

Alaska Natives Combating Substance Abuse and Related Violence Through Self-Healing: A Report for the People

Prepared for
The Alaska Federation of Natives

by

**The Center for Alcohol and Addiction Studies
The Institute for Circumpolar Health Studies**



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Bernard Segal, Ph.D.

Preface

This report reflects the six contributing authors' combined personal and professional knowledge and experience about events affecting Alaska Natives. Its purpose is to inform readers about alcohol-related violence, why it happens, its effects, and the ways to reduce it. Although this report focuses on Alaska Natives, the discussion can apply to all people.

The report also discusses acculturation changes, and describes the effects of cultural change experienced by Alaska Natives. The relationship among acculturation stress, substance abuse, and violence is described. Of primary importance is the recognition of how loss of culture is interwoven with substance abuse and violence, and how vital cultural values and tradition are to the integrity of Alaska Native communities. In learning from Rupert Ross (1992), the following question applies: How does the unwillingness of the non-Native society in Alaska to acknowledge that Alaska's indigenous people have different values and institutions that have not lost their relevance and application despite over a hundreds years of cultural and technological advances, bear upon their affairs with indigenous people?

The answer, again learning from Rupert Ross, is that as long as the government and the agencies of Alaska, as well as federal authorities, fail to recognize that Alaska Natives still value their traditional practices and institutions, and as long as non-Natives insist that Alaska Natives abandon their ancestral heritage and embrace western ways, cultural stress will continue and Alaska Natives will be vulnerable to its effects. Ross (1992) also stated that, "And so long as the government and the officials . . . continue to act as if the original people are the only ones in need of instruction and improvement, so long will suspicion and distrust continue" (p ix).

A large section of the report deals with this situation, and talks about how the non-Native community can begin supporting Native communities to regain traditions and to achieve healing. Neither the Native nor non-Native worlds can live apart. Each has to learn from one another.

In discussing the issues described above, attempts were made to be non-judgmental. If any offense was committed or facts misrepresented, the responsibility is solely mine.

Bernard Segal, Ph.D.

EXECUTIVE SUMMARY

ALASKA NATIVES COMPATING SUBSTANCE ABUSE AND RELATED VIOLENCE THROUGH SELF-HEALING: A REPORT TO THE PEOPLE

Statement of Purpose

For more than a decade, the Alaska Federation of Natives (AFN) has sought to bring attention, understanding and solutions to the problem of substance abuse and related violence among Alaska Natives. Progress has been made in some communities, but substance abuse continues to cause suffering, pain, death and despair among many Alaska Native families. At the request of AFN, this report was undertaken to provide a basis for deriving effective, lasting solutions.

Dimensions of the Problem

Substance abuse in Alaska Native communities is a complex problem that encompasses elements far beyond the act of drinking or drug abuse and their immediate effects. Alaska Native substance abuse is intimately linked to events that have transpired in Alaska since its occupation by non-Native people. Drinking and drug use are intricately tied to cultural and economic changes that have affected Native people since the early Russians, and those who followed, began imposing their cultures and values on the Native way of life.

Scope of Analysis

This report provides perspective on how drinking and drug use have come to be so prominent within the Alaska Native community. It details the extent and effects of substance abuse and suggests strategies to reduce these problems and to improve treatment outcome for Alaska Natives. The report includes statements from Native people about how they were impacted by cultural change, and describes difficulties experienced by Alaska Natives resulting from acculturation stress. It also illustrates how Alaska Native groups have begun to deal with substance abuse issues in their own communities. This report includes discussions of:

- The origins of the current predicament facing Alaska Natives concerning substance abuse;
- The prevalence of alcohol-related health and social problems within the Alaska Native community, including homicide, suicide, family violence, child abuse (both physical and sexual), accidental death, inhalant abuse, and drinking and other forms of substance abuse;
- An analysis of the relationship between violence and substance abuse with respect to cause and effects, and the development of effective intervention strategies, with special attention given to violence against women;

- A comprehensive discussion of Fetal Alcohol Syndrome (FAS), specifically detailing the problem of obtaining reliable estimates of FAS prevalence levels in Alaska;
- Examples of the experiences of other indigenous cultures, and the methods they are pursuing to reduce their alcohol-related distress and accompanying violence;
- Examples of efforts undertaken in Alaska to deal with problems within Native communities; and
- A critical discussion of what can be done to reduce problems related to substance abuse, to achieve healing, and to restore cultural integrity.

Specific Findings

Historical Context: Culture in Crisis

- Since Russians, Europeans and Americans first settled in Alaska during the 18th Century, they attempted to dominate Alaska Natives through economic policies, religion, laws, and by imposing cultural changes.
- The Russian and early American traders frequently drank until highly intoxicated, thereby establishing a pattern of binge drinking modeled by Alaska Natives.
- Alaska Natives were told that their “problem” was their culture. Many of their children were taken away and sent to boarding schools where, among other things, they were punished if they used their own languages.
- Alaska Natives were told that their spirituality was based on superstition, and that to be “saved” they needed to adopt the religions of different missionary groups.
- Many Alaska Natives today remember the loss of entire families and villages due to diseases from which they had no immunity.
- Whereas Elders tended to exercise control over drinking in the early days in many villages, this traditional role was lost as successive non-Native governments dictated policies regarding the sale and use of alcohol by Natives.

Results of Acculturation and Cumulative Stress

- The widespread occurrence of cultural loss and social disintegration puts stress on minority groups, such as Alaska Natives, that results in the loss of physical and mental well-being.
- Acculturation stress can become cumulative within communities, and its effects can be experienced over time as intergenerational grief.
- Any culture in crisis experiences significant stress-related problems, such as homicide, suicide, family violence, child abuse (both physical and sexual), drinking and other forms of drug-taking behavior, including inhalant abuse, all of which have been experienced by Alaska Natives.
- The destructive effects of substance abuse, including inhalant abuse by youth, are inextricably interwoven into all aspects of the abusers’ lives; any effort to alleviate these problems must be comprehensive in scope, and account for all these elements.

Alcohol, Drug Abuse and Violence

The findings below characterize the severity of substance abuse and related violence within the Alaska Native community. The information is provided to illustrate the seriousness of the situation and to highlight the need for continued efforts to overcome these problems.

- Alaska Natives' alcohol problems are severe and frequently involve other drugs, such as marijuana and cocaine.
- Many Alaska Natives in treatment manifest psychiatric problems such as depression and Antisocial Personality Disorder.
- Alaska Native men in treatment have perpetrated higher rates of alcohol-related violence compared to non-Natives.
- Alaska Native women entering substance abuse treatment have experienced exceptionally high rates of victimization.
- In a study of women in treatment for substance abuse, 100% of the Native women reported being victims of either physical and/or sexual abuse.
- Violence against Native women takes many forms, including sexual abuse (i.e., incest, rape and other kinds of sexual offenses), psychological abuse, and physical assault and murder.
- Violence can occur any time during a woman's life, and alcohol and/or drugs may be used to ease the pain associated with victimization.
- When compared to other ethnic groups (Whites, African Americans and Latinos), Alaska Natives are more likely to be perpetrators or victims of alcohol-related violence.
- Alaska youth reportedly start at early ages abusing inhalants.
- Children are dying from inhalant abuse, adding to the cascade of substance abuse fatalities among Native people.
- To date, research has shown that Alaska Natives do not possess any unique or identifiable genetic characteristic related to metabolizing alcohol that makes them susceptible to alcoholism (i.e., they are not different from people of European heritage, American Indians, Hispanics or African Americans).

Improving Treatment Outcomes

- The problems Alaska Natives bring to substance abuse treatment programs are more complex than just alcohol or drug addiction; therefore, it is critical that these complexities are addressed to improve treatment outcomes.
- Alaska Native women who maintain a sense of cultural identity are more likely to complete treatment than women who have lost their cultural identity.
- Many Native women who have experienced severe childhood sexual abuse and/or physical assault are at high risk for Post-Traumatic Stress Disorder (PTSD), similar to that experienced by war Veterans; PTSD must be addressed for treatment to be effective.

- Substance abuse counselors must work within the cultural framework of their clients' backgrounds with an understanding and appreciation of Native values and traditions.
- Traditional Native healing methods help individuals regain a balance of body, mind and spirit, and should be incorporated into treatment programs.

The Role of Alaska Natives and Non-Natives

- Change cannot occur without the participation of the non-Natives who must recognize their historical role in the transformations that occurred in Alaska; non-Natives need to make amends and support Native initiatives.
- Alaska Natives are the people who best understand their dilemma and what can be done about it.
- Any new programs to find the "road back" must incorporate what each community decides will be helpful in meeting its needs.
- Western knowledge can complement traditional knowledge if it is contextualized within a culturally and community relevant framework.
- Alaska Natives have taken action to reduce the incidence of substance abuse-related problems in a variety of ways, from small village initiatives to large formal programs. All these programs should be supported.
- More can be done, and Alaska Natives have the power to take control of their own destinies and forge a new, united and strong future based on the traditions of the past.
- The non-Native community's responsibility is to recognize and support the process of change and self-healing.

Conclusion

These conclusions are based on: (a) a comprehensive analysis of information pertaining to cultural change and substance abuse among aboriginal peoples, (b) the history of events in Alaska, (c) the words and writings of Native people, and (d) an evaluation of the effectiveness of initiatives undertaken to combat substance abuse in Alaska and elsewhere. Consideration of all the information gathered has led to one major conclusion: significant progress in restoring the lives, the dignity and the cultural pride of Alaska Native peoples can only be achieved through self-healing. Alaska Natives must unite, despite their individual cultural differences, to create solutions in their various communities that draw strength from their cultures, traditions, heritage and spirituality. With lives no longer shattered by the violence resulting from alcohol and substance abuse, Alaska Natives can move into the 21st Century as a united, strong and healthy people.

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INTRODUCTION

Each of us is caught up in his own way between two worlds. Please try to fathom our great desire to survive in a way somewhat different from yours. The United States has allowed many diverse cultures to maintain their cultural identity. Let us keep ours! Poverty has only recently been introduced to Native communities. Native languages have no words for being rich or poor. If everyone were just looking out for himself, Native cultures would have vanished long ago. It has been through sharing and helping each other that people have survived.

The ownership of the land has been broken into many small pieces, but land itself is not broken into pieces and villagers' use of the land cannot be broken into pieces if the native way of way of life is to continue. This is the land that our Ancestors were the first ones to walk on and were the first ones to live here quietly.

When Russia claimed Alaska as its territory, the Native people had no voice; when the United States bought Alaska, Native people had no voice. When Alaska became a state, Native people had no voice. When large wildlife refuges were established in Alaska, Native people had no choice. When fish and game regulations were formulated, Native people had no choice. Even when the Alaska Native Claims Settlement Act was passed, Native people were not heard; many villagers did not even know their land claims were being settled. One Native stated:

"Every time I go hunting, survival hunting, I have this guilt feeling that I am stealing behind someone's back for the food I need for myself and my family. The people will not sit around and obey a law when their families are starving. It is our conviction that the Native way of life can be saved and only our youth can save it. Professionals are teaching our children to read and write, repair a car, weld two pipes together, but they are not teaching the children the most important thing, "who he is." We do not dislike western civilization or White man, we simply treasure our young and culture. It is our belief that both can live together side by side, but not necessarily eating out of the same bowl."

The purpose of western education is for the individual to find ways to excel and promote himself, whereas the purpose of the Native education has always been for the individual to find ways to serve his family and his people. If the education our children receive helps them retain some of the subsistence skills and self-sufficiency of our ancestors, they will carry, into the uncertain future, tools which may make the difference between surviving and perishing in difficult times.

Unless we are willing to let change take over and the forces of western civilization just sweep us along, we must gain control of this process of change.

-Harold Napoleon

This statement captures the current situation facing Alaska Native people. It also expresses a solution. The question that arises is how has the situation in Alaska come to the point where, as Harold Napoleon asked, “does one culture may have to die so another can live?” A second question is: “What can be done about it?”

The purpose of this report is to present answers to these and other questions in order to prevent the death of a people. It begins by providing a perspective on the problems and issues facing with which Alaska Natives and concludes by suggesting actions that can be taken to overcome these problems. This report contains (a) a brief historical overview of the origins of the current predicament among Alaska Natives; (b) a selected description of the prevalence of health and social problems within the Alaska Native community; (c) a review of some of the primary problems facing Alaska Natives today, specifically focusing on violence and substance abuse, and exploring the relationship between these two phenomena with respect to causes, effects, and strategies to reduce these problems; (d) an analysis of what some other indigenous cultures have experienced, and methods pursued to reduce their distress; (e) a review of efforts undertaken in Alaska to deal with problems within Alaska Native communities; and (f) a critical discussion of what can be done to combat problems and achieve healing.

