Based upon several years' experience at a center for Amerindians in Chicago, the author analyzes the problem of alcoholism and the possibilities of treatment, rehabilitation, and control.

ALCOHOLISM, ILLNESS, AND SOCIAL PATHOLOGY AMONG AMERICAN INDIANS IN TRANSITION

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Introduction

THIS report is written from the vantage point of several years' work at the St. Augustine's Center for American Indians. The center is located in the heart of Chicago's Uptown area, which is characterized by high rates of transiency, crime, mental illness, and unemployment. There are many vacant or abandoned buildings. Some of these are being wrecked to make room for expensive high-rise buildings under the Urban Renewal program. In the process, the instability of the area is increasing. (Our own premises have been burglarized five times within one month.) The population of Uptown is a mixture of Appalachians, other whites, Indians, Puerto Ricans, and black Americans. For a better description of the area we turn to Jack Newfield:

"The tenements are run-down, the hallways smell of urine, many windows are broken. Drunks are folded in grotesque shapes in the doorways. The garbage is uncollected, and whiskey bottles wrapped in paper bags seem to grow in every front yard. The fugue of the police siren and the ambulance wail is heard often. Unemployment is about 25 per cent."[39]

The misery, frustration, despair and apathy that prevail in the area are harder to describe, for these are people who live in what Oscar Lewis calls "the culture of poverty." He states:

". . . only about 20 per cent of the population below the poverty line (between six and ten million people) in the United States have characteristics which would justify classifying their way of life as that of a culture of poverty. Probably the largest sector within this group would consist of very low-income Negroes, Mexicans, Puerto Ricans, American Indians and Southern poor whites."[32]

These are the very groups who live in Uptown, or more accurately stated, are squeezed into what remains of decaying buildings. Oscar Lewis's description of the culture of poverty is most pertinent for our purposes:

"The culture of poverty is both an adaptation and a reaction of the poor to their marginal position in a class-stratified, highly individuated, capitalistic society. It represents an effort to cope with feelings of hopelessness and despair which develop from the realization of the improbability of achieving success in terms of the values and goals of the larger society.

"On the family level the major traits of the culture of poverty are the absence of childhood as a specially prolonged and protected stage in the life cycle, early initiation into sex, free unions or consensual marriages, a relatively high incidence of the abandonment of wives and children, a trend toward female- or mother-centered families.

"On the level of the individual the major characteristics are a strong feeling of mar-

ginality, of helplessness, of dependence and of inferiority.

"Other traits include a high incidence of maternal deprivation, of orality, of weak ego structure, confusion of sexual identification, a lack of impulse control, a strong present-time orientation with relatively little ability to defer gratification and to plan for the future, a sense of resignation and fatalism, a widespread belief in male superiority, and a high tolerance for psychological pathology of all sorts."[32]

It is against this background that we must examine Indian alcoholism in Uptown. It would be an oversimplification, however, to assume that the culture of poverty is a primary reason for alcoholism among urban Indians. First of all, this symptom is far more prevalent among American Indians and Appalachians than among the other ethnic minority groups of Uptown. Secondly, as we shall see, alcoholism is also very widespread among many other groups of American Indians living under very different conditions from those of Uptown.

The much higher arrest rates for drunkenness and alcohol-related crimes for American Indians than for non-Indians has been revealed in several studies.[13,14,22,33,51] In proportion to San Francisco, California, which has the greatest number of alcoholics among the larger cities, Gallup, New Mexico, has one hundred times as many alcohol arrests. There is, of course, always much excessive drinking in communities near dry reservations. Also, Indians drink more openly, frequently on the street even in Chicago, which is an indication that there is little or no shame in being drunk. Most studies point to the absence of negative sanctions against drunkenness.[6,9,13,14,28,54] Because of the prevalence of public drinking and intoxication among Indians, they are more subject to police arrests than other ethnic groups.

All this must be kept in mind before drawing conclusions from alcohol arrest rates. Some observers point out that the high alcohol arrest rates for Indians are influenced by the aforementioned factors, and are the result of a proportionately small number of Indian alcoholics with repeated arrests. However, contrary evidence reveals that alcoholism is widespread among many groups of American Indians. For instance, 1965 statistics from the Chicago House of Correction (city jail), made available to me for the purpose of this study, indicate that 180 male American Indians were admitted altogether 207 times. Of this group, 150 men were admitted only once. The remaining 30 men (one-sixth of the group) were recidivists constituting the other 57 arrests, including one man with 17 arrests.

According to Graves,[18] police records indicate that about half of all Navaho migrants are arrested at least once during their stay in Denver, Colorado. Over 95 per cent of these arrests are alcohol-related. Whittaker[54] found drinking and alcoholism more widespread among the Standing Rock Sioux than among the surrounding white population. The Mescalero Apache Reservation, which the author visited in 1968, reports that 23 per cent (almost one-quarter) of its adult population were problem drinkers as compared to 4.5 per cent for the adult United States population. The same study[6] reports that nearly half of the adult deaths on the reservation were directly or indirectly due to alcoholism, and that a third of all the children on the reservation had one or both parents with a drinking problem.

While alcoholism is considered the fourth major health problem nationally, the Division of Indian Health of the United States Public Health Service, and the Navaho Health and Navaho Alcoholism Committees, consider it the number one health problem of American Indians. In 1966 the Indian death rate from cirrhosis of the liver, a disease fre-

quently resulting from alcoholism, was three times the rate for the total population.[20]

Obviously, alcoholism is a severe and extensive problem among American Indians and is so regarded by most of them. To those who feel offended by this fact or who think that I am trying to perpetuate a common stereotype, it can only be said that no serious problem can ever be solved by sweeping it under the rug or by pretending that it does not exist. There are very good reasons for widespread alcoholism among Indians and this paper will attempt to examine these reasons critically and in detail. Rather than deny the existence of disagreeable symptoms, I aim to expose some of their causes and to explore solutions.

