Mental Health among Elderly Native Americans. By James L. Narduzzi. New York: Garland Publishing, 1994. 225 pages. $61.00 cloth.

Rough estimates indicate that by the year 2000 the population of American Indians over the age of seventy-five will double (S.M. Manson and D.G. Callaway, "Health and Aging among American Indians: Issues and Challenges for the Behavioral Sciences," *Behavioral Health Issues among American Indians and Alaska Natives* 1 [1988]: 160–210). As the number of American Indian elderly increases, the need for culturally relevant mental health service delivery and policy development increases as well.

In his exploratory study on elderly American Indian mental health, James Narduzzi states that his objective is to determine the specific causal factors that are related to poor mental health. In exploring those factors, he utilizes the stress-strain coping model already established in non-Indian physical health research. Few studies have examined stress and coping factors in Indian mental health; only recently have some authors postulated three-way relationships between stress, coping, and mental health outcomes among American Indians in general, much less Indian elderly (see N.G. Dinges and S.K. Joos, "Stress, Coping, and Health: Models of Interaction for Indian and Native Populations," in *Behavioral Health Issues among American Indians and Alaska Natives* 1 [1988]: 8–64).

Narduzzi approaches the secondary data with minimal theoretical attention, relying on the data themselves to unravel and illuminate the complex stress-coping relationships affecting Indian elderly mental health. Utilizing non-Indian research as the guide for identifying the appropriate variables to explore in the stress-coping relationship, Narduzzi hypothesizes that physical health, income, and education are chronic stressors that have direct effects on the mental health functioning of Indian elders. Specifically, Narduzzi hypothesizes that social support (measured as frequency of contacts) and coping (measured with two items on life satisfaction and one item on level of worry) mediate the relationship between chronic life stresses and mental health functioning for Indian men and women as well as reservation and urban Indian elderly. Mental health outcome is assessed with the Short Psychiatric Evaluation Schedule (SPES) developed by Pfeiffer in 1975. The SPES is a fifteen-item abbreviated version of the MMPI, which measures the presence or absence of psychopathol-

ogy. Previous research has raised questions about the validity of the MMPI among American Indians.

Narduzzi's study was based on the 1978–80 data from the National Indian Council on Aging's (NICOA) study of older American Indians and Alaska Natives (aged forty-five and over). Despite the methodological limitations of the NICOA survey (e.g., there was a 40 percent nonreturn rate from the survey interviewer protocol), Narduzzi's findings highlight critical areas for future research on intragroup variation among Indian elderly and lay the foundation for future Indian stress-coping mental health research.

Narduzzi's findings were provocative. Of the 682 Indians sampled, he found that the stress-strain coping model (where physical health, income, and education were the stressors, social support and coping were the mediators, and mental health was the outcome) accounted for 35 to 45 percent of the change in mental health symptomatology among the total sample. Moreover, income, education, and social support were not significant predictors of mental health. Only physical health and coping had significant direct effects on mental health. Additionally, for women and reservation-based Indians, coping mediated the impact of physical health on mental health. Thus, for Indian women or Indians living on reservations, the more life satisfaction and the less worry one has, the less physical health problems will negatively affect mental health outcomes.

Interestingly, unlike the women and the reservation sample, for urban Indians or Indian men coping did not mediate the relationship between physical health and mental health. Thus the relationship between physical health and mental health does not depend on life satisfaction and level of worry (i.e., coping) for urban Indians or Indian men.

Narduzzi highlights the implications of these results for future policy and program development among Indian elderly. Consistent with other Indian mental health researchers, he suggests that future program planning develop gender-specific modalities accounting for the importance of internal mediators in Indian women's coping. Additionally, he suggests that policy planners remain flexible in developing policy, since numerous factors that are not explained by his model are also affecting Indian mental health outcomes. Unfortunately, he does not speculate as to what some of these factors might be. Finally, he suggests that mental health programs should be developed to support, simul-

taneously, the coping capacity and the physical health of all Indian elderly.

Despite the benefits gained from the findings, the usefulness of this book is diminished by Narduzzi's somewhat uncritical approach. Although he acknowledges the limitations of utilizing secondary data, Narduzzi does not adequately address the epistemological shortcomings of the study, nor does he adequately address how cultural factors affect the instruments used, the data collected, or the relationships among the variables. Moreover, no attempt is made in the book to draw any theoretical inferences about Indian-specific stress-coping processes. For me, Narduzzi's failure to integrate a culturally relevant paradigm pre-or post-hoc is one of the most disappointing aspects of the book.

In terms of future research, studies of Indian elderly need to look at the intracategory variability within different elder age groups. For example, in many studies of Indian elders, the definition of *elderly* generally begins around the age of forty-five. Given that the age range of Indian elders might be quite large, future research needs to explore how subgroups of Indian elders experience stress-coping patterns in mental health functioning. In fact, these intracategory age variations might provide evidence as to what factors are associated with the "crossover effect" found among Indian elderly (see Manson and Calloway, 1988). In addition to intragroup variation by age, other factors to be considered in future studies of Indian elderly are intragroup variation by tribe, quantum blood status, acculturation level, identity attitudes, and boarding school experience, just to name a few.

