Health Needs of American Indian Women

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AMERICAN INDIAN WOMEN

An American Indian woman is believed to hold the heart of the culture. To develop an article about her is both an honor and a challenge. A discussion of women as a special group of interest, although a straightforward topic, becomes a greater challenge when the consideration of American Indian ethnicity is added. In fact, the challenge becomes almost hazardous. Once a group is defined in a way that distinguishes it from the general population, the accuracy and meaning of that definition is always challenged, and should be.

It has been well established that American Indians are a diverse group of people (Trimble et al. 1996, pp. 177-209). Women from the various American Indian tribes and regions would likely describe their challenges and needs, as well as their resources, in different terms. Therefore, this chapter is not comprehensive enough to adequately reflect the many and diverse health needs of all American Indian women or to identify all of the issues that challenge them. Certainly an Indian woman raising three children in an urban environment would have needs different from those of a woman living a traditional lifestyle in a remote reservation or village area. There are significant differences in rates of problems, such as alcoholism, inhalant use, and fetal alcohol syndrome, from one tribal group to another (May 1982). This chapter presents brief and general data, data inconsistencies, and the health needs of American Indian women as evidenced from those data. It is hoped that this exposition will lead to a better sense of needed interventions and further research.

The general quality of life for today's rural Indian woman is influenced greatly by the day-to-day realities of life in an isolated community (LaFromboise et al. 1995). Indian women in urban environments also may feel socially estranged from those around them. Too often these realities include alcoholism and its associated consequences, economic problems, limited opportunity, and violence that intrudes into daily life.

Related to this is a profound concern for the future of Indian children. This topic is always on the minds of Indian women, who worry about learning disabilities, poor nutrition, early initiation of substance abuse and smoking, and teen pregnancy. Substance use and violence are becoming ways in which some Indian children learn to "solve" problems. Too many youths are becoming victims of violence and perpetrating violent acts against others (Thurman and Edwards 1996). As keepers of the culture, American Indian women feel a special responsibility for these problems. The search for solutions to the problems for all Indian youth is a burden that is added to the day-to-day demands of life.

American Indian people have numerous strengths and resources in their communities. There are many happy, healthy families, but the problems they face are often enormous and can quickly become overwhelming when they are struggling to make ends meet. Many tribal women are single parents and may also be caring for the children of friends or relatives, stretching resources even further. However, an important hallmark of Indian life is the extended family—even in the bleakest of times, struggling families or single mothers can count on the love and support of even distantly related tribal members. This may be one of the Indian family's greatest strengths.

Unfortunately, many American Indian families still carry with them the far-reaching and negative effects of the boarding school experience, which are manifested as mistrust of and lack of involvement in the child's school activities. In addition, boarding schools did not provide children with the role modeling for effective parenting, resulting in tentative and sometimes even neglectful parenting by parents who attended boarding schools. The boarding school experience cuts across all tribes and is recent enough that its effects are still felt by a significant number of families. In fact, many believe that the intergenerational effects of the abuses suffered in those environments, combined with the separation from tribe and family, are variables affecting American Indians today. For the American Indian woman, roles focusing on caring that were well defined from cradleboard to grave—being cared for, preparing to care for, and caring for—were interrupted (Red Horse 1980). The boarding school experience probably significantly disrupted this developmental cycle. Combined with the many contemporary realities, this has resulted in American Indian women being one of the most impoverished and isolated groups in the country (LaFromboise et al. 1995).

DEMOGRAPHIC AND HEALTH STATISTICS

Forty-five percent of all Indian households are headed by women (for the United States, all races [USAR], the figure is 24 percent), and 42 percent of those women are younger than 20 when they have their first child (LaFromboise et al. 1995). As the number of their children increases, the demands on American Indian women expand (LaFromboise et al. 1995). Likewise, unemployment is high in Indian communities (Snipp and Aytac 1990), with 31.6 percent of Indian people living below the poverty level, compared with 13.1 percent for the USAR population (U.S. Department of Health and Human Services 1996).

Focus groups of American Indian women conducted in various tribal areas indicate that they do not have transportation or money for gas and that they want improved access to health care, healthy children, affordable child care, and safety from violence and victimization.

In any discussion of health needs for American Indian women, the Indian Health Service (IHS) is a solid source of knowledge. The 1994 statistics indicate that the top two causes of death for Indian men were diseases of the heart and accidents, yet for Indian women, the top two causes were the same as for all women: diseases of the heart and malignant neoplasms. Joe and Justice (1992) reported that American Indian and Alaska Native women experience a much higher rate of cervical cancer, more than twice the rate of women of all other races. Cervical cancer in these women is also diagnosed in later stages than in other women, resulting in a poorer survival rate. The IHS (1994) has also reported that age-adjusted mortality rates for some diseases are considerably higher for American Indians than for the USAR, although no gender breakdowns were reported. From 1989 through 1991 the age-adjusted mortality rate for tuberculosis among American Indians was 440 percent greater than the USAR rate. Likewise, greater rates were found for alcoholism (430 percent), accidents (165 percent), diabetes mellitus (154 percent), homicide (50 percent), pneumonia and influenza (46 percent), and suicide (43 percent).

