilizing mental health services. It is hoped that knowledge gained from this study will increase health care providers' sensitivity to their American Indian clients and, hence, the quality of mental health care provided to this group.

CHAPTER 2

The literature review compares traditional health practices of American Indians with current practices and delivery of health care. The reasons for migration to urban areas are discussed. Finally, the mental health of urban Indians is discussed, noting conflicting values and mental health needs. Ways in which programs address needs are also included. The conceptual framework addresses concepts from role theory, and their relationships to the concepts of social support systems and residual persistence. The research questions, based on the literature and conceptual framework, conclude this chapter.

Review of Literature

Traditional Health Practices

Some urban Indians are reluctant to use mental health services. Examination of traditional cultural practices and values of American Indians gives us clues as to why this is so. The traditional American Indian in pre-contact times and later on reservations lived within his tribe within an extended family of either or both parents. Childrearing was a task of the extended family: different specific roles were delegated to mother, father, grandparents and mother's brother (Attneave, 1969, 1982; Hanson, 1980; Red Horse et al, 1978; Shore & Nicholls, 1977). The elders were respected and utilized as teachers. For example, an elder was assigned to each adolescent to train him before his vision quest, an adult initiation ritual in many tribes. (Ray, 1933).

Traditional health beliefs included: 1) Mother Earth is a living

organism, and varies in degrees of healthiness just as humans do; 2) people must treat their bodies and the earth with respect in order to maintain this relationship with nature; 3) illness stems from disharmony of spiritual origin (Primeaux, 1977). While illness could come from breaking a taboo, or using magic against another, accidents were recognized as accidents (Ray, 1933). Herbs were gathered with respect, and only those needed were taken; many of these herbs are still in use today by traditional healers (Boyd, 1974) and "modern medicine".

The involvement of the extended family and other significant tribal members was also necessary for healing. Traditional American Indian healers treated their patients in the social support system of both the patient and the healer (Coulehan, 1980; Martin, 1981). The following beliefs are emphasized:

> "Healer and patient share a system of beliefs about the nature of the world and the nature of disease...The patient's sickness places a responsibility on patient and family to participate in healing rites...The healer focuses on illness rather than on disease. The healer enlists participation of others via ceremonies, rituals, songs, and dances. The healer surrounds himself with helpers who support ceremony and patient...The helpers welcome the patient, give him time, listen, answer questions, and explain..." (Martin, 1981, p. 141).

American Indians' perceptions of current health practices

The traditional American Indian healer treats the patient in his familiar home, with a supportive family present, in an unhurried manner,

incorporating familiar religious practices into the healing ritual (Coulehan, 1980; Martin, 1981; Ray, 1933). In contrast, the white sanctioned healer treats patients in an unfamiliar, isolated, sterile environment, rushing between patients and using foreign techniques. Because the American Indian is accustomed to individual treatment, it is not surprising that Kane and Kane (1972) noted that Navajo patients in Shiprock, New Mexico, hospital and clinic complained of long waiting periods, lost records, lack of doctors, poor interpretations of care, and impolite staff. When asked how they would improve care, they requested more facilities and staff, health education translated into Navajo, and better home sanitation. Noteworthy is their emphasis on improving patient-staff ratio (as with former native healers) and preventive measures. Similar to their rural counterparts, urban Indian clients in a metropolitan clinic complained of long waiting times, long delays in actually getting appointments, long travel times, all of which resulted in a decrease in returning for follow-up visits (Shannon & Bashshur, 1982).

Fuchs and Bashshur (1975) conducted a study of the current use of traditional Indian medicine among American Indians living in the San Francisco Bay area. They found that the use of traditional medicine was reported by 28% of the families surveyed across all represented tribes; those respondents also used modern white medicine. The authors believed that this figure underestimated the use of traditional medicine because some respondents were reluctant to discuss the subject for fear it would be misunderstood. Those American Indians who spoke their native

language, lived in the city for a shorter period of time, preferred to live on the reservation, and who visited their American Indian friends and reservation, more frequently used traditional medicine. There were no correlations between use of traditional medicine and either income or education. The authors recommended that American Indians organize to study their culture so that the healing arts are not lost, since length of time in the city was negatively correlated with the use of traditional medicine.

Migration to Urban Areas

Although many tribes were previously nomadic, thousands of Indians were forcibly relocated by the U.S. government to reservations in the western states in the 1800's. In exchange for Indian land, the treaties promised that the U.S. government would always care for the American Indians. This set the stage for a paternalistic government with dependent Indians. The reservation land, often originally undesirable to whites, is tax-free--so long as it is held "in trust" by the government. Food and housing are made available to the poorest families. Health care and education are provided. Depending on each current U.S. administration's philosophy, policies have ranged from genocide attempts (giving American Indians blankets from smallpox patients killed many since the American Indians had no immunity to smallpox) to passivity (Barsh & Henderson, 1980; Townsley & Goldstein, 1977), or an almost forced assimilation with the white culture (Lockhart, 1981). Practicing traditional religions was illegal. Because "religion" was a part of life, and anything vaguely resembling a

"pagan custom" was persecuted as such, there was a loss of much traditional healing. Religious groups "adopted" various tribes, intent on teaching them the "right"--that is, Christian--way. Other government programs managed to interfere with tribal autonomy, although the American Indians were supposed to be "independent nations" within their reservation boundaries (Spicer, 1965). The government was intent upon making their wards "white" (Task Panel Reports, 1978).

The present increase in numbers of American Indians in urban settings is, in part, a result of U.S. government intervention. As a result of World War II, American Indian men entered the military service and women migrated to the cities to help in factories. Upon their return after the war, American Indian men also began migrating to the cities because of their discouragement with the poor economic situation on the reservations (Margon, 1977). The government was also aware that reservations were the poorest communities in the country (Kunitz, 1976); therefore, migration to cities was encouraged by the passage of the Relocation Act of 1952, designed to relocate American Indians from reservations to cities. Assistance was given in employment training and job placement, housing, and how to live in the city (Ablon, 1964, 1971; Martin, 1964; Price, 1968, 1975; Sorkin, 1969). Because many American Indians had never previously spent time in a city, the programs were often confusing and inadequate. While the standard of living in the city was better by white standards, American Indians missed the quiet, clean air, open space, and friendship and kinship ties (Ablon, 1971; Graves, 1974; Price, 1968). Those who stayed in the cities were usually

younger and were better educated prior to migration (Martin, 1964). Although employment continues to be the major attraction in the city, urban Indians still have problems with employment (Ablon, 1971; Borunda & Shore, 1978; Graves, 1974), as well as with marital discord (Attneave, 1982) and the law. Most of the latter problems are alcohol-related (Ablon, 1971; Graves, 1970, 1974; Resnick & Dizmang, 1971).

Graves (1974, 1979) studied Navajo males who moved to Denver. He found that most of them had no previous urban experiences before arriving in the city. The Navajo were given weekly subsistence checks, rooms in boarding houses, and often had only positions of temporary labor. Drinking with other Navajo acquaintances became a common social activity. Those who drank less were usually those who were accompanied by wives and/or found steady jobs. Those unable to find work often returned to the reservation. Graves believed that the Navajo men initially drank because they were not "successful" by white standards (that is, holding a job), rather than that losing their jobs was a result of drinking.

According to Price (1968), the American Indian population of Los Angeles doubled from 1950 to 1960 as a result of the training programs. Of 158 households interviewed, all had come to the city for jobs, more money and a better standard of living. Over time, the frequency of visits to the reservations decreased, but 37% did return to stay. Those who stayed in the city had better fluency in English, were younger, and had gone to a public school (instead of a boarding or mission school), but the levels of education were the same, unlike Martin's (1964)

findings. Price (1968) found that the Navajo portion of the population actually had less arrests and more employment than other tribes interviewed. The American Indians maintained some traditional values, as evidenced by spending more money on travel to and from the reservations and entertainment, compared with whites who spent more on clothing and housing. These American Indians mentioned alcohol and unemployment as major problems.

Another program besides the Relocation Act that encouraged migration and assimilation was the boarding schools. Children would begin to learn traditional values of respect for self, kin, neighbors and the land from relatives on the reservations. At age six, they were often forced to go to schools with children from other tribes, sometimes as far as two-days' drive away from home. Houseparents discouraged the use of native languages (Townsley & Goldstein, 1977). History classes taught of the ignorant, pagan, savage, lazy Indians. American Indian children in all schools tested comparably on standarized tests until about seventh grade, then began to slowly drop below grade level. Eventually, they dropped out of school altogether, having to face not only the identity crisis of adolescence but also of being a minority in a white world (Townsley & Goldstein, 1977). These unskilled youths would then return to the reservations only to find that the value of "ambition" as learned at school clashed with the elders' value of "co-operation" (Hanson, 1980; LaFromboise, 1979). Because of poor employment opportunities and value clashes, the youths would then set out for the cities (Ablon, 1964, 1971; Graves, 1970, 1974; LaFromboise,

1979; Martin, 1964; Roy, 1962; Sorkin, 1969; White & Chadwick, 1972).

Urban Indian Mental Health

Conflicting values. American Indians have always been a transient group. However, some American Indians continue a transient way of life because the city life conflicts with the traditional value of harmony with nature (Westermeyer, 1976). Other values are often in direct opposition to white values. For example, the American Indian's wealth is measured by what he gives away, not accumulates (Attneave, 1982; Hanson, 1980; LaFromboise, 1979). One must help his kin and friends at all costs, and share whatever is available (Ablon, 1971; Hanson, 1980; Red Horse et al, 1978).

Wherever they live, American Indians value special times with special people (LaFromboise, 1979). The difference in this value and that of persons with a white orientation is in the manifestation: American Indians may leave work abruptly for a summer powwow. Because of their present orientation (Attneave, 1982), American Indians may be goal-oriented to save money for a specific purpose and spend it for that purpose, then earn more later with another goal in mind, instead of accumulating money and possessions for longer periods of time (Braroe, 1975). They relate collaterally (Attneave, 1982), making decisions by concensus instead of majority, which often prolongs the decision-making process.

Because American Indians have a network of relatives with whom they can stay for indefinite periods of time without necessarily contributing money, they may move often, knowing that later on the situation may be

reversed (Ablon, 1971; Martin, 1964; Red Horse et al, 1978). This allows for frequent moves within cities and to reservations, not unlike Italians and Blacks (Margon, 1977) and Hispanics (Falicov, 1982) who make periodic visits "back home". The extended family is the American Indians' most valuable asset (Attneave, 1969; Task Panel Reports, 1978).

Frustrations from the poorer standard of living and conflicting values of the white world contribute to American Indians' feelings of inadequacy. Often women find work in the city sooner than men, disrupting family relationships because it is the man's traditional role to be breadwinner (Hanson, 1980; Resnick & Dizmang, 1971). Out of frustration over usurped roles, men become depressed and turn to alcohol, contributing further to family disorganization. Children are sometimes neglected due to adults' inadequate levels of functioning (Resnick & Dizmang, 1971), although it is believed that children would not be neglected if extended family were present (Attneave, 1969; Red Horse et al, 1978). Neglected children often come to the attention of Children's Services Divisions; this may result in American Indian children being placed in white foster homes (Shore, 1978; Westermeyer, 1979). Such events contribute to confused values, promoting the cycle of confused adolescents who quit school and cannot find work, so drink out of boredom and frustration, and neglect their own children.

American Indian adolescents are aware of their families' problems. Maynard (1968) found that many Sioux high school students viewed whites as more trustworthy than Sioux, and thought that Sioux had more problems than whites. The Sioux students blamed poor education and alcohol for

their people's problems; the white students blamed white prejudices and less opportunities available to the Sioux for their problems. This study and Martin's (1978) study emphasize that Sioux students had lower self-esteem than whites.

Some solutions to urban cultural conflicts. In an attempt to recapture the American Indian traditions which had been suppressed by local white authorities, American Indians are now trying to learn about their traditional religions and heritage. Urban "pan-Indian" movements teach urban Indians about traditional practices, borrowing customs from many tribes. Oral histories are passed on by those who remember (Ablon, 1964, Price, 1968, 1981). The pan-Indian movement has the additional effect of expanding the urban Indians' social support systems. Because religion was incorporated into daily living, native ceremonies and healing practices are also being revived (D. Eastman, personal communication, March 13, 1981).

Current alcohol programs for American Indians incorporate traditional practices. Jilek (1974) described the Guardian Spirit Ceremonial which was revived in 1970 among Salish Indians in British Columbia. In this ceremony, which took place every winter, each participant danced in order to renew his bond with the animal that is his guardian. The ceremony included fasting and sensory deprivation prior to the dance, and may have resulted in a naturally-induced altered sense of consciousness. Jilek reported that 21 of the 24 dancers who had previously exhibited symptoms associated with alcohol abuse (depression, anxiety and behavioral problems) improved; only one

dancer's behavior deteriorated. This suggested that the ceremony promoted well-being, although it is unclear from the account what other factors, if any, may have contributed to the decline in symptoms. Jilek suggested that traditional ceremonies be incorporated into alcohol-prevention programs. At least three other urban residential alcohol programs for American Indians incorporated traditional healing practices and teachings (D. Eastman, personal communication, March 13, 1981).

The U.S. government has attempted to increase the number of traditional healers by funding a Navajo apprentice medicine man program, offering stipends to student medicine men while they study traditional Navajo medicine to try to prevent the loss of this skill. Encouraging visits by the medicine men and women to Navajo hospitals, where traditional rituals accompany modern medical practices, assures patients the best of both worlds (Beiser & Attneave, 1978). In support of this approach, the President's Commission on Mental Health recommended the use of traditional medicine (Task Panel Reports, 1978).

Based on the different ways of treating illness (Fuchs & Bashshur, 1975; Liberman & Knigge, 1979; Martin, 1981; Primeaux, 1977), and the past distrust of government programs due to treaty-breaking (Lockhart, 1981), it is not surprising that American Indians would prefer to go to clinics staffed by American Indians (DeGeyndt, 1973). American Indian paraprofessionals are being trained to try to address this staffing preference (Beiser & Attneave, 1978). Sue, Allen and Conaway (1978) found that white mental health staff in Seattle treated all clients of all races similarly, but urban Indians tended to drop out of therapy

sooner than Hispanics and whites. The authors speculated that the urban Indians were dissatisfied with the white-operated services.

More attempts are being made to incorporate American Indian values into mental health approaches. For example, Attneave (1969, 1982) described case histories of working with urban Indian psychiatric patients and their extended families, and pointed out that family therapy works because the families want to be involved in the care of their relatives. Furthermore, some mental health programs are now managed by Indians (Ostendorf & Hammerschleg, 1977).

Lastly, children now have a choice of which schools they can attend: local public, boarding or mission. Families and tribes may influence decisions but no one is presently forced to attend any certain school. The Indian Child Welfare Act encourages placement of American Indian children with trained American Indian foster parents, and adoption by whites is now difficult (W. Standing Bear, personal communication, January 21, 1982).

Summary

Life for pre-contact American Indians, and for some present-day reservation American Indians, was and continues to be quite different from modern urban life. The transition from the rural reservation with distinctly-defined roles for each member of the extended family to a crowded city with strangers and unclear role definitions has been difficult. Many American Indians have only come to the cities in recent decades; and many of those who have lived in cities for years may have been raised traditionally. Since American Indians' cultural values were

often not compatible with those of the dominant culture, confusion and frustrations occurred as American Indians tried to adapt to the city and white cultural values. Mental health problems among urban Indians have been one outcome of unsuccessful attempts to cope with these stressors and conflicts. Overcoming mental health problems, such as depression and alcoholism, will require an understanding of traditional American Indian values and health practices and incorporating them into relevant mental health strategies and programs for this population.

Conceptual Framework

Concepts from Role Theory

Role theory assumes that man is a social being, interacting with other men, and that behavior has purpose (Meleis, 1975). Role is defined as the pattern of behavior expected of persons who occupy a certain status (position) within the community (Deutsch & Kraus, 1965; Gordon, 1966; LaRocca, 1978). Role expectations of the dominant society are clarified by a person's social support system (Norbeck, 1981).

The role path (Hanson & Simmons, 1968) is a particularly useful concept for describing adaptation to city life by rural people. The adjustment to the new life in the city depends on one's socialization experiences. The newcomer must deal with the problem of uprooting as well as adjusting (Giordano, 1976). The process of urbanization requires that an individual acquire a new set of role prescriptions to deal with his new status. Tracing the experiences of the newcomers allows the observer to study the acquisition of new city roles. In an urban area, extended family may be miles away, and the city congestion

forces one to deal with strangers with less clearly-defined norms in common (Caplan, 1974). Following an urban dweller during the day would allow the observer to note many role changes depending on the situation and persons present: neighbor, worker, consumer, budgeter, friend, parent, spouse. The rural dweller might change roles according to situation demands, but the urban newcomer forms a new network of interpersonal relations different from those of the rural area (Hanson & Simmons, 1968). The role paths of those successfully adjusting to city life and those not adapting may differ.

