
POVERTY AND MENTAL HEALTH IN THE AMERICAN INDIAN COMMUNITY

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More than twenty-five percent of the US American Indian population lives at or below the poverty line; unemployment is nearly ten percent higher than that of the general population (U.S. Census, 2006). On or near reservations, the numbers are much higher. American Indian youth commit suicide at a rate three times that of the general population, (Indian Health Services [IHS], 2001) while American Indians as a group have a higher mortality rate due to alcoholism than any other group in the US (Gray & Nye, 2001). The following will examine both the mental health and socioeconomic condition of this community in order to understand the ways in which the experience of poverty and the high rates of poor mental health might relate. There are a number of challenges facing the American Indian community; this paper will explore poverty as only one of the potential factors adding to the mental distress exhibited in the population. Poverty is defined from both an absolute and social exclusion perspective. The suggested influences on mental health include economic stress, sociohistorical trauma, and isolation from institutional resource.*

Poverty can be explained as an absolute and in terms of social exclusion. Absolute poverty refers to a fixed measurement of paucity. In the United States this measurement is defined by the poverty line. All individuals who earn an income less than or equal to the federally mandated poverty line are considered to be living in absolute poverty. Poverty defined in terms of social exclusion refers to a lack of institutional resources. This formulation has less to do with one's financial standing, and more to do with the non-monetary variables that affect a person's life. Silver and Miller (2003) champion the use of the concept of social exclusion as a way to encourage a multidimensional understanding of the experience of poverty. According to the European Union (2004), social exclusion refers to the process by which individuals are systematically marginalized, resulting in consistent disadvantage in terms of educational resources, hous-

*Because the term American Indian is used by the National Congress of American Indians, the nation's largest inter-tribal organization, it will be used throughout this paper to refer to Native Americans or First Nations people living in the United States.

ing conditions, employment opportunities, formal justice, political participation and freedom of cultural expression. Silver and Miller expand this definition to include the degree to which discrimination or racism affect economic and social opportunities. Exclusionary poverty should not be confused with a lack of interpersonal or cultural assets, but instead understood as inopportunity for equal resource acquisition at the institutional level. While closely related, absolute and exclusionary poverty offer different insights into the ways in which individuals experience being poor.

Poverty in the American Indian Community

The experience of the US-based American Indian population† offers a rich context within which to examine the association between mental health and poverty. American Indians live in some of the most economically depressed conditions in the country and experience significant rates of mental illness. (Beals, Piasecki, Nelson, Jones, Keane, Dauphinas, Red Shirt, Sack & Spero, 1997; Andersen & Brownson, 2000, Harris, Edlund, & Larson, 2005). It is therefore important to examine the factors and influences that have gone into shaping these conditions within the community.

One factor greatly affecting the American Indian population is poverty. In absolute terms and according to the 2000 U.S. Census, nearly twenty-six percent of American Indians nationwide live below the poverty line; among the fifteen major tribes, this statistic ranges from almost forty to no lower than fifteen percent. For American Indians living on or near reservations, the unemployment rate is at forty-nine percent, with thirty-four percent of those working still living below the poverty line (BIA, 2003). These numbers show improvement from only a decade earlier and yet they still signal serious economic trouble within the community. In their exploration of the impacts of the socio-historical experience of American Indians, Kawamoto (2001) and Beals et al. (1997) highlight the exclusionary element of poverty within the community. The multiple historical traumas endured by the community, coupled with cultural and geographical marginalization from the mainstream, have left many resource gaps. Impacts of cultural assault enacted through a number of assimilation-focused U.S. policy choices can be clearly seen. The 1881 policy prohibiting the practice of American Indian ceremonies, the Dawes Act of 1887 which took from the American Indian population nearly 93 million acres of tribal land, the infamous Indian Boarding Schools, and the Termination and Relocations Acts of the 1950s are only a few such policies. These violent interruptions to tribal life have left much

of the American Indian community with limited resources. Efforts to maintain tribal communities have consistently been challenged, as has access to full participation in the majority culture. The effects of poverty, in the form of economic deprivation and social exclusion, as influenced by racist US policy and marginalization, are felt on a day-to-day basis.

While reservations in many ways ensure cultural growth and sustainability – and for those tribes that escaped removal, a connection to tribal homelands – the economic and social conditions on reservation are such that residents often go without basic amenities. Currently, slightly more than half of the American Indian population lives off the reservation, but the reservation environment is still important to explore for a number of reasons. Not only have reservations played an important part in the recent history of the community, but the majority of the people living on reservations are younger than those living outside of tribal lands (U.S. Census, 2002). This means that for the most part, the newest generation of American Indians is being brought up in an environment with extremely low employment rates, poor housing quality and a host of other indicators of poverty. In addition, Lobo (1998) asserts that most American Indians living in urban settings still have a strong sense of “back home” in regards to tribal lands. She notes that return visits to reservations and rural territories for family and cultural events are common. There has been a consistent history of migration between urban sites and reservations within the population (Snipp, 1997). Finally, conditions on the reservation also offer an interesting perspective with regard to the relationship between mental illness and poverty. The fact that a great portion of the American Indian population operates in a different economic sector from the rest of the country, and as such is removed from direct socioeconomic competition with national peers, challenges the commonly held belief that individuals with mentally illness slowly drift towards poverty as a result of their inability to successfully compete for societal resources. Reservations offer the opportunity to observe the relationship between mental health and poverty outside of the influence of direct competition.