Anecdotal data from physicians and nurses working in various tribal programs throughout the United States suggest the presence of high rates of sexually transmitted diseases (STDs), raising the concern that HIV/AIDS rates will increase as well. Many STDs are preventable and

may even be a direct result of self-neglect or failure to seek prevention or early detection. Physical and emotional self-care is too often given low priority and rarely practiced (LaFromboise et al. 1995).

IHS statistics also indicate that for accidents and motor vehicle deaths, the rate for Indian females was more than twice the USAR rate. Of American Indians who died during 1989 and 1991, 32 percent were younger than 45 years of age, compared with 11 percent for the USAR.

Statistics such as these reflect a need for more effective and immediate prevention and early intervention strategies, strategies that are culturally specific, and improved health education and outreach. It is also apparent, given the information gained from focus groups and possibly reflected in the statistics cited above, that American Indian women also need improved availability of and access to services.

AMERICAN INDIAN VIOLENCE AND VICTIMIZATION

Between 1979 and 1986, more than 2.2 million people suffered nonfatal injuries from violent and abusive behavior (U.S. Department of Health and Human Services 1991). The Department also notes a lack of adequate data on violence and victimization among minority and impoverished youth, although it is commonly acknowledged that these groups endure significantly greater problems in this regard.

The literature on the nature and extent of crime and violence among American Indians is not extensive, and what does exist has been found to be inconsistent and inadequate. This could be attributed to several factors: lack of sufficient management information systems, confusing or ambiguous legal and law enforcement jurisdictions related to reservations and tribes, limited time for documentation, and perhaps even ethnic bias in existing records.

Older data (Stewart 1964; Reasons 1972, pp. 319-326; Jensen et al. 1977) indicate high rates of crime among American Indians. For example, arrests for Indians were recorded at a rate eight times higher than for whites. More recent data (Silverman 1996, pp. 58-74) are not as extreme but do show Indians having a 50 percent higher rate of "all reported crime." Unfortunately, gender data are not available.

The one source of data relevant to gang involvement among American Indian youth indicated that 15 percent of reservation American

Indian youth report some level of gang activity (*The State of Native American Youth Health* 1991). Yet given the evidence for gender differences in other populations (Harris 1992), it is imperative that gender patterns be further delineated and more fully described for American Indian females and their needs for prevention and intervention.

The information on Indian crime that does exist suggests that there are three distinct patterns: (1) There are higher levels of crime against persons, as opposed to property (Lee 1993); (2) alcohol is highly associated with crime and deviance (Lujan et al. 1989); and (3) high rates of arrest are related to high recidivism rates (May 1992). Still, the research is sparse, and there are no consistent data sources that offer a comprehensive and representative picture that accurately reflects the trends, especially those trends specific to American Indian females.

A good initial step would be to establish a continuing source of accurate data on American Indian females to track and monitor the trends. The Tri-Ethnic Center at Colorado State University in Fort Collins, CO, has collected valuable data on violence and victimization through two separate projects.

Beauvais and colleagues' 1996 study of American Indian, Mexican-American, and white American dropouts identified two patterns with respect to violence. First, school dropouts have the highest rates of having perpetrated violence on another person, followed by students at risk of dropping out or students with academic problems, and students in good academic standing from the same areas (Beauvais et al. 1996). This pattern is consistent across these three ethnic groups. Second, for American Indian, Mexican-American, and white students, there is more violence perpetration found among the males who have dropped out than among female dropouts. Reports of being raped or sexually assaulted are higher for dropout females than for those still in school in all ethnic groups (20.6 percent of American Indian dropouts and 22.3 per-cent of Mexican-American dropouts), with exceptionally high rates being reported by white female dropouts (57.5 percent).

In another study examining rural violence specific to women (Jumper-Thurman et al. 1996), data were collected during the 1993-94, 1994-95, and 1995-96 school years in 165 communities across the United States from the Prevention Planning Survey insert to the American Drug and Alcohol Survey. The sample is one of convenience and represents those communities that contracted for survey services

using both instruments. Of the 165 communities, 59 are categorized as nonmetropolitan, according to U.S. Census classifications of the counties in which they are located. Twenty-eight States were represented in the sample, with eight in the Western United States, seven in the Midwest, six in the Northeast, and seven in the South, as determined by regional breakdowns used by the Federal Bureau of Investigation to report crime statistics. Although communities are categorized according to standard Census criteria, most of the metropolitan communities represented in the database of the American Drug and Alcohol Survey have populations of less than 500,000; therefore, these data should not be considered representative of the largest cities in the United States.