CHAPTER I

CULTURAL CHANGE

The Alaska Natives' lifestyle is relatively uncomplicated. A written language or higher level of education were not relevant to the immediate needs of the Native peoples and did not concern them. Their values were in hunting, fishing, and berry picking for food, and gathering wood and burnable materials for warmth. A home was a simple structure that would house the whole family unit. The great land and "Nature" itself was what they gave praise to.

-Ralph Amouak

Childhood experiences with my grandfather taught me a great deal about this wonderful world we live in. I cannot explain the emotions I experienced as I discovered some of the secrets of the earth and how terrified I would feel because of my own inadequacies in facing the power of those mysterious secrets. Grandfather said we come from "ngan" and grow like the "Gidagadah." The root is connected to the earth, which is our source of life. From the earth comes strength through the food we eat and from the thought generated into knowledge. He taught me that the Chief Spirit communicates with us through our connection with the earth. The thoughts we generate because of this connection is put into the mind before it is put into words. The words come from nothing into being and are a gift that is very sacred and must not be abused. He referred to this as "our way," or the "way of our people."

-Ernie Turner

A. Changes in Alaska

The traditional world of the Alaska Native has changed, and the nature of this change is profound. In 1990, the U.S. Congress authorized the formation of the Alaska Native Commission (the Joint Federal-State Commission on Policies and Programs Affecting Alaska Natives) to examine how changes have affected Alaska Natives. A significant factor in the establishment of the Joint Commission on Alaska Natives was the report issued by the Alaska Federation of Natives (AFN) in January 1989, titled "The AFN Report on the Status of Alaska Natives: A Call for Action." AFN's report emphasized the destructive effects of alcohol and other factors on Alaska Native communities, and conveyed an urgent need to address the social, cultural, economic and spiritual causes of alcohol abuse. The report also called for improving the physical and mental health of Alaska Native villages, families and individuals. Further, it emphasized that the Alaska Native community must begin to deal with domestic violence, sexual abuse and incest and other significant problems.

The Alaska Native Commission's (ANC) report, released in 1994, covered a myriad of concerns ranging from health to economic issues. It attributed all the disruptions to Alaska Natives' ways of life to the fact that "village people lost hold of their communities and their children's lives" (Alaska Native Commission, 1994a, p. 4).

The Commission recommended a number of steps to address problems in the following areas:

- Economic
- Village Economies and Cottage Industry
- Judicial and Law Enforcement
- Local Self-Determination
- Local Resource Management Issues
- Physical and Behavioral Health
- Child and Family Health
- Health Education and Preventative Health

B. Alaska, "The Great Land"

Events taking place in Alaska have to be understood in terms of Alaska's geographic and climatic features, which have a significant bearing on the lifestyle of all its people. Alaska encompasses 586,400 square miles, or one-fifth the area of the continental United States. Four major mountain chains and 12 major river systems are found within Alaska's borders. About one-quarter of the land mass is above the Arctic Circle, where permafrost locks about two-thirds of the Arctic lands in perpetual ice. The southcentral and southeastern coasts, part of the total 33,000 miles of coastline, are the only sections that thaw completely during the summer months.

Transportation in Alaska, except for the Alcan Highway, is chiefly restricted to airplanes, which is extremely expensive and unpredictable due to weather fluctuations. No road system exists other than between Seward, Homer, Anchorage, Fairbanks, Tok, and Valdez. A ferry system serves the southeast, but service is restricted during the winter months.

Alaska is still very much of an immense wilderness, with many of its Native people living in isolated villages or communities, resulting in unique, adaptive lifestyles. Their culture and communities, however isolated, have nevertheless been affected by the influx of non-Natives and accompanying technology. Television, for example, is now beamed in by satellite to all remote communities, and internet capability is available throughout the State.

For purposes of demographic statements and analysis, the State of Alaska has been divided into four large, contrasting regions. These are (1) Southeastern Alaska, (2) Central and Interior Alaska, (3) Northern Alaska, and (4) Western Alaska. Each of these regions contains Alaska Native groups with different language and cultural traditions, as well as rural hubs and urban centers with a mixture of non-Native and Native residents.

The rugged terrain of Alaska experiences extreme variation in climate. The Aleutian Islands, which extend over 500 miles from the mainland, can be buffeted by storms with winds exceeding 100 miles per hour. Daylight hours vary from total

sunlight in the summer to complete darkness in the winter in northern areas, with variations of seasonal daylight and darkness in the Interior, Southcentral, Western and Southeastern regions.

Historically, Alaska's indigenous people have adapted well to arctic and sub-arctic conditions. Environmental changes, however, combined with dramatic social and cultural shifts, appear to be overburdening their ability to adapt and survive (Paschane, 1998).

C. Alaska's Original People

In 1995, Alaska Natives comprised 17% of the total population of 608,000. Athabascans, Yup'ik, Inupiat, and Aleuts are scattered throughout the cities (30%) and villages (70%), which are mainly in the Interior, North, and Southwest. The southeastern part of the State is inhabited by the Tlingit, Haida, and Tsimshian peoples.

Many Alaska Natives live in remote village communities ranging from several hundred to several thousand persons. Some of the more isolated communities strive to maintain a subsistence economy, hunting and fishing for survival. Life centers around the extended family and some traditional practices are carried on. Many rural hubs reflect the western cash economy practices, including competition for wages, and contain all the problems inherent in larger communities. Broken village ties, the presence of a dominant non-Native culture found in most large rural hubs, and a high rate of transience and economic instability, contribute to make some Alaska towns disorganized and stressful places to live.

Alaska Natives who live in large western urban centers, such as Anchorage and Fairbanks, are generally at a distinct disadvantage from the dominant culture. Alaska Natives are at a higher risk than non-Natives for suicide in urban settings (Blackwood, 1978; Brems, 1996, Kraus and Buffler, 1979).

D. Impact of Change on Native Cultures

No one has made a concentrated effort to force assimilation upon other ethnic groups who were defeated upon the field of battle, such as the Japanese or the Germans. To the contrary, all efforts were directed toward helping these groups to rebuild upon their own cultures and value systems. Why then, this seemingly urgent need to have the Alaska Native become as all American people?

To the Alaska Native -- Eskimo, Aleut, or Indian -- alcoholism is different, and the definition of the problem and methods of correction must come from the Natives themselves.

-An Anonymous Alaska Native

1. Acculturation Stress

When Western Europeans migrated to Alaska, they imposed their cultural traditions on Alaska Native people without concern for their traditional values. As AFN noted:

...the pace of economic, social and cultural change in Native villages has been so rapid and the change so profound that many Natives have been overwhelmed by a world not of their making -- a world of conflicting values and increasingly limited economic opportunity. For many Natives, the sense of personal, familial and cultural identity that is a prerequisite to healthy and productive life is being lost in a haze of alcohol-induced despair that not infrequently results in violence -- perpetrated upon self and family. (AFN, 1989, pp. 1-2)

Nearly two decades ago, Annie Bowen, an Inupiat woman from Wainwright, described how the Inupiat values and traditions were impacted (Annie Bowen, Personal Communication, April 24, 1981):

Nomadic life dictated by hunting and fishing was dominant. Small family groups. Expression of feelings/emotions was also affected/dictated by close family living situations - one room homes. No talking in the sense of western conversation. Closeness of living in village allowed everybody to be aware of what was going on - no need to communicate feelings or emotions. Body language and facial gestures sufficed.

Adaptation to demands of western culture resulted in:

- Rules and regulations.
- Schools.
- Loss of communication patterns.
- Loss of sense of kinship, community, sharing, passing on traditions, and extended family relationships.
- Loss of personal freedoms associated with subsistence and nomadic lifestyle.
- Loss of personal freedoms associated with being able to respond to seasons.
- Diet and food changes.
- Loss of permissiveness as part of the culture – have to abide by a new set of parental controls. The community was governed by common sense in relation to subsistence living - solving the problems of the hunt and survival were the major problems and challenges.

Ms. Bowen asked:

- Should acculturation have taken place?
- Should it continue?
- Should old ways be retained?
- What should change?

Two Yup'ik men gave a similar description of cultural change. They said that living on the Tundra in the Yukon-Kuskokwim involved:

- Running barefoot during the summer.
- No poverty.
- No concern with “world” problems.
- Dance was an important function, and served as a social gathering at ceremonial house.
- Using boats to hunt and fish in the traditional way.
- Living in sod houses.
- Burning wood as fuel.
- Making clothing from skin of salmon and pike. (Wassilie Evon and Louie Andrew, Personal communication, April 24, 1981).

Both men also believed there was a need to assess the impact of change. They were concerned that alcohol had become a significant disruptive influence in their community, and that individuals had lost respect for personal property. Implied in their messages is a disturbing concern that their cultures were unalterably changed.

Stress was also placed on the traditional lifestyles of Alaska Natives when natural resources were developed, particularly oil. Discovery of oil at Prudhoe Bay in 1968 led to a period of tremendous upheaval, which contributed to a movement to have Natives settle their aboriginal land claims. As a result, the Alaska Native Claims Settlement Act, which Congress enacted in 1971, allotted 44 million acres (changed from aboriginal title to fee simple title), and compensated them with nearly a billion dollars for extinguishing their claims to the rest of Alaska.

The impact of the Native Claims Settlement Act is on-going. This quantum leap into the corporate world, with all of its ramifications, has presented a challenge to all Native people. Further, the construction of the 800-mile Trans-Alaska Pipeline to transport Prudhoe Bay oil stimulated a boom economy and the influx of a large non-Native population, lured by high income jobs. This development initiated new interest in Alaska for its money-making opportunities due to the State's rich mineral resource base and on- and offshore oil and gas reserves. Due to the global need for energy resources, Alaska undoubtedly will continue to face major development. Social and economic change can be expected to affect all Alaskans, but Alaska Natives will continue to be subjected to inordinate amounts of stress related to development of their lands.

Alaska's development led to the onset of a host of new problems, including new diseases, social changes, and the introduction of alcohol. Berry (1985) noted that one of the consequences of cultural change is an increase in health problems that occur “not simply because [cultural changes] are newly-introduced...but also because the widespread occurrence of cultural loss and social disintegration renders individuals more susceptible to these novel elements; thus, the new concept of stress is equally relevant to loss of physical health as to mental health” (p. 22).

A byproduct of acculturation is conflict, resulting from pressures exerted by the dominant culture to have the minority group change its way of life. When conflict and stress or tension are present, which are increased when the minority group resists

change and no solution is in sight to preserve its ways, the minority culture may be in crisis (Berry, 1985). This crisis continues over time, depending on the extent of adaptation that takes place, but the stress may nevertheless become cumulative, both on a group and individual level. A culture in crisis thus experiences more stress-related problems such as homicide, suicide, family violence, child abuse (both physical and sexual), drinking and other forms of drug-taking behavior, phenomena that are well-documented among cultures experiencing change (Olsen, 1985).

Alaska's development has also significantly affected the ability of its indigenous people to maintain their heritage of spirituality and live with nature. Alaska Natives were intensely involved in their traditional spiritual beliefs. The spiritual content of the people, along with tribal traditions of culture, formed what is often referred to as the "sovereignty" that held people together. To the individual, deep spiritual feelings and respect for all of creation were as much a part of their being as their physical features and personality. Spiritual power flowed like energy from their bodies, guiding their thoughts and actions throughout their lives, endowing them with values and a world view that gave meaning to their existence. French & Hornbuckle (1990) stated:

The continuing loss of this tradition has also contributed to acculturation stress. Berry (1985) defined acculturation stress as "stress related to cultural change resulting from continuous, first-hand contact between two distinct cultural groups." Acculturation stress occurs at both a group and individual level, the latter of which is referred to as psychological acculturation (Berry, 1985). The impact of cultural change has been clearly reflected in the following statement that describes the dilemma of Native Americans:

The steamrolling effect of the civilized society upon the Indian people has wreaked havoc which extends far beyond that of loss of material possessions. The American Indian and Alaska Native are caught in a world wherein they are trying to find out who they are and where they are, and where they fit in. The land which was once their mother, giving them food and clothing, was taken. Their spiritual strengths were described as pagan, and familial ties were broken. Their own forms of education, that of legends, how to live, how to respect themselves and others, were torn asunder by the white society's reading, writing and arithmetic. No culture could, or can be expected to be thrust into a world different from its own and adapt without problems of cultural shock. The Indian people of today are proud of their heritage and are fighting to maximize its influence upon their lives in a dominant White world. Many have succeeded. Many have not... The destructive use of alcohol and drugs among Native Americans and Alaska Native individuals, families, and communities is inextricably interwoven into all aspects of their life and any effort to alleviate the problem must be comprehensive in scope and with the full commitment of the Indian people. (p. 275)

As is described above, acculturation stress results in cultural disruption that affects normal or traditional behaviors. Additionally, when traditional child-rearing values and practices, as well as other aspects of cultural behaviors involved in child rearing are impacted or even lost to the culture, the result (such as a lack of cultural identity) appears to serve as a particular susceptibility to early involvement in drinking or other forms of drug-taking behavior. The effects of cultural disruption can thus lead to an at-risk predisposition for drinking and other forms of drug-taking behavior early in one's development. These conditions can also affect or involve the biological domain (e.g., Fetal Alcohol Syndrome (FAS), or a drug-related birth defect, malnutrition, etc.) or the psychological domain (e.g., physical or sexual abuse).