According to Meleis (1975), role transitions require processing new knowledge, changing behavior, and thereby changing the definition of self in the social context. Since no role exists without a counterrole, changes in one role require adjustment in the counterrole. When definitions and role norms are not shared and supported by all members of the society, role enactment problems are seen, resulting in dysfunctional role transition. This causes role insufficiency, that is, difficulty in performing a role due to incongruity between role behavior and expectations, or incongruency of self-concept and role expectations as defined by self or others. When one perceives conflicting expectations, symptoms of role conflict emerge (LaRocca, 1978).

The absence of well-defined, familiar, tribal norms may cause adjustment problems for urban Indians (Margon, 1977). When urban Indians face conflicting values between their traditional culture and those of the dominant, white society, different expectations of behavior may occur, resulting in role conflict and insufficiency. These, in

turn, may contribute to mental health problems, such as, anxiety, depression and substance abuse.

Concept of Social Support Systems

A social support system offers feedback for behavior by setting expectations, evaluating, supporting, assisting, and rewarding. It provides counterroles involving reciprocal actions between persons, since the exchange process and ratio of rewards and punishments influence the development of role behavior (Meleis, 1975). Caplan (1974) stresses that supportive people share tasks and offer guidance, thus mobilizing resources. Social support also serves as a buffer against stress (Dean & Lin, 1977; Kahn & Antonucci, 1980). Persons who have a functioning social support system may be able to handle stress better than those who do not, since they do not have to deal with stressful events entirely alone. However, there is lack of agreement on exactly what is seen by the client as social support and how it buffers against stress (Gottlieb, 1981; Norbeck, Lindsey & Carrieri, 1981).

Mitchell and Trickett (1980) noted characteristics useful in analyzing social support systems. Size is defined as the number of individuals with whom a person has contact. Frequency measures how often a person makes any sort of contact (face-to-face, phone, letter) with the individual. Intensity pertains to feelings toward each member in the system. Durability refers to length of time the person has known each individual. Multi-dimensionality refers to the number of functions served by each relationship. Reciprocity refers to a give-and-take relationship with the other. Dispersion refers to geographical

proximity of each individual, indicating how easy it is to make contact. The normative context of a relationship defines how one is related to each individual: primary kin, secondary kin (extended family), friends, neighbors, co-workers, teammates, others. The role path is another concept that may be helpful in describing the network of role relations and counter-positions (Hanson & Simmons, 1968) within the social support system.

Norbeck's (1981) model for social support demonstrates the utilization of the concept of social support systems in clinical practice. The demographic properties of the person, and the properties of the situation (for example, role demands and resources) determine the need for social support. The actual social support available is then assessed as well as the individual's skills for acquiring and maintaining the system. Norbeck believes that if, after assessment, the social support system appears to be adequate then there is a greater possibility for positive outcome in crisis; if it is inadequate, intervention is indicated. Additionally, the value of the social support system to the individual must be assessed: some "support" may actually be perceived by others as control (Kahn & Antonucci, 1980).

Vaux (1985) reviewed ethnic literature on social support systems and found variations across groups (Anglos, Hispanics, Asians) with regards to kind, amount and satisfaction with social support systems. Such variation implies that different ethnic groups utilize social support system members differently. Wise (1982) studied social support systems and mental health among urban Indians, using 74 female and 14

male parents of schizophrenic children for his sample. The 90-minute survey interviews covered the subjects' mental statuses, feelings of well-being, and nature and extent of social support systems. He compared the scores from the 20-item symptom checklist with the numbers and sources of "help", and compared these scores with national survey data from 1977-78. The urban Indian sample showed increased psychological and physical distress, increased alienation, and a decreased number of informal social support system members. Disorganized families were evident in half of the subjects.

Concept of Residual Persistence

Residual persistence is defined by Hanson (1980) as the persistence of traditional cultural practices. Despite earlier years of persecution by whites, these practices persist because the elders have passed them on via oral histories. Residual persistence is seen by many authors (Gordon, 1964; Jacoby, 1956; Roy, 1962) as being at one end of a continuum of acculturation with assimilation at the other end. However, McFee (1968) argues that some assimilated Indians continue traditional practices, and hence, residual persistence and assimilation are separate and not opposite ends of acculturation as an unidimensional, bipolar concept.

The following definitions of acculturation and assimilation have been adapted from Jacoby (1956) and Gordon (1964). Acculturation is the process of adopting traits of the dominant society. Since American Indians are now a minority, it is assumed that they adopt white traits, not the reverse. Assimilation is the total engulfment (including

acceptance of norms, statuses and roles) of the minority culture by the dominant society such that they become one in the major, dominant society. Thus, acculturation includes degrees of assimilation. A group may possess some traits of the major society without total immersion in that society. Jacoby (1956) stated that assimilation has three steps after two groups initially meet: first, the minority group experiments with trying customs of the other, for example, clothing, language, manners, beliefs, food; next, they mingle socially in clubs; third, families unite and intermarry (amalgamation). Wagner (1976) studied the role of interracial marriages in acculturation of urban Indian women, and concluded that interracial marriages occur as a result of role models and some degree of asssimilation. After studying urban Indians who had spent time in white foster care, Westermeyer (1979) concluded that ethnic affiliations are a result of learned behavior not inheritance. Other researchers (Chadwick & Strauss, 1975; Roy, 1962; White & Chadwick, 1972) have found that assimilation does not occur in the neat, step-wise fashion Jacoby (1956) described. Instead, no set order for total assimilation to occur exists, and it occurs infrequently.

Gordon (1964) proposed a model which offers a good description of types of assimilation that can occur. While he predicted that total assimilation would occur after structural assimilation occurs, Chadwick and Strauss (1975) found that one or more components of the model could occur in any order. This model is not viewed as a continuum. (See Appendix A.)

Each level of this model can be measured, as described by Chadwick and Strauss (1975). Cultural or behavioral assimilation can be measured by asking subjects about educational attainment, occupation, religious preference, ability to speak a native language, and attendance at powwows. Structural assimilation notes the extent of social interaction with the members of the dominant group. Marital assimilation is defined as marriage to a white, or members of the family married to a white person. Identificational assimilation is associated with the individaul feeling as if he were white. Attitude receptional assimilation is associated with stereotypes, such as laziness, drunkenness, and the resulting social distance with members of the dominant group. Behavior receptional assimilation occurs if one does not feel discriminated against by people in power, such as, social services, police. Civic assimilation indicates that the minority group is willing to engage in civil activities, including protesting, thus suggesting that the minority group believes it can succeed in the majority's legal system.

Because many Indians desire to keep in contact with their native heritage, full asssimilation into white culture has not occurred (Chadwick & Strauss, 1975; Roy, 1962; White & Chadwick, 1972). Roy (1962) applied Jacoby's (1956) three steps of assimilation (adoption of some traits, social integration, and amalgamation) with 40 Spokane Indian families on the reservation. He compared this rural sample with norms of 620 local white families for education, level of living, occupation. The Spokane Indians approached a standard of living similar to whites, but had not attained the white's standard. The Spokane

Indians were not members of many white social groups; the distance from the city may have discouraged this. The Spokane Indians held a greater number of public offices on the reservation only. The average blood quantum (percent of Indian blood, based on one's ancestry) among Spokane males was 55% and 59% for females; thus intermarriages must have taken place. This study indicates that amalgamation occurred, but the other two steps did not occur to any great extent.

White and Chadwick (1972) used Jacoby's (1956) model to study randomly-selected adult Spokane Indians: 48 lived on the reservation and 39 in the city of Spokane but were enrolled in the tribe. Subjects were asked if they felt more "white" or "Indian", and if they were more comfortable with Indians or whites. Responses did not correlate with either educational level or work regularity. Fifty-five percent of the Spokane subjects interviewed identified themselves as Indians, 31% as whites, and 14% were uncertain. Identification with whites was found among Spokane women married to whites. Urban residence contributed to a greater frequency of white identification. The Spokane subjects who felt accepted by whites through amalgamation or social integration also identified with whites.

Chadwick and Strauss (1975) used Gordon's model to study assimilation of 134 randomly-selected urban Indians living in Seattle in order to examine the types and extent of assimilation, and if greater levels of assimilation occur after individuals had lived in the city for a number of years. They also wanted to see if structural assimilation correlated with the six other types of assimilation. The results stated

that many of the 248 randomly-selected white subjects were not openly prejudiced and supported the American Indians' rights to traditional cultural practices. Many urban Indians supported assimilation, and were structurally assimilated in varying degrees. They also complained of being victims of discrimination. The degree of assimilation did not correlate with time spent in the city; some reservation-born Indians felt asssimilated and some urban-born continued cultural practices, concurring with McFee's (1968) study. Subjects were not identified by tribe, which may have correlated with the degree of assimilation. This study agreed with Fuchs and Bashshur (1975) and Liberman and Knigge (1979) in that programs are needed to preserve traditional American Indian cultural practices in order to instill pride in their heritage.

Boyce and Boyce (1983) measured the assimilation levels of Navajo boarding school students on two scales and found that students were more likely to be ill when the scores from the scales were incongruent. This study suggests that varying degrees of types of assimilation may cause confusion and result in physical or emotional illness.

Summary

Role theory notes that an individual behaves according to his interpretations of the norms of his dominant culture. A minority group in the dominant culture would need knowledge of dominant culture expectations in order to comfortably perform roles required of that society. How assimilated one is into that society affects one's knowledge of and comfort with those expectations. Social support systems are useful because they provide feedback to an individual, thus

enabling one to adjust his role performance. Role conflict may prevent one from forming a social support system; however, inadequate social support may prevent one from using feedback to meet role expectations. Thus, role insufficiency or conflict may increase the stress on the individual. If an adequate social support system is not available to buffer stress, the result may be symptoms of emotional distress, for example, depression, marital problems, alcoholism, anxiety.

Urban Indians may have varying degrees of social support readily available to them and may be assimilated to varying degrees. How do these factors affect mental health? What distinguishes urban Indians who use mental health services to assist in coping from those urban Indians who do not use mental health services? The literature lacks conclusive research. There are no studies comparing residual persistence (i.e., the continued persistence of traditional cultural practices) and social support systems of urban Indians utilizing mental health services of an urban Indian center with urban Indians who do not utilize the mental health services of such a center.

Research Questions

Based on the above concepts, the following research questions were posed:

1. Do demographic variables differ for urban Indian mental health clients compared with urban Indians who are not utilizing those services?

2. Do the characteristics of social support systems differ for urban Indian mental health clients compared with urban Indians who are

not utilizing those services?

3. Does residual persistence differ for urban Indian mental health clients as compared with urban Indians who are not utilizing those services?

4. Is there a relationship between the characteristics of size of and frequency of contact with social support systems and the degree of residual persistence for either group of urban Indians?

CHAPTER 3

Methods

This chapter describes the design, setting, sample, instrument, data collection procedure, scale construction, data analysis, and human subjects' considerations of this study. This descriptive study entailed a secondary analysis of data from a larger survey study (Ryan, 1982) conducted with urban Indians who utilized a mental health clinic, and urban Indians who did not utilize the mental health clinic but utilized other services offered by the urban Indian agency.

Setting

The only urban Indian agency in a major Northwest city was utilized to obtain volunteer subjects. This agency offered the following services: legal aid, employment (day labor), social services, and health clinic. The clinic had three programs: primary health care, dental health, and mental health. The primary care and dental clients were self-referred, and usually made appointments, although walk-ins were seen for urgent problems.

The mental health program was arranged similarly to other outpatient mental health clinics in the city. Clients were referred by self or others, and made appointments for psychiatric evaluations and therapy sessions (individual, family, and/or group). Psychotropic medications were available as needed, as were home visits and twenty-four hour crisis intervention. This program differed from other outpatient mental health clinics in the city in that it had an American Indian supervisor, and attempted to offer services that were specific to

the needs of urban Indians. Therapy approaches addressed individuals' needs, but there were no preventive programs offered at the clinic to enhance mental health.

This clinic attracted clients who had little or no income. The clinic did third-party billings to insurance companies and Medicaid; other clients were charged a sliding-scale fee. Most of the clinic funding depended on two federal grants.

Design

The original study (Ryan, 1982) was a survey designed to assess the needs of a convenience sample of urban Indians utilizing the urban Indian agency. The study conducted by this author was a secondary analysis of data from the original survey. It focused on describing the socio-demographic characteristics, systems of social support, and the degree of residual persistence of two groups of urban Indians utilizing service of the agency. There was no manipulation of independent variables.

Sample

The mental health subjects for the original study were urban Indian clients who came to the mental health clinic before or during March-June, 1982, and were recruited to participate in the study. The comparison group subjects were recruited from the American Indian population who utilized the primary health care, dental, day-labor or social services during that same time period. All potential subjects were offered a $5 gratuity to complete the survey interview. If persons from either group agreed to be subjects, they made an appointment to be

interviewed at a time agreeable to them and a research assistant. Only clients over the age of 18 were asked to be subjects. No information was gathered on those who refused to participate, so no comparisons were possible to determine if they differed in any way from those who agreed to participate. No one was denied access to any services if he/she refused to be a subject. This selection of subjects resulted in a non-probability convenience sample of two groups: mental health clients (n=30), and other agency clients (n=36) hereafter referred to as "comparison group subjects", who had not utilized any mental health services anywhere in the city.

Data Collection Instrument

The tool. A structured interview guide, American Indian Survey Interview (see Appendices B & C), was developed by the principle investigators of the original study to be used with any rural or urban Indian population. The interview guide assesses the relevant life experiences of American Indians in order to predict and handle their specific problems. The goal of this tool is to identify what barriers interfere with optimal functioning of American Indians (L.M. Ryan, personal communication, November 9, 1981).

The interview guide covers demographic data, as well as other variables: residual persistence, social support systems (natural and contrived), and risk factors for mental health problems (violence, substance abuse, parenting, and family planning data). The total interview guide consists of 188 questions.

Instrument validity. The interview guide, American Indian Survey

Interview, was developed as follows. Consultation took place with a consultant from the sociology department of a local university, the staff of the National Center of American Indian/Alaskan Native Mental Health Research, and the clinic mental health staff. They critiqued the developing interview guide in great detail. In this manner, face validity was established. The interview guide was pre-tested with volunteers from the urban Indian community who had not utilized the mental health services, and revised as necessary (L.M. Ryan, personal communication, February 26, 1982).

Procedure

The American Indian Survey Interview was administered to subjects as an interview and took one to two hours for each subject to complete. Some mental health subjects were interviewed by their therapists; other mental health subjects and comparison group subjects were interviewed by trained undergraduate or graduate nursing students, and were seen by whomever was available at that time. Thus, subjects were assigned an interviewer by convenience. All questions were read to the subjects open-ended, and their responses noted by the interviewer. The subjects were not offered the choices that appeared on the interview guide; these were merely to facilitate coding later. Subjects were paid $5 after completing the interview.

The study undertaken by this researcher, entailing a secondary analysis of the survey data, examined responses to selected questions from the interview pertaining to the research questions. Only the interview questions used in this study appear in Appendix C.

Construction of scales for independent variables

After data collection and coding for the major study were completed, scales were constructed using interview guide survey items that related to the independent variables of social support systems and residual persistence.

Measurement of Social Support Systems. In this study, social support system is defined by two variables, size and frequency of contact. Size is defined as the number of individuals in one's social support system with whom the subject has contact. To measure the size of social support systems, 13 ratio-level subscales were constructed from items related to the number of friends and relatives identified by subjects as members in their social support system. A total of 9 items from the interview guide were used to construct these subscales (Appendix D). Scores could range from 0 to 999.

Frequency of contact measures how often the subject is in contact with each individual in one's social support system. Thirty-six ordinal-level "frequency of contact" items were recoded from items from the interview guide related to contacts through visits, telephone calls and letters with friends and relatives identified by subjects as members of their social support systems (Appendix E). Answers were recoded to form scale items such that 7=most frequent amount of contacts and 1=least frequent contact. In coding the individual members of the social support system, the first-mentioned individual was designated as "one". Thus, whomever the subject mentioned first would have been considered "sister 1" or "brother 1" and so on. Because members were

not necessarily mentioned in the order of frequency of contact, they were neither coded nor compared in that order but rather in the order chosen by the subjects. Frequency of contact was compared for only one mother and father, two sisters and brothers, three Indian relatives and friends, because less than half of the subjects were in contact with any additional members. The scores ranged from 1.00-7.00.