Alcoholism, Illness, and Social Pathology

Although there are examples of cultures with high standards of living and high alcoholism rates, such as Scandinavia, Indian alcoholism appears to flourish under opposite socioeconomic conditions.

In 1967 it was estimated that 90 per cent of Indian housing was substandard and that the unemployment average on reservations was 46 per cent.[4] The average income for an Indian family is $30 a week, in comparison to $130 a week for the average non-Indian family.[12] The health status of American Indians is about 20 years behind that of the general population as a result of an unfavorable environment, poor land, substandard housing, and nonexistent water and sanitary facilities.[2]

More than 70 per cent of American Indians are using unsafe water, and more than 80 per cent have to haul it for a mile or more.[11] Most of the Navahos travel between 1 and 25 miles and many spend as much as six hours a day to get their water supply. The United States Public Health Service estimates that only a third of the reservations have running water and waste disposal facilities.[4] The high incidence of trachoma among Indians is attributed to the contaminated water situation.

There is 7 to 15 times as much tuberculosis among Indians as among non-Indians.[2] In 1966, Indian infant mortality was 38.5 per 1,000 compared to the United States average of 24.8 per 1,000.[4] Life expectancy for Indians is 63.5 years compared to 71 years for white Americans.[20] As a result of malnutrition, Indian children are less able to withstand infectious disease, frequently develop secondary complications, and require prolonged periods of hospitalization.[2] Respiratory diseases, gastroenteric diseases, streptococcal sore throats, and otitis media, are particularly prevalent among Indian children.

A USPHS officer from Red Lake, Minnesota, confirmed the high incidence of infectious diseases among the Chippewa. Ear infections, pneumonia, and skin diseases are most common. He emphasized that where alcoholism was absent there was less infectious disease, such as hepatitis and impetigo. A social worker from the USPHS in Tuba City, Arizona, told me that most cases of pneumonia, burns, accidents, fatalities from freezing, malnutrition among children, and infant mortality, are alcohol-related. Between 1962 and 1964, 11 children under the age of two were hospitalized on the Mescalero Apache Reservation[6] because of "malnutrition, dehydration, and neglect directly related to the excessive drinking of their parents." During the same period, 44 per cent of all adult deaths on the reservation were alcohol-related and 3 (14%) of 22 children's deaths were due to excessive alcohol use by their parents.

Between 20 per cent and 25 per cent of American Indians suffer from psychiatric disorders. "Family disorganization and mental illness are far more

common among them than among poor urban Negroes."[20] The Third National Conference on Indian Health listed the major causes for psychiatric disorders as

> ". . . the disintegration of their culture, the generally poor level of education, poverty, disturbing childhood experiences, and the ambivalent position of the federal government, the trustee of the Indian's land, in relation to the Indian."[11]

The Indian was described as caught between two cultures. It was felt that this situation "calls for a direct attack on both the psychiatric and economic fronts."[11] As for alcoholism, some of the conference participants felt that alcohol serves the Indian primarily as a safety valve—an outlet without which he might develop serious psychiatric problems.

Contrary to widespread belief, the Indian suicide rate is not much higher than the national suicide rate of 11 per 100,000. However, there is considerable variation in suicide rates between different groups of Indians, depending on acculturation pressures and the resultant social disorganization, as well as on tribal traditions and attitudes toward suicide as a response to stress. While some groups have much lower rates than the national average, others have rates that are more than 10 times as high.[20]

A rate of 31 suicides per 100,000 (not including deaths from self-destructive acts like accidents, refusal of medical care, and the like) was reported for two reservations in Idaho.[37] On the Pine Ridge Reservation, South Dakota, the rate for suicide attempts was more than twice as high as for Los Angeles, California.[38] A resident from a small, relatively acculturated Pueblo told me that six of his relatives had committed suicide within a six-month period. On the other hand, the suicide rate in the more traditional Pueblos is far below the national average. Although the Navaho suicide rate is only 8.28 for 100,000, relatively high suicide rates have been reported for their younger, more acculturated males.

Frequently, feelings of depression and/or alcohol intoxication, sometimes caused by family discords, precipitate these suicides.[31] As we shall see below, Indian suicides frequently seem to reflect the breakdown of traditional patterns and consequent impossibility to express aggression in culturally acceptable ways. When this occurs, the aggression is directed toward the self instead of, as formerly, toward members of the outgroup.

A high death rate resulting from automobile accidents has been observed. On the Crow and Cheyenne reservations that rate was 28 times higher than for the state of Montana.[48] Death from homicide occurs nearly three times as often among Indians as for the total population.[20]

Indian Attitudes Toward Disease

Self-destructive behavior, including traffic accidents, is, of course, not uncommon among alcoholics[34] and, whenever it occurs, it creates a severe handicap in therapy or rehabilitation. Usually the patient needs help to become aware of his hostile and self-destructive impulses. However, I have found American Indians generally more ready to admit their unwillingness to give up drinking than non-Indians. Perhaps this is because the Indian alcoholic does not feel stigmatized by his alcoholism, as we have pointed out earlier. Some observers[48] believe that Indians tend to regard alcoholism more as a social than a psychiatric problem, and as more within the province of the police, courts or Alcoholics Anonymous than a subject for a psychiatric clinic. I was told that on one northern reservation excessive drinking is accepted as a way of life, as is ear infection.

Frequently Indians exhibit a resigned attitude toward illness which seems to tie in with certain religious beliefs. The traditional, unacculturated Ojibwa believe serious illness to be due to sorcery,[19] something inflicted magically by an enemy. Traditional Navahos tend to view illness as the result of being out of harmony with spiritual, physical, and emotional forces, contact with a wild animal, or touching wood struck by lightning.[2] According to Kaplan and Johnson,[25] witchcraft is assumed to be the main cause of emotional illness, i.e., "ghost sickness." In contrast to this, "crazy violence" is not considered a mental illness and is regarded as a normal consequence of drunkenness. The person engaging in violent behavior is thought to be either unaware of his actions or indifferent to the consequences of his violence. Ari Kiev[26] sees the expression of violence among the Navaho as a substitute expression for their former hunting and raiding traditions. Others[10,16] share this opinion and view Indian suicides, homicides, accidents, and violent behavior while drinking, in terms of a breakdown of tribal culture patterns, and the inability to handle aggression in previously acceptable ways. Since this type of patient is not thought to be the victim of witchcraft, the culture has no provision for ceremonial exorcising techniques. Instead, the usual method is to restrain the violent person and to take him to jail.