Deeply rooted values are an essential part of existence. If they are lost, a person, in a western term, faces "anomie," a loss of a sense of self. Cultural disruption and anomie are related, and regaining a sense of self is intricately connected to reestablishing cultural control. It is possible to suggest that the loss of self-identity underlies many of the social, and even health, problems found among Alaska Natives.

In addition to personal feelings of anomie, "people experiencing acculturation changes may also experience feelings of distress caused by the perception that the acculturation process is unpredictable, on-going, and with no end in sight." (Brian MacLean, personal communication, February, 18, 1999). It is essential to understand how Alaska Natives struggle to survive in their changing world by incorporating two perspectives: (a) learning about the process of how a dominant culture affects the minority culture, and (b) learning how the minority culture adapts to or copes with changes in its own culture.

Part of seeking solutions to the effects of cultural change involves appreciating the "world view" of different Alaska Native groups, derived from their cultural heritage, and understanding how these belief systems guide behavior. Such knowledge must be incorporated into any plan or organizational effort to deal with problems within Native communities.

E. Addressing Cultural Change

One important effect resulting from the development of Alaska by non-Natives was the decline of traditional Native cultural ways. Many non-Natives sought to replace traditional languages and culture with western values, religions, language, and cultural traditions. A lasting effect of over 100 years of this process has been cultural change and accompanying acculturation stress. Further, the introduction of alcohol contributed to hasten the decline of the cultural integrity of Native communities.

Given the above perspective on acculturation stress and alcohol, several questions arise:

1. How are the stresses and strains related to cultural change manifested?
2. What are the psychological impacts and outcomes of acculturation?
3. To what extent are alcohol and other drugs used to mediate or cope with the impact of a society in transition?
4. How are the strains and stresses of emotional conflict attributed to being a member of a minority group undergoing cultural change?

5. What are the processes that a cultural group goes through when impacted by the larger and dominant culture? Related questions are:
 - How do subgroups resist such change?
 - What are the perceived roles of drinking and other forms of drug-taking behavior in these processes?
6. To what extent is the drinking and drug-taking behavior among subgroups a reflection of what they have learned from the dominant culture?
7. How has alcohol-related violence come to be associated with acculturation stress?

Answers to these questions could help ease the effects of cultural transition, and might also help Alaska Natives retain many of their cultural values and traditions. Such information could also facilitate a better understanding of the onset of drinking and drug-taking behaviors, as well as help to develop prevention and intervention strategies which deal directly with issues that reinforce drinking and drug-taking behavior within given cultural groups.

Direct and indirect responses to these questions are presented throughout the remaining chapters. It is stressed throughout that, although Alaska Natives have been overwhelmed by the abuse of alcohol and alcohol-related violence, resolutions are possible, and that the means of overcoming adversity within the Native community largely rests with the Native people themselves. Non-Native Alaskans also have a responsibility to assist in this “healing” process. How this assistance can occur is discussed more fully in Chapters XII and XIII.

Prinz (1995) has noted that “With the clash of cultures and economies, a significant number of Alaska Natives find they and their families are caught in a circle of destruction (domestic violence, neglect and child physical and sexual abuse). That circle is glued together by alcohol and other substance abusing behavior that, for some, has become normal” (p. 15). The path back to cultural integrity and healing begins with understanding the nature of the impact of cultural change on the traditional lifestyle of Alaska Natives.

CHAPTER II

EFFECTS OF CULTURAL CHANGE ON NATIVE PEOPLE

Culture in transition simply means the changes village people experience through time after contact with another culture. To explain these changes isn't simple because these changes happen in many ways. Someone once quoted 'sixty million factors are involved when a village goes through the process of change.'

There is nothing wrong with change. Change happens all the time. But when people experience any kind of change too quickly and this change is literally forced on them and affects every area of their life then change becomes trauma. Transitional trauma is a term we can use to describe this change.

We, that is, Alaska Native people, do not fully understand the extent to which we were adversely affected by this change. It isn't easy for us to compare ourselves to other Native or indigenous people around the world. And like us, they continue to live through this same type of transition. This fact, however, does not diminish or lessen the significance of the extent to which we suffered nor does it lessen our need to understand the trauma we have and continue to experience.

-Anonymous Alaska Native Woman

A. The Effects of Contact with Western Cultures

This chapter describes the effects of cultural change resulting from the colonization of Alaska, and starts to answer some of the questions cited at the conclusion of Chapter I. The following two statements are taken with permission from Bridges to the Future: Traditional and Local Healing Practices in Alaska (Saylor & Henkelman, 1998).

Many Native cultures experienced similar changes with the interactions and eventual take-over by the Russian and European hunters, traders, and missionaries. For some, initial contact brought useful trade of Native goods (e.g., furs, ivory, baleen) for technical tools (e.g., steel needles, knives, rifles, and cloth)...

Tragically, the same meetings brought harmful influences such as alcohol and communicable diseases (e.g., smallpox, diphtheria, typhoid, and influenza)...The unbelievable horror of watching one's entire family, and even village, die within days is unimaginable for most of us in today's society. It sounds like a nightmare to hear Elders speak about the death of entire families, even villages, within days.

In the face of new and terrifying diseases, the “old” ways were not effective in saving the people. Some Alaska Natives reacted by turning to missionaries for medical and spiritual answers to the massive loss of life. But as Martha Demientieff described it, Christianity came at a time when people were vulnerable.

Doctors, teachers, and missionaries came to Native communities with the idea that there was something wrong with these people and we’re going to fix it. Everything we knew was put underground. It happened during a time when epidemics were hitting our people so hard and so bad. People had no immunity. At the same time that they were suppressing our healing practices, the diseases were killing us like flies.

-Key Informant Interview

The people’s doubts and fears about their own practices were fed by the European Christian and Russian Orthodox missionaries who told them their ways were ineffective because they were based on superstition. The traditional healing practices diminished significantly because of the influence of the churches and due to the loss of so many Elders in the epidemics. The goal for Alaska Natives, in the eyes of the federal government, was assimilation into the dominant culture. As one Southcentral Foundation Board member put it, “Many of our traditional ways had relevant information that was cast aside wrongly.”

-SCF Board Focus Group

To truly understand the state of Alaska Natives today, it is crucial to recognize that the events describe above were fairly recent. The devastation of major disease epidemics, the destruction of an entire subsistence way of life by non-Native hunters, and the total shift in belief systems occurred within the lifetimes of the Elders. The memory and grief related to these events are fresh in the minds of many Alaska Natives, and have been instilled in the consciousness of younger generations.

Part of the legacy that Alaska Natives have to contend with is the paternalism practiced by the non-Native settlers who perceived the Native people as their “charges.” These newcomers believed that the way to improve the health and well-being of Alaska Natives was to educate them and bring them into the western world. Consistent and profound messages were delivered by religious leaders and educators that Alaska Natives’ cultural traditions were primitive, unfounded and bad; the new ways that were offered by Christian churches were better.

Nomadic seasonal activities by Alaska Natives were prohibited by the insistence that young children go to school in urbanized settings, and that older children continue their education at boarding schools. Alaska Native parents had to comply with these requirements, which resulted in their children being physically removed from their homes and family influence, and forced to live in a new, alien environment.

The boarding schools established an entirely new set of social and cultural values which were foreign to the children's traditional up-bringing. They imposed a new language, English, which affected village life. Further, the discipline that was inflicted in the boarding schools was very different from the traditional means of gaining child

compliance and participation. The children developed in a different environment far removed from their families and communities. They were forced to obey rules, and to conform to a strange culture.

The boarding school environment produced an emotional cleavage. What had been learned about traditional family life and parenting was lost. During the boarding school period, which involved several generations, Native children were denied an opportunity to be raised by their parents and learn their culture's traditions. They had to acquire western values, and were told that their traditional beliefs were no good.

This era in Alaska Native history ended with the Molly Hootch decision and the Tobeluk consent decree in 1976. The Molly Hootch decision was applauded by Native people because it enabled children to stay in their home towns to be educated. But the decision was too late for children who went to boarding schools. Many of them had been denied the opportunity to grow and develop normally in a family environment and to experience village life.

Thus, a generation of Native youth had no opportunities to learn parenting skills or traditional ways. As these youth matured and raised families of their own, many lacked the knowledge and experience needed to provide a stable cultural foundation for their children. Many parents became frustrated because they felt that they could not control their children's behavior except by displaying the often harsh discipline they received at boarding school. Rifts emerged in families, with children experiencing a lack of discipline or rebelling against strict rules. Parents were at a loss to know how to relate to them.

In the years following the Molly Hootch decision, there have been new efforts to provide programs for parents. Schools are under greater local control, and are seeking innovative ways to enrich multicultural education. Yet, middle aged and older Alaska Natives continue to carry strong memories of how they were treated as children.

Many Alaskans believe the problems faced by Native people today are a direct result of their historical experiences. Current problems such as personal violence, child abuse and neglect, and alcoholism are a reflection of the stress passed down through families (Napoleon, 1990). Hence, we witness intergenerational grief. Harold Napoleon (1990) describes this phenomenon, with an emphasis on Native males:

Alaska Native villages and their people are indeed depressed. Not only are they suffering spiritually as a result of seemingly forgotten assaults to their psyche, but this psychological depression is exacerbated by their almost total dependence on "handouts" from federal and state governments. From birth to death an Alaska Native is "cared" for by government. He is even buried in a casket paid for by the government. He holds a high school diploma, but is "unemployed." His family, living on government dole, does not "need" him for support. So he feels useless and has "nothing" to do.

Today's generation of Alaska Native people are a generation which have turned on themselves. They blame themselves for being "unemployed," or being second class citizens, for not being "successful" as success is portrayed to them by the world they live in. They measure themselves by the standards of the television America and the textbooks America, and they have "failed." For

this they blame themselves. There is no one to tell them that they are not to blame, that there's nothing "wrong" with them, that they are loved. Sometimes they don't even know who they are, or what they are. This of course does not describe all young Alaska Native people. But it describes the suicides, the alcohol abusers, the ones in prison, the ones with "nothing to do" in the villages. These are the numbers we hear in reports. They are living human beings -- Eskimos, and Indians -- the ones we pay no attention to until they become a number.

Chances are good they saw violence in the home - physical, verbal, psychological. Chances are good that they were "ignored," not paid attention to. Chances are that they were disappointed as children, emotionally hurt, heartbroken. Chances are they thought themselves unloved, unwanted. Chances are they knew hunger, were dirty, rested little, and did not do well in school. Chances are that they were disappointed by their parents -- maybe they loved them, but were not loved in return. Chances are they yearned for happiness and a normal home but were denied it. Chances are they no longer communicate with others -- not their parents, not their relatives, not with friends, with no one.

By the time they are grown they are deeply depressed in their souls. By the time they are grown they have become demoralized, discouraged, and they do not think very much of themselves. Deep in their hearts they hurt, are angry, frustrated and confused children. They never talk, they have turned inward.

These are the ones who when they drink alcohol quickly become addicted to it, psychologically first, physically second. And soon under the influence will begin to vent their anger, hurt, frustration and confusion, seemingly out of the clear blue sky. And sadly, it is directed at themselves and those closest to them -- their parents, their brothers, their friends, members of their village. And the most tragic events are those with a "blacked out" male Eskimo, Aleut or Indian who, while completely out of control, vents these deadly emotions or violence and mad acts resulting in dismemberment and death, thereby leaving even more traumatized victims and witnesses. (pp. 18-19)

Dr. Clare Brant (cited in Ross, 1992), a Canadian psychiatrist, has reported similar experiences among Canadian Indian tribes. But she attributes the reasons for alcohol-related traumatic outbursts to their need to express emotions, which are otherwise prohibited in their Indian culture. She states that:

This "anger must not be shown" principle gives rise to a certain number of difficulties psychiatrically. For instance, it gives rise to explosiveness under the influence of alcohol. That is to say, anger that has been stored up, never shown, not ventilated and discharged, comes pouring out when the person is intoxicated. It also results, by a complicated psychological mechanism, in a high incidence of grief reactions among the Indian people. (p. 144)

Every society or culture has developed its ways of expressing emotions, such as anger, joy, grief, etc. Some are explicit while others are quite subtle. Members of any given cultural group can observe and interpret signs of anger and other emotions that outside observers frequently miss.