Mental Health Issues in the American Indian Community

Compromised mental health is an area of great concern within the American Indian community. Specifically suicide, alcoholism, and post-traumatic stress disorder (PTSD) all exist at levels higher than that of the general population. The importance of examining poor mental health and its causes within the American Indian community is made abundantly clear when looking at mortal-

ity statistics. Suicide is the second leading cause of death for American Indians between the ages of fifteen and twenty-four and occurs at a rate twice that of the national average (IHS, 2001). For American Indian youth between the ages of fifteen and nineteen, this statistic rises to three times that of the national average (LeMaster, Beals, Novins & Spero, 2004). Deaths related to alcoholism are higher for American Indians than for any other racial group in the US, at four times the national average. Moreover the loss of productive years of life due to alcohol abuse is nearly five times the national average (Cameron, 1999). LeMaster et al. note that while the occurrence of PTSD in a random selection of American Indian participants from one community was nearly twenty-two percent, findings for other American-based populations typically range from one to nine percent. Gray and Nye (2001) note that this percentage is equivalent to that seen in survivors of traumatic events such as mass shootings, major burns, and combat. PTSD is often found in tandem with depression, substance abuse, anxiety, and violence, which makes its exaggerated presence in portions of the American Indian community a source for real alarm. In a study comparing the mental health status of women of differing ethnic backgrounds in the United States, Andersen and Brownson (2000) showed that American Indian women exhibited the highest rates of depression of any other group. Because of the extreme nature of the mental distress present within this community, it is critical to try and understand the factors driving it. Examining the relationship between the deterioration of mental health and the consistent experience of poverty may offer some insight and thus lead to better strategies for addressing the problem.

Poverty's Impact on Mental Health

Within the United States, the relationship between mental health and poverty is often explained through a causal lens: poor mental health acts on the individual to increase his or her potential for poverty-level existence. The practical and imposed hurdles to social and economic functioning encountered on a day-to-day basis by people with mentally illness may compromise their ability to stay afloat in American society. Individuals suffering from mental illness either find themselves drifting to the bottom of the socioeconomic pool or barely able to keep their heads above water.

While there is definite value in recognizing this directional link between mental health and socioeconomic standing, it is also important to examine the relationship through an inverse lens. In order to truly grasp the nature of mental illness as well as the effects of poverty, it is imperative to explore the ways in

which poverty may also intensify the potential for poor mental health. Link and Phelan (1995) suggest that the more commonly held belief about the interplay between mental health and poverty is reflective of a Western vision of the world, wherein a kind of sanctity is assigned to the responsibility and agency of the individual. What can sometimes be problematic about this perspective is that it does not allow for human vulnerability to external influence. By giving weight to the alternative analysis, a departure from the dominant perspective is possible and a more nuanced understanding of the potential for successful interventions in mental health and poverty work can be attained.

There are a number of identifiable points of intersection between the effects poverty and mental health within the American Indian community that seem to confirm Link and Phelan's (1995) proposed explanation of the relationship between these variables. These authors state that an individual's health must be understood from within their socioeconomic context because it is only from within that context that all of the risks factors an individual encounters can be clearly seen. Link and Phelan urge the health community to use this contextualization to begin to identify the circumstances of poverty that may act as "fundamental causes" of poor health. Kawamoto (2001) locates these "fundamental causes" in American Indian history. Alcoholism, other forms of substance abuse, suicide and PTSD can all be linked to a historically-born exclusionary poverty. He references the communal memory of the Indian Boarding Schools which did not allow children to speak their native language, practice their own religion, or connect with their families on a regular basis; the 1954 Termination Act which saw 109 tribes formally dissolved and 109 communities scattered; and the 1956 Relocation Act which encouraged the dissolution of a portion of the remaining nations into large American urban centers. Kawamoto argues that each of these key periods or moments in American Indian history, instrumental in inflicting the exclusionary elements of poverty, have served to create a sense of hopelessness and loss of control in the psyche of the community. Duran, Duran, Brave Heart, & Yellow Horse (1998) also contend that beyond the immediate economic stresses encountered within the population, the traumatic history of genocide, displacement, and cultural assault has resulted in what they term a "soul-wound" within the American Indian community. Szlemko, Wood, and Jumper Thurman (2006) suggest that the pervasiveness of alcoholism may be in part an attempt to medicate the sense of loss and alienation produced by this communal shock. The pain that has resulted from these historical experiences, which were very much a part of growing exclusionary poverty, has tipped the scales of health in

the American Indian community.