Such beliefs about illness tend to complicate modern treatment approaches. Perhaps this is one of the reasons why patients are frequently not seen until their illness is far advanced.[2]

Many Indian women do not take full advantage of the prenatal medical facilities in Uptown, and frequently they do not report to the nearby Infant Welfare Station until the third trimester of pregnancy. As I was told by their medical and nursing staff, many of the expectant Indian mothers are undernourished, have low hemoglobin, and their newborn babies are highly susceptible to infectious diseases. This situation is quite common and has been confirmed by other observers[2] who point out that childbearing is considered a natural life experience and a very personal matter. This and feelings of modesty preclude many Indian women from seeking prenatal and even postnatal care.

A pilot project initiated some years ago in the Lakeview-Uptown area by the Planned Parenthood Association failed to attract Indian women and was not considered successful by that agency. Last year, the nearby Infant Welfare Station reported that of 75 Indian women who started on oral contraceptives only 18 remained in the program. The rest dropped out. More recently, the Women's Club of the American In-Indian Center of Chicago voted against inviting a Planned Parenthood social worker to speak to them because this subject was considered to be too personal to discuss, particularly in a group. Similar failures have been reported on a Chippewa reservation, where a family planning program was being conducted by the Bureau of Indian Affairs and the United States Public Health Service under Secretary Udall's direction. Indians, who have had to fight century-long white attempts to annihilate them, frequently and understandably respond to such programs with great anxiety and hostility.

The "Indian Personality" as Seen by Non-Indians

Problems arising from divergent cultural attitudes toward illness, treatment, and prevention lead us to a consideration of the "Indian personality." It might be simplistic, perhaps erroneous, to think in such terms if we stop to consider the cultural differences between tribes and individual variations within each tribe. Nevertheless, Indians seem

to share some basic cultural characteristics and personality traits which are only rarely encountered among Anglo-Americans, and which set them apart from the dominant culture.

The Spindlers have described the psychological features most widely exhibited among North American Indians as a whole as "nondemonstrative emotionality and reserve."[47] Hallowell refers to "a multifaceted pattern of emotional restraint and inhibition."[19] He describes the reluctance of Indians to tell others what to do, including the more permissive parental attitude toward children, for fear that otherwise the children may retaliate against the imposed parental discipline. In other words, much of this behavior is motivated by a wish to avoid provoking resentment in others. Consequently, hostility and aggression must be inhibited, which frequently leads to depression and somatic complaints. The disruption of a close, hostile-dependent relationship is another reason for such symptom formation, according to Mindell.[38] The practice of noninterference with the needs of others is adhered to so pervasively that Indians find it difficult to interact with aggressive whites and to respond to our usually coercive behavior.

In the light of this observation,[53] the "stoic and passive" behavior of Indians is seen as a defense mechanism, an attempt to withdraw from the onslaught of a disagreeable confrontation. Furthermore, Indians are inclined to react more by engaging in quiet observation than by responding with direct and premature action. We see this, to some extent, in social situations among unacculturated young Indians.

A Winnebago told me that he started drinking on the reservation at 15. "It made it easier for me to talk with girls —alcohol removes the restraints—boys and girls won't mix otherwise." He stressed that he used to feel self-conscious and shy in social situations and that "Indians need to drink to talk with each other." Similar observations have been made about Navahos.[13] At a dance, which I attended in Gallup, New Mexico, I noticed a number of late adolescent Navaho boys grouped together. The girls were standing off by themselves. Some were dancing with each other, some were sitting by themselves as were a number of boys. Drinking was not allowed at the dance. There was very little verbal communication between boys and girls, even while they were dancing together. Similar observations have been made about the Chippewas. By contrast, the dancing I observed among a similar age group of Indians in Chicago was far less inhibited. There was considerable drinking, boisterousness, and near violence. The role of alcohol in breaking down communications barriers will be discussed more fully at a later point.

L. Mayland Parker[40,41] outlines and compares Indian and non-Indian cultural values. He describes Indians as more present-oriented, patient, in harmony with nature, pragmatic, and as less competitive, aggressive, materialistic. They are more subject to feelings of shame than guilt. Religion is experienced as a way of life rather than a segment of life, and there is an absence of time-consciousness. As a Mescalero Apache told me, "White people denounce their God if He doesn't meet their requests, but the Indian believes that if he's killed in battle it's his own fault. . . ." He added, "You always have a time limit in the city . . . even on vacation . . . the first week is fine, nothing bothers you . . . the second week you are worried about the money or lack of time . . . in the city there's never enough time . . . people rushing . . . you wished you'd never heard of work. . . ." One of my informants, who had worked with Navahos, believes that many Navahos try to escape from the pressure and tension created by this kind of time-consciousness through drinking.