Many of the effects of a culture in transition were described by an Inupiat woman in a talk with Alaska Natives:

- Identity confusion
- Absent father
- Overworked mother
- No parental bonding
- Children avoiding the home
- Little or no self-esteem
- Unemployment
- Feelings of emptiness, hopelessness, and despair
- Alcoholism
- Physical, sexual, and psychological abuse
- Rape and incest
- Violence in the home
- Having little or no direction in life
- Silence in the home
- Rage – unresolved rage because of unresolved multiple losses and delayed grief
- Denial
- Poor parenting skills
- Lack of spirituality
- Loss of traditional customs, practices, languages, and oral tradition
- Little or no intimacy or closeness among family members
- Gossip
- Multiple losses
- Delayed grief
- Lack of structure in daily activities
- Loss of control in life
- Loss of clan structure in villages
- Resentment/anger projected toward non-Natives
- Basic needs are not met

This woman said, “You have to remember that there is a continuum of characteristics; one family may have had all the characteristics, another just some of them.”

The effects of change continue, but it is time to transform negative changes to positive gains. This will happen only when Alaska’s Native community begins to heal itself from the effects of past traumas, and it must begin to do that in ways familiar to the culture.

Native Elders and others recognize the need for healing of grief, anger, and other spiritual and emotional ills, and they recommend traditional ways of healing. The “cures” include learning one’s language and living according to the values of the ancestors. A woman from Bethel, Alaska explained that a healthy family has many roots. To establish future generations, we must be physically well. She said, “If you are able to take on physical tasks you are healthy. In past times, there were hunters. They were physically strong and hardly ever sick. Young people should learn to live the life of their ancestors. If they do this, they will be aware and strong” (Cited in Bridges to the Future: Traditional Healing Practices in Alaska, 1998).

B. A Call for Traditional Healing

Recently, the Institute for Circumpolar Health Studies (ICHS), working under the auspices of the Southcentral Foundation (SCF), completed a study of traditional healing practices within Alaska’s Native ethnic groups. This important work, Bridges to the Future: Traditional Healing Practices in Alaska (referenced above) was undertaken to identify and preserve traditional healing practices. It provides valuable information about traditional healing so that it can be integrated with other health and human services provided by both Natives and non-Natives, and passed on to the Native community. The information presented represents a synthesis of traditional practices across Alaska Native groups. Portions of this study are reproduced with the permission of ICHS and the Southcentral Foundation.

C. Origins of "Traditional Healing" in Alaska

The origins of the indigenous peoples of the land mass now called “Alaska” are known mostly through oral histories passed down through families and communities. From those histories, and the few available published accounts, we know that people who inhabited Alaska prior to contact with Russian or European explorers lived in harmony with their environments. As Walter Austin put it, “Here in Alaska, there are many people who were self-sufficient before the Europeans arrived. These people were satisfied with the way things were going” (Walter Austin, Key Informant Interview). In most Alaska Native communities, the people also lived in harmony with others in the village because the “Elders tapped into resources/gifts of everyone to better the community” (Pat Frank, Key Informant Interviews).

The general health of the early peoples of Alaska was observed by initial explorers to be quite good (Fortuine, 1989). As the people of St. Paul Island observed, “Good health was essential to people who had to face a brutal climate in order to feed themselves. An uncured illness exacerbated by cold, wet weather would often lead to death” (Torrey, 1978, p18).

It is apparent from the stories of early Alaskans that most cultural groups had a great interest in wellness and prevention of disease through healthy lifestyles. For example:

One health problem that was non-existent on the Aleutian Islands before the 18th century was tooth decay. The skulls of ancient Aleuts reveal

almost perfect teeth with few if any cavities. Such excellent dental hygiene was due largely to the fact that they had no refined sugar in their diets. (Torrey, 1978, p 20)

The indigenous peoples of Alaska lived in a variety of climates, from the frozen plains of the far north to the more temperate rain forests of the southeast, but all lived by subsisting on the resources hunted and gathered from their own regions. This subsistence was difficult, as starvation was always a threat, but most accounts by Native Elders report that the lifestyle was a healthy one.

During the summer, our forefathers prepared for winter life. The women worked hard sewing, hunting small game, fishing, gathering edible plants, picking berries and preparing clothing for the winter. The men would hunt together and would divide the catch equally amongst each other. They truly helped each other and did not waste anything. They did not seem to be as sick as we are today. Most deaths were caused either by accident or starvation. (cited in Timimun Mamirrutit, 1976, p. 39)

For some groups, their interest in health extended beyond prevention to more complex practices. For example, Aleut people living along the Aleutian chain and on the Pribilof Islands were known to gather tremendous information about the anatomy of both animals and humans. They expertly preserved the remains of some individuals after death, and used “surgical” techniques for healing and inserting decorative labrets and other ornaments (Torrey, 1978). Central Yup'ik people (from parts of the Alaska Peninsula, the Bristol Bay area, the Yukon-Kuskokwim Delta, Nunivak Island, and some of the shores of Norton Sound) and Siberian Yup'ik people (specifically those from St. Lawrence Island) have a rich tradition of healing through the use of plants and herbs, medicinal animal products, and through practices that promote the health of the body, mind, emotions and spirit. The Inupiat and Nunamiut people who lived in the far north were also known to be well-versed in healing practices, and to have an intensely spiritual relationship with the people and beings around them (Fortuine, 1989).

D. Definition of Traditional Healing in Alaska

Although language enables us to learn traditional practices, healing does not depend on verbal language. We understand each other, Pat Frank explained, because “people have energy attached to emotions” (Key Informant Interviews). This is important because emotions can be felt by others, so they can be passed from one person to another. The energy of emotions such as grief and anger can be passed from one generation to the next without the younger people understanding what they are feeling.

It is important to understand that emotions can affect the physical body. As Rita Blumenstein explained, “That is what anger does to us -- it attacks our liver” (Key Informant Interviews). While western medicine is only beginning to recognize and study the effects of emotions on disease, such as the association between anger and cancer, traditional healers have known this for centuries.

Traditional healers have long recognized a relationship between all parts of an individual; the spirit, the mind, emotions, and body. This primary relationship is with the universal spirit, whether we call it God, or life, or any other name. We also have spiritual relationships with our families, other people around us, our ancestors, all living things (e.g., plants and animals), and all of Nature (e.g., the rocks, water, and soil). In traditional healing, one of the most important concepts to understand is that spiritual relationships connect all things.

"Illness" or "disease" occurs when the relationships within ourselves, with others, or with some aspect of Nature are interrupted. This causes a "block" that can affect the spirit, and the mind, body and emotions. Walter Austin described these interfering factors as "the nine negations: anger, obsession, passion, greed, covetousness, ignorance, jealousy, envy and suspicion" (Key Informant Interviews). "If there is a negative emotion filling one inside, it displaces the spirit. We must get rid of barrier and fill the void" (Pat Frank, Key Informant Interviews). Rita Blumenstein said, "When we are angry we should not hold it — THROW IT OUT...That's why we get anxieties, from harassing ourselves" (Key Informant Interviews).

Dr. Robert Morgan explained that, "Traditional healing is finding a way to let the spirit in, through balancing the body and the mind" (Focus Group Summary). The purpose of traditional healing is to help people find the cause of their illnesses and to help them restore healthy relationships within themselves, other people, and all of Nature.

Because traditional healers seek to restore an individual's own balance, they work on the assumption that each person holds the answers within. "The loudest thing that comes to you is your instincts. Everybody has them, but we ignore them," explained Rita Blumenstein. "If you want to become healthy and be a healer, you have to learn to open yourself" (Focus Group Summary). Candyce Henkelman, Coordinator of the Traditional Healing Program for SCF, summarized the idea perfectly, "I've built my listening skills, and I practice looking past people's pain and look at their goodness. I assume that people already have all that they need to heal and I am more a sounding board" (Focus Group Summary).

E. Accessing the Spirit and Traditional Values

The purpose of traditional customs and healing practices is to help people access their own answers and abilities to restore healthy relationships. Silence is one way to find the greater spirit to provide these answers. One participant reported that in his work, the quiet times come through "being in Nature," or just taking the time to sit quietly. The important point is that solutions to all physical, mental, and emotional conditions exist, and healing is the art of helping oneself or others find them.

Healing may come by finding answers in the community. Sometimes, healing can come through connecting with others. Dr. Bob Morgan explained that, "A healer connects a person with things they may be missing" (R. Morgan, Focus Group Summary).

Healing is the process of reconnecting to the spirit of all things, so learning and practicing traditional values is a critical part of that process. Once we understand that Nature and all living beings are related, we can see the importance of respect for all

things as part of our own health. These values include caring for others, sharing, and humility. There is also the value of humor – many participants talked about the healing nature of laughter. Also, of great importance is the value of respect for Elders and ancestors. One must show respect for all living things — the spirit of the water, the animals, berries, everything in Nature.

F. How One Knows Their Gifts: Definition and Characteristics of Traditional Healers

When people suffer a traumatic event that affects the body and spirit, they may experience a physical, mental, or emotional "illness." If they are not aware of the problem causing the condition, or cannot restore the personal balance on their own, they may seek the assistance of a "healer." Most participants defined a healer as a person, male or female, who has the ability to help individuals find the source(s) of their illnesses and to help them restore healthy relationships within themselves, with other people, and with all living things of Nature. The healers interviewed did not see themselves as "doctors" who provide people with external cures, but rather as facilitators who assist others in finding their own solutions.

Rita Blumenstein said that, unlike western medicine, traditional healers around the world trust that people have the ability to heal themselves. She added that, instead of seeing herself as a healer, she thinks of herself as a "friend."

All of us, all of these healers in these countries say the same thing. We don't heal people, they heal themselves. We are just an instrument of how to do it. Just instruments. We are just friends — a friend. When you're open to a friend — when you really have a friend, you are open to them. You can share everything you want to a friend, a very best friend. We are just best friends. And we're the only ones that can take it (the illness) and we're the only ones that can give it away. We help you give it away. That's how the healing comes. We don't keep it, we don't heal, we just receive it and give it away. Let it go. We help them let it go.

-Key Informant Interviews

Each facilitator, or healer, has particular "gifts" or skills they use to help in their work. These gifts are tools, provided by the Universe or Nature, to be used by the healer as individual clients and situations demand. An important point is that healers can work at many levels: the individual, family, or even the community. For example, Rita Blumenstein said she often works with all the people in a household. Pain is very real to those who experienced the loss of families and villages to disease, to those who lost contact with parents when forced to attend boarding school away from home, and to those who experienced what alcohol has done to their communities.

Yet, Alaska Native values and traditions persist. But because Native communities have been caught between two worlds, the struggle to survive has focused energy away from traditional practices. Energy has to be redirected towards identifying and using traditional ways to deal with and overcome today's problems.

CHAPTER III

ACCULTURATION AND ALCOHOL IN THE ARCTIC: AN INTERNATIONAL CIRCUMPOLAR PERSPECTIVE

If there is to be any noticeable change in the direction of less heavy drinking in village life then there must be marked change in the demands made of the people to be other than what they are. Is it not time for the white, dominant society to take some of the blows of introspection about our directions and demands? Can we of the white community not look at ourselves with a critical eye to the values we impose or imply? Have we enough inherent security to allow Native solutions to Native problems, or must we insist on our solutions to what we think are their problems? Increasing weight and responsibility should be put on those of us in the white community to expand our values to include a sincere appreciation for the beauty of the ethnic diversity which the Natives of Alaska have devised and maintained.

-Nancy Yaw Davis (1973)

The indigenous people of the North American Arctic are not alone with respect to their alcohol-related problems. Among Arctic or Circumpolar countries, alcohol abuse is a severe problem for both Natives and non-Natives. Arctic areas generally have a greater problem than more southern areas (Hild, 1987). Russia, for example, has declared war on alcohol many times over. Iceland has had serious problems. The Nordic countries have had a longstanding problem with alcohol. The residents of northern Canada and the United States also share a common problem with alcohol. Even organized western military bases and scientific research stations are not free from alcohol-related incidents, including killings, resulting from the drinking of "home brew."

A high prevalence of alcohol abuse in Arctic and sub-arctic areas has led to a search to identify common causes. The extent to which the causes are related to cultural, climate or geographical factors is not known. Yet, clearly an interaction exists. Since the northern physical environment has remained constant, it would appear that for the Inuit and other northern people, climate and geographical factors may be less important than sociocultural factors. The task thus becomes one of determining the extent to which psychosocial and other factors are involved in drinking behaviors.

