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# Commentary: Cultural Perspectives on Research among American Indians

JOHN RED HORSE, TROY JOHNSON, and DIANE WEINER

Recent initiatives implemented by the Indian Health Service target health promotion and disease prevention as service goals for the 1990s. In partial support of these initiatives, the Indian Health Service sponsored a research planning meeting in September 1988. The meeting was intended to initiate thought on research priorities consistent with the initiatives, to identify a cadre of American Indian scholars interested in health promotion and disease prevention, and to frame a research training agenda for a follow-up meeting with the identified scholars. Budget constraints led to cancellation of the second meeting as originally planned. However, in collaboration with the National Institute for Drug Abuse, the Indian Health Service sponsored an alternative meeting in September 1989. Unfortunately, the focus of the meeting shifted from priorities in health promotion and disease prevention to training for research careers in the field of drug abuse.

At first glance, one cannot argue with the change in focus. Drug abuse is certainly a vital research concern. Little is known or written about its extent and impact in Indian communities. Dr. Joseph Trimble, an American Indian psychologist, noted that through September 1989 only fifteen research articles had been published on American Indian drug abuse and that nine of these

John Red Horse is Associate Professor in the School of Social Welfare and Director of the American Indian Studies Center at the University of California, Los Angeles. He is a California Cherokee. Troy Johnson is a doctoral student in history at the University of California, Los Angeles. Diane Weiner is a doctoral student in anthropology at the University of California, Los Angeles.

were reviews of literature. Dr. Trimble built a compelling case supporting a need for drug abuse research. However, few of the presentations were as culturally germane and enlightening as Dr. Trimble's. Most presenters harped on application procedures in efforts to hone individual skills for writing research grants. While useful, this approach did not satisfy the aspirations of the visiting scholars. Midway through the meeting, in a polite and refreshing manner, American Indians objected to research paradigms that failed to account for unalterable cultural factors which are essential conditions overlooked by most research. While this diversion did little to influence the direction of research at the National Institute for Drug Abuse, it does serve as important commentary for health-related research.

## CULTURAL AND COMMUNITY CONSIDERATIONS

Concerns expressed by American Indian scholars focused on limitations inherent in existing research that is designed to investigate health problems. Such research is guided by disease models that draw upon clinical populations. While important for the collection of aggregate statistics, for tracking clinical visits, or for ascertaining recovery rates among drug abusers, this kind of research lends only limited insight into health behavior among representative proportions of the total American Indian population. Accordingly, the visiting scholars suggested a different research agenda to tease out cultural norms, tribal customs, and intellectual traditions that are indispensable for initiatives in health promotion and disease prevention.

First, we ought to launch a national baseline study in health behavior to examine regional differences in health attitudes, knowledge, and beliefs among American Indians. This would introduce a vital stream of research data to guide efforts in health education and primary prevention. It would refine our understanding of demographic differences that contribute to significant cultural diversity among American Indians. The importance of such data cannot be overstated. For example, the majority of Indians in Arizona and New Mexico live on reservations and speak native languages on a daily basis. Conversely, the majority of Indians in California and Oklahoma live in urban or metropolitan

areas, and less than 30 percent speak native languages. Moreover, diverse religious practices are common among American Indians in general. These include Traditional Medicine Societies, the Native American Church, and various Christian sects. Finally, the urban movement, largely a post-World War II phenomenon, mushroomed in the 1970s. By the 1980 census reporting period, the majority of American Indians lived in urban or metropolitan areas of the United States. The vast majority of urban Indians are excluded from the federal health service chain. They are a forgotten majority. With the exception of the United States Bureau of the Census, no federal or state agency routinely gathers or analyzes data on urban Indians to guide health promotion and disease prevention efforts.

Second, we ought to introduce social conservation models of research. Such models draw upon critical life circumstances to operationalize research variables. This would complement health promotion and disease prevention in the following manner. First, it would structure research that is congruent with Indian lifestyles. This would facilitate research paradigms that capture salient features of successful health behaviors common among Indian communities, families, and individuals. In this manner, health promotion and disease prevention could be informed through cultural strengths rather than through deficit models. Second, social conservation models would heighten the focus on principal threats to health among Indians. In this respect, current morbidity and mortality rates are somewhat misleading. We can, for example, readily identify the leading causes of death and note that accidents are the second leading cause, cirrhosis fourth, diabetes mellitus seventh, homocide eighth, and suicide ninth. However, such ranking does little to guide research or to deploy resources to mitigate the effects of the chief marker, alcoholism, that is associated with these leading indicators of mortality among Indians.

Third, we ought to investigate relationships between quality of care, health promotion, and disease prevention. This would ferret out important dimensions of resource allocation, professional readiness, and continuity of services. Health promotion and disease prevention assume a broad brush of human services organized to reach out to communities. Current allocations in the Indian Health Service suggest that resource deployment falls far

short of this standard. In 1985, 85 percent of fiscal resources went to hospitals and clinics, 5 percent to alcoholism, and 2 percent to mental health. Essentially, this distribution of funds appears to support secondary and tertiary care. The distribution may also explain the professional readiness of personnel in different service categories. Hospitals and clinics are staffed with highly trained professionals. Most alcohol treatment programs and suicide prevention services, however, are staffed with paraprofessional providers. While the latter receive intermittent training in disease factors and interventions associated with service delivery, they are not able to offer continuity of professional care commensurate with the impact of the presenting problems. This may, in fact, impede efforts in health promotion and disease prevention, which rely, to a great extent, on personal contact with service providers who are knowledgeable and caring.

## SUMMARY DISCUSSION

This commentary does not exhaust considerations raised by American Indian scholars attending the federal research meetings. It does provide a flavor of the challenges American Indians face as new health initiatives are launched for a new decade. The issues, however, are certainly not new. They echo concerns articulated twenty years ago by students and community representatives who worked arduously to develop research and academic programs in institutions of higher education. At that time, the primary concern was to foster an institutional climate in support of an American Indian intellectual tradition. This included unconditional positive regard for cultural diversity that respected the strengths of American Indian languages, religion, cultural behavior, philosophical world view, and traditional healing practices.

Unfortunately, adversity accompanied the temper of the times. American Indians retrenched and organized highly ethnocentric models. Even today we see the remnants of this in the language guiding American Indian centers for research and academic programs. We struggle to seek Indian solutions to Indian problems, to conduct research that is relevant to Indian communities, and to promote community awareness of Indian cultural needs and aspirations. Our gains during the past twenty years have been

modest, but noticeable. We have gained allies who are bona fide scholars. The guest editor and several authors included in this special edition are non-Indians who are deeply committed to Indian communities and to cultural relevance in research. More importantly, as the federal research meetings noted, we have gained among ourselves. We have a new wave of research and academic talent that will reaffirm cultural perspectives as vital conceptual themes in research.