Indian-Caucasion Relations

From the foregoing, it becomes easy for us to understand why most of the Mescalero Apaches who were relocated into urban communities during the years of the Eisenhower Administration have returned to their reservation. Statements that "their contact with White society has effectively made the Apache more aware of their inferior position . . ." and that "they are reluctant to attempt to compete with the White man, and almost always return to the Reservation after attempting to live outside,"[8] seem to imply that Indians are poor losers, not because they lost the ball game but because they refuse to play it by our rules. The literature,[48,49] and my personal contacts with Mescalero Apaches and other Indians convince me that many have no particular desire to adjust to urban life. They come to the city for technical training under the Bureau of Indian Affairs (BIA) programs but do not intend to remain here in the first place. One observer expressed it very well: "We want the Indian to get off his reservation and get a welding job in Detroit so he can afford to buy a steak which he won't be able to eat because of ulcers or, in other words, 'why don't you get a mortgage like us?' "

When people express agreement with plans imposed on them by paternalistic government agencies, they are bound to resist and sabotage these plans in a passive-aggressive manner.[30] I believe that, as in other minority groups, we will see definite changes in the long-standing use of passive-aggressive defense mechanisms. Increasing interaction with whites is likely to bring about further modifications in the "Indian personality." D'Arcy McNickle cites a workshop report analyzing the characteristics of a group of Indian students as follows:

> "The students . . . could be divided into four groups, as follows: (1) 'conservatives' with little or no conflict about their identity; (2) 'shaper-uppers' who accept the negative definition of Indian given by the majority culture and who resolve their negative self-definition by being 'good Indians' and trying to make other Indians into 'good middle-class Americans'; (3) the 'angries,' influenced by pan-Indianism and Indian 'nationalism' who, while accepting much of the definition of Indians given by the majority culture, refuse to accept the majority culture and display a certain amount of hostility toward it; and (4) 'self-haters' who, as yet, haven't discovered how to handle the situation."[35]

Unfortunately, representatives of Western culture have ignored the needs and aspirations of American Indians, particularly in the area of education and employment. Consciously or unconsciously we have tried to alienate Indians from their own culture, from their own people and from their own traditions.[48] It is not surprising that all of this has resulted in confusion and social problems such as:

> "Unemployment, welfarism, alcoholism, abandoned children, and juvenile delinquency, most of which could be severely curtailed if educational programs were developed which more adequately met the peculiar needs of the Indian student."[52]

Instead, we find widespread truancy among Indian school children in both Uptown and Lakeview. I have surveyed some of the grade schools in those two areas and spoken with several teachers, principals, guidance counselors, and attendance officers. Here are some typical comments about their pupils:

> "very difficult to motivate";
> "has no interest in school";
> "uncooperative, poor attendance";
> "does little work but is no problem in the classroom";
> "is absent quite a lot";
> "very immature; comes to school unwashed, tired";
> "does not wish to be part of the group";
> "resents authority, daydreams and plays most of the day."

These comments could well apply to a substantial portion of the school population who live in the culture of poverty

in Lakeview-Uptown, and not only to Indian school children, some of whom adjust reasonably well to unreasonable educational requirements. There are, however, some differences. I was told that Indians are more likely to be truant, and that they do not disturb the classroom situation by noisy, aggressive behavior which is more symptomatic of maladjusted Puerto Rican children. One guidance counselor told me that Indian students become more listless and truant when they reach the upper grades.

I believe that much of this is a reflection of an educational system that does not address itself to the needs and interests of the population in the area. It is a system which overlooks that, "for the American Indian, education, as we know it, is primarily a process of adjusting an individual to a foreign culture."[52] The goal of "'helping" Indians adjust to Western culture has frequently been pursued with a vengeance. Unfortunately, the psychological effects of the boarding school system cannot be discussed adequately within the context of this report. This system of removing six-year-old children from their homes, and letting them see their families only once a year during the summer vacation, has been characterized succinctly by the late Senator Robert F. Kennedy as "barbarous." We know of situations where homesick children have run away from boarding schools and frozen to death on their way home.

The educational situation is dismal throughout the country. The Minneapolis high schools report a 60 per cent dropout rate for Indian students. Transiency is one of the reasons for this failure. Compulsory school attendance and the stereotype portrayal of Indians in textbooks compound the problem further.[3] A 13-year-old Chippewa, referred to me by the school because of a truancy problem, was subsequently suspended for a minor infraction.

What holds true for the attitudes of school personnel toward Indians applies equally to other representatives of the establishment. As we see in our daily contacts with courts, welfare agencies, hospitals, clinics, and so on, none of these institutions are geared to relieve suffering, because their ineffectual procedures prevent the rendering of tangible services. The impersonal nature of these agencies and their bureaucratic methods of operating provoke mistrust and hostility.[3] Indian patients, whom I interviewed in the local Tuberculosis Sanitarium appeared depressed and invariably expressed feelings of helplessness and hopelessness. They spoke of feeling "cooped up." One patient felt too depressed to get out of bed in the morning. At other times he felt so angry that he "could tear the building down." Most of these patients, desperately lonely alcoholics, left the hospital prematurely. Frequently, after lung surgery, there was anxiety about their inability to support themselves by unskilled labor.

One of the major areas of conflict between whites and Indians is in different attitudes toward work. Our employment counselor found that many Indians do not like the monotony of factory work, that they do not like to travel long distances to and from their jobs, and that they find restaurant work too demeaning and unmanly. This accounts for much frustration, drinking, and instability. Furthermore, advancement on the job has little or no meaning, and sometimes it is actively avoided in order not to place oneself in a position of authority over one's fellow men.

To combat the terrific unemployment problem on the reservations, the BIA has been relocating Indians into more industrial urban areas. In the words of one Indian Community Action Program employee with whom I spoke in the Southwest,

"Relocation is not the answer for our Indian people. We should try to bring industry to the

Pueblos. . . . The BIA doesn't consider the attachment and deep roots we have to the land. If a Pueblo eats beans it becomes a part of him and he becomes a part of the soil and part of God. . . . Breaking away from the land is like breaking away from one's children . . . besides, it's hard for Indians to look for work in the city . . . they are shy and not persistent and don't return . . . it's a matter of pride."

However, bringing industry to the reservation is not necessarily the answer either, if the work to be done is unrelated to the life of the individual, yields no fulfillment, and is not meaningful to the tribe.[40,41] Contrary to commonly held assumptions that unemployment on Indian reservations leads to increased drinking, we find that on the Sioux Reservation at Standing Rock, South Dakota, the amount of drinking increased with an increase in employment.[54] Furthermore, we have learned that interest in steady employment does not fit in with the background of a nomadic hunting culture, and that frequently Indians prefer not to be tied down to a job, particularly if the work is not meaningful.