Johnson and Tomren (1999) also look at the roots of alcoholism and suicidal behavior through lens of the poverty with special attention paid not only to the historical events that have played a part in shaping the health of the community, but also to current experiences. Johnson and Tomren contend that most schools do not cater to American Indian children's sense of cultural functioning nor do they address any language needs. American pop culture also moors American Indian identity in the past, often stripping the community of any contemporary agency, and racism and cultural marginalization keep many American Indians alienated from an ever-present mainstream. Johnson and Tomren suggest a potential connection between these larger experiences of disaffection and the feelings of anomie, helplessness and hopelessness that often accompany suicide. Whitbeck, McMorris, Hoyt, Stubben, and LaFromboise (2002) contend that as a result of the pervasive economic deprivation and social stress encountered by many American Indian communities, some individuals experience high levels of consistent depression, which in turn increases their potential for suicidal ideation and substance abuse. They specify that continued financial strain as well as feelings of unrelenting social assault, in the form of experienced or perceived discrimination or racism creates significant social stress. This in turn compromises the individual's capacity for free, unfettered development, increasing their risk for developing mal-adaptive behaviors.

Gray and Nye (2001) write specifically about the prevalence of PTSD in the community and also connect it to the larger context that surrounds many American Indian lives. They assert that the trauma that comes with constantly living under economic and social stressors can eventually take its mental toll. Robin, Chester, Rasmussen, Jaranson, and Goldman (1997) suggest that the American Indian community's disproportionately high exposure to traumatic events accounts for the unusually high rates of non-combat related PTSD. According to their study, which was conducted in a Southwest American Indian community, the traumatic events most often cited by individuals suffering from PTSD included motor vehicle accidents and the death or severe injury of a loved one. These are events often linked to alcohol abuse and suicide, the high rates of which have been shown to be the result of or at least greatly exacerbated by the poverty experienced in the community. Brave Heart (1998) expands this analysis even further, suggesting that American Indians as a community are suffering from Historical Trauma Response (HTR) as a result of hundreds of years of traumatic events. All of these authors maintain that the damaging effects of the

acute poverty experienced by the American Indian population, both in absolute and exclusionary terms, has had an undeniable effect on the mental health of the community.

Changing Poverty; Changing Mental Health

Costello, Compton, Keeler, and Angold (2003) present a relevant study in which they track the mental health of a group of children from varied socioeconomic backgrounds. About one quarter of the study participants are American Indian children from one reservation, while the rest are White children from the surrounding area. In the middle of the eight-year study, a casino opened on the reservation and each American Indian family began to receive a benefit from the casino profits in addition to their annual income. Each year the benefits went up, and by the end of the study each family was receiving an additional six thousand dollars per year—almost half of what a family of four living at the poverty line would have made at the time of the study. While the American Indian children who qualified as persistently poor had scored much worse on their mental health evaluation in the first years of the study, four years after the opening of the casino almost all of the behavioral problems that the American Indian children had been exhibiting improved to the point that they were on par with the non-poor White children in the group. It seems that relieving poverty in absolute terms was having a measurable impact on the health of the community. Unlike the behavioral problems, many of the emotional problems that had occurred with more frequency among the poor American Indian children still remained. Costello et al. suggest that this may be because emotional dysfunction takes more time to rectify itself with intervention than do behavioral problems. Another analysis is that while the relief of absolute poverty can bring about some definite improvement in the mental health of the community, it is not a panacea. Kawamoto (2001), Szlemko et al. (2006), Johnson et al. (1999), Whitbeck et al. (2002), Gray and Nye (2001), Robin et al. (1997) and Brave Heart (1998) all suggest that the long-term effects of exclusionary poverty are very real and cannot be eased so quickly. The Grand Traverse Band of Ottawa and Chippewa Indians have attempted to address this long-term damage by using gaming profits to create a comprehensive health department, complete with counseling and psychological services (Cornell, Kalt, Krepps & Taylor, 1998). They are only one in a great number of tribes that have taken similar action (Taylor & Kalt, 2005; Grant, Spilde & Taylor, 2004; Cornell et al., 1998). Grant et al. (2004) suggest that using

increased revenue in tribal communities in this way not only increases personal funds, but elevates the quality of life. With the means to attend to problems, both through direct services and by building on strengths with the creation of culture and language preservation programs, heritage centers, and community building initiatives, the American Indian community can continue to heal and strengthen on a holistic level. Real change in the health of an individual can be found by assuaging economic hardship, but improving poverty must also involve attention to in one's lived experience.

Conclusion

The American Indian population is just one example of a community that is currently experiencing great stress due to poverty. The challenges that poverty creates are felt on a day-to-day basis, and are only amplified when the person in poverty is not a member of the majority race or culture. By understanding mental health not only as a determinant of poverty, but also as an outcome, we can begin to develop productive treatment models. Gray and Nye (2001) argue that if it seems preposterous for a mental health practitioner to treat a young woman suffering from PTSD without addressing a past experience of incest, then it should seem preposterous to treat the mental health of the American Indian community without addressing the experience of poverty. Bringing to bear the ill effects of the larger context of poverty on the mental health of an individual has great implications for the future well being of the American Indian community, as well as for the wider populations of poor. If we can engage in treatments that take into account the observable strain that results from the experience of poverty, both in absolute and exclusionary terms, honest and productive health care can begin to happen.

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