

Preferences of Old and Young Navaho Indians for Western and Indigenous Health Care Providers: An Exploratory Study

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Preferences for Western versus traditional health care providers were assessed in 27 older (M = 61.5 years) and 21 younger (M = 22.6 years) American Indians living on the Navaho reservation. Participants were read standardized vignettes depicting diagnosable physical and emotional illnesses, and they completed a series of forced-choice questions indicating their preference for traditional or Western health care providers for treating these conditions. Analysis of variance (ANOVA) was used to assess health care provider preference with age, interviewer, and illness type as independent variables. Medical doctors were preferred over all other health care providers for physical problems, and this was particularly true for the younger group. Although it was anticipated that the older participants would favor traditional healers and the younger participants would prefer Western options, there was no main effect for age. This lack of differentiation by age in provider preference was interpreted in terms of informal utilization patterns and the role of the family referral system inherent in this group of indigenous adults. © 1998 John Wiley & Sons, Inc.

• Navaho Indians • Western health care • indigenous health care

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When two distinctly different cultures meet, a conflict of values and practices is inevitable. This is particularly true when contrasting indigenous and contemporary cultures. In this context, tensions may develop between the need to preserve traditional values and the desire to be enriched by the pervasive ideology of the dominant culture. The provision of health care to indigenous people who live in the United States highlights this issue (Guilmet & Whited, 1988).

Because Western health services are typically available to American Indians living both on and off the reservation, studies have sought to identify patterns of utilization, as well as factors that may influence underutilization. It is noteworthy that much of the available research describes patterns of utilization in mental health care. For example, the literature suggests that ethnic similarity is a significant factor in seeking mental health care. Cultural differences may lead to cultural misunderstanding and a lack of trust between Indians and non-Indians. Haviland, Horswill, O'Connell, and Dynneson (1983) reported that American Indian students prefer ethnically similar counselors, and that the likelihood of using a college counseling center may increase as more counselors in ethnic minority groups are represented. Atkinson, Jennings, and Liongson (1990) found evidence that American Indian students chose not to seek assistance when an ethnically similar individual was not available. In contrast, a survey of 150 American Indian students administered by Dauphinais, LaFromboise, and Rowe (1980) found that ethnicity made no difference in the perceived helpfulness of the counselor. Some American Indians feel so strongly about this that they will travel great distances to seek healers who are considered qualified by their community and are sensitive to community values and norms (LaFromboise, 1988).

Several studies have found that American Indians report feeling most comfortable seeking help from social workers, friends, and family members. In a survey of mental health care facilities, Sue (1977) found that Ameri-

can Indians saw more social workers and fewer nonprofessionals (e.g., family members) than did Whites. Similar studies have found that preferred resources for psychological help among American Indians include parents, other family members, and friends (Bee-Gates, Howard-Pitney, & LaFromboise, 1992; Dauphinais et al., 1980; LaFromboise, 1988; Sue, Allen, & Conaway, 1978). Neligh (1988) suggested that those providing treatment to American Indians must consider their attitudes toward the delivery system, beliefs about the efficacy of the treatment model, and community attitudes toward traditional versus Western medicine, as well as the type of service provider.

The Navaho approach to Western medicine is somewhat selective, because its members have shown eager acceptance of some Western medical practices and some resistance to others (e.g., mainstream psychological intervention). According to the Navaho view, health, spirituality, and physical wellness are not perceived as separate domains, and good health is dependent on a balance between the individual and his or her physical, social, and supernatural environment (Adair, Deuschle, & Barnett, 1988; Kluckhohn & Leighton, 1946; Peregoy, 1993). Diagnosis and treatment of an illness is usually performed by a *singer*, or medicine man, who understands the complex relationship between health and the prevailing cultural physical, and metaphysical worlds. Unlike Westerners, the Navaho do not make the distinction between physical and mental health; consequently, the medicine man treats the whole individual (Adair, Deuschle, & Barnett, 1988). Because fundamental differences exist between the healing methods of their culture and Western medical practices, a complete integration of the methods (e.g., conducting a healing ceremony that incorporates contemporary pharmacotherapy) is difficult. Instead, Western and indigenous health care on the Navaho reservation may exist primarily as independent systems, allowing the individual to decide which methods are most appropriate.