Several of the alcoholic men, whom I interviewed at St. Augustine's Center, indicated that they preferred irregular employment (daily pay) to a steady job. Others, however, complained that they had come to Chicago in search of better job opportunities, only to be disappointed. I surveyed a sample of the agency's clients and many expressed disillusionment at their inability to find good jobs and decent housing. Some people said they were selling blood in order to have the necessary carfare and clothes to look for work.

Additional frustration arose from difficulties in learning how to get around in the city. Some feel overwhelmed by its vastness and impersonality and by the complexity of the transportation system. Another complaint was that, frequently, family and friends had to be left behind on the reservation because of economic circumstances. Excessive drinking was usually admitted quite openly and many considered it their major problem. Some noticed an increase in their drinking since coming to Chicago and blamed their alcoholism on boredom and on not wanting to hurt their friends' feelings by refusing to drink with them.

The Nature of Indian Drinking Problems

Various attempts have been made to uncover the dynamics of American Indian alcoholism and to find the key to treatment, rehabilitation, and prevention. Because of individual differences in intrafamilial relationships, in tribal background, and in the degree of acculturation to the city, it is difficult to find a simple set of dynamics that would apply to urban Indian alcoholics. There are far too many variables to consider Indian alcoholics a homogeneous group about whom we can make generalizations. Indian drinking, as we have observed it in Chicago, cannot be reduced to a simple formula of either cultural dynamics or psychodynamics. On the basis of clinical experience, I believe that the dynamics of American Indian alcoholism are extremely complex, that different groups of Indians have adopted different drinking patterns, and that there are *many* reasons which underlie their drinking.

Ferguson[14] discusses some of the reasons for alcohol use among American Indians. It may serve to:

(1) relieve psychological and social stress produced by their own tribal culture;
(2) facilitate the release of repressed hostility and aggression;
(3) help attain a state of harmony with nature;
(4) make for more pleasant social interaction with friends, particularly where people live in relative isolation as on the Navaho Reservation;
(5) relieve psychological pain because of pressures from acculturation.

Whatever the reasons, there appears to be general agreement that (1) no social stigma or moralistic attitudes are connected with Indian alcoholism[6,9,13,14,54]; (2) there is no evidence of any unusual physiological sensitivity toward alcohol or predisposition toward alcoholism on the part of any ethnic group, including American Indians[24,51]; (3) most Indians drink in groups and solitary drinkers are rare, except in category (5) above.

American Indian alcoholism has been described as a "unique pattern of use in which drinking is periodic and explosive, but nonaddictive."[9] This closely resembles Jellinek's description of Finnish drinking patterns (although Jellinek never used the category "Zeta alcoholism"). Here, too, we have periodic and explosive drinking which frequently results in violence. There are other interesting similarities between Finnish and certain American Indian alcoholics, namely the emphasis by the Finnish culture on "maximum control from the individual. This is particularly so in the work situation where cooperation and absence of conflict is essential. . . ."[24] This illustration of Finnish lumbermen, who work and live in relative isolation and who come to the city only once every three or four weeks, describes their explosive drinking and violent homicidal behavior. They show no overt signs of acute intoxication and they do not become addicted to alcohol. Because much of American Indian alcoholism appears to coincide with this description, it might be valuable to further explore this whole area at a future time.

A. *Drinking to Relieve Anxiety*

This report has stressed the economic insecurities and physical hardships under which most American Indians and Eskimos are living today. Some observers believe this to be the major cause for Indian alcoholism. Horton[23] believed that the degree of alcoholism in a primitive society corresponds to the degree of anxiety generated among its people because of lack of food and acculturation. Although rejecting a simplistic explanation for Navaho alcoholism, Dr. Robert Bergman, chief psychiatrist of the Navaho Indian Health Area, believed some of his patients to be suffering from depression because their children are starving. Whether such depression leads to alcoholism is not clear, however. Besides, there appears to be much controversy among experts as to starvation among Navahos, although few would deny that many children die from secondary complications as a result of severe malnutrition.

Although Horton's theory has come under much scrutiny by other anthropologists[28,54] who have observed an increase in alcoholism with an increase in prosperity, we cannot afford to disregard certain implications of Horton's theory. In rejecting Horton's theory, Field states that:

> "Drunkenness in primitive societies is determined less by the level of fear in a society than by the absence of corporate kin groups with stability, permanence, formal structure, and well-defined functions."[15]

He concludes that:

> "Horton's measures of an insecure food supply and acculturation indicated a loose social organization rather than fear. Indices suggested by psychoanalytic hypotheses about alcoholism (oral fixations, latent homosexuality, and drives toward self-injury) did not predict primitive drunkenness."[15]

We will examine these two statements within the context of our subsequent discussion (B and C).

B. *Drinking to Release Repressed Aggression*

From our own clinical experience and those of others, psychodynamics appear quite useful. In his study of Navaho alcoholism, Savart observed that "many

more alcoholics than nonalcoholics indicated that they considered their childhood to have been not too good or pretty bad," and that "many more alcoholics than nonalcoholics had trouble letting people know when they were angry."[44] Similar observations have been made of other tribes. Hallowell[19] describes the use of alcohol by the Salteaux to release inhibited aggression. Whittaker reviews the same phenomenon in his study of the Sioux. He noted a "tendency to excuse normally unacceptable behavior when the individual is drunk" and "to accept the individual back into the group, once he sobers up, without any reservations."[54] Dizmang describes the breakdown of culturally acceptable ways in dealing with aggression among the Cheyenne and their unsuccessful "attempt to dissolve some of the unmanageable aggression in alcohol."[10] In a recent study on the Kiowa Apache, Freeman states that

> ". . . severe alcoholism is virtually universal among adolescent and young males . . . alcoholism serves too as an outlet for aggression, now that no idealized outlet for instinctual behavior is available."[16]

Clinical evidence from our case load at St. Augustine's Center supports the latter. We have seen repeatedly that ego-alien behavior is acted out under the influence of alcohol.

