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THE NAVAJO INDIAN: A DESCRIPTIVE STUDY OF THE PSYCHIATRIC POPULATION

by

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Abstract

This is a descriptive study of 348 new cases coming to the attention of the Mental Health team serving the Navajo Indian. Tribal affiliation, sex, marital status, age, type of schooling, religion, referral source, disposition, and primary diagnosis are presented and discussed.

THE United States Public Health Service, Navajo Area Indian Health Service, provides medical care to more than 100,000 Navajo Indian Americans in northern Arizona, northwestern New Mexico, and southern Utah. The medical care is provided in eight service units, including six hospitals and four health centres, as well as through field and environmental health staffs.

In 1966, a psychiatrist joined the Navajo Area Indian Health Service with the goal of developing a comprehensive mental health programme for the Navajo Nation. Today, the mental health staff has expanded to include three psychiatrists, two psychologists, a psychiatric social worker, a mental health nurse consultant, and three Navajo community mental health workers. There are eight United States Public Health social workers and three social work associates working as an integral part of the mental health programme.

In October, 1968, the mental health programme began to collect descriptive information about those individuals referred for psychiatric care in order to better plan for the future development of the mental health programme. It was felt that an accurate description of the population served would allow for more relevant programme development. Although the data is neither prevalence nor incidence data, it does offer an indication of the pattern of illness seen.

The study had an additional purpose. Despite the contact with the surrounding culture, the Navajo culture today remains as it has been for many years. In addition the rate of inter-marriage with either whites or other Indians has been very small. For these reasons we feel that it is important to see if the diagnostic pattern of illness is perhaps grossly different from that seen among other groups.

The data presented represents 348 new cases coming to the attention of the mental health team in an elevan month study period. Only those cases seen by members of the mental health team are reported. In the eleven month study period

there were two psychiatrists, a clinical psychologist, a mental health nurse consultant and three mental health workers. It should be understood that many patients, with a variety of emotional problems, were treated by other practitioners in the United States Public Health Service, by sectarian reservation hospitals, and by "helping individuals" on or near the reservation. These patients are not included in the 348 cases.

RESULTS

Of the 348 new cases seen, 89.94% were from the Navajo nation (Table 1) and 98.8% were seen on a non-emergency room basis. The majority of the patients (Table 2) were female (58.33%) and single (Table 3) (52.3%) and were seen as outpatients (81.71%). They were relatively young (Table 4) with 55.6% between the ages of 16 and 40. Over half (Table 5) had attended Bureau of Indian Affairs boarding schools and had completed less than eight years of education (Table 6). In regard to religious preference (Table 7), they were fairly evenly distributed among the Navajo, Catholic and Protestant religions. It is of interest to note that at the time of the initial visit, no patient stated that he was a member of the Native American Church. The beliefs and practices of this church include the use of peyote in the rituals.

Of the 348 patients seen, 67% were referred[1] (Table 8) by employees of the United States Public Health Service (other than the mental health team), 60% by Bureau of Indian Affairs (94% of these by the Bureau schools), 14% by tribal agencies, 14% by state welfare programmes, 15% were self-referred, and 6% were referred by the state mental hospitals in New Mexico and Arizona. The clinical psychologist saw 33.05% of the patients and the two psychiatrists saw 43.97%

After the first visit of the patient to the mental health professional, it was the responsibility of the evaluator to arrive at a disposition.[2] Of the 348 patients evaluated, it was decided that 96% were to be followed by members of the United States Public Health Service Mental Health Team. The Bureau of Indian Affairs received 9% of the referrals, tribal programmes 5%, state welfare 2%, and the state mental hospitals 5% (Table 8). Diagnostically (Table 9) approximately 30% received a diagnosis of neurosis, 18% were diagnosed psychotic, and 8% were classified as personality disorder. 76% of the diagnosed neurotics were thought to be depressed (see Miller and Schoenfeld, 1971).

DISCUSSION

A number of interesting observations and hypotheses can be made on the basis of this data. Certain limitations should, however, be pointed out. First of all, the data represents an elevan month sample. We feel that this is a representative sample of psychiatric illness on the Navajo reservation although there is the possibility that a larger sample might have made some difference.