In general, the highest percentages of victimization were in the categories of beatings by siblings and rape or sexual assault. Nonmetropolitan American Indian females in the 7th through 10th grades reported somewhat higher rates of sexual assault than their metropolitan counterparts, although the sexual assault rate for 11th- and 12th-grade metropolitan females was 42.6 percent. With the exception of two categories (being beaten by siblings and hurt with a club, knife, or gun), American Indian youth reported higher levels of violence and victimization in all categories than their white counterparts.

DRUG AND ALCOHOL USE AMONG AMERICAN INDIAN FEMALES

Beauvais (1992) also found interesting data on lifetime prevalence of tobacco and inhalant use. For reservation 8th- and 12th-grade females, cigarette use rates were 75 and 87 percent, respectively, compared with 46 and 63 percent, respectively, for white 8th- and 12th-graders. However, among both groups of females, cigarette use equaled or was higher than that of their male counterparts. Inhalant use among females is cause for concern as well. Thirty-five percent of 8th-grade reservation females and 21 percent of 12th-grade females reported inhalant use. Although use of inhalants is often believed to be a male problem, there were no differences between inhalant use rates of males and females (Beauvais 1992).

There are considerable variations in alcohol use across reservations and tribes, but alcohol does appear to be a universal problem among American Indians. Gender comparisons show only slightly higher alcohol use among adolescent Indian males than among females. In

fact, the death rate for American Indian women for chronic liver disease and cirrhosis exceeds the rate for American Indian, black, Hispanic, Asian, and white males (National Institute on Alcohol Abuse and Alcoholism 1978). Alcohol use among women of childbearing age is especially serious given the potential for fetal alcohol syndrome and fetal alcohol effects.

Beauvais (1992) also points out that the index of lifetime prevalence does not give a complete picture of drug use patterns. He presents a drug use hierarchy, classifying three groups of users: low risk, moderate risk, and high risk. Since about 1977, the high-risk group has not changed substantially; between 17 percent and 20 percent of Indian youth have used drugs enough to place them at high risk. It is important to note that Indian females are as likely to be in this high-risk group as Indian males.

Given this information, it is apparent that there is a need for further exploration of the barriers to the use of prevention, early intervention and detection, and treatment services. Likewise, prevention strategies and treatment modalities must take into account cultural factors so that they more consistently meet the prevention and treatment needs of American Indian women.

MENTAL HEALTH NEEDS OF AMERICAN INDIAN WOMEN

Threaded throughout these topics and closely interrelated are mental health issues. Although the IHS provides a great wealth of information on health issues, there is not a significant amount of information related to the mental health of American Indian females. The exception to this is suicide data indicating that American Indian females 15 to 34 years old have higher rates of suicide than their white counterparts. Jacobs and colleagues (1991) found that the typical client seeking help from the IHS, on or off reservation, is depressed or anxious; is usually experiencing situational crises such as domestic violence, disruption, and/or victimization; and has been or is now using alcohol or other drugs. Fleming (1989) reported that the problem categories for which American Indian women seek help from the IHS include adult-child relationships, grief reactions, child management or abuse, and marital conflict. Another study reported that 80 percent of American Indian

women at a regional psychiatric center serving a five-State area had experienced sexual assault (Old Dog Cross 1982).

The time has come to establish an accurate database for mental health tracking. Given the nature of the disorders that have been reported, it is time to take a strong and critical look at interventions targeting grief, parenting support, family systems, and posttraumatic stress disorder.

BARRIERS TO AND STRATEGIES FOR EFFECTIVE INTERVENTION

In focus groups, American Indian women listed mistrust of new programs as one of the primary barriers to seeking help. Most programs are temporarily funded demonstration projects that are introduced for anywhere from 2 to 5 years and then cease to exist. Because the women perceived that these programs were staffed with people who knew their families, they were reluctant to trust the credibility and confidentiality of yet another new program. They said that they just stand back for a year or two to see what will happen.

The women also indicated that the programs were usually developed by "outsiders," people who did not know their community or their needs sufficiently. Certainly this emphasizes the need to recognize that, when planning to work with an American Indian community or any ethnic community, the first step should be to build a collaborative and equal partnership that will empower and engage the targeted population. The program must also use the strengths and resources identified by those community members and improve the living conditions of the people. The community readiness model (Oetting et al. 1995; Jumper-Thurman et al., in press) can provide strong direction in this endeavor. In applying the Tri-Ethnic Center's work in community readiness for intervention, community members collaborate in identifying the specific characteristics that demonstrate levels of problem awareness and readiness for change. Therefore, the interventions are developed by community members, including them in the process; as a result, the interventions have a greater chance for success.

Finally, it is imperative that current research developments reach those people providing services to American Indian women. Although a single study may not be of great interest to the providers, a cluster of

studies demonstrating similar findings can assist them in forming a strong foundation for the development of health interventions. Because service providers seldom read academic and research journals, effective methods for knowledge transfer must be established.

These are honorable directives for all researchers. The authors close with an equally powerful directive from the Great Law of the Six Nations Iroquois Confederacy that is appropriate for an article on American Indian women. It states, "In our every deliberation, we must consider the impact of our decisions on the next seven generations."

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