Another dimension must be added to encompass those alcoholics whose excessive drinking serves not only to reduce inhibition and to release aggression, but where it becomes a direct substitute for aggression. We have seen some instances among non-Indians where alcohol helped to repress rather than release hostility and, according to Bunzel's study[7] of the Chichecastenango, this appears to hold true for an entire cultural group.

We recognize that not all Indian alcoholism is the result of psychopathology or of cultural breakdown. As we said before, there are several types of Indian alcoholism. However, our own case load at St. Augustine's Center leads us to believe that psychodynamic factors are important. Many of our cases seem to follow Zwerling's and Rosenbaum's description of the etiology of alcoholism, i.e. an early disruption of the mother-child relationship, followed by distrustful withdrawal, persistent passive-dependent longings, frustrations, rage, ambivalent dependency relationships, and depressions. Cultural attitudes which provide an outlet for these tensions through alcohol use are, of course, essential.[55]

C. *Drinking to Relieve Pressures from Acculturation*

The impact of culture conflict has long been considered a major cause for Indian alcoholism.[23] Whether acculturation can take place without leading to culture conflict and without producing anxiety while weakening the tribal social structure[15] appears questionable. Alfred found a significant increase in blood pressure among Navahos after they had moved to Denver, and he concludes that "migration is a source of stress for the Navahos."[1] Half of them return to the reservation after six months.[46]

In spite of this, we cannot always account for alcoholism on the basis of cultural stress. Graves[17] demonstrates that, while acculturation for Spanish-Americans was consistently associated with higher rates of drinking, the opposite held true for Indians. Unacculturated Indians had higher rates of drinking behavior than acculturated ones, except for the acculturated Indians without satisfactory employment. This latter group expressed feelings of deprivation and alienation. The unacculturated group felt even more deprived and alienated.

Ferguson[13] differentiates between *anxiety drinkers* and *recreation drinkers*. The anxiety drinkers are more accul-

turated. They avoid arrests to protect their new self-image, but appear more disturbed than the other group. Anxiety drinkers, "frequently the most well-educated and well-employed, . . . suffer most from psychic conflict in their contacts with the dominant society." The recreation drinkers, on the other hand, "are not greatly affected by acculturation difficulties." They drink because "drinking is one of the pleasures of town," and are more subject to the pressures from drinking peers.

Although the recreation drinkers have high rates of arrests, there are no sanctions against their excessive drinking. Nevertheless, it is this group which has been treated most successfully by Antabuse and supportive therapy. The anxiety drinkers appeared unresponsive to any form of therapy. While this seems at first surprising, it is not too difficult to understand when we consider the psychological confusion of living between two worlds and of not feeling fully accepted by either.

Madsen notes that "alcoholism increases with accelerated acculturation but incompleted assimilation."[36] The whole problem of identity and of guilt over abandoning the ancestral heritage and tradition in exchange for economic gain is brought into focus.[5,37,43] One college-educated Indian told me that the people from his Pueblo considered him a white man since he left home for a government job in a larger city. "What shall I do?" he asks, "give back my degree to become an Indian again?. . . . I've even become a Catholic dropout and embraced the Indian religion again . . ."

William Douglas of the University of New Mexico told me that, in most Pueblos, many young people in the 18- to 25-year-old bracket are rejecting the values of their communities and are refusing to participate in dances, Kachina ceremonies, and the like. However, in time they return home and frequently they become the mainstay of their communities. Perhaps this earlier acting-out behavior does not constitute an adolescent rebellion nor any real disaffection from their tribal culture, but rather a desperate attempt to establish their own identity in the absence of ego ideals, and in the face of a breakdown of earlier cultural traditions. This seems similar to the alcoholism of the Kiowa Apache boys in their late teens and early twenties. By the time they get to be 30 or 40 years old, the drinking tapers off considerably, according to Freeman.[16] Robert Bergman told me that he made similar observations of severe drinking among Navaho men and women between the ages of 18 and 25, and subsequent decrease. However, William Spining of San Francisco reports of contrary observations among Navahos.

In many cultures, including our own, adolescents are very sensitive about their self-image and unclear about their role in society. Under pressures of acculturation, such problems are likely to increase. For instance, in Isleta—a village 15 miles from Albuquerque, New Mexico, which I visited briefly—people are continuously forced to move back and forth between two cultural worlds. Many of the inhabitants have jobs in the city but continue to live in the Pueblo.

The inability of many to adjust to the demands and tempo of urban, industrial America (even where the stay in the city is time-limited as in the case of Eskimos brought to Chicago by the BIA for training) leads to increased anxiety, withdrawal, and alcoholism. A local protestant (fundamentalist) minister, whose congregation included several Eskimo families, told me that occasionally he conducted worship services in their homes because many of the Eskimos were afraid to walk or travel the one mile distance to the church. Distances had never been an obstacle back in Alaska. Except for some of the

younger, single men, who had been in military service, Eskimos were not used to urban transportation, shopping in supermarkets, inside plumbing, and so on. "It was all new to them."

According to this minister, Eskimo children were more susceptible to influenza than white children. Some of them died. In one case the mother did not know how to obtain medical help in time. The baby was buried in a common grave near the wall in Graceland Cemetery for lack of money. There was alcoholism and occasional breakup of Eskimo families, necessitating placement of the children in foster homes. The minister told me that

> ". . . the Eskimos practically lived on the lake—taking them on outings to the forest preserve did more for them than anything else could have done. They'd enjoy sitting in the most open, untamed areas in the midst of weeds rather than at picnic tables. Sometimes we'd let them cook food here in the church basement; they'd buy the toughest grades of meat to simulate reindeer stew."

Obviously the church was providing an important and meaningful social outlet.

