INFORMATION TO USERS

This reproduction was made from a copy of a document sent to us for microfilming. While the most advanced technology has been used to photograph and reproduce this document, the quality of the reproduction is heavily dependent upon the quality of the material submitted.

The following explanation of techniques is provided to help clarify markings or notations which may appear on this reproduction.

1. The sign or “target” for pages apparently lacking from the document photographed is “Missing Page(s)”. If it was possible to obtain the missing page(s) or section, they are spliced into the film along with adjacent pages. This may have necessitated cutting through an image and duplicating adjacent pages to assure complete continuity.

2. When an image on the film is obliterated with a round black mark, it is an indication of either blurred copy because of movement during exposure, duplicate copy, or copyrighted materials that should not have been filmed. For blurred pages, a good image of the page can be found in the adjacent frame. If copyrighted materials were deleted, a target note will appear listing the pages in the adjacent frame.

3. When a map, drawing or chart, etc., is part of the material being photographed, a definite method of “sectioning” the material has been followed. It is customary to begin filming at the upper left hand corner of a large sheet and to continue from left to right in equal sections with small overlaps. If necessary, sectioning is continued again—beginning below the first row and continuing on until complete.

4. For illustrations that cannot be satisfactorily reproduced by xerographic means, photographic prints can be purchased at additional cost and inserted into your xerographic copy. These prints are available upon request from the Dissertations Customer Services Department.

5. Some pages in any document may have indistinct print. In all cases the best available copy has been filmed.

University Microfilms International
300 N. Zeeb Road
Ann Arbor, MI 48106
Locklear, Von Sevastion

A CROSS CULTURAL STUDY TO DETERMINE HOW MENTAL HEALTH IS DEFINED IN A TRI-RACIAL COUNTY IN SOUTHEASTERN NORTH CAROLINA

The Ohio State University

University Microfilms International 300 N. Zeeb Road, Ann Arbor, MI 48106

Copyright 1986 by

Locklear, Von Sevastion

All Rights Reserved
PLEASE NOTE:

In all cases this material has been filmed in the best possible way from the available copy. 
Problems encountered with this document have been identified here with a check mark ✓.

1. Glossy photographs or pages _____
2. Colored illustrations, paper or print ______
3. Photographs with dark background _____
4. Illustrations are poor copy ______
5. Pages with black marks, not original copy ______
6. Print shows through as there is text on both sides of page ______
7. Indistinct, broken or small print on several pages ✓
8. Print exceeds margin requirements ______
9. Tightly bound copy with print lost in spine ______
10. Computer printout pages with indistinct print ______
11. Page(s) _______ lacking when material received, and not available from school or
    author.
12. Page(s) _______ seem to be missing in numbering only as text follows.
13. Two pages numbered ______. Text follows.
14. Curling and wrinkled pages ______
15. Dissertation contains pages with print at a slant, filmed as received ______
16. Other _________________________________________________________
    _________________________________________________________
    _________________________________________________________

University Microfilms International
A CROSS CULTURAL STUDY TO DETERMINE HOW MENTAL HEALTH IS
DEFINED IN A TRI-RACIAL COUNTY IN SOUTHEASTERN NORTH
CAROLINA

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy in the Graduate School
of The Ohio State University

By

Von Sevastion Locklear, B.A., M.S.W., M.A.

* * * *

The Ohio State University
1985

Dissertation Committee:
Beverly Toomey
Roberta Sands
Daniel Lee
Alfred Clarke

Approved by
Beverly Toomey
Adviser
College of Social Work
DEDICATION

This book is dedicated to my mother, Clara Locklear. She has, as always, provided her support and encouragement during this most challenging professional endeavor. The other person to whom this dissertation is dedicated is Susan Elizabeth Williams, without whose support, encouragement, love, and devotion, this truly would not have been possible.
ACKNOWLEDGEMENTS

The responsibility for this study is mine and mine alone but it represents the contributions of many in both tangible and intangible ways. I would like to take the opportunity to acknowledge some of those individuals.

My Committee members have been most helpful in ways too numerous to identify. I am forever indebted to my adviser, Dr. Beverly Gail Toomey, for the support, encouragement and the confidence she has given me during my three years of study at The Ohio State University. I would also like to thank the other members of my committee, Dr. Lee, Dr. Clarke, and especially Dr. Sands for the editorial support she has given me in the preparation of this dissertation. I would like to thank Kathleen Holland for the use of her computer in writing this dissertation, Wilbur Dale for his patience and assistance in helping to correct the many problems I encountered while typing, and Steve Cuvelier for his assistance in printing.

There are many folks in Robeson County that contributed to this dissertation. I would like to especially thank the individuals who served as nominators and to those who agreed to serve as a key informant in this study without your support and participation I would not have been able to collect the data.

iii
This dissertation would not be complete if I failed to mention the support both personal and professional, that Susan Elizabeth Williams has given me over the past two years and particularly this last year, during the writing of this dissertation. Susan, I thank you from the bottom of my heart for your love and much needed support and encouragement.
CURRICULUM VITA
VON SEVASTION LOCKLEAR

BIOGRAPHICAL INFORMATION

Date of Birth: May 21, 1953
Place of Birth: Lumberton, North Carolina
Address: Route 3, Box 189
Maxton, North Carolina 28364
Telephone: (919) 521-4764
Race: Native American Indian (Lumbee)

EDUCATIONAL EXPERIENCE

M. A. 1982 Pembroke State University
Major: Educational Administration
M. S. W. 1976 University of Maryland
Major Social Work Administration
B. A. 1974 Pembroke State University
Major: Sociology

EDUCATIONAL STUDY AWARDS/FELLOWSHIP

Nominated for University Graduate Associate Teaching Award (1984)
Awarded Outstanding Graduate Teaching Associate for the College of Social Work, The Ohio State University (1984)
Awarded HANA Fellowship from the United Methodist Board of Higher of Higher Education and Ministry (Academic year 1983-84 and 1984-85)
Special Minority University Fellowship for my first year of study at Ohio State University University (1982)
Fellowship from the Joint Center for Political Studies (1979)
Full Fellowship from the U. S. Department of Housing and Urban Development to study at the University of Maryland (1975-76)
Full Fellowship from the National Institute of Mental Health to study at the University of Maryland (1974-75)
CURRICULUM VITA (CONTINUED)

WORK EXPERIENCE

1983 - Present  Full time student at The Ohio State University, College of Social Work.
1981 - 1982  Part-time Lecturer, Pembroke State University, Department of Sociology and Social Work
1980 - 1982  Deputy Director/Operations Officer, Lumbee Regional Development Association, Pembroke, North Carolina
1979 - 1980  Fellow, Joint Center For Political Studies, Washington, D. C.
1976 - 1979  Program Analyst, Mayor's Office of Manpower Resources, Baltimore, Maryland

PROFESSIONAL MEMBERSHIPS

National Association of Social Workers
Alpha Delta Mu, National Social Work Honor Society
TABLE OF CONTENTS

DEDICATION .............................................. ii
ACKNOWLEDGEMENTS ..................................... iii
VITA .................................................................. v
LIST OF TABLES ........................................... vii
LIST OF FIGURES .......................................... xii
Dissertation Quote ....................................... xiv

CHAPTER Page

I. INTRODUCTION ........................................... 1
   Purpose of The Study ................................. 4
   Major Research Questions ............................ 5
   Ethnicity, Social Work and Mental Health .... 5
   Significance of Study ............................... 13
   Description of Study Site ........................... 17
   Limitations of The Study ............................ 24
   Lumbee Indians ...................................... 25
   Lumbee Indian History .............................. 25
   Lumbee Indian Values ............................... 28
   Lumbee Indian Education ............................ 28
   Lumbee Indian Religions ........................... 29
   Lumbee Indian Family Life ....................... 30
   Organization of The Study ...................... 31
   Chapter Summary ...................................... 33
   Footnotes For Chapter 1 ........................... 34

II. LITERATURE REVIEW ................................. 35
   Mental Health in The United States ............ 35
   Joint Commission of Ment Health and Mental Illness .......................... 39
   Community Mental Health Movement .......... 40
   Medicaid and Medicare Legislation .......... 41
   Indian Mental Health ............................... 43
   Indian Mental Health Development and Program ................................ 44
   Review of Relevant Mental Health Research .................................. 50
   Mental Health Definition Research: An Overview ................................ 51
   Mental Health and Mental Illness Confusion .................................. 52
   Mental Health Definitions .......................... 54
   Cross-Cultural Studies of Mental Health .......... 61
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS (CONTINUED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Standardized Psychological Tests in Evaluation of Minorities .............................. 66</td>
</tr>
<tr>
<td>Literature on Discussion of Indian Mental Health Definitions ..................................... 69</td>
</tr>
<tr>
<td>Chapter Summary .......................................................... 73</td>
</tr>
<tr>
<td>III. THEORETICAL FRAMEWORK ................................................................................... 74</td>
</tr>
<tr>
<td>Behavioral-Ecological Perspective ................................................................. 75</td>
</tr>
<tr>
<td>Behavioral Community Technology ........................................................................ 77</td>
</tr>
<tr>
<td>Bio-ecological Analogies ..................................................................................... 78</td>
</tr>
<tr>
<td>Environment-and-Behavioral Field ......................................................................... 79</td>
</tr>
<tr>
<td>Networks and Social Support ................................................................................ 82</td>
</tr>
<tr>
<td>Values Guiding Behavioral-Ecological Perspective ................................................ 83</td>
</tr>
<tr>
<td>Enhancing Personal Competence ............................................................................. 84</td>
</tr>
<tr>
<td>Psychological Sense of Community ........................................................................ 85</td>
</tr>
<tr>
<td>Cultural Diversity .................................................................................................. 85</td>
</tr>
<tr>
<td>Application of Behavioral-Ecological Model to The Definition of Mental Health .......... 86</td>
</tr>
<tr>
<td>Transactional Field ................................................................................................. 89</td>
</tr>
<tr>
<td>Social Work and Behavioral-Ecological Perspective ................................................ 91</td>
</tr>
<tr>
<td>Utility of Behavioral-Ecological Perspective ........................................................ 95</td>
</tr>
<tr>
<td>Chapter Summary .......................................................... ........................................ 97</td>
</tr>
<tr>
<td>IV. RESEARCH METHODOLOGY .................................................................................. 98</td>
</tr>
<tr>
<td>Restatement of Problem and Major Research Questions ........................................... 99</td>
</tr>
<tr>
<td>Research Design ..................................................................................................... 99</td>
</tr>
<tr>
<td>Sample Procedures ................................................................................................ 100</td>
</tr>
<tr>
<td>Key Informant Survey ............................................................................................ 100</td>
</tr>
<tr>
<td>Rationale ................................................................................................................ 101</td>
</tr>
<tr>
<td>Process for Nominating Key Informants ................................................................ 102</td>
</tr>
<tr>
<td>Recruitment Process for Key Informants ................................................................ 103</td>
</tr>
<tr>
<td>Methods Employed to Contact Potential Key Informants ........................................ 105</td>
</tr>
<tr>
<td>Compliance Rate ..................................................................................................... 106</td>
</tr>
<tr>
<td>Data Collection ....................................................................................................... 106</td>
</tr>
<tr>
<td>Research Instrument ............................................................................................... 109</td>
</tr>
<tr>
<td>Pretest ..................................................................................................................... 110</td>
</tr>
<tr>
<td>Validity and Reliability .......................................................................................... 111</td>
</tr>
<tr>
<td>Procedures for Data Analysis ................................................................................ 113</td>
</tr>
<tr>
<td>Description of Study Population ............................................................................ 115</td>
</tr>
<tr>
<td>Protection of Human Subjects ................................................................................ 121</td>
</tr>
<tr>
<td>Chapter Summary .......................................................... ........................................ 122</td>
</tr>
</tbody>
</table>

viii
TABLE OF CONTENTS (CONTINUED)

V. FINDINGS ...................................... 123
   Views About Socially Deviant Behavior as Mental Health Problems .......... 124
   Identification of Mental Health Characteristics and Signs of Mental Health Problems .......... 132
   Exploring Various Social Factors as They Affect the Definition of Mental Health .......... 149
   Variations of Mental Health Definition in Terms of Age, Gender Wealth and Employment .......... 165
   Racial Variations in The Definition of Mental Health .......... 172
   Causes of Mental Illness .......... 183
   Belief In The Treatment Techniques of The Formal Mental Health System .......... 185
   Subjects' Feelings About This Kind of Research .......... 190
   Chapter Summary .......... 194
   Chapter V Notes .......... 195

VI. INTERPRETATION AND DISCUSSION OF DATA .......... 196
   Discussion of Comparative Analysis of The Three Racial Groups' Definition of Mental Health .......... 198
   Overview of Findings .......... 198
   Variations in the Identification of Socially Deviant Behaviors .......... 204
   Apparent Confusion Between Mental Health and Mental Illness .......... 205
   Tolerance .......... 209
   Mind/Body Holism .......... 219
   Perceptions of Racial Variations in the Definition of Mental Health .......... 220
   Status Effects of Age, Gender, Wealth and Employment in Defining Mental Health .......... 221
   Factors Related to The Promotion and Maintenance of Mental Health .......... 225
   Maintenance and Promotion of Mental Health by Family, Community and Environment .......... 227
   Support Systems .......... 321
   Lumbee Indian Elders .......... 234
   Causes of Mental Illness .......... 236
   Belief in Treatment Techniques of the Formal Mental Health System .......... 237
   Respondents' Feelings About The Value and Usefulness of This Research Study .......... 238
TABLE OF CONTENTS (CONTINUED)

Application of Behavioral-Ecological Values to This Study ................. 239
Chapter Summary ........................................ 242

VII. SUMMARY, CONCLUSION AND IMPLICATIONS .......... 244

Overview of Research Study ............................... 245
Study Conclusion ......................................... 246
Limitations of The Study ................................... 249
Implications
  for Mental Health and Social Work ............... 251
Mental Health and Social Work Practice ........... 253
Mental Health and Social Work Education ....... 259
Use of Standard Psychological Test
  Evaluation of Lumbee Indians ....................... 261
Use of Paraprofessionals ............................... 263
Potential Administrative Changes .................... 266
Future Research ........................................... 266
Concluding Statement .................................... 267

APPENDIXES

A. Interview/Questionnaire Guide ..................... 272
B. Responses From Juror Process
  For The Instrument ..................................... 279
C. List of Participating Organizations In
  The Key Informant Survey Process ........... 270
D. Introduction Used for
  Each Key Informant ................................... 276

BIBLIOGRAPHY ................................................ 279
<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Age Distribution of Study Population</td>
<td>115</td>
</tr>
<tr>
<td>2 Gender Distribution of The Study Population</td>
<td>116</td>
</tr>
<tr>
<td>3 Income Distribution of The Study Population</td>
<td>117</td>
</tr>
<tr>
<td>4 Educational Status of The Study Population</td>
<td>118</td>
</tr>
<tr>
<td>5 Occupation Distribution of The Study Population</td>
<td>119</td>
</tr>
<tr>
<td>6 Subjects' Views About Alcoholism as an Indication of Mental Health Problem</td>
<td>125</td>
</tr>
<tr>
<td>7 Subjects' Views About Spouse Abuse as an Indication of Mental Health Problem</td>
<td>126</td>
</tr>
<tr>
<td>8 Subjects' Views About Use of a Gun as an Indication of a Mental Health Problem</td>
<td>127</td>
</tr>
<tr>
<td>9 Subjects' Views About Fist Fighting as an Indication of a Mental Health Problem</td>
<td>128</td>
</tr>
<tr>
<td>10 Subjects' Views About Use of Drugs as an Indication of a Mental Health Problem</td>
<td>130</td>
</tr>
<tr>
<td>11 Subjects' Views About Criminal Activity as an Indication of a Mental Health Problems</td>
<td>131</td>
</tr>
<tr>
<td>12 Subjects' Descriptions of The Term Mental Health</td>
<td>134</td>
</tr>
<tr>
<td>13 Subjects' Views of Characteristics of a Mentally Healthy Person</td>
<td>139</td>
</tr>
<tr>
<td>14 Subjects' Views of The Characteristics of a Mentally Ill Person</td>
<td>142</td>
</tr>
<tr>
<td>15 Subjects' Views of Mental Health Problems</td>
<td>145</td>
</tr>
<tr>
<td>16 Subjects' Views About Signs and Characteristics of Mental Illness</td>
<td>147</td>
</tr>
<tr>
<td>17 Subjects' Views of Mental Health Resources</td>
<td>150</td>
</tr>
<tr>
<td>18 Subjects' Views About Preference of Mental Health Over Physical Health Problems</td>
<td>153</td>
</tr>
</tbody>
</table>
LIST OF TABLES (CONTINUED)

19 Subjects' Views About How Factors such as Family, Environment, Community and Culture Influence The Definition of Mental Health .................. 155

20 Subjects' Views About Employing The Insanity Plea In Defining Mental Health .................. 161

21 Subjects' Views About Hiring A Formerly Mentally Ill Person For Employment .............. 163

22 Subjects' Views About Differences Between A Mentally Health Rich and Poor Person ........ 165

23 Subjects' Views About The Difference of Age In The Definition of Mental Health .............. 167

24 Subjects' Views About Gender Differences In The Definition of Mental Health ............. 169

25 Subjects' Perceptions of Racial Differences In The Definition of Mental Health ............ 173

26 Subjects' Perceptions of Differences in A Mentally Healthy Indian, Black and White ...... 177

27 Subjects' Views of Large Percentage of Mental Illness Among The Three Racial Groups ...... 179

28 Subjects' Views About the Differences In The Perception Of Mental Health Between an Indian, Black and White In Robeson County .................................. 182

29 Subjects' Views About Causes of Mental Illness ............................................. 184

30 Subjects' Views About Complete Recover From Mental Illness ................................. 185

31 Subjects' Views About The Ability of Drugs To Cure Mental Illness ........................... 187

32 Subjects' Views About The Ability of Drugs To Treat Mental Illness .......................... 188

33 Subjects' Views About The Worthiness of This Study ..................................... 190

34 Subjects' Identification of Issues, Concerns Not Addressed In The Interview/Study ........ 192
LIST OF FIGURES

FIGURE
1. Transactional Field Model ...................... 89
Dissertation Quote

Everyman is in certain respects
a. like all other men
b. like some other men
c. like no other men
(Kluckhorn and Murrary, 1956 p. 53)
CHAPTER I

INTRODUCTION

Historically, the United States has been viewed as a great "melting pot", priding itself in the ability to assimilate many diverse ethnic and racial groups/cultures into one American culture. Nevertheless, experts in the helping professions, such as social work, are beginning to realize that although diverse cultures may be superficially assimilated, the values, traditions, beliefs, and customs that are deep-rooted in these various cultures must be considered when dealing with their members if services are to be successfully delivered. Martinez (1979) suggested "that the failure of social and behavioral scientists to recognize and control for extensive inter-group differences has led to a body of literature replete with errors of conceptualization, design, analysis and interpretation" (p. 3). Martinez goes on to state that "two of the most pervasive shortcomings appearing in the literature are 1) the tendency to homogenize minority group populations and 2) the propensity to use Anglos as the reference group against which minority group dimensions are measured" (p.3). The literature on mental health has begun to
address these problems. There is a growing concern (e.g., Giordano & Giordano, 1977; Green, 1982; Martinez, 1979; McCoy, 1981; Rhoades, et al., 1980) about the need for more information and empirical data that define mental health for minority groups. As Carillo (1979) has suggested, "people have the right to culturally-based, culturally-appropriate and non-class bound mental health services" (p. 11).

One minority group that is currently receiving attention is the American Indian community* (see chapter notes). This group will be the focus of this study. As Trimble and Medicine (1976) noted, "a plethora of research has focused on mental health, social pathology and psychotherapy of American Indians" (p. 161). One need only to examine the index of journals such as Psychiatric Annals, Public Health Reports, Arizona Medicine and Community Mental Health Journal to see that Trimble and Medicine are indeed correct. Yet, as they conclude their extensive discussion of approaches that have been used in such research, "disproportionate problems related to mental health among American Indians (sic) are apparent in spite of our best efforts" (p. 134). This conclusion would be supported by Rhoades, et al. (1980) who reported that "it is not unusual for Indians to assert that mental health afflictions are now their primary health problems" (p. 329). McCoy (1981) cited work done by Ryan and Spencer (1978) suggesting that despite increased programs,
research does not indicate an improvement in the mental health status of American Indians. Mental health professionals appear to have realized that in order to truly understand and treat mental health problems, the culture of the individual must be considered. As McCoy (1981) suggested, factors such as values, traditions, customs, language and beliefs are extremely pertinent to mental health services and are the ingredients that "must be identified and placed in perspective in order to serve the individual" (p. 1). These factors could potentially be important in defining mental health.

Whereas studies (e.g., Halpert, 1963) have been done which attempt to identify the Anglo/Western concept of mental health and mental illness, a preliminary review of the literature failed to uncover any studies which addressed the identification of the American Indian concept of mental health. (There were reports, e.g., Shore, 1974, which described attempts to assess Indian mental health but not Indian concepts of mental health.) To adequately meet the mental health needs of this country's American Indian population, systematic efforts to define the American Indian concepts of mental health are needed. For this reason the following study is important.
This study represents an initial yet much needed effort that seeks to determine whether an Indian tribe's (specifically the Lumbee's) concept of mental health can be defined. Although the literature suggests that it should be done, one must wonder why it has not been done thus far and whether it is possible to do so. This study provides a justification for similar studies with other tribes and minority groups/special populations. It also provides those involved in the mental health profession with valuable information by which to enhance the delivery of services to minority groups, especially American Indians, by allowing them to make the services culturally based and culturally relevant. If an Indian concept of mental health can be defined, this, too, is valuable information that could be used to help future researchers channel their efforts into more promising directions.

Purpose of the Study

This is a descriptive, exploratory study with the purpose of determining how 60 residents of Robeson County, North Carolina define the concept mental health. The subjects represent three racial groups White, Black, and Indian. The main focus of this study is the definition of mental health in the American Indian community. This study is an attempt to determine whether there are differences in the way the three racial groups from the same geographic area define the concept of mental health.
If there are differences, it is hoped that this study is able to identify them.

Major Research Questions

It is not the purpose of this study to provide any definitive answers or conclusions as to how mental health concepts are defined but, to determine if there are differences in the way the Lumbee Indian Tribe defines mental health in relation to the White and Black communities of Robeson County, North Carolina. With this as a goal, the following questions will serve as a guide in this study:

1. What is the Lumbee Indian definition of mental health?
2. What is the Black definition of mental health?
3. What is the White definition of mental health?
4. What are the similarities/differences between the Lumbee Indian definition of mental health and the Black definition of mental health?
5. What are the similarities/differences between the Lumbee Indian definition of mental health and the White definition of mental health?

Ethnicity, Social Work and Mental Health

Social work has been defined by many social work professionals. For the purpose of this research project, social work will be defined by using a definition put forth by Pincus and Minahan (1973):
Social work is concerned with the interaction between people and their social environment which affects the ability of people to accomplish their life tasks, alleviate distress and realize their aspirations and values. The purpose of social work therefore, is to (1) enhance the problem-solving and coping capacities of people, (2) link people with systems that provide them with resources, services and opportunities, (3) promote the effective and human operation of these systems and (4) contribute to the development and improvement of social policy (p. 9).

Social work is concerned with the interaction between people and their environments with the purpose of improving that relationship and helping them more clearly define the purpose of that relationship. The change that takes place may be with the people, social environment, or the relationship between these two systems. One of the areas in which social work has been developing and expanding is in the area of mental health. Social work is primarily concerned with helping individuals, groups and communities define problems as they relate to them within the particular boundaries of their environment. Social work is also concerned with determining/defining how those problems can best be resolved by using the resources within the environment.

There are many definitions of mental health and there is not total agreement on any one of the present definitions. A detailed discussion of the various definitions of mental health will be discussed in greater detail in the following chapter. Because of the confusion and disagreement regarding mental health definitions, this
research study is all the more important. There is a need to learn more about mental health and how it is defined, particularly on a cross-cultural basis. However, for the purpose of this study, the following definition of mental health from the *International Encyclopedia of Psychiatry, Psychology, Psychoanalysis and Neurology* (1977) will be used. It defines mental health as "behavior that meets the demands of social roles and norms" (p.172)

The social work profession, along with other helping professions, has only recently begun to acknowledge and act upon the many social, cultural, religious, ethnic and racial differences that exist in our society. As early as 1917, Mary Richmond, a pioneer social worker, cautioned social workers about making generalizations about immigrants or ignoring national and racial characteristics in defining and solving problems. Mary Richmond (1917) states:

> In dealing with foreign clients the caseworker finds himself in danger of falling in to one of two errors: he may think of them as member of a colony or of a nationality and racial characteristics and try to apply to them the same standards of measure that he would to his fellow countrymen. He is liable to surprise, if he adopts the latter course. Before long he will have learned that he cannot ignore national characteristics all together (p. 382).
Until recently the profession has failed to act upon Mary Richmond's admonition. Egalitarian motives led many social workers to the conclusion that overlooking ethnic differences in human behavior is consistent with social work's commitment to equality and the uniqueness of each individual.

For many years the profession adopted a "color blindness" in its approach to social problem definition and solution when working with members of ethnic and racial groups. For the purposes of this discussion ethnicity will be identified as "a classification in which the members share a unique social and cultural heritage passed on from one generation to the next" (Atkinson, Morten and Sue, 1983, p. 4). Burgest (1982) wrote "they denied the existence of ethnicity and race as having any importance on the problem presented by the clients" (p. Introduction). The assumption of this premise was that the recognition of race somehow denotes discrimination and racism. However, by the denial of racial differences, social workers did not have to relate to their own racial prejudices. Today there has been a complete turnabout. The profession is beginning to recognize the social and ethnic implications in the problems presented and defined especially in the area of mental health. Burgest (1982) further states, "it (social work) recognizes that minority identity has implications for the interactional relationship between worker, client, diagnosis and
therapeutic technique, as well as the setting of goals" (p. Introduction).

Harriet Trader (1977) states that the practice of social work, for the general welfare, may not promote the welfare of members of oppressed minority groups. She goes on to say that:

It may be that the requirements for the general welfare and those of the welfare of the oppressed are not always identical. Also a certain contradiction is that although the profession is committed to helping minority groups, it is also being financed for the most part by a majority society whose primary interests may be opposed to minority group interests (p. 10).

The way problems are defined by minorities may not be the way they would be defined by the larger society. Because of inequality in economic and social conditions there are environmental differences between minority groups and the larger society. Consequently, one can expect that there are differences in the problem identification process, especially in the area of mental health. This may be true in the way mental health is defined, particularly by the American Indian community. While the social, cultural differences have always been present, it is only within recent times that active and genuine efforts have been made to incorporate those differences into the way problems are defined and resolved in the practice of social work, especially in the field of mental health.
A major step was taken in 1977 by the Council on Social Work Education (CSWE) to meet the unique needs of ethnic minority groups. Attention was given to the desirability of expanded recruitment of minority students and faculty and the need for scholarships and grants. The council was responsible for a series of publications on each of the minority groups that required focused attention. These groups comprised of Blacks, Chicanos, Asians, American Indians and Puerto Ricans (Donald Lum, 1982). The National Association of Social Workers (NASW) has contributed in this area by developing literature on minority social work. The seventeenth issue of the Encyclopedia of Social Work (1977) included a number of articles that were primarily concerned with minority groups. The NASW publication Social Work devoted one issue to minority concerns entitled "People of Color". In addition, the Family Service Association of America has developed minority group material and has consistently published minority practice articles in Social Work.

Several major social work journals are beginning to publish articles about American Indians. Particularly Social Work which has recently published a number of articles (i.e., Goodtracks, 1975; Ho, 1975; Locklear, 1977; Farris and Farris, 1976; and Ho and Lewis, 1975) that address American Indian concerns. Social Casework has also given some special attention to the needs of American Indians and recently published a series of
articles entitled "The Phoenix" about American Indian issues and concerns (i.e., Wilkinson, 1980; Carpenter, 1980; Red Horse, 1980; Miller, Hoffman and Turner, 1980; Goodluck and Short, 1980; Red Horse, 1980; Edwards and Edwards, 1980; Ryan, 1980;). While some attention is being directed toward minority groups from several associations through various publications, there remains much to be done by the profession before it can say it has successfully achieved its goal. Many social work practice books that are being published today are not including principles concerning practice that are distinctly geared to address people of color. Donald Lum (1982) in a published article, notes these problems in several major social work practice books.

A major limitation in the practice of ethnic social work is a severe shortage of ethnic-relevant theoretical practice frameworks. A review of the literature finds that only a limited number: two of these frameworks are being developed by Harriet Trader (1982) and Donald Lum (1982).

Donald Lum (1982) has developed a psychosocial framework for practice that is sensitive to the needs of minorities. It is based on their definition of how problems are defined and how they should be solved. In addition, he states, "Beyond the need for an understanding of the psychosocial process from a minority perspective is the need to be familiar with some of the commonly
occurring problems in minority practice" (Lum, 1982, p. 246). He identifies five problem areas: 1) oppression vs. liberation, 2) powerlessness vs. empowerment, 3) exploitation vs. parity, 4) acculturation vs. cultural maintenance and 5) stereotyping vs. a unique person, as important in developing a social work practice framework with minorities.

In a similar, yet unique approach, Harriet Trader is developing a model of minority social work practice specifically for the Black client/community. The focus of this model is on transactional teaching learning. This model implies a shared experience in the teaching-learning process and it rejects the traditional vertical transmission of knowledge from the "expert" practitioner to the "inexpert" client (Trader, p. 11). This model is based on a reciprocal teaching-learning experience. The emphasis in this practice model is on the production of observable changes in coping with behavior geared to the survival in a capitalistic society.

A recent trend in social work literature has been recognizing the unique needs of minority groups/populations, particularly in the approach that is employed in the definition of mental health and related social problems. As minorities gain access to decision-making positions, they have been influential in expanding and more fully developing the mental health system, in relation to problems definitions within the
communities and environment of minority populations. This is creating a greater sense of responsiveness to the individual and to the unique needs of various minority groups including the American Indian population.

Although some recent developments show strong possibilities of improving ethnic social work practice, there remains much to be done in the area of defining mental health. The profession of social work is beginning to recognize and appreciate the cultural diversity in our society and to incorporate that diversity into the practice of social work, especially in determining how problems are defined within the cultural boundaries of minority populations.

Significance of the Study

Within the past decade, there has been a growing interest in how the concept of mental health is defined. This growing concern is being expressed not only by minority mental health professionals, but also by the general professional mental health community.

A quick review of how the concept of mental health is defined will reveal that the definition has been almost totally influenced by Western thinking and philosophy. The current definitions (Jahoda, 1955; Gallagher, 1981; Henry; 1953; Scott, 1958) of mental health appear to be too limited from a theoretical and therapeutic perspective to meet the increasing needs and demands of today's
diverse society, and especially that of the American Indian population. As a result, minority populations are demanding a mental health system that is based on their definitions of mental health.

Given the amount of money and time that has been devoted to document and research, in the area of mental health, one would expect that there would be a sufficient body of knowledge available to understand how mental health is defined in a diverse society such as the United States. However, this is not the case of the present mental health system. Present definitions of mental health appear to be too narrowly defined to meet the needs of many minority groups, notably the American Indian community.

The literature in anthropology (Mead, 1971; Benedict, 1934) substantiates that cultures are different in terms of held values, societal norms, and defined behaviors, particularly as these relate to the way behavior is defined. Assuming that this is true, some mental health professionals are beginning to question the entire premise upon which the prevailing definition of mental health is based. Until very recently, most of the research that has been conducted in the area of mental health has been done according to White, middle-class values, norms and definitions, employing Western theory, research design and methodology. Today, many mental health professionals agree that the time has come to examine the premise upon
which mental health is defined, and to expand the present
definition to include the mental health definitions of
minority groups, especially American Indians. This is
imperative if mental health concepts and definitions are
to be culturally relevant and effective in meeting the
needs of American Indians (McCoy, 1981).

If the definition of mental health is to be
culturally relevant and used effectively, it becomes of
paramount importance to help each minority group clearly
define the concept of mental health as it relates to its
particular social, physical, cultural and psychological
well-being (McCoy, 1981). More research in this area can
be useful in understanding how behavior is expressed, how
it is defined and the meaning given to it by different
racial, cultural, or religious groups within specific
environment.

An American Indian community is the focus of this
study. In many ways, this group has the greatest
disadvantages in that they are not immigrants, but are in
their native land. They have struggled for several
hundred years, with the immigration from Western Europe
and other parts of the world. They have been forcibly
acculturated, and as a result, have lost much of their
native culture. Each Native American Indian community
today is recognized as having a distinct culture that is
unique one that is based on a set of values quite
different from the larger society (Trimble, et.al. 1984).
The present mental health system has been designed and defined from a Western European paradigm of mental health. Recognizing that the American Indians have distinct cultures, it would appear that their definitions of mental health may be different. Until recently, differences in defining mental health were neither recognized nor acknowledged by the professional mental health community.

Although, the mental health profession has increased and expanded its service delivery system to American Indians, it has done so without recognition of the cultural differences. It is important to understand these differences in order to provide effective culturally relevant mental health services. The successful accomplishment of this task, requires an understanding of how American Indians define the mental health. It is equally important to know whether American Indians' definitions of mental health vary from the larger culture's definition of mental health. This study is an attempt to determine the differences regarding the definitions of mental health among White, Black and American Indian (Lumbee) groups, of Robeson County, North Carolina.
Description of Study Site

Robeson County is located on the coastal plains in Southeastern North Carolina. The county contains approximately 950 square miles, making it the second largest county in the State of North Carolina. It is mostly a rural county with rich farm land and has a developing technological and industrial base.

Robeson County may have several distinguishing features, but none more noteworthy than its tri-racial composition. This gives it a unique distinction in the state, and indeed, in the country. According to the 1980 census, the population consists of 101,610 residents. Of the total population 39,989 are White, 35,511 are Indian and 25,590 are Black. The largest percentage of the population is White at 39.5 percent. The American Indian (Lumbee) population is second at 35 percent and the remainder is Black at 25 percent (Ross, 1980).

The Indian population in the county is much younger than the other two races. Among the Indian population almost one-half of the population, 40 percent are below the age of eighteen. Among the White population, 6.4 percent are under five (5) years old, compared to ten percent for the Black population. For several reasons, the Indian population dies at a much younger age than the other two races. In the State of North Carolina, the median age of death for all causes is 71 for Whites, 65 for Blacks and 60 years for Indians (Lumbee Regional
Poverty is a severe problem in Robeson County, especially among the Black and Indian populations. Many of the residents of the county fall below the poverty guidelines established by the United States Department of Agriculture. The 1980 census for Robeson County, indicated that 12 percent of the White population had incomes at or below the poverty level, whereas the Black population had 29 percent, and the Indian population had 40 percent. The average family income for the White community was $20,150. The average family income for the Indian community was $14,134, and the average family income for the Black community was $11,345 in 1980. The average per capita income for Robeson County in 1980 was $5,644, however, the state average was higher at $7,832 (Lumbee Regional Development Association, 1984).