Additionally, six total contact ordinal-level subscales were constructed to measure frequency of contact: total visits with all of the family, total calls with all of the family, total visits with Indian friends, total calls with Indian friends, total visits with non-Indian friends, and total calls with non-Indian friends (Appendix F). The item scores were averaged so subscale scores ranged from 1.00-7.00.

Neither size nor frequency of contact social support subscales was tested for internal consistency because it was not anticipated that they would be consistent since each member of the social support system was individual and not dependent upon the activities of other members.

Measurement of Residual Persistence. Residual persistence is defined as the persistence of traditional cultural practices (Hanson, 1980). Two interval-level scales were constructed to measure residual persistence. The "Non-controlled traditional cultural practices" scale consisted of affirmative responses to ten dichotomous survey questions concerning life experiences that involved traditional cultural practices (e.g., subject given an Indian name) over which the subject had no control; that is, fate or guardians determined these experiences for the subject (Appendix G). The item scores were averaged and ranged from 0-

1.00. The internal consistency of this scale was found to have an alpha coefficient of .79. The "Controlled traditional cultural practices" scale consisted of affirmative responses to seven dichotomous survey questions concerning life experiences that involved traditional cultural practices (e.g., subject went to a native healer) over which the subject had a choice (Appendix H). The item scores were averaged and ranged from 0-1.00. The internal consistency for this scale was found to have an alpha coefficient of .73.

To further compare the two groups on residual persistence, responses to four additional interview questions were used to form four ordinal scales. The first is the "Indian response" scale. Interview question 46 asked how the subject thought other Indians responded to him (5 being very positively and 1 being very negatively). The higher end of the scale was interpreted as residual persistence. The second was called the "Non-Indian response" scale. Interview question 47 asked how the subject thought non-Indians responded to him (5 being very positively and 1 being very negatively). The higher end of the scale was interpreted as assimilation. The next scale was called "Comfort with Indians". Interview question 48 pertained to whether the subject felt more comfortable with Indians (3), both (2), or non-Indians (1). It was recoded such that high scores (3) were interpreted as residual persistence. The final scale was called "Census response". Interview question 49 referred to how the subject responded to the 1980 census. Those who did not complete the census were assigned a score of 1 because White and Chadwick (1972) found that more traditional people did not

complete government forms. Those who responded that they checked "Indian" were assigned a score of 2, and those who responded that they did not indicate Indian were assigned a score of 3. A higher scale score was interpreted as assimilation.

Data Analysis

To answer research question one, "Do demographic variables differ for urban Indian mental health clients compared with urban Indians who are not utilizing those services?", variables were compared for the two groups using frequencies, ranges and, when appropriate, measures of central tendency. The Chi Square statistic was chosen to test for homogeneity of variance of categorical data from the two groups' demographic characteristics: sex (interview question 2), age (interview question 3), marital status (interview question 4), education (interview question 7), work doing (interview question 9), household income (interview question 16), and religion (interview question 45). Significance level was set at $p < .05$, two-tailed.

To answer research question two, "Do the characteristics of social support systems differ for urban Indian mental health clients compared with urban Indians who are not utilizing those services?", the network properties of "size" and "frequency of contact" were examined because there were sufficient numbers of items from the interview guide with which to construct scales, and because these were found by Mitchell and Trickett (1980) and Norbeck, Lindsey and Carrieri (1981) to be important properties of a social support system. Student's t-tests were used to analyze differences between the two groups on 13 size subscales, and on

36 items and six frequency of contact subscales. This statistic was chosen because it determines if differences between the means of the two groups are due to chance or true differences. Two-tailed results were examined because no direction was predicted in the research question. Significance level was set at $p \leq .05$.

To answer research question three, "Does residual persistence differ for urban Indian mental health clients as compared with urban Indians who are not utilizing those services?", the means of the scores on the six scales (Controlled traditional cultural practices, Non-controlled traditional cultural practices, Indian response, Non-Indian response, Comfort with Indians and Census response) were compared between the two groups using two-tailed Student's t-test, with accepted significance set at $p \leq .05$.

To answer research question four, "Is there a relationship between the characteristics of size and frequency of contact with social support systems and the degree of residual persistence for either group of urban Indians?", scores on the six residual persistence scales were correlated with scores from the social support system size subscales and total contact subscales using the Pearson Product-Movement Correlation Coefficient statistic. This statistic tests for magnitude and direction of relationships existing between two sets of continuous data. Scores for the mental health and comparison groups were correlated separately in order to see if significant relationships existed between residual persistence and social support systems aspects for each group.

Human Subjects Considerations

Approval for the major study (American Indian Survey Interview) was obtained from the agency's Health Advisory Committee and the Urban Indian General Council. The research committees at the regional offices for the two federal grants, Urban Health Initiative and Indian Health Service, who funded most of the clinic expenses, also approved the study and the interview schedule. The Oregon Health Sciences University Human Subjects Committee approved the protocol for the author's Master's Thesis.

Each subject signed a consent form (Appendix I), which was removed from the rest of the interview schedule immediately to insure anonymity. Each page of the interview schedule had a subject number listed; however, the consent forms were not numbered or identified in any way. All completed interview schedules were kept in a locked file in a separate drawer from the signed consent forms. All interview schedules and consent forms were destroyed after the data analysis was completed. All results were reported in such a manner as to insure anonymity of subjects.

The only risk to each subject was the possible discomfort from answering some personal questions. A direct benefit to each subject was the $5 paid to volunteer subjects in this study. In the future, subjects may benefit from new mental health approaches and services to the urban Indian community.

CHAPTER 4

Results

This chapter presents the findings of the data analysis. The results for each research question are discussed separately.

Findings for Research Question One: Demographic Characteristics

To answer research question one, "Do demographic variables differ for urban Indian mental health clients compared with urban Indians who are not utilizing those services?", demographic characteristics (gender, age, education, income, marital status, occupation and religion) were examined for frequencies, and, when appropriate, means and ranges. The Chi Square statistic was used for group comparisons.

Gender. The majority of the mental health subjects were female (67%) while the majority of the comparison group were male (58%). (See Table 1.) There was a significant difference between the two groups: $\chi^2(1, N = 66) = 4.11, p < .04$.

Table 1

Gender of Mental Health and Comparison Subjects by Percentage

Sex	Mental health		Comparison group		Total	
	n	%	n	%	n	%
Female	20	67	15	42	35	53
Male	10	33	21	58	31	47

Age. The ages of the respondents ranged from 18-83; mean age was 43 years and median age was 31. The age range for mental health subjects was 19-56 with a mean age of 31; the range for comparison group subjects was 18-83 with a mean age of 35. The majority of both groups of subjects were in the 18-39 years of age range. The two groups did not differ significantly on age: $\chi^2(3, N = 66) = 6.6, p < .09$.

Education. The education of the respondents ranged from 6 to 16

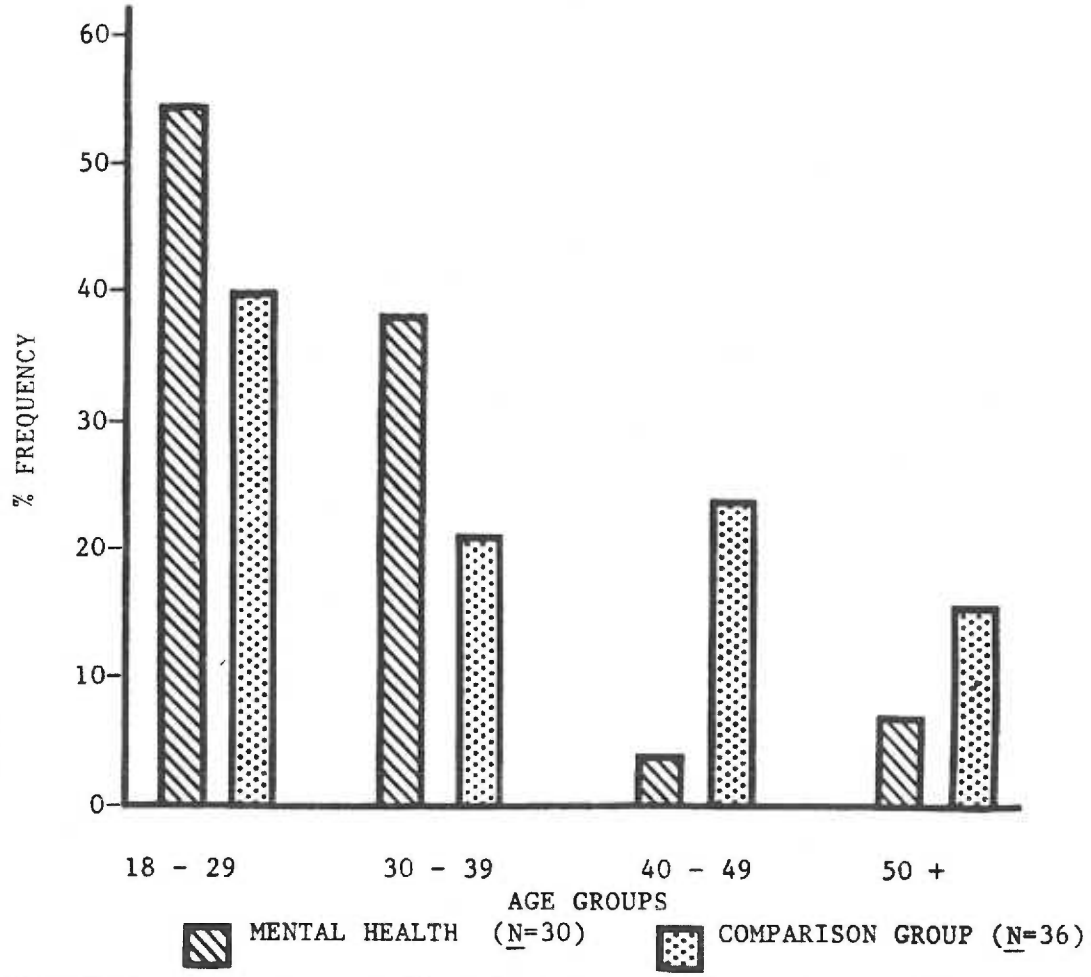

Figure 1. Percentage of Mental Health and Comparison Subjects by Age Groupings.

years of formal schooling with a mean of 11.6 years and median of 11.7. The range for mental health subjects was 8 to 16 years with a mean of 11.6 years; the comparison group subjects ranged from 6 to 16 years of education with a mean of 11.7. The majority of mental health subjects had a high school education while an equal proportion of the comparison group subjects had completed high school and some college. There was no significant difference between groups on education: $\chi^2(2, N = 63) = 2.29$, $p < .32$. (See Figure 2.)

Income. The income of the households of the subjects in both groups ranged from less than $200 a month to over $800 a month. The mean was

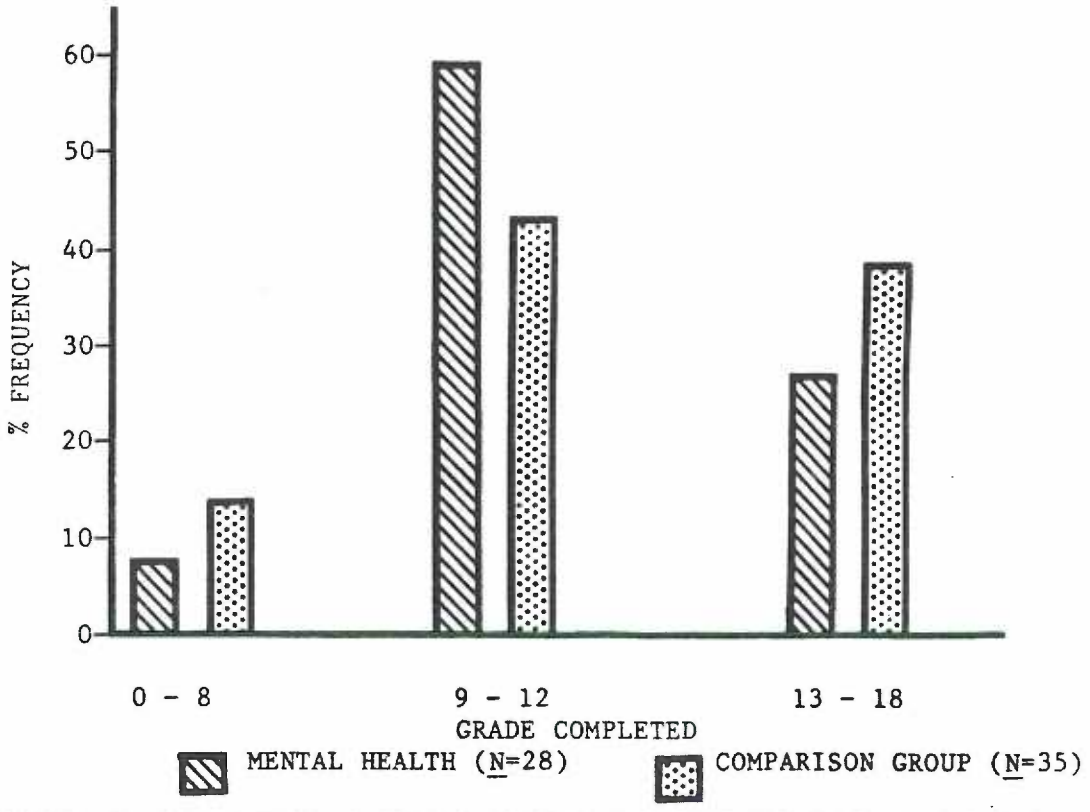

Figure 2. Percentage of Mental Health and Comparison Subjects by Educational Level.

$350 a month for mental health subjects and $390 a month for comparison group subjects. There was no significant difference between groups on income: $\chi^2(4, N = 62) = 2.8, p < .59$. (See Figure 3.)

Marital Status. Subjects' marital statuses varied. The mean number of marriages for the entire sample was 0.96, with a range of 0 to 6. Of the 25 subjects who had been divorced, the majority (n=22) had been divorced once, two subjects had been divorced twice and one subject six times. The majority of subjects from the mental health group did not currently have a partner, while the majority of comparison group

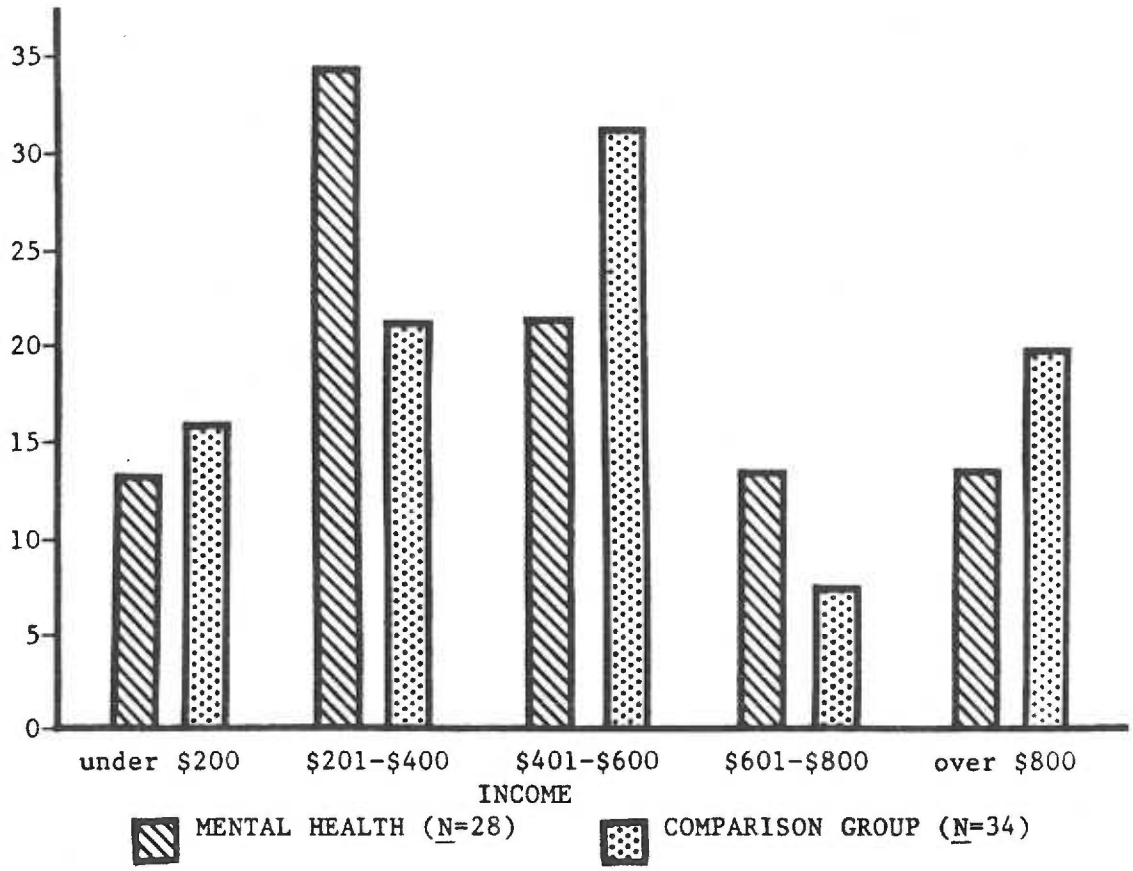

Figure 3. Percentage of Mental Health and Comparison Subjects by Monthly Household Income Level.

subjects did. However, there was no significant difference between groups on this characteristic: $\chi^2(2, N = 66) = 2.10, p < .35$. (See Table 2.)