Alcohol abuse in Alaska is not exclusive to the Inuit and other Native groups. High consumption rates exist for non-Natives as well, whether in Arctic or sub-Arctic environments. The situation has been described as follows:

Alaska was, in short, just the locus of points enclosed by a certain line on the map, and about the only things "Alaskan" shared by a Croatian goldredge mechanic in Fairbanks, the Tlingit fisherman in Hoonah, a teaching nun on the Lower Yukon, an Eskimo hunter in the Arctic, an

Irish wheel box oiler in Chitina, and a Coast guard radioman based in Kodiak, were a desperate struggle with the weather, the tenuousness of any ties they might have with anybody outside Alaska, and more likely than not, a love affair with demon rum. (Morehouse, 1984)

A. Stress in Circumpolar Environments

Environmental factors associated with northern latitudes cause physical stress that impacts human health. Seasonal light patterns vary greatly from almost constant daylight to extended darkness, which many people find oppressive. Conditions like “Cabin Fever,” “Arctic Hysteria,” “Polar Insomnia,” and “Seasonal Affective Disorder,” may all be associated with biochemical changes in the body, stemming from brain activity not controlled by the daily rhythm of the sun. Serotonin and melatonin levels impact sleep and mental alertness (Booker, 1991). In addition, poor judgement and depression are more prevalent during the dark winter months in polar communities.

“Low frequency air pumping” is another factor associated with mental clarity. Cold dense air is moved by winds over large uninterrupted terrain, causing changes in atmospheric pressure that are associated with sleep disturbances and even hallucinations (Mocellin, 1984; Rey, 1982; Suedfeld & Mocellin, 1987). Extreme cold can produce hypothermia and mental illusions that may be associated with aberrant, counterintuitive behavior. Even the aurora borealis, or “northern lights,” which is associated with shifting magnetic fields at ground level, may cause neurological disturbances, auditory illusions, and other central nervous system effects (Frey, 1973; Becker & Selden, 1985).

The environment becomes ripe for mental depression and irrational behavior when the above factors are combined with physical isolation and hazardous winter travel. Northern indigenous people have established traditional ways that help to overcome the effects of winter. The non-Native people, including researchers, explorers and exploiters, who came to “North-to-Alaska” were not equipped to deal with the northern climate in the same adaptive way as the indigenous people. After alcohol was introduced, a transition occurred within the Native community, in which individuals tended to emulate the winter “party environment” established by the new settlers. In more modern times, psychoactive drugs have been added to or substituted for alcohol.

Another source of stress among northern indigenous people is acculturation stress. Acculturation stress is the processes that result when one culture meets and is impacted by the other. The response to acculturation can occur in five ways (Berry, 1990):

- Establishing or maintaining ties with one's cultural group in order to reestablish or continue the traditional culture in the new setting. This choice is difficult to make when one's cultural group is losing its traditional practices.
- Behave as if one is in the traditional culture, despite new surroundings, and let others know as much as possible that they have to adjust to him/her. This is a difficult choice when the dominant culture negates the traditions of its ethnic minority groups.

- Accept the new values and behavioral patterns. This may be a practical choice, but it presents difficulties when the new ways conflict with traditional values.
- Take selective elements of the new culture and combine them with traditional ways in order to adapt to the new order without totally losing one's identity.
- Reject both cultures and do nothing, thereby being caught between two conflicting value systems.

Each choice has consequences for the person's physical and mental health and vulnerability to substance abuse. Understanding the role that acculturation stress plays in a culture's adaptive behavior, particularly among children, is instrumental when trying to understand why a culture is in distress. Thus, it is important to understand (a) what choice individuals make, (b) what forms of behavior are associated with the choice, (c) what is the nature of the relationship among choices, and (d) what are the consequences of each choice.

Once two cultures come into contact, no matter what level or length of time, they are no longer pristine. The longer the contact, the greater the acculturation stress on the minority culture. Two small groups trading once a year for a week causes little stress, but millions of European descendants interfacing with 60,000 Alaska Natives through schools, churches, hospitals, radios, and televisions elevates stress greatly. Such is the case for the Inuit and other indigenous people in Canada, Greenland, Russia and the United States.

The Saami in northern Norway, Sweden, Finland and Russia experienced acculturation stress for decades. They were the first people to live in the north of Scandinavia. Their nomadic reindeer herding culture dates back to the time of the Vikings. As northern European and eastern Russian armies moved through this region, followed by settlers, the Saami were "pushed to the margins."

When educational systems were mandated and land ownership restricted, the nomadic Saami were forced into structures and living conditions that were not in keeping with their cultural ways. Their language was prohibited, their religion suppressed, and their health practices rejected as the European culture actively worked to assimilate them. However, after World War II, a renewed recognition of the Saami culture occurred, leading to their establishment of a self-government.

In 1977, the four-nation Inuit population was united under the leadership of Eben Hopson, then Mayor of the North Slope Borough (NSB) in Barrow, Alaska, as the Inuit Circumpolar Conference (ICC). The ICC takes strong stands on Native rights and lands. Within the North Slope Borough, the movement toward self-determination culminated in the formation of the North Slope Borough as a home rule government, the strongest form of local governance in the United States. Greenland also used a similar process to separate from Denmark and established a home rule government. The most recent example of this movement to home rule is that of the newly formed Nunavut Territory of Canada. By taking leadership and confronting the majority culture, northern indigenous people are achieving independence and assuming responsibility for themselves.

B. Circumpolar Directions Towards Solutions

At present, progress is being made among circumpolar nations to overcome acculturation-related problems. For example, the similarity of northern health problems has been recognized for decades, but little was done to address them collectively prior to 1967. Since then, there have been regular meetings of the international health care community to share ideas and information about how to improve life in the north. Such meetings focus on health trends that are responsive to the health needs of Arctic residents.

A constantly expanding theme among indigenous northern people is to regain a sense of self-efficacy and self-esteem through reestablishing cultural pride. As individuals, families, and programs work toward preventing the loss of local languages, values, and customs, they succeed in helping to build a sense of community. The more local pride is engendered, the greater the ownership of the endeavor, and the more likely communities will continue to participate in the healing process. The inclusion of cultural ceremonies and values further enhances the interest of the participants. The greater the local involvement, the greater the success in completing programs and regaining health. Community programs allow people to heal within their hometowns and with their friends and families.

A second circumpolar theme concerns increasing local control of health care. This is not only about funding programs through local agencies, but about building local infrastructures to handle the introduction of new programs and the expansion of existing ones.

A third circumpolar theme is to have programs locally staffed. When community members are trained to provide the services needed, the program takes a major step toward being solely “owned” by the community. It is theirs, and they will make it work for their members.

Locally administered health programs reflect the values of their communities. Most have three themes: positive, holistic, and community based. Programs administered at the local level, such as alcohol treatment programs, have to be integrated into other health-related activities. The alcohol program needs to be perceived not only as an alcohol treatment program but also as part of a family health initiative. It needs to be a “positive” program that does not focus on restricting behavior, but on offering positive and healthful alternative activities to drinking. Successful local programs are culturally based. Many of the indigenous populations work at addressing the entire family and community in the services provided. Healing involves family, friends, and community.

Governmental support is essential if self-determination is to occur. At the Tenth International Congress for Circumpolar Health, Julie Kitka (AFN Executive Director) stated:

[Sovereignty] is a movement to sweep away, in Alaska, the residue left behind by the discarded policies of termination and assimilation when this nation decided that the best thing for its Native people was to discard their cultures and languages and have them become like White men, and be forced to do it if they resisted -- a time when Indian people were deemed not intelligent enough to care for themselves.

It is a movement away from helplessness and dependency, a movement away from victimization, a movement toward self-reliance, and self-determination. The movement is a reaffirmation of who we are as a people, a movement to fulfill the natural yearning for freedom planted in every human heart.

As Alaska Natives it is our responsibility to accomplish this end, but we cannot do it alone. Our national government, whose legal wards we remain, must also live up to its responsibilities and assist us as it is required to do by the written and unwritten laws that bind us together.

But the help cannot come by way of new handouts, or the creation of new social programs to be run by its agencies. The help must come by way of strengthening our Native grassroots, by supporting our initiatives, and by investing in the economy of our people.

Our state government must also realize that our aspirations do not constitute a threat to its political integrity; that our return to good health and well-being could only benefit the rest of the state.

In 1983, the Inuit Circumpolar Conference Elders passed a resolution (E-02-83) that included the statement: "Inuit as a unique people with sovereign authority within the Inuit lands are to govern themselves and exercise traditional methods of control relating to the banning of alcohol and drug substances locally." This declaration of independence led to a revolution of new thought in how personal and cultural freedom can be achieved.

The Polar Research Board of the National Research Council (PRB) targeted these issues in 1985 by stating:

It...[is] crucial to focus research on social and cultural conditions in order to reduce such behaviorally based pathologies as alcoholism, suicide, drug abuse, and violence...Without question, one of the greatest challenges in the development of the Arctic is the well-being of Native peoples. High rates of suicide, homicide, accidents, alcoholism, abuse, and unemployment among Native groups are all salient indicators of stressed well-being...Most important, we need to understand how people in the face of pervasive social and cultural change retain a sense of control over their lives and an ability to cope with the changes they confront. (PRB, 1985)

These statements are clear, and have been made a number of times and over a number of decades. Whenever a minority group wishes to influence a majority and dominant body, they must be consistent and tenacious. They must build on small changes and show the value of any new approach. The establishment of the home-rule North Slope Borough, formation of the ICC, and the signing of the Alaska Natives Claims Settlement Act, all occurring in the early 1970s, were just a start. Even though they have since been modeled in other areas of the world, the movement to independence is still evolving. Now, other circumpolar peoples have expanded on these ideas and put forward new

programs. The cycle continues, and Alaska Natives can keep on finding ways to achieve self-determination. This process can be accelerated when the social systems and policies of the dominant society are adjusted to accommodate the efforts made by indigenous people to solve their problems through local control.

In summary, the stresses experienced by Alaska Natives are not without comparison to other indigenous peoples in the Arctic, who have been impacted by the colonization of their traditional lands. Cultural change has been accelerated, however, through fast-paced, technological advances. There is, nevertheless, a universal desire among circumpolar people to regain traditional ways to preserve their societies and to face the future. Alaska Natives are part of this effort.

CHAPTER IV

BEHAVIORAL HEALTH EFFECTS OF CULTURAL CHANGE

Members of all Native groups have experienced a process of accelerating cultural changes which began during the past two centuries and continues today. Of the many social and health problems facing our people, perhaps none is greater than alcoholism and alcohol abuse. We must remember that alcohol abuse and other related problems were non-existent in Alaska until alcohol was introduced to the Alaska Natives by the White Russians and the European whalers in the early 17th Century. Even then the stability of the aboriginal society in the remote areas of Alaska was intact. This is because the older generations were still regarded as the pillars of the old traditional native community structure -- in other words, recognized as unwritten law.

The elders' work and knowledge which enabled them to survive in the harsh environment were built-in teachings or directions of the unwritten governing laws of the villages. This law was a very important factor for stable family relationships within the villages for a society without a written language or law enforcement agency in the days of old.

The disease of alcoholism among Alaska Native people has its causes in the not too distant past. The tragedy of this illness is the extent which it has passed through and helped destroy some of the Alaska Native culture. Many of the old chiefs and community tribal elders were strong in their condemning of alcohol. But their efforts did not prevail. Native people now reap the bitter fruits of this harvest of decay.

As we all know, alcoholism affects young people as well as adults and profoundly affects the social life as well as health of the community. Drunken young adults are now a regular sight in youth centers, and visitors from villages may make the bar his first stop upon arrival to the urban area. But the hidden costs of drinking to the community are recognized not so often: the direct expense of medical care and social services as well as the indirect social and economic losses.

If we conservatively assume that half of Alaska Native deaths due to accidents and homicide involved consumption of alcohol, add death to cirrhosis of the liver, as well as death to alcoholism, the total number of deaths involving alcohol would amount to over 50% of all deaths among the Native population, and 18% among non-Natives. Alcohol can, therefore, be considered the leader among specific causes of deaths in Alaska.

-Arnakin (Personal Communication, 1977)

Alaska Natives die from alcohol-related causes at an alarming rate. Drinking also contributes to significant health and social problems. Further, cultural changes and

their effects continue to be an important and urgent problem facing Alaska Natives. For many Alaska Natives, especially adolescents and young adult men and women, cultural identity conflicts create behavioral and lifestyle problems that are frequently compounded by the effects of abusive drinking and drug-taking behaviors. Many of these drinkers, over time, abuse alcohol, and alcohol-related violence has become all too common. This situation is particularly injurious for Native women because it places them, and their children, at extremely high risk for physical and sexual abuse (Segal, 1999a, 1999c). This chapter discusses some of the different kinds of behavioral health problems that have affected Native communities, with a particular emphasis on intergenerational grief. It begins with an overview of types of problems and the extent to which they are experienced by Alaska Natives.