The current exploratory study will focus specifically on Navaho Indians of different ages and will examine the interactions that occur between the Navaho people and Western society with respect to preferences for health care providers. Navahos were selected as participants in this study because of their fierce independence in the face of persistent social influences of assimilation into the dominant culture. In their own language they call themselves *Dine*, "The People," a term indicating that each person holds a strong identity with fellow Navahos—those who speak the Navaho language and who believe and know Navaho ideology (Kluckhohn & Leighton, 1946).

The Navaho reservation, which is located in New Mexico, Arizona, and Utah, is inhabited by approximately 191,582 people (U.S. Department of Health and Human Services, 1990). There are approximately 2.6 people per square kilometer, with ranchers, the unemployed, and the elderly living in the most remote areas. Ready access to hospitals and outpatient clinics is difficult because of rough and unmarked dirt roads and scarce transportation (Haraldson, 1988). In more remote areas, the *Dine* live in trailers, cabins, or hogans, which are round dwellings constructed of wood and mud. Many living places have no electricity, plumbing, or running water. Family income on the reservation is generated primarily from agriculture and from raising livestock. The provision of modern medicine to this rather impoverished but proud people has posed a difficult problem for Western health care providers. Currently, it is not known whether there is a trend among younger adults to abandon traditional methods of healing for the use of hospitals and clinics. Likewise, it is unclear whether older adults may show this same tendency, or whether they continue to prefer indigenous forms of health care.

This study specifically compares attitudes toward indigenous and Western health care providers among older and younger Navaho Indians living on the reservation. Three different types of health care problems were presented to participants: (a) physiological,

(b) psychological, and (c) neutral. Problems were presented by means of vignettes that describe common physical and mental health problems that occur on the Navaho reservation. Health care provider options included (a) medicine man, (b) family member, (c) social worker and (d) medical doctor. It was hypothesized that based on socialization forces from the dominant culture, which should be stronger for younger adults, older adults would tend to prefer indigenous health care providers (medicine man or family member), whereas younger adults would prefer Western health care providers (social worker or medical doctor). It was also hypothesized that "medical" options would be chosen primarily when physiologic problems were present, whereas the "mental health" options would be chosen primarily when psychological problems were present.

Methods

Participants

Participants in this study were 48 Navaho Indians (30% male, 70% female) living on the Navaho reservation in the Utah–New Mexico area. Of these, 27 were older adults, with a mean age of 61.5 years ($SD = 8.36$; range: 50–79). Ninety-seven percent of the older individuals spoke Navaho as a first language; 3% reported English as their native language. With the exception of one participant, all individuals in this age grouping required an interpreter during the interview. Of the 21 younger adults whose mean age was 22.6 years ($SD = 4.7$; range: 15–30), 33% spoke English as their first language; 67% listed Navaho as their native language; none in this age grouping required an interpreter during the interview.

Instruments

The instruments used in this study included a demographic survey and a series of five vignettes that incorporated a set of 12 paired comparison questions for each vignette. The