Table 2

Marital Status of Mental Health and Comparison Subjects by Percentage

Marital status	Mental health		Comparison group		Total	
	n	%	n	%	n	%
With partner	13	43	22	62	35	53
Single	8	27	7	19	15	23
Lost partner	9	30	7	19	16	24

Occupation. The categories of work in which the subjects were currently engaged differed from the categories of work usually held by subjects (see Table 3). Unemployment for the 37 (56%) unemployed subjects across both groups (who chose to respond to the question regarding length of unemployment) ranged from 1 to 77 months, with a mean of 22.5 months. Nineteen (29%) of the subjects worked, 11 (17%) were students, and one held a job as well as being a student. The two groups did not differ significantly on work: $\chi^2(1, N = 65) = 1.45, p < .23$.

Religious affiliations. Subjects' religious affiliation was predominantly Christian (see Table 4). Only 12 subjects (17%) practiced a traditional religion: 4 (6%) were members of the Native American

Table 3

Categories of Work in which Mental Health and Comparison Subjects Engaged

Category of work	Mental health		Comparison group		Total	
	n	%	n	%	n	%
Unemployed						
Current	23	76	22	63	45	68
Usual	5	17	1	3	6	9
Unskilled						
Current	3	10	5	14	8	12
Usual	9	30	16	14	25	38
Semiskilled						
Current	2	7	4	11	6	9
Usual	5	17	10	28	15	23
Clerical						
Current	2	7	3	9	5	8
Usual	6	20	3	8	9	13
Paraprofessional						
Current	0	0	1	3	1	2
Usual	4	13	5	15	9	13
Professional						
Current	0	0	0	0	0	0
Usual	1	3	1	3	2	3

Church (which originated in Southwestern U.S. and now incorporates the pan-Indian peyote ceremonies), and 2 (3%) were Shakers (the Northwest Indian version incorporates traditional practices); the other subjects did not specify a name for their traditional religion. There was no significant difference between groups on this characteristic: $\chi^2(2, N = 66) = .17$, $p < .92$.

Table 4

Religious Affiliation of Mental Health and Comparison Subjects

Religion	Mental Health		Comparison Group		Total	
	n	%	n	%	n	%
Christianity	17	57	19	53	36	55
Traditional	6	20	6	17	12	18
No preference	7	23	11	30	18	27

Summary. The typical profile of an urban Indian using the services of the agency in this study was a 34-year-old Christian married unemployed female with an eleventh grade education earning between $200 and $400 a month. The typical mental health subject was a 31-year-old Christian unemployed female with at least an eleventh grade education earning between $200 and $400 a month and without a current partner. The typical comparison group subject was a 36-year-old Christian unemployed male with at least an eleventh grade education earning between $200 and $400 a month and living with a partner.

The two groups differed signficantly on gender in that a larger portion of the mental health subjects was female and a larger portion of the comparison group subjects was male. Although not statistically significant, another noticeable difference was in marital status: more mental health subjects were without a current partner than comparison group subjects. Another difference was in the nature of employment, although again no statistically significant differences were found. According to self-reports, comparison group subjects usually worked more often than did mental health subjects, and at higher skilled jobs.

Findings for Research Question Two: Social Support Systems

To answer research question two, "Do the characteristics of social support systems differ for urban Indian mental health clients compared with urban Indians who are not utilizing those services?", measures of central tendency were examined for selected size characteristics and for frequency of contact variables.

Size. When the means of size characteristics were compared using Student's t-tests, no significant differences were found between the two groups for size of family (Table 5) or number of friends (Table 6). However, a trend toward larger social support systems among comparison group members versus mental health subjects was found. In general, both groups had slightly larger non-Indian families than Indian families, but had more Indian siblings, grandparents and distant relatives than non-Indian siblings, grandparents and distant relatives. Since parents were not analyzed separately for being Indian or non-Indian, this may account for the larger non-Indian families found.

The mean size for total extended family was 124.7 for both groups combined. The median of 30 is probably a more accurate measure of central tendency since three subjects reported over 500 members each.

Table 5

Mean Family Size of Mental Health and Comparison Groups

	Mean number of members			
Size characteristic	MH	CG	t-value	p-value
Number in Indian family	7.2	8.2	-1.31	.32
Number in non-Indian family	7.5	8.5	-0.97	.31
Number siblings	3.8	4.7	-1.22	.23
Number Indian siblings	3.5	4.5	-1.15	.26
Number non-Indian siblings	.23	.25	-0.10	.92
Number parents	1.7	1.4	0.75	.45
Number grandparents	.43	.47	-0.16	.87
Number Indian grandparents	.33	.44	-0.49	.63
Number non-Indian grandparents	.10	.03	0.75	.46
Number uncles, aunts, cousins[a]	4.8	5.7	-	-
Number Indian u, a, c	3.8	4.7	-	-
Number non-Indian u, a, c	1.0	1.0	-	-
Number children	1.7	1.9	-0.46	.65

[a]T-tests were not computed for this variable. The group values are presented for visual inspection.

Table 6

Mean Number of Friends of Mental Health and Comparison Groups

	Mean number of members			
Size characteristic	MH	CG	t-value	p-value
Total friends	5.7	7.4	-1.60	.12
Total Indian friends	2.8	3.6	-1.31	.20
Total non-Indian friends	3.0	3.6	-0.97	.33

The mean for number of extended family members with whom subjects felt close was 19.8 for both groups combined. The median of 7.8 is a more accurate measure of central tendency as four subjects reported being close with over 100 members each.

Twenty-two percent of the comparison group subjects still had at least one grandparent living (14% had two grandparents) whereas only 17% of the mental health subjects had at least one grandparent. The mental health subjects had more living parents and non-Indian grandparents than did the comparison group subjects. Otherwise, the comparison group had more living members from their families of origin, including extended families. The comparison group subjects also had more children than did the mental health subjects.

The mental health subjects had slightly more non-Indian friends than Indian friends. The comparison group subjects had the same number of Indian and non-Indian friends, and more total friends than did mental health subjects.

Frequency of contact. The two groups were next compared on 34 frequency of contact items[1] and 6 frequency of contact subscales. Because the data was collected using ordinal categories, measures of central tendency are estimated, with a range of one (least often) to seven (most often). For example, total family visits ranged from never (least often) to weekly (most often), with an average of 2-5 times a year (for a mean score of 3.3).

There were no significant differences between the two groups on the six total contact subscales (see Table 7), although calls to non-Indian friends approached significance. The means for total family visits for both groups fall in the category of 2-5 times a year, as do the frequency of phone calls with all family members, with mental health subjects maintaining slightly more contact with family than comparison group subjects. Total visits to Indian friends were once a month for mental health subjects and about twice a month for comparison group subjects. The number of phone calls with Indian friends was 1-2 times a year for mental health subjects and about 5 times a year for comparison group subjects. The frequency of visits with non-Indian friends was approximately once a month for both groups. The frequency of phone calls with non-Indian friends was approximately 2-5 times a year for mental health subjects and 6-8 times a year for comparison group subjects. Thus, comparison group subjects communicated with all friends

[1]Two frequency of contact items were accidentally omitted from the analysis (letters with Indian relative 1 and letters with Indian friend 3), so only 34 results are reported here.

Table 7

Comparison of Mental Health and Comparison Groups on Total Contacts

	Scale Mean			
Frequency characteristic	MH	CG	t-value	p-value
Total family visits	3.3	3.1	0.67	.51
Total family calls	3.1	3.0	0.26	.79
Total Indian friend visits	5.1	5.7	-1.26	.21
Total Indian friend calls	2.8	3.9	-1.69	.10
Total non-Indian friend visits	4.9	5.2	-0.76	.45
Total non-Indian friend calls	3.0	4.2	-1.96	.06

somewhat more often than did mental health subjects.

Table 8 reports the comparisons of means between the two groups on the 34 frequency of contact items. There were significant differences between the two groups on only two items: calls with Indian friend 1, t (10) = -2.57, $p < .02$; and letters with sister 1, t (13) = -5.00, $p < .000$. In both cases, comparison group subjects had more contacts than mental health subjects. Except for two frequency of contact items with Indian friends (letters with Indian friend 2 and visits with Indian friend 3), the comparison group showed a trend toward more frequent contacts with friends through all three modes (visits, calls, letters) than mental health subjects.

The frequency of contact with family was evenly divided between the two groups. Comparison group subjects tended to maintain more frequent

Table 8

Comparison of Mental Health and Comparison Groups on Frequency of Contact

	Scale Mean			
Frequency characteristic	MH	CG	t-value	p-value
visits with mother	4.1	3.4	1.32	.20
calls with mother	4.3	4.5	-0.53	.60
letters with mother	3.2	3.7	-0.81	.43
visits with father	2.9	3.1	-0.30	.77
calls with father	3.8	3.8	-0.02	.98
letters with father	3.2	3.6	-0.52	.61
visits with sister 1	2.8	2.5	0.41	.68
calls with sister 1	3.4	3.7	-0.35	.73
letters with sister 1	1.7	4.3	-5.00	.00**
visits with sister 2	3.3	2.2	1.51	.14
calls with sister 2	3.6	2.9	0.67	.52
letters with sister 2	1.7	3.8	-1.81	.13
visits with brother 1	3.1	2.2	1.30	.20
calls with brother 1	3.6	3.2	0.46	.65
letters with brother 1	2.8	2.4	0.34	.74
visits with brother 2	2.2	2.1	0.14	.88
calls with brother 2	2.3	2.8	-0.32	.76
letters with brother 2	5.0	3.3	1.27	.26
visits with Indian relative 1	2.4	3.0	-0.76	.46
calls with Indian relative 1	3.3	4.1	-0.82	.43
visits with Indian relative 2	2.9	2.4	0.75	.46
calls with Indian relative 2	4.7	3.7	1.02	.33
letters with Indian relative 2	3.0	3.6	-0.46	.66
visits with Indian relative 3	2.6	1.8	0.93	.36
calls with Indian relative 3	4.6	2.9	1.63	.13
letters with Indian relative 3	2.7	2.8	-0.06	.95
visits with Indian friend 1	4.5	4.8	-0.63	.53
calls with Indian friend 1	3.9	5.5	-2.57	.02*
letters with Indian friend 1	2.5	5.0	-1.86	.16
visits with Indian friend 2	4.6	5.0	-0.69	.49
calls with Indian friend 2	4.7	5.2	-0.74	.47
letters with Indian friend 2	4.0	1.8	2.01	.10
visits with Indian friend 3	5.4	4.9	1.03	.31
calls with Indian friend 3	5.4	5.7	-0.62	.54

*$p < .05$. **$p < .001$.

contact with parents (except for visits with mother). Mental health subjects tended to maintain more frequent contacts with siblings than did comparison group subjects (except for calls and letters with sister 1, letters with sister 2, and calls with brother 2). The contacts with Indian relatives in the extended family showed mixed results, and no clear pattern was apparent.

Findings for Research Question Three: Residual Persistence

To answer research question three, "Does residual persistence differ for urban Indian mental health clients as compared with urban Indians who are not utilizing those services?", responses to various questions pertaining to residual persistence were examined.

Regarding parental characteristics of the combined groups, 61 (92%) of the subjects had Indian mothers, of which 56 (85%) were enrolled in a tribe. Forty-eight (73%) of the subjects had Indian fathers, of which 40 (61%) were enrolled. Thirty-three (50%) of the fathers spoke a native language, as did 38 (58%) of the mothers.

Regarding traditional cultural characteristics over which subjects had no control, the results for the combined groups were as follows. Fifty-four (82%) subjects were enrolled in a tribe. Twenty-seven (41%) of all subjects were born on a reservation. Twenty (30%) subjects were given Indian names and 29 (44%) had a totem. Of all subjects in both groups, 49 (74%) were told Indian legends as children.

Regarding traditional cultural experiences over which the subjects had control, 22 (33%) of the combined sample spoke a native Indian language, and 42 (64%) cooked traditional foods. Thirty-three (50%) of

the subjects had had at least one Indian partner. Forty-nine (74%) of the sample attended powwows regularly, 33 (50%) attended Indian ceremonies, and six (9%) attended Indian cultural clubs. Fifty-one (77%) subjects had visited a reservation, 40 (61%) at least yearly.

In regards to traditional health practices, 15 (23%) of the subjects had gone to a traditional healer at least once in their lives; 12 (18%) continued to go as adults. Of this group, 8 (27%) mental health subjects had gone once, and seven (23%) continued to do so. Seven (19%) comparison group subjects had gone at least once, and five (14%) continued to go. Thus, although the majority of neither group went to the traditional healers, there appeared to be a trend for mental health subjects to utilize traditional healers more so than comparison group subjects.

To compare the two groups on residual persistence, Student's t-tests were used to compare group means on the following scales: Non-controlled traditional cultural practices, Controlled traditional cultural practices, Indian response, Non-Indian response, Comfort with Indians, and Census response. No significant differences were found between the two groups on these measures (Table 9). The means for both groups on the Non-controlled traditional cultural practices scale showed a trend toward residual persistence. The means for both groups on the Controlled traditional cultural practices scale showed a slight trend toward assimilation. For the Comfort with Indians scale and the Census response scale, there was a slight trend toward assimilation for both groups. The Indian response and the Non-Indian response scales indicate

that both groups believed that Indians responded slightly more positively to them than non-Indians. In summary, the two groups showed no outstanding differences on the variable of residual persistence.

Findings for Research Question Four: Relationship between Residual Persistence and Social Support Systems

To answer research question four, "Is there a relationship between characteristics of size of and frequency of contact with social support systems and the degree of residual persistence for either group of urban Indians?", the six residual persistence scales were correlated with the size and total contact social support subscales for both groups separately using Pearson Product-Movement Correlation Co-efficient. Of

Table 9

Mean Residual Persistence by Mental Health and Comparison Groups

	Scale Mean			
Characteristic	MH	CG	t-value	p-value
Non-controlled traditional cultural practices	.71	.71	-0.09	.93
Controlled traditional cultural practices	.45	.45	-0.08	.94
Comfort with Indians	1.8	1.8	0.66	.51
Census response	1.7	1.8	-0.21	.84
Indian response	3.7	3.9	-0.72	.47
Non-Indian response	3.6	3.7	-0.35	.73

the 228 correlations computed, 183 (80%) were not found to be significant. This indicates that there is little evidence to support an association between residual persistence and social support system characteristics of size and frequency of contact. The 45 correlations significant at $p < .05$ are listed in Tables 10, 11, 12, and 13.

Overall, these correlations suggest few patterns of association, and, in some cases, patterns contradictory to what might be expected. For example, mental health subjects had more non-Indian friends than Indian friends. One might expect this characteristic to be associated with assimilation, but it was not. However, having more Indian friends was associated with residual persistence on Controlled traditional cultural practices and Indian response scales for this group, as anticipated. Likewise, there was an association between assimilation on the Non-controlled traditional cultural practices scale and having non-Indian siblings and grandparents for mental health subjects, as anticipated. However, having larger non-Indian families was associated with residual persistence on the Indian response and Non-controlled traditional cultural practices scales, but with assimilation on the Census response scale. As anticipated, having more children, friends and Indian friends was associated with residual persistence on the Controlled traditional cultural practices scale, and having larger Indian families and number of Indian siblings were associated with residual persistence on the Non-controlled traditional cultural practices scale for mental health subjects.

The patterns were also unclear for comparison group subjects.

Although having larger non-Indian families was associated with assimilation on the Non-controlled traditional cultural practices and Census response scales, it was associated with residual persistence on the Indian response scale. Likewise, having larger Indian families was associated with residual persistence on the Indian response scale as anticipated, but with assimilation on the Census response scale.