Narduzzi's study highlights future methodological needs in conducting Indian mental health research. In general, mental health researchers frequently acknowledge that cultural worldviews, values, and diverse tribal experiences influence how Indian people conceptualize and express psychological dysfunction. However, in most Indian mental health studies, one of two dialectic frameworks frequently predominate: the universalist approach (etic) or a cultural relativist approach (emic). Narduzzi's study incorporates the etic framework, in which he attempts to understand mental health problems and factors associated with those problems through a set of mental health categories that are assumed to be universal and applicable across Indian and non-Indian populations (e.g., the SPES).

Difficulties arise in Indian mental health research when non-Indian constructs of psychopathology and psychiatric nosology

are assumed to be universal and applicable to Indian populations (see T.D. O'Nell, "Psychiatric Investigations among American Indians and Alaska Natives: A Critical Review," *Culture, Medicine, and Psychiatry* 13 [1989]: 51–87). For example, O'Nell points out that past studies that have classified the presence of visions as "psychotic" (thereby imposing non-Indian psychiatric nosology) clearly misrepresent situations where some Indian people's "visions" are not hallucinatory in their cultural context.

In addition to problems of psychiatric nosology, there is a critical problem of valid measurement across many Indian mental health studies. Many standardized measures, items, response formats, and concepts subsumed in the standardized instrument may not be comprehensible or relevant to Indian respondents. Moreover, if a standardized instrument such as the SPES is used with Indian samples, it is imperative to monitor cross-cultural congruence of concepts of mental health symptomatology. The meaning of the symptoms may vary across tribes, regions, and ages. Researchers must not rely solely on the normative adjustment of current instruments but must integrate or select items that are firmly consistent and based on Indian experience and culture. Narduzzi apparently felt he had addressed this problem by providing internal consistency reliability coefficients for his measures. However, even with acceptable levels of reliability (which is not a substitute for validity) there can still be problems with validity of the measure in terms of factor invariance, construct validity, and measurement equivalence (W.A. Vega, "Theoretical and Pragmatic Implications of Cultural Diversity for Community Research," *American Journal of Community Psychology* 20 [1992]: 375–91).

Although Indian mental health researchers acknowledge that the lack of orienting theory makes it difficult to distinguish psychological processes from sociocultural ones, simply defaulting to the data, allowing the data to dictate the theoretical development, forces us to rely on the reliability of sampling methods, which, for Indian research, is almost always problematic. Although I do not expect us to reinvent the stress-coping theoretical wheel, the lack of "pushing" to develop a framework that might be more culturally appropriate or to incorporate other culturally relevant variables into our equations leaves the interpretation of the results problematic. Failure to mention indigenous explanations of mental health categories or nosology, or to infuse current Indian mental health studies adequately into our a priori concep-

tual framework leaves us theoretically undernourished. A combined etic-emic model guiding Narduzzi's approach to the data might have developed a more parsimonious explanatory model, without subsuming cultural issues. The fusion of etic-emic approaches provides more accurate and comprehensive interpretations of the stress-coping processes that are mediated by cultural factors. Narduzzi's book offers an important point of departure for future research on elderly Indian mental health stress-coping processes.

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Mi'kmaq Hieroglyphic Prayers: Readings in North America's First Indigenous Script. Edited and translated by David L. Schmidt and Murdena Marshall. Halifax, Nova Scotia: Nimbus Publishing, 1995. 182 pages. $16.95 (Canadian) paper.

From the back cover of this book we learn that David L. Schmidt teaches in "the Department of Culture and Heritage at the University College of Cape Breton" and that Murdena Marshall is a "designated Prayer Leader to the 'Santewi Mawio'mi' (Grand Council) of the Mi'kmaq First Nation" and an "associate professor of Mi'kmaq Studies at the University College of Cape Breton." Their introduction (pp. 1–16) is devoted primarily to "A Brief History of the Hieroglyphs," a revised version of Schmidt's 1993 publication, "The Micmac Hieroglyphs: A Reassessment" *(Papers of the Twenty-Fourth Algonquian Conference,* ed. William Cowan, pp. 346–63).

The Micmac call their hieroglyphs *"komqwejwi'kasikl,* literally 'sucker fish writings'—the sucker fish *(komqwej)* being a riverine bottom feeder that, in its quest for food, leaves a muddy filigree" (p. 2). The hieroglyphic script seems to have evolved from an indigenous tradition of pictographic writing attested by seventeenth-century French missionaries (p. 4). The script was standardized in 1677 by Father Le Clercq, who disseminated it on the Gaspé Peninsula among Micmac people wishing to learn to pray. The glyphs were written with charcoal on birchbark. By 1678, this literacy had spread to Restigouche, in northern New Brunswick (pp. 6–7). By the close of the century, it had reached Nova Scotia. In the mid-eighteenth century Father Pierre Maillard "organized