five vignettes described an individual experiencing a physical, social/emotional, or neutral problem. The physical and emotional problems were selected from *Harrison's Principles of Internal Medicine* (Braunwald et al., 1987) and the *Diagnostic and Statistical Manual of Mental Disorders, III-R* (American Psychiatric Association, 1987). Two of the vignettes described physical problems (acute abdomen and pneumonia), both of which are common on the Navaho reservation (N. S. Ashton, personal communication, August 1992). Acute abdomen is a condition that would typically require further evaluation, if not surgery, and could include gallbladder inflammation or appendicitis. Because of the high intake of mutton on the Navaho reservation, many gallbladder problems exist. Pneumonia is also a common illness on the reservation, because a majority of families depend on coal or wood-burning stoves for heat in the winter, which can cause respiratory irritation. The two vignettes describing social/emotional problems included alcoholism and depression, both of which are prevalent among American Indian populations and are common on the Navaho reservation. A neutral vignette was also included that depicted a social dilemma (e.g., a situation not requiring a specific individual diagnosis). The neutral vignette was not included in subsequent analyses. The rationale behind using a neutral vignette was to provide a situation that was neither psychological or physiologic in nature to help prevent the potential for participants to arbitrarily group the vignettes into the two categories.

For each vignette, participants were presented with a series of 12 forced-choice response options, each depicting two of four possible health care choices including: (a) medical doctor, (b) social worker, (c) medicine man, and (d) family member. Each provider was paired against the other in random order, with all possible pairs presented so that each choice appeared a total of six times.

This paired comparison technique has been described in detail elsewhere (Beauchamp & Cowart, 1990; Hill, Olympia, & Angelbuer,

1991; Justice & Weaver-McDougall, 1989; Pelham, et al., 1992) and has been used to assess individuals who may have difficulty providing an ordinal ranking of preferences on ambiguous stimuli e.g., comparing different types of tangible rewards for children with attention deficit hyperactivity disorder (ADHD). This measurement approach was chosen because it anticipated that some of the participants would be unfamiliar with a Likert-type rating scale. It was, however, reasonable to let participants choose between one of two options (e.g., "Would Harrison benefit more if he sought help from a medical doctor or a medicine man?").

To assess whether the disorders described in the vignettes represented the purported disease states, a group of board-eligible internal medicine physicians ($N = 8$) employed at the University of Utah Medical Center independently read each of the vignettes and provided the most likely diagnoses for each problem. Full diagnostic agreement was obtained for each type of physiological and psychological problem presented, and these diagnoses were consistent with the identified problem in each vignette.

Procedure

Participants were recruited by a female Navaho community member who had a long history of trust and respect by those living in the targeted geographic area and was fluent in the Navaho language. To interview the selected participants, the first author (who lived on the Navaho reservation for three years before the time that the data were collected for this study) and the Navaho community member drove to various hogans and trailers that were located within 10 miles of the local hospital. Two of the selected individuals refused to participate in the study. The reasons these individuals declined to participate are unknown. Participants living within this area had access to both a hospital as well as several indigenous healers. To reduce the possibility of response bias, great care was taken to ensure culturally appropriate access to each of the *Dine* dwellings. For

example, on arrival to a hogan, the researcher and community member waited in the car until a member of the household approached and invited them to enter the home. Once in the home, the Navaho community member explained the purpose of the study in the language that was most comfortable to the family. On agreement to participate, participants signed the consent form. Eighteen percent of the older participants indicated consent by signing an "X" or by imprinting their thumb on the informed consent document; all younger participants provided their written signatures. It should be noted that in the young adult age group, 90% of the respondents were age 18 or older. For the two participants who were younger than age 18, parents were present during the interview, indicating culturally congruent parental consent. After consent, and before the interview, each participant was given a loaf of bread to convey respect and to preserve cultural congruency.

After completion of the consent form and demographic survey, participants were read the five vignettes by the Navaho community member. After each scenario, participants expressed their preferences for specific health care providers by answering the 12 paired comparisons, read one at a time, presenting the respective health care provider choices in random order. The comparisons were verbally read in the language preference of the respondent (Navaho or English). As a control for the effects of the presence of a second interviewer, the first set of participant interviews ($n = 23$) were conducted by the Navaho community member while a non-Indian researcher (the first author), was present. The second set of interviews ($n = 25$) was conducted by the Navaho community member alone.