Despite the appearance of a number of educational institutions in Robeson County, the educational system is deficient. There is evidence of a major gap in educational quality between the White and non-White population. Minority test scores remain low and are far below the state average. The high school dropout rate for the county is also above the state average. Minority scores on standardized tests continue to rank well below the state average. According to the State of North Carolina educational standards, Robeson County ranks next
to the bottom in the median school years completed for persons 25 years or older and ranks at the bottom in the percentage of those having completed high school. The 1980 Census data report that 45 percent of the Indian population of Robeson County, age 25 years or older had less than eighth grade education (Lumbee Regional Development Association, 1984).

Robeson County is gradually changing from an agricultural based economy to an agricultural-industrial based economy. Even though there is a strong developing industrial and technological base in Robeson County, the hourly wage continues to rank well below that of the national average. Robeson County ranks in the bottom 7 percent of the scale within the state (Labor Resources Division). This seems to be true for all areas of employment, but particularly in textile work. This is not surprising as there are few, if any, union activities.

In January, 1985 the state unemployment rate was 8.8 percent while the rate for Robeson County was 11.2 percent. Among its many problems, unemployment continues to remain higher in Robeson County than other areas of the state and region. Based on 1982 data (Manpower Information for Affirmative Action Program) prepared by the local Employment Commission Office in Region N (of which Robeson County is a member), the Indian population accounted for 12,410 or 17 percent of the total civilian labor force. Indian females accounted for 4,610 or 34
percent of the total Indian labor force. Indian males comprised 7,800 or 63 percent of the Indian work force.

Robeson County continues to be plagued with various social problems, but none more tragic than the devastating health problems. Poor health is a social problem that permeates the entire county, especially within the Indian population. Both Indian males and females have a life expectancy of eleven years less than their White counterparts.

While many suffer from an inadequate health care system, the rural poor, infants, children, and the elderly who lack sufficient financial resources seem to be most affected. Many do not practice preventative health care and are ignorant about and physical health education. As such they only solicit the services of the medical community in extreme emergency situations. The Indian community appears to have more problems with physical diseases than the White or Black race. This is supported by the following data: the death rate for Indians is at least 30 percent higher than the Robeson County rate. The following underlying causes of death are the most common for the state: arteriosclerosis, leukemia, diabetes, nephritis, nephrosis, motor vehicle accidents, cirrhosis of the liver, suicide and homicide. These are higher for the Indian than for the state population (LRDA Overview, 1980).
Indian infants, as stated earlier, have special health problems and suffer a greater chance of not surviving. In the time period between 1976 and 1980, the state infant death rate was 15.9 deaths per 1,000 live births, while Robeson County's rate was 18.5 deaths per 1,000 live births. In the years between 1978 and 1980, the county statistics on infant death rates by race were as follows: 11.5 deaths per 1,000 live births for Whites, 21.5 deaths per 1,000 live births for Blacks, and 18.1 deaths per 1,000 live births for Indians.

Inadequate housing is another social problem with which many residents of Robeson County must cope. Robeson County, like most other counties in the state, has a high percentage of substandard housing. As many as one-fourth of all rural housing units may be substandard, in that they lack indoor plumbing and possess structural weakness (Ross 1982, p. 69). Robeson County's population has recently increased and this is a contributing factor to the housing shortage. Additional economic factors contributing to the housing shortage are insufficient capital investment, limited land space for development and low family income.

In addition to the above identified social problems, Robeson County has mental health problems. A review of the Southeastern Regional Mental Health Center statistics Report for Robeson County indicates that the presenting diagnoses varies for people in the county. The four major
diagnostic categories are mental retardation, alcohol related organic disorders, schizophrenic disorders, and adjustment problems. The same report indicates that most referrals are self-referrals, or referrals from other services including the police, courts, the local hospital and local physicians.

In an effort to combat these and other related mental health problems, Robeson County has established a county mental health center. The center was originally established and funded by the Community Mental Health Center Act of 1963, however, as federal funds began to decrease, the center has maintained itself through funds from state and local resources. Even though the center is part of the public services offered in the county, clients are expected to pay the services rendered. A sliding fee scale based on to the client's family income and size is used to determine the cost of each visit.

The center was originally developed on the model of the Community Mental Health Center Act of 1963. This center offers a variety of services. The philosophy of the center is consistent with the goals and objectives of the Act of 1963 with an emphasis on community oriented mental health services. The center is equipped to offer a variety of service programs including, but not limited to, inpatient/outpatient services, alcohol and drug abuse services, partial hospitalization services, children's treatment center and aftercare services.
Robeson County Mental Health Center is a member of the Southeastern Regional Mental Health Center. The Southeastern Regional Mental Health Center is an area program of the North Carolina Division of Mental Health/Mental Retardation and Substance Abuse. The Robeson County Center is designed to respond to a variety of mental health problems. The Center has been in operation since 1965.

It should be noted here that the Lumbee Indians do not receive services from the Indian Health Service, a division of the U.S. Department of Health and Human Services. The Indian Health Service provides services only to those tribes that have treaties with the U.S. Federal Government. The responsibility for providing services to the remaining American Indian population comes under the jurisdictions of state and local governments in conjunction with federal assistance. The Lumbees, although recognized by the Federal Government, do not receive health (including mental health) services through the Indian Health Service. Therefore, any mental health services they receive will be from the local mental health center in Robeson County.

It is safe to say that Robeson County, like many of its neighboring counties in North Carolina, is still experiencing rapid industrial, environmental, social, economic, educational and cultural changes. As these changes take place, they will inevitably have a profound
impact on the various communities of Robeson County. How well each of the communities survive these changes will depend on how well the environment is able to respond in a positive, constructive, and culturally relevant way to their particular needs. This seems most important here as Robeson County is unique in its cultural/ethnic and racial composition.

Limitations of the Study

The major limitation of this study is generalizability and this is for two reasons: (1) the unusual tri-racial composition of the county in this study and (2) the data are relevant only the Lumbee Indian tribe.

First, Robeson County, North Carolina is unusual for many reasons. Its tri-racial composition is most unusual. It has a relatively balanced population of White, Black and Indian residents. There are few counties in the country that have a racial composition similar in nature and population to that of Robeson County. For this and other reasons, generalizations about the data collected and the results of this study may be limited to other counties or areas similar to Robeson County.

Second, there are more than 250 active, identifiable and recognized Indian tribes in the United States today. Although each of these tribes come collectively from the American Indian community, each tribe is unique.
Therefore, generalizations about the data collected and the conclusions drawn from this study in reference to the Lumbee Indian tribe, will be limited to the Lumbee tribe. However, these conclusions may be indicative of the views of other American Indian communities, of similar economic, social, cultural, religious, geographic and governmental status.

**Lumbee Indians**

The Lumbee Indians are located in Robeson and its surrounding counties in southeastern North Carolina. They are the largest tribe of American Indians east of the Mississippi River.

The Lumbee Indians have received full recognition from the State of North Carolina as a tribe of American Indians with similar recognition from the State's Federal Government. While the Lumbee Indians do not receive services from the Bureau of Indian Affairs, they do participate in various other federal programs that are targeted toward American Indian tribes.

**Lumbee Indian History**

The history of the Lumbee Indians is not known. However, there are several theories about the genesis of this group of American Indians. Most historians believe them to be the descendants of the Hatteras Indians of the coastal regions of North Carolina and Sir Walter Raleigh's
"Lost Colony of 1587." The early historical records of Lumbees show them as having many European characteristics in dress, agricultural skills, language and art. The Lumbees have always been a peaceful, non-nomadic group. However, when their livelihood is threatened they will defend themselves fiercely. They lived on the banks off the Lumber (Lumbee) River and held land in common by right of possession until the arrival of the White man to Robeson County around 1730.

During the early part of the 18th century, the State of North Carolina instituted several constitutional changes which affected all non-White people, including the Lumbee Indians. As a result of these changes, the Lumbee Indians were disfranchised and lost the right to carry weapons.

During the period of the Civil War, efforts were undertaken to force the Lumbee into labor camps. They resisted this effort, but agreed to serve in the Home Guard, however they were denied participation in the Home Guard. This, along with other events, created tension and led to the beginning of the Henry Berry Lowry War. Henry Berry Lowry was the leader of a "gang" of Lumbee Indians, seeking revenge for the deaths of family members. Later he became a hero of the Lumbees, and was the inspiration of an outdoor drama entitled "Strike at The Wind".
The period of 1875-1885 has been called a "decade of despair." However, through the friendship of a prominent local lawyer and a member of the North Carolina Legislature, legislation was passed establishing a separate school system (college) for the Lumbee Indians. It should be noted that during this time the same piece of legislation designated this group of Indians as Croatan Indians. The school's original name was Croatan Normal School. Like its people, the school has had many names: Croatan Normal School, 1887; Indian Normal School of Robeson County, 1911; Cherokee Indian Normal School, 1913; Pembroke State College, 1949; and Pembroke State University, 1969.

During the 1970s, the Lumbees have been involved in political movements at the local, state and national level. While some social and political ties with other Indian tribes have been established at the state and national level, there is still some tension within the Lumbee Indian community. This tension is due to ongoing debates regarding the origins of this tribe particularly in reference to links with the Tuscaroras Indian tribe which is now located in New York state.
Lumbee Indian Values

This section will present several values that are important within the Lumbee Indian community. There are many important values however for the purposes of this study a discussion of education, religion and family life seem most appropriate. These are some of the values that have helped to sustain the Lumbee Indian people during their many past as well as present struggles.

Lumbee Indian Education

The Lumbees have always had a strong desire for the White man's education. Much of the recorded and oral history of the Lumbee people reflects the struggle for education. The Lumbees have been called the most progressive American Indian tribe in the United States. However, much of the progressiveness of the Lumbee Indians can be attributed to the pursuit, development and expansion of education.

The Lumbees were forced to attend a separate school system because they were denied the right to attend the local public schools. Through determination and pride, the Lumbees were instrumental in establishing a school system by which to meet their needs. Their pursuit for an education became the basis for pride and dignity, as well as enhancing their status as an identifiable race of people. The Lumbees learned early the importance of education as a tool for survival in the White man's world.
Education still remains a very strong value within the Lumbee Indian tribe. As the results of education are seen in the Indian community, it becomes a much stronger and influential value within the Lumbee Indian community.

Lumbee Indian Religions

One of the most important values within the Lumbee Indian community is that of religion. This can be witnessed by the numerous churches and the variety of practiced religions within the Lumbee Indian community. There are many religious denominations or sects as well as several religious conferences to which the Lumbee Indians belong. The most active religious sects or dominations are the Baptist, Methodist, Latter Day Saints (Mormons), Freewill Baptist, Church of God, Plymouth Brethren, Assembly of God, Pentcostal Holiness and the Jehovah's Witness.

As with most other American Indian tribes, the traditional religions have been replaced with the White man's Christian religion within the Lumbee Indian community. The process of religious conversion began with the influence of missionaries in most American Indian communities. Because of the unique history of the Lumbee Indians, there was little need for conversion, as they have historically practiced the White man's religion. Religion has become an integral part of Lumbee Indian life. As Dial and Eliades (1975) note about Lumbee
Religion in a rural area is an extremely important social force. It brings people together for the exchange of ideas, and information, and it provides opportunity for a host of other social functions... The church has been the focal point of community spirit... Their daily contact with nature makes their religion an integral part of their existence. In short, Lumbee religion and life are intertwined in such a fashion as to give the people the opportunity for joy in this world while preparing for the next.

Religion has been and will continue to serve as a vital role in the culture and environment of Lumbee Indian people.

Lumbee Indian Family Life

While there are many important values within the Lumbee Indian community, none is more important than that of family. This along with other traditional values the Lumbees share with other American Indian tribes. Family has a very special meaning to Lumbee Indian people. When Lumbees talk about family, they are talking not only about immediate family, but about grandparents, uncles, aunts, cousins and sometimes individuals that are not necessarily blood related. The extended family has helped to sustain the Lumbee Indian people through many very difficult and important struggles. Lumbee Indians are very strong and proud people. They are very proud of their past struggles and survival through some very challenging situations. Many Lumbees believe a major contributing factor to their survival has been the strength and determination of the
family. For many Lumbees, family is a very important part of their environment.

Education, religion and family are strong survival tools for the Lumbee Indians. Their religion has been a source of strength during some of the most difficult periods of their history. Education has always been an important value within the Lumbee Indian community. It is through education that skills have been developed which have allowed them to successfully compete in the outside world. Family is perhaps the greatest value of the Lumbee Indian people. It is through helping each other and developing strong family ties that Lumbees have sustained themselves to become a very productive and successful tribe of American Indians.

Organization of The Study

The introductory chapter presents an overview of the present study. This chapter has provided basic background information for the problem to be studied, the purpose of the research study, and a description of the study site. A historical perspective of the Lumbee Indians is included in this chapter.

Chapter Two, the literature review, provides a historical development of the mental health system in the United States, and Indian health and mental health services are also explored. Special emphasis is devoted to an explanation of the past and present status of a
definition of mental health, along with various cross-cultural studies on mental health.

Chapter Three is concerned with the theoretical framework used in this study. The Behavioral-Ecological Framework will be used as the guiding theory in this study.

Chapter Four presents the methodology in this study. This exploratory, descriptive study explores how mental health is defined in a tri-racial county. The key informant process is used in selecting the sample, which receive a one-time structured interview. Content analysis is used to analyze the data.

The next chapter, Chapter Five, presents the findings of this study. The findings are presented in both qualitative and quantitative form.

Chapter Six is a discussion of the findings guided by the behavioral-ecological perspective, linking the findings to the theory.

The concluding chapter, Chapter Seven, includes a summary statement of the study, a conclusion identifying the major characteristics of Lumbee Indian mental health, and an examination of the implications of the findings of this study.
Chapter Summary

This chapter has presented an overview of this research. The purpose of the present study is to determine how mental health is defined in a tri-racial county in Southeastern, North Carolina, composed of Lumbee Indian, White and Black residents.

Social work is concerned and committed to learning more about how minorities define mental health. The results of this study will make a valuable contribution in learning more about minority concepts of mental health. Additionally, it is hoped this study will add to the growing body of literature on American mental health.
1. The author is aware of the various terms that have used to refer to the original people of this country. However for the purposes of this dissertation the American Indian will be used to refer to the Lumbee Indian tribe.
CHAPTER II

LITERATURE REVIEW

This chapter introduces the reader to literature relevant to understanding mental health as viewed by the dominant American culture and by American Indians. This chapter is divided into three sections. The first section provides a historical overview of the development and expansion of the mental health system in the United States. This historical overview also reflects the evolution of definitions of mental health. The second section presents a historical perspective of mental health services provided to the American Indian communities. The third and final section presents an overview of the research that has been done in the area of how mental health is defined with special attention being focused on cross-cultural studies and American Indian mental health.

MENTAL HEALTH IN THE UNITED STATES

Some of the earliest work done in the area focused on mental illness rather than on mental health. Mental illness has been well documented throughout the history of mankind, as evidenced by the works of George Rosen (1954) and Murray Levine (1981). These and other classical works
have traced the treatment of mental illness from the Middle Ages through the present.

Most of the early literature that is available on the topic of mental health focused on mental illness and the development of institutions for the care of mentally ill persons. There appeared to be very little concern about how mental health is defined or what mental health was. It was not until the mid 1600's that individuals really became concerned about the needs of the mentally ill and organized efforts were made to care for "mad" individuals. With the advent of the Industrial Revolution and the subsequent large rise in the pauper class, the number of "mad" persons or those considered to be lunatics increased (Pany-Jones, 1972). Even with the influence of the Industrial Revolution and its impact on the society, there was more concern about mental illness than mental health.

Organized efforts/provisions included the building of several state mental hospitals (Grob, 1973; Levine, 1981). As attention to mental health and mental illness grew, several social reformers and activists became involved, including Horace Mann and Dorothea Dix. Horace Mann, a strong advocate for the insane, was instrumental in convincing the Massachusetts State Legislature to authorize use of state money to finance institutions for the care of the mentally ill. Dorothea Dix, a former school mistress, had, in her public crusades, a tremendous impact in this area. She traveled extensively in this
country, visiting institutions, collecting data and making speeches in favor of reform. Through her efforts the number of institutions for the insane increased by 32 (Deutsch, 1949; Levine, 1981; Encyclopedia of Social Work, 1977). It was not until Clifford Beers published his book *A Mind That Found Itself* in 1908 that concern for mental health as well as mental illness and institutional care began to emerge. Through his efforts, The Connecticut Society for Mental Hygiene and a National Committee for Mental Hygiene were established in 1908 and 1909 respectively.

Social work became involved in the development of the mental health movement early in the twentieth century, following the creation of the first medical social work program in 1905 by Dr. Richard Cabot (Macman, 1977; Callicutt and Lecca, 1983). Soon psychiatric social work developed as a main service function of mental hospitals through the efforts of Mary C. Jarrett, Dr. James J. Putnam, Dr. Adolph Meyer and others. Social work's role in the field of mental health grew in response to the needs of World War I servicemen who developed mental health problems and needed mental health services.

Around the turn of the twentieth century, several other factors influenced the way mental health was defined. Some of these factors were the advent of World War I, a huge influx of immigrants from Europe, and an increased use of drugs and alcohol. Other significant
developments that influenced mental health definitions were expansion of mental health institutions and services, the experimentation with drug treatment programs for the mentally ill, and the cooperation of government (i.e., legislation, grants, services) in mental health and mental illness (Williams & Ozarin, 1968; Brand, 1965).

From the late 1930's to the end of World War II in 1945, a renewed sense of optimism spread over the country. The nation had survived two of its greatest challenges, and a new outlook became widespread. New drugs were being used to treat mental illness representing a new relationship between science and government. Later, history would suggest that this was indeed a fit and proper relationship because it produced many positive effects for many people. This new relationship between science and the government provided an added "boost" for more attention to be paid to mental health.

In the meantime, Dr. Robert Felix, a leading and respected psychiatrist, was successful in developing, drafting and promoting the passage of legislation called the National Mental Health Act. In 1948, the National Institute for Mental Health was created. A goal of this agency was to conduct research in the area of mental health. Another major goal was to find out more about mental health and to develop a better understanding of how mental health is defined (Windousky, 1964).
Much progress was made during the 1940's in understanding how stress affected the body potentially causing mental illness. Selye (1964) wrote about the advances made in mental illness and the view of mental illness from the medical model. Mental illness was seen as a physiological, organic problem that could respond to physiological treatment. During this time scientists began to recognize the influence of environmental and cultural factors in defining mental health.

The 1950's did not see much progress in the way of mental health legislation. However mental health needs continued to grow. As a result of this need people began to use a variety of resources (clergy, teachers, family, etc.) to meet their mental health needs. Mental health professionals, realizing the usefulness of these services, endorsed education and consultation programs with frontline workers providing mental health services (clergy, family physicians, teacher, probation worker, public health nurses, judges, welfare workers and police) (Levine, 1981).

**Joint Commission of Mental Illness and Health**

In 1955, the Joint Commission on Mental Illness and Mental Health was established to further explore the problems of mental and emotional illnesses. As a result of their study, an innovative period began in the field of mental health. The Commission's final report, *Action for*
Mental Health (1961), served as a major impetus for the development of the community mental health center movement.

This report, along with the personal interest of President John F. Kennedy, called for a "bold new approach" to mental health (Levine, 1981; Bloom, 1975 and 1982). President Kennedy was concerned about the impact of environmental conditions and cultural influences in determining and defining mental health. As efforts were being expanded in this area, mental health concerns gained respect and consequently more was being learned about mental health.

Community Mental Health Movement

President Kennedy promoted a preventative approach to mental illness. The scope of his program went beyond earlier views of mental health and encompassed the idea that social problems were often at the root of not only mental illness/mental health and retardation but, poverty in general. President Kennedy realized that any potential solution to mental health problems would have to be broad and far-reaching and include social, cultural and educational aspects. His thoughts for the solutions were humanitarian in nature and included the efforts of the political, social, professional, and scientific communities. Boundaries were expanded, establishing new fields of community psychology and community mental
health. The President's ideas about mental health were developed into legislation creating The Community Mental Health Centers Act which was passed in 1963 as Public Law 88-164 (Bloom, 1984).

Subsequent legislation further enhanced the mental health movement by providing and designing mental health programs for special populations. This was an effort to recognize that differences exist in our society, and to provide mental health services based on those differences. Special mental health programs were designed to meet the needs of children, the elderly, alcohol and drug users, and the developmentally disabled (Callicutt and Lecca, 1983). The mental health system was attempting to meet the needs of a diverse population with special needs and interests (Bloom, 1984).

Medicaid and Medicare Legislation

There are two other pieces of legislation that had an impact on the mental health delivery system, the Medicare and Medicaid programs. The general philosophy of these programs was to make the health care delivery system available to all Americans regardless of age, geographical location, or economic status (Levine, 1984). The Medicare program is a form of insurance which helps to pay hospital costs and other related expenses for persons 65 and older who are active recipients of Social Security income. The Medicaid program, on the other hand, is a federally funded
program to help provide health and rehabilitative services to persons who are needy.

Both of these programs have contributed heavily to the growth, development and expansion of the mental health field. They have increased the government's role in mental health, by expanding of the whole concept of mental health, by taking on new meanings and responsibilities in terms of definition and utility. The mental health center, not a new concept in mental health was certainly a "bold new approach" to providing services to the general public and to special population groups, especially the poor and the needy.

In 1980 another major piece of legislation was passed, the Mental Health Systems Act (Public Law 96-398). This Act specified the continuation of present services while expanding and developing new services to large groups such as minorities. This Act provided grants for protection and advocacy programs for the mentally ill, for rape prevention and control, and other services (Callicutt and Lecca, 1983). While this legislation was being passed, a new Presidential Administration was inaugurated in Washington, D.C. As a result of the new administration, funds were not subsequently allocated in the federal budget to implement the 1980 Act.
INDIAN MENTAL HEALTH

In the past two decades awareness of the cultural, social, economic, industrial, technological, and political, diversities that exist in our society today has increased. With this expanding awareness the study of mental health has begun to focus on mental health issues of various ethnic groups. The study of mental health is beginning to recognize the impact cultural differences in the determination of "appropriate" behavior, and consequently influencing the definiton of mental health. According to McGoldrick (1980), work has been done in recent years with Blacks and Hispanics. Another ethnic group that is presently receiving attention is the American Indian.

There is a fascination with psychopathology, mental health, and personality within the American Indian community. Federal and State agencies are initiating new and presumably more culturally sensitive programs (Nanson, 1983). Simultaneously, research and reporting with regard to the Indian mental health "problem" is increasing (Trimble, 1984, p. 199). Most of the mental health programs have been guided by Euro-American psychiatric and professional traditions (Attneave and Kelso, 1977; Trimble and Medicine, 1976). Trimble (1984) states that "Euro-American tradition conflicts with the basic world view of many Indian communities. Continuation of these conflicts will in all likelihood create more problems than
are solved" (p. 199). One of the greatest needs in the area of mental health is to learn more about how American Indians define mental health.

**Indian Mental Health Development and Program**

The federal government has historically been responsible for providing the social, educational, and medical needs to most of the American Indian communities. This responsibility was assumed during the late 1880's when treaties were signed between the United States Government and many American Indian tribes. A typical formula prevailed. The tribe surrendered land; in exchange, the United States Government guaranteed sovereignty and agreed to provide certain services to the tribes, particularly education and health services (Dana, 1981).

During the early development of programs and services to American Indians, the War Department, now known as the Defense Department, was responsible for administering Indian programs. Under that Department, the Bureau of Indian Affairs (BIA) was established to manage Indian affairs. The Bureau of Indian Affairs (BIA) was specifically authorized to expend funds for the "conservation of health" and in 1924, the BIA set up a special Division of Health (President's Commission on Health, 1978).
In 1955, a major administrative change shifted this responsibility from the Bureau of Indian Affairs (BIA) to the United States Department of Health, Education, and Welfare. This Department is now called the Department of Health and Human Services. Within the this Department a Division of Indian Health Services was created with the responsibility for providing health services to appropriate American Indian tribes. Mental health services were not offered or made available through the Indian Health Service until 1965. The mental health program was initiated to combat a number of growing social problems such as alcohol abuse, drug overdose, suicide attempts, depression, obesity and sexual acting out. In 1965, a formal Mental Health Program was inaugurated (Dana, 1981). The Indian Mental Health Program today is divided into eight administrative districts and two subareas. Each area unit is responsible for providing the mental health services for the population it serves. The community mental health movement of the 1960's has helped to influence and shape the Indian Mental Health Program. The centers are equipped to handle a variety of psychological, social and community issues/problems. Specifically, the mental health centers provide direct services involving such problems as depression, anxiety, drug and alcohol abuse, suicide, marital conflicts, child and youth problems, social and economic adjustment and crisis intervention services (La Due, 1980 and Rhoades, et
The community mental health movement, the Indian Health Service, and the Indian Mental Health Program have all contributed to the growing interest and concern for providing better quality mental health programs to the American Indian population. Trimble and Medicine (1976) noted "a plethora of research has focused on the mental health, social pathology, and psychotherapy of American Indians" (p. 161). One need only to examine the index of journals, such as, *Psychiatric Annals, Public Health Reports, Arizona Medicine,* and *Community Mental Journal* to see that Trimble and Medicine are indeed correct. Here, in one issue of *Psychiatric Annals* Volume 4, 1974, one can find articles such as "Indian Mental Health" (Beiser, 1974); "On Helping the Casualties of Rapid Change" (Meyer, 1974); "Psychiatric Epidemiology Among American Indians" (Shore, 1974); "Suicide and the American Indian" (May and Dizmang, 1974) and "The Drunken Indian: Myths and Realities" (Westermeyer, 1974).

The American Indian community may lack many resources, but one of these is not a lack of studies and reports about the American Indian and his/her mental health needs. In fact, according to the 1978 Report to the Presidents's Commission on Mental Health, "probably no other group in the United States has been more studied and reported on and billions of dollars spent than...in the name of Indian people" (p. 209). The first major
comprehensive study was the Meriam Report in 1928, which documented many of the social needs and problems of the American Indian. Less than 50 years later a similar report was conducted by the American Indian Policy Review Commission, with similar documentation and recommendations. Other reports and studies on mental health are The Kennedy Report: Indian Education: A National Tragedy—A National Challenge (1961) and The Indian Child Welfare Act of 1974. Additionally, a number of other reports and studies have been done by various federal agencies and are listed in the Task Panel Report on Mental Health, 1979.

Yet, as Trimble and Medicine (1976) conclude after their extensive discussion of approaches that have been used in research, "disproportionate problems related to mental health among American Indian (sic) are apparently increasing in spite of our best efforts" (p. 194). There may be a variety of reasons for this increase in mental health problems, but a lack of services is not one of the reasons. As Beiser and Attneave (1981) suggest, the notion that few, if any, mental health services exist for American Indians is a myth. In their report tracing the history of the Indian Health Service, they noted that between the period 1969-1977, the operating budget of the Indian Health Service had increased from $580,000 to $4,200,000, and the staff had increased from 26 persons to 232 persons.
Trimble and Medicine (1976) go on to suggest that much of the research that has been done, has been structured to elicit negative data and to depict the subjects in an unfavorable light. Reports on American Indians tend to emphasize social problems such as poverty, poor health conditions, inadequate educational resources and opportunities and a perpetual dependence created by federal government policy.

The mental health of American Indians cannot be viewed in the context of traditional Western mental health, which has no understanding of the American Indian environment and the unique characteristics and personality structure of the aboriginal peoples (Commission on Mental Health, 1978). Discussion of mental health definitions in reference to Indians must take place within the context of Indian history and consider their cultural strengths. It is important to note the strong emphasis on natural support systems (e.g., the nuclear and extended family, the tribe or clan, elders and their roles in the family or tribe, and the use of traditional caretakers or healers) within most American Indian communities. These and other strengths that have sustained the American Indian communities through periods of cultural, social, economic, political, religious, educational and technological changes.
A review of the literature reveals a state of confusion about the mental health delivery system to American Indians. Much of that confusion can be attributed to a lack of awareness of the specific mental health needs of the American Indian population. Because of an insufficient body of knowledge about how mental health is defined by American Indians and the particular mental health needs of the American Indian population, services and programs do not appear to be culturally relevant. American Indians are beginning to identify their mental health as their greatest need (McCoy, 1981).

In order to provide and establish mental health programs that are culturally relevant, there is a need to understand how mental health is understood and defined within the cultural boundaries of the Indian community. Mental health as it is generally understood, does not have a universal meaning. Its definition is limited by such factors as race, ethnicity, culture, values, norms and other factors. With these and other potential influences it becomes necessary to understand how mental health is defined by various ethnic groups.
REVIEW OF RELEVANT MENTAL HEALTH RESEARCH

The field of mental health has gained a great deal of momentum over the past fifty years. The establishment of permanent institutions, the introduction and use of drugs for treatment, the community mental health movement, and the recent Mental Health Task Panel Reports submitted to The President's Commission on Mental Health (1978), have all contributed to the growth, development and expansion of mental health services. In spite of the research and the vast amount of interest in this area, very little progress has been made in the area of providing mental health services that are culturally relevant to diverse populations in this society. There are probably numerous reasons for this, one of which is the sheer complexity of defining mental health. Another is the richness and diversity of the populations to be served. One of the greatest challenges facing the mental health community is defining mental health in terms that are acceptable to everyone, professionals and consumers alike. At the present time, every effort is being made to compose a definition of mental health that will be acceptable.

Gallagher (1981) states:

It is presently impossible to construct a universal definition of mental health because there is considerable disagreement regarding the components of 'normal' behavior. What is viewed as normal in one cultural context may be quite unacceptable in another. This is the major barrier to objectively defining mental health, although it is by no means the only obstacle (p. 23).
Mental Health Definition Research: An Overview

This review of relevant literature on mental health looks at the work that has been done in defining mental health. Special attention will be given to cross-cultural studies.

One of the most pressing and debatable problems in mental health research has been defining mental health. A search of the social sciences literature concerning the nature and meaning of mental health/mental illness reveals several basic themes as identified by Wechsler, Solomon and Kramer (1970):

1. There is no consensus regarding a definition of mental health and mental illness.

2. There is general agreement that the two terms mental health and mental illnesses refer to behavior which is interpersonal in nature and, with respect to mental illness, is judged to be dysfunctional according to the norms of the observer. This judgment is often made without any somatic or physiological evidence.

3. Many social scientists oppose the application of a "medical model" to the area of disturbances in interpersonal behavior.

4. Many others question the medical model on pragmatic grounds. They assert that treatment under this model has not been effective.

5. Use of the medical model has led to a preoccupation with pathology and a relative absence of work in the area of positive health. (p. 9)
It should be noted here that it is not possible to
discuss the definition of mental health without some
reference to mental illness. This review of the
literature will focus on mental health. However,
reference will be made to mental illness as it is revealed
in the literature.

Mental Health and Mental Illness Confusion

Despite the great amount of research that has been
done in the mental health field in the past century,
mental illness is still, as Gallagher (1981) suggests, "an
invincibly obscure concept" (p. 19). He suggests that
experts often answer with silence the question of, "What
is mental illness?" and that it is not an accident that
much of the psychiatric literature skirts the issue.

Perhaps even harder to define than mental illness is
the concept of mental health. In a rather lengthy
discussion of the topic, Gallagher (1981) suggests that
every attempt to define mental health has failed in part,
because there is not a universal agreement on the
definition of "normal behavior." According to him, mental
health is not necessarily the mirror image of mental
illness. Gallagher notes that one definition of mental
health sometimes offered is "the absence of mental
disorder." This definition is limited for two reasons.
First, there is no universal definition of mental
disorder. Second, this does not take into account the
cross-cultural differences in acceptable behavior. A second definition of mental health is "a correct perception of reality." This definition is also limited by cross-cultural definitions of "correct perceptions." A third approach to the definition of mental health suggests that it is an "adjustment to the environment" which translates to "a person who has established a workable arrangement between his personal needs and his social relations" (p. 24). Gallagher also suggests that the problem with this definition is that mentally ill persons could be classified as normal and this might ultimately lead to the conclusion that the passive acceptance of all environmental conditions is mental health. A fourth approach to the definition of mental health is one taken by psychoanalysts. This definition is oriented toward "a state of intrapsychic equilibrium." The problem with this definition is that some mentally ill individuals are in a state of intrapsychic equilibrium but their view of reality is extremely distorted.

Gallagher (1981) finally suggests in his discussion that "presently there is no single definition of mental health that can deal with many of the cross-cultural and philosophical questions relative to this issue" (p. 29). It is presently impossible to construct a universal definition of mental health because there is considerable disagreement regarding the components of "normal behavior." What is viewed as normal in one cultural
context may be quite unacceptable in another (Benedict, 1934). This is a major barrier to objectively defining mental health. As Marie Jahoda (1950) suggests, "there exists no psychologically meaningful and...operationally useful description of what is commonly understood to constitute mental health (p. 80).

Mental Health Definitions

In 1955, Marie Jahoda, in her inspection of the literature, identified six major categories of positive mental health concepts. These are: the attitude of an individual toward his own self; the degree of growth, development, or self-actualization as expressions of mental health; integration, a central synthesizing psychological function; autonomy; perception of reality and environmental mastery. Frank (1953) spoke of the "positive aspect of mental health." He characterized healthy persons with personalities as those who continue to grow, develop, and mature through life, accepting responsibilities and finding fullfillments without paying too high a cost personally or socially as they participate in maintaining the social order and carrying on our culture (p. 60).

Henry (1953) viewed mental health as being able to successfully cope with "normal stressful situations."
The mental health movement has historically been defined as containing a certain set of values, ideals, and standards by which behavior could be assessed as appropriate or inappropriate (Scott, 1959). The particular set of values chosen depend upon who is doing the judging and can lead to confusion in the usage of the term "mental health" in scientific research. Kingsley and Davis (1938) take the position that mental health, as a social movement, has been strongly influenced by Protestant Ethic inherent in the larger majority culture. The main features of the Protestant Ethic are democratic, worldly, ascetic, individualistic, rationalistic and utilitarian orientations (Scott, 1958). Therefore, in defining mental health from a Western perspective, these values are very important.

Offer and Sabshin (1966) offer another perspective which involves four distinct approaches to normality or mental health. The first approach, health, seems to equate health with the absence of disability, illness or undue pain. The second approach, utopia, is a set of definitions seeming to strive for some state of being (never to be attained), or optimal functioning by such terms as "self-actualizations of potential" or "self-knowledge." The third approach, average, is a class of concepts which equate normality as falling somewhere in the middle range and deviancy with variation in either direction. The fourth approach, process, has concepts
which view normality from the perspective of temporal regression. An example of this is the work by Erikson (1950). In his discussion of the attainment of normal functioning and maturity through the mastery of the stages of development, normality is defined, as "in terms of the end product in an unfolding process over time" (Offer and Sabshin, 1966 p. 111).