A. Alcohol-Related Problems in Alaska

The seriousness of alcohol-related problems in Alaska is reflected in the fact that the State has been leading (or within the top 4 states) the nation with respect to child abuse, suicide, accidental death, rape and assaults, all of which are significant alcohol-related phenomena. For example, in 1985, Alaska's rape rate of 53 per 100,000 was 1.5 times the national rate of 38 per 100,000 (Phillips, 1991). Alaska Natives constitute a large proportion of offenders involved in such violent actions.

Alaska is an especially violent place for children, with 1,392 reported cases of child abuse for FY 1993, and with over 2,000 unsubstantiated reports for the same time period (Severson, 1993). It has been noted that "families are under much more severe stress than they ever have been and we're seeing a greater depth of violence in families" (Weber, cited in Severson, 1993, p. F3). Child abuse is considered an epidemic within Alaska, with children being hurt at rates higher than the national average. Sixty-three out of every 1,000 children in Alaska were alleged to be victims of child abuse in 1992; the national rate is 39 children per 1,000 (Severson, 1993). The high rate of child abuse in Alaska has not abated.

Child abuse and neglect have been a significant problem among Alaska Natives since the early 1970s (Brown et al., 1974). The Alaska Native Commission (1994b) reported that "Alaska Natives are over-represented in cases of child abuse by a factor of two-to-one, with the percentage of substantiated cases of abused children being over twice what would be expected based on the overall percentage of Alaska Natives in the population" (p. 70).

The severity of the alcohol problem among Alaska Natives is further evidenced by the rate of death caused by alcohol-related accidents and suicides, which are at least double those of Caucasian populations in both Alaska and the lower-48 states (ANC, 1994). The percentage of alcohol-related suicides in Alaska is almost twice the national average. Among Alaska Natives, the percentage is significantly higher than among non-Natives (Hlady & Middaugh, 1988). The suicide rate for Alaska Natives has increased over 500% between 1964 and 1989 (AFN, 1989). More recently, of the 192 Native deaths (of any cause) that occurred in rural Alaska between 1990 and 1993, 128 (66.6 percent) were found to be alcohol-related (i.e., the deceased had a blood alcohol content of 0.08 or higher [Demer, 1997]). The suicide rate in Anchorage has increased since 1990 from 11.0 to 16.1 per 100,000 population, and is 39% higher

than the national average (ADHHS, 1999). Alaska Natives constitute a large proportion of these suicides. (The average suicide rate for the US is 11.6 [ADHSS, 1999]). The suicide rates in Alaska correspond to a period of rapid growth and industrialization, and to a related loss of Native cultural traditions.

The question arises as to why such events are occurring among Alaska Natives. The opening reflection by Arnakin provides a large part of the answer — cultural loss, alcohol, and its effects. Martens (1988) summed up the situation concisely: “Through the clash of two cultures, the disruption caused by assimilation and the entrance of alcohol into the Native society, there was a breakdown in the social fabric [of society] which maintained order” (p. 9). This breakdown led to the emergence of behaviors that had rarely been seen before, many of which were alcohol-related: sexual abuse, encompassing incest and forced sex, and physical abuse. It is important to point out, however, that such acts, as they are being better understood, happen to both males and females, but they happen more frequently to women (Segal, 1999a).

B. Alcohol, Sexual Abuse and Post-Traumatic Stress Disorder

Some Native communities, Canadian and American, are suffering from intergenerational sexual abuse, which can lead to such behaviors being interpreted as accepted or as a cultural norm (Martens, 1988). The pervasiveness of the problem creates an impression among non-Natives that such behavior has, over time, become accepted as a cultural practice. Some Natives apparently share such thinking. Interpreting sexual abuse as a cultural practice is wrong. It is easy to accept such thinking, however, when sexual abuse continues unabated.

For sexual abuse, and other violent behaviors, the emotional injury or trauma that results is not easily overcome. A child's development is affected by child abuse (Herman, 1992). Such abuse, as the child matures, will most likely contribute to a poor self-image, to faulty perceptions of the child's social environment, and to not trusting adults, among other adverse affects. A child's negative experiences will also influence peer relations, contributing to the extent to which s/he will identify with peers. Additionally, an early traumatic childhood experience, particularly sexual abuse, can sufficiently traumatize a child to the extent that its effects become malignant and manifested as a post-traumatic stress disorder (PTSD). Herman (1992) noted that "with severe enough traumatic exposure, no person is immune" (p. 57), and the condition [PTSD] can be experienced in the immediate aftermath of the event or in years subsequent to it. The essential element of child abuse is the physical and psychological impact it has on the child, and involvement with drugs or drinking in later life can serve as a means of helping one to escape from unwanted thoughts and emotions related to an earlier traumatic experience.

PTSD is described by the American Psychiatric Association (1994) as an anxiety disorder characterized by the re-experiencing of a traumatic event, accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma. Zweben et al. (1994) indicated that "the stressor or trauma need not be directly experienced, but may instead be witnessed [such as in children exposed to violence]; the fear of the trauma is a sufficient precursor to the development of PTSD" (p. 329). The relationship between trauma, specifically sexual assault, PTSD and

substance abuse is well documented (cf. Brown, 1994; Harvey et al., 1994; Kilpatrick et al., 1997; and Zweben et al., 1994). Indeed, as Harvey et al. (1994) stated: "Clinical reports suggest that unresolved trauma-related symptoms can contribute to relapse, as individuals may eventually return to alcohol and other drug use to cope with unresolved long-term effects of trauma" (p. 361). Zweben et al. (1994) also stated that: "Clinicians have noted that many patients describe a pattern of alcohol or drug use motivated by a desire to obscure or escape from uncomfortable experiences. Some are now conceptualizing the alcohol and other drug use as one method (among several) to dissociate painful states" (p. 330).

Dick et al. (1993) reported that American Indian youth "may turn to alcohol to relieve symptoms of negative affect" (p. 175), and that the youth in their study "showed an association between stressful life events and quantity/frequency of alcohol use" (p. 176). King et al. (1992) found a relationship between life stress, depression and substance use for American Indian adolescents. They also found that the greater the life stress, the more likely these adolescents would feel depressed and tend to use drugs. Gray (1998) indicated that "American Indian adolescents are likely to experience psychological and physical trauma as part of their everyday life and may be at risk to develop substance abuse, PTSD, depression, or other emotional problems as a result. They are frequently exposed to death through accidents, suicides, homicides, alcoholism, and health problems" (p. 394). Similar experiences apply to Alaska Native youth.

Khantzian (1985) noted that the drug-taking behavior described above is consistent with a "self-medication" hypothesis. "Self-medication refers to use of drugs to medicate oneself for a range of psychiatric problems and painful emotional states. The hypothesis infers that the user selects drugs to achieve a 'short-term effect' to help cope with distressful subjective states, and an external reality otherwise experienced as unmanageable or overwhelming" (Khantzian, 1985, p. 1263). The self-medicating hypothesis is consistent with the more recently described "tension reduction hypothesis" (Cappell, 1987; Cappell & Greeley, 1987; Epstein et al., 1998), in which different substances are used by individuals experiencing stress in an effort to self-medicate and cope with stress.

Thus the early use of alcohol and other drugs for many Alaska Natives may represent behavior that proves rewarding because it alleviates a sense of personal distress. Heavy reliance and continuous use of alcohol or other drugs can contribute to problems of abuse and dependency, but the self-medication effects tend to be more compelling than any adverse health, social, behavioral or legal consequences of drinking or drug use. Violent, prolonged, or intrusive experiences at an early age, including the effects of acculturation stress, represent events that can result in a traumatic experience that is beyond the adaptive capacity of the child, resulting in a long-lasting traumatic syndrome which, at a later age, may be self-medicated through drinking and other forms of drug-taking behavior. For some, the more severe the trauma, the earlier they may initiate substance abuse due to a greater vulnerability to precipitating events. Gray (1998) wrote that "Not only has substance abuse been viewed as a behavioral response to childhood traumatization...but several studies have shown strong associations between substance abuse and different types of trauma" (p. 394).

People who experience PTSD often experience other psychiatric conditions such as depression, other anxiety disorders and intermittent explosive disorders (Friedman et al., 1994). Sometimes the presence of PTSD may diminish the level of psychological adjustment that was present prior to the trauma; it may also increase alcohol and drug use (Gallagher et al., 1988). Stark & Flitcraft (1996) noted that battered women reveal a "battering syndrome" that, in addition to physical injuries, includes signs and symptoms of mental illness. It may also be, as Leonard (personal communication, May 21, 1999) suggested, that battered women may not necessarily meet PTSD criteria, but may present a broad symptom pattern of chronic stress.

Substance abuse is only one of many results of child abuse and other traumatic experiences. Studies show that abused children have a fourfold increased lifetime risk for psychiatric disorders and a threefold risk for substance abuse (Finkelhor et al., 1994). Russell and Wilsnack (1991) found that, when the degree of trauma a woman remembers experiencing as a girl is considered, one finds downward mobility in the social class she attains as an adult. In general, it appears that severe childhood trauma may result in the adult survivor's inability to reach or surpass the socioeconomic level of her parents. Russell and Wilsnack (1991) also indicated that women survivors of severe trauma often used up their energies coping with the profound consequences of the abuse, while less constrained peers were better able to actualize their potential. Thus, when such women enter treatment, what could be interpreted to be a lack of client motivation, may be one of many reverberations of sexual abuse in childhood. This awareness must be integrated into treatment efforts, especially with Native women.

CHAPTER V

ALCOHOL AND DRUG ABUSE AMONG ALASKA NATIVES

Some people think curbing alcohol and substance abuse and the related problems is too sensitive an issue. It isn't. I believe villagers are ready to begin the healing process. We are a tough, strong people.

-Anonymous Alaska Native Woman

The legacy of the introduction of alcohol to the Alaska Native, as with that experienced by their American Indian counterparts, has been one of drinking to excess at almost every drinking event. This chapter reviews drinking behavior and its effects, and serves as a prelude to the succeeding chapter which discusses the relationship between drinking and violence against women.

The Alaska Native Commission (ANC) (1994a) reported that for the period 1980-1989 officials estimated that the cumulative years of potential life lost (YPLL) attributable to alcohol was 6,607 among Alaska's non-Native population of 450,000, but was 6,323 for Alaska Natives during the same time period, who constituted only 17% of the state's total population. This figure corresponds to an "Alaska Native alcohol-related death once every 12 days" (ANC, 1994a, p. 70).

Alaska Natives ranked fifth among 11 national Indian Health Service sites for diagnosis of alcohol-related illnesses and symptoms between 1980 and 1987 (Hisnanick, 1992). In a study of homeless men and women who were alcohol-dependent (Segal, 1991), of 502 repeated users of a Sleep-Off Center in Anchorage, 63% were Alaska Natives, of which 83% were men and 17% women. Their average annual blood alcohol level (BAL), based on a year's assessment for 311 Alaska Natives entering the facility, was 0.186, compared to 0.137 for 122 Caucasians. (The difference was statistically significant.) No differences in BALs were found between genders for either ethnic group.

A. Patterns of Drinking

As emphasized throughout this report, alcohol consumption in Alaska is quite high, and surpasses consumption in the lower 48 states (Segal, 1999; Segal & Hesselbrock, 1997). In 1989, the National Institute on Alcohol Abuse and Alcoholism (NIAAA, 1993) reported that the per person consumption of alcohol (i.e., the total quantity of alcohol sold divided by the total population age 14 and over) in Alaska in 1989 was 3.28 gallons. This was higher than the consumption in all states except Nevada (4.85), New Hampshire (4.38), and the District of Columbia (4.23). Unlike Alaska, these are locations where cross-border alcohol sales are common, making the Alaska consumption level comparatively higher. In 1990, the per capita rate in Alaska for alcohol consumption was 3.33 gallons for persons 21 years and older (DHSS, 1994). The national per capita rate for those 15 and older for 1990 was 2.46 gallons (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1997).

Alaska's high per capita consumption level has decreased since 1990, but it remains higher than most other states (Segal, 1999). The social, economic, and health consequences of alcohol consumption also remain quite extensive (Segal, 1999). Drinking affects Natives and non-Natives alike, but the health and social impact are more pronounced for Alaska Natives.

B. Genetic Research

Until recently, in the absence of empirical evidence, it was assumed that Alaska Natives were genetically similar to or decedents of Asian ancestors, specifically Orientals. Alaska Natives were believed to resemble some Asians groups with respect to the genes that regulate alcohol metabolism -- alcohol dehydrogenase (ADH) and aldehyde dehydrogenase (ALDH) -- as well as exhibiting an alcohol-flush reaction that is observed in some Orientals when drinking (Shibuya & Yoshida, 1989; Singh et al. 1989). Research has shown that a flush reaction (reddened cheeks, dizziness, headaches, etc.) tends to prevent heavy drinking and the onset of alcoholism (Thomasson et al., 1991).