Results

General Preference for Indigenous vs. Western Health Care

The first analysis tested whether there was a general preference for Western versus in-

digenuous health care provider across age, problem type, and interviewer. For each of the four vignettes, a preference score was computed ranging from 0 (no indigenous responses) to 8 (all indigenous responses). A vignette score of 8 could be obtained by exclusively choosing an indigenous option (medicine man or family member) each time a pair was presented. Four of the 12 paired comparisons per vignette were not used in this general analysis because these items only compared the two indigenous options (medicine man vs. family member) or the two Western options (e.g., medical doctor vs. social worker).

Because the questions were forced-choice, each time an indigenous health care provider was chosen, a Western option was, by default, *not* chosen. We will comment further on the limitations of this approach in the Discussion section. Mean preference scores for Western and indigenous providers were perfectly negatively correlated; therefore, the primary dependent variable was a mean score for indigenous health care preference derived from the eight paired comparisons across the four vignettes. Age (young adult vs. older adult) and interviewer (non-Indian and Navaho interviewer vs. Navaho interviewer only) were the two between-subject variables, and problem type (physiological vs. psychological) was the within-subjects variable.

Table 1 shows mean preference scores for indigenous health care options by age, problem type, and interviewer. The overall mean was significantly less than 4, $F(1, 44) = 21.17$, $MSE = 5.36$, $p < .05$. In this instance, a mean score of 4 or greater represents a preference for indigenous health care providers, whereas a mean score of less than 4 represents a preference for Western health care providers. Thus, a reliable preference for Western health care providers was found in the overall analysis.

There was no main effect of age, $F(1, 44) < 1$; that is, there was no difference between younger and older adults in their preferences for health care provider, and there was no main effect of interviewer, $F(1, 44) < 1$; in other words, interviewer type did not impact

TABLE 1. Mean Preference Scores for Indigenous Health Care Collapsed Across Providers

Age Grouping	Problem Type	
	Physiologic	Psychological
<i>Navaho Interviewer</i>		
Young adult (<i>n</i> = 12)		
<i>M</i>	3.20 ^a	3.00
<i>SD</i>	1.75	2.18
Old adult (<i>n</i> = 13)		
<i>M</i>	2.50	2.65
<i>SD</i>	2.00	1.81
<i>Navaho and Anglo Interviewers</i>		
Young adult (<i>n</i> = 9)		
<i>M</i>	2.38	3.00
<i>SD</i>	1.69	1.85
Older adult (<i>n</i> = 14)		
<i>M</i>	2.92	3.50
<i>SD</i>	1.35	1.64

^aScores ranged from 0 to 8. Higher scores indicate stronger preferences for indigenous health care providers.

the preference for health care provider across age groups, regardless of presented problem. Two- and three-way interactions between age, problem type, and interviewer were tested, but none was significant ($p > .05$). Because all of the individuals depicted in the vignettes were male, an analysis was conducted to test whether there was an effect of respondent gender; no effects were found, $F(1, 46) < 1$.

Provider Preferences Within Western and Indigenous Health Care

Because two options were represented within the general categories of Western and indigenous health care providers, a subanalysis was conducted to determine whether a specific provider was preferred within the Western or indigenous categories, and whether a preference for a specific provider differed as a function of age, interviewer, or problem type. Interviewer was not included as a vari-

able in these analyses because of its negligible effect in previous analysis. Table 2 summarizes the mean preferences for provider options within the indigenous category, and Table 3 summarizes mean preference scores for the provider options within the Western category. In both cases, a score of 4 represents a maximum provider preference.

There was a significant main effect of type of indigenous provider, $F(1, 44) = 4.13$, $MSE = 1.43$, $p < .05$, corresponding to a mild preference for family member over medicine man (Table 2). There was also a significant age \times indigenous provider interaction, $F(1, 44) = 8.19$, $MSE = 1.43$, $p < .05$, indicating that the preference for family member was strongest in the younger age group. Finally, there was a significant age \times problem type \times indigenous provider interaction, $F(1, 44) = 3.56$, $MSE = .34$, $p < .05$. As can be seen in Table 2, only the older adults preferred a medicine man over a family member, and they only exhibited this preference for physiologic problems.