D. *Drinking to Promote Group Solidarity*

Heath suggests that, according to anthropological studies, "the act of drinking, like eating, may in itself have a peculiar significance as a means of expressing corporate solidarity."[21] In such cultures "alcohol plays a predominantly integrative role and serves to facilitate rapport between individuals who are normally isolated and introverted." New emphasis has been given to alcohol as a way of expressing group identification and solidarity by Field,[15] Lemert,[29] and Simmons.[45] It is in this context that we must look again at Ferguson's recreation drinkers, described earlier. Drinking appears to be an integral part of their culture. Like most Indian drinkers in Chicago, "a Navaho is seldom found drinking alone for very long. . . . The pressure to drink with friends is very great. Refusing to accept or to buy a drink is an affront."[14] Unlike other alcoholics, these drinkers are not alienated from their people. There are lessons to be learned from this for ourselves. I believe that much of Indian drinking which I have observed in Chicago, particularly in Uptown, has similar characteristics.

As mentioned earlier, we have encountered several types of drinkers such as those who drink to:

(1) cope with internal anxieties and depressions stemming from severe trauma in early childhood;
(2) release repressed aggression;
(3) find a substitute outlet for aggression;
(4) withstand pain and conflict from acculturation pressures;
(5) find a new identity (particularly adolescents);
(6) be or to become part of a group.

In view of such diversity we will, of course, have to be equally diversified in our treatment and rehabilitation approaches.

Treatment, Rehabilitation, and Control

Because of the varieties of drinking patterns among American Indians and the many reasons for excessive drinking behavior, it would be unrealistic to design a single treatment modality. The problem is further complicated by the fact that most urban Indian alcoholics may not wish to give up their excessive drinking habits for fear that life would become even more unbearable than it is at present. Also, we must consider the additional function of alcohol as a form of symbolic resistance, enabling the individual or the group to assert its independence from a hostile, alien, moralistic society.[29] Thus it becomes necessary to carefully determine the specific role alcohol plays for each culture group, and for the individual within that group, before attempting rehabilitation. Furthermore, regardless of the treatment

modality, full cooperation is essential. Because we cannot successfully treat uncooperative alcoholic patients, we must avoid increasing their resistance by superimposing our treatment goals and methods on them.

Alcoholics Anonymous has, by and large, not had much appeal among American Indians, perhaps because of its emphasis on the alcoholic's need to admit his personal weakness. This very concept is, I believe, offensive to most Indians. Nor are the religious overtones of the AA program acceptable to many Indian alcoholics. Frequently Indians consider this "a white man's program" which is unacceptable to them. I understand that AA has had some success on certain reservations when nonalcoholic family members, including children, were allowed to become involved. A Navaho explained it to me this way: "We don't like to be exclusive. When we become exclusive we lose touch with our people."

In the Gallup, New Mexico, area some efforts are being made to reach alcoholic Navahos through groups with whom the patient has closer contact, such as his family, clan meeting, powwow, council meeting, or a ceremonial or ritual group. Because of the absence of a detoxification center, the "cold turkey" method is employed, either with the patient's cooperation or, sometimes, by default if the patient has been arrested and is being detained in jail. According to Herbert Blatchford of the Gallup Indian Community Center, the rehabilitated individual is, at first, rejected by his own group. However, if he maintains his sobriety, he gains their respect and later he is imitated by those other group members who want to become rehabilitated too. This method has interesting sociological implications and brings to mind some aspects of Rubington's experiment[42] in New Haven, Connecticut.

Throughout New Mexico and Arizona, disulfiram (Antabuse) is used fairly extensively in the treatment of Indian alcoholics. Ferguson[13] describes the employment of Antabuse as an adjunctive treatment method with unacculturated recreation drinkers discussed earlier. However, she told me that there was some recidivism over a period of time.

The alcoholic patient who goes to the United States Public Health Service in Gallup, New Mexico, is given a five-day supply of Antabuse, is sent home and told not to drink alcohol during that period. The patient is then given a wine test in the presence of a Community Alcoholism Worker. This method varies with each USPHS hospital facility, depending on bed space, staff time, and so on. In the USPHS Hospital in Tuba City, Arizona, for instance, the patient stays in the hospital for the five days under medical supervision. Then the wine test (4 ounces of 20% wine) is administered and the patient's reactions are carefully observed and recorded. After the test, a one-month supply of Antabuse is issued to the Community Alcoholism Worker. He remains responsible for the patient and has to visit him for the next six months. The Community Alcoholism Worker appoints the Helping Person, usually someone the alcoholic himself suggests, such as a storekeeper, employer, missionary, or even a family member from whom he will receive his regular supply of Antabuse along with the necessary reassurance and support. Sometimes the relationship between patient and Helping Person is maintained after the patient has been discontinued on Antabuse.

Some regard Antabuse as incidental to the total treatment process and see its function primarily as interrupting the drinking cycle by helping reduce the alcoholic's continuous ambivalence over whether or not to take a drink. "The decision not to drink, therefore, is needed only every two or three days when it's time to take the pill, rather

than being a constant strain especially when in an environment when many old friends offer drinks."[5] Judge Andrew Little of the Mescalero Apache Tribe expressed a similar view: "Indian people have great respect for each other and, therefore, they do not refuse a drink —the person on Antabuse can always blame the judge or the Public Health Service."

Several people with whom I spoke in the Southwest have reported favorable results with metronidazole (Flagyl) as an agent in the detoxification process (250 mg TID for the first month and 250 mg a day thereafter). However, this is still in the experimental stage and requires further validation.[27] Librium and Dilantin (100 mg TID) continue to be used more generally.

What conclusions can we draw from the preceding discussion? We are mindful that

> "today the Indians' way of life provides neither mechanisms of control nor guidelines for treatment. But even if the Indian were motivated to seek help the chances for success would be slim indeed, simply because our clinical methods are predicated upon feelings and values which the Indian does not have. On the other hand, there are indications that Indians can be treated successfully by methods of chemotherapy such as is being done in the Gallup project."[9]

Can we derive any encouragement from this statement? Is it possible to adapt any of the above mentioned treatment approaches to heterogeneous groups of urban Indian alcoholics? Most of them do not avail themselves of the services of our new detoxification centers. Nor do they take much advantage of Alcoholics Anonymous or of psychotherapy.