Another limitation is that the data represents only patients seen by the mental health team. Many people with emotional problems are seen by either general medical officers within the Public Health Service, by private physicians in towns bordering the reservation, or by doctors working in the sectarian hospitals on the reservation. In addition, many individuals never reach medical personnel but are treated by the traditional healer, the medicine man. The Navajo medicine man continues to be active among the people today as he has been for hundreds of years. Not only is he important in the treatment of mental illness, but he is the prime source of medical care for many people with various organic illnesses. A final

1 A patient may have been referred to the mental health team by more than one agency.
2 A patient may have been referred to more than one agency for management.

problem in the interpretation of the data is the lack of adequate base rate information with which to make comparison.

Although the Navajo reservation is somewhat isolated and insulated from the "mainstream" of American life, many agencies and organisations function within its 25,000 square mile area. It is of interest to us that over two-thirds of the referrals come from the United States Public Health Service. This occurs in spite of the stated objectives of being a community mental health team responsive to the needs of the reservation. It is our feeling that many organisations are seen by members of the mental health team in a negative light (Schoenfeld, Lyerly and Miller, 1971) and that this is communicated to them directly by refusal to use their services. The result is a lack of co-operation between agencies in the furthering of mental health objectives. This emphasizes the importance of recognising and dealing with inter-agency attitudes and feelings as attempts are made to develop community mental health services.

In the total sample there were no patients with a diagnosis of drug dependency. The most obvious explanation for this is the very low level of income on the reservation. It would seem that the suppliers have not found the potential profit sufficient to risk attempted sales on the reservation. Drugs may be obtained in larger cities in Arizona and New Mexico and it may well be that Navajos using drugs leave the reservation and are therefore lost to our sampling. There is one drug which should be singled out for discussion. Peyote, a hallucinogen, is used legally on the reservation by members of the Native American Church as an integral part of their ritual. Although our figures do not reflect the fact, we do know from school officials that non-church members occasionally experiment with peyote in the boarding school dormitories. There does not, however, seem to be the same devotion to its use by non-church members as is seen in other groups using LSD. This absence of drug dependency in a society that has legalised the use of peyote is intriguing.

Only nine patients received a primary diagnosis of alcoholism. From our observation on the reservation this figure grossly fails to indicate the magnitude of the problem. There are at least two major factors which might explain this result. First of all, alcoholics are not often referred by the general medical officers because of an attitude condeming the alcoholic rather than treating him as a patient. The other major reason for such a low frequency is because the Office of Economic Opportunity on the reservation has established an alcoholism treatment programme. The programme is primarily involved with the administration of Antabuse and although a physician is needed for a prescription to get the drug, there is a general feeling that the mental health specialist has little to offer. The programme is run primarily by ex-alcoholics who operate under the philosophy that the ex-alcoholic is most qualified to treat the alcoholic patient. Although this programme has few reliable statistics, it is the general impression that alcoholism is one of the major health problems on the reservation. It should be pointed out that this is so despite the fact that the possession and/or the use of any alcoholic beverage is illegal within the borders of the reservation. Supplies, however, are obtained in off reservation towns as well as from Navajo bootleggers operating on the reservation. Sale by the bootleggers is made to anyone, regardless of age, who has the money to buy. Drinking among teenagers is fairly frequent and a major problem for the school personnel, both public and federal. It is of interest that for the Navajo what is permitted (peyote) does not seem to be abused and what is prohibited (alcohol) is abused.

A particularly interesting result was the absence of the major affective disorders. Only two patients were seen in this category and both had depressions of psychotic proportions. No manic patients were seen. When this result was noted, a

number of Navajo social workers as well as other Navajo employees of both the Public Health Service and other agencies were asked if they could remember ever having had contact with a manic patient. In all cases, the answer was no. Two possible explanations exist. First of all, the child rearing practices, the cultural, and intra-psychic methods of dealing with affects, particularly aggression, may explain the observation on a purely psychological basis. The other explanation is on a genetic biochemical basis. In the past as well as presently, inter-marriage with either whites, Spanish Americans, or other Indians is looked on with disfavour. Although exact rates are not available, inter-marriage has been infrequent among Navajos who continue to live on the reservation. This tends to create a fairly pure Navajo genetic pool. If the genetic mechanism is absent from the pool, it might explain the absence of manic illness. This is an area in which further research would be quite fruitful.

Lastly, the lack of sexual deviations is difficult for us to explain. We do feel that homosexuality is not, in general, in the behaviour repertoire of the Navajo as demonstrated by our data and the lack of a Navajo word for this behaviour.