TABLE 2. Mean Preference Scores for Types of Indigenous Health Care Providers

<i>Age grouping</i>	<i>Indigenous Provider</i>	
	<i>Medicine man</i>	<i>Family member</i>
<i>Physiological problems</i>		
Young adults (<i>n</i> = 21)		
<i>M</i>	1.21 ^a	1.64
<i>S</i>	1.23	1.05
Older adults (<i>n</i> = 27)		
<i>M</i>	1.53	1.18
<i>S</i>	1.27	.66
<i>Psychological problems</i>		
Young adult (<i>n</i> = 21)		
<i>M</i>	.83	2.16
<i>S</i>	1.39	1.11
Older adult (<i>n</i> = 27)		
<i>M</i>	1.51	1.57
<i>S</i>	1.31	.79

^aScores ranged from 0 to 4. Higher scores indicate stronger preferences for indigenous health care providers.

As reported in Table 3, there was a main effect of type of Western provider, $F(1, 44) = 32.49$, $MSE = .75$, $p < .05$, with greater preference for medical doctor over social worker. In addition, there was an interaction between problem type and Western provider, $F(1, 44) = 30.60$, $MSE = .52$, $p < .05$, with a greater preference for medical doctor for physiologic problems. Finally, there was a three-way interaction of age \times problem type \times type of Western provider, $F(1, 44) = 9.14$, $MSE = .52$, $p < .05$. With regard to this interaction, the younger adult group had the strongest preference for medical doctor when the problem was physiologic in nature.

Discussion

The purpose of this investigation was to contrast preference for indigenous versus Western health care providers in a sample of

young and old Navaho Indians who were currently living on the Navaho reservation. In this context, we addressed two specific questions: (1) Would the relative age of the participants influence health care provider preference? and (2) What type of health care provider would be preferred when the presenting problem was primarily medical or psychological in nature?

With regard to the first question, our findings suggest a modest but significant general preference for Western health care providers in both older and younger Navahos. The finding that Western providers were preferred over traditional healers does not indicate that traditional healers are not being used. Given that mean indigenous preference scores were closer to 4 (equal preference with Western options) than 0 (complete preference for Western options), it appears that both the old and young adults in the current sample were not different in their

TABLE 3. Mean Preference Scores for Types of Western Health Care Providers

Age Group	Western	
	Medical doctor	Social worker
<i>Physiologic problems</i>		
Young adults (<i>n</i> = 12)		
<i>M</i>	3.45 ^a	1.69
<i>S</i>	.56	1.38
Older adults (<i>n</i> = 27)		
<i>M</i>	3.07	2.20
<i>S</i>	.78	1.21
<i>Psychological problems</i>		
Young adults (<i>n</i> = 21)		
<i>M</i>	2.47	2.52
<i>S</i>	1.18	1.04
Older adult (<i>n</i> = 27)		
<i>M</i>	2.63	2.27
<i>S</i>	.95	1.08

^aScores arranged from 0 to 4. Higher scores indicate stronger preferences for Western health care providers.

preferences for Western and indigenous health care options. This is consistent with the history of the *Dine* people, which has been characterized by integration of ideas and methods (e.g., language, weaving skills, metallurgical techniques, and animal husbandry practices) from other peoples (Kluckhohn & Leighton, 1946). Acculturation among the Navaho may be seen from a bicultural socialization model (Valentine, 1971) in which acculturation is cast on two continua: one representing high and low commitment to the indigenous culture, and the other representing high and low commitment to the dominant culture. It is possible within this expanded scheme that an individual could select the most positive aspects of outside cultural groups as a way to improve day-to-day living without losing one's core cultural identity.