Howard Kaplan (1972) identified four basic issues that appear to underlie much of the variability in the conceptualization of mental health and mental illness. The first one is the relationship between mental health and mental illness. This issue is one of the independence of the concepts (Jahoda, 1958; Scott, 1961; Stanford, 1966; Offer and Sabshin, 1966). The second conceptualization issue addresses the universality of defining criteria for mental health (Maslow and Mittleman, 1951; Linton, 1956; Devereux, 1956; Jahoda, 1958; Scott, 1961; Offer and Sabshin, 1966). Affective, cognitive and psychomotor responses which in one culture might be regarded as symptoms mental illness (or some functionally equivalent concept), in another culture might be perceived as normal responses in the range of anticipated and appropriate behavior (Kaplan, 1972; Benedict, 1934). The third issue of mental health and mental illness conceptualization relates to the determination of whether mental illness and mental health should regarded as unidimensional or multidimensional (Scott, 1969; Blum,
1962; Davis, 1965). Klein (1960) in his work identified five components of the integrated personality: emotional maturity, strength of character, capacity to deal with conflicting emotions, a balance between internal life adaptations to reality and integration of the different parts of the personality (Offer an Sabshin, 1966). Maslow and Mittleman cite eleven manifestations of psychological health: adequate feelings of security, adequate self-evaluations, adequate spontaniety and emotionally, sufficient contact with reality, adequate bodily desires and ability to gratify them, adequate self-knowledge, integration and consistency of personality, adequate life goals, the ability to learn from experiences, the ability to satisfy the requirements of the group, and adequate emancipation from the group or culture (Kaplan, 1974).

The fourth issue is one of defining mental health and mental illness. A distinction is often made between manifest behavior patterns at one of the spectrum and personality characteristics at the other, which are believed to be underlying processes or causes of these behavior patterns (Kaplan, 1974).

In another approach to the definition of mental health, Sauland and Pulver (1966) argue that maturity in personality development is characterized by certain traits which are highly valued by the culture - the value determined concept. Maturity, they go on to suggest, is achieved when psychobiological patterns of personality
develop without being warped by adverse environmental influences.

English and Pearson (1963) envisioned a mature person as

one who is (1) able to work usefully without undue fatigue or strain; (2) able to fully like and accept many lasting friendships and to love and be affectionate with close friends; (3) able to conquer guilt, doubt or indecision and to oppose impositions on himself and his family; (4) able to treat men and women with appropriate respect; (5) able to give and receive love with joy in a conventional heterosexual way; (6) able to extend his interests and seek to contribute to general welfare; (7) able to advance his own welfare without exploitation of his fellow man; (8) able to alternate work with play; (9) dependable, truthful, open-minded and imbued with a philosophy that includes a willingness to grow, improve and achieve wisdom and (10) interested in passing on his knowledge to the young (p. 420-421).

Wallace (1961) defines mental health as a state in which the person is performing to his own and other's satisfaction the roles appropriate to his situation and society.

In a report published in 1970 by the Joint Commission on Mental Health of Children, mental health was defined as a complex state of being - a sense of confidence in oneself and one's world. The mentally healthy person is able to see and gradually deal with the realities concerning himself and the world; to relate to other people in ways that are satisfying to both him and them; to accept and control his impulses for sexual and aggressive expression; to learn and apply what he has learned (Encyclopedia of Social Work, 1971, p. 783)
Through his/her process of growth and development he/she has acquired a set of values that help him/her to know who he is to accept him and to be able to effectively interact with other systems within his environment. There is a sense of community that evolves through this development and growth. The mentally healthy person continues to grow throughout his lifetime, building on earlier foundations of strength and flexibility as he meets new tasks and situations.

Erikson (1963) made a valuable contribution to mental health by his theory of human development. According to Erikson, a mentally healthy person is one who successfully develops through eight basic psychological stages in a socio-cultural context. The eight stages are: trust vs. mistrust, autonomy vs. shame, initiative vs. guilt, identity vs. inferiority, identity vs. role confusion, intimacy vs. isolation, generativity vs. stagnation and ego-integrity vs. despair.

Another interesting development in the area of mental health has been the work of scientists such as Thomas Szasz (1960), Thomas Scheff (1966), (1984), Goffman (1964), Howard Becker (1963), Edward Lemert (1951) and others. Their collective contribution has been in the area of questioning the usefulness of the concept of mental illness—what it means, and how it is defined. Thomas Szasz (1966) posed the question of whether mental
illness exists. He argued that such a phenomenon does not exist because it is not a tangible thing or physical condition and hence, it can only "exist" in the same sort of way other concepts exist. He does not deny that some mental health problems may be biologically related but, most are "problems in living."

Szasz (1960) goes on to say,

Our adversaries are not demons, witches, fate, or mental illness. We have no enemy whom we can fight, exorcise, or dispel by "cure." What we do have are problems in living—whether these be biologic, economic, political, or sociopsychological... The field to which modern psychiatry addresses itself is vast, and I made no effort to encompass it all. My argument was limited to the proposition that mental illness is a myth, whose function it is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations (p. 49).

Szasz develops an argument that the "problems in living" are from a socio-psychological perspective as they are guided by the values of our society.

Thomas Scheff (1960, 1984), in his work on mental illness, develops a theoretical framework of "chronic mental illness." In this sociological study he develops a social system model based on nine propositions for mental disorder. These approaches, as asserted by Scheff (1960), Lemert (1951), Erikson (1957), Goffman (1961), Szasz (1961), and Laing and Esterson (1964) give more emphasis to social processes than does traditional psychoanalytic theory, yet do not neglect entirely individual aspects.
Cross-Cultural Studies of Mental Health

The review of the literature did find some cross-cultural studies of mental health. A number of these studies found a strong relationship between attitudes toward health, illness, and ethnic factors (Sauna, 1960; Zborowski, 1969; Zola, 1966). These studies seem to indicate that there may be a difference in the way mental health is defined among groups that have cultural differences. Zborowski's classic study (1966) of physically ill patients of Jewish, Italian, Irish, and White Anglo-Saxon Protestant (WASP) descent is an example. There were quite distinct differences in the way each of these groups identified pain, their ability to accurately describe and locate pain and healing systems utilized. Eisenberg (1977) found that some Indian tribes/groups did not identify nor perceive stuttering to be a problem; although it existed in the community, it was not identified as a problem.

Research studies (Malzberg, 1963; Torres-Matiullo, 1976) within the Puerto Rican Community find disagreement about how behavior should be addressed and labeled or diagnosed. Malzberg (1963), in his work on schizophrenia, found a high proportionate of schizophrenia among Puerto Ricans in New York State. In contrast, Torres-Matiullo (1976) in his research with the same population indicated that there were high rates of depression, not schizophrenia. Malzberg's observation of
Puerto Ricans were based on those types of behaviors that are typically found in the middle class Anglo society. It is likely that the results would have been different had their behavior been diagnosed in a Puerto Rican sociocultural context.

Saunders (1954), in his work with Hispanics, found they view that health is a "matter of chance and . . . that there is very little a person can do to keep it" (p. 137). In the Hispanic community, strong values such as fatalism, strong family solidarity, orientation to the present, male dominance, and personalism affect the way health is defined.

Probably no other Indian group has more attention than the Navaho Tribe. Much of that attention has focused on health (Adair, Deuschle, McDermott, 1957). Grossman (1976), in writing about Navaho health, states,

Health is a reflection of unseen harmony between man and his environment. It encompasses the natural world, fellow men, and the supernatural. Illness indicates an unbalance between man and his environment and is usually attributed to the breaking of a taboo, to contact with ghosts, or to malevolence on the part of others (p. 139).

The Navaho (1962), by Dorothea Leighton and Clyde Kluckhohn, described Navaho life which emphasized "the people's view of the world, their health and their religion" (Shore 1974, p. 57) and their importance within the Navaho culture.
Other works on ethnicity and health have looked at how health is defined and explored health patterns. Poll (1969) looked at health among the Hasidic community in Brooklyn, New York. Poll (1969) states "in this Orthodox Jewish group, concepts of health and illness are prescribed by the Talmud and the Torah. Health and illness emanate from a divine source, and men must pray continuously to stay well" (p. 140). Hostetler (1964) studied health among the Amish, and found that they respond to illness by employing old and tried traditions. Hostetler (1964) states, "The Amish who value face-to-face associations rely on the advice of friends rather than physicians. Because they reject higher learning, there are no Amish doctors" (p. 141).

There appears to be a difference in the way symptoms are defined and reported among ethnic groups. This brings into question the usefulness of the present diagnostic nomenclature (Fantl, 1959; Shiro, 1959; Opler and Singer, 1956; Tseng, and McDermott, 1981). Tseng and McDermott (1981) made the following statement about how mental health is defined:

we need to continue to examine ourselves to see on what grounds, and for what purposes we recognize label, and conceptualize certain emotional behavior disturbances as mental disorders and what are the sociocultural implications of our conclusions (p. 36).
It is the opinion of some, that mental health problems should be diagnosed and treated within the cultural, social and environmental frame of reference in which the problems are occurring. McGoldrick (1982) reports several studies (Giordano and Giordano, 1977; Tseng and McDermott, 1981, Rabkin and Struening 1976; Harwood, 1981; Rakel, 1977) that have identified a number of ways in which people differ in:

1) their experience of pain
2) what they identify as a symptom
3) how they communicate about their pain of symptoms
4) their beliefs about the causes of their illness
5) their attitude toward helpers (doctors and therapists)
6) what treatment they desire and expect

Kleinman in his work in the health care system state:

Illness behavior is a normative experience governed by cultural rules; we learn "approved" ways of being ill...And doctors' explanations and activities, as those of their patients, are culture specific' (Kleinman, Eisenberg, Good 1978, p. 252).

Additional work by Stoeckle, Zola, and Davidson (1964) found that "patients' illness" (the experience of being ill) is very different from the cause of their "disease" (a physically identifiable dysfunction) and is strongly influenced by cultural beliefs. Each of us has a repertoire of belief systems that we turn to when we need help. In addition to the medical or psychotherapeutic system, we also use religion, self-help groups, alcohol or
yoga, just to mention a few. Many of us still use home remedies taught by our mothers (McGoldrick, 1982).

One of the problems found in the literature was the inadequacy of applying major definitions of mental health and mental illness to the American Indian population. Shortly after the Indian Health Service was formed, a study was conducted among the Navahos at Many Farms (Adair and Deusche, 1970). The purpose of the research was to study the climatic differences that are associated with cross-cultural perceptions of illness. One example of a difference is congenital hip disease which will be discussed here. Within the Navaho culture, congenital dislocation of the hip, even when bilateral, was not viewed as a disease or even a particularly important disability (Shore, 1974). When modern medicine was introduced, and corrective surgery performed, it transformed something that was not previously culturally identified as a handicap, into something that represented a very serious handicap indeed. This represents one example of the difference in a cross-cultural view of physical illness.

Cross-cultural differences become more complex and confusing when one is dealing with behavior, mental health or illness (Shore, 1974). In an example from his experience, Shore reveals that a "drunken Indian" was refused treatment only to later find out that he was actually suffering from an unsteady gait secondary to a
Dilantin interaction — too much anticonvalescent medication. Another example of cultural differences in behavior is auditory hallucinations that are often experienced among certain Indian people after a family death. The hallucinations are usually erroneously interpreted as a psychotic symptom rather than an event or activity associated with unresolved grief (Shore, 1974).

Use of Standard Psychological Tests in Evaluation of Minorities

No review of the Indian mental health literature would be complete without addressing the problems and issues associated with the misdiagnosis and problems of using standardized psychological instruments to evaluate American Indians and other minorities. In the past few years there has been considerable debate over the appropriateness of using psychological tests with minorities (Meketon, 1983; Chin, 1983, Fenz and Arkoff, 1962; Lesser, Fifer, and Clark, 1965; Hsia, 1981). One of the major problems with the present mental health system is the improper use of psychological tests in evaluating American Indians. Chin (1983) presents an overview of research literature on diagnostic issues in working with Asian-Americans. Chin (1983) concludes her discussion with a proposal that the diagnostic process include a focus on the adaptive potential of particular forms of
cultural behavior (p. 100). Even though the article focused on Asian-Americans, the issues are similar with American Indians. Martinez (1979) states in reference to misdiagnosis

In various ways misdiagnosis is one of the most destructive aspects of minority contact with the mental health delivery system. Indeed these are encounters of the worst kind. The mis-diagnosis, (not just mis-labeling but mis-understanding, not only serves to misappropriate treatment), resources and the client's time and energy, but more importantly, it provides the possibility for serious damage to the client (p. 13).

The problems of misdiagnosis and differential diagnosis (Shapiro, 1975; Maas, 1976; Willie, 1973;) have been discussed in the literature. At this point, one must wonder if biased tests are part of the problem plaguing research on American Indian mental health. The literature documents that people of color have been diagnosed as psychotic or psychopathic for the same behaviors as whites that were labeled as neurotic (Gross, 1969).

Sanchez (1932) has addressed some of these issues in relation to Spanish children. Jane Mercer has studies identity variables that affect the measurement of I. Q. (e.g. Mercer, 1972).

The following are examples of improper usage of psychological tests in evaluating and determining mental health needs and services for minorities especially American Indians. Leighton (1962), in a study to define patterns of illness, found the most common problems were alcoholism, depression, anxiety, and psychophysiological
reactions. The rate of psychiatric impairment seemed high when compared to non-Indians in Stirling County (Leighton, 1962). However, when controlling for alcohol abuse, the overall impairment rates were no higher than for other cultures. The Leighton research did identify the importance of tribal differences among Indians by uncovering a specific tribal pattern of psychophysiological adjustment (Shore, 1974). It found an increase in prevalence of duodenal ulcer among Indian women (Shore, 1973).

Nelson (1964), using the Cornell Medical Index with Indian students at a boarding school, found a significant difference in response of "normal" and "abnormal" student group. The screening was significantly sensitive for Navaho but not for Eskimo students (Shore, 1974). In 1935, Anderson (1936), administered a mental hygiene survey among "problem" boarding school students in the State of Oklahoma. The most outstanding finding was the relatively large number of children, 32 percent, who were identified as mentally defective. Further investigation however, revealed their real difficulty was a lack of opportunity, this is another example of misdiagnosis. In other work, Martin, et, al. (1968) used the Cornell Medical Index, to substantiate the existence of psychiatric problems, and to verify socio-psychological theories of psychological problems among northeastern Oklahoma Indians. The study found the 25 percent of the
Indians were psychiatrically impaired. One wonders what the difference would have been if the Indians had been evaluated by criteria which are relevant to their culture. In another case Jewell (1952) writes about an American Indian male that was hospitalized and improperly evaluated using standard psychological evaluation instruments.

**Literature on Discussion of Indian Mental Health**

**Definition**

While there do not appear to be any empirical studies regarding the American Indian definition of mental health, the literature review did uncover some articles on discussions of defining mental health. Of particular importance is a series of articles entitled *American Indian Families: Development Strategies and Community Health* published in 1983. Sharp (1983) in writing about Indian mental health, identified criteria for defining mental health:

The definition of mental health is the feelings, thoughts, actions and relationships that a person has about himself and with others. These determine how he gets along in the community. It can be either negative or positive (p. 46).

In further discussion on Indian mental health Sharp (1983) also indicated that, mental health is a new concept in Indian communities and that there is a stigma attached to mental health. This idea is revealed in evaluation studies of mental health programs. In these it becomes
evident that Indian people associate mental health care with being 'crazy'. They do not associate mental health programs with general counseling. They think that all people are 'crazy' who visit mental health programs.

To learn more about Indian mental health needs and the definition of mental health Sharp (1983) conducted an informal survey in one American Indian community. When asked to define a crazy person or a person who needs mental health, the typical response was, "Well we call it crippled thinking, a person is crippled in his thinking." This seems to indicate that perhaps thoughts or thinking processes are one criteria by which to measure mental health. This also provides insight into the stigma that is attached to mental illness in the American Indian community. Sharp goes on to identify tribal values, roles, and psycho-historical experiences such as disenfranchisement, enforced dependency and powerlessness as factors which influence the definition of mental health.

Robert Thomas (1982) identified other factors in within American Indian communities that are important in relation to the definition of mental health. These characteristics are: a kin-based society, a network of relationships, traditional societies, sacred societies, responsive to the physical and natural environments to which they are bounded and closed by definition. All of these are important to American Indian people in defining
who they are and how they feel about themselves regarding mental health.

One of the more important issues regarding mental health definition is that of deviance in American Indian communities. Indian tribes, for the most part, do not appear to operate on an ideological base. In discussing deviance Thomas (1983) states:

Most tribes can stand a lot of deviance as long as it isn't socially destructive. Tribal groups are not conformists. If you evidence strange behavior that is not socially destructive you will be allowed to be "strange". There's all kinds of support for this seemingly permissive attitude. (p. 99)

In some communities there appears to be a strong paranoid component (Thomas, 1982). This may be due to the very close relationship tie within the community. Some mental health professionals have identified a schizophrenic component also. However on closer observation, Indian people tend to be 'low key' and 'low cue' not catatonic. When intolerable behavior is expressed, efforts are undertaken to contain the person. This is usually handled by family members. When these same behavior are expressed in the larger culture, they are labeled as deviant by members of that culture. This shows the way the larger culture labels Indian behavior. If these behaviors were evaluated within the American Indian culture they would not be identified as deviant.
As the review of the literature revealed, there have been a number of studies conducted in attempts to understand and define mental health. Each of these contributions has been significant to the advancement of mental health. However, none of these studies have done a cross-cultural study as proposed in this research study. If mental health professionals are to provide culturally relevant, culturally based mental health services, then it is important to understand the concepts of mental health as they are defined by the recipients of these services. The literature review supports this notion. Rhoades et al. (1980) suggested that "the very concept of mental health remains to be worked out" (p. 34). McCoy (1981) suggested that extensive explorations are needed to answer questions such as "What is Native (sic) American mental health? and How is Native (sic) American mental health different form non-Native American mental health?" Yet, a review of the literature reveals few studies that address these questions.

While mental health professionals appear cognizant of the needs to address the problem, empirical efforts are lacking. This cross-cultural study is an attempt to determine the mental health concepts of three races. This study was conducted in Robeson County, North Carolina and focused on the identification and comparison of mental health definitions of Lumbee Indians, Blacks and Whites of this county.
Chapter Summary

This chapter presents an historical overview of mental health and the present status of mental health definition. Particular attention is devoted to how mental health has been defined in the United States, and how the definition has affected the genesis, development, and expansion of mental health.

Until very recently, there was little recognition of the possibility that the definition of mental health within minority communities may be different from the majority culture's definition. With the recognition of this limitation, the mental health profession has begun to acknowledge the potential differences in the way mental health is defined on a cross-cultural basis. As this review of the literature indicated, while some work has been done in the area of defining mental health for minority groups, much remains to be done. This is particularly true for the American Indian community. Even though services have recently been made available to this minority population, the definition of mental health for the American Indian community remains unresolved. Therefore, there is a need to help the American Indian population define mental health.
CHAPTER III

THEORETICAL FRAMEWORK

During the past twenty years the mental health field has witnessed a number of changes in administration, planning, policy development, practice, research and theory development. The diversity of approaches that have been introduced influence the way in which mental health is defined. Several issues are being raised and discussed that have the potential for expanding the present conceptualization and definition of mental health. The expansion and development of how the concept mental health is defined is especially relevant to minority groups and particularly to the American Indian population.

This research is an effort to look at how mental health is defined in the tri-racial community of Robeson County, North Carolina. The primary objective of this project is to determine how mental health is defined within the social, cultural, economic, and political contexts of life in this county. Although there are other theoretical frameworks that might be useful in this study, none appears more applicable than the behavioral-ecological perspective.
BEHAVIORAL-ECOLOGICAL PERSPECTIVE

What is mental health? What constitutes a mental health problem? What are elements or characteristics of a mental health problem? What are the concepts of mental health? These are the questions that are tied to one's perspective of mental health (Jeger and Slotnick, 1982). There has been much academic discussion about the nature of mental illness and mental health (Gottesfeld, 1977; Mehr, 1980; Szsaz, 1971). Mental health, as it is practiced today, is characterized by a plethora of concepts and practices - all operating under and tied to different ideological perspectives (Jeger and Slotnick, 1982).

The behavioral-ecological perspective is a relatively new approach to mental health research that is rapidly gaining a high level of recognition and prominence. It is specifically selected here because of its great potential for expanding the ability to understand cultural diversity in the definition of mental health. It is particularly applicable when examining mental health concepts on a cross-cultural basis. Given the nature of this study, the behavioral-ecological perspective is appropriate in serving as a theoretical guide for studying mental health from various cultural perspectives.
At its most basic level, the behavioral-ecological perspective is concerned with the interdependence among people, their behavior and the bio-psycho-social-physical environment. Behavioral-ecology focuses on the transactions between people and their settings, rather than viewing mental health problems as rooted exclusively within individuals or environments (Jeger and Slotnick, 1982). More specifically, the notion of behavioral-ecology represents a merging of two broad perspectives - "behavioral" approaches which derived from the individual psychology of learning and "ecological" approaches as encompassing the study of communities and social systems (Jeger and Slotnick 1982, p. 43).

The behavioral-ecological perspective, as it is used in the field of mental health, draws on diverse bodies of knowledge. Specifically these are sociology, biology, ecology, behavior modification/therapy, psychology, technology, environment, ecological psychology, community psychology, and anthropology.

This perspective is composed of several streams from other fields that have been converged to create a unique approach for studying mental health. Specifically, these streams are (1) behavioral community technology, (2) bio-ecological analogies, (3) environment-and-behavior field and (4) networks and social support (Kazdin, 1980; Rimm and Masters, 1979). These streams are neither distinct nor mutually exclusive, but have coalesced to
form the basis of the behavioral-ecological perspective to be used as a guiding force in theory, research and practice of community mental health.

**Behavioral Community Technology**

Behavioral community technology has been defined by Fawcett, Matthews and Fletcher (1980) as "concerned with the application of behavioral principles to the analysis and solution of problems in open community setting...and developing the capacities of communities to achieve their own goals" (p. 505). Behavior modification therapy has been used and developed as a major part of this approach. Kazdin (1980) and Rimm and Masters (1979) identified several major characteristics by which to distinguish it from the more traditional approaches: (1) an analysis of overt behavior rather than on any underlying disease entity as a cause; (2) a premise that "abnormal" or "maladaptive" behavior is acquired through the same learning processes as "normal" behaviors; (3) a supposition that maladaptive behaviors can be modified through applications of learning techniques; (4) a belief that specific and clearly defined treatment goals be employed in therapy and; (5) that emphasis be placed on the evaluation of treatment and on obtaining support for behavioral techniques (Jeger and Slotnick, 1982). These innovative approaches applied to community mental health, provide a useful basis for behavioral modification in the
behavioral-ecological perspective. It should be noted, does have some limitations, in that it attempts to reshape the individual rather than the environment, when dealing with human suffering and dissatisfaction (Beit-Hallahmi, 1974).

Bio-ecological Analogies

Another major stream contributing to the behavioral-ecological model is bio-ecological analogies. There are four important principles identified in the biological-ecology stream: (1) interdependence, (2) cycling of resources, (3) adaptation and (4) succession (Kelly, 1968).

Interdependence recognizes that changes in part of a system will effect changes in other components. This ecosystem axiom predicates the reciprocity between structure and function (Jeger and Slotnick, 1982). The behavioral-ecological perspective states that mental health professionals must be aware of this reciprocity principle and that intervention in one area will cause changes in other areas, and these changes must be planned for and/or anticipated. Lack of sufficient planning and anticipation in this ecological feature of communities can create additional problems. The principle of cycling resources is based on concern in biological-ecology with the utilization and replacement of energy forms (e. g., in food chains), (Jeger and Slotnick, 1982).
The principle of adaptation (Jeger and Slotnick, 1982) is "the relative diversity of environments in which organisms can survive" (p. 53). In human societies, environmental constancy leads to a particular adaptive capacity, environmental uncertainty expands one's "niche breadth" (i.e., generalized adaptation).

The principle of succession (Jeger and Slotnick, 1982) "draws attention to observations in biology that activities through which organisms exploit their habitats will, over time, make them unfavorable for their own survival" (p. 53). The destruction of natural communities, unanticipated consequences of intervention, and a changing environment will lead to spieces changes, that over a period to time will develop a new "spieces-environment gestalt". Future planning is needed to develop assessing interventions as well as understand unintended consequences.

Environment-and-Behavioral Field

The next major feature in behavior ecology is the environment-and-behavior field. This stream is developed through the coalescing of ecological psychology and environmental psychology (Stokols, 1977). Major contributions have been made to ecological psychology by Barker during the period of 1947 to 1972, and his colleagues at the Midwest Psychology Field Station (Barker and Cump, 1964; Barker and Schoggen, 1973). A number of
researchers, (Altman 1975; Ittleson, Proshanky, Rivlin and Winkel, 1974; Proshanky and Altman, 1979) have advanced the field of environmental psychology tremendously. Environmental psychology, in a general sense, is seen as "focusing on reciprocal influences between person and his/her environment, and, as such, it is compatible with the behavioral-ecological perspective" (Jeger and Slotnick, 1982, p. 60).

Ecological psychology has been used extensively in the ecological perspective of community mental health (Holahan, Wilcox, Spearly, and Campbell 1974; Mann 1978; Weinstein and Frankel, 1974). The major question, based on Barker's (1978) work in this area is, "To what degree are people and to what degree are locales resources of behavior attributes?" (pp. 285-286). This work is important in determining how behavior of different people changes in parallel patterns as they move between different locales. These locales, identified by Barker as "behavior settings" constitute the basic environmental units in ecological psychology (Jeger and Slotnick, 1982). Behavior settings are interdependent, dynamic, and homoestatic entities in semi-stable equilibrium with people as the existential component (Barker, 1978). Rappaport (1977) in discussing ecological psychology states the purpose of ecological psychology at the individual level is "knowledge of a community's behavior setting should be a strong weapon in the armory of the
professionals who counsel individual persons" (Barker, 1978, p. 287). The greatest contribution of ecological psychology lies in its ability to specify the unique interdependence of people and settings and how this interaction can influence and enhance citizen empowerment.

Environmental psychology, as defined by Proshansky and Altman (1979), is a field "concerned with establishing and understanding the relationship between human behavior and the physical environment" (p. 4). Environmental psychology focuses on the mutual influences of people and the built environment. Stokols (1977) views environmental psychology as most concerned with the roles of such psychological processes as perception, cognition, and learning as mediators in environment behavior relationships.

The utility of environmental psychology within the behavioral-ecological perspective lies in its distinct yet compatibility and productive approaches to studying mental health. This stream emphasizes the absolute integrity of person/physical setting events, "that is, only the real world, as opposed to the laboratory is the appropriate focus of study for environmental psychologists (Jeger and Slotnick, 1982, p. 61). This implies that studying the behavior of people should take place in their natural context, observing persons and setting extensively over long periods, and involving subjects (e. g., community residents) in the research process (Slotnick and Jeger,
1982). The focus of the ecological perspective is on people's adaptation to the physical world and consequently the influence of the physical world on internal psychological processes.

Networks and Social Support

The fourth and final major stream contributing to the development and expansion of the behavioral-ecological perspective in community mental health consists of the: (1) individual social network and (2) interorganizational resource exchange network. Caplan (1974), a major contributor in the development of the Community Mental Health Movement, defines support systems as:

Continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validations of their expectations about others... People have a variety of specific needs that demand satisfactions through enduring interpersonal relationships... Most people develop and maintain a sense of well-being by involving themselves in a range of relationships in their lives that in toto satisfy needs (pp. 4-5).

Mental health professionals, within recent times, have begun to pay attention to informal helping networks in the community as potential resources of individual social support systems. Specifically, attention is focused toward self-help groups, social network, community gatekeepers, and neighborhood-based support system (Gottlieb, 1976). These are being explored as possible ways of generating mental health within communities, and also as possible interventions in moderating stress in
life.

Interorganizational networks are primarily concerned with agency change rather than with the individual change. Recognizing that there are limited resources available, Sarason (1974) and others are encouraging agencies to develop network to provide better quality and cost effective services as these efforts also enhance a psychological sense of community. These efforts can best be achieved through one type of interagency network the "resource exchange network" (REN) Sarason and Lorenz, 1979; Sarason et. al. 1977) as this is compatible with the behavioral-ecological viewpoint.

VALUES GUIDING THE BEHAVIORAL-ECOLOGICAL PERSPECTIVE

Values play a major role in community mental health from planning/administration, practice, intervention, evaluation to research efforts. The behavioral-ecological perspective is guided by three general values: (1) promotion of individual competence, (2) enhancing the psychological sense of community, and (3) supporting cultural diversity. Even though these particular values are most supportive of intervention efforts, they are nonetheless useful and supportive of research projects, particularly the kind of research proposed in this study, where the emphasis is placed on investigating and exploring how mental health as defined within the environmental boundaries as operationalized in this study.
Enhancing Personal Competence

A major value or goal in mental health is to enhance personal competence. The behavioral-ecological perspective seeks to strengthen the individual's coping skills and abilities to encounter potentially stressful life events. Competence, as defined by White, (1959) refers to the ability of the individual to influence his/her environment, and is characterized by a "feeling of efficacy." Another term used is adaptation. White (1959) refers to adaptation as striving toward an acceptable compromise between total triumph and total surrender to the environment. All behavior, as described by White, is an attempt at adaptation in the course of an individual's transaction with his/her environment. Adaptation is the way people cope with the environmental stressors they encounter and create. In addition to examining the environmental sources of coping abilities, behavioral-ecology considers individual competence (behavioral skills) in which one may be required to engage in optimally adaptive responses to environmental stress (Jeger and Slotnick, 1982).
Psychological Sense of Community

Another guiding value of the behavioral-ecological perspective is one's "psychological sense of community" (Jeger and Slotnick, 1982). Belonging to a community enhances one's mental health. Through a network of relationships, the individual's needs for intimacy, diversity, usefulness, and belonging can be expressed. This sense of identity with one's community helps individuals overcome the feelings of alienation, anomie, and social isolations prevalent in contemporary life (Jeger and Slotnick, 1982). This value emphasizes giving and sharing with others as you would have them do with and for you.

Cultural Diversity

The third and final guiding value of the behavioral-ecological perspective is cultural diversity, which suggests that it is advantageous to support a multi-cultural society because of its differential adaptative capacities in a broad range of environments. Cultural diversity can contribute to a positive sense of mental health because it allows for a variety of actions and behaviors and adaptative mechanisms to accommodate and explain behaviors. This theory suggests that the adaptative capacities of individuals and communities are enhanced by interaction with members of culturally diverse groups. Everyone benefits from a culturally diverse
society because people learn from each other and grow and develop to the maximum capacity both individually and collectively. (Jeger and Slotnick, 1982, p. 35).

The behavioral-ecological perspective seems most appropriate in studying mental health, particularly the present research study. This framework is concerned not only with the external and internal forces of person and environment but their reciprocal influence on each other and the influence of this interaction impacts on the definition of mental health.

**Application of Behavioral-Ecological Model to the Definition of Mental Health**

This perspective is derived from two broad perspectives, "behavioral" in terms of the psychology of the individual, and "ecological" in terms of encompassing the study of communities, environments and social systems. Together, these two components provide an alternative to the traditional disease model that looks exclusively at the "person-centered" situation for casual explanations of mental health problems.

The behavioral-ecological perspective focuses on behavior, however, it an provides an opportunity for behavior to be defined within the context of the cultural environment in which it is expressed. Rather than looking exclusively at individuals or environments as sources of mental health problems or the way mental health is
defined, the behavioral-ecological framework focuses on the transactions between persons and settings. Thus, behavioral-ecology is an alternative to approaches that tend to blame individuals for their problems (e.g., biological, psychological deficits) as well as those that blame the environment (e.g., cultural deprivation) (Jeger and Slotnick, 1982). The "medical model" is very limited because it focuses on cause and cure and places most of the blame and responsibility on the individual without considering the impact and influence of the environment. The behavioral-ecological perspective as presented here is concerned with both the person and his/her environment. Therefore, it is more consistent with the principles and values of social work.

A major feature of the behavioral-ecological perspective is its focus on overt behavior. The major premise of this perspective is that mental health goals and definitions are defined in behavioral (i.e., measurable) terms. Behavioral psychology operates on the principle that behavior is learned through experiences with the environment. The behavioral psychology theory encompasses learning through association, positive and negative reinforcement, and modeling/imitation (Krasner, 1971). Individual self-efficacy or competence is formed and defined by his/her ability to influence the environment.
Ecology, as it is developed in the biological sciences, is generally defined as the study of functional relationships between organisms and their environments. The behavioral-ecological perspective places primary emphasis on the interdependence among environment, people and behavior. Jeger and Slotnick (1982) state:

The focus is on natural settings, molar behaviors and reciprocal influences, processes between people and their environment. That is, people act on their environments, just as environments influence people. Both the social and physical (natural and built) aspects of environments are incorporated into an ecological viewpoint. The interventions that are carried out are more system oriented (p. 9).

The ecological perspective views linkages between persons and their environments as forming an integrated whole, with the parts interdependent. A change in any one part of this whole, the person or environment, will have a transactional influence and effect changes in other parts. When these two approaches (behavioral and ecological) are combined, individual behavior is viewed as part of a dynamic person-environment interplay. The continuous changes of the environment provide a context within which to view behavior. As well as considering environmental influences on behavior, individuals have the capacities to have an impact on their environment as well. Instead of the unilateral cause-effect relations of behavior, the behavioral-ecological perspective envisions a more holistic person-environment transactional view of behavior, mental health, and the definition of mental
health. (Jeger and Slotnick, 1982).

**Transactional Field**

To further enhance the importance of studying behavior within its environmental/cultural context, the transactional model developed by Papajohn and Spiegel (1975) will be included in the development of the behavioral-ecological perspective. The transactional field approach is an attempt to look at systems in process with other systems without attempting to address the issue of cause. Of particular importance is the idea that whatever behavior is displayed, it should be viewed within the context of the person's ecological niche or transactional field. A model of the transactional field and description is provided below. This model is from the work of Spiegel (1971); and Papajohn and Spiegel (1975).

![Transactional Field Diagram](#)

**FIG. 1.1** Organization of the transactional field.
A brief explanation is provided from the work of Spiegel (1971). The Universe is concerned with the nonliving world in general (e.g., air, land, houses). The Soma is the anatomical structures and physiological processes within the human organism. The Psyche is composed of factors such as cognition, perception, problem-solving and communication skills. Personality results from the integration of processes within Psyche, and from its transactions, with Soma and, with the focus called Group (Spiegel, 1971). Group include the family, which gives situational definitions and role attributions. Society and other institutions such as religion, government and economic, are anchored in a set of beliefs and values about the nature of the world and human existence know as Culture. Culture completes the circle and contributes to the survival of a society in its ecological niche, forming the basis of a people's beliefs about the nature of the Universe (Spiegel, 1982).

From the transactional perspective of behavioral-ecology, there are neither "good" nor "bad" environments, "good" nor "bad" persons. Rather the emphasis is on the notion of person-environment "fit", a goal of behavioral-ecology (Holan and Wilcox, Spearly and Campbell, 1979; Isel, 1980; and Rappaport, 1977). The notion of congruence or incongruence (i.e., mismatch) between individuals and their environments exist where the two do or do not "fit" or are or are not supportive of
each other. The environment places demands on the individual and likewise the individual places demands on the environment. The level of congruence between person-environment depends on how well the demands of the individual are matched by the resources within the environment. This leads to optimal adaptations. Thus, ecology is concerned with maximizing fit (and reducing discord) between people and their environment (Insel, 1980; Jeger and Slotnick, 1982).

Social Work and Behavioral-Ecological Perspective

Social work has historically been concerned with the character and circumstances of people and their environment. This concern has focused on the inter-relations and for the whole unit which encompasses them (Siporin, 1980).