Table 10

Social support system Size characteristics that significantly correlated with residual persistence items for mental health subjects

Size characteristic Number of:	Residual Persistence Scale	Significant Level
	Controlled traditional cultural practices[a]	
Children	r (30) =	.3134, $p < .046$
Friends	r (30) =	.3112, $p < .047$
Indian friends	r (30) =	.3847, $p < .018$
	Non-controlled traditional cultural practices[a]	
Indian family members	r (30) =	.4499, $p < .006$
Non-Indian family members	r (30) =	.3195, $p < .043$
Siblings	r (30) =	.4171, $p < .011$
Indian siblings	r (30) =	.4885, $p < .003$
Non-Indian siblings	r (30) =	-.4441, $p < .007$
Grandparents	r (30) =	-.3799, $p < .019$
Non-Indian grandparents	r (30) =	-.5785, $p < .000$
	Indian response[a]	
Indian family members	r (30) =	.3120, $p < .047$
Non-Indian family members	r (30) =	.3243, $p < .040$
Indian friends	r (30) =	.4168, $p < .011$
	Non-Indian response[b]	
Children	r (30) =	.3864, $p < .017$
	Census response[b]	
Siblings	r (29) =	.3514, $p < .031$
Indian siblings	r (29) =	.3590, $p < .028$

[a]Positive correlation indicates relationship between social support systems and residual persistence; negative correlates with assimilation.

[b]Positive correlation indicates relationship between social support systems and assimilation; negative correlates with residual persistence.

There were fewer significant correlations (11 out of 45) for frequency of contact and either residual persistence (seven correlations) or assimilation (four correlations) (see Tables 12 and 13). Again, no clear patterns were found. For mental health subjects, frequency of contact with Indian friends was associated with residual

Table 11

Social support system Size characteristics that significantly correlated with residual persistence items for comparison group subjects

Size characteristic	Residual Persistence Scale	Significant level
Number of:		
	Controlled traditional cultural practices[a]	
Indian friends	r (36) = .3323,	$p < .024$
Non-Indian siblings	r (36) = -.3426,	$p < .020$
	Non-controlled traditional cultural practices[a]	
Non-Indian siblings	r (36) = -.4769,	$p < .002$
Non-Indian grandparents	r (36) = -.3468,	$p < .019$
Non-Indian friends	r (36) = -.3305,	$p < .024$
	Indian response[a]	
Indian family members	r (36) = .4741,	$p < .002$
Non-Indian family members	r (36) = .4610,	$p < .002$
Siblings	r (36) = .4010,	$p < .008$
Indian siblings	r (36) = .4232,	$p < .005$
	Non-Indian response[b]	
Parents	r (36) = .3751,	$p < .012$
	Census response[b]	
Indian family members	r (33) = .3653,	$p < .018$
Non-Indian family members	r (33) = .2955,	$p < .048$
Indian siblings	r (33) = .3184,	$p < .035$
Non-Indian siblings	r (33) = -.4331,	$p < .006$
Friends	r (32) = .3242,	$p < .035$
	Comfort with Indians[b]	
Siblings	r (36) = -.3460,	$p < .019$
Indian siblings	r (36) = -.3325,	$p < .024$
Parents	r (36) = .3137,	$p < .031$

[a]Positive correlation indicates relationship between social support systems and residual persistence; negative correlates with assimilation.

[b]Positive correlation indicates relationship between social support systems and assimilation; negative correlates with residual persistence.

Table 12

Social support system Total Contact characteristics that significantly correlated with residual persistence items for mental health subjects

Frequency of contact characteristic	Residual Persistence Scale	Significant Level
	Controlled traditional cultural practices[a]	
Visits with family	r (29) = -.4696,	p <.005
Visits with Indian friends	r (23) = .3511,	p <.050
Calls with Indian friends	r (24) = .3825,	p <.033
	Non-controlled traditional cultural practices[a]	
Visits with family	r (29) = -.3847,	p <.020
	Census response[b]	
Visits with Indian friends	r (23) = -.3557,	p <.048

[a]Positive correlation indicates relationship between social support systems and residual persistence; negative correlates with assimilation.

[b]Positive correlation indicates relationship between social support systems and assimilation; negative correlates with residual persistence.

Table 13

Social support system Total Contact characteristics that significantly correlated with residual persistence items for comparison group subjects

Frequency of contact characteristic	Residual Persistence Scale	Significant level
	Controlled traditional cultural practices[a]	
Calls with Indian friends	r (31) = .3079,	p <.046
	Non-Controlled traditional cultural practices[a]	
Calls with non-Indian friends	r (31) = .4090,	p <.011
	Indian response[a]	
Calls with Indian friends	r (31) = .3378,	p <.032
	Non-Indian response[b]	
Calls with family	r (35) = .3724,	p <.014
	Comfort with Indians[b]	
Calls with family	r (35) = .3432,	p <.022
Calls with non-Indian family	r (31) = -.3273,	p <.036

[a]Positive correlation indicates relationships between social support systems and residual persistence; negative correlates with assimilation.

[b]Positive correlation indicates relationship between social support systems and assimilation; negative correlates with residual persistence.

persistence on the Controlled traditional cultural practices and Census response scales as might be expected. However, frequent visits with all family members was associated with assimilation on the Controlled and Non-controlled traditional cultural practice scales. One might expect that comparison group subjects who engage in traditional cultural practices and think that American Indians respond positively to them would call their Indian friends more often. The results support this expectation since calls with Indian friends was associated with residual persistence on both the Controlled traditional cultural practices and Indian response scales. However, a seemingly contradictory finding was that frequency of calls with non-Indian friends was also associated with residual persistence on the Non-controlled traditional cultural practices scale. Likewise, frequency of calls with all family members was associated with assimilation on the Non-Indian response and Comfort with Indians scales.

There does appear to be a pattern of association between size of and frequency of contact with the non-Indian social support system and assimilation, and between size of and frequency of contact with Indian social support system and residual persistence on Controlled and Non-controlled traditional cultural practices scales for both groups. Thus, subjects who maintained contact with non-Indian members and/or had more non-Indian relatives were more assimilated than those who maintained fewer contacts and had fewer non-Indian relatives, as was expected.

CHAPTER 5

Discussion

This chapter discusses the findings for each research question, and compares them with the literature for the variables of social support systems and residual persistence. Limitations of the study and suggestions for further research are discussed. Implications for mental health care providers, including nurses, conclude this chapter.

Discussion of Research Question One: Demographic Characteristics

Comparison of the two groups in the study on demographic characteristics. The major differences between mental health and comparison group subjects were in gender, marital status and usual employment. More women availed themselves of the mental health services provided by this agency. This may fit the picture of the independent Indian male who does not want to seek help (Ablon, 1964, 1971).

More comparison group subjects currently had a partner than did mental health subjects. According to the literature on social support systems (Caplan, 1974; Cohen & Sokolovsky, 1979; Dean & Lin, 1977), having a supportive person available provides a source of feedback regarding roles and behavior which, in turn, may alleviate stress. Hence, American Indians without partners may seek out the mental health services to provide that sort of support and help deal with stress. Thus, the finding that the comparison group subjects had partners more often than mental health subjects is consistent with theoretical perspectives on social support systems reported in the literature review.

More comparison group subjects were more regularly employed than were mental health subjects. Emotional disturbances often interfere with working (Liem & Liem, 1978); contrariwise, lack of a job may interfere with self-concept and contribute to depression (Ablon, 1964, 1971;) Borunda & Shore, 1978; Graves, 1974; Townsley & Goldstein, 1977).

Comparison with 1980 census. U.S. Bureau of Census (1983) data will be compared with the demographic data from the study to ascertain if the sample studied is representative of the American Indians living in the area at that time. The 1980 census (Appendix J) indicated that 7051 American Indians were living in the three counties that comprise the metropolitan area which served as a setting for this study. Of this population, 4282 (61%) were over the age of 19. Of this total, 68% lived in the county in which the city is located, while 32% lived in the two adjourning counties. In this study, 50 (76%) subjects lived within the city limits in the most densely populated county, while 21% lived in the other two counties. Two (3%) subjects in the study lived within a day's drive of the agency, but beyond the tri-county area. The study was conducted before this breakdown of census statistics was available, so the definitions of locale in the study differed from those used in the census. The study attracted a larger percentage of American Indians living within the city, perhaps due to accessibility (e.g., public transportation, carpooling).

The breakdown by gender for American Indians over age 19 living in the metropolitan area of the study who responded to the 1980 census is summarized in Table 14. Sixty-seven percent of the subjects in the

study were female compared to 51% of the American Indians reported as living in the city in the census. Therefore, the study sample is close but not entirely representative of the American Indian population of the city with regards to gender.

Table 14

Gender of Indians Living in the Sample Area, 1980 Census Data by Percentage

Sex	n	%
Females over age 19	2183	51
Males over age 19	2049	49

It is difficult to compare the ages of the subjects with the census data due to different breakdown of the census ages (Figure 4). Since teenagers were grouped together, the decision was made to compare the census population beginning with age 20. The mean age was estimated by using midpoints of grouped data. The mean for all urban Indians in the metropolitan area over the age of 19 was found to be 37 years of age. The study consisted of 65 subjects between the ages of 18 and 56, and one subject aged 83, with a mean of 33 years of age. The subjects in the study tended to be younger than those of the metropolitan area in 1980. However, it must be noted that the grouped census data lacked the first two years (ages 18 and 19) included in the study sample. Without comparable census data it cannot be ascertained that the sample is

representative of the American Indian population of this city with regards to age.

The educational levels for this tri-county area according to the 1980 census data ranged from a grouping labeled "0-8" (15%) to over four years of college (10%) (Figure 5). The ordinal grouping of this data

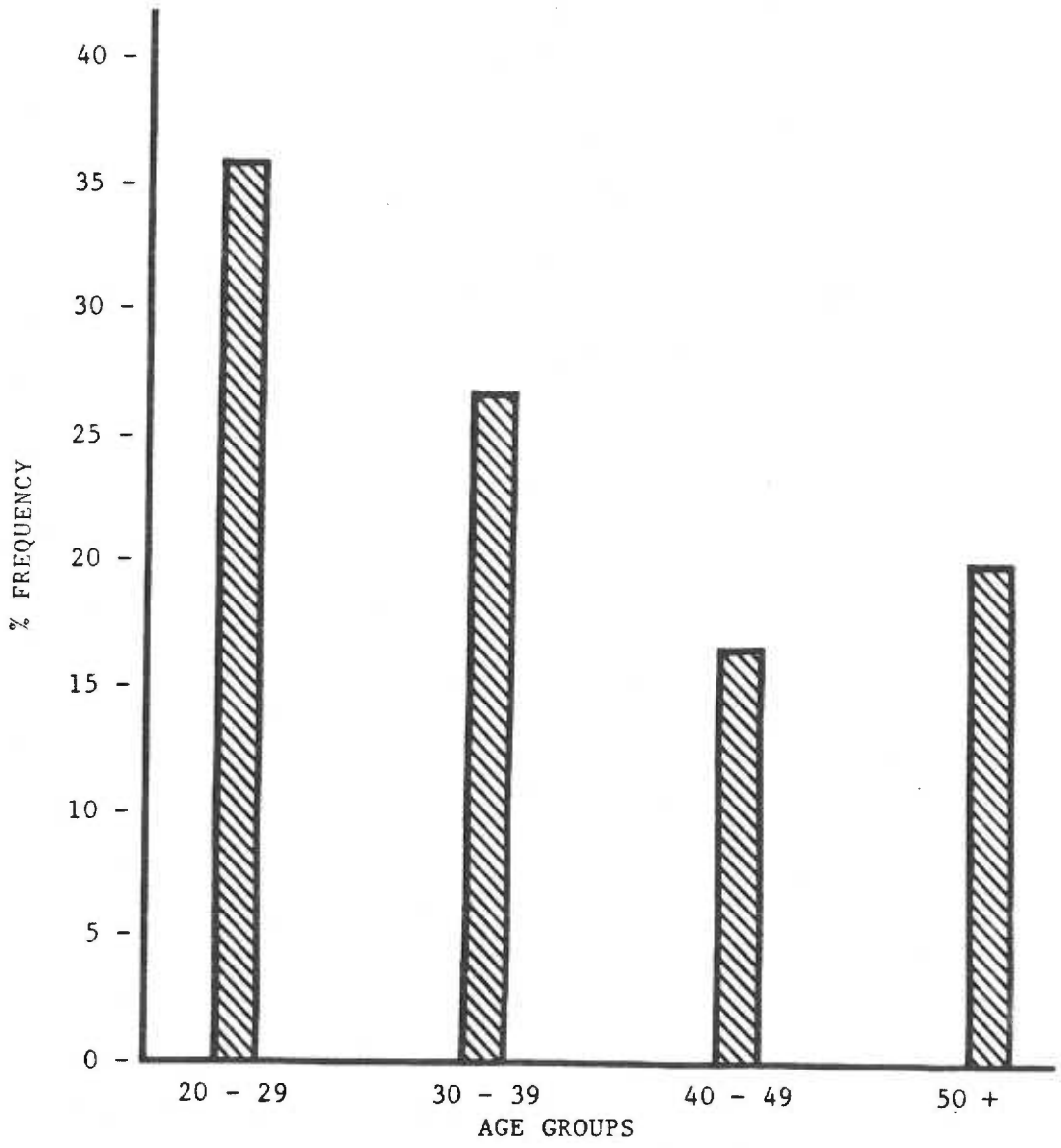

Figure 4. Ages of Indians Living in the Sample Area, 1980 Census Data.

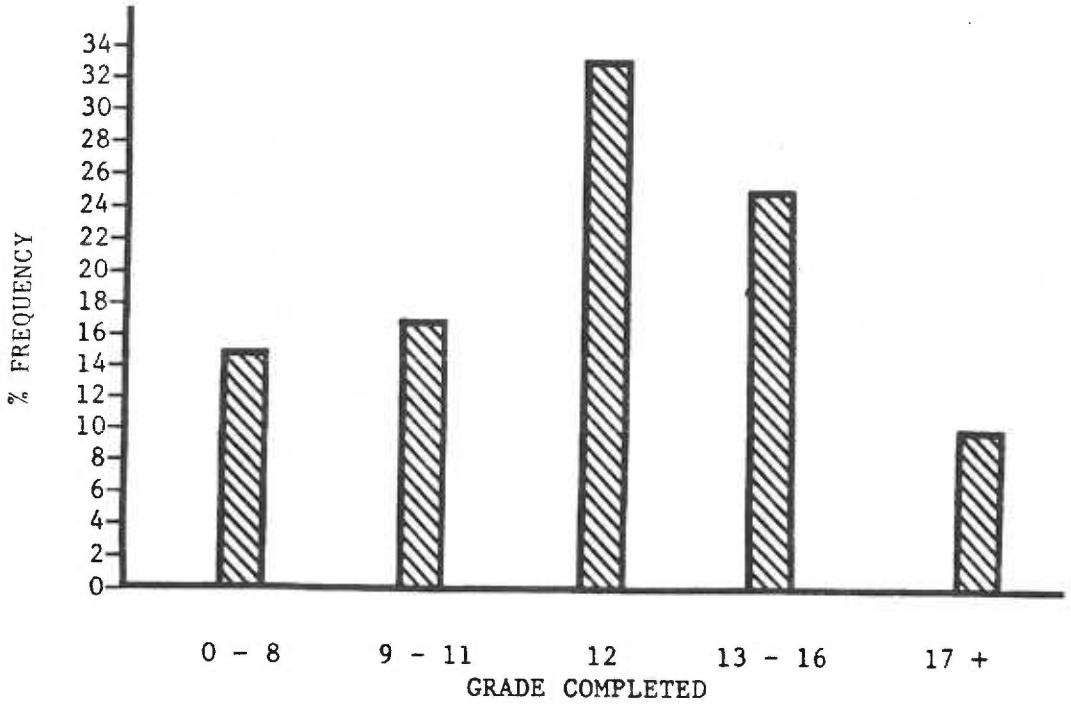

Figure 5. Education of Indians in the Sample Area, 1980 Census Data.

makes calculation of measures of central tendency difficult. The median educational level for the census population falls between the groupings of "1-3 years of high school" and "high school, four years", at about 11.9 years. The subjects in the study had a median education of 11.7 years. Each survey measured the attainment of the General Education Diploma (G.E.D.) differently. The census placed subjects with the G.E.D. in the category of "high school, four years". This study first asked subjects how far they went in school. If the subject considered the G.E.D. to be equivalent to 12 years of education, he would have responded accordingly; if not, the actual years of formal schooling would have been recorded. Seventeen (26%) of the subjects did indicate a G.E.D., but it is unclear how may of those subjects stated 12 years of

schooling and how many stated less. Subjects in both surveys who had a G.E.D. and continued on to college would have been counted at the college level. Census data for education was not available for the 18-24 year olds (comprising 18% of the sample in this study) preventing equitable comparisons for education. However, since both the census population and the sample studied had an average of 11 years of schooling, with the qualifications noted, the two groups are similar with regards to education.