A series of studies examining genetic factors among Alaska Natives (Avksentyuk et al., 1994, 1995; Segal et al., 1998; Thomasson et al., 1992) found that Alaska Natives were not genetically similar to Asians with respect to the genes regulating alcohol metabolism in the liver. The implication of this finding is clear -- Alaska Natives do not resemble Asians with respect to possessing a genetic mutation that affects the metabolism of alcohol that contributes to a flush reaction. Thus, Alaska Natives are not protected, in the form of a flush reaction, from the risk of alcoholism in the same way that Asians who possess an atypical genotype are considered to have a negative risk factor. Alaska Natives do not possess any unique or identifiable genetic characteristic related to metabolizing alcohol.

It has to be noted, however, that alcohol dependence has been found to occur more frequently in families with a history of alcoholism. This occurrence has led to the belief that while alcohol dependence is a complex phenomena, it is in part hereditary. No specific gene, however, has been identified thus far as causing alcoholism. It is currently thought that a combination of genes may be responsible, but researchers have not established which genes interact to cause alcoholism.

C. Alcoholism and Co-Existing (Co-Morbid) Disorders

High levels of drinking and alcohol-related problems among Alaska Natives have been well documented (see above). However, almost no research describes causal factors, clinical features, and behavioral correlates of alcohol dependence among Alaska Natives. In order to learn more about how alcohol affects Alaska Natives, Segal and Hesselbrock (1997a) have been collecting data from clients entering three inpatient alcoholism treatment facilities in Anchorage. The information gained from this on-going study helps to further an understanding of some of the causes, course and consequences of alcohol dependence among Alaska Natives.

In addition to the severity of their drinking problems, one of the most important findings was that a large proportion of men and women also presented other forms of

drug dependence. Forty-four percent of the persons were also dependent on cocaine, while 63% were also dependent on marijuana. Significantly more men (60%) than women (40%) exhibited marijuana dependence, while significantly more women (54%) than men (46%) manifested cocaine dependence.

Co-morbid psychiatric disorders were also present -- 33% of the cases admitted for treatment met diagnostic criteria for Antisocial Personality Disorder (ASPD), a pattern of irresponsible and antisocial behavior beginning in childhood or early adolescence and continuing into adulthood; 13% reported a Lifetime Major Depressive Episode, and 96% met diagnostic criteria for experiencing a current major depressive episode. Significant gender differences were found with respect to ASPD, where men revealed a significantly higher prevalence rate than women (men = 68%, women = 32%), but no statistically significant difference was found between men and women for having experienced a Major Lifetime Depressive Episode (men=44%, women=56%).

These findings are in agreement with conclusions derived from other studies of gender and substance abuse, specifically concerning drinking behavior and manifestations of drinking-related problems. There is, for example, a consistency with reports that ASPD is more prevalent among polydrug users than among alcoholics who do not use drugs (Brown & Nixon, 1997), and agreement with reports that ASPD tends to be higher among men than women alcoholics (Hesselbrock & Hesselbrock, 1997).

The importance of these findings, nonetheless, is that they convey that Alaska Natives entering treatment, despite some gender differences, present a complex clinical picture that involves more than only alcohol-related symptomology. The question that arises is whether the ASPD-related behaviors are representative of an underlying personality disorder, or represent symptomatic characteristics of a culture in change in which traditional guidance and values have been diminished for many youth growing up in a changing world. The answer to this question has important implications for developing treatment interventions responsive to the needs of Alaska Native clients.

D. Alaska Natives and Other Ethnic Groups

Given the severity of the clinical manifestations presented on admission to treatment by Alaska Natives, a comparison of some of their alcohol-related behaviors with those from other ethnic groups would help to determine if the Alaska Native clinical profile is unique or consistent with behaviors found in other ethnic groups. Table 5-1, below, provides a comparison of Alaska Natives with other ethnic groups on selected characteristics.

Table 5-1 shows that Alaska Natives, in many categories, present a more severe clinical picture than other ethnic groups. Alaska Native men exhibited higher rates of alcohol-related violence, while Alaska Native women varied in comparison to women in other ethnic groups. Alaska Native women threw/hit things, hit others, and reported more physical fights than women in other ethnic groups.

Alaska Natives also experienced higher levels of some serious alcohol symptoms, particularly morning drinking. Men also experience higher levels of DTs and stomach problems. Alaska Natives exceed other ethnic groups with respect to alcohol-related

behavioral problems, such as arrests for DWI, alcohol-related arrests, and alcohol-related accidents and injuries. This latter statistic is linked to the fact that 25 percent of all deaths in Alaska are alcohol-related (Department of Health and Social Services [DHSS], 1994), and, in 1997, the distribution of criminal arrests by ethnicity showed a disproportionately higher percentage of Alaska Native perpetrators (Alaska Department of Public Safety, 1999).

Table 5-1
Comparison of Alaska Natives with Other Ethnic Groups
on Selected Characteristics*

	Alaska Native		Caucasian		African American		Hispanic	
	<u>Male</u> n=141	<u>Female</u> n=120	<u>Male</u> n=1087	<u>Female</u> n=443	<u>Male</u> n=285	<u>Female</u> n=119	<u>Male</u> n=74	<u>Female</u> n=25
	<u>PERCENT</u>							
<u>Alcohol-Related Violence</u>								
Arguments	94.3	95.8	84.7	80.7	84.6	80.7	86.5	96.0
Threw/Hit Things	88.6	80.8	69.1	65.5	59.3	52.1	64.9	76.0
Hit Family	81.8	35.0	33.8	37.0	37.2	37.0	35.1	48.0
Hit Others	53.9	49.1	25.8	28.2	34.4	28.6	29.7	46.1
Physical Fights	88.6	75.0	66.6	46.3	68.4	42.9	71.7	72.0
<u>Serious Alcohol Symptoms</u>								
Morning Drinking**	64.0	63.0	51.5	41.8	57.5	56.3	50.0	32.0
DTs	36.9	26.7	21.6	24.4	18.9	20.2	23.0	28.0
Seizures	7.8	6.7	6.7	4.1	4.9	9.2	12.2	4.0
Stomach Problems	29.8	18.3	13.7	11.3	16.5	12.6	8.1	20.0
Liver Disease	4.2	5.8	12.9	6.8	9.8	10.1	13.5	12.0
Pancreatitis	2.1	2.5	3.6	2.3	7.0	9.2	4.1	4.0
<u>Alcohol-Related Behavior Problems</u>								
DWI	68.8	45.8	62.6	28.9	34.4	7.6	56.8	16.0
Arrests	73.8	69.2	46.6	23.9	44.6	29.4	45.9	28.0
Accident/Injury	68.8	72.5	62.7	58.9	50.2	47.1	50.0	60.0
Reckless Behavior	95.7	89.2	97.3	90.7	87.7	58.0	95.9	88.0

	<u>Antisocial Personality Disorder</u>							
			<u>Marijuana</u>	<u>Cocaine</u>	<u>Stimulant</u>			
Alaska Native	34.3%		62.5%	44.1%	14.6%			
Caucasian	20.1%		42.8%	37.6%	23.4%			
African American	20.3%		39.6%	63.5%	10.7%			
Hispanic	34.3%		45.5%	44.9%	29.3%			

* Source for the Caucasian, African American and Hispanic Data: Hesselbrock, Hesselbrock, Bucholz, and Schuckit, 1988.

**The number of Alaska Native cases for this variable only is 50 males and 46 females.

The comparison of drug use with other ethnic groups conveys that Alaska Natives greatly exceed prevalence levels for having used marijuana, but do not reach the extent of use for other drugs by Caucasians, African Americans or Hispanics.

Finally, and most apparent, is that the proportion of Alaska Natives (64%, males; 63%, females) meeting DSM-III-R criteria for ASPD greatly exceeds the prevalence levels reported for the other ethnic groups. Consistently, 62 percent of the Alaska Natives also met DSM-III-R criteria for the diagnosis of Conduct Disorder, suggesting that there were early childhood antecedents for the onset of ASPD; sixty-two percent of those individuals meeting criteria for Conduct Disorder also met criteria for ASPD.

In response to the question raised above, of whether the Alaska Native clinical profile is unique or consistent with behaviors found in other ethnic groups, it seems that not only are some manifestations of alcohol abuse quite severe, but drinking is also related to high rates of violence and problem behaviors.

E. The Problem of Inhalant Abuse

In addition to the adverse effects associated with alcohol abuse in Alaska, there is also an inhalant abuse problem, especially among youth. The distress within the Alaska Native community over inhalant abuse came to the forefront following two publicized inhalant abuse deaths. One report (Doto, 1992) described a fatality that involved a 20-year old man living in a small Native village who succumbed after sniffing rubber cement with friends behind his parent's house. It was noted that inhalants were popular among the youth in his village, and that several teenagers had also died in other villages in the State.

The second report described a young Native boy who died from sniffing gasoline in a small village. Elders saw his death as representative of the serious inhalant abuse problem among Alaskan Native youth, which they considered to be an "epidemic" (Pagano, 1993). The youth's death elicited the following reactions from village people concerning inhalant abuse: "I see it weekly, in almost every village I visit"; "Gas is everywhere"; ". . . a core group, of three or four young men . . . were enticing kids as young as 7-years old, a first grader, to get involved"; and "I think the least you would find in most villages was 20 percent 'experimentation' rate" (cited in Pagano, 1993, p. B1).

Inhalants are volatile solvents or chemicals whose vapors, when inhaled, can produce psychoactive or mind altering effects. Among the earliest industrial chemicals that were abused were the petrochemicals, primarily gasoline, which date back to the early 1930s (Segal, 1997). Since the early 1960s, the practice of solvent sniffing or inhalation of solvents and aerosols for their intoxicating effects has emerged as a widespread phenomenon of major proportions in the U.S. (Segal, 1997).

Chemical solvents can be highly toxic, and death or severe physical damage can result from their use. Death can occur from liver, kidney, bone marrow, or other organ failure; asphyxiation; paralysis of breathing mechanisms; or accidents as a result of inebriation. Continued use of these drugs can lead to kidney, liver, lung, and brain damage. In spite of the toxicity of the drugs, there is no evidence that tolerance develops, and physical dependence has not been demonstrated.

Prinz (1998) reported that "Alaskan youth abuse commercially produced chemicals, and that if they are living in rural and/or western Alaska they are very likely sniffing gasoline" (p. 1). He indicated further that:

some children reportedly start by age four and continue on into at least mid-adolescence. They may also use/abuse other substances, most likely marijuana, and come to the attention of a family member, health service providers, teacher or law enforcement as a result of poor school performance or attendance; having passed out (become unconscious) under the influence; and/or anti-social behavior. The worst case scenario is discovery after death by suicide, accidental injury, "sudden sniffing death" (heart stoppage) or asphyxia related to sniffing. (p. 1)

The use of inhalants is immediately reinforcing because its effects are quick and experienced as pleasant. The euphoria also helps to alleviate any sense of personal distress. Heavy reliance and continuous use can result in brain damage and other serious physical anomalies. Nevertheless, the euphoria induced by inhalants tend to be extremely compelling regardless of any adverse health, social, behavioral or legal consequences.

In summary, substance abuse has extracted an exceedingly high human toll within the Alaska Native community, ranging from children dying from inhalant abuse to a cascade of alcohol-related fatalities. Few families have escaped the affects of alcohol or drug abuse and their related adverse effects. As stated at the outset of this chapter by an anonymous Native woman, "I believe villagers are ready to begin the healing process. We are a tough, strong people."

CHAPTER VI

UNDERSTANDING THE RELATIONSHIP BETWEEN ALCOHOL AND VIOLENCE

My name is Coline and I was sexually assaulted by my dad and two of his brothers. Also my brothers sexually abused me. I am sixteen years old now, and I've been sexually abused for seven and a half years, that I can remember. Everybody where I lived were always drunk and everybody was being sexually abused. I hurt. Before I was sexually abused I was drinking only a little bit but after I was sexually abused I became an alcoholic. Everybody else that I saw was an alcoholic "cause alcohol kills the pain." My pain was from sexual abuse and the alcohol I drank killed it. After we left the reserve I met lots of people who didn't drink but I kept drinking because the sexual abuse kept going on. It seemed like when- ever I was sexually abused and started thinking about the sexual abuse I would have to go out and get drunk. Usually when I went out and got drunk I also usually got raped.