The "ecological systems theory" as it is known today, has a long history in social work. The early developments of ecological systems theory had its roots in diverse intellectual sources, particularly in organismic biological ecology, the social survey movement in social work, "human ecology" in sociology information theory, and cybernetics (Siporin, 1975; Germain, 1973; Meyer, 1976; Germain, 1979). The ecological model of man refers to a conceptual system about mind-body-environment in transactional relationships (Siporin, 1980).
Max Siporin (1980) a leading social work scholar and advocate of the ecological systems model, has made a valuable contribution to the development of this perspective. Specifically, his writing has focused on the utility of the ecological model as a guiding framework for the practice and research of social work problems (Siporin, 1980). In reference to ecological systems theory, Siporin (1980) makes the following statement:

The ecology perspective is concerned with the interacting in real life time and space within the territorial habitats reciprocal complementary, or resources exchange, and adaptative fit between subsystems of persons and situations of client milieu. It is also concerned with process; of mobility and distribution of population of the use of land technology, energy, and social organization and other resources in natural input-output flows; of life cycles and developmental tasks in evolution, adaptation, deviance, conflict self regulaltion and change (p. 509).

The ecological model is useful in developing a more unitary and comprehensive approach for a holistic dynamic understanding of people and their socio-cultural-physical milieu (Siporin, 1980). One of the goals of the ecological approach is to bring about changes in persons and situations and in their transactional relationships, thereby achieving the goal of social work of helping people "achieve at one and the same time their own and society's betterment" (Richmond, 1930, p. 374-5).
Germain (1973) states that ecological theory, "is an appropriate metaphor for social work, which seeks to enhance the quality of transactions between people and their environment" (p. 46). Siporin (1980) in further discussions about the ecological model in social work research states, "it can help to resolve current value and ideological conflicts and enhance the effectiveness of social work practice" (p. 526).

Because of its emphasis on human values within the environmental contexts, the ecological model seems to be particularly relevant to this study of mental health. Part of the conflict in understanding the definition of mental health, particularly from a multi-cultural perspective, is recognizing the impact of values and ideologies in the formation of mental health definitions.

The ecosystem consists of people, their life situations, the well-functioning or dysfunctioning of people and their behavior in the process of interacting with their environment. Social functioning refers to a system's integrated and coordinated application of well-developed working capacities and abilities, within basic social relationships, utilizing internal and external resources so as to accomplish life tasks and functions, to meet needs, and to perform life roles (Siporin, 1980). Gitterman and Germain (1976) state:
human beings are conceived as evolving and adapting through transactions with all elements of their environment. In these adaptive processes the human being and the environment shape each other. People mold their environment in many ways, and in turn, must then adapt to the changes they create (p. 606).

Mental health, in its definition, is part of that environment and consequently, is shaped by and helps to shape the environment.

Karen Horney (1937), a leader of the psychoanalytic movement, recognized the importance of cultural factors in psychotherapy. She warned that the way human problems are defined should relate to the cultural context in which they are expressed. There is a need for awareness of cultural relativity in psychotherapy:

Thus the term neurotic, while originally medical, cannot be used now without its cultural implication...one would run a great risk in calling an Indian boy psychotic because he told us that he had visions in which he lived...The conception of what is normal varies not only with culture, but also with the same culture in the course of time (p. 14-15)

Horney appears to indicate that there is a need for awareness of cultural relativity in psychotherapy. In a similar vein Ruth Benedict (1934), an anthropologist, suggests that in order to understand behavior, it must be viewed within the environmental and cultural context in which it is expressed.
The work done in cross-cultural studies has focused on international cross-cultural comparisons rather than on the ethnic groups within the American culture (Carpenter and Strauss, 1974; Giordano and Giordano, 1977; Kiev, 1972). There is a need to explore cross-cultural definitions of mental health, especially, how ethnic groups define mental health in our society.

Utility of Behavioral-Ecological Perspective

The behavioral-ecological perspective can be very helpful in further expanding the present conceptualization and definition of mental health among minority groups such as American Indians. As indicated in other parts of this study, this perspective provides the necessary flexibility to view and understand human behavior within the environmental/cultural context in which it is expressed. The total environment must be taken into consideration as research studies explore how mental health is defined by minority groups.

As more is learned about how mental health is defined, greater emphasis will be placed on how the interaction between individuals and their environments which contributes to this definition. This process of interaction and mutual reciprocal influences may be the same in all cultures, but the meanings given to these interactions and the way they influence each other may vary from culture to culture.
Exploration and determination of how mental health is defined within the boundaries of a particular environment will greatly enhance the mental health system through the delivery of culturally relevant mental health services. The creation of a greater and more flexible "fit" between persons and resources within their particular environment. The environment-and-behavior stream of the behavioral-ecological perspective is particularly useful in this area as it focuses on behavioral definitions within the boundaries in which it is expressed.

For many years, the mental health system operated on the premise that ethnic groups were losing their identity in the "melting pot" (McGoldrick, 1980; Greeley, 1969; 1978; 1981; Lieberman, 1974; Teper, in press). Presently there is evidence to support the belief that most ethnics retain their own individual group identity generation after generation (McGoldrick, 1980; Greeley, 1969; 1987; 1981; Lieberman, 1974; Teper, in press). As more is learned about this social phenomenon, social scientists will have a better understanding of the social, cultural, and political ramifications of this phenomenon. The issue of concern here is the way mental health is defined along cultural and racial/ethnic lines. Without an appropriate, culturally relevant definition of mental health, the mental health service system is limited in its ability to understand the necessary ingredients for being mentally healthy in various cultures.
Chapter Summary

The behavior-ecological perspective, as it is applied in this study, provides a framework through which the definition of mental health can be studied. In order to understand how mental health is defined in various cultures, it must be studied within the particular environmental boundaries of each culture, in this case the Lumbee American community.

The behavioral-ecological perspective as the focus of this study does not assume that mental health has a universal definition. On the contrary, it assumes that the transactions between individuals and their environments greatly influence the definition of mental health. It further assumes that these transactions and their meanings must be understood within the environmental cultural context in which they are manifested. Therefore, definitions of mental health may vary from one culture to another.

The present study is an attempt to learn more about the positive aspects of various cultures, especially the American Indian culture, by attempting to help minority groups define mental health within the cultural boundaries of their environment.
CHAPTER IV

RESEARCH METHODOLOGY

This is an exploratory descriptive study employing the key informant process in identifying the population. Data were collected using an instrument developed by the researcher specifically for this project. A one time scheduled interview was employed. After the data collection process was completed, a content analysis was made to identify how mental health was defined by each of the three racial groups. The purpose of this project was to determine if there is a difference in the way in which the three racial groups of Robeson County, North Carolina define the concept of mental health.

Restatement of Problem and Major Research Questions

Mental health professionals have struggled to define the concept of mental health for the general population for many years. In spite of their continued efforts, they have not come to a consensus regarding the definition of mental health. Meanwhile the mental health field has increased and expanded its service delivery system to the American Indian.
In order to provide effective mental health services which are culturally relevant, it is important to understand the Indian culture. The successful accomplishment of this task, requires an understanding of how Indians define mental health. It is equally important to know whether their concepts of mental health vary from the larger culture's concept of mental health. Recognizing that behaviors are culturally defined, this study is an attempt to determine what differences regarding the concepts of mental health exist among three population groups: the Lumbee Indians of Robeson County, North Carolina and their White and Black counterparts in the same County. This study is an attempt to answer the following questions:

1) What is the Lumbee definition of mental health?
2) What is the Black definition of mental health?
3) What is the White definition of mental health?
4) What are the similarities/differences between the Lumbee definition of mental health and the Black definition of mental health?
5) What are the similarities/differences between the Lumbee definition of mental health and the White definition of mental health?

Research Design

This study is exploratory and descriptive, using the key informant approach (Liebow, 1967; Lofland, 1979; 1984; Babbie, 1979). Sixty (60) participants were nominated to be interviewed in this study. An instrument was designed to investigate the area of concern. Because the topic of this research is a relatively unexplored area, other
available instruments of data collection were ruled out as inappropriate. Several sources (Babbie, 1979; Lofland, 1984) were used to guide the preparation of the instrument.

Sample Procedures

Sixty residents of Robeson County, North Carolina were participants in this study. A resident is defined as anyone who was either born in the county or resided in the county for the past five years. As stated earlier, the key informant approach was used in selecting the population for this study. Because this is a cross-cultural study in a tri-racial county, twenty participants were selected from each of the three racial/ethnic groups.

Key informant Strategy

This section will present an overview of the key informant strategy. This was the approach that was used in selecting the population for the study. This discussion will concentrate on the various steps used by the researcher as this approach was employed in this study.
Rationale

A key informant approach was employed to select the sample for this study. This procedure was chosen as appropriate for this study, because this study is exploratory in nature and takes advantage of the researcher's personal and professional knowledge of the area. The key informant approach is based on a similar procedure that was used in another research project, Children's Services Training Needs Assessment: Ohio-Wisconsin Project, sponsored by the College of Social Work - The Ohio State University. The use of the key informant approach has been reflected in the work of Washington and Rindfleisch (1979) and Baumheir and Hellar (1974). A basic assumption is that selected community leaders and agency executives, who will be called nominators, representing all three racial groups would be able to identify individuals in the county who would be knowledgeable and informative in the area of mental health. A further assumption is that these individuals would be able to adequately respond to the questionnaire and provide answers that would be representative of the three racial groups of Robeson County, North Carolina.
Process for Nominating Key Informants

A two-round nomination process was used to identify the key informant population. The first round involved, asking community leaders and organization executives from all three races, to serve to nominate individuals from their respective communities and racial groups. There were 5 nominators from each of the three racial groups who served a nominator, for a total fifteen nominators. These individuals were seen as community leaders. The next stage or round required all nominators to nominate 25 individuals from their respective racial groups and communities to be included in a pool of potential key informants from which the actual 60 key informants would be selected. After the second round of nominations, these individuals from the pool were approached by the researcher and informed about the study. It is from this pool of potential subjects that the sixty key informants were selected. Key informants who became subjects were those who were nominated in the second round and agreed to participate in the study. Key informants were defined as people who were influential in their communities and who were aware of and concerned about mental health needs, problems in their communities and in the county. The researcher tried to select key informants from the various professions and elected officials such as judges and county commissioners in the population. The key informants were individuals from a variety of backgrounds such as
teachers, ministers, factory workers, senior citizens, students, and a variety of social service representatives. The key informant population included both male and female subjects and a wide range of age subjects from 18 to 50 and over. In addition there were key informants from various economic, social and educational backgrounds. A more detailed analysis will be presented later in this chapter. It should be noted that a potential bias might be present due to selection process, in that the researcher chose key informants who were highly articulate and expressed an interest in mental health. Hence, the data might not be representative of all county residents.

Recruitment Process of Key Informants

After the second round of nominations had been completed, these individuals became the pool of potential key informants. Following the introduction to each key informant, the researcher explained in detail the purpose of and the potential usefulness of this kind of research. Subjects were encouraged to be open and complete in expressing their ideas about mental health. The researcher emphasized the need for each participant to respond to the questions as he/she felt others in the county would respond. Each key informant was asked to express, as much as possible, his/her view of mental health, as well as how they felt others in the county would respond to the interview questions if given the
opportunity. Part of the criteria used in selecting key informants was the ability to articulate ideas about mental health.

While the community leaders were very useful in nominating individuals as key informants, participation was also solicited from a number of major organizations/professional agencies within the county to nominate individuals as key informants. For a listing of the agencies contacted by the researcher see Appendix A.

The researcher worked with each of community leaders/organizations in the process of selecting and nominating individuals as key informants. Each of the community leaders/organizations employed different methods of identifying potential key informants. The researcher was very flexible in working with each of these individuals to accommodate their needs, time schedules, and commitments. Some of the individuals chose to provide a list of potential participants, with their names, addresses, race and telephone numbers to the researcher. Others decided to call the researcher over a period of weeks and provide him with their list as they contacted each person. Some had the individuals call the researcher and introduce themselves. Each of these methods proved to be effective and useful as they met the needs of the community leaders and the researcher.
Each nominator had been given clear instructions about the kinds of potential subjects that would be useful in this project. As each individual was nominated he/she was further screened by the researcher. Potential subjects were asked whether they were interested in this project; whether they felt they could discuss mental health as it relates to the county and whether they would participate in this study. Those individuals who appeared to meet the above criteria and agreed to participate were asked to serve as a key informant in the study.

Methods Employed To Contact Potential Key Informants

Two methods were used to contact the potential interview participants who were nominated. Telephones were used to establish contact with those who had telephones. For others, a personal visit was made to their homes. A great deal of time and attention was given to this matter, as it was a very important part of the project.

At the time of the face-to-face contact an explanation was provided about the nature of the study and questions were answered. Some refused and were not interviewed. Then potential subjects were asked to participate in the project. Each respondent was fully informed about his/her voluntary participation and protection of their confidentiality as a research subject in the study. If he/she agreed to participate, an
appointment was scheduled at the subject's convenience. If a negative response was given, the person was thanked for his/her time and communication was terminated. All scheduled interviews were then conducted.

Compliance Rate

The compliance rate for the study was very good. There were only 6 refusals out of sixty-six contacts. A refusal is identified as someone who was contacted but refused to participate. It should be noted that only one of the six refusals was someone who did not desire to participate, whereas the other 6 expressed an interest but due to time constraints were not able to participate. This was true for a number of professional individuals, especially, those in the medical community.

Data Collection

The means of data collection was a taped-recorded personal interview by the researcher, guided by a questionnaire/instrument guide. There were several reasons for using this method of data collection. Babbie (1979) provides a full explanation of the advantages and disadvantages of this method of data collection. Because this study was concerned about a subject about which little is known, it was hoped that through the use of a personal interview, with open-ended questions, the subjects would be given ample opportunity to explore the
concept of mental health. One of the major advantages of this method is that it allows the use of secondary and/or probe questions, thereby eliciting more relevant responses. Since all interviews were personally conducted by the researcher, many of the potential problems in interviewing, as identified by Babbie (1979), were controlled. The researcher was able to reduce the potential number of "don't knows and "no answer", as well as any potential confusion over questionnaire items. Babbie (1979) identifies several general rules (i.e., appearance and demeanor, familiarity with questions, following question wording exactly and probing for responses) that were considered by the researcher. In addition, the researcher was able to observe each participant and keep written and mental notes.

As each participant agreed to be interviewed, arrangements were made for the interview to be conducted, allowing sufficient time for the one-and-a-half hour interview. In some instances, more than one interview had to be scheduled because the interview lasted longer than the assigned time. In those instances, the second interview was scheduled at the convenience of the interviewee. Most of the interviews were conducted in places of employment or in the home of the informant.
Each interview was tape recorded, with the subject's permission, so as to allow maximum attention of the interviewer to the participant. The use of the recorder reduced the need for note taking and allowed more concentration on the interview. Much to the surprise of the researcher, there was almost no resistance to the use of the recorder during the interview. For the purpose of describing the sample, prior to each interview, demographic data were collected on each subject. Each subject was asked to provide the following information: age, sex, race, income, and educational background and this was recorded by the researcher. This information was recorded on paper by the researcher. It should be noted code numbers but not names were recorded on this document.

The researcher was personally responsible for conducting all sixty interviews. The interviews were conducted during two different time periods. During the first stage of data collection, summer of 1984, forty interviews were completed. The second stage of data collection was in the month of December, 1984 in which the remaining twenty interviews were completed. Initially, the data collection was to have been completed during the summer of 1984. Delays prohibited the achievement of this goal.
Research Instrument

The design of the instrument followed the theoretical framework of this study (behavioral-ecological) as much as possible. In discussing the behavioral-ecological perspective, Jeger and Slotnick (1982) stated:

"behavioral-ecological is concerned with the interdependence among people and their behavior and their socio-physical environment. Behavioral ecology focuses on the transaction between person and their setting, rather than viewing mental health problems as rooted exclusively within the individual or environment (p. 43)"

With this as a guide, the development and design of the instrument represents the principles, values and guiding forces of the behavioral-ecological framework. (For an in-depth explanation of this framework, please refer to Chapter III).

Although there are a number of different approaches to the content, structure and form to the questionnaire, open-ended questions were deemed most appropriate. Such questions provided an opportunity for the participants to express their ideas and opinions about mental health. Specifically, the questions asked respondents to discuss their ideas about mental health and how they felt people from the other comparison groups would respond to the questions. They were asked questions about behavior, about the environment, and family and about the influence of these and other factors on mental health and how it is defined in the county. A number of questions were designed to gather information about how behavior is
defined as being acceptable or unacceptable. Several questions considered mental health in relation to mental illness and how they are different. Another group of questions, addressed the potential differences in the way the three racial groups defined mental health. These questions also tried to get at how each of the three groups perceived each other in relation to defining mental health. Still another group of questions focused on different populations in relation to mental health. This group of questions dealt with the mental health populations of such groups as old and young people, men and women, rich and poor people. A final draft of the instrument used is provided in Appendix B.

**Pretest**

The instrument was designed by the researcher. Because the instrument was new, it was pre-tested. This involved selecting individuals who would not officially participate in the project, but were similar to the subjects in the study to be interviewed. The pre-test included 9 (3 from each race) individuals. The same procedures used in selecting the 9 pre-test subjects were also employed in selecting the sixty subjects for the study.
After the 9 subjects were selected, the pre-test was conducted. The pre-test did not reveal any major problems with the questionnaire/interview guide. The pre-tested subjects seemed to be able to understand the questions and were able to provide data that appeared to be useful in defining mental health. There were no changes made in the instrument.

**Validity and Reliability**

For the purpose of the study, reliability will be defined as "that quality of measurement method that suggests that the same data would have been collected each time in repeated observation of the same phenomenon" (Babbie 1979 p. 583). In designing the questionnaire every effort was made to develop reliable measurements of mental health. Careful consideration was given to the wording of the questions and their relevance to the subject under investigation as well as the characteristics of the subjects in the study. Since the researcher conducted all interviews, any questions for clarification that the subjects had could be directly answered by the researcher.

To further enhance reliability the researcher conducted all 60 interviews. As much as possible all 60 interviews were conducted in the same manner and method. The same questions in the same sequence were asked of every subject (except for probe questions). Additionally,
the researcher limited the number of interviews to a maximum of three per day. This was done so that adequate attention could be devoted to each and every interview.

According to Babbie, (1979), validity refers "to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration" (p. 132). The questionnaire/instrument has face validity as it appears to elicit the subject's definition of mental health. In Nachmias and Nachmias (1981), their discussion on face validity states, "the main problem with face validity is that there are no replicable rules for evaluating the measuring instrument, and one has to rely entirely on subjective judgements" (p. 141). In order to ensure validity the questionnaire/instrument was subjected to a "juror process" by a group of graduate students and a panel of professionals from the county, including mental health professionals, college professors (of social work, sociology and psychology) and members of the medical community. Their tasks were to determine whether the questions (1) were relevant to the field of mental health, (2) were related to determining how mental health is defined, and (3) would be understandable and easy to respond to by residents of Robeson County. These individuals were given copies of the instrument and were asked to respond verbally or by letter. Six responses were received none of which indicated that there were problems with the questionnaire/instrument. A sample of
some of the responses are attached See Appendix C.

As a second measure of validity each subject was asked whether there was anything relevant to mental health that was not asked in the interview. Most subjects indicated the need for this kind of research and that they were happy that the issue of mental health was finally being addressed.

One problem inherent in this social survey was the tendency of subjects to provide socially acceptable rather than honest responses. Because the questions here were not personal in nature, there was no reason for any subject to be dishonest. In addition, subjects were informed that if they could not respond to a question they should say so rather than make up or give false data.

**Procedures for Data Analysis**

Given that this is an exploratory, descriptive study with open-ended and closed-ended questions, the process of content analysis was employed to analyze the data. Lindsey (1974) states, "Content analysis is any technique for making references by systematically and objectively identifying specified characteristics. Burelson (1952) suggests, "that units of analysis or themes must be selected and classified; how intensely the theme is expressed should also be considered" (Children's Services Training Needs and Assessment, 1979, p. 65).
Because each interview was audiotaped it was decided to transcribe each tape. Therefore, all sixty tapes were transcribed. The researcher was primarily responsible for transcribing the tapes. In addition, two undergraduate students were used to help transcribe some tapes. Since the students did not have any experience in transcription, it was thought the best way to handle this was to require that each tape be transcribed verbatim. The researcher reviewed each of the four tapes along with their written responses to ensure that they corresponded. Although it was originally hoped that the students would transcribe more than four tapes, the researcher was responsible for the remaining fifty-six tapes.

The data were analyzed from the transcribed tapes. The closed-ended questions, of which there were many, were easily coded. The open-ended questions required more analysis. For these questions the researcher went through the transcriptions and recorded themes in each response. For a number of questions it was necessary to develop a list and use the list of responses to develop themes. This procedure was used when many of the responses appeared to be similar, with many subjects reporting essentially the same responses. Frequencies of responses were tabulated, as were percentages of similar responses, by groups. Because of the obvious richness of the data, every effort was made to include as many different responses as possible.
Description of Demographics of Study Population

The population of the study is representative of the county's populations in many ways. The participants came from a variety of economic, social, cultural, racial, religious, educational and occupational backgrounds. An effort was made to maintain a balance among the three groups but that was not always possible. For example, if two White teachers were used, then the researcher tried to get two Black and two Indian teachers. This was not always possible, because not all three races are equally represented in all areas.

To provide the reader with an overview of the study population, data were complied on the actual 60 participants in the study. The data collected are presented in Tables 1-5.

Table 1
Age Distribution of Study population

<table>
<thead>
<tr>
<th>Age</th>
<th>Indian n</th>
<th>Indian %</th>
<th>Black n</th>
<th>Black %</th>
<th>White n</th>
<th>White %</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 and below</td>
<td>0</td>
<td>1 5</td>
<td>1 5</td>
<td>1 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 to 30</td>
<td>4 20</td>
<td>3 15</td>
<td>1 5</td>
<td>1 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 to 40</td>
<td>6 30</td>
<td>12 60</td>
<td>13 65</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41 to 50</td>
<td>5 25</td>
<td>1 5</td>
<td>1 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51 and over</td>
<td>5 25</td>
<td>3 15</td>
<td>3 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20 100</td>
<td>20 100</td>
<td>20 20</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 1 presents the age data collected for the 60 subjects in the study. The largest number of subjects were in the 31 to 40 age range for all three racial groups. There were 6 (30%) Indian subjects, 12 (60%) Black subjects and 13 (65%) White subjects in the range. There were almost (50%) more Blacks and Whites in this age range than Indians. In the 20 and below age range there was 1 (5%) Black and 1 White subject. In the 21 to 30 age range, there were 4 (20%) Indians, 3 (15%) Blacks and 2 (10%) White subjects. In the 41 to 50 age range there was a total of 7 subjects, 5 (25%) Indian, 1 (5%) Black and White 1. In the 51 and over age range there were more Indian subjects than Black or White. There were 5 (25%) Indian, 3 (15%) Black and 3 (15%) White subjects.

Table 2

<table>
<thead>
<tr>
<th>Gender</th>
<th>Indian n</th>
<th>%</th>
<th>Black n</th>
<th>%</th>
<th>White n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10 50</td>
<td></td>
<td>7 35</td>
<td></td>
<td>9 45</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10 50</td>
<td></td>
<td>13 65</td>
<td></td>
<td>11 55</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20 100</td>
<td></td>
<td>20 100</td>
<td></td>
<td>20 100</td>
<td></td>
</tr>
</tbody>
</table>
Table 2 presents the data collected in reference to gender differences in the subject population. With regard to gender, The Indian population was equally distributed between males and females, each having 10 (50%) subjects. However, among the Black and White population the distribution was not equal. In fact among the Black population there were almost twice as many females as males, 7 (35%) males, and 13 (65%) females. In the White population there were close to an equal distribution of males and females. There were 9 (45%) males and 11 (55%) females.

Table 3

Income Distribution of The Study Population

<table>
<thead>
<tr>
<th>Income</th>
<th>Black</th>
<th></th>
<th></th>
<th>White</th>
<th></th>
<th></th>
<th>Indian</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000 and below</td>
<td>4</td>
<td>20</td>
<td>3</td>
<td>15</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,001 to 15,000</td>
<td>3</td>
<td>15</td>
<td>6</td>
<td>30</td>
<td>7</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$15,001 to 20,000</td>
<td>7</td>
<td>35</td>
<td>8</td>
<td>40</td>
<td>4</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20,001 to 25,000</td>
<td>2</td>
<td>10</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$25,001 and over</td>
<td>4</td>
<td>20</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3 presents the data collected in regard to income distribution for the subjects in the study. The largest number of subjects for all three racial groups was in the $15,001 to $20,000 income range. In this range there were 7 (35%) Indians, 8 (40%) Blacks and 4 (20%)
White subjects. The second highest range was the $10,001 to $15,000 range, with 3 (15%) Indians, 6 (30%) Blacks and 7 (35%) White subjects. The lowest and highest income ranges had almost equal numbers of subjects. In the $10,000 and below income range there were 4 (20%) Indians, 3 (15%) Blacks and 1 (5%) Whites. In the highest income range there were 4 (20%) Indian subjects, 2 (10%) and 3 (15%) White subjects.

Table 4
Educational Status Demographics For Study Population

<table>
<thead>
<tr>
<th>Education</th>
<th>Indian n</th>
<th>Indian %</th>
<th>Black n</th>
<th>Black %</th>
<th>White n</th>
<th>White %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>2</td>
<td>10</td>
<td>5</td>
<td>25</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>College Graduate</td>
<td>12</td>
<td>60</td>
<td>12</td>
<td>60</td>
<td>11</td>
<td>55</td>
</tr>
<tr>
<td>M. A.</td>
<td>3</td>
<td>15</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Ph.D.</td>
<td>2</td>
<td>10</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>J. D.</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. D. (medical doctor)</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4 presents the educational status for the subjects in the study. The largest number of subjects were in the college graduate category. In this category there were 12 (60%) Indian subjects, 12 (60%) Black subjects and 11 (55%) White subjects. There were equal numbers of subjects in the high school graduate and master level category. In the high school graduate category
there were 2 (10%) Indians, 5 (25%) Blacks and 2 (10%) White subjects. In the master level category there were 3 (15%) Indians, 1 (5%) Black subject and 5 (35%) White subjects. In the more advanced levels of education such as Ph.D there 2 (10%) Indians, 1 (5%) Black and 1 (5%) White subject. There was 1 (5%) White lawyer and 1 Black medical doctor.

Table 5

Occuaption Distribution of The Study Population

<table>
<thead>
<tr>
<th>Occupations</th>
<th>Indian n</th>
<th>Indian %</th>
<th>Black n</th>
<th>Black %</th>
<th>White n</th>
<th>White %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minister</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policeman</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Teacher</td>
<td>3</td>
<td>15</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lawyer</td>
<td></td>
<td></td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Mental health worker</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Social worker</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Professor</td>
<td>3</td>
<td>15</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Student</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Health worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired Persons (Sr. Citizen)</td>
<td>3</td>
<td>15</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Probation officer</td>
<td>1</td>
<td>10</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community worker</td>
<td>3</td>
<td>15</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician's assistant</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortician</td>
<td></td>
<td></td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritionist</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factory worker</td>
<td></td>
<td></td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrator</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>100</strong></td>
<td><strong>20</strong></td>
<td><strong>100</strong></td>
<td><strong>20</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Table 5 presents the data collected in reference to occupation for the subjects in the study. In reviewing table 5 there are a variety of occupations represented by all three racial groups. The various occupations range from unskilled, skilled to professional. While there is not equal representation among all three racial groups, for all the various occupations there are some similarities. For example, there almost equal representation in the following occupations: nursing, social work, teaching, and mental health.

In reviewing the subjects in the population, there are similarities between the three racial groups in terms of socioeconomic variables. The researcher made effort to control for these variables as much as possible to develop a population that was similar in background and at the same time representative of the racial groups in the county. The subjects include a variety to individuals from various backgrounds, including people of low and high incomes, professionals and unskilled laborers. In addition, the population includes a variety of ages, educational backgrounds as well as both men and women.
Protection of Human Subjects

The protection of the rights of the subjects was a major concern in this study. Prior to the data collection process, the study was approved by the Office of Human Subjects Review Committee of The Ohio State University. In addition, several steps were taken to ensure the protection of the human subject rights and confidentiality.

On several occasions, each subject was fully informed about the study. A copy of the introductory statement is attached (See Appendix D). During the first contact, subjects were clearly informed that their participation in the study was voluntary and that their confidentiality was assured. At the time of the interview, they were once again given the opportunity to affirm their willingness to participate. Additionally, they were told they could terminate the interview at any time. They were further instructed not to answer questions they deemed personal or threatening. Any questions or concerns they had were answered to the best of the ability of the researcher.

As further protection of their rights, they were assured of their confidential participation in this project. Since the researcher was solely responsible for conducting all interviews, only the researcher was aware of who participated.
The researcher was a professional social worker whose education and prior work experience provided him with knowledge and familiarity with the interview process. Since the questions were not personal in nature, the potential for a subject to be under stress was minimal.

**Chapter Summary**

This chapter has presented the research methodology that was used in this research project. This is an exploratory descriptive research study using the key informant approach in selecting the study population. Sixty subjects were selected to be interviewed in collecting the data for this study. After the data had been collected, it was subjected to content analysis, of determine how mental health is defined by the 60 subjects. A description of the population is provided. The means for protection of the rights and confidentiality of the subjects are discussed in the chapter.
CHAPTER V

FINDINGS

This chapter presents the findings of this research study. The findings for this study are quite varied and encompassing. The procedures used for analyzing the data focused on identifying themes that contributed to the definition of mental health for the three racial groups in this study.

To provide some organization and clarity to this chapter the various themes have been presented under sub-headings. There are a total of eight sub-headings. The sub-headings were selected as they seem to represent the themes of the study. Each sub-heading will be presented individually with appropriate tables and a discussion. The discussion of each sub-heading will focus the themes of mental health definition that are in qualitative and quantitative forms, highlighting the important data contributing to the definition of mental health.

Although this study is primarily qualitative in nature, some quantitative data were collected. To accommodate the need for presentation of both quantitative and qualitative data, tables have been constructed and are included in this chapter. There are a total of 34 tables in this chapter. To present the full scope of the
responses and the richness of the study, specific quotes from many of the interviewees have been selected and are included in the discussion.

Views About Socially Deviant Behavior as Mental Health Problems

The first questions were closed-ended questions in which subjects were asked to respond to various social issues, indicating whether they would identify these as mental health problems. The purpose of these questions was to ease each subject into the interview and to provide the subjects with the opportunity to begin thinking about mental health.

One of the major growing social problems in our society is the increase in the consumption of alcohol. As a result of public awareness, there is more concern about the effects of alcoholism on the individual and on society in general.

To learn more about the subject's view on whether alcoholism is considered a mental health problem they were asked "Do you think an alcoholic has a mental health problem?" The responses are presented in Table 6.
Table 6
Subjects' Views About Alcoholism as an Indication of a Mental Health Problem

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian n</th>
<th>%</th>
<th>Black n</th>
<th>%</th>
<th>White n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20</td>
<td>100</td>
<td>16</td>
<td>80</td>
<td>16</td>
<td>80</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>20</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

The subjects were very similar in their responses to this question. However, all 20 (100%) of the American Indian subjects answered positively. This is not surprising in light of the problem of alcoholism in the American Indian community. There was very little hesitancy on the part of any of the subjects about how they thought the community felt about this. They indicated that most American Indian people do not think about mental health. As one of the Indian subjects said:

Since I don't know what else to identify it as, calling it a mental health problem seems applicable. While most Indian people might not associate it as a mental health problem they certainly would classify it as a problem. Most Indian people do not think about or understand what mental health is.
Many of the subjects indicated that alcoholism was a major problem in the county for all races but particularly among the American Indian community.

The issue of spouse abuse, particularly wife abuse, is also receiving attention today. As this issue is brought to public attention, it is slowly being recognized as a major social issue that needs public attention. To further investigate this issue with the subjects they were asked, "Do you think a husband/wife who abuses their spouse has a mental health problem?" The responses are in Table 7.

Table 7

<p>| Subjects' Views About Spouse Abuse as an Indication of a Mental Health Problem |
|-------|-------|-------|
| Racial Groups | Indian | Black | White |</p>
<table>
<thead>
<tr>
<th>Response</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>19</td>
<td>95</td>
<td>17</td>
<td>85</td>
<td>18</td>
<td>90</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

As Table 7 indicates there seems to be a general consensus among all three racial groups, that anyone who abuses his/her spouse has a mental health problem. One White subject said, "This is a major problem here in this county. It is only recently that we are beginning to talk
about it and bringing it "out of the closet" and in the open. Another White subject said, "Any time one person inflicts pain on another person, that is a mental health problem."

The American society is increasingly becoming a very violent society in which to live. During the past 20 years there has been an increase in violent crimes using guns. To learn more about how the subjects felt about the issue of guns, they were asked "Do you think someone who settles an argument with a gun has a mental health problem?" The responses are in Table 8.

Table 8

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n %</td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Yes</td>
<td>14 70</td>
<td>14 70</td>
<td>18 90</td>
</tr>
<tr>
<td>No</td>
<td>3 15</td>
<td>5 25</td>
<td>0 0</td>
</tr>
<tr>
<td>Unsure</td>
<td>3 15</td>
<td>1 5</td>
<td>2 10</td>
</tr>
<tr>
<td>Other</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Total</td>
<td>20 100</td>
<td>20 100</td>
<td>20 100</td>
</tr>
</tbody>
</table>

The responses to this question were somewhat different between the White and non-White subjects. The results were almost the same for the Indian and Black subjects. Seventy percent of the Indian and Black subjects said yes. Of the remaining Indian subjects 3
(15%) said no and 3 (15%) reported they were unsure. Similar were found with the Black subjects with 5 (25%) who said no and 1 (5%) who said he/she was unsure. Almost all 18 (90%) of the White subjects said yes, 2 (10%) said they were unsure.

Most of the subjects indicated that there are other acceptable ways of solving problems or resolving conflicts. Nevertheless, one Indian subject said, "While it may not be an acceptable formal way of solving problems, it is obviously used by at least a segment of the Indian population."

Along the same lines, the subjects were asked, "Do you think someone who settles an argument with a 'fist fight' has a mental health problem?" The responses to this question revealed a much greater difference between the Indian subjects and the Black and White subjects. The responses are in table 9.

Table 9

| Subjects' Views About Fist Fighting as an Indication of a Mental Health Problem |
|---|---|---|---|
| Racial Groups | Indian | Black | White |
| Response  | n  | %  | n  | %  | n  | %  |
| Yes       | 6  | 30 | 11  | 55 | 14  | 70 |
| No        | 5  | 25 | 5   | 25 | 3   | 15 |
| Unsure    | 9  | 45 | 4   | 20 | 3   | 15 |
| Other     | 0  | 0  | 0   | 0  | 0   | 0  |
| Total     | 20 | 100| 20  | 100| 20  | 100|
As seen in Table 9, of the 20 Indian subjects only 6 (30%) said yes, 5 (25%) said no and 9 (45%) were unsure or did not know. The Black subjects responded with 11 (55%) saying yes, 5 (25%) said no and 4 (20%) were unsure or did not know. Among the White subjects, 14 (70%) said yes, 3 (15%) said no and 3 (15%) were unsure or did not know. This seems to indicate that the American Indian subjects differed from the White and Black subjects. As one Indian subject said, "Within the Indian Community an Indian man is expected to defend himself and stand up for what he believes is right." Another Indian subject stated, "There is a frontier atmosphere around here. It is just accepted that from time to time, that men will fight." In contrast, among the White subjects, a couple of typical responses were, "The use of any form of violence is inappropriate" and "Yes, that is a mental health problem."