Existing facilities in Chicago are obviously not meeting the needs of Indian alcoholics or, for that matter, of non-Indian alcoholics. As in other communities, the homeless, chronic alcoholic periodically relies on the jail cell or the TB sanitarium for food and shelter, particularly in winter. Father Dunston of the Catholic Indian Center in Gallup, New Mexico, told me that in the winter many hard-core alcoholics will wander into the center's front yard and fall asleep there even in 0° weather. When it is too cold to let them sleep in the agency's bus, and because of fire hazards in their basement, Father Dunston will notify the police to pick them up. Usually they are not booked and are allowed to sleep on the stairway inside of the police station. Because Chicago police are less benign, many of our hard-core Indian alcoholics take refuge in nearby condemned and deserted buildings colloquially referred to as "haunted houses." In the absence of more appropriate facilities for the homeless, chronic alcoholic, we are forced to rely on whatever cooperation and understanding we can expect from law enforcement officers. Stern observes that:

> "When the New York City Police Department recently decided to stop making drunk arrests, the loudest protests came from the ranks of chronic offenders who had relied upon the good food and warmth of the local jailhouse."[50]

For the marginal, unattached, homeless Indian alcoholic in Chicago we need comprehensive medical, psychiatric, vocational programs within the context of a sheltered living arrangement. We also, have to think more in terms of work programs that are meaningful for Indians, and in terms of jobs that are likely to yield some measure of fulfillment; as we have pointed out, occupation in itself may lead to increased, rather than decreased, alcoholism.[54] Finally, we must free ourselves from thinking in terms of abstinence as the exclusive criterion for improvement. It is, as has been pointed out, "a grossly insufficient and even misleading index."[55] As our own findings indicate, other psychological symptoms can be equally or more disruptive, and a nonalcoholic's relationships with his family or his work performance might be equally bad or

worse depending on the nature and degree of the underlying pathology.

Of 60 American Indians whom I have evaluated at St. Augustine's Center because of various psychological complaints, over half were found to be chronic alcoholics. They appeared to have a similarly disturbed background from our nonalcoholic, psychiatric patients. In both instances there were severe disturbances in the relationship between the patient and his/her parents, and frequent dissolution of the home during the patient's childhood. The difference between our alcoholic and nonalcoholic patients was not so much in terms of their backgrounds as in their adaptation of different defense mechanisms (symptom choice).

Therefore, it is necessary to recognize and accept the role that alcohol plays in promoting psychological and social integration for those who are unable to function otherwise, and where the Anglo-American culture does not provide substitute outlets. While Indians are making every effort to rehabilitate alcoholics on reservations, some tribes are, at the same time, moving away from the old concept of maintaining the "dry" reservation. The Navahos have been considering putting a bar in each of the five areas on the reservation. This is still a controversial matter, and I understand there is no consensus among tribal leaders. The Community Alcoholism Treatment and Education staff with whom I spoke is taking a completely neutral position on that issue.

The Jicarilla Apache tribe are studying the results of changing from a "dry" to a "wet" reservation some years ago. Mescalero Apaches told me that there has been no increase in drunkenness since they opened their bar and liquor store four years ago. When I visited the reservation's jail I noticed mostly teenagers. I was told they go on drinking sprees "quite a bit," but they are not considered to be alcoholics. Andrew Little, the tribal judge, told me that when the bar first opened it was a novelty and it used to be very crowded. Now, fewer people are seen in the bar but more seem to be buying their liquor through the window and taking it home. There was general agreement here that keeping the reservation "dry" was hypocritical since those who want to drink will do so anyway. Furthermore, prohibition on reservations has encouraged bootlegging, gulping, and has made moderate social drinking impossible. The Community Action Program director, Fred Heckman, also expressed the view that, as long as people drink on the reservation, they can have better protection from their own tribal police than they might get if they passed out in nearby Ruidoso. We are all familiar with people who become victimized by those who would rob and roll them. Drinking on the reservation makes it unnecessary to travel, and many alcohol-related traffic accidents are being prevented. A final reason for opening bars and liquor stores on reservations is to help the economy of the tribe rather than forcing people to spend their money in outside bars.

From the foregoing, it appears that one should further evaluate these concepts in an urban setting and explore possibilities for establishing a cooperative bar and grill run by and for Indians, with all the profits going to the Indian community of Chicago. Preferably, such a bar should be located in Uptown or Lakeview where much of the drinking is taking place. Because of prevailing community attitudes toward drinking and drunkenness, the bar could not have any affiliation with religious or social agencies.

I have asked some of my Indian friends what they thought of such an experiment and their response was mixed. Some voiced strong objections to the idea on the basis that it would increase Indian alcoholism and per-

petuate an old stereotype. Others responded with enthusiasm and made suggestions for implementation. One man thought we should serve food as well as drinks, a recommendation also made by Dailey.[9] There were practical suggestions on how to prevent violence and fights that are bound to occur just as they do now. However, at the present time, Indians have almost no control over these situations, nor over the environment that gives rise to violence or the setting where it breaks out. All this leaves them completely at the mercy of the bartender and of the white police. It should be pointed out that a privately owned Indian bar is now operating in Lakeview. On weekends it usually gets very crowded; on one occasion as many as 100 Indians were gathered there. The owner reports no incidents of violence.

Dailey reminds us that "the Indian cannot learn in a vacuum any more than anyone else can," that we have to engage in "imaginative experiments." If we expect Indians to drink in moderation, "they must be placed in situations where they can make decisions and recognize their consequences."[9] Unlike whites, Indians have not had centuries of experience with social drinking. Perhaps the necessity of the moment and the vicissitudes of nature have prevented Indians from acquiring a sense of moderation in their drinking habits.

Of course, it would be unwise to superimpose any more programs on Indians. Such attempts will inevitably lead to failure. Therefore, Indians would have to assume full responsibility for implementation of programs.

It may be costly, perhaps risky, to engage in medical, psychological, and social experimentation. However, not to engage in meaningful experimentation would be even more costly and far more risky. At times of great social unrest, a retreat from reality would be most unwise, if not irresponsible and dangerous. Sooner or later we will have to face up to our problems and learn how to solve them.

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