The annual income of the American Indians in the metropolitan area of the study in 1979 ranged from under $5,000 ($416.67 per month) to $49,999 annually ($4,166.67 per month) (Figure 6). Due to the grouping of the census data, it was not possible to calculate measures of central tendency. The median occurred in the grouping of $15,000-$19,999; the midpoint of this grouping is $17,500 ($1,458.33 per month). In contrast, the incomes of the households in this study sample ranged from less than $2,400 per year (15%) to over $9,600 (17%). The median occurred in the grouping of $2,412 per year to $4,800. This is a considerable contrast to the 1980 census data described above in which incomes were four times as high. It is important to note that the census was based on 1979 incomes, and this study was conducted in 1982. The lumber-dependent northwestern states were plagued by higher unemployment rates in 1982 than in 1979; at the time of the study, 56% of the subjects were unemployed. Therefore, the census figures may not reflect the actual household incomes for urban Indians in 1982. The results of the study cannot be generalized to the American Indian

population of the metropolitan area, but rather only to those in the lower income brackets. This is congruent with the fact that the agency from which the subjects were drawn attracts clients from lower income brackets.

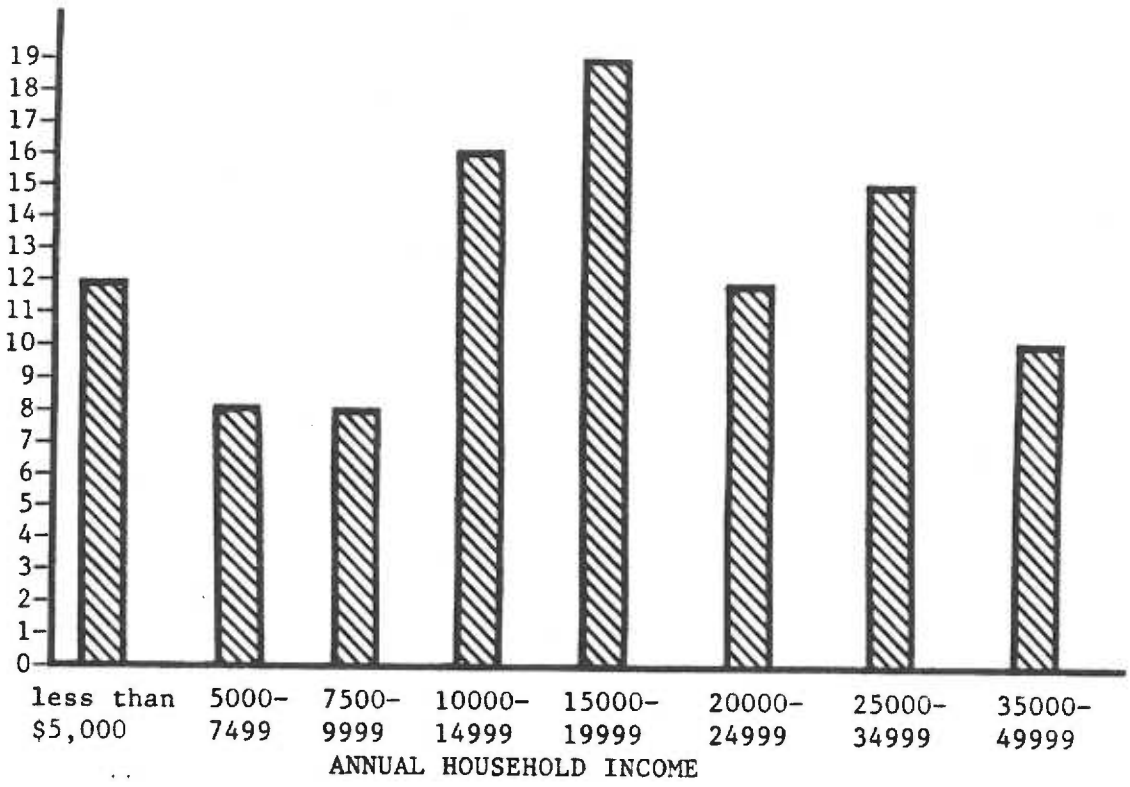

Figure 6. Income of Indians in the Sample Area, 1980 Census Data.

The marital status of the urban Indians in the city over the age of 14 who responded to the 1980 census is summarized in Table 15. Fifty-three percent of the subjects in this study had partners compared with 43% reported in the census. Thus, the subjects in the study more often had a current partner than did the city population of urban Indians responding to the census. However, again the definitions differed: the

study classified marriage and living with a consistent partner together; the census probably did not. Also, the census breakdown for marital status included younger respondents who were more likely to be single. For these reasons, it is unclear whether the urban Indians in the study are representative of urban Indians in the city with regards to marital status.

Table 15

Marital Status of Indians over Age 14 Living in the Sample Area, 1980 Census Data

Marital status	Males		Females		Total	
	n	%	n	%	n	%
Married	1063	43	1101	43	2164	43
Single	887	36	765	30	1652	33
Lost partner	505	21	722	27	1227	24

Census data for types of work in which American Indians in the metropolitan area were engaged were not available. The census did not ask religious affiliation due to respect for privacy. Therefore, comparisons between the study sample and the census population cannot be made on these two variables.

The tribes represented in this study were representative of the tribes using the agency at that time. Noteworthy is that two of the most represented tribes are of Plains origin. The tribes that have

reservations within a three-hour driving radius were less represented (12%) in this study. This suggests that members of these tribes may receive health care on their reservations (Auram et al, 1974; Fuchs & Bashshur, 1975), while individuals from tribes located beyond this radius may seek services within the urban area. Relocation from the Plains to the metropolitan area in this study was encouraged by the government. While this study did not ask why American Indians relocated to this city, poverty on reservations may be a factor (Kunitz, 1976). Because 56% of the sample were unemployed, it is difficult to ascertain if employment was the reason for relocation. The subjects who responded (N=61) had been in the city for a range of 3 to 59 years, with a mean of 22 years; some had been born in cities. There is clearly a diversity of tribes and immigration patterns represented in this sample; however, the tribes cannot be compared with census data because that information is unavailable.

Discussion of Research Question Two: Social Support System characteristics

The sizes of the mental health and comparison group subjects' social support systems did not differ significantly between the two study groups. However, the comparison group subjects did have more members among total family and friends in their support systems. Family members could be considered involuntary members of the support system in that they are not chosen; they may contribute to one's well-being by offering assistance in times of need (Caplan, 1974; Dean & Lin, 1977). Friends, however, are chosen voluntarily: one must be acceptable

enough, according to local standards, to attain friendship. Friends give the necessary feedback that keeps one acceptable enough to form more friendships (Meleis, 1975). The mental health subjects (who had a larger number of members in only two involuntary categories: parents and non-Indian grandparents) may have lacked certain interpersonal skills needed to attain voluntary social support system members, i.e., friends. Mental health subjects may have been recent migrants to the urban area (length of time in the city was not analyzed), lacked family and were unable to make friends. Such deficits in their social support systems may have limited their access to feedback about their behavior. This may have encouraged them to seek assistance from the local urban Indian mental health center. The mental health professionals could then assist them in role clarification and other problems often associated with loneliness (e.g., providing social support and social skills training for their clients).

There were two significant differences between the two groups on the frequency of contact scale. These differences suggest that the comparison group subjects called the first-mentioned Indian friend more often, and exchanged letters with their first-mentioned sister more often. Frequency of contacts is a voluntary activity. The literature suggests that mentally healthy subjects would maintain more frequent contacts with others than would psychiatric patients (Caplan, 1974; Cohen & Sokolovsky, 1979; Dean & Lin, 1977). However, several other factors may have influenced this behavior. For example, geographic proximity to one's social support system affects frequency of contact.

However, this relationship was not examined in this study.

One possible explanation for the lack of significant differences is that the comparison group may not have differed remarkedly from the mental health group. Many comparison group subjects were primary care patients at the same clinic; some may have had emotional problems that were manifested as physical complaints. The subjects were not asked what problem brought them to this agency, nor were they asked if they had ever had emotional problems. Because these variables were not controlled, this study can only suggest that the mental health subjects had smaller social support systems and less contacts than comparison group subjects.

Further, methodological problems are evident in the coding procedure. The order of the support system members was determined by the subject for whatever reason: chronological, geographical, emotional. Whomever the subject mentioned first was coded first (e.g. "sister 1," "friend 1," etc.). Had the coding been done in a descending order of contact frequency, the comparisons between the two groups would have been consistent and more accurate, and perhaps, more significant. Two variables, letters with Indian relative 1 and letters with Indian friend 3, were accidentally omitted from the data analysis, so these characteristics were not compared. Therefore, the total contact subscales were more comparable. They revealed that mental health subjects maintained slightly more frequent contact with family, while comparison group subjects were in more frequent contact with all friends. This finding is consistent with the findings of Tolsdorf

(1976) (i.e., that mental health subjects maintain more contact with family).

Another methodological problem is that only two properties of social support systems were examined in this study, although Mitchell and Trickett (1980) suggest others are equally important. Perhaps other differences may have emerged had it been possible to compare other properties.

Discussion of Research Question Three: Residual Persistence

Although no significant differences existed between the two groups with regard to residual persistence, this study has shown that some urban Indians in this Northwest city still maintained traditional cultural practices and ties with the reservation. The higher mean for Non-controlled traditional cultural practices than for Controlled traditional cultural practices may indicate that while subjects were raised with traditional influences, fewer continued these practices in later years. Powwows in this city were pan-Indian events featuring traditional foods and dances from various tribes, congruent with the findings of Price (1975) and Red Horse et al (1978), although the predominant influence was Sioux. The powwows were often sponsored by an American Indian alcohol treatment center in an attempt to instill pride in one's heritage and find social alternatives to drinking. Sweats were often held by the same treatment center, and usually run in a manner that was traditionally Sioux. In fact, Indians from any tribe who wanted to learn to run sweats could go to a Sioux reservation and learn (D. Eastman, personal communication, March 13, 1981).

The Sioux traditional healer was partially responsible for this Sioux influence. He treated patients and also referred them to the urban Indian health clinic when appropriate. While the number of subjects (18%) who visited a healer was less than in Fuchs and Bashshur's (1975) San Francisco study (28%), the Northwest Indians in this study gave several reasons for seeing a traditional healer. "Spiritual need" was the most frequent reason given, followed by physical need and alcohol; one subject said she was "raised that way". Whereas Fuchs and Bashshur (1975) found that Indians returned to the reservation for traditional healing, this study did not attempt to ascertain why over half of the subjects returned regularly.

Research Question Four: Relationship between Social Support Systems and Residual Persistence

The findings regarding the relationship between social support system characteristics and residual persistence were mixed and inconclusive. The literature (Ablon, 1964; Attneave, 1969; Doran, 1972; Kunitz, 1976) suggested that American Indians have larger families than whites. Ablon (1964), Attneave (1969), Red Horse et al (1978) and Wagner (1976) suggested that contact with one's family was valued by American Indians. Wagner further postulated that continued relationships with other urban and reservation Indians may stifle the process of acculturation. For this reason, it was speculated that the characteristics of size and frequency of contact for social support systems would increase as residual persistence increased. The results were contradictory in this respect. Chance alone may account for the 45

significant correlations out of a possible 228 correlations between social support systems and residual persistence factors.

A methodological problem may also account, in part, for the findings. The small range of possible responses for four residual persistence one-item scales (Indian response, Non-Indian response, Census response, and Comfort with Indians) resulted in clustered data. The close means for the first two items indicated that most subjects believed that all other people responded positively to them, but Indians slightly more so than non-Indians. Subjects from both groups felt almost as comfortable with non-Indians as with Indians. Subjects who completed the census usually marked "American Indian" as their race. For this reason, Census response is the least informative item measured. Hence, the single item scales may not have been valid measures of residual persistence.

One puzzling result is the fact that the total non-Indian family size was larger than the Indian family, although it was not due to large numbers of non-Indian siblings, grandparents, or uncles, aunts and cousins. This only leaves non-Indian parents. The characteristic "parents" was not analyzed separately by race because it was decided to incorporate the race of the parents into the Non-controlled traditional cultural practices scale. The variable of race of parents could not be used on both the social support system and the residual persistence scales since they were to be correlated with each other. Therefore, because of this methodological decision, the relationship between the race of the parents and residual persistence remains undetermined.

Whether or not non-Indian parents account for the size differences between non-Indian and Indian families also remains undetermined.

Another possible explanation for the contradictory results between social support system characteristics and residual persistence could be the effect of income. Liem and Liem (1978) noted that many life events experienced by members of the lower class are beyond their control due to lack of money. The perception of having no control has such an impact--especially if lower class members are without adequate social support systems--that members often exhibit physical symptoms. Mueller (1980) found that members of the lower class often have disrupted family lives, more transiency, less community activities, and more psychiatric symptoms. Subjects from both groups in the study may have been affected by income with regards to their social support system characteristics. For example, subjects with higher incomes may have scored lower on residual persistence (i.e., toward the assimilation end of the scale) since they were "successful" in the white world. But they may have scored higher on social support system characteristics because subjects who earned more could afford more costly contacts with long-distance support persons (Wagner, 1976). The size of family of procreation also may correspond to income; hence, those subjects with higher incomes who were "successful" in the white world may have had more children. Hence, the relationship between social support system characteristics and residual persistence remains unclear.

The Controlled traditional cultural practices and Non-controlled traditional cultural practices residual persistence scales are stronger

indicators of residual persistence than the four one-item scales because each is the summation of many items (see Appendices G and H). However, results using these scales were also contradictory. For both groups, the majority of significant relationships between social support system characteristics and assimilation were with non-Indian members of the support system. Wagner's (1976) study revealed that reservation-raised Mohawk women in New York City with white fathers married white husbands, and were more assimiliated than peers who had married American Indians. The choice of race of husband was admittedly influenced by family biases. Assimilated women also maintained frequent contacts with the Indian community. Northwest Indian subjects in this study who maintained more contact with non-Indian members of their social support system, and/or had more non-Indian relatives, were more assimilated than those subjects with fewer relatives and less contacts. It is worth repeating Wagner's question: does assimilation encourage amalgamation or does the reverse occur? In summary, the results of this study regarding comparisons between the two groups on residual persistence, or the relationship of residual persistence to selected social support system characteristics, are inconclusive.

Limitations

Several methodological problems imposed limitations on this secondary data analysis. These occurred with sample selection, procedure for assigning subjects to interviewers, instrument development and methods for data collection in the original study. A major limitation was that the original study used a non-probability

convenience sample of urban Indians who were predominantly clients of an urban Indian health clinic at an urban Indian agency. This sample represented the poorer American Indians in the metropolitan area. No attempt was made to assess mental health subjects and comparison group subjects using standard measures of psychiatric symptoms or established diagnostic interview procedures. Hence, how different, if at all, the mental health subjects were from the comparison group subjects on the variable of mental health is unclear.

Convenient assignment of interviewers may have resulted in inconsistency in the degree of subject honesty. Some mental health subjects had already established rapport with their therapist interviewers while others were assigned an interviewer with whom they had no previous contact. Individual subjects may have been biased by the age, race and/or sex of the interviewer. Subject honesty is a necessary assumption when interpreting self-reports.

The instrument, which was designed to describe life experiences and psychopathology of American Indians, was new and did not include valid and reliable measures of social support system characteristics or of residual persistence. Creating the scales after the data were collected made analysis difficult because the researcher was limited to the questions as asked in the original study. A completed code book may have facilitated consistent training of volunteer interviewers before data collection was begun. When coding the frequency of contact, each subject's responses should have been coded in order of descending frequencies, instead of as the subject mentioned them. This would have

facilitated comparisons between groups.

Implications

This researcher continues to believe that social support system characteristics and residual persistence are important factors in understanding the needs and concerns of urban Indians seeking mental health services. Because of the methodological problems in the design of the original study and encountered during secondary analysis of the data, research questions could not be answered clearly. Hence, this researcher realizes that redesigning the study and conducting it in another location would be an important step in clarifying the relationship between social support systems and residual persistence.

Suggestions for a new study are as follows. The instrument chosen should reflect life experiences pertaining to residual persistence (as did the American Indian Survey Interview), but the scales within the instrument should be pretested to establish their validity and reliability. The code book should be completed before interviewers are trained and subjects interviewed. The subjects could be screened using a tool to determine the presence of psychiatric symptoms to determine to which group (mental health or comparison) the subjects should be assigned. Each subject should have an interviewer who is a stranger to counteract any differences resulting from the fact that some subjects had already established rapport with their interviewer-therapists. It is hoped that future studies would eliminate methodological errors so that real differences between the mental health and comparison group subjects, if any, could be determined and the relationship between

social support systems and residual persistence clarified.

Future studies could also clarify the effects of extraneous variables on the relationship between social support system characteristics and residual persistence. Analysis could ascertain if income or geographic location or length of time spent in a city are related to mental illness, social support system characteristics, and/or to residual persistence or assimilation. For example, telephone existence may depend on income and/or assimilation; geographic location of relatives may affect availability of social support system members.