With regard to the second issue, it was hypothesized that older adult Navaho Indians would exhibit a greater preference for in-

digenous health care providers than would younger Navahos. Counter to our expectations, both old and young Navaho adults were similar in their preferences for Western or indigenous health care providers. Western medicine is one of many alternative forms of health care that have been integrated from other cultures, and similar to many other American Indian tribes, a referral system may be used similarly by old and young Navahos (Adair et al., 1988). If, for example, a medicine man is unable to heal an illness through traditional methods, other practitioners may be considered as treatment options until successful health care is obtained. In some American Indian tribes, this system is described as a "village network" in which extended families, regardless of proximity, provide a structure in which many social transactions take place (Red Horse & Red Horse, 1981). Some research suggests that family relationships are relied on to initially

define the health-related problem as well as the appropriate treatment mechanism (Peregoy, 1991).

Because two different health care providers were used to represent the categories of Western and indigenous options, it was anticipated that there would be differences in preferences for specific types of Western options as well as for indigenous options. It was found that there was a preference for family member over medicine man across age groups and across problem types. Only older adults showed a preference for medicine man over family member, and they only exhibited this preference for physiologic problems. It was also found that the preference for family member was strongest in the young adults. Because the mean age of the young adults was 23 years, it is possible that a parent or grandparent would be consulted first in the case of a physiological or psychological problem, and then a referral would be made to the appropriate health care provider.

Finally, it was found that there was a difference in preference for type of Western health care options across age groups, with stronger preferences for medical doctor over social worker. The three-way interaction of age \times problem type \times Western type, in which younger adults showed the strongest preference for medical doctor when the problem was physiologic, highlights the more flexible role a medical doctor may play while working on the reservation when compared with that of a social worker. Specifically, medical doctors may be sought for a variety of psychologic and physical health care problems, whereas social workers may only be involved when difficulties are related to psychosocial issues.

Several limitations of this study are noteworthy. First, one goal of the study was to provide participants with a vignette-based response format that would minimize self-consciousness regarding personal situations. However, this indirect response method may have limited the extent to which stated preferences represented the respondents' actual preferences in a similar situation (i.e., stating

a preference to an anonymous situation as opposed to one's personal preferences). Traditional healing in the Navaho culture is a broad concept, and incorporates many different types of healing. Healing may not necessarily be precipitated by illness, and is often used as a preventative measure. The vignettes used in this study describe various illnesses, and participants were responding to healing preceded by an illness (C. White, personal communication, May 10, 1996).

Second, regarding the limitations of a forced-choice method, it should be noted that whereas some forced-choice instruments yield ipsative scores (e.g., scores that can only compare scale scores within a person rather than across the normative sample), this was not the case with these data because all comparisons represented the same two preference categories (e.g., an indigenous option and a Western option). Consequently, the proportion of indigenous responses is comparable across individuals. The advantages of using such a forced-choice method are reviewed in the Methods section.

Third, the results of this exploratory study should be interpreted cautiously, because all participants had relatively easy access to medical clinics and hospital care, and may not be representative of many Navaho who have limited access to these resources. For those with more limited access, it is likely that they may be more involved in Navaho customs and traditions, and may be more dependent on native healers. In addition, elderly Navahos who are more isolated and immobile when compared with younger adults may also use traditional healers more consistently. These assumptions warrant further empirical testing and represent a natural extension of the current study.

One extension of this research might be to track actual referral patterns among traditional healers and Western practitioners on the Navaho reservation. An interview similar to the one in this study might be used to determine whether traditional healers would feel comfortable treating certain medically diagnosable illnesses. Likewise, a similar pro-

cedure could be conducted with medical practitioners and social workers employed in various clinics and hospitals across the reservation, in an effort to determine whether they would be willing to refer clients to traditional healers. This type of research might serve to increase communication between indigenous and Western practitioners, and could be used to predict relative utilization rates among the Navaho people.

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