The next question asked was, "Do you think someone who uses drugs on a regular basis has a mental health problem?" The responses to this question were similar among all three racial groups, as can be seen in Table 10.
Table 10

<table>
<thead>
<tr>
<th>Response</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>80</td>
<td>16</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>

Among the Indian subjects 16 (80%) responded positively to the question, 3 (15%) said no and 1 (5%) unsure or did not know. The Black subjects had similar responses to the White subjects with 16 (80%) saying yes, 2 (10%) said no 2 (10%) were unsure or did not know. Of the 20 White subjects 15 (75%) said yes, 2 (10%) said no and 3 (15%) were unsure or did not know.

The last question in this section was about crime and mental health. The question was, "Do you think someone who commits a crime has a mental health problem?" The responses to this question like the previous question, were similar. Responses to this question can be seen in Table 11.
Table 11
Subjects' Views About Criminal Activity as an Indicator of a Mental Health Problem

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th></th>
<th>Black</th>
<th></th>
<th>White</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>30</td>
<td>9</td>
<td>45</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>20</td>
<td>3</td>
<td>15</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Unsure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>50</td>
<td>8</td>
<td>40</td>
<td>14</td>
<td>70</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

In constructing Table 11, as with constructing other tables, a category of "other" was included. However, with this question many of the responses fell into this category. The "other" category includes all subjects who said something similar to the following statement:

It would depend on the crime; not all crimes means (sic) someone has a mental health problem. Committing a murder probably indicates someone has mental health problems but someone who gets a speeding ticket probably does not.

Among the Indian subjects, 6 (30%) said yes, 4 (20%) said no and 10 (50%) responded in the "other" category. A higher percentage of Blacks, 9 (45%) said yes, 3 (15%) said no and 8 (40%) responded in the other category. Of the 20 White subjects 5 (25%) said yes, 1 (5%) said no and 14 (70%) responded in the "other" category.
It should be noted here that most subjects initially responded to this question by saying, "It would depend on the crime." A follow-up question was, "Give me an example of a crime in which the person would and would not have a mental health problem." Almost invariably all of the subjects said, for example, "Someone who commits a murder would have a mental health problem and someone who gets a ticket for speeding would not have a mental health problem." This seemed to be true for all three races. There seems to be general consensus among the subjects that most of the identified social issues above are indicators of mental health problems.

Identification of Mental Health Characteristics and Signs of Mental Health Problems

The second set of questions were open-ended questions, constructed specifically to allow subjects the opportunity to fully explore and/or express their ideas about mental health, as well as how they felt others around them would respond to these questions. These questions deal with the definition of mental health by asking questions about mental health characteristics, as well as signs which would indicate mental health problems.

Mental health is an elusive concept despite the many efforts to determine its definition. One of the major problems in defining mental health in American society is the heterogeneous composition of the population. Realizing
there is probably not a universal definition of mental health, the subjects in this study were asked, "How do you think most people would describe the term mental health?" It was anticipated that the responses to this question would provide some further insight into the definition to mental health from a cross-cultural perspective. There were a variety of answers to this question, as can be seen in Table 12.
Table 12  
Subjects' Descriptions of The Term Mental Health

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Indian</th>
<th></th>
<th>Black</th>
<th></th>
<th>White</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Unable to control self</td>
<td>4</td>
<td>20</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Crazy</td>
<td>11</td>
<td>55</td>
<td>8</td>
<td>40</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>Person is weak/cannot solve problems</td>
<td>12</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>4</td>
<td>20</td>
<td>3</td>
<td>15</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Something wrong with mind</td>
<td>6</td>
<td>30</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking problem</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td>10</td>
<td>50</td>
<td></td>
<td></td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Indian people have a vague impression</td>
<td>6</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain not functioning properly</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invading privacy</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demon possessed</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannot cope with pressure</td>
<td>3</td>
<td>15</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Disease</td>
<td>3</td>
<td>15</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental illness</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannot do things for themselves</td>
<td>4</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth defect</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acting against norm</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>1</td>
<td>10</td>
<td>1</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most people cannot distinguish between mental illness and mental health</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Positive

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Indian</th>
<th></th>
<th>Black</th>
<th></th>
<th>White</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Socially well adjusted to environment</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Function within standards of society</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well adjusted to family and Level headed</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive self image</td>
<td></td>
<td></td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to lead a positive life</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being able to control emotions</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepts one's self and others</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish goals and objectives</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to solve problems</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
From the variety of answers it appears that most people did not make a distinction between mental health and mental illness. Many of the subjects began with a statement similar to, "Most people in this county rarely think about mental health and those who do usually do not make a distinction between mental health and mental illness."

Of the three races, only the Indian and the Whites, seemed to make a distinction between mental illness and mental health. The Black subjects did not seem to make a distinction and interestingly enough seemed to be describing mental illness rather than mental health. Therefore, two different lists were developed to adequately and properly present the data collected.

One of the most common themes was the word "crazy". Of the 20 Indian subjects 11 (55%) identified the term, as did 8 (40%) of the Black subjects and 7 (35%) of the White subjects. When asked what "crazy" meant there were a variety of responses such as disturbed, not normal, different, mentally sick, someone who is different, unusual and someone who does not seem to fit in. However, some subjects also said that the word "crazy" has several meanings, for example, the word could be used to describe someone who is funny, comical, easy to get along with, someone who is of free spirit and someone who enjoys life without worrying about what others maybe saying about them. When used in this context, the word has a positive
meaning. One Indian subject said, "Indians have interesting or different ways of using many of the words in the English language." The subject seemed to be saying that words have more than one meaning, and one must understand the context in which they are used to understand the meaning of the word or sentence. The subject gave the following example, "I'm going to kill you," as one phrase that is used quite frequently among the Lumbee Indians. This is a phrase that could be used in a variety of situations, all with very different meanings. Without some familiarity with the Lumbee Indians and their community, it is not possible to understand what the phrase means. In a situation of anger or dispute, it would be interpreted in a literal sense. However, in another situation, it would be interpreted as being silly, shameful or embarrassing. The meanings of other words and phrases, such as those describing mental health and mental illness, can only be understood or interpreted in the social, cultural and environmental context in which they are expressed. In further descriptions of the term mental health, more than one half, 12 (60%), of the Indian said the person was weak. It should be noted that this was a description identified by the Indian subjects exclusively.
For 6 (30%) of the Indian subjects and 3 (15%) of the Black subjects, the term implied something wrong with the individual's mind; he is sick in the mind. Interestingly enough for, 5 (25%) Indian subjects the term also would be defined as invading one's privacy. In addition, 5 (25%) of the Indian subjects identified demon possession as a description of mental health.

Many subjects, 10 (50%) of the Indian subjects and 6 (30%) of the White subjects, noted that for many people the term mental health had a stigma attached to it. This is a theme that was consistent throughout this study. It should be noted here that several subjects in all three races, especially the Indian subjects, said that this may account for part of the rationale for the apparent low use of mental health services.

The Indian and White subjects identified themes that appeared to be more in line with the definition of mental health rather than mental illness. The Black subjects did not. However only 5 (25%) of the Indian subjects identified positive terms, while 17 (85%) of the White subjects identified positive terms. One of the themes was, "Someone socially well adjusted to the environment. A mentally healthy person should be able to solve problems in a rational way and be able to conform to the norms of society." Others identified such factors as controlling emotion, being able to get along with yourself and others, establishing goals and having a sense of purpose as
important in defining mental health.

One of the ways in which a distinction is made between mental health and mental illness is in the actions, attitudes, values and behaviors of individuals. To learn more about how a mentally healthy person is defined by the subjects of this study, they were asked to describe a mentally healthy person. As Table 9 indicates, there was a variety of responses to this question. However, there do not appear to be major differences among the three racial groups.
Table 13

Subjects' Views of Characteristics of a Mentally Healthy Person

<table>
<thead>
<tr>
<th>Identified Characteristics</th>
<th>Indian n</th>
<th>%</th>
<th>Black n</th>
<th>%</th>
<th>White n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responds in a normal way to problems</td>
<td>1 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to adjust</td>
<td>1 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family is important in mental health</td>
<td>6 30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likes themselves and others</td>
<td>7 35</td>
<td>9 45</td>
<td>10 50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to solve problems</td>
<td>4 20</td>
<td>10 50</td>
<td>14 70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can cope with environment</td>
<td></td>
<td></td>
<td></td>
<td>6 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health affects physical health</td>
<td>2 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confident, positive</td>
<td>2 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good outlook on life</td>
<td>4 20</td>
<td>3 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept what happens to them</td>
<td>4 20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerant of a variety of values</td>
<td>3 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responds to stimuli (physical and mental)</td>
<td>3 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aware of limitations</td>
<td>2 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes decisions, rational</td>
<td>6 30</td>
<td>10 20</td>
<td>20 100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hold a job</td>
<td>2 10</td>
<td>3 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust, love, share, care</td>
<td>3 15</td>
<td>2 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can communicate with all three races</td>
<td>3 15</td>
<td>5 25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future oriented</td>
<td>1 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stable, happy, optimistic</td>
<td>15 75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can function within society's rule and norms</td>
<td>14 70</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to grow and develop</td>
<td>1 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were some similarities in their answers. For example, 7 (35%) of the Indian subjects, 9 (45%) of the Black subjects and 10 (50%) of the White subjects felt a necessary characteristic was the ability to get along with other people. Being able to communicate with all three
races was identified by 3 (15%) of the Black subjects and 5 (25%) of the White subjects. Able to solve problems was identified by 4 (20%) of the Indian subjects, 10 (50%), and 14 (70%) of the Black and White subjects respectively.

Another interesting theme among the subjects was that all three races indicated they would define a mentally healthy person differently. When asked if they could identify the differences, most were not able to do so. Another theme in response to this question was that a mentally healthy person should be able to hold a job and be productive, as identified by 2 (10%) Black and 3 (15%) of the White subjects. One White subject said said, "One of the things we expect from the average person is that they be able to work and take care of themselves."

Getting along with other people was very important to many of the subjects. Many of the subjects said that it was important to have people around you and to be able to relate to other people. As one Black subject said, "Most people are not loners, they need and want to be with other people. That contributes to our development." Another Indian subject stated, "Being part of a family, is important in forming (sic) and developing mental health." This was a feeling that was shared by several of the Indian subjects.
One of the major differences in response this question, which was the unique to the American Indian subjects, was the theme of tolerance for a variety of values. Some 3 (15%) of the Indian subjects indicated that it was important to be tolerant of a variety of value systems and this, they felt, contributed to defining mental health. Mental health it would seem, then, is the ability to be able to live successfully in an environment in which there is a variety of value systems, a wide range of behaviors, and more than one way of defining and solving problems.

More than half 14 (70%) of the White subjects identified functioning within society's norms and rules as important. As one White subject said, "A person who behaves in a socially acceptable way, given the rules and the norms of the culture (sic). The culture includes the behaviors and lifestyles which in this county, sometimes means fighting with your fists."

In contrast to the above discussion, the subjects were asked to identify and explore characteristics, behaviors, and attitudes that would be associated with mental illness or someone who is not mentally healthy. The question was, "Do you know anyone who, in your opinion, is not mentally healthy? If yes, what about that person makes them different?" The responses to both part of the question can be seen in Table 14.
Table 14

<table>
<thead>
<tr>
<th>Subject's Description</th>
<th>Indian</th>
<th>%</th>
<th>Black</th>
<th>%</th>
<th>White</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wandering</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Something about actions</td>
<td>3</td>
<td>15</td>
<td>20</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worries a lot</td>
<td>4</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facial expression</td>
<td>7</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most people do not distinguish mental illness and mental health</td>
<td>10</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feelings about people and things around them</td>
<td>8</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not much conservation</td>
<td>8</td>
<td>40</td>
<td>10</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not able to cry, love, share</td>
<td>8</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking problems</td>
<td>15</td>
<td>75</td>
<td>10</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violent, abusive</td>
<td>15</td>
<td>75</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstable, irrational</td>
<td>7</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannot deal with stress</td>
<td>15</td>
<td>75</td>
<td>13</td>
<td>65</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Quick tempered</td>
<td>13</td>
<td>65</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Racism, prejudice</td>
<td>15</td>
<td>75</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complains of being possessed</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present oriented</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not able to adjust to physical changes</td>
<td>8</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low self esteem, self concept</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
<td>14</td>
<td>70</td>
</tr>
<tr>
<td>Drug and alcohol problems</td>
<td>15</td>
<td>75</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loner</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td>8</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not in touch with reality</td>
<td>10</td>
<td>50</td>
<td>10</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with eye contact</td>
<td></td>
<td></td>
<td>10</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannot follow instructions</td>
<td></td>
<td></td>
<td>4</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responds to situation with inappropriate behavior</td>
<td></td>
<td></td>
<td>14</td>
<td>70</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Most of the subjects indicated they knew at least one person they would consider to be mentally ill. The majority of the Black subjects 18 (90%) said yes and 2 (10%) said no. Similar results were found among the
Indian subjects with 17 (85%) saying yes, and 3 (15%) saying no. The results for the White subjects were somewhat different from the other two races with 14 (70%) saying yes, and 6 (30%) said no.

There were a variety of responses to this question. Even though the responses were quite varied for each group, there does not appear to be any major differences between the three groups. There were similar characteristics that were identified by each racial group. These included not being able to handle/cope with stress, 15 (75%) Indian, 13 (65%) Black, and 10 (50%) White; facial expression, 7 (35%) Indian; thinking problems, 15 (75%) Indians and 10 (50%) Black; abuse of drugs and alcohol 10 (50%) Blacks.

One of the characteristics similar among the Indian and White groups is low self-concept, poor self-esteem, as identified by 5 (25%) Indians and 14 (70%) White subjects. One Indian subject said:

> While there may be many problems in the Indian community, one of the major problems is poor or undeveloped self concepts, poor self-esteem. This I believe contributes to many of the problems facing Indians and causing them to behave the way they do. Many people don't feel good about themselves.

Of the 20 Indian subjects 15 (75%) identified violent or abusive behavior as a problem. In relation to this, one Indian subject said "Violence is a major problem around here, especially with the Indians."
In relation to the above question, 3 (15%) of the Indian subjects and 20 (100%) of the Black subjects identified actions of the person as an indication of a mental health problem, but this was not identified by the White subjects. Along the same line, 8 (40%) of the Indian subjects identified "feelings about people and things around them." A Black subject stated, "It is not always possible to identify exactly what is different about the person, sometimes it is action, behaviors, that are inappropriate, it can be expressed feeling, or some other unusual activity."

One of the means of gaining insight into defining mental health is to ask people about mental health problems. The subjects were asked to discuss mental health problems in the county. The question was, "What do you consider to be mental health problems?" There were a wide variety of answers to this question. Most subjects agreed that any one of a number of problems would be considered mental health problems. For responses to this question please see Table 15.
Table 15
Subjects’ Views of Mental Health Problems

<table>
<thead>
<tr>
<th>Identified Mental Health Problems</th>
<th>Indian n</th>
<th>Indian %</th>
<th>Black n</th>
<th>Black %</th>
<th>White n</th>
<th>White %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
<td>20</td>
<td>100</td>
<td>8</td>
<td>40</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Alcohol/drug abuse</td>
<td>19</td>
<td>95</td>
<td>8</td>
<td>40</td>
<td>12</td>
<td>60</td>
</tr>
<tr>
<td>Poverty problems</td>
<td>10</td>
<td>50</td>
<td>5</td>
<td>25</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Thinking problems</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment problems</td>
<td>4</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family problems</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Racism, oppression</td>
<td>9</td>
<td>45</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood experiences</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Stress</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low self concept</td>
<td>6</td>
<td>30</td>
<td></td>
<td></td>
<td>4</td>
<td>20</td>
</tr>
</tbody>
</table>

Subjects in all three races, 10 (50%) of the Indian subjects, 5 (25%) of the Black subjects and 1 (5%) of the White subjects, identified environmental problems under the umbrella of poverty, such as unemployment, inadequate health care, stress, poor nutrition and diet, racism would all be considered mental health problems. Drug and alcohol abuse were identified as mental health problems by 19 (95%) of the Indian subjects, 8 (40%) of the Black subjects and 12 (60%) of the White subjects. Domestic violence was identified by 20 (100%) of the Indian subjects, 8 (40%) of the Black subjects and 8 (40%) of the White subjects as a mental health problem. As one Indian subject, said "It is an area that is still relatively new and unexplored in the Indian community, therefore, people are naturally afraid of it because they really don't
One White subject responded by saying:

Depression, various forms of psychoses, might be viewed as mental health problems. I don't think people around here view alcoholism, spouse abuse, drug abuse and other forms of domestic violence, as mental health problems. There seems to be tacit, silent approval. The community is reluctant to intervene in this kind of activity. Home and family matters are sacred here. We do not intervene.

One Black subject said, "Child abuse, sexual abuse, child molestation, wife beating, alcohol and drug abuse, incest, homicide among Indians males, and possibly teenage pregnancy would be considered mental health problems."

In relation to this question, one White subject noted that while the subject of mental retardation was not addressed, it was a problem in Robeson County. She continued saying that there was a high incidence of mental retardation in this area, which may have something to do with mental illness. She further indicated it was a major problem in the minority communities, especially in the Indian community.

The next question was, "What are some signs that may indicate that a person is not mentally healthy?" This question gave the subjects the opportunity to identify signs or characteristics they would identify as abnormal. Responses are in Table 16.
Table 16

Subjects' Views About Signs Characteristics of Mental Illness

<table>
<thead>
<tr>
<th>Identified Signs and Characteristics</th>
<th>Indian n</th>
<th>Black n</th>
<th>White n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent behavior</td>
<td>6 30</td>
<td>6 30</td>
<td>6 30</td>
</tr>
<tr>
<td>Isolation from family, etc.</td>
<td>5 25</td>
<td>6 30</td>
<td>6 30</td>
</tr>
<tr>
<td>Strange facial expressions</td>
<td>8 40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of appetite, sleep, change in appearance</td>
<td>11 55</td>
<td>4 20</td>
<td>6 30</td>
</tr>
<tr>
<td>Depression</td>
<td>2 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repetition in speech/thinking problems</td>
<td>2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narrow range of feelings</td>
<td>3 15</td>
<td>2 10</td>
<td>5 25</td>
</tr>
<tr>
<td>Nervous energy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/drug problems</td>
<td>7 35</td>
<td>3 15</td>
<td></td>
</tr>
<tr>
<td>Overly suspicious</td>
<td>3 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of eye contact</td>
<td></td>
<td>5 25</td>
<td></td>
</tr>
<tr>
<td>Inappropriate behavior for situations</td>
<td>3 15</td>
<td>7 35</td>
<td>8 40</td>
</tr>
<tr>
<td>Communication problems</td>
<td></td>
<td>5 25</td>
<td></td>
</tr>
<tr>
<td>Cannot cope with problems</td>
<td></td>
<td>1 10</td>
<td></td>
</tr>
</tbody>
</table>

In response to this question many subjects said Robeson County was unusual in many ways. As such it was difficult for them to identify signs that may indicate someone is mentally unhealthy. However, 5 (25%) of the Indian subjects, 6 (30%) of the Black subjects and 6 (30%) of the White subjects said isolation from family or friends was a sign. Many of the subjects, 11 (55%) of the Indians, 4 (20%) of the Black and 6 (30%) of the White, indicated that changes in appearance, eating, sleeping habits were signs. Inappropriate behavior for various situations was identified by 3 (15%) of the Indian...
subjects, 7 (35%) of the Black subjects and 8 (40%) of the White subjects as a sign of a mental health problem. One Indian subject said, "People here seem to have a high threshold for mental illness or abnormal behavior." This was a theme that was evident among many of the subjects, not only to this question but to others in this study.

One White subject said:

There are three races in this county, whether we want to admit it or not there is a difference possibly (sic) I'm not sure between the races. That difference must be explained in cultural, social, environmental, and political terms. I would assume there would be a difference in mental health also.

Another Black subject said, "It is difficult to know whether someone who is acting different (sic) is abnormal or responding to the needs of his environment." There were several common themes found in all three groups in response to this question. Many of the subjects identified signs such as violent behavior, changes in the overall character of a person (e.g., style of dress, eating, sleeping habits,), fatigue, drastic mood changes, expression of nervous energy, (e.g. biting nails, talking to one's self) as behaviors associated with mental illness. Violent behavior was identified by 6 (30%) of the Lumbee Indian population as a sign of mental illness. This is somewhat surprising since in earlier questions the Lumbee subjects did not seem to indicate that violence was a sign of a mental health problem. In addition someone who is withdrawn, loner, cannot communicate with people,
overly suspicious were identified as signs of someone who was not mentally healthy. Two Indian subjects said, "Someone who has a narrow range of feelings."

**Exploring Various Social Factors as They Affect The Definition of Mental Health**

This set of questions, although varied in their composition, asked about a number of situational factors and their influence in defining mental health. The researcher was interested in learning more about where individuals go for help and their preference between mental illness and physical illness. In addition, the questions focused on factors such as family, environment, community, culture, and the use of the insanity plea in reference to the definition of mental health. There was one question that dealt specifically with employment of formerly mentally ill individuals.

There are a variety of mental health resources that can be used when assistance is needed. The researcher wanted to learn more about the various resources that are used by the three racial groups. Even though there is a mental health center in Robeson County, the center is not used extensively by the all the racial groups, especially the Lumbee Indian community. The question asked, "What should a person do if he/she suspects either themselves or someone around them has a mental health problem?" As can be seen in Table 7 there were basically four different
resources that were identified by all three racial groups, but used to different degrees. The four most often identified resources were: 1) consulting a physician, 2) consulting the mental health center (e.g., psychologist, or psychiatrist) 3) consulting a family member or friend and 4) consulting a minister or clergy person.

Table 17

Subjects' Views of Mental Health Resources

<table>
<thead>
<tr>
<th>Identified Resources</th>
<th>Indian n</th>
<th>%</th>
<th>Black n</th>
<th>%</th>
<th>White n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consult a physician</td>
<td>4</td>
<td>20</td>
<td>10</td>
<td>50</td>
<td>19</td>
<td>95</td>
</tr>
<tr>
<td>Consult a mental health center (psychologist)</td>
<td>5</td>
<td>25</td>
<td>11</td>
<td>55</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Consult a minister</td>
<td>19</td>
<td>95</td>
<td>8</td>
<td>40</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Consult a family member/friend</td>
<td>10</td>
<td>50</td>
<td>9</td>
<td>45</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Avoid the situation</td>
<td>10</td>
<td>50</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Other (social service, hospital, rehabilitation center, or social worker)</td>
<td>4</td>
<td>20</td>
<td>7</td>
<td>35</td>
<td>4</td>
<td>40</td>
</tr>
</tbody>
</table>

The majority of the 20 White subjects 19 (95%) indicated they would visit a physician, 10 (50%) identified mental health center, 10 (50%) mentioned consulting with a minister, 4 (20%) said they would consult a family member/friend. Of the remain subjects indicated that 4 (20%) would avoid the situation and 4 (20%) identified various other ways of handling the situation or resources they would use. In contrast, 10 (50%) of the Black subjects indicated that they would
consult a physician, 11 (55%) said they would use the mental health center, 8 (40%) would use a minister, 9 (45%) would consult a family member/friend 1 (5%) indicated avoiding the situation, the remaining 7 (35%) would use other resources. The Indian subjects were somewhat different in their responses with only 4 (20%) indicating they would consult a physician, 5 (25%) identifying the mental health center. However 19 (95%) mentioned they would use a minister or clergy, 10 (50%) would consult family or friend, 10 (50%) would avoid the situation and 4 (20%) would use other resources.

While the White and Black subjects seem to rely or use the modern mental health system for help. The Indian subjects indicated more of a preference for solving mental health problems using resources that with which they are familiar, with such as their family, friends or a minister. As one Indian subject said, "If Indian people use the system (mental health) at all, it is only used as a last resort." Another Indian subject said:

They would go see a doctor or specialist, if it has to do with a physical problem. If it is a mental problem, probably most would not go see a psychologist (sic) or psychiatrist would not see this as a way of help. But this is changing in the Indian community.

Another Indian subject said, "Decide the severity of the problem... Most Indians will go to a friend quicker than a stranger. The church is seen as an appropriate way of handling mental health problems." He continued by saying "the church is family controlled and therefore, when one
has a problem, that is where he/she turns for help. The extended family and church are all tied into one." The White subjects seem to indicate that the use of professional medical personnel and the mental health center was more acceptable and readily used than in the Black or Indian community. The White subjects indicated the importance of the family and friends but, were less reluctant to identify these as resources as mental health services. As one White subject said:

Around here White people are much more willing to use the mental health center or private resources than Black or Indian people. There is not as much stigma attached to mental illness as there is in the Black and Indian community.

The Black subjects were somewhere in the middle between the two other races on this question. As indicated by the Table 15 most would not be reluctant to visit a medical professional or use a member of the clergy for help in this area. As one Black subject said, "Whenever possible Black people will use county services when they feel they will help or if they have access to the service." One Black subject said, "I thought I was going to have a nervous breakdown, I prayed about it and the Lord answered with a victory for me. Talk to God."

The next question was a attempt to determine if there was a difference in the way people viewed mental health problems and physical health problems. This was also an attempt to determine if there was a difference between these two problems. The question asked, "If you had to
choose between a physical illness and mental illness, which would you choose? Why?" The responses to this are in Table 18.

Table 18

| Subjects' Views About Preference of Mental Health over Physical Health Problems |
|---------------------------------|---|---|---|
| Racial Groups                  | Indian | Black | White |
| Response                       | n  | %   | n  | %   | n  | %   |
| Mental illness                 | 1  | 5   | 0  | 0   | 2  | 10  |
| Physical illness               | 18 | 90  | 19 | 95  | 17 | 85  |
| Do not know/unsure             | 1  | 5   | 1  | 5   | 1  | 5   |
| Total                          | 20 | 100 | 20 | 100 | 20 | 100 |

There was almost a consensus on this issue among all three races. When asked why, most of the subjects responded with one or more of the following answers: 1) less stigma (used most often) 2) easier to diagnose, define, treat 3) greater faith in the health system to help physical problems, 4) mental illness is usually long term with less chance of recovery. The issue of stigma attached to mental illness was identified by most subjects but, seemed to be more pronounced among the Indian subjects. As one Indian subject said, "Once you enter those doors (mental health center) you are never the same within the Indian community."
There many issues that influence the way mental health is defined such as family, environment, community and culture. In an effort to further explore how these factors influence the definition of mental health the subjects were asked, "How do such factors such factors as family, environment, community and culture make a difference in whether an individual is mentally healthy? In what ways does these factors make a difference?" As with other questions there was a variety of responses to this question. The responses can be seen in Table 19.
### Table 19

Subjects' Views About How Factors such as Family, Environment, Community and Culture Influence The Definition of Mental Health

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian n</th>
<th>Indian %</th>
<th>Black n</th>
<th>Black %</th>
<th>White n</th>
<th>White %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Influence of Family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Learn behavior from parents</td>
<td>7</td>
<td>35</td>
<td>6</td>
<td>30</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>B. Broken/Intact homes</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>15</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>C. Love, security</td>
<td>4</td>
<td>20</td>
<td>9</td>
<td>45</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>D. Support system</td>
<td>12</td>
<td>60</td>
<td>7</td>
<td>35</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>E. Role model</td>
<td>8</td>
<td>40</td>
<td>6</td>
<td>30</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>F. Belief system</td>
<td>5</td>
<td>25</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>G. Problem definition resolution</td>
<td>4</td>
<td>20</td>
<td>2</td>
<td>10</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>H. No difference</td>
<td>2</td>
<td>10</td>
<td>4</td>
<td>20</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td><strong>Community Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Sense of belonging</td>
<td>8</td>
<td>40</td>
<td>6</td>
<td>30</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>B. Being part of something</td>
<td>10</td>
<td>50</td>
<td>5</td>
<td>25</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>C. Indians are clannish</td>
<td>5</td>
<td>25</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>D. Extension of family</td>
<td>7</td>
<td>35</td>
<td>3</td>
<td>15</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>E. Friends</td>
<td>8</td>
<td>40</td>
<td>5</td>
<td>25</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>F. Community support</td>
<td>9</td>
<td>45</td>
<td>3</td>
<td>15</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>G. No difference</td>
<td>2</td>
<td>10</td>
<td>4</td>
<td>20</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td><strong>Culture</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Religion</td>
<td>5</td>
<td>25</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>B. Beliefs</td>
<td>5</td>
<td>25</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>C. Values</td>
<td>8</td>
<td>40</td>
<td>7</td>
<td>35</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>D. Norms</td>
<td>9</td>
<td>45</td>
<td>3</td>
<td>15</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>E. No difference</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>15</td>
<td>9</td>
<td>45</td>
</tr>
<tr>
<td>Environment (air, noise, chemicals)</td>
<td>7</td>
<td>35</td>
<td>4</td>
<td>20</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Living in harmony with nature</td>
<td>4</td>
<td>20</td>
<td>3</td>
<td>15</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Discrimination, oppression</td>
<td>6</td>
<td>30</td>
<td>7</td>
<td>35</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Changes in job, economy</td>
<td>4</td>
<td>20</td>
<td>3</td>
<td>15</td>
<td>4</td>
<td>20</td>
</tr>
</tbody>
</table>
As with the other questions there was a variety of responses to this question. Many of the subjects indicated these factors were very important in defining mental health. Judging from the responses given, it seems that most felt that the family was the most important and influential factor. This seem to be consistent among all three races.

There were a number of important themes that were identified in response to this question. Some will be identified in the text, others can be seen in the table 19. For example, learning behavior from parents was a theme in which 7 (35%) of the Indian subjects identified, 6 (30%) of the Black subjects, and 8 (40%) of the White subjects. Another important theme was support system which 12 (60%) of the Indian subjects identified, 7 (35%) of the Black subjects, and 5 (25%) of the White subjects. Role model was another answer with 8 (40%) of the Indian subjects identifying it as well as 6 (30%) of the Black subjects and 7 (35%) of the White subjects. Another area that was important was love, security, protection, which was identified by 4 (20%) of the Indians and 9 (45%) of the Black and 6 (30%) of the White subjects.

In reference to community there were several important themes which will be identified here in the disucssion. One of the most important was a sense of belonging, which was identified by 8 (40%) of the Indians, 6 (30%) of the Black subjects and 6 (30%) of the White
subjects. Another important theme was "being part of something" in which 10 (50%) of the Indians identified, but only 5 (25%) of the Black and the White subjects each identified as a theme. Friends were also identified as a factor in mental health with 8 (40%) of the Indian subjects, and 6 (30%) of the Black and White subjects each noting that as important. Extended family was identified by 7 (35%) of the Indian subjects, but not by any of the Black or White subjects. It should be noted that 8 (40%) of the White subjects indicated that community did not make any difference, while only 2 (10%) of the Indians and 3 (15%) of the Blacks agreed that community did not make in difference in the definition of mental health.

In reference to culture, the subjects identified several areas such as religion, beliefs, values, and norms as important in culture. In reference to norms, 9 (45%) of the Indians felt that these were important, 3 (15%) of the Blacks agreed, and 10 (50%) of the White subjects. Values were identified as important by 8 (40%) of the Indian subjects, 7 (35%) of the Black subjects, and 8 (40%) of the White subjects. There were 9 (45%) White subjects who said that culture did not make a difference, while only 3 (15%) of each the Indian and Black subjects felt it was not important. Environment (air, land, pollution, etc.,) was identified by 7 (35%) of the Indian, 4 (20%) of the Black and 6 (30%) of the White subjects. Another theme identified by only the Indians subjects was
living in harmony with nature, which 4 (20%) of the Indian identified. Several subjects, 6 (30%) Indians, 7 (35%) Blacks and 5 (25%) Whites, identified factors such as discrimination, prejudice and oppression as important in defining mental health.

In response to this question it is interesting to note that several of the Indian subjects made statements indicating that all of these factors were related in defining mental health. As on Indian subject stated, "Family is the greater part of physical and mental health." Another Indian subject said:

Indians have always been taught not to destroy nature. We take nature as a whole, and have it work for us as we work with it. We can't change it, so therefore work with it...Good mental health starts with the food you eat, the way it is cooked and the kinds of chemicals that are used today in food affects mental health. Chemicals can effect food which affect mental health.

Another Indian subject said, "The community takes over where the influence of the family stops. Support from your community will help you try things you otherwise might not try." Community so it seems, is an extension of the family, within the Indian community. As one Indian subject said, "It provides you with a sense of belonging, being part of something" Another Indian subject said, "The community is like an extended family. The two work together." Another Indian subjects said:
Culture has a lot to do with maintaining family style. Family styles don't disappear easily, bonds of religion, education, teachings tends to solidify family. Any kind of abnormality that occurs in that situation would be a mental health problem.

Several of the Indian subjects discussed various changes (i.e., economic, cultural, industrial, social) that are taking place in the county and the effects as these changes take place. Several Indian subjects stated that they were losing their identity and that was contributing to mental health problems. One Indian subject said, "Technology has a tendency to cause a family to be dysfunctional, information changes the behavior of people." In reference to community, there appears to be a greater sense of community among Indians than Whites or Blacks. Mainly because the Indian community can be more clearly defined with physical and psychological boundaries. Another Indian subject in discussing psychological changes stated, "There are demands upon us that we (Indians) survive in the large society and at the same time retain our Indian identity."

Similar responses were found among the White and Black subjects. One Black subject said, "Family is the strongest support system. What you are around (sic) is what you tend to learn." Another Black subject said, "When you are part of a community there is a sense of oneness or a feeling of commonality. That is extremely important." Another said, "Family helps your feel good about yourself..." The White subjects also indicated that
family and environment were important to mental health. However, it is interesting to note most of the White subjects indicated that family was important in learning how to cope with and solve problems, as opposed to the Indian and Black subjects. For example, one White subject said, "Family is most important. If your family has mental illness you will have those problems." While subjects in all three racial groups indicated that behavior is learned and that each individual is a product of their environment, this was emphasized more by the White subjects.

During the past several years, there has been much debate about using the insanity plea as a defense stance when individuals have committed serious crimes. As the number of serious offenses increase, so does the use of the insanity plea as an excuse for committing the crimes. To learn more about how the subjects felt about using the insanity plea as a defense, the subjects were told, "There has been a growing use of the insanity plea and blaming mental health problems for crimes. Would you agree or disagree that people who commit crimes are mentally ill? Why?" The responses to this issue can be seen in Table 20.
Table 20

Subjects' Views About Employing the of Insanity Plea In Defining Mental Health

<table>
<thead>
<tr>
<th>Response</th>
<th>Indian n</th>
<th>%</th>
<th>Black n</th>
<th>%</th>
<th>White n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>11</td>
<td>55</td>
<td>9</td>
<td>45</td>
<td>11</td>
<td>55</td>
</tr>
<tr>
<td>Disagree</td>
<td>5</td>
<td>25</td>
<td>7</td>
<td>35</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Unsure</td>
<td>4</td>
<td>20</td>
<td>4</td>
<td>20</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

Among the 20 White subjects, 11 (55%) agreed, 5 (20%) disagreed and 4 (20%) unsure. In regard to the Blacks subjects, (45%) agreed, 7 (35%) disagreed and 4 (20%) were unsure. Again, similar results were found among the Indian subjects, with 11 (55%) agreeing and 5 (25%) disagreeing and 4 (20%) who were unsure. For those who agreed, when asked why, the majority of all the subjects said that sometimes people do things for which they cannot be held responsible. As one Indian subject said:

> We live in a very complex, changing, unsettling society. There are many pressures on individuals today. Sometimes the pressures are greater than the individual, which can cause people to do strange and bizarre things.