From the original instrument, it was difficult to measure any other characteristics of social support systems besides size and frequency of contact. Future studies could measure effectiveness of social support systems by asking subjects about their satisfaction with their social support system. Or, studies could be done that examine the time spent in therapy for the mentally ill, or by correlating extent of social support with scores from a symptom checklist, as Wise (1982) did. Studies could also be done to determine to what extent social support systems do buffer stress. This could be done by correlating social support characteristics with scores from a tool to measure stress. Examining the normative context, that is, how members of a social support system have become acquainted, would give researchers an idea of how subjects form relationships. It may be easier to do these studies if one of the variables (mental health, social support or residual persistence) is held constant so that any true relationship between the other two may be viewed more clearly.

This study did have some implications for mental health professionals, including nurses. For example, this study found that comparison group subjects did have more members in their social support systems and more frequent contact with some members than did mental health subjects. Mental health professionals can assist mental health clients to develop social skills necessary to form social support systems and to confide in members of their social support systems. Because this study found varying degrees of residual persistence existing among all subjects interviewed, as did Boyce and Boyce (1983), therapists may want to work on values clarification issues. Pan-Indian clubs and events may assist urban Indians who are in role conflict, as well as contribute to the development of a social support system. More traditional Indian practices need to be recognized as valuable and, hence, therapeutic to urban Indians who are not fully assimilated.

Summary

The mental health of urban Indians is of concern to both urban Indians and mental health care providers. Although American Indians in general experience a higher prevalence of mental health problems than white Americans, urban Indians are particularly susceptible. The literature suggests that differences in social support systems and persistence of traditional cultural practices may be two factors that distinguish urban Indians who utilize mental health services from those who do not. Both a functioning social support system and the use of traditional cultural practices are thought to affect the adjustment of American Indians to urban areas.

No studies had been reported that compared social support systems of urban Indians who utilized mental health services with other urban Indians. Hence, one purpose of this study was to describe the social support system characteristics of urban Indian clients who utilized the mental health services of an urban Indian clinic and whether they differed on those characteristics from urban Indian clients who used other services at an urban Indian agency. A second purpose was to describe the degree of residual persistence existing in the urban Indians who utilized mental health services of the urban Indian health clinic compared to those who used other services at the agency.

This was a descriptive study that entailed a secondary analysis of data from a needs assessment survey study (Ryan, 1982) conducted with urban Indians who used the services offered by an urban Indian agency in a major Northwest city. The convenience sample consisted of mental health subjects (N=30) and comparison group subjects (N=36) who used other services at the agency. The American Indian Survey Interview was administered to each subject who volunteered to participate in the study. For the purposes of the secondary analysis, scales were constructed from items in the American Indian Survey Interview to measure two social support system variables (size and frequency of contact) and persistence of traditional cultural practices.

The Chi Square statistic was used to compare the two groups on demographic characteristics (gender, age, marital status, education, income, work, and religion), all of which were analyzed as categorical data. Student's t-test was used to compare the two groups on social

support system size and frequency of contact scales and on residual peristence scales. Pearson-Product Movement Correlation Coefficient was used to test for associations between social support system variables (size and total contact scales) and residual persistence scales for each group separately.

The findings for each research question were as follows:

(1) Do demographic characteristics differ for urban Indian mental health clients compared with urban Indians who are not utilizing those services?

The two groups differed significantly on gender in that a larger portion of the mental health subjects was female. Although not statistically significant, more mental health subjects were without a current partner than comparison group subjects. Additionally, comparison group subjects reported working more often than mental health subjects and at higher skilled jobs.

(2) Do the characteristics of social support systems differ for urban Indian mental health clients compared with urban Indians who are not utilizing those services?

No significant differences were found between the two groups on the social support system characteristic of size. There were statistically significant differences on only two frequency of contact items: calls with Indian friend 1, $\underline{t}$ (10) = -2.57, $p < .02$; and letters with sister 1, $\underline{t}$ (13) = -5.00, $p < .000$, with comparison group subjects maintaining more frequent contacts. In general, the comparison group showed a trend toward more frequent contact with friends.

(3) Does residual persistence differ for urban Indian mental health clients as compared with urban Indians who are not utilizing those services?

No significant differences were found between the two groups on the variable of residual persistence. However, it is evident that traditional cultural practices do continue among this sample of urban Indians.

(4) Is there a relationship between characteristics of size of and frequency of contact with social support systems and the degree of residual persistence for either group of urban Indians?

Only 45 (20%) of the 228 correlations were found to be statistically significant, and there was no pattern in those relationships.

This study had many methodological problems occurring with sample selection, procedure for assigning subjects to interviewers, instrument development and methods for data collection and coding of the original study, so implications for mental health professionals were not clear. However, further studies could be done to determine effects of extraneous variables on social support systems, residual persistence and mental health. Also, the concept of social support could be broadened to study its true effectiveness. For example, studying the characteristic of normative context would give researchers an idea of how social support is formed. Examining satisfaction would give researchers a picture of subjects' perceptions of how supportive their systems really are.

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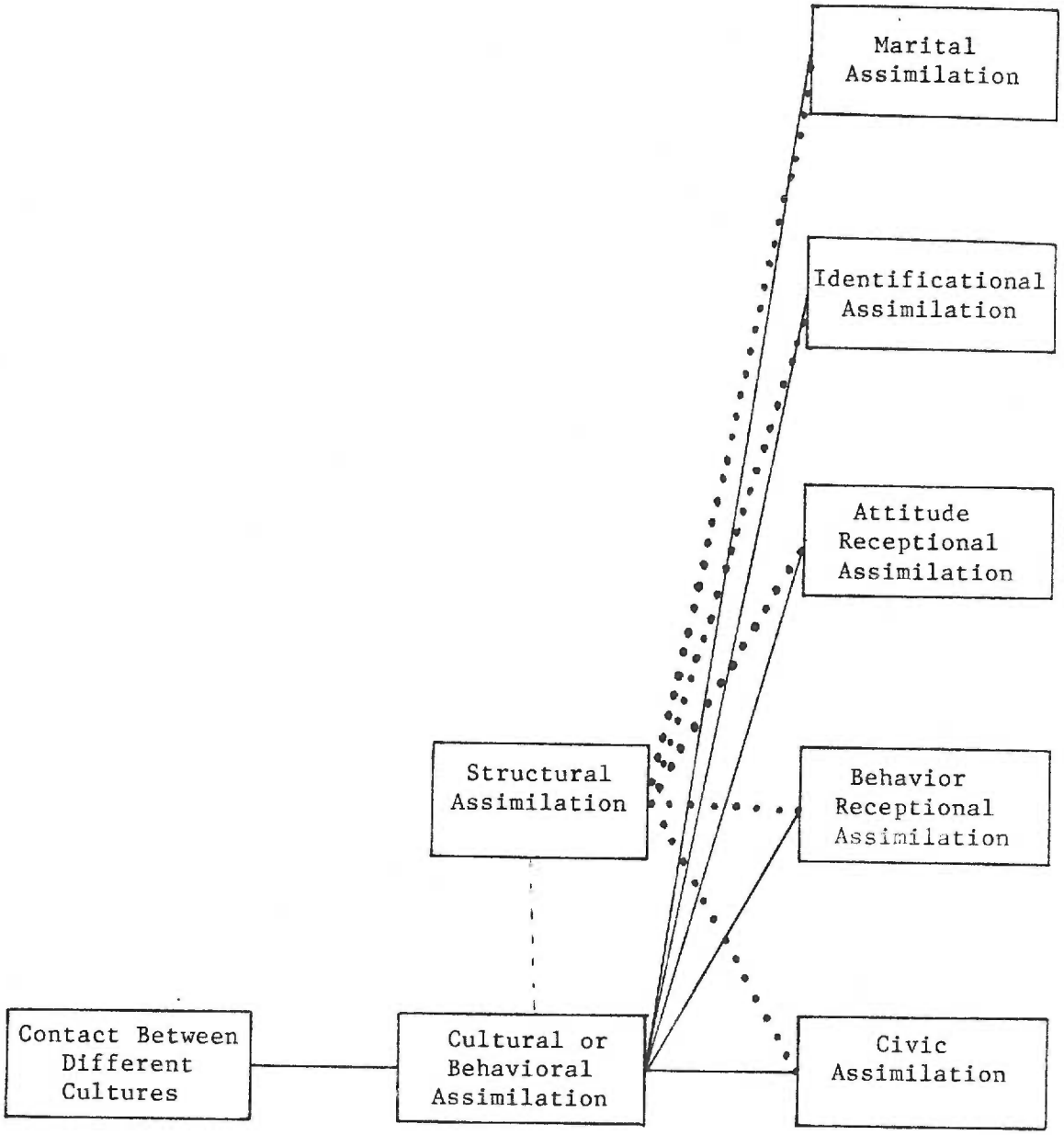
Appendix A

Chadwick and Strauss' adaptation of Gordon's Assimilation Model



GORDON'S ASSIMILATION MODEL

From: Chadwick, R., & Strauss, J. (1975). The assimilation of American Indians into urban society. Human Organization, 34, p. 61.

Appendix B

Permission to use AMERICAN INDIAN SURVEY INTERVIEW in study

HEALTH PROGRAM
URBAN INDIAN COUNCIL Inc.

735 N. W. 21st Street • Portland, Oregon 97209 • (503) 248-4663

March 5, 1982

To Whom It May Concern:

Ms. Kathy Glatz, R.N., B.A., has my permission to use the American Indian Survey Interview Instrument for her Master's thesis at Oregon Health Sciences Center.

[redacted]

March 5, 1982
Date

Loye Ryan, Ed.D.
Mental Health Supervisor
Health Program
Urban Indian Council, Inc.

Appendix C

AMERICAN INDIAN SURVEY INTERVIEW

items used in the study

AMERICAN INDIAN SURVEY INTERVIEW

Case #:____ ____ ____

1. Group 1 = MH 2 = CG (observe, do not ask)

2. Sex: 1 = Female 2 = Male (observe, do not ask)

3. Date of Birth _____

4. What is your marital status? (probe for "2")
   1 = married 3 = single 5 = divorced 9 = don't know
   2 = living with someone 4 = widowed 0 = no response

6. How many of your partners are/were Indian? _____
   8 = N/A 9 = don't know 0 = no response

7. Highest grade completed: (circle) (circle "GED", if used) GED
   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18+

8. Are you working now or are you a student?
   1 = yes, working 3 = student 9 = don't know
   2 = no, neither 4 = both 0 = no response

9. What kind of work are you doing? (Interviewer: write answer given, then code it according to codes below)_____
   01=professional, temporary 02=professional, permanent
   03=semi-professional, temporary 04=semi-professional, permanent
   05=office/clerical, temporary 06=office/clerical, permanent
   07=semi-skilled, temporary 10=semi-skilled, permanent
   11=unskilled, temporary 12=unskilled, permanent
   08 = N/A, unemployed 09 = don't know 00 = no response

10. What kind of work do you usually do? _____
    01=professional, temporary 02=professional, permanent
    03=semi-professional, temporary 04=semi-professional, permanent
    05=office/clerical, temporary 06=office/clerical, permanent
    07=semi-professional, temporary 10=semi-skilled, permanent
    11=unskilled, temporary 12=unskilled, permanent
    08 = N/A, unemployed 09 = don't know 00 = no response

16. Your monthly household income is: (for all household members)
    _____(exact amount)
    1 = less than $200 4 = more than $800
    2 = $201=$400 9 = don't know
    3 = $401=$800 0 = no response

19. Are you officially designated as a member of your tribe?
    1 = yes 2 = no 9 = don't know 0 = no response

20. Were you born on a reservation or region?
1 = yes 2 = no 9 = don't know 0 = no response

22. Is/was your mother Indian?
1 = yes 2 = no 9 = don't know 0 = no response

23. Is/was your mother officially designated as member of the tribe?
1 = yes 2 = no 9 = don't know 0 = no response 8 = N/A (Mother not Indian)

25. Is/was your father Indian?
1 = yes 2 = no 9 = don't know 0 = no response

26. Is/was your father officially designated as member of the tribe?
1 = yes 2 = no 9 = don't know 0 = no response 8 = N/A (Father not Indian)

28. Have you ever sought help from a medicine man or woman or native healer? 1 = yes 2 = no 9 = don't know 0 = no response

29. If you feel comfortable telling me, I'd like to know why._____
_____
8 = N/A 9 = don't know 0 = no response

31. Do you speak an Indian language?
1 = yes 2 = no 9 = don't know 0 = no response

33. Does your father speak an Indian language?
1 = yes 2 = no 9 = don't know 0 = no response

35. Does your mother speak an Indian language?
1 = yes 2 = no 9 = don't know 0 = no response

37. Do you have an Indian name?
1 = yes 2 = no 9 = don't know 0 = no response

38. Have you participated in a traditional Indian ceremony?
1 = yes 2 = no 9 = don't know 0 = no response

40. Do you occasionally prepare any of your favorite Indian foods?
1 = yes 2 = no 9 = don't know 0 = no response

42. Is there an important animal, totem, or Guardian Spirit from your Indian culture? (Note: They do not have to name it)
1 = yes 2 = no 9 = don't know 0 = no response

43. Do you remember Indian stories or legends that were told to you?
1 = yes 2 = no 8 = N/A 0 = no response

45. What is your religion?

2 = none	5 = Shaker (Indian)
1 = no preference	6 = Native American church
3 = Catholic	7 = American Indian religion
4 = non-Catholic Christian	9 = don't know
Other: _____	0 = no response

46. How do you think other Indians respond to you, on a scale of "1" positive, to "5" being negative? (circle)
1 all negative 2 3 4 5 all positive
9 = don't know 0 = no response

47. How do you think non-Indians respond to you, on a scale of "1" positive, to "5" being negative? (circle)
1 all negative 2 3 4 5 all positive
9 = don't know 0 = no response

48. Do you feel more comfortable with Indians or non-Indians, or equally comfortable with both?
1 = more comfortable with Indians
2 = more comfortable with non-Indians
3 = equally comfortable with both
9 = don't know 0 = no response

49. Did you check either "American Indian" or "Tribal Affiliation" on the 1980 census?
1 = yes 2 = no 9 = don't know 0 = no response
8 = didn't fill out census

73. Who acts as your mother? (Let subject describe and the interviewer code) (Probe: to what female person do you turn to when you have problems?)
01 = Indian blood/natural mother
03 = Indian stepmother
04 = Indian foster mother (or adopted)
05 = Indian grandmother
06 = Indian, other female relative
07 = Indian, other female non-relative
08 = non-Indian blood/natural mother
10 = non-Indian stepmother
11 = non-Indian foster mother (or adopted)
12 = non-Indian grandmother
13 = non-Indian, other female relative
14 = other non-Indian female non-relative
02 = no one
09 = don't know
00 = no response
Other: _____

75. On an average, how often do you get together?

2 = never	6 = 1 x/year
1 = once a week or more	7 = less than once/year
3 = 2-3 x/month	8 = N/A
4 = 6-12 x/year	9 = don't know
5 = 2-5 x/year	0 = no response

76. How often do you phone your mother?

2 = never	6 = 1 x/year
1 = once a week or more	7 = less than once/year
3 = 2-3 x/month	8 = N/A
4 = 6-12 x/year	9 = don't know
5 = 2-5 x/year	0 = no response

77. How often do you write your mother?

2 = never	6 = 1 x/year
1 = once a week or more	7 = less than once/year
3 = 2-3 x/month	8 = N/A
4 = 6-12 x/year	9 = don't know
5 = 2-5 x/year	0 = no response

82. Are there other people who also act as your mother? (Let subject describe and interviewer code) This mother is:

01 = Indian blood/natural mother
03 = Indian stepmother
04 = Indian foster mother (or adopted)
05 = Indian grandmother
06 = Indian other female relative
07 = other Indian female non-relative
08 = non-Indian blood/natural mother
10 = non-Indian stepmother
11 = non-Indian foster mother (or adopted)
12 = non-Indian grandmother
13 = non-Indian, other female relative
14 = other non-Indian female non-relative
02 = no one
09 = don't know
00 = no response
Other: _____

92. Who do you consider your father? (Probe: What male person do you turn to for help?)
01 = Indian blood/natural father
03 = Indian stepfather
04 = Indian foster father (or adopted)
05 = Indian grandfather
06 = Indian, other male relative
07 = other Indian male non-relative
08 = non-Indian blood/natural father
10 = non-Indian stepfather
11 = non-Indian foster father (or adopted)
12 = non-Indian grandfather
13 = non-Indian, other male relative
14 = other non-Indian male non-relative
09 = don't know
02 = no one
00 = no response
Other: _____