This investigation has pointed to many areas for further research. It also has pointed out the need for a community mental health programme to be aware of and improve inter-agency co-operation. Characterisation of the target population served is crucial in the planning of programme direction and in the development of services and methods to deal effectively with that population. Preventive efforts may be undertaken only in light of such a description.

TABLE 1

Tribal Affiliation

(N=348)

Tribe	Number	%
Navajo	313	89.94
Hopi	12	3.45
Zuni	2	.57
Indian, Other	19	5.46
Non-Indian	2	.57

TABLE 2

Sex

(N=348)

Sex	Number	%
Male	145	41.67
Female	203	58.33

TABLE 3

Marital Status

(N=348)

Marital Status	Number	%
Married	118	33.91
Single	182	52.30
Widow	16	4.60
Divorce	13	3.74
Separated	18	5.17
Unknown	1	.29

TABLE 4

Age
(N=348)

Age	Number	%
0–10	32	9.20
11–15	52	14.94
16–20	42	12.07
21–30	73	20.98
31–40	78	22.41
41–50	35	10.06
51–60	19	5.46
61–70	12	3.45
71+	0	0
Unknown	5	1.44

TABLE 5

Type of School
(N=348)

School	Number	
Bureau of Indian Affairs (Boarding)	177	50.86
Public School	90	25.86
Mission School	16	4.60
Other	12	3.45
Not Reported	53	15.23

TABLE 6

Education
(N=348)

Years	Number	%
None	70	20.11
1–3 yr.	48	13.79
4–8 yr.	95	27.30
8+	68	19.54
High School Graduate	34	9.77
College Graduate	6	1.72
Graduate School	1	.29
Other	9	2.59
Unknown	17	4.89

TABLE 7

Religion
(N=348)

Religion	Number	%
Traditional	84	24.14
Native American Church	6	1.72
Catholic	87	25.00
Protestant	130	37.36
Mormon	20	5.75
Other	8	2.30
Not Known	13	3.74

TABLE 8

Referral Source and Disposition*
(N=348)

	Referral Source		Disposition	
	Number	%	Number	%
United State Public Health Service	233	66.95	334	95.98
Bureau of Indian Affairs	208	59.77	33	9.48
Tribal Agencies	52	14.94	17	4.89
Self	52	14.94	0	0
State Welfare Programmes	49	14.08	6	1.72
State Mental Hospitals	21	6.03	17	4.89

*A patient may have been referred from more than one source.
A disposition may also have involved more than one agency.

TABLE 9

Primary Diagnosis
(N=348)

	Number	%
Mental Retardation	34	9.77
Psychoses Associated with Organic Brain Syndromes	7	2.01
Alcholic Psychosis	4	
Other cerebral condition	1	
Other physical condition	2	
Non-Psychotic Organic Brain Syndrome	14	4.02
With alcohol	2	
With brain trauma	4	
With disturbance of metabolism	3	
With degenerative disease of CNS	1	
With other physical condition	4	
Psychoses not Attributed to Physical Conditions	55	15.80
Schibzophrenia	51	
Major Affective disorders	2	
Paranoid states	0	
Other Psychoses	2	
Neuroses	105	30.17
Anxiety	12	
Hysterical	8	
Phobic	1	
Obsessive-compulsive	2	
Depressive	81	
Other	1	
Personality Disorders and Certain Other Non-Psychotic Disorders	28	8.05
Personality Disorders	18	
Sexual Deviations	1	
Alcoholism	9	
Drug Dependence	0	
Psychophysiological Disorders	13	3.74
Skin	1	
Respiratory	7	
Cardiovascular	1	
Genito-Urinary	1	
Special Sense	1	
Other Type	2	
Special Symptoms	9	2.59
Speech Disturbance	4	
Learning Disturbance	2	
Enuresis	2	
Cephalalgia	1	
Transient Situational Disturbances	33	9.48
Childhood	10	
Adolescence	16	
Adult Life	5	
Late Life	2	
Behaviour Disorders of Childhood/Adolescence	22	6.32
Hyperkinetic	0	
Withdrawing	11	

Overanxious	[redacted]	
Runaway		
Unsocialised Aggressive		
Group delinquent		
Other		
Conditions without Manifest Psychiatric Disorders	[redacted]	[redacted]
Marital		
Non-Specific		
No mental disorder		

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