However one White subject said, "Many people use the insanity plea as a 'cop-out' to avoid responsibility for their behavior or actions." A number of people said that whenever an individual commits a crime, regardless of the
circumstances, they should receive treatment, but that they are ultimately responsible for their behavior.

One of the most challenging issues today in the field of mental health is deinstitutionalization. As former mentally ill persons are returned to the community, they are confronted with many potential problems, none more serious than employment. In the past, the stigma that has been associated with mental illness has been an obstacle to employment. While the stigma has been reduced, it is still a problem for former mental ill person in seeking employment. To learn more this issue, the subjects were asked, "If you were an employer would you hire someone who has been mentally ill to work for you in a factory? on a farm? or in the school system?" The responses are in Table 21.
Table 21
Subjects' Views About Hiring a Formerly Mentally Ill Person for Employment

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td><strong>Factory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>65</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Unsure</td>
<td>5</td>
<td>25</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td><strong>Farm</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>75</td>
<td>14</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Unsure</td>
<td>4</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td><strong>School</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>70</td>
<td>11</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>

In response to factory work, 10 (50%) of the White subjects said yes and 10 (50%) were unsure. In reference to farm work, 11 (55%) said yes and 9 (45%) were unsure. The school question was more difficult for them to answer. While most would hire, the majority 13 (65%) would not as a teacher but perhaps in some other capacity as janitor,
maid, or cafeteria worker.

The Black subjects had similar responses with 12 (60%) saying yes to factory employment 4 (20%) said no and 4 (20%) saying they were unsure. In reference to farm employment 14 (70%) said yes 1 (5%) said no and 5 (25%) were unsure. However, in regard to school employment the Blacks were ambivalent also, with 11 (55%) saying no as a teacher and 9 (45%) saying to some other kind of employment in the school such as maid, janitor or cafeteria worker.

Among the 20 Indian subjects, 13 (65%) agreed they would hire someone to work in a factory, 1 (5%) said they would not and 6 (30%) were unsure. When asked about farm employment 15 (75%) said yes and 1 (5%) said no and 4 (20%) were unsure. The Indian subjects also expressed concern about hiring a former mentally ill individual in the school. While more than half 14 (70%) said they would hire a former mentally ill person for school employment, 10 (50%) said they would not hire that person in a teaching capacity. The remaining subjects said would consider that person for other positions such as janitor, maid or cafeteria.
Variations of Mental Health Definitions in Terms of Age, Gender, Wealth and Employment

These questions asked subjects to discuss mental health in terms of how age, gender and wealth influenced the definition of mental health. The researcher felt the information collected in regard to these areas would provide additional insight into how the definition of mental health is defined. Sometimes these are the criteria that is used to make distinction in the way people behave, attitudes developed, expectations and values.

The first question in this section was, "Do you think there is a difference between what is considered a mentally healthy rich person and a mentally healthy poor person?" Responses to this question can be seen in Table 22.

Table 22
Subjects' Views About Differences Between Mentally Healthy Rich and Poor Person

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>75</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>
In reference to this question there was a difference between the White subjects in comparison to the Black and Indian subjects. Less than half of the White subjects, 9 (45%), said yes, however, among the Black and Indian subjects the majority 15 (75%) in each group said yes. Of the remaining 11 White subjects 8 (40%) said no and 3 (15%) were unsure. Among the Black subjects 5 (25%) said no, 3 (15%) of the Indian subjects said no, and 2 (10%) were unsure. Among the Black and Indian subjects, most of them immediately stated that there was a definite difference. As one Indian subject stated, "When you have money, that makes all the difference. That is just as powerful a tool as the color of one's skin or one's ethnic background." As one White subject said, "Because of some of the unique characteristics in this county (economic, social, political, cultural) there is a double standard for rich people and for poor people." Another White professional pointed out that he, "did not believe that Robeson County was unusual in that respect but that was true for the country for a whole. People who have money also have the ability to more easily control or manipulate the circumstances around them."

Another issue that has received some attention in the area of mental health definition is age. There has been some discussion about how age affects mental health. To learn more about how the subjects felt about age as a factor in the definition of mental health, the subjects
were asked, "Do you think there is a difference between a mentally healthy old person and a mentally health poor person?" Table 23 presents the responses to this issue.

Table 23

Subjects' Views About the Difference of Age in The Definition of Mental Health

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n %</td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Yes</td>
<td>15 75</td>
<td>12 60</td>
<td>10 50</td>
</tr>
<tr>
<td>No</td>
<td>3 15</td>
<td>6 30</td>
<td>5 25</td>
</tr>
<tr>
<td>Unsure</td>
<td>2 10</td>
<td>2 10</td>
<td>5 25</td>
</tr>
<tr>
<td>Other</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Total</td>
<td>20 100</td>
<td>20 100</td>
<td>20 100</td>
</tr>
</tbody>
</table>

Again in this question, as the previous question, there was a difference between the White and non-White subject responses. Of the 20 White subjects, 10 (50%) said yes, 5 (25%) said no, and 5 (25%) were unsure. Of the 20 Black subjects 12, (60%) said yes, 6 (30%) said no, and 2 (10%) said they were unsure. Among the 20 Indian subjects 15 (75%) said yes, 3 (15%) said no, and 2 (10%) were unsure.

Among the minorities, and especially the Indian subjects, there seemed to be a greater difference in reference to age, with 15 (75%) of the subjects saying they felt there was a difference. There may be several reasons for this higher percentage among the minority populations and particularly among the Indian population.
One of the stronger values within the American Indian community is respect for the elderly (Red Horse, 1980). A number of Indian subjects seemed to indicate that part of the differences in responses to this question was the respect for Indian elders within the Lumbee community. A number of Indian subjects also indicated that wisdom was a factor in making a distinction between an old and a young person. There were a number of White and Black subjects who indicated that age does make a difference. One Black professional stated, "Society seems to have different expectations and overall standards of behavior for young people and for old people." The difference in expectations and standards of behavior, was a major factor for many of the subjects in saying there was a difference.

One White subject stated, "There is a difference in standards of behavior, expectation of people acting their age...In this society, we have clearly defined ways of behavior for each age group." This was expressed by many subjects who indicated that this attitude was prevalent in the country. Even though this was a general attitude, a number of Indian subjects also stated that within the Indian community, age was given respect. One Black subject stated, "As a society, we are more likely to tolerate extreme behaviors or unusual behaviors of an elder moreso than of a younger person." There were other factors that seemed to contribute to the perceived difference. For instance, in a youth-oriented society,
elderly people were thought of as having potentially more mental health problems. Overall, their view of life was perceived as being different.

As women continue to influence various social institutions and challenge "traditional" philosophy about their roles and responsibilities in society, they are beginning to question the mental health system, and the way and manner in which services are provided for them. This is happening at a time when the overall roles of women are drastically changing in society. To learn more about how the subjects felt about gender differences in the definition of mental health, they were asked the following question, "Do you think there is a difference between a mentally healthy woman and a mentally healthy man?" Responses to this question can be seen in Table 24.

Table 24
Subjects' Views About Gender Differences in The Definition of Mental Health

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian n</th>
<th>Black n</th>
<th>White n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8 40</td>
<td>9 45</td>
<td>9 45</td>
</tr>
<tr>
<td>No</td>
<td>6 30</td>
<td>9 45</td>
<td>5 25</td>
</tr>
<tr>
<td>Unsure</td>
<td>6 30</td>
<td>2 10</td>
<td>6 30</td>
</tr>
<tr>
<td>Other</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Total</td>
<td>20 100</td>
<td>20 100</td>
<td>20 100</td>
</tr>
</tbody>
</table>
As Table 24 shows, among the Indian subjects 8 (40%) said yes, 6 (30%) said no and 6 (30%) were unsure. With the Black subjects 9 (45%) said yes, 9 (45%) said no and 2 (10%) were unsure. Similar results were found among the White subjects, as 9 (45%) said yes, 5 (25%) said no and 6 (30%) were unsure. Slightly less than 50% of all the subjects of all three races said there was a difference between a mentally healthy woman and a mentally healthy man. As one White female subject said, "While we have made some progress in reducing sex discrimination and reducing double standards for men and women, there is still at least a perceived difference." Most subjects said that there was a double standard for men and women and this double standard had an influence on how mental health is defined. Another White male subject stated, "Clinically no but we do have a double standard of behavior for both sexes." Most stated it is still much more acceptable for a woman to show emotion (e.g., crying) to be indecisive, or to be dependent on a man. Several identified how roles are defined and assigned according to sex roles in our society. Even though most said that there was a double standard and that basically women were seen as the weaker sex, there were a number of individuals, especially women, who indicated that most women were much stronger mentally than most men.
As one Indian female subject said, "Women can deal with more stress than men." One Indian male subject stated, "I think there is a difference of expectations for men and women. Feelings of depression are more accepted among women than men. Violence is more accepted by men than women." An Indian woman stated:

Women are becoming assertive and have higher positions and are making more money. There is still the belief that the man should be the bread winner. However, overall there is no difference. But, the average person will say there is a difference.

One White female subject stated, "Men are taught they are superior. They make all the decisions and that they are the leaders (sic). Women are taught to follow men." Another White male subject added, "There is a double standard in emotions, dress, thoughts, actions, feelings, attitudes and values are very different between men and women."

According to a Black female subject, "People think there is a difference. Men are superior to women. Men do not do things like crying. Most women should be pampered." Another Black female subject said, "We do have certain expectations of men and women, and these expectations are different. If a woman is defined as an unfit mother, her children can be taken away, but the same is not necessarily true for men." When asked if a man and woman can express the same emotion, she replied, "I don't think so, a woman can cry and carry on but a man expressing the same emotions would be called, "a mamma's
boy or a weakling."

It should be noted that there was an unequal gender distribution in the population used in this study. This may account for the differences in relation to responses to this question.

Racial Variations in The Definition of Mental Health

This set of question gave the subjects the opportunity to discuss their perception of racial differences in the definition of mental health. As such, it sought to identify those differences that may be perceived as linked to race.

While all of the questions in the instrument are designed to elicit information about mental health definition on a cross-cultural basis, the researcher felt it necessary to ask specific questions that would require the subjects to compare the three racial groups in the definitions of mental health. Questions which asked for specific racial comparisons would provide the subjects the opportunity to think about mental health in relation to the three racial groups in the county.

The first question in this section asked, "Do you think there is a difference in the way the three racial groups in this county define mental health? If yes, what is the difference?" The responses to this question can be seen in Table 25.
Table 25

Subjects' Perceptions of Race Differences In Defining Mental Health

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response</strong></td>
<td><strong>n</strong></td>
<td><strong>%</strong></td>
<td><strong>n</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>70</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived differences in the definition of mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difference in problem definition and solution</td>
<td>3</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Difference in attitudes</td>
<td>6</td>
<td>30</td>
<td>4</td>
</tr>
<tr>
<td>Difference in values</td>
<td>5</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>Difference in behaviors</td>
<td>4</td>
<td>20</td>
<td>3</td>
</tr>
</tbody>
</table>

Among the 20 Indian subjects 14 (70%) said yes, 3 (15%) said no and 3 (15%) were unsure. This seemed to be a question about which most individuals felt strongly. Of the 20 Black subjects, 12 (60%) said yes, 4 (20%) said no and 4 (20%) were unsure. Of the 20 White subjects 10 (50%) said yes, 6 (30%) said no and 4 (20%) said they were unsure.
One White professional made the following statement:

Indians are quicker to settle with a gun or knife (sic) and this is socially acceptable. Got to show you mean business. Peers expect them not to let some walk over you. Black fight a lot with their spouse. The Indians divide sides, Whites argue and curse more often, more verbal. Black and Indians will turn to violence more often (sic).

Another White professional makes the following observation:

Mental health constitutes different things for different people and definitely the community. Behavioral patterns at funerals are examples. Black have very disruptive behaviors, almost hysterics. At Indian funerals, there is a sense of silence, the crowd is almost stoic. Ministers become emotional but not so much the family. White funerals are very emotional also. There seems to be more self-abuse in the Indian community.

The same person continues by saying that once he saw a young man with his head shaved, when he inquired about this, he discovered, the man had recently lost his brother and this was part of his grieving process. Another White subject said in reference to the Indian community, "There is an acceptance of pain and suffering and a need to work things out. Acting out these things may not be expected, but it is accepted." Many minority individuals appear to be accepting of unusual or different behavior because, as one minority person said, "You have to take into account the kind of life he has had." A White professional who has direct contact with all three races, said:
Students see these problems in their family, but are not able to do anything about them. Most of the family members seem to just ignore the problems. The accept that 'mama seems to have a drinking problem...Blacks and Whites seem to ask for help more often than Indians.

In reference to the above question, one Indian subject made the following statement, "In the Indian community, the behavior of the mental person (sic) would have to be more severe...before it would be recognized as a problem. Part of the difference is the level of tolerance." Another Indian subject commented along the same lines saying, "Minorities, Indians, would say mental health is for crazy people. They need to get in the church and turn their life over to Christ, there is a spiritual aspect." Several of the Indian subjects noted that because of the extended family aspect, they (Indians) will try to work on the problem in the family, if a mental health problem exist, before they will go to outside resources.

Many of the subjects in all three racial groups said Whites and Blacks would use the mental health center for help because they have become more aware of its existence. In reference to the Indians and the mental health center, one Indian subject said, "Even when they know about the mental health center, they will not use it." The subject goes on to say, "The whole process of intervention is defined differently for the Indian community. They feel they should be able to solve their problems without intervention." She further comments that when they do use
mental health services, they will request to see "one of my people."

Although most of the subjects felt there was a difference, it was very difficult to identify what that difference was in concrete terms. However, there were some very broad and vague areas that were identified as part of the difference, for example, the way problems are defined and solved. Many of the subjects said minority people, especially Indians, are much more prone to use violence to solve problems, rather than using verbal skills which would be much more practiced in the White community. A number of individuals, identified problems such as racism, prejudice, values, and religion as potential differences in the definition of mental health. One Black subject said, "It has to do with environment, culture, behaviors, definition of reality, definition of goals, values, attitudes, action feeling and ambition." Another Black subject said, "Whites are more concerned about mental health than mental illness. It is something minorities have not been concerned about." Another Black subject said, "I think the average White's definition of mental health would be different from the average Black or Indian. Because the White person has not been exposed to the added pressures, stresses and strain that minorities have encountered."
The tri-racial composition along with the political problems are contributing factors in defining mental health. Mental health has to be practical, and thus defined and exercised differently in a tri-racial community. Another Black subject said, "From a value perspective, it seems that competition is much stronger in the White community, the Indian community would be next and the Black community is less competitive."

The next question was, "Do you think there is a difference between a is considered a mentally healthy White, Black and Indian?" The responses to this question can be seen in Table 26.

Table 26

Subjects' Perceptions of Differences in Mentally Healthy White, Black and Indian

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>65</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>30</td>
<td>7</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>

Of the 20 White subjects 8 (40%) reported yes, 10 (50%) said no and 2 (10%) were unsure. In response to this question, 8 (40%) of the Black subjects said yes, 7 (35%) said no and 5 (25%) were unsure. In a much greater
contrast, more than half the Indian subjects 13 (65%) said yes, 6 (30%) said no and 1 (5%) was unsure.

It should be reported that all of those subjects in the three races who said no, were very strong in their position, saying that mental health/mental illness was the same for all people, regardless of one's culture, environment or skin color. Some went on to say that there is a need to de-emphasize the differences between races of people and try to find out or identify the similarities people have.

In reference to this question, one White subject made the following statement,

Biologically (all three races) they are the same, socially and culturally they are different. Blacks seem to more readily to accept illegitimacy and they take care of their elderly in their home. Whites, on the other hand, will not accept illegitimacy and, for the most part care of their elderly through institutional placements. Blacks and Indians view the elderly with respect, they have wisdom and knowledge and their families value that. They believe it is important to take care of them in their own environment.

Another White subject indicated foster care placements were easier in the Indian and Black community, "They are more family-oriented, there seems to be a stronger sense of sense of responsibility for each other."

Another Indian subject said, "Certain behaviors may be expressed in the Indian or Black community, whether normal or abnormal they will be accepted, but not in the White community. They will label you." Two Indian subjects indicated that an Indian may not get locked up
for drunkedness in Pembroke (the Indian town) but most likely would in Lumberton (the county seat, and a mostly White town). Another Black subject said,

It is difficult to identify what the differences are in real terms. Right now, I would say it has to do with differences in standards, expectations, pressure, attitudes, values, culture and norms. Minorities are more tolerant of behavior of minority people because perhaps, they understand why one would act that way.

Another Black subject said, "Levels of expectation of behaviors are higher for Whites than for Indians or Blacks."

The next question asked, "Do you think a larger percentage of White, Black or Indian are mentally ill?"

Responses to this question can be seen in Table 27.

Table 27

<table>
<thead>
<tr>
<th>Subjects' Views of Larger Percentage of Mental Illness Among The Three Racial Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racial Groups</td>
</tr>
<tr>
<td>----</td>
</tr>
<tr>
<td>Indians (more)</td>
</tr>
<tr>
<td>Black (more)</td>
</tr>
<tr>
<td>White (more)</td>
</tr>
<tr>
<td>Same/Equal</td>
</tr>
<tr>
<td>Unsure</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
In reference to this question, the Indian and White subjects had similar responses. Of the 20 Indian subjects 14 (70%) indicated that they felt there was no difference among the races in the prevalence of mental illness. However, 2 (10%) indicated that they perceived a higher percentage of mental illness among Indians and 3 (15%) among Black and 1 (5%) among Whites. Similar responses were found among the White subjects, 15 (75%) reporting no difference, 2 (10%) saying they believed Indians had a higher percentage of mental illness and 2 (10%) said Blacks and 1 (5%) unsure. Among the Black subjects 11 (55%) said they did not know 2 (10%) said Whites and 3 (15%) said Indians had a higher percentage of mental illness.

Many of the subjects indicated that most people would expect a larger percentage of minorities to be mentally ill. One White subject said, "I think a larger percentage of Blacks and Indians are mentally ill because of their treatment by the larger society. Their environments are not conducive to good mental health, because of racism, poverty and other problems." One Indian subject said, "Indians are more often diagnosed as mentally ill."

The next question was, "Do you think there are more mentally ill people than mentally healthy people in this county? Why? Do you think others would agree?"
Since there was complete agreement among all three racial groups the researcher decided a table was not necessary. While most of the subjects agreed that Robeson County had its share of mental health problems and mental illness, they were confident that there were more mentally healthy people than mentally ill people in the county. There was complete agreement (100%), among all three racial groups on this question. They also agreed unanimously, that others in the county would agree with them. When asked why, most said that the county would not be able to function effectively, if most of the residents were mentally ill.

The last question in this section was, "Do you think there is a difference in the perception of mental health between Whites, Blacks and Indians in this county? If so, what is the difference." The responses to this question can be seen in Table 28.
Table 28

Subjects Views About the Differences In The Perception of Mental Health Between an Indian, Black and White In The County

<table>
<thead>
<tr>
<th>Response</th>
<th>Indian n</th>
<th>%</th>
<th>Black n</th>
<th>%</th>
<th>White n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14</td>
<td>70</td>
<td>15</td>
<td>75</td>
<td>15</td>
<td>75</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>15</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
<td>15</td>
<td>4</td>
<td>20</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

In all three races, at least 70% of all the subjects said yes, with the Whites and Blacks 15 (75%) saying yes with 14 (70%) of the Indian subjects saying yes. The remaining White subjects 3 (15%) said no and 2 (10%) were unsure. One (5%) the Black subject said no and 4 (20%) were unsure. Of the remaining 6 Indian subjects 3 (15%) said no and 3 (15%) were unsure. Most of the subjects clearly indicated they were not able to identify what the difference was. However, as one Indian subject said:

Whites are more concerned with status, leadership, economic status and educational attainment, material possession and wealth. Indians are more with social functions, church attendance, not overly concerned with material possession. Blacks not sure (sic).
One of the Indian subjects stated, "Even though I would say yes, I'm not sure I can explain what that difference is. Perhaps it is in values, behaviors, attitudes and just different ways of doing things". Very few of the subjects could identify any particular criteria for the answer they gave, except to say they felt that there was a difference.

Causes of Mental Illness

Even though this study is primarily investigating mental health, the researcher though it would be interesting and relevant to the study to explore what the subjects considered to be the primary causes of mental illness. In keeping with the overall framework of this study the following question was asked, "What causes mental illness?" Answers provided by all three races were similar. Table 29 gives the variety of answers provided to this question.
Table 29
Subjects' Views About Causes of Mental Illness

<table>
<thead>
<tr>
<th>Categories of Causes</th>
<th>Indian n</th>
<th>Indian %</th>
<th>Black n</th>
<th>Black %</th>
<th>White n</th>
<th>White %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic</td>
<td>4</td>
<td>20</td>
<td>6</td>
<td>30</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>Evil spirit, demon possessed</td>
<td>5</td>
<td>20</td>
<td>5</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Drugs, alcohol</td>
<td>16</td>
<td>80</td>
<td>3</td>
<td>15</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Environment (poverty, racism family problems)</td>
<td>8</td>
<td>40</td>
<td>17</td>
<td>85</td>
<td>11</td>
<td>55</td>
</tr>
<tr>
<td>Childhood experiences</td>
<td>3</td>
<td>15</td>
<td>4</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure, stress, tension</td>
<td>5</td>
<td>25</td>
<td>10</td>
<td>50</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Changing society</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Depression</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>10</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

It should be noted that most subjects gave more than one answer to this question, as they felt that mental illness could be caused by more than one factor. In reviewing the table, it is obvious that most of the subjects felt that environmental factors were a major factor in causing mental health problems. Specifically, the subjects identified such factors as stress, racism, drug and alcohol abuse, unemployment and a changing society. Several subjects in all three races identified genetics or inheritance as a cause for mental illness. It should be noted that among the Black and Indian subjects 5 (25%) felt that evil spirits, demon possession and belief systems could cause mental health problems.
Belief In The Treatment Techniques of the Formal Mental Health System

This set of questions was designed to elicit information about subjects' perceptions of the mental health system in treating mental health problems. There is a great deal of concern about the ability of the mental health system to provide effective mental health services in helping mentally ill patients recover from mental illness. To learn more about how the subjects felt about this issue they were asked the following question, "Can a person ever completely recover from mental illness?"

Table 30 presents the responses to this question.

Table 30
Subjects' Views About Complete Recovery From Mental Illness

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th></th>
<th>Black</th>
<th></th>
<th>White</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>75</td>
<td>10</td>
<td>50</td>
<td>14</td>
<td>70</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>15</td>
<td>5</td>
<td>25</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>10</td>
<td>5</td>
<td>25</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

In response to this question 14 (70%) of the White subjects said yes, 3 (15%) said no and 3 (15%) were unsure. However, among the Black subjects 10 (50%) said yes with 5 (25%) saying no and 5 (25%) were unsure. In a
contrast to the Black subjects, but more like the White subjects, 15 (75%) of the Indian subjects said yes, 3 (15%) said no, and 2 (10%) were unsure. Most of the subjects felt individuals who had mental health problems could recover. As one white subject said, "I believe people can recover from mental problems, but I think they need some help." Most of the subjects felt it was necessary for some kind of intervention to take place before the person could have a full recovery. Most felt it was necessary to see some kind of professional, or at least talk to someone.

As identified earlier, the issue of stigma was identified again in relation to this question. One subject said:

In the Indian community, once you enter through those doors (mental health center), you have been labeled by the Indian community. That is a label, a stigma, you will carry for the rest of your life. For some reason, the Indian community does not allow you to re-enter the community and assume your previous status.

While there may be a number of reasons for the stigma, perhaps some of it might be, as suggested by one of the Indian subjects, "that mental health is a new concept in the Indian community. It is something that most people are not very familiar with." To a certain extent, the researcher feels that because the mental health center is relatively new and not completely accepted by the Indian community, fear of the unknown contributes to the stigma.
The next two questions were asked in reference to the treatment of mental health problems or mental illness. The first question was, "Do you think drugs can be used to cure mental illness?" The responses to this question can be seen in Table 31.

Table 31

Subjects' Views About The Ability of Drugs To Cure Mental Illness

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>85</td>
<td>14</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>

As with other questions, the responses to this question were very similar among all three races. There seems to be a consistency in the belief that drugs alone cannot cure mental illness. Of the 20 White subjects 3 (15%) said yes, 15 (75%) said no and 2 (10%) were unsure. Among the Indian subjects, 4 (20%) said yes and 14 (70%) said no and 2 (10%) were unsure. Among the Black subjects 1 (5%) said yes, 17 (85%) said no and 2 (10%) said they were unsure about whether drugs could be used to cure mental illness. Most of the subjects appear to have very little hope that drugs can cure mental illness. As one
Indian subject said, "Sometime this is the very problem we are dealing with and trying to control." Another White subject said, "It appears that a number of drugs have been used successfully in the treatment of mental illness, but most people do not believe that drugs can cure mental illness." Another Indian subject said, "Most people believe drugs may help in the cure and treatment of mental illness, but they are limited in their ability to cure mental illness. As long as a person is on drugs, they can be controlled but that does not solve the problem."

Another Indian subject said, "Most Indian people do not use the system (mental health) very much. Very few would believe that drugs could be used to cure mental illness."

The next question was, "Do you think drugs can be used treat mental illness?" Responses can be seen in Table 32.

Table 32
Belief In Drugs Treating Mental Illness

<table>
<thead>
<tr>
<th>Response</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>10 50</td>
<td>10 50</td>
<td>12 60</td>
</tr>
<tr>
<td>No</td>
<td>7 35</td>
<td>9 45</td>
<td>0 0</td>
</tr>
<tr>
<td>Unsure</td>
<td>3 15</td>
<td>1 5</td>
<td>8 40</td>
</tr>
<tr>
<td>Other</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Total</td>
<td>20 100</td>
<td>20 100</td>
<td>20 100</td>
</tr>
</tbody>
</table>
Again, the answers were similar by all three races. However, the answers are quite different from the previous question. The responses of the White subjects were as follows: 12 (60%) said yes and 8 (40%) were unsure. Among the Black subjects 10 (50%) said yes, 9 (45%) said no and 1 (5%) was unsure. Similar results were found among the Indian subjects, 10 (50%) saying yes 7 (35%) said no and 3 (15%) were unsure. Among all three races at least 50% of all the subjects reported a belief in the use of drugs in the treating of mental illness. There was a difference in the "no" and "unsure" responses between the White and non-White subjects. It is interesting to note that none of the White subjects said no to this question, in contrast to the non-White subjects. Most of the subjects did not feel drugs could be used to treat mental illness. However, many of the subjects felt drugs could be used in conjunction with other forms of treatment. One Indian subject said, "Probably no one form of treatment can be used in treating or curing mental illness, especially severe mental health problems." There seems to be much skepticism about the use of drugs in treating and curing mental illness.
**Subjects' Feelings about Usefullness of This Kind of Research**

The last two questions were asked to investigate how the subjects felt about this kind mental health research in this county. This was an important question, given that not much has been done in the area of mental health research. Responses to this question are in table 33.

**Table 33**

**Subjects' Views About the Worthiness of This Study**

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response</strong></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
<td>90</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>

The question was, "Do you think this is a worthwhile study?" Responses to this question can be seen in Table 34. It seems clear from the responses that this is an area of concern for the residents of Robeson County. In all three groups, at least 75% of the subjects indicated the usefulness and need for this kind of research. More than half 15 (75%) of the White subjects said yes and 5 (25%) said they were unsure. The same results were found for the Black subjects. However, among the Indian
subjects, a stronger positive response was given, with 18 (90%) saying yes and 2 (10%) saying that they were unsure. Even though not all of the subjects said yes, none of them said no. Many of the subjects, indicated that mental health/mental illness was still a 'taboo' subject in the county. This was especially true for the Indian subjects. As one Indian subject said, "One of the ways we will overcome this fear of mental health/mental illness is to talk about it and to learn more about mental health." One White subject said:

Robeson County is making a lot of progress in terms of social, economic, industrial, and technological improvement, however in the area of both physical and mental health there remains much to be done. This is especially true for mental health. For so long it has been a 'taboo subject' especially among the minority community. It is gratifying to know that research is being conducted in this area, especially by someone from the area.

Several subjects indicated that they felt that mental health was different for the three races, yet this in not reflected in the mental health system. Most of the subjects indicated a need for professional investigations into the area of defining mental health for the three races.

The researcher attempted to develop an instrument that would identify a number of issues that may influence the way mental health is defined. Realizing that there are limitations with the instrument, the last question was designed to give each subject the opportunity to identify any issues, concerns they might have that were not
addressed in the interview. Therefore the following question was asked, "Is there anything else that you would like to say about the issue of mental health that is relevant in this county, that was not addressed in the previous question?" The responses to this question can be seen in Table 34.

Table 34

Subjects' Identification of Issues, Concerns Not Addressed In The Interview

<table>
<thead>
<tr>
<th>Racial Groups</th>
<th>Indian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n  %</td>
<td>n  %</td>
<td>n  %</td>
</tr>
<tr>
<td>Yes</td>
<td>5  25</td>
<td>4  20</td>
<td>5  25</td>
</tr>
<tr>
<td>No</td>
<td>15  75</td>
<td>16  80</td>
<td>15  80</td>
</tr>
<tr>
<td>Unsure</td>
<td>0   0</td>
<td>0   0</td>
<td>0   0</td>
</tr>
<tr>
<td>Other</td>
<td>0   0</td>
<td>0   0</td>
<td>0   0</td>
</tr>
<tr>
<td>Total</td>
<td>20  100</td>
<td>20 100</td>
<td>20 100</td>
</tr>
</tbody>
</table>

As Table 34 indicates of the 20 Indian subjects, 5 (25%) said yes and 15 (75%) said no. Similar results were found among the Black and White subjects. Of the 20 Black subjects, 5 (25%) said yes and 15 (75%) said no, 5 (75%) of White subjects said no and 15 (75%) said no. The responses were for the most part reiterations of earlier statements about the need for this kind of research and the need for more attention in the area of mental health.
By this point in the interview, most of the subjects seem to be tired and ready to terminate the interview. It should be noted that during the interview, on several occasions the subjects indicated a need and an expressed interest in mental health research. One Indian subject said, "I think it's a problem that needs some attention. We need to find out more about how different people define mental health." A White subject stated, "The data would be beneficial for human service agencies such as social service, mental health, school, etc". Several of the Black subjects indicated a need to learn more about mental health and mental illness. It is interesting to note that one Black subject said, "Most people do not know much about it. There are usually more pressing problems that get attention such as hunger, housing, and physical health."

A number of subjects indicated the need for more education in the area of mental illness/mental health to reduce the stigma that is attached to it. Along those lines several subjects also noted the need to learn more about mental health, particularly in this county because of its unique tri-racial make-up.
Chapter Summary

This chapter has presented the findings for this study. The analysis revealed a number of themes that were identified by the subjects in their definition of mental health. To provide some organization to the findings and for the presentation of the findings the major themes were placed under sub-headings with a discussion following.

The is primarily a qualitative study. However, to properly present the data qualitative and quantitative methods were employed. The qualitative data have presented in the form of tables for each question. A discussion of each table was presented to highlight the major themes for each question. In an effort of enhance and enrich and discussion of each table and to present the qualitative data, quotes were extracted from the taped interviews and were included in the discussion. The researcher attempted to identify quotes that would enhance the discussion of the tables and at the same time focus on those themes that were not in the tables.
1. For many of the questions the subjects gave more than one response. Therefore, the total number of responses exceeded the total number of subjects. The researcher decided not to include total for those tables.
CHAPTER VI

INTERPRETATION AND DISCUSSION OF DATA

This chapter presents a discussion of the findings of this study. The objective of the study, as stated in Chapter I, is to determine how mental health is defined by the Lumbee Indian community in Robeson County, North Carolina. To determine the specific definition of Lumbee Indian mental health, data were collected on all three major racial groups in the study site. This discussion will therefore focus on a comparative analysis of how the Lumbee Indian subjects defined mental health in relation to the Black and White subjects. To maintain consistency, the discussion will follow as much as possible, the format used in analyzing the data. A number of major themes were extracted from the data and are presented in this discussion. To enhance the discussion and interpretation of data, direct quotes have been selected from the interviews and are included.

This study utilizes the behavioral-ecological perspective as the theoretical guide for studying the definition of mental health. Specifically, this perspective is employed in an effort to specify how mental health is defined within the racial environments of the studied populations, particularly the Lumbee Indians.
The discussion presented is based on the major research questions in Chapter I and the examination and analysis of the data in Chapter V. Briefly stated, the research questions focused on: 1) identifying the Lumbee Indian definition of mental health, 2) identifying the Black definition of mental health, 3) identifying the White definition of mental health 4) identifying the major differences and similarities between the Indian and Black definitions of mental health 5) identifying the major differences and similarities between the Indian and White definitions of mental health.

As stated in Chapter IV, a questionnaire/interview guide was developed to collect the data from the 60 subjects. The development of the questionnaire which contained 31 open-ended questions, was guided by the behavioral-ecological perspective. The questions were constructed specifically to elicit the definitions of mental health from the three racial groups represented in the study.

The findings of this study are quite varied and encompassing. This is not surprising given the wide range of mental health topics, issues and concerns that were addressed in each interview. Some of the findings were directly related to the definition of mental health; others were not. In an effort to provide some organization and clarity to these findings, this chapter has been divided into two sections. The first section
presents those findings that directly relate to the definition of mental health. The second section presents other findings that are not directly related to mental health definition, but were identified as important by the subjects in promoting and understanding mental health in Robeson County, North Carolina. Even though the findings have been divided for discussion purposes, the Overview of Findings will discuss all the major findings, both those related to the definition of mental health and those related to the promotion of mental health.

DISCUSSION OF COMPARATIVE ANALYSIS OF THE THREE RACIAL GROUPS' DEFINITION OF MENTAL HEALTH

This discussion will focus on comparing and contrasting the Lumbee Indian definition of mental health with the Black and White definitions of mental health. The remainder of the discussion will focus on the various themes identified in the data that contribute to the definition as well as the differences in the way mental health is defined by the three racial groups in the study.

Overview of Findings

This study found that there were differences as well as similarities in the way mental health was defined by the three racial groups. Although similar themes were identified by all three racial groups, there were varying degrees of emphasis that each group placed on these themes
in its definition of mental health. The various themes addressed in this discussion are as follows:

- Variations in the definitions of socially deviant behavior
- Confusion between mental health and mental illness
- Level of tolerance for behaviors
- Mind/body holism
- Status effects of age, gender, wealth and employment on the definition of mental health
- Racial variations in mental health definitions
- Mental health support systems
- Lumbee Indian elders
- The importance of family, community and environment in the promotion of mental health
- Causes of mental illness
- Belief in treatment techniques of the modern mental health system
- Respondents' feelings about the value and usefulness of this research study

The Lumbee subjects identified several themes that they perceived to be influential in their definitions of mental health. In an attempt to define mental health, the subjects identified the following manifestations of mental health: something is wrong with the mind, the person is weak, or the brain was not functioning properly. As such, there appeared to be an emphasis on factors that were psycho-dynamic.