94. On an average, how often do you get together?

2 = never	6 = 1 x/year
1 = once a week or more	7 = less than once/year
3 = 2-3 x/month	8 = N/A
4 = 6-12 x/year	9 = don't know
5 = 2-5 x/year	0 = no response

95. How often do you phone your (this) "father"?

2 = never	6 = 1 x/year
1 = once a week or more	7 = less than once/year
3 = 2-3 x/month	8 = N/A (no father)
4 = 6-12 x/year	9 = don't know
5 = 2-5 x/year	0 = no response

96. How often do you write your (this) "father"?

2 = never	6 = 1 x/year
1 = once a week or more	7 = less than once/year
3 = 2-3 x/month	8 = N/A (no father)
4 = 6-12 x/year	9 = don't know
5 = 2-5 x/year	0 = no response

101. Are there other people who also act as your father?
01 = Indian blood/natural father
03 = Indian stepfather
04 = Indian foster father (or adopted)
05 = Indian grandfather
06 = Indian, other male relative
07 = other Indian male non-relative
08 = non-Indian blood/natural father
10 = non-Indian stepfather
11 = non-Indian foster father (or adopted)
12 = non-Indian grandfather
13 = non-Indian, other male relative
14 = other non-Indian male non-relative
09 = don't know
02 = no one
00 = no response
Other: _____

111. Ask for each Indian relative. Repeat questions if more than one of each relative (e.g., several aunts).

Relative Be specific. Note: "Steps", "½", & "Foster"	Distance from subject in miles	Frequency Visit	Phone	Write	Are you close? How do you express closeness?	Happy with frequency of contact 1=yes 2=no
Sister:						
Brother:						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						
Maternal Uncles						
Maternal Aunts						
Paternal Uncles						
Paternal Aunts						
Maternal Cousins						
Paternal Cousins						

112. Ask each non-Indian relative. Repeat questions if more than one of each relative (e.g., several aunts).

Relative Be specific. Note: "Steps", "½", & "Foster"	Distance from subject in miles	Frequency Visit	Phone	Write	Are you close? How do you express closeness?	Happy with frequency of contact 1=yes 2=no
Sister:						
Brother:						
Maternal grandmother						
Maternal grandfather						
Paternal grandmother						
Paternal grandfather						
Maternal uncles						
Maternal aunts						
Paternal uncles						
Paternal aunts						
Maternal cousins						
Paternal cousins						

113. How many are there in your extended (whole) blood family? _____

114. How many of these relatives do you consider close? _____

115. Indian friends

Relationship - (How do you know this person?) Note: neighbor, co-worker, classmate, club/church member, teammate, drinking buddy, etc. Be specific. If the friend is known due to two common places, note both on same line.

Relationship	Distance from subject in miles	Years known	Frequency			How do you express closeness?	Happy with frequency of contact 1 = yes 2 = no
			Visit	Phone	Write		

116. Non-Indian friends

Relationship - (How do you know this person?) Note: neighbor, co-worker, classmate, club/church member, teammate, drinking buddy, etc. Be specific. If the friend is known due to two common places, note both on same line.

Relationship	Distance from subject in miles	Years known	Frequency			How do you express closeness?	Happy with frequency of contact 1 = yes 2 = no
			Visit	Phone	Write		

117.	Social & religious organizations/ athletic teams to which you belong	Purpose	Frequency it meets: 1=wkly. or more 2=every other wk. 4=monthly 5=less than monthly	Your attendance: 1=almost every time 2=about every other time 4=less than every other time	Active on committees 1=yes 2=no

118. How often do you go to Powwows?
1 = monthly or more often
3 = 5-11 x/year
4 = 3-4 x/year
5 = 1-2 x/year
6 = less than once/year
2 = never
9 = don't know
0 = no response

119. How often do you visit an Indian reservation?
1 = once a week or more
3 = 2-3 x/month
4 = 1 x/month
5 = 6-11 x/year
6 = 2-5 x/year
7 = 1 x/year
8 = less than once/year
2 = never
9 = don't know
0 = no response

127. Number of children: _____

151. When did you first come to a city? _____
8 = N/A (never in a city)
9 = don't know
0 = no response

185. Have you ever been in contact with, or received help from any of these agencies?
Codes: 1 = yes 2 = no 8 = N/A 9 = don't know 0 = no response
(Be sure to ask what mental health facilities subject has utilized in the past.)

Appendix D

Items used to form SIZE Social Support System subscales

Appendix D

Interview guide items used to form SIZE Social Support System subscales

Item number from interview guide	Characteristic measured	Possible range
127	number of children	0-99
73, 82, 92, 101, 111	total size of Indian family	0-999
73, 82, 92, 101, 112	total size of non-Indian family	0-999
111, 112	total number of siblings	0-99
111	total number of Indian siblings	0-99
112	total number of non-Indian siblings	0-99
115, 116	total number of friends	0-999
115	total number of Indian friends	0-999
116	total number of non-Indian friends	0-999
73, 82, 92, 101	total number of parents	0-4
111, 112	total number of grandparents	0-99
111	total number of Indian grandparents	0-99
112	total number of non-Indian grandparents	0-99

Appendix E

Items used to compare FREQUENCY OF CONTACT

Social Support System characteristics

Appendix E

Items used to compare FREQUENCY OF CONTACT Social Support System characteristics

Item number	Characteristic measured	Range
75	visits with mother	1-7
76	calls with mother	1-7
77	letters with mother	1-7
94	visits with father	1-7
95	calls with father	1-7
96	letters with father	1-7
111	visits with first-mentioned sister (sister 1)	1-7
111	calls with sister 1	1-7
111	letters with sister 1	1-7
111	visits with sister 2	1-7
111	calls with sister 2	1-7
111	letters with sister 2	1-7
111	visits with first-mentioned brother (brother 1)	1-7
111	calls with brother 1	1-7
111	letters with brother 1	1-7
111	visits with brother 2	1-7
111	calls with brother 2	1-7
111	letters with brother 2	1-7
111	visits with first-mentioned Indian relative	1-7
111	calls with Indian relative 1	1-7
111	letters with Indian relative 1	1-7
111	visits with Indian relative 2	1-7
111	calls with Indian relative 2	1-7
111	letters with Indian relative 2	1-7
111	visits with Indian relative 3	1-7
111	calls with Indian relative 3	1-7
111	letters with Indian relative 3	1-7
115	visits with first-mentioned Indian friend	1-7
115	calls with Indian friend 1	1-7
115	letters with Indian friend 1	1-7
115	visits with Indian friend 2	1-7
115	calls with Indian friend 2	1-7
115	letters with Indian friend 2	1-7
115	visits with Indian friend 3	1-7
115	calls with Indian friend 3	1-7
115	letters with Indian friend 3	1-7

Appendix F

Items used to form TOTAL CONTACT subscales

Appendix F

Items used to form TOTAL CONTACT subscales

Item numbers	Characteristic measured	Range
	total visits with all the family	1-7
75	visits with mother	
94	visits with father	
111	visits with sister 1	
111	visits with sister 2	
111	visits with brother 1	
111	visits with brother 2	
111	visits with Indian relative 1	
111	visits with Indian relative 2	
111	visits with Indian relative 3	
	total calls with all the family	1-7
76	calls with mother	
95	calls with father	
111	calls with sister 1	
111	calls with sister 2	
111	calls with brother 1	
111	calls with brother 2	
111	calls with Indian relative 1	
111	calls with Indian relative 2	
111	calls with Indian relative 3	
	total visits with Indian friends	1-7
115	visits with Indian friend 1	
115	visits with Indian friend 2	
115	visits with Indian friend 3	
	total calls with Indian friends	1-7
115	calls with Indian friend 1	
115	calls with Indian friend 2	
115	calls with Indian friend 3	
	total visits with non-Indian friends	1-7
116	visits with non-Indian friend 1	
116	visits with non-Indian friend 2	
116	visits with non-Indian friend 3	
	total calls with non-Indian friends	1-7
116	calls with non-Indian friend 1	
116	calls with non-Indian friend 2	
116	calls with non-Indian friend 3	

Appendix G

Items used to form

NON-CONTROLLED TRADITIONAL CULTURAL PRACTICES scale

to measure RESIDUAL PERSISTENCE

Appendix G

Items used to form the NON-CONTROLLED traditional cultural practices scale to measure RESIDUAL PERSISTENCE

Item number from interview guide	Characteristic measured	Range
19	if subject was enrolled in the tribe	0-1
22	if mother was Indian	0-1
23	if mother was enrolled in the tribe	0-1
25	if father was Indian	0-1
26	if father was enrolled in the tribe	0-1
33	if father spoke a native language	0-1
35	if mother spoke a native language	0-1
37	if subject was given an Indian name	0-1
42	if subject had a totem	0-1
43	if subject was told Indian legends	0-1

scores were averaged for a total scale range of 0-1

Appendix H

Items used to form

CONTROLLED TRADITIONAL CULTURAL PRACTICES scale

to measure RESIDUAL PERSISTENCE

Appendix H

Items used to form the CONTROLLED traditional cultural practices scale to measure RESIDUAL PERSISTENCE

Item number from interview guide	Characteristic measured	Range
6	if subject had an Indian partner	0-1
28	if subject went to a native healer	0-1
31	if subject spoke a native language	0-1
38	if subject attended an Indian ceremony	0-1
40	if subject prepared Indian foods	0-1
117	if subject is member of Indian cultural club	0-1
119	if subject visited a reservation	0-1

scores were averaged for a total scale range of 0-1

Appendix I

Subject consent form

HEALTH PROGRAM
URBAN INDIAN COUNCIL Inc.

735 N. W. 21st Street • Portland, Oregon 97209 • (503) 248-4663

SUBJECT CONSENT

I, _____ agree to partake in this interview study, entitled, "American Indian Survey Interview", being conducted by the staff (paid, volunteer, and students) of the Urban Indian Council, Inc., Health Program. The purpose of this interview is to help the mental health staff meet the mental health needs of the Portland American Indian community by planning appropriate programs. Individuals who use the Urban Indian Health Program will be asked to help in this study.

I agree to be interviewed by one of the mental health staff who may also review my charts. The interview may take up to two hours of my time. I may feel uncomfortable answering some of the questions because they may be personal. There are no other risks to me; and I could possibly benefit from new mental health approaches and services as a result of this study. Another benefit is the $5.00 donation I will receive.

All information will be kept confidential. My name will not appear on any questionnaire, and only the staff conducting the study will know who completed the questionnaires. No one else will be allowed to see the questionnaires and they will be kept in a locked file. All questionnaires will be destroyed when the study is over. I understand that part of the data will be reported by Kathy Glatz, R.N., B.A., in her masters thesis for Oregon Health Science University under the supervision of Beverly Hoeffer, R.N., D.N.S. Data reported (e.g., Ms. Glatz's thesis, U.I.C. statistics, publications, etc.,) will be done in such a manner that the subjects will be kept annonymous and unidentifiable.

Any questions I have during or after the study is completed will be answered by Dr. Loye Ryan. I also understand that I may refuse to be in this study at any time without affecting any treatment or services I may need at the Urban Indian Council, Inc., Health Program.

The Urban Indian Council, Inc., Health Program is not responsible for any injury that may result from this interview. It is not the policy of the Urban Indian Council, Inc., to give monetary benefits for participating in this interview, however, through collaboration with the National Center of American Indian Mental Health Research I will receive $5.00 for my cooperation in the American Indian Survey Interview.

_____ _____

Witness' Signature Subject's Signature

_____

Date

Appendix J

1980 Census Data for Indians living in the area sampled

Appendix J

1980 Census of Population and Housing

Data for race category American Indian, Eskimo, and Aleut only.

Age groups	Clackamas	Multnomah	Washington
20-29	226	1051	273
30-39	208	756	184
40-49	148	461	103
50+	143	632	99
Family income in 1979 by all family members 15 years old and over			
under $5000	18	140	34
5000-7499	2	120	13
7500-9999	13	96	22
10000-14999	51	150	61
15000-19999	76	170	69
20000-24999	43	101	43
25000-34999	65	130	46
35000-49999	28	65	70
50000+	0	0	0
Years of school completed by persons 25 and older only			
elementary (0-8 years)	87	415	90
High School, 1-3 years	93	450	122
High School, 4 years	259	819	226
College, 1-3 years	183	592	201
College, 4+ years	61	247	67

Data on years of school completed are derived from two questions, one identifying the highest grade attended in regular school; the second determining whether the respondent finished the grade specified. Persons who passed a high school equivalency examination (G.E.D.) were marked "12" under the highest grade attended (if they had not completed or were not enrolled in a higher grade). To obtain a count of high school graduates, the categories "High School, 4 years," "College, 1-3 years," and "College, 4 or more years," are to be added together.

From: U.S. Bureau of the Census. Prepared for the Center for Population Research and Census, Portland State University, Portland, Oregon, May 1983.

AN ABSTRACT OF THE THESIS OF

KATHLEEN J. GLATZ

FOR THE MASTER OF NURSING

Date of Receiving this Degree:

Title: Social Support Systems and Residual Persistence among Urban Indians utilizing an Urban Indian Agency

Approved: [redacted]

Beverly Hoeffer, R.N. D.N.Sc., Thesis Advisor

The mental health of urban Indians is of concern to both urban Indians and mental health care providers. Although American Indians in general experience a higher prevalence of mental health problems than white Americans, urban Indians are particularly susceptible. The literature suggests that differences in social support systems and persistence of traditional cultural practices may be two factors that distinguish urban Indians who utilize mental health services from those who do not. Both a functioning social support system and the use of traditional cultural practices are thought to affect the adjustment of American Indians to urban areas.

No studies had been reported that compared social support systems of urban Indians who utilized mental health services with other urban Indians. Hence, one purpose of this study was to describe the social support system characteristics of urban Indian clients who utilized the mental health services of an urban Indian clinic and whether they differed on those characteristics from urban Indian clients who used other services at an urban Indian agency. A second purpose was to

describe the degree of residual persistence existing in the urban Indians who utilized mental health services of the urban Indian health clinic compared to those who used other services at the agency.

This was a descriptive study that entailed a secondary analysis of data from a needs assessment survey study (Ryan, 1982) conducted with urban Indians who used the services offered by an urban Indian agency in a major Northwest city. The convenience sample consisted of mental health subjects (N=30) and comparison group subjects (N=36) who used other services at the agency. The American Indian Survey Interview was administered to each subject who volunteered to participate in the study. For the purposes of the secondary analysis, scales were constructed from items in the American Indian Survey Interview to measure two social support system variables (size and frequency of contact) and persistence of traditional cultural practices.

The Chi Square statistic was used to compare the two groups on demographic characteristics (gender, age, marital status, education, income, work, and religion), all of which were analyzed as categorical data. Student's t-test was used to compare the two groups on social support system size and frequency of contact scales and on residual persistence scales. Pearson-Product Movement Correlation Coefficient was used to test for associations between social support system variables (size and total contact scales) and residual persistence scales for each group separately.

The findings for each research question were as follows:

(1) Do demographic characteristics differ for urban Indian mental

health clients compared with urban Indians who are not utilizing those services?

The two groups differed significantly on gender in that a larger portion of the mental health subjects were female. Although not statistically significant, more mental health subjects were without a current partner than comparison group subjects. Additionally, comparison group subjects reported working more often than mental health subjects and at higher skilled jobs.

(2) Do the characteristics of social support systems differ for urban Indian mental health clients compared with urban Indians who are not utilizing those services?

No significant differences were found between the two groups on the social support system characteristic of size. There were statistically significant differences on only two frequency of contact items: calls with Indian friend 1, $\underline{t}$ (10) = -2.57, $p < .02$; and letters with sister 1, $\underline{t}$ (13) = -5.00, $p < .000$, with comparison group subjects maintaining more frequent contacts. In general, the comparison group showed a trend toward more frequent contacts with friends.

(3) Does residual persistence differ for urban Indian mental health clients as compared with urban Indians who are not utilizing those services?

No significant differences were found between the two groups on the variable of residual persistence. However, it is evident that traditional cultural practices do continue among this sample of urban Indians.

(4) Is there a relationship between characteristics of size of and frequency of contact with social support systems and the degree of residual persistence for either group of urban Indians?

Only 45 (20%) of the 228 correlations were found to be statistically significant, and there was no pattern in those relationships.

This study had many methodological problems occurring with sample selection, procedure for assigning subjects to interviewer, instrument development and methods for data collection and coding of the original study, so implications for mental health professionals were not clear. However, further studies could be done to determine effects of extraneous variables on social support systems, residual persistence and mental health. The concept of social support could be broadened to study its true effectiveness. For example, studying the characteristic of normative context would give researchers an idea of how social support is formed. Examining satisfaction would give researchers a picture of subjects' perceptions of how supportive their systems really are.