There were four Indian subjects that identified positive aspects of mental health definition. These responses were: socially well adjusted to the environment, function within standards of society, well adjusted to family and friends, and "level-headed."
A major theme identified as influential in the promotion of mental health by the Lumbee Indian subjects was the role and influence of the extended family. This was not a surprising finding given that research has highlighted the importance of family within American Indian communities. The Lumbee Indians specifically identified the influence of elders in their discussions of mental health. While there may not be a direct link between mental health definition and family, particularly Indian elders, the Indian subjects nonetheless placed importance on these factors in their discussions of mental health.

Equally important in the promotion of mental health was the emphasis placed on community as identified by the Indian subjects. The term "community" was never clearly defined by the Indian subjects in this study. However, based on the data collected from the Indian subjects, community appeared to be defined as a psychological sense of belonging, established by ethnic identification as a member of the Lumbee Indian tribe. It is rather clear that from the Lumbee Indian perspective, there exists a distinction between the Lumbee Indian community which may be referred to as the "in group" and the larger society referred to as the "out group."
The Lumbee subjects also made several references to nature in their discussion of mental health definition. The subjects identified such factors as air, land, and water as important. This indicates that for the Lumbee Indians, the definition of mental health evolves from the whole of the social and physical environment.

Another major finding in the definition of mental health within the Lumbee Indian community was a high level of tolerance for behavior. The Lumbee Indians clearly felt that there was a greater level of tolerance for behavior within their community as opposed to the Black and White communities. This higher level of tolerance appears to provide greater independence for expression of behavior within the Lumbee Indian community.

One of the major ways mental health is promoted and maintained within the Lumbee Indian community is through the use of natural support systems (e.g., extended family members, clergy, and community leaders). The Lumbee Indians appear to rely heavily on these resources within their community to resolve problems.

Another interesting finding/theme in regard to the Lumbee Indian definition of mental health was mind/body holism. In their discussions of mental health, the Lumbee Indians often referred to a linkage between physical and mental health.
The Black subjects identified themes that were similar in some respects but different in others, to those of the Indian subjects. The Black subjects emphasized mental illness, rather than mental health when describing the term mental health. For example, the Black subjects identified such factors as being unable to control one's self; being weak; disease; or acting against the norm as descriptions of mental health.

The Black subjects were similar to the Indian subjects in that a high level of tolerance was identified in their community. However, the level of tolerance was not found to be as high as was identified in the Indian community. The Black subjects, like the Lumbee Indian subjects, agreed that the criteria by which behavior is defined as being acceptable/unacceptable was more clearly defined within the White community, than in the Indian or Black communities. As such, the level of tolerance for "abnormal" behavior was thought to be more restricted within the White community by both the Blacks and the Lumbee Indians.

The influence of the family, and community was also deemed important to the Black subjects in their discussions of mental health, but not to the extent as identified by the Lumbee Indians subjects. The Lumbee Indian subjects appeared to place much more importance on Indian elders within the community. The Black subjects indicated respect for their elders, but did not imply any
particular existence of roles for the elderly in either the definition formation or promotion of mental health within the Black community.

Like the Lumbee Indian subjects, the Black subjects identified using informal support systems in resolving mental health problems. However, it was found that the Blacks were also likely to use the formal mental health system, as were the White subjects.

The White subjects identified positive aspects in their definition of mental health. Along these lines the White subjects identified competence skills such as: adjustment to environment; controlling emotions; solving problems; and living with the rules and norms of society as themes that defined mental health. Like the other two races the White subjects indicated that family, community and environment were important but apparently not as important as identified by the Indians and Black subjects. The White subjects like the Black subjects, did not indicate any particular importance to elders in either defining or promoting mental health.

In addition, most of the White subjects indicated deviant behavior was more clearly defined in the White community than in the minority communities especially, the Indian community. There was also a much greater emphasis on using the formal mental health system for help by the White subjects, as opposed to the Indian subjects and to a lesser extent the Black subjects.
Variations in the Identification of Social Problems By The Three Racial Groups

Several questions asked whether such problems as alcoholism, crime, spouse abuse, the use of guns and "fist fights" would be identified as mental health problems. The results indicate that subjects of all racial groups agreed that most of these problems would be identified as mental health problems. A number of Indian subjects however, qualified their answers to the above issues. Most felt that while they personally would probably agree that the above problems would be considered mental health problems, they were not sure that the Indian community as a whole would agree. The researcher notes here that it is not possible to determine whether these were honest answers or if the subjects gave responses that they felt would be acceptable.

In relation to the above social problems, there was one question to which the Indian subjects' responses differed from the Black and White subjects. The Lumbee Indian subjects did not feel that "fist fights" are an indication of a mental health problem. There appears to be a belief in the Indian community that the use of physical force is a way of solving problems. In contrast, the Black and White subjects agreed that engaging in a "fist fight" was an indication of a mental health problem. One Indian subject said, "There are a lot of Indians that
feel this can be one way of resolving a difference."
Another Indian subject said, "There is a frontier
atmosphere here, that is strong in the Indian community.
In many ways, it is still acceptable to solve differences
by engaging in fist fights."

**Apparent Confusion Between Mental Health and Mental Illness**

One of the most important themes among all three
population groups was the apparent confusion between the
concepts of mental health and mental illness. This was
particularly true among the Black and Indian subjects. It
appears, that many of the Indian and Black subjects do not
make a distinction between mental health and mental
illness, that these two concepts are used interchangeably
within both communities. The researcher is careful to
point out that perhaps there is not confusion, but that
the Indians and Blacks have different approaches to
defining mental health. As one Indian subject said, "Most
Indian people do not make a distinction between mental
health and mental illness. When the issue is discussed
most people think in terms of mental illness."

There were a variety of answers that were provided to
question seven. The question asked, "How do you think
most people around here would describe mental health?"
Based on the responses, many of the Indian and White
subjects addressed mental illness and mental health giving
many of each type of responses. The Black subjects did not respond to the question of mental health; they spoke in terms of mental illness exclusively.

A number of respondents identified positive aspects of mental health. The majority of these responses were given by the White subjects; however, several Lumbee Indian subjects identified similar themes of positive mental health. Some of these were: being able to solve problems; coping with one's environment; getting along with other people; establishing goals and having a sense of purpose in life.

The review of the literature found that several studies uncovered definitions of mental health that were similar to the definitions identified by the subjects particularly the White subjects in this study. Jahoda (1955) identified 6 categories of mental health that were similar to the findings in this study, such as the attitude of individual toward himself; autonomy; perception of reality and environmental mastery. Along these lines Frank (1953), characterized a mentally health person as someone who continues to grow, develop, and mature through life; someone who can accept responsibility and participates in the maintenance of social order and carrying on the culture. Offer and Sabshin (1966) made reference to factors such as knowledge of one's self; absence of illness; disability or pain in defining mental health. Maslow and Mittleman (1951) cited a number of
manifestations of psychological health (e.g., life goals, satisfying group requirements, sufficient contact with reality, adequate feelings of reality and ability to learn from experiences) that are similar to the manifestations of mental health identified by the subjects in this study. In further support of the findings of this study, English and Pearson (1963), envisioned a mature person as someone who is able to work without undue pain; able to conquer guilt and indecision; able to alternate between work and play; dependable; open-minded and able to love and be affectionate with friends. Many of the White and Lumbee Indian subjects in this study identified similar themes in their definitions of mental health.

In contrast, many of the Indian subjects were much more psycho-dynamic in their orientation to the definition of mental health. Mental health was defined by the Indian subjects as: something wrong with thinking processes; the brain not functioning properly; personal weakness; or something wrong with the brain.

Although there is not empirical support in the literature for the findings in relation to the way the way the Lumbee Indians defined mental health, this is because the literature indicates that the definition of mental health remains to the "worked out" and defined. As one Indian subject stated, "Mental health is a new concept within the Indian community. Therefore, most people really do not know what mental health means." Sharp
(1983) indicates that mental health is a new concept in the Indian community, and consequently it is not something with which the Indian community is familiar. Sharp (1983) goes on to say "that mental health is the feelings, thoughts, actions, and relationships that a person has about himself and with others and how he gets along with others" (p. 99). Some of the findings in relation to the Lumbee definition of mental health seems to support this statement of how American Indians define mental health.

As previously stated, the Black responses emphasized mental illness rather than mental health. For example, the Black subjects identified such factors as being unable to control one's self; being weak; cannot cope with life; disease; and acting against the norm. This further supports the confusion in the general population in relation to these two concepts. The apparent confusion between mental health and mental illness is shared by the general society. Gallagher (1981) presents a rather lengthy discussion about the difficulty in discussing mental health and mental illness. He further contends even among the mental health professional community there is much confusion and disagreement about what constitutes mental health and the difference between mental health and mental illness.
In addition, several of the Black and Indian subjects indicated that most people do not think about mental health concerns because they were pre-occupied with physical health problems. As one Black subject said, "Most people around here, especially the Indians and Blacks, don't have to worry about mental health because we are more concerned with other health problems."

It is worth noting that in an effort to discuss mental health, several subjects made references to a building, or facility or place. This could refer to the community mental health center located in the county. Although this structure is not contributing directly to the definition of mental health, the finding is nonetheless interesting. It appears that, for the general population, the definition of mental health remains very vague and elusive. Reference to a building gives substance to the abstract idea.

Tolerance

Subjects were asked about behaviors which they perceived to be indicators of mental illness. One of the most interesting and important findings of this study was that there appears to be a more flexible attitude and a wider span of acceptable behavior within the Lumbee Indian community than was identified within the White or Black communities. This suggests that the concepts of "normal" and "abnormal" appear to have different meanings for the
Lumbee Indians than for the Whites and possibly for the Blacks. The results of this study indicate a greater agreement between the Lumbee Indian and Black communities in the definition of mental health.

This finding was supported by all three racial groups. Although several subjects identified a higher level of tolerance within the Black community, the subjects were quick to point out that the Black community does not appear to be as tolerant as the Lumbee Indian community. The Lumbee Indian community appeared to allow for a wider variety of behaviors in which feelings could be expressed without determining or labeling those behaviors as negative or unacceptable. For example, several subjects indicated that an Indian who was drunk would be less accepted in the White community than in the Indian community, and that he/she would have a greater chance of being incarcerated in the White community than in the Lumbee Indian community. In addition, a White subject related an experience of seeing an Indian man who had shaved his head as an expression of grief. By talking with other Lumbee Indians, he discovered that although this was not necessarily an expected or routine part of the grieving process, this kind of behavior was accepted when an individual felt the need to mourn in this or other ways. One Indian subject said, "The Lumbees just seem to have a higher level of tolerance for behavior that otherwise might be considered 'abnormal' by the standards
of the larger society." Several Lumbee Indian subjects stated that when these behaviors were expressed in the larger environment, there was a greater chance that they would be misunderstood and inappropriately labeled as pathological. This indicates that the criteria and value system used by the Lumbee Indian community for defining and evaluating behavior as appropriate or inappropriate is different from those employed in the larger society.

Assuming that the level of tolerance is indeed higher within the Lumbee Indian community, this definitely has a profound impact on how mental health, as well as mental illness, is defined by the Indian community, and how mental health services are conceptualized and subsequently delivered. Thus, there is a need to identify the criteria and perhaps the value systems that are used within the Lumbee Indian community to evaluate behavior. By understanding the environment in which behavior occurs, actions can be culturally assessed and appropriate interventions provided.

The need to culturally understand behavior is supported by the behavioral-ecological perspective which emphasizes the necessity to evaluate behavior within the cultural context in which it is expressed. This theory states that when behavior is evaluated outside the cultural environment in which it is expressed, there is often an incongruence, a mismatch between the person and environment. This perspective further emphasizes the
transactional influence of the person-environment "fit."
As such, there are neither "good" nor "bad" persons,
"good" nor "bad" environments; but, rather a congruence or incongruence between the individual and the environment.
In addition, such incongruence also influences how other systems (e.g., family, religion, government, education) within the individual's ecological niche or transactional field will be affected (Spiegel and Papajohn, 1975).

Thus, according to the behavioral-ecological perspective, behavior must be culturally understood in the environment within which it is demonstrated in order to be judged properly. Furthermore, in determining whether a particular behavior is labeled "good" or "bad," one must first examine the ecological niche of the person. The culture or society doing the labelling may not use the culture of the individual but rather their own culture to evaluate behavior.

Environment-and-Behavior Field is a major stream of the behavioral-ecological perspective. This stream is formed through the merging of the ecological psychology and environmental psychology. Ecological psychology focuses on naturalistic observation with implications for a psychological sense of community. The emphasis is on ecological interventions which aim "to involve local member of a community in the control of their own social institutions" (Pappaport, 1977, p. 145).
Ecological interventions can take place at the individual or agency level. Baker (1978) notes that "knowledge of a community's behavior settings should be a strong weapon in the armory of those professionals who counsel individual persons" (p. 287). To provide effective culturally relevant, culturally appropriate, non-class bound mental health services, practitioners must be aware of the "behavioral range" of an individual or group of persons. This study found that there are differences in the various behaviors that are accepted by the Lumbee Indian community.

To further the understanding of the operationalization of this perspective in this study, incorporation of some of the literature is useful. Thomas (1980) discusses deviance within Indian communities. He states that there is much support for a permissive attitude within the Indian community. This further supports the idea of transactional influence of the person-environment "fit" in relation to understanding behavior. Individuals are permitted to express "non-conformist" behavior because tribes do not seem to operate from the ideological perspective of the larger society. Because of this there is opportunity for individuals to express a wide span of behaviors within their environment. Behavior, as it expressed within the Lumbee Indian community, is generally consistent with the
environment because the environment allows for a greater expression and acceptance of behavior within that particular culture. Therefore, within the boundaries of the Indian community, the person-environment "fit" is achieved and there is congruence. The Indian community therefore, employs flexibility by looking to the environment to meet the needs of the individual, rather than forcing that individual to conform to the needs of larger environment. However, once these same behaviors are expressed in a multi-cultural environment, discord often occurs.

It is possible that a greater sense of independence exists within the Indian community than in either the White or Black communities. Sharp (1983) and others indicate that Indian communities do not operate from an ideological perspective and thus there is not pressure for individuals to conform to a particular standard of behavior. The findings of this study indicate that the Lumbee Indian community (and to a certain extent the Black community) does not demand that the individual conform to the set of norms that are established by the larger society. Behaviors which are defined as being acceptable within the Lumbee Indian community are not tolerated by the larger society. This implies that there are not universal definitions for determining and evaluating behavior as well as the definition of mental health. The environment influences the definition of behavior and
consequently how mental health is defined. The work of Benedict (1934), Horney (1932), and others discuss the influence of environment and culture in evaluating behavior. These studies appear to support the findings of this study.

In discussing "normal" behaviors within the Lumbee Indian community, Thomas (1982) identifies "a paranoid component" in most American Indian communities. This "paranoia" can partly be explained by the close relationships that exists within American Indian communities. Thomas (1982) states, "If you're that cued into your relatives you are going to be a little paranoid" (p. 101). He does not believe that this paranoia poses major problems for those communities. Along these same lines, some psychiatrists have suggested that "there seem to be a schizophrenic component, too, in Indian behavior" (Thomas, 1982, p. 101). Thomas (1982) however, suggests that this is a grave error; a bad observation. Indians are encouraged to get along with their kinfolks. This encourages their behavior to be "laid back" with an emphasis on observation. So what appears to the non-Indian observer be catatonic behavior is misobservation. Tribal Indians, may be low key and low cue people, but not catonic. Thomas (1982) further indicates this is normal in such a personality and culture.
Assuming there is a difference in the level of tolerance, this raises some interesting questions about when the level of tolerance reaches its capacity within the Indian community and what intervention might be used. In further exploration of the level of tolerance phenomenon, the researcher attempted to determine the point at which intervention becomes necessary and who decides when to intervene. In spite of efforts to define the point of intervention, the researcher was not able to do so. Several Indian subjects indicated that as long as a person does not harm him/herself or others, intervention is not necessary. As one Indian subject said, "As long as the person does not harm himself or others and does not exhibit socially unacceptable behavior or action, nothing is done." Further probes did not provide clarification on how behavior is defined as acceptable within the Indian community. However, it was found that when it does become necessary to provide assistance, a number of different persons or systems could potentially be involved in determining the necessary course of action.

Providing assistance in terms of intervention is not necessarily the sole responsibility of any particular system or resource within the cultural environment of the Lumbee Indian community. The Lumbee Indian subjects suggested that the family, clergy, and "trusted individuals" as well as others could potentially become involved in resolving mental health related problems.
The difference in level of tolerance suggest that this is indicative of a unique definition of mental health within the Lumbee Indian community. In further discussions about this aspect of Lumbee Indian mental health definition, several of the Black and Indian subjects indicated that the White community seemed to have a more formalized criteria for defining mental health, and also, are not as tolerant as the Indian and to a lesser extent the Black community. In contrast, Blacks and Indians did not appear to have a clearly defined set of criteria by which to determine who is mentally healthy.

As one Black subject said:

All three would see a difference in each other, in terms of values, behaviors and attitudes, in terms of how these would influence the definition of mental health. The minorities do not seem to have rigidly defined way of behaving or acting in certain situations. A lot of it would have to do with religion, education, government, power, racism, discrimination and oppression.

Another Black subject stated:

With patients in general, the White person will tell you how crazy the Indians and Blacks are, but I never hear the Indians or Black talking about each other...If the average White person is committed to a mental hospital, it always seems to be someone's fault. If it is an Indian or Black, there seem to be no need for an excuse, it seems to be more acceptable, normal for them to be admitted or to have mental health problems.

To develop a better understanding of this differences in levels of tolerance within this tri-racial environment there is a need to understand how power influences the behavior and the definition of mental health. Minorities
at the present time do not have sufficient power to control and influence their environment, to give
definition to their perception of reality and their
definition of mental health. As Hammerschlag (1982)
states

I think mental health is power and I think that
we are agents of power, gropers of power. And
when people feel that they have the power to
control their destiny and lives, that they can
make a difference in their lives, that they can
move and make changes. (p. 76)

Having access to and using power helps people feel
good about themselves and their environment. Power comes
from feeling good about yourself and believing that what
you think, feel and believe is going to make a difference.

In further discussion about power and mental health,
Hammerschlag (1982) states, "One has to get rid, in some
way, of what I believe is the stain of psycho-historical
enslavement in order to believe that one can take the
power...take the power" (p. 77). This is beginning to
take place with some of the movements/advancements
(educational, political, cultural, social) that have
occurred during the 1960's and 1970's. Blacks, Indians
and other minorities do not have the power to enforce
their own definitions of mental health/mental illness.
Therefore, must live by definitions established by the
larger society which may not have their best interest in
mind.
Mind/Body Holism

Another finding/theme identified by the Indian subjects is the relationship between mental health and physical health. Many of the Indians subjects indicated that the two cannot be separated or discussed independently; that one strongly influences the others. As one Lumbee Indian subject said, "There is a lot of cancer, heart disease, kidney disease, and blood pressure problems around here. For those individuals that are affected by any kind of physical disease, their mental health is affected also." The subject continued to say he believed that a lot of other Indian people would agree with him.

Behavioral-ecology views persons and their environments as linked in an integrated whole, with an interdependence among all parts. When there is a change in one part there will be a change in other parts. Several of the Indian subjects indicated that there is a linkage between mental health and physical health, and that when there is a change in one the other is affected also. This constitutes a holistic concept of physical and mental health.
Perceptions of Racial Variations in the Definition of Mental Health

Many of the questions were designed to give the subjects the opportunity to discuss and/or address a wide variety of issues that potentially effect the definition of mental health. As such, the researcher posed questions to the subjects which gave them the opportunity to identify perceptions of each racial group in terms of mental health. Therefore, several of the questions asked the subjects to specifically compare the three racial groups in the county in defining mental health. As indicated by findings in Chapter V, most of the subjects felt that the each racial group would define mental health differently. However, when this was explored further, the subjects were unable to specify what those differences were, other than to say that values, expectations, attitudes, actions and behaviors were involved.

In further attempts to define the differences, several White subjects commented that Indians seem to define mental health problems and mental health problem-solving methods differently. This was never clearly defined in discussion, but may be influenced by the higher level of tolerance within the Indian community and the use of informal helping systems in solving mental health problems as identified in this study. Although many of the subjects were not able to identify those differences in defining mental health, Whites and Blacks
felt that Indians had a higher level of tolerance for deviant behavior and that there were less clearly defined boundaries for acceptable behavior within the Indian community than would be defined within the Black or White community.

In further exploration of their perceptions of mental health definition differences, one Black subject said, "The expectation is that Blacks will not be successful and will only be able to survive on a day-to-day basis. The expectations are not very high, certainly not the same as for White individuals." Several Black subjects indicated that all members of society are taught to strive for basically the same things in society. The difference as identified by the Black subjects, are the strategies that are employed to attain those goals due to inadequate availability of resources and opportunities among all three racial groups.

**Status Effects of Age, Gender, Wealth and Employment in Defining Mental Health**

There are numerous ways by which this society determines whether certain behaviors are appropriate and thus acceptable. It is important to understand/identify those ways as they are important in influencing the definition of mental health.
There were several questions about the definition of mental health in relation to gender, age, wealth and employment factors. Many of the subjects in all three groups indicated that these factors made a difference in relation to the definition of mental health. There was greater similarity between the responses of the Black and Indian subjects than the Whites, in the way these factors were perceived to influence how mental health is defined. When this was further explored among all three races, the subjects who revealed that these factors were influential, said that there was a double standard in our society, in reference to gender, income and age. Most felt that there were different expectations of behavior particularly in reference to gender and age, for example, it is acceptable for women to show emotions in public but not for men. Several of the subjects identified differences in the way roles are defined based on gender. This was found to be true across all racial groups. The literature review found that some research has been done in relation to gender differences by mental health professionals, particularly the Broverman and Broverman (1977) study. This study found that most of the subjects believed that there were differences in the criteria (behaviors and characteristics) used by clinicians in evaluating men and women for mental disorders.
In relation to wealth, most subjects of all three racial groups agreed that money gives one access to power, which greatly influence the environment. As one Black subject said, "If you have money, you have better access to the mental health system in terms of better quality services and a lesser chance of being 'labeled' by the mental health system." Several subjects in all three racial groups indicated that society as a whole, is usually more accepting of wealthy people with mental health problems than poor people. Research in this area by Thomas Scheff (1966, 1984) indicates that money, power and influence are factors in determining who gets labeled as mentally ill. This reinforces the influence of power in determining how individuals and groups of people feel about themselves in relation to their ability to influence the environment to meet their needs. This is particularly true for this society which is composed of diverse racial, ethnic, religious, and culturally different peoples.

In an environment or society, where power is not shared, such as the American society, the way mental health is defined will only reflect the views of those who hold and wield the power. At the present time the way mental health is defined, does not reflect the cultural diversity in this society, in that mental health is defined by a system that is dominated by White, middle men. People without power who are culturally, racially, ethnically, religiously and socially different they will
be measured by the standards, norms and values that are established by the predominant group. Without access to power and influence these groups will be limited in their ability to influence how mental health is defined. Therefore, it is important for these groups to have access to power and to the mental health system to influence the way mental health is defined.

The behavioral-ecological perspective, emphasizes various methods by which communities can become directly involved in influencing institutions that are providing services for them including the mental health system. Furthermore, implicit within the behavioral-ecological perspective, is the responsibility of mental health administrators to provide the opportunity and skills needed for individuals or groups of people to actively participate in program and policy development of mental health services. From the behavioral-ecological perspective interventions are appropriate only as they engage participants in the process of planning programs and services to meet their needs. The concept of "user participation" as a strategy for optimizing environments enhances individual and community control in the operation of their environments.

In relation to employment, there was almost total agreement among all three races, that a past history of mental illness should not be a factor in employment, although these responses were qualified. Most of the
subjects agreed that they would hire a formerly mentally ill patient for farm and factory employment, however many of the subjects were reluctant to hire that person as a teacher. The subjects indicated that they would hire that person for other school employment such as janitor or cafeteria worker. This indicates that most of the subjects seem to feel that mental illness can be cured and that individuals can have a full and complete recovery from mental illness. This is somewhat surprising given that on numerous occasions many of the subjects, particularly the Lumbee Indians indicated that mental illness had a stigma attached to it. The researcher is not able to explain this discrepancy except to recognize negative feelings about mental illness are common in the county. Perhaps the subjects in this study, because of an interest in promoting mental health are more likely to change their attitudes quicker, and this will be indicative to the county in the future.

FACTORS RELATED TO THE PROMOTION AND MAINTENANCE OF MENTAL HEALTH

The remainder of this chapter is devoted to a discussion of those factors that were identified by the subjects that are not necessarily related to the definition of mental health but appear to be important to the subjects in terms of maintenance and promotion of
mental health. To maintain consistency with the organization of the chapter, these factors have been identified by sub-headings and with discussion following. Specifically these factors are: maintenance and promotion of mental health by family, community and environment, informal or natural supports systems of mental health maintenance, causes of mental illness, treatment methods of the formal mental health system, and the respondents' feelings about the subject matter engaged in this kind of research study. The usefulness of these factors in mental health appear to be more in terms of avenues that are used to promote methods of mental health maintenance within the county particularly among the Lumbee Indian community. For this reason, they are important findings and thus warrant discussion in this chapter. The author's purpose for discussing these findings to increase social work's professional knowledge base about how mental health is understood and promoted in the study site. It is further hoped that this discussion of findings will provide some new insights into how one American Indian tribe solves mental health problems.
Maintenance and Promotion of Mental Health by Family, Community and Environment

Through the process of socialization, the family teaches individuals how to behave based on definitions of acceptable behavior as identified within particular cultures. It is during childhood and adolescence that identity is formed and self-esteem nourished. This socialization process, is an integral part of the promotion of mental health.

One of the important themes identified by the subjects in relation to mental health maintenance was the influence of the family. There seems to be general consensus among all three racial groups that the family plays an important role in promoting mental health and thus influencing whether individuals feel either "good" or "bad" about themselves. Within the Lumbee Indian community, there appears to be a greater emphasis on mental health promotion and maintenance within the family. Many of the Lumbee Indian subjects indicated the influence of family in helping Lumbee Indian feel good about themselves, both as members of the Lumbee Indian community and as members of the larger culture in which they interact. As one Indian subject said, "Your family has a tremendous impact on mental health. Your family helps you determine who you are, how you feel about yourself and your ability to survive. Family is an extension of one's self. It is a part of you, but, not all of the part."
Another Indian subject stated, "Mental health means everything around you, your self, your family, community, the physical and social environment." Another Indian subject stated that, "The community begins where the influence of the family ends. They work together to influence the way a person feels about himself and influences mental health."

One of the findings of this study was a difference in the way behavior is defined as being socially acceptable between the Lumbee Indian community and the larger culture. Realizing the influence of family in promoting mental health, and this discrepancy between the Lumbee Indian and larger cultures, increases the likelihood of conflicts between these two cultures to arise. As the Lumbee Indian community struggles to retain its identity, it must balance those needs with the demands for survival in the larger culture. This places additional responsibility on the Lumbee Indian family and community to meet the demands of both environments. This also has ramifications for the Lumbee Indian community as it strives to maintain a community identity that is separate and different from the larger culture.

According to this research, the environment plays a major role in mental health. In response to the questions about the environment, a number of factors involving how the social and physical aspects of the environment affect mental health and mental health definitions were
identified. Subjects in all three racial groups discussed factors such as racism, discrimination and prejudice as influencing mental health. These factors were thought to directly contribute to mental health because they influence how individuals and groups of people feel about themselves. As one Indian elder said, "We have endured a lot here in this county. The past history of racial discrimination and oppression is a key to the mental health of Indian people." Another Indian subject said:

We (Lumbees) still cannot feel very good about ourselves and that is important in mental health, because so much has been taken away and so much has changed. Feeling good about who you are is very important to mental health. Past as well as present discrimination problems are important in defining mental health.

It is through the social evils of discrimination, prejudice, oppression and psychological warfare created by the larger society that the social problems that American Indians are experiencing today have been created. The Lumbee Indians are reluctant to solicit mental health services from a culture that has historically practiced racial discrimination and oppression. Consequently, the Lumbee Indians, along with other American Indian tribes and other minority groups, have been forced to rely on the family and community for support, encouragement, strength and developing their identities both collectively and individually. The formal mental health system cannot be relied upon to promote mental health within the Lumbee Indian community because it is a part of the larger
culture that has helped destroy the fabric and the very essence of the Lumbee Indian community. Harriett Trader (1977) made reference to this issue as she discussed the practice of social work for oppressed minorities. Indicating that the needs of the general welfare may not be consistent with the needs, goals and objectives of these oppressed groups. Further highlighting the conflict between the Lumbee Indian community and the larger culture, the Lumbee Indians have not had access to participating in the development of mental health system, therefore they have nourished those resources within their community that could provide culturally relevant mental health services.

The transactional field developed by Spiegel and Papajohn, (1975) is consistent with the behavioral-ecological perspective. Their model denotes a number of systems interacting as they influence behavior and consequently, the way mental health is defined. These systems, the universe, soma, psyche, group, society and culture are influential as they form a whole in which mental health is promoted. The transaction of each system with others gives meaning to actions, behaviors, attitudes, values and roles as these are developed and expressed within the ecological niche of the individual groups of people. The transactional field will be different as environments and cultures are different.
This study found that the Lumbee Indians made clear distinctions between their environment and culture and that of the larger culture. This distinction gives different meanings to each of the components of the transactional field within the Lumbee Indian community. The Lumbee Indians appear to be very concerned about retaining their identity and maintaining a separate environment which defines and promotes mental health based on their definitions of acceptable behaviors, values and helping resources.

Support Systems

To further enhance the impact of the family and other environmental influences on the promotion of mental health, most of the Lumbee Indian subjects stated that informal community social support systems (e.g., family, clergy, and community leaders) were more highly prized and sought after in solving problems than were the formal support systems (mental health centers). The mental health center is defined by the Lumbee Indians community as part of the problem emanating from the larger environment, therefore it is not viewed as a resource. The Lumbee Indians seem to rely heavily on resources within their community. When in need of help, they were more likely to solicit support from family, friends, clergy or other influential support systems with whom they were familiar and trusted than resources of the general
community. By using and promoting these resources, the Lumbees encourage and develop an "in group" identity that separates them from the larger society. As one Indian subjects said, "Probably, they (the Lumbees) will not use the mental health system because it is not viewed as a way of solving problems." Through promoting and using resources with their ecological niche, they are more likely to receive mental health services that will not conflict with their defined ways of behaving and are acceptable within their community. This also encourages a greater sense of community because it reinforces their beliefs about identity as a unique race of people. If there was more reliance on the formal mental health system, a Lumbee Indians would have a much greater chance of being labeled "sick" by that system. The Lumbees are a very proud and strong people and are very independent in many ways. There appears to be a strong emphasis on solving problems within the Lumbee Indian community rather than using external resources.

This may, in part, explains why Lumbee Indian subjects said that most Indians probably would not consult a psychologist/psychiatrist or use the mental health center. While the White and Black subjects stated that the community was an important mental health resource, it was not identified as important as by the Lumbee Indian subjects. One explanation for this might lie in the more clearly defined geographical community boundaries within
the Indian community that are not so well defined in either the Black or White communities. For the most part, the Indian community has not changed geographically much since its original settlement. Unlike the White and Black communities, the Indian community is not divided by economic, political, religious or social class distinctions. Therefore, it is possible that there is a greater sense of an Indian community that there is in either of the other racial communities.

The Black and White subjects, seemed to rely more on formal mental health services for assistance than on family or friends. They were less reluctant to consult the mental health center for help. Several White subjects indicated felt that White people might not always use local mental health services because of the stigma but would use mental health services outside the county.

This finding of differential support systems is consistent with the behavioral-ecological perspective. One of the major streams of this perspective is networks and social support. This stream emphasizes the need to clearly understand the role that "lay treatment network" plays in solving problems. Gottlieb (1976) identified four informal helping systems: (1) self help groups, made up of people sharing a common need or problem; (2) social networks, consisting of an individual's "primary group members" (e.g., extended family); (3) community gatekeepers, which include such persons as family
physican, clergy, teachers and so on; and (4) neighborhood based support systems, composed of block association leaders, PTA organizers, opinion leaders and "natural neighbors" (p. 28).

The networks and social support stream as identified above seem to be consistent with the findings of this study regarding where and how the Lumbee Indians utilize support systems. The Indians indicated that they were not receptive to outside intervention for mental health related problems; that they were more likely to utilize resources (family, friends, clergy) with which they are most familiar and trust.

The use of social support networks is recognized as influential in conceptualizing mental health problems and the delivery of mental health services. Support systems such as family, friends, and communities are significant in optimizing transactions between individuals and their environments. Based on the results of this study, these factors are important in the promotion of mental health.

Lumbee Indian Elders

In the larger society mental health is seen as diminishing in old age. As individuals age, they become less productive and useful. Consequently, they are given less responsibility within the general community. To learn more about how the subjects viewed age in relation to mental health definition, they were asked about their
ideas on age and mental health.

The study found that within the Lumbee Indian community mental health was promoted through the use of Indian elders. Indian elders have knowledge and wisdom from which young people can learn. The elders are perceived as being instrumental in developing Indian identity. As one Indina subject said, "They have much to give. They can help us learn about ourselves and who we are....They are a link between the past and the present." As such the role of Indian elders has been identified as playing an important role in the maintenance of mental health within the Lumbee Indian community. Some of the problems identified in the Lumbee Indian community are poor self-concept and weak Indian identity formation. Through structured contact between Indian elders and youth, these problems are reduced. As a resource through social networks (e.g., extended family) Indian elders are given more attention as a potential contributors to enhancing mental health within the Lumbee Indian community.

Although there were some references to Black elderly by the Black subjects the study did not find that the elderly in the Black or White community were given similar roles in the promotion and maintenance of mental health. Thus, with the differentially defined roles for the elderly, there exists the potential for conflict in the larger society because of the different expectations by
Causes of Mental Illness

Most of the subjects indicated that there were a variety of causes for mental illness. Most of the Indian subjects identified drugs and alcohol as major causes; whereas the Black subjects identified such factors as poverty, racism, unemployment, stress and pressure as contributors to the cause of mental illness. The White subjects identified factors such as racism and poverty as causes of mental illness but not to the extent identified by the Black subjects. It is noteworthy that the Black and Indian subjects also identified other factors as evil spirits and demon possession as possible causes of mental illness.

As stated above, some of the Black and Indian subjects believed that the cause of mental illness is derived from satanic or other related influences. This may in part be explained by the strong fundamentalist religious beliefs imbedded within the Black and Indian cultures in the county. One of the components of the transactional field is religion. Religious values and practices influence the meaning and promotion of mental health within particular cultures as seen here.
Belief in Treatment Techniques of the Formal Mental Health System

The researcher was interested in learning about how the subjects felt about the mental health of the county in general and about the ability of the formal mental health system to provide effective services.

When asked about the mental health of the county in general, the subjects indicated that they thought most people felt that there were more mentally healthy people than mentally ill people. All the subjects agreed that they believed others would agree with them. In addition, most of the subjects indicated that they felt that such a person could make a full and complete recovery from mental illness. However, some of the subjects in all three races believed that a person with a history of mental illness would always be more vulnerable than others without past histories of mental illness.

In reference to the use of drugs in the treatment and cure of mental illness, most of the subjects did not feel that drugs could be used to cure mental illness. However, there was a greater belief that drugs could be used to treat mental illness. Several of the subjects indicated that treatment usually requires more than one approach or therapeutic method to solve mental health problems. It should be noted that several subjects felt that if the problem was environmental in nature (e.g., lack of employment, educational skills or opportunities) drugs
would not be the solution.

**Respondent's Feelings About the Value and Usefulness of This Research Study**

The researcher was interested in knowing whether the subjects felt that this was a worthwhile study. Responses suggest that there was a great deal of support for this study. Several of the subjects said that the study was useful because of the county's tri-racial composition. A few subjects stated that there had previously been some informal discussions about potential differences in the way mental health is defined by the different racial groups in the county, but that there had not been any studies by which to determine the differences. They indicated that although much progress has been made in various social problems, mental health was an area that needed more attention and research. Many of the subjects felt that this study could make a valuable contribution in understanding how mental health is defined by various racial groups. As such several subjects indicated that this kind of study could potentially be useful in the development and delivery of culturally relevant mental health services.

The behavioral-ecological perspective supports the full participation of citizens in the process of planning programs and services to meet their needs. This is achieved through the process of human-environment
optimization (HEO), an important link in the interface between environment and ecological psychology. Human-environment optimization is defined as "the ways in which individuals and groups rationally guide their transaction with the environment in accordance with specified goals and plans" (Stokols, 1977, p. 25). The concept of "user participation" (e.g., consumer, client, resident, etc.,) (Wandersman, 1978) involves optimizing environments as participation increases individual feelings of control over environment and is likely to yield greater satisfaction with a particular setting (Slotnick and Jeger, 1982, p. 66). Studying the definition of mental health through the participation of local subjects enhances individual and community participation in the development of mental health definition, providing some control over their living environment. Slotnick and Jeger (1982) state, "Optimization is based on the ecological view, which assumes a natural tendency for people to play active roles in designing their environment" (p. 66).

Application of the Behavioral-Ecological Values to This Study

The behavioral-ecological perspective has been developed as an innovative force to help structure practice, teaching and research in the field of mental health. As it is operationalized in this study, it has
been most useful by providing insight into how mental health is defined and promoted in a tri-racial community. This perspective supplies flexibility and strength by which to study how mental health is defined in one American Indian community in conjunction with their local counterparts, the White and Black residents. The behavioral-ecological perspective is consistent with the goals, values and objectives of social work in that it helps to shape, mold and improve both the individual and environment to achieve maximum social functioning. This perspective further emphasizes the usefulness for enhancing cultural diversity in society.

This perspective is guided by three important values (1) promoting individual competence, (2) enhancing the psychological sense of community, and (3) supporting cultural diversity. These values are very important and useful in this study of determining how mental health is defined by each of the three racial groups.

The use of promoting individual competence allows the individual, as well as the group, the opportunity to define mental health as it relates to the individual or group's particular needs/environment. Special attention is devoted to identifying behaviors that are acceptable within each ecological niche. This is particularly important in this study as the major objective was determining differences in the way the three racial groups define mental health.
The second value of "enhancing a psychological sense of community" was identified by all three racial groups when discussing mental health. The Indian subjects seemed to place greater importance on this value, as they made clear distinctions between "the Indian community" and that of the larger culture. Similar distinctions in reference to community were not as clearly emphasized or defined by either the Black or White subjects. The term "community," when used by the White or Black subjects seem to refer to the county in general as opposed to a specific racial population.

One of the major problems of American Indian communities is alienation and feelings of powerlessness (Mail, 1980; May, 1977; Schafer, 1981; Weibel, 1982;). The behavioral-ecological perspective advocates strengthening "mediating structures" of the community. Berger and Neuhaus (1977) define mediating structures as "those institutions standing between the individual and his/her private sphere and the large institutions of public life" (p. 2). By strengthening mediating structures (e.g., family, church, neighborhood), alienation caused by distant "megastructures" including "government, big labor, education and other modern bureaucracies" (p. 38) will be reduced. This in turn provides for a stronger psychological sense of community.
Cultural diversity is the third and final guiding value of the behavioral-ecological perspective, which encourages the maintenance and growth of various culturally and racially different peoples. Subjects in this study encouraged cultural difference in the definition and promotion of mental health.

Chapter Summary

This chapter presented a discussion of the findings of this study. The discussion was two-fold. The first objective was to discuss those findings that were related to the definition of mental health relating previous research wherever possible and incorporating theory. The second objective was to discuss those findings that were not necessarily related to the definition of mental health, but were identified by the subjects as important in the promotion of mental health. Theory was incorporated where possible to understand the findings.

This chapter identified several major findings that contribute to the development of the definition of mental for the three racial groups in this study, particularly the Lumbee Indian subjects. The results of the study identified differences as well as similarities in the definition of mental health among the Black, White and Lumbee Indian subjects. While there were similarities among all groups, the major differences were in terms of emphasis placed on each of the similar findings in
relation to the various racial groups.

This study was guided by the behavioral-ecological perspective as it provided the necessary framework through which behavior can be viewed and appropriately evaluated within the cultural and environmental contexts in which it was expressed. This perspective recognizes and acknowledges the influence that culture has on behavior and consequently the definition of mental health. The behavioral-ecological perspective emphasizes the need to study human behavior within its natural setting and to include residents in the research process. As such this perspective proved most satisfactory as a theoretical guide for this study.
CHAPTER VII

SUMMARY, CONCLUSION AND IMPLICATIONS

American society is a very complex, multi-ethnic, heterogeneous phenomenon that is constantly changing. At a time when the "melting pot" concept is under serious challenge and investigation, other similar issues/problems are also being re-evaluated. However, none of those issues/problems is potentially more important than that of mental health.

As minority groups begin to assert their influence and power, they are beginning to question many of the traditional assumptions of human service delivery systems. This is particularly true of the American Indians in relation to the mental health system, and the current definition of mental health. The American Indian communities other minority groups, and some mental health system are now having serious questions about whether there are differences in the way mental health is defined in relation of diverse cultures.
Overview of Research Study

The purpose of this research study was to determine the differences in the way mental health is defined by three racial/ethnic groups in Robeson County, North Carolina. As such, this research may have implications about how mental health is defined by other ethnic groups. This could potentially be very beneficial in influencing the overall philosophy of the mental health system if that system is to provide culturally relevant, culturally appropriate, non-class bound mental health services to American Indian communities.

This was an exploratory, descriptive study. A two-stage key informant strategy was employed, using community representatives and agency executives as nominators to identify the 60 subjects (the subjects key informants) from the resident population of Robeson County.

A review of the literature did not reveal any instruments that were appropriate for collecting data for this study. Therefore, the researcher developed an instrument guided by the behavioral-ecological perspective because it provided the concepts and values which appeared useful and appropriate to the study and development of the instruments. The instrument was pretested and subjected to a juror process. A one-time interview was scheduled using the instrument/questionnaire to ask questions. With the permission of each subject, the
interview was recorded.

After the completion of all interviews, the recorded audiotapes were transcribed. The transcribed tapes were then subjected to content analysis. This process included coding responses wherever appropriate and identifying and counting themes in the non-coded responses. Tables were constructed to properly reflect the richness of the data collected in this study.

Upon completion of the analysis, a discussion was presented which highlighted the major findings study. The discussion focused on a comparative analysis of the major findings of the three racial groups' definitions of mental health. The behavioral-ecological perspective was employed to provide a theoretical understanding of how mental health was defined by the three racial groups. This theoretical perspective proved most appropriate as it provided the necessary flexibility to understand behavior and the definition of mental health within cultural and environmental contexts.

Study Conclusion

As the American society becomes more heterogeneous, minority groups are seeking to clarify those factors in their particular ecological niche that shape, mold and provide meaning to their environment. One of the issues that is gaining increased attention is mental health. The American Indian is one minority group that has particular
concerns about mental health.

This study attempted to explore and describe the definition of mental health of one American Indian tribe, the Lumbee Indian tribe of Robeson County, North Carolina. Selected Lumbee Indian definitions of mental health were explored in comparison with Black and White subjects from the same county.

The results of this study found that there were differences in the three racial groups' definitions of mental health. However, the differences were primarily in the emphasis placed on similar findings/themes.

The researcher does not claim to have captured all the elements or characteristics of the Lumbee Indian definition of mental health. However, the study did identify some of the features of Lumbee Indian mental health. One of the most important finding was the level of tolerance for extreme or unusual behavior. This study found that Lumbee Indians appear to be more tolerant of unusual or extreme behavior than the Black or White communities. This finding suggest that as long as individuals are not expressing "socially destructive behavior" they are for the most part accepted by the Lumbee Indian community. This is not be congruent with the definition of mental health used by the larger or predominant community which views deviance found normative behavior as symptoms of mental disturbance. There are several reasons for this higher level of tolerance,
related to the importance placed on such factors as family and the "Indian community" as identified by the subjects in this study. Within the family, the role of Indian elders seems particularly important in the helping to form a positive self concept both collectively, as a group of people, and as individuals within that group. As such, it was identified as being important for the promotion of mental health.

The Lumbee Indians, for the most part do not rely on formal helping systems of the greater community; rather, they are much more likely to utilize "natural" helping systems within the Lumbee Indian community with which they are most familiar. As a result, there appears to be a sense of self-reliance within the Lumbee Indian community, because their mental health needs being met by extended family members, clergy, and other "trusted" individuals.

The Lumbee Indians also indicated that nature plays an important role in the definition of mental health. They appear to hold a special reverence for nature as they believe it helps maintain a balance within their total environment along with such factors as family, community, and religion. A change in any of these systems is seen as having an impact on the other systems. In support of this, they indicated that there was an interdependence between mental health and physical health.
The Lumbee Indians indicated in their definition of mental health a linkage between mental and physical health, referred to as mind/body holism. The implication is that these two components are linked together and cannot be discussed independently.

Since the study of American Indian mental health and specifically Lumbee Indian mental health is a relatively unknown area, the findings must be viewed in that context. Nonetheless, this study is an initial, yet much needed effort to begin developing and building a body of knowledge about American Indian mental health definitions. As such, this study has potential values as it has identified some important themes of mental health definition that are unique to one American Indian tribe, the Lumbees.

Limitations of the Study

There are several important limitations of the study. The limitations of the study identified below, place constraints on both the strength of the findings and on the range of the implications that could be derived from the findings. Although there are other limitations in the study, the two identified here, in the author's opinion, are the most important and the foundation for other limitations. The two limitations which are primary are:
1. Measurement.

2. Generalizability.

Given that there were not appropriate data collection instruments available, the researcher developed one for this study. As with any new instrument, the traditional limitations of validity and reliability were present. To reduce these limitations, the researcher took measures to enhance these qualities. To enhance the reliability the instrument was pre-tested on "typical subjects" from Robeson County. In an effort to ensure limited validity, the researcher requested a number of professionals in Robeson County to review the questionnaire and provide comments that would enhance the validity of the instrument. The purpose of each of these steps are to enhance the potential richness of the responses given by the subjects. The study utilized open-ended questions to increase the potential richness of the responses. However, many of the questions used in this study could be easily answered with either a negative or positive responses, reducing the substance of potential responses given by the subjects. There are some biases that effected the responses provided in this study. Even when probe questions were employed, the responses were still limited. This is not to imply that the study is fruitless, but that subsequent research studies in this area must revise the instrument or develop a new one.
The second major limitation is the inability of these findings to be generalized to other populations specifically to other American Indian tribes. The data collected and subsequent findings and implications generated from this data are limited in their generalizability. As stated earlier, Robeson County is very unusual in many respects. Therefore, the researcher does not claim that it is possible to generalize to the American Indian community. Any potential use that the findings may have for other American Indian tribes is solely the responsibility of the reader.

Implications For Mental Health and Social Work

The author feels that the findings of study have some implications for both the mental health and social work professions. Given that this is an exploratory, descriptive study, the implications are designed more in terms of directions for future research than in terms of practical applications.

In many ways, American Indians are the marginal type people described by Park in 1928. They are living on the edge of two worlds, two cultures. While realizing the benefits of becoming assimilated into the White world, they are as yet, unable or unwilling to give up their Indian heritage. They represent the "cultural hybrid" described by Park. As Park (1928) said of the marginal man:
He is never quite willing to break, even if he were permitted to do so with his past and his tradition, and not quite accepted, because of racial prejudice in the new society in which he now sought to find a place. He was a man on the margin of two cultures and two societies, which were completely interpenetrated and fused (p.892).

Living on "the edge of two worlds" is certainly not making life for American Indians any easier and may be contributing to the mental health afflictions they suffer. As indicated earlier, Rhoades, et.al. (1980) reported that "it is not unusual for Indians to assert that mental health afflictions are now their primary health problems" (p.329) and, according to Trimble and Medicine (1976) the disproportionate number of mental health problems among American Indians are apparently increasing in spite of our best efforts. The work by Ryan and Spencer cited by McCoy (1981) also suggests that despite increased programs, research does not indicate an improvement in the mental health of American Indians.

The section below identifies these implications. To avoid repetition, the implications for both social work and mental health have been combined.
Mental Health and Social Work Practice

The mental health profession and more recently the social work profession have been charged with the responsibility of providing mental health services for all the citizens of the American society. This has been and continues to be a large responsibility for the professions, given the unique cultural, ethnic, religious, social, economic, political, and racial characteristics of the American culture.

As indicated in Chapter Two, The Literature Review, the community mental health system as it is known today, is still relatively new. It was not until the late 1950's and early 1960's that much organized effort and attention was given to creating, establishing and expanding the mental health system. Furthermore, it was not until late in the 1960's that very limited organized efforts were undertaken to develop a mental health program to provide services to American Indian communities. The literature review further indicates that these mental health programs that were established were based on the model and philosophical, political, and cultural orientation of the larger society. Very little attention was given to developing programs based on the culture of American Indians. Consequently, American Indians for the most part are not satisfied with the present mental health system, and are demanding mental health programs that are in line with their culture. Nevertheless, not much attention has
been devoted to developing a mental health system that would be able to provide culturally relevant, culturally effective services that represented the ethnic and multi-cultural features of this society.

This study has uncovered some potentially very important differences in the way behavior is viewed and evaluated within one American Indian community, the Lumbee Indian tribe. There seems to be a different level of tolerance for behavior within the Lumbee Indian community. This needs to be further explored to determine as much as possible the precise meaning of that level of tolerance and how it can be incorporated into the mental health and social work definitions that used to identify mental health problems among and provide services to American Indian tribes.

Barter and Barter (1974) note that many American Indians perceive an "attitude problem" when they seek services (particularly mental health) in an urban area. They cite that "American Indians complain about 'not feeling welcome' and feeling as though they were being treated in a cursory fashion or even with outright hostility. They often say this is because 'the people in the clinics don't understand our culture" (p. 42). This, for the most part, is supported by this study. One of the findings of this study is that Lumbee Indians do not use the mental health center on a regular basis. In fact, it seems that the mental health center is not seen as a
resource or place to go for help for the Lumbee Indian community. The Lumbee Indians rely on traditional resources within their community, such as family, friends and the clergy. This implies that mental health professions needs to examine these resources within the Lumbee Indian community as support networks in order to provide more effective services. Specifically, there is a need to clearly identify the resources that are used and to incorporate these as much as possible into the formal mental health system.

The networks and social support stream seems to be consistent with the findings of this study regarding how the Lumbee Indians utilize support systems. The Lumbee Indians indicated that they were not receptive to outside intervention for mental health related problems; that they were more likely to utilize the people with whom they are most familiar and whom they trusted. Many of the Indian subjects stressed the importance of the extended family, friends, clergy and other reliable persons when they needed help in solving mental health problems. These responses are consistent with the way problems are defined by the Lumbee Indian community and they believe the formal mental health system should be structured to meet their needs.
This suggests that there is a need to reconsider what Lumbee Indian community mental health needs are and, how these needs can be better met by the mental health system. This also seems to indicate that more study is needed about the Lumbee Indian mental health "natural helping systems." The behavioral-ecological perspective supports this finding that there is a need to identify the resources that are used by the Lumbee Indian community. In addition, there is a need to strengthen the ability of those community or natural resources to enhance the ability of individuals and communities to establish goals and achieve those goals. Even though this was not a direct finding in this study, the implications are present nonetheless.

The use of social support networks is recognized as influential in conceptualizing mental problems and the delivery of mental health services. Support systems such as family, friends, and communities are significant in optimizing transactions between individuals and their environments. Based on the results of this study these systems are important in the definition of mental health. These support systems do not necessarily rely on mental health definitions of the larger culture to define whether a particular behavior is normal or abnormal. It seems that they operate on definitions of problems and solutions that are consistent with the needs of the individuals within their particular environment. This then is
supported by the behavioral-ecological perspective as it implies that behavior must be evaluated within the ecological niche of the individual and that interventions must be accordingly developed again within the cultural environment of the individual.

The finding about how certain support systems are used by the Lumbee Indian community is supported by the bio-ecological analogies as discussed by Trickett, Kelly and Vincent (1982). Bio-ecological analogies emphasizes that research is an "evolutionary process" and highlight the importance of adapting the research process to the community. This view is influenced by the value that the research should enhance community resources rather than deplete them. The work of Munoz, Snowden and Kelley (1979) states: "Community reseach would ideally combine the value of helping people achieve psychological well-being with the value of empirically evaluating results" (p. 3). This study has identified a number of helping resources. These resources are influential in helping people achieve psychological well-being in the Lumbee Indian community and to a lesser extent in the Black community. To determine their effectiveness, resources would be further defined and empirically evaluated. Following this, the next step should be to provide assistance to these resources in order to improve their ability to provide cost-effective quality services to their communities.
The behavioral-ecological perspective suggests that communities should be encouraged to take active leadership roles and incorporate full citizen participation in the decision making and management of mental health services. This can be accomplished through empowering local citizens and groups with the skills and knowledge needed to influence the environment to meet their needs. Individuals and groups should have the option of participating through informed choices; it "is the responsibility of administrators to ensure that people have the know-how to participate; mere awareness of opportunity is hardly of value" (Slotnick and Jeger, 1982, p. 65). Providing training for Lumbee Indian community residents to effectively serve on community mental health boards is perhaps a beginning step. This is a group of people that has traditionally been denied power and, consequently, has not been able to influence their environment to meet their needs. Giving the opportunity and training for minorities to effectively plan and consume mental health services is extremely important and as such, is potentially a valuable contribution to the promotion of mental health.

One of the most sensitive practice issues in working with American Indians is intervention. This study found that Lumbee Indians do not readily accept services from "outsiders." They rely primarily on resources within their community to solve problems. Assuming that this is
true, it would then become the responsibility of the mental health and social work professions to work with and improve the knowledge and skill base of those "inside community resources" to provide culturally relevant and appropriate services. Since the use of informal support systems is known, there is a need to learn more about intervention. The questions to be explored in future research include but are not limited to: "How is intervention (help, assistance, care, concern) defined within the Lumbee Indian community? Who can effectively intervene and provide assistance? At what point in a problem situation, does intervention become necessary?" These are questions that need further exploration and in terms of their importance in the promotion of mental health in future research.

Mental Health and Social Work Education

Another issue that needs to be addressed by the mental health profession is the stigma that is attached to the mental health center, particularly within the Lumbee Indian community. One of the ways to reduce and hopefully eliminate this stigma is by educating the Lumbee Indian community about mental health and the programs and services offered at the local mental health center.
The results of this study clearly indicate that the mental health profession should develop educational programs about the services available at the mental health center. These programs should be designed to better inform the general public, but specifically to provide information to the Lumbee Indian community.

During the past 20 years some progress has been made in addressing the needs and concerns of American Indians. This is not to imply by any standard that all that can be been done has been achieved; it has not. This exploratory study, past studies and future research will add to the body of knowledge, theory development, skills and techniques relevant to providing culturally appropriate services based on the problem definitions as they are defined jointly by both Indian client and social worker. As more knowledge is discovered about various American Indian tribes, it then becomes the responsibility of the social work profession and social work educators to incorporate that knowledge into the curricula to prepare future social workers to work with and for American Indian tribes.
Use of Standard Psychological Test in Evaluating Lumbee Indians

Any discussion of implications of mental health among American Indians would be incomplete if it did not address the issues of misdiagnosis and the specific problem of psychological testing of American Indians. The literature review identified some of the specific problems in this area. Martinez (1979) discussed some of the pertinent issues of this problem. One case of misdiagnosis was documented by Jewell (1952). In this instance, a Navajo patient was institutionalized on the basis of psychological testing with a diagnosis that was completely incorrect.

In the past few years there has been considerable debate over the appropriateness of using standardized psychological tests with minorities, including American Indians. The concern stems from the fact that many of the tests were validated on and reflect white middle class clients. As such, many believe they are not suitable measures for non-white, non-middle class clients.

One of the findings of this study is the difference in the level of acceptable behavior within the Lumbee Indian community as compared with the White and, to a lesser extent, the Black communities. This level of tolerance has some potential implications for using various standardized measurement instruments in determining whether an individual is mentally healthy.
Those instrument that attempt to identity and evaluate behavior must be carefully weighted in determining whether they are culturally appropriate as evaluation instruments for Lumbee Indians. If the instruments are based on certain predetermined behaviors which are judged to be characteristic of mental illness, then using those instruments in cultures or environments with other defined mental health definition and value bases would be a inappropriate use of the instruments. Based on the results of this study, there is a need to further explore this phenomenon within the Lumbee Indian community to learn more about how behavior is judged as acceptable or unacceptable. If particular behaviors are acceptable within the cultural boundaries of the Lumbee Indian community but are unacceptable within the larger society, there is the need to evaluate those behaviors within the cultural context of the Lumbee Indian community. Otherwise, the mental health profession may misdiagnosis certain behaviors and consequently, provide services/treatments that are neither appropriate nor culturally relevant. Although the researcher is not making a conclusive statement here, the results of the study indicate that there is a need for mental health professionals to be aware of this potential difference with the Lumbee Indian tribe and possibly with other American Indian tribes as well.
Use of Paraprofessionals

Another implication of this study is the use of paraprofessionals in providing mental health services. Although this was not the focus of this study it was an issue identified in the discussion of the definition and promotion of mental health.

Lumbee Indians like other American Indians are a very proud people, proud of who they are, proud of their rich and unique heritage and culture, and proud of being different. As such they are not willing to readily share their problems especially personal ones with "outsiders" who define mental health and treatment differently. As one mental health worker said, "When they (the Lumbees) do come in for services, they will ask to see 'one of my people!'."

The literature (Bergman, 1974; Attneave, 1974; Jilek and Jilek-Aall, 1978; Lewis, 1977) supports the use of Indians as mental health workers in providing mental health services to American Indian clients. As Bergman (1974) has suggested Indian patients are much more willing to talk to an Indian person than they are to a white physician. Because of the use of Indian paraprofessionals many "uncooperative" patients have become cooperative. The use of Indian mental health paraprofessionals can help with misunderstandings, hostility, suspiciousness, ignorance and anxiety. Although this is an exploratory study, the results of this study does suggest that the use
of paraprofessionals would enhance providing mental health services in the community. The cultural differences could be lessened if paraprofessionals with similar orientations were used. The results of this study also suggest that mental health professionals need to be made aware of cultural differences and be trained to incorporate those differences in providing services to the Lumbee Indians.

The behavioral-ecological perspective promotes the idea that identified resources be maintained and strengthened to enhance personal competence and a psychological sense of community. By way of interventions, family network therapy should be available to help individuals communicate with network members. Furthermore, Indian paraprofessionals should be trained to help Indian clients establish networks as well as link clients with community resources.

In terms of community assessment, Mitchell and Trickett (1980) suggest community assessment should examine "network patterns across different groups and neighborhoods in order to identify problem areas (e.g., high risk groups) as well as community strengths and resources" (p. 69). This study has found that there are some differences between the racial groups in how and where they seek mental health services, for example, family, church and "trusted community members." Given the findings of this study, these resources would be a logical
starting point for program and service delivery development.

**Potential Administrative Changes**

Given that there are some differences in the way mental health is defined this would indicate that perhaps there is a need to look at potential administrative and policy changes to reflect these differences. There is a need to involve Lumbee Indians community members in the management decision-making process and service providing positions since they would be working from the orientation of Lumbee Indians.

Indian people are aware that their people do not at the present time possess the technical knowledge and skills in providing mental health care from the Western perspective but they are not receiving quality care from the present service providers. Additionally, unless they get in the driver's seat in this matter, they will never have any control over the quantity and quality of services that are provided. They feel they are in a better position to understand the problem American Indians are experiencing and can better design and implement mental health services that are culturally relevant to the Indian community.
Future Research

As social work research becomes more advanced, there appears to be a greater emphasis on quantitative research over qualitative research. The author feels however, that there is a need for both quantitative and qualitative research as both can make a contribution to the knowledge, practice and theoretical base of social work. The author further contends that one is not superior to the other, that both proceed in somewhat different directions in making needed and valuable contributions to the understanding of human behavior, human suffering and different definitions of reality. There are as many potential methods of learning about and resolving and/or reducing human suffering, as there are problems to be resolved and solutions to be discovered.

This exploratory study and its particular approach has gained some new insights into a problem, that is agreed by all both provider and recipient, to be a relatively new and unexplored area. As the literature review indicates, providing mental health services to American Indians is still a relatively new service providing area. In spite of the services that are provided and the research that has been conducted, mental health among American Indians still remains a very serious social and political problem. With the knowledge available there is only one way to proceed in the area of research, and that is to further investigate definitions of mental
health among other American Indians tribes. As such the author suggests the following future areas of research.

- Initiate similar studies with other Native American tribes to determine their definitions of mental health.

- Initiate research projects to compare and contrast the definition of various Native American Indian tribes.

- Further explore natural helping system with American Indian communities in relation to mental health definition and promotion of mental health.

- Further investigate the level of tolerance with the Lumbee and other American Indian Tribes.

**Concluding Statement**

Mental health is a very complex and difficult field. Even though recent research has made some progress in building a body of professional knowledge and theory, building much remains to be accomplished, particularly in the area of mental health definitions. Research efforts have made some valuable contributions to furthering the professional and lay understanding of the definition of mental health. However, the goal of achieving a definition of mental health is becoming more complex and challenging as various minority groups in this society begin to request mental health services that are culturally relevant and culturally appropriate. As the mental health system responds to these requests, there many issues to be addressed. Perhaps none is more important than developing a better understanding of how mental health is defined on a cross-cultural basis. This is particularly important in this society which is composed of many ethnic, racial and
religious groups, all demanding mental health services based on their particular definition of mental health.

This study has attempted to address the issue of mental health definition with one American Indian tribe, the Lumbee tribe of Robeson County, North Carolina. Through this exploratory study, some interesting findings and observations have been documented that provides some new insight into how one American Indian tribe defines mental health. The author is very much aware that this one study will not change the course of history for mental health in this country, however it is hoped that the findings and observations of this study will generate interest in this area. It is hoped that as a result of that interest, similar kinds of research studies will be undertaken not only with other American Indian tribes but with other minority groups as they attempt to utilize and influence the mental health system.
Appendix A

List of Participating Organizations in the Key Informant Survey
1. Lumbee Regional Development Association
2. Robeson County Mental Health Association
3. Robeson County Church and Community Center
4. Southeastern General Hospital
5. Robeson County Area Mental Health Association
6. Robeson County Mental Health Center
7. Cardinal Health Agency
8. Robeson County Department of Social Services
9. Robeson County Department of Health
11. Robeson County Prison
Appendix B

Interview/Questionnaire Guide
1. Do you think an alcoholic has a mental health problem?

2. Do you think a husband/wife who abuses their spouse has a mental health problem?

3. Do you think someone who settles an argument with a gun has a mental health problem?

4. Do you think someone who settles an argument with a 'fist fight' has a mental health problem?

5. Do you think someone who uses drugs on a regular basis has a mental health problem?

6. Do you think someone who commits a crime has a mental health problem?

7. How do you think most people would describe the term mental health?

8. Describe a mentally healthy person?

9. Do you know anyone who, in your opinion, is not mentally healthy? If yes, what about that person makes them different?

10. What do you consider to be mental health problems?

11. What are some signs that may indicate that a person is not mentally healthy?

12. What should a person do if he/she suspects either themselves or someone around them has a mental health problem?

13. If you had to choose between a physical illness and a mental illness which would you choose? Why?

14. How does such factors as family, environment, community and culture make a difference in whether an individual is mentally healthy? In what ways does the factors make a difference?

15. There has been a growing use of the insanity plea and blaming mental health problems for crimes. Would you agree or disagree that people who commit crimes are mentally ill? Why?
16. If you were an employer would you hire someone who has been mentally ill to work for you in a factory? on a farm? or in the school system?

17. Do you think there is a difference between what is considered a mentally health rich person and a mentally healthy poor person?

18. Do you think there is a difference between what is considered a mentally healthy old person and a mentally healthy young person?

19. Do you think there is a difference between what is considered to be a mentally healthy woman and a mentally healthy man?

20. Do you think there is a difference in the way the three racial groups in this county define mental health? If yes, what is the difference?

21. Do you think there is a difference between what is considered a mentally healthy White, Black and Indian?

23. Do you think a larger percentage of White, Black or Indians are mentally ill?

24. Do you think there are more mentally ill people than mentally health people? Why? Do you think others in this county would agree?

25. Do you think there is a difference in the perception of mental health between Black, Whites and Indians in this county? If so, what is the difference?

26. What causes mental illness?

27. Can a person ever completely recover from mental illness?

28. Do you think drugs can be used to cure mental illness?

29. Do you think drugs can be used to treat mental illness?

30. Do you think this is a worthwhile study?
31. Is there anything else that you would like to say about the issue of mental illness that is relevant in this county that was not addressed in this interview?
Appendix D
Introduction to each Key Informant
My name is Von Sevastion Locklear. I am a graduate student that The Ohio State University College of Social Work, working on a Doctorate Degree in Social Work. I am presently engaged in a research study to determine how American Indians (Lumbees), Blacks and Whites in this county define the term mental health. I am asking your permission to participate in my study. As a participant, I will be asking questions about mental health in general. If you should decide to participate the questions asked of you are general in nature about mental health. I will be asking you how you think other people in the county would respond to these questions and for you to respond accordingly. Therefore, I am asking to represent other people in the county as much as you can in responding to these question. It is important not to respond personally, as I am interested in finding out the people in the county define mental health.

If you should decide to participate in this study you may stop the interview at anytime prior to the completion of the interview. Additionally, you may request at a later date to have the material or data you provided withdrawn and your request will be completely honored. I would like you permission to tape record this interview, as it will assist me in more accurately recording your responses. Your name will not be recorded, and only I will know that you participated and what you said. Your name will not be used in anyway in this research. You
will remain anonymous. Whether you agree to participate in this study, thank you very much for your time.
Appendix E

Sample of Written Responses From Jurors
Dear Von,

I have three basic comments related to your interview questions. 1) There are several words that would be foreign to many Robeson County Residents. There is no doubt that they will have trouble with words like "environment," and "culture." If they have trouble with these words, I feel that they would be intimidated and thus become less than honest. I also suspect to a lesser degree that the phase "mental health" and "mental health problem" would be confusing. I think that folks around here understand what "mental illness" means but have trouble with the other terms. 2) I think that QUESTION # 15 would be the best first question. I believe that you would receive your best cooperation if 15 was 1. It is an important issue locally. 3) Make sure you have probes to go with each question. For questions like number 8, I would suspect that you'd get a lot of "I don't knows."

In general it seems like a great idea for a dissertation. I'm sure the results will make a contribution to the social work body of knowledge and to our understanding of the "three peoples in one land."

With respect,

Steve Marson
Director, Social Work Program
Acting Chair, Department of Sociology & Social Work

An Equal Opportunity Employer
A CAMPUS OF THE UNIVERSITY OF NORTH CAROLINA
MEMO

TO: Vaughn Locklear, P.H.D. Candidate

FROM: Bobby E. Rogers, Administrative Assistant

Robeson County Health Department

SUBJECT: Comments on Mental Health interview questions

1. The interview questions on mental Health are open-ended, exploratory and stimulating.

2. If other controls are applied appropriately, the responses should be very revealing.

3. Some questions may be combined and the list shortened. Perhaps the list should be reviewed for repetition.

4. It is apparent that much thought has gone into the development of the questionnaire.

5. Thank you for the opportunity to review them. Good luck!


Demographic Overview Of Lumbee Regional Development Association Published by The Lumbee Regional Development Association, 1983.


Erickson, Kai T. "Patient Role and Social Uncertainty-A Delimma of The Mentally Ill" Psychiatry Volume 20 1957, pp. 263-274


Halpert, H.P., Public Opinions and Attitudes About Mental Health: A Summary of Survey...Implications for Communications.


Lewis, R. "Cultural Perspective on Treatment Modalities with Native Americans" In Human Services for Cultural Minorities R. H. Dana, (Ed.) Baltimore: University Park, 1981.


Matthews, M. & Taylor, Marcus. A. R. Mental Health States and Beliefs Among Southern-Born Residents of Butler County, Ohio The Ohio State University, The Division of Mental Hygiene and The Ohio Department of Public Welfare. 1949.


Park, R. E. "Human Migration and the Marginal Man"  
The American Journal of Sociology Volume 33, 1928.  
pp. 881-893.

Panzetta, A. F.  Community Mental Health. London: Lea and  

Pincus A. Minahan, A. Social Work Practice: Model and  

Plog, Stanley C., & Edgerton, Robert B. Changing  
Perspectives in Mental Illness New York: Holt,  
Rinehart and Winston Inc. 1969.

Plunkett, Richard J., & Gordon, John E. Epidemiology  
1960.

Polack, D., Jones, M. "The Psychiatric Non-hospital: A  
Mode for change" Community Mental Health Journal  

Poll Solomon, The Hasidic Community of Williamsburg New  

Rabkin, J. & Struening, E. Ethnicity, Social Class and  
Mental Illness in New York City. New York:  
Institute of Pluralism and Group Identity, 1976.

Rabkin, Leslie Y. & Cam John E. Sourcebook in Abnormal  

Rakel, R. E. Principles of Family Medicine. Philadelphia:  

Rappaport, J. Community Psychology: Vlaues, Research and  

Rappaport, J. and Chinsky, J. M. "Models for Deliverly for  
Services From a Historical and Conceptual  
pp. 42-50.

Red Horse, J. G. "American Indian Elders: Chief of Indian  
pp. 490-494.

_________ . "Family Structure and Value Orientation in  
pp. 462-468.


Shapiro, R. "Discrimination and Community Mental Health" *Civil Rights Digest* Fall, 1975.


Strike at The Wind Booklet Lumbee Indians, Published by Strike at The Wind Inc. 1982.


Trimble, J. E., & Medicine, B. "Development of Theoretical Models and Levels of Interpretation in Mental Health" In J. Westmeyer (Ed.) *Anthropology and Mental Health Setting a New Course* Paris: Mouton Publishers, 1976.