-On the relationship between sexual abuse and drinking, cited by a young Canadian Indian girl in Martens, 1988

The question has arisen as to whether violence and sexual abuse are different in Native and non-Native communities. The answer is that "there are both similarities and differences between what we see in the white world and what we see in the Native world. Our greatest challenge is in clarifying and defining these" (Martens, 1988, p. i). This chapter provides a framework for understanding the relationship between alcohol and violence, especially violence against women, and reviews implications for improving treatment outcome for abused women.

A. Alcohol and Violence

The connection between alcohol and different forms of violence has led to the presumption of a cause and effect relationship. However, drinking associated with violent acts does not necessarily mean that alcohol caused the behavior of the persons involved. Alcohol by itself may not be sufficient to account for violent acts, but its role in violent behavior is better understood when the issue is explained from two perspectives, pharmacological violence and alcohol expectancy.

1. Pharmacological Violence

Pharmacological violence occurs as a function of alcohol's effects on the brain. Alcohol is a powerful psychoactive drug that affects the entire neurological system, similar to the actions of barbiturates. Alcohol is classified as a sedative-hypnotic

compound because it contributes to a generalized depression of the central nervous system, even though the drinker feels an initial "high." The effect of such compounds is the inhibition of transmission of sensory signals in the brain.

Changes in behavior after drinking are directly linked to the amount of alcohol in the bloodstream. As blood alcohol level (BAL) increases, there is a loss of behavioral control, which is referred to as "disinhibition." Disinhibition can be defined as a "temporary state of release from internal constraints on an individual's behavior." Therefore, with sufficient alcohol in one's bloodstream aggressive behavior can be displayed when it might normally be suppressed or inhibited by social or personal constraints. As a person's BAL increases, the brain's natural controls become more impaired, leading to a breakdown of one's ability to control his/her own behavior. Aggressive or violent behavior is more likely to occur under this condition.

2. Alcohol Expectancy

The potential for violence is also related to one's drinking environment and to the drinker's personal drinking history, which involves expectations about what alcohol will do. Alcohol expectancy is defined as "the beliefs that an individual has about the effect that alcohol will have on their moods, emotions, and behavior." People who believe that alcohol makes them "tougher," for example, might become aggressive when they drink. Increased sexuality and decreased anxiety that occur with drinking also involve alcohol expectancies.

Alcohol expectancies are very strong influences on alcohol-related effects. They are also deeply rooted in any society and its learned drinking behaviors. The style of drinking among many Alaska Natives previously described represents a form of alcohol expectancy.

Alcohol expectancies are believed by some researchers to be strong enough to override the pharmacological effects of alcohol. It is possible that we may have reached the point in time where alcohol expectancies may be providing license to engage in behaviors that are not acceptable unless carried out while intoxicated. Research has demonstrated that expectations or beliefs about the effects of drinking are related to the drinking behavior of both adolescents and adults (Garcia-Andrade et al., 1996).

Alaska Natives are not immune to the influence of alcohol expectancy as a factor involved in drinking behavior. Because their drinking behavior represents a synthesis of western and unique cultural influences, it is possible that a particular set of alcohol expectancies is present that represents motives for drinking.

Alcohol expectancy may have also become an important factor in Native drinking. Rupert Ross (1992) asserts that:

Native people may have been left with no other culturally sanctioned way to vent that steam [their anger]. Quite clearly, their sources of sorrow, anger and personal desperation regularly exceed anything the rest of us are ever likely to experience. When, at the same time, traditional ethics forbid even expressing those sentiments and traditional methods of spiritual healing have all but been eradicated, the bottle remains almost

the only avenue available to pursue release. Alcohol “permits” the saying and doing of things which would otherwise not be tolerated, for it permits the individual and his community the comfort of being able to say, “It wasn’t really me who broke all those traditional rules and did all those immoral things; I was just drunk.” (p. 149)

B. The Special Problem of Women, Alcohol and Violence

When I was first told that I wasn’t responsible for what my dad did to me, I just couldn’t believe it. I thought that there must have been something that I had done that made my dad want to do that to me. I remember I used to walk around the house with a real skimpy T-shirt on, and I thought for the longest time maybe that’s what it was that made him want to touch me sexually. I was told that’s not true and that my dad wanted to control and dominate me more than anything else. That’s beginning to make some sense to me. Because some of my friends walk around the same way, and their fathers don’t do that to them. When I look back before my dad started touching me, I remember that I was blamed for everything that went wrong in the family. I really thought that it was my responsibility whether or not the family stayed together because all the time my mom and dad told me that I was responsible for everything. I felt so guilty when they would argue and fight that I didn’t know what to do. The biggest thing that I felt guilty about, and this may sound really dumb, is that I thought I was responsible to make my dad feel better. When he didn’t feel better, I felt guilty about that. So sometimes what I would do would be to rub his back down and maybe pay attention to him, but when I did, it usually turned into sex. I felt guilty that he felt bad at the start, and then after he touched me sexually, I felt guilty because I thought I led him on. It was really so confusing for me. I just didn’t know how to deal with it.

-Cited in Martens (1991, p. 14)

Violence against women takes many forms, from sexual and psychological abuse to physical assault and murder. National crime statistics (U.S. Department of Justice, 1996) indicated that, between 1992 and 1994, the number of violent crimes committed against women reached almost 12 million nationwide. A recent report issued jointly by the Departments of Justice and Health and Human Services (National Institute of Justice [NIJ], 1998) indicated that among a sample of 8,000 women, nearly 18% had been raped or were the victims of attempted rape at some point during their lives. The joint report also stated that more than half of the women, at one point in their lives, were physically assaulted, ranging from slaps and punches to gun violence. [This sentence is used a few paragraphs down:]

Violence can occur at any time in a woman’s life. It may happen in childhood, young adulthood, adulthood or in old age. Whatever the form or whenever it may happen, violence is a condition that threatens the health of women in more ways than the obvious. Violent experiences are especially traumatic not only because of the physical injury that may result, but also because it may trigger harmful health

behaviors. One of the effects of violent experiences is drinking (Grice et al., 1995; Kilpatrick et al., 1997, 1998; Miller, 1996). For a woman who is abused or battered, alcohol becomes an ideal medication to ease the pain. With alcohol, a woman can obtain temporary relief from anguish by obliterating traumatic memories and associated rage.

About half to two-thirds of women presenting for substance abuse treatment have a history of being sexually abuse as a child (Pearce & Lovejoy, 1995). Even more distressing is the National Institute on Drug Abuse (NIDA) (cf. Swan, 1998) announcement that "as many as two-thirds of all people in treatment for drug abuse report that they were physically, sexually, or emotionally abused during childhood..." (p. 1), indicating that men are not exempt from experiences of personal violence. NIDA's conclusion added to data from other studies attesting to the importance of understanding the role of personal violence, such as child abuse, physical trauma, rape and sexual abuse, neglect and emotional abuse in the onset of drug-taking behaviors.

Such violence has become all too common among Alaska Native women. Recent research, conducted at the Women's and Children's Residential Program (WCRP) in Fairbanks, Alaska, illustrates the severity of violence among Alaska Native women entering treatment for substance abuse. As of December 31, 1998, of 122 Alaska Native women, 90% were victims of either physical or sexual abuse. Table 6-1 describes the types of victimization experiences.

The data represents the number of Alaska Native women answering each question about their personal experiences of physical or sexual abuse. Ninety percent of the women encountered some form of physical abuse, of which 64% of the incidents originated before age 13. Over three-quarters (78%) of the women responding also reported being victims of sexual abuse, with 76% of the incidents also occurring before the age of 13.

Nearly half (48%) of the respondents were physically abused by their parents; 89% were beaten in a relationship, 70% were pushed or slapped by an adult, and 81% were battered by a significant other. Other physical abuse-related events also show high prevalence levels. Further, of the women reporting having been abused by their parents, 69% described the abuse incidents as alcohol-related, that is, the abuser was drinking at the time of the incident.

Over half the women (52%) in this study attempted to harm themselves in some way, while 51% attempted suicide at least once. Fifty-eight percent of the suicide attempts were reported to be alcohol-related.

Twenty-four percent of the women indicated that one (or more) of her children was physically abused, while 19% of the women reported that one or more of her children were sexually abused. Further analysis of the data, however, revealed no statistical demonstration that if a mother was physically abused, her child was also abused (χ^2 (1, N = 97) = 3.262, p < .068), and that if a mother was sexually abused, her child was also sexually abused χ^2 (1, N = 72) = 873, p < .575.

Almost three-quarters of the women (68%) lost someone close due to suicide or murder, and of these losses 85% were alcohol-related. Over three-quarters of the women (77%) reported having been arrested at least one time. These data further implicate alcohol and other drugs in violence against women.

Table 6-1
Personal Violence and Other Related Experiences of
Alaska Native Women Entering Treatment*

	<u>N**</u>	<u>Percent***</u>
<u>Physical Abuse</u>		
Ever physically abused	107	90
Before age 13	98	64
After age 13	98	36
Parents physically abused you	107	48
Abuse alcohol-related		
Adult hit you with an object	75	49
Adult push or slap you	74	70
Beaten in a relationship	78	89
Battered by significant other	118	81
Adult kick or beat you	75	39
Adult threaten you with a weapon	76	16
Adult use weapon on you	75	7
Spent night in a shelter to avoid violence	75	44
<u>Sexual Abuse</u>		
Ever sexually abused	83	78
Before age 13	63	76
After age 13	63	24
Adult exposed genitalia to you	75	49
Adult fondled you	75	61
Forced vaginal intercourse		
before 12	74	29
Raped (any age)	19	84
Your child(ren) physically abused	103	24
Your child(ren) sexually abused	103	19
<u>Personal Harm</u>		
Ever harmed yourself	107	52
Attempted suicide	105	51
Attempt alcohol/drug related	57	58
<u>Other</u>		
Lost someone close due to suicide or murder	105	68
Loss alcohol/drug related	65	85
Ever arrested	111	77

*Source: Segal, 1999

**Represents the number of women responding to each item.

***Represents the percent of respondents who gave an affirmative answer.

Among non-Native women, one study found that 47% of the women in treatment for substance abuse were sexually violated (Copeland & Hall, 1992), while another reported that 74% of women in treatment were sexually abused (Roshenow, et al., 1988). Jarvis and Copeland (1997) related that 70% of women in treatment as victims of child sexual abuse had tried suicide; they also indicated that 58% of the group reported self-harm. Further, Miller et al. (1993) found that two-thirds of the alcoholic women in their sample experienced some form of childhood sexual abuse as compared to approximately one-fifth of a sample of women drinking drivers and one-third of the women from a household sample.

The prevalence rates of violent experiences among Alaska Native women entering treatment attest to the relationship between physical and sexual abuse and their substance abuse. More specifically, it appears that sexual victimization is directly related to women's substance abuse problems.

A further study of Alaska Native women in WCRP found a relationship between sexual abuse and attempts to harm oneself. If a woman was sexually abused, she was 9.8 times more likely than a non-abused woman to have attempted to harm herself in some manner. It was also found that women who were sexually abused were almost 4 times more likely to have attempted suicide than non-abused women.

The connection between abuse experiences and increased risk for self-harm and/or suicide attempts is consistent with reports in the literature, which heightens the importance of recognizing that the problems women bring to treatment are more than just alcohol and/or other drugs. Often, it involves dealing with the effects of victimization. A focused treatment component that helps women identify and deal with the effects of abuse would enhance treatment retention, improve treatment outcomes, and decrease the probability of relapse.

The question these findings raise is what contributes to the high level of violence experienced by Alaska Native women entering treatment for substance abuse. One factor is the disruption of their culture. As noted in a report by the Alaska Federation of Natives (1989), these changes have been so rapid and dramatic that they have served as "a prerequisite to healthy and productive life being lost in a haze of alcohol-induced despair that not infrequently results in violence-perpetrated upon self and family" (pp. 1-2).

C. Treatment Implications for Substance Abusing and Abused Women

I was once a young child, although I find it very hard to remember the time. When I look back it seems that I grew up so quickly. The fears that I had were plenty. The stories that my friends tell me of their childhood and growing up years I cannot relate to. It's strange, oh so strange, because neither can they. Although we are of the same age, our experiences are so different. They tell me it's hard for them to accept mine, but as I assure them, it is not as difficult as it is for me to accept it.

I've been asked many times, since my growing up years, what it would have taken for me to stop and change the direction of my life. I believe that it is easy for me to answer. All I would have needed back then was to feel love and be trusted. All I would have needed was for someone to

*hold me and care for me, and most of all, someone to believe in me.
Nothing more than that.*

*-The story of Sharon's needs, who was abused early
in her life. (Cited in Martens, 1988).*

Among American Indian women entering treatment for substance abuse, sexual issues are important elements related to long-term recovery, but this aspect of a woman's life is often overlooked in treatment programs (Gutierrez et al., 1994). These researchers concluded that "Family dysfunction (substance use and physical and sexual abuse) appeared to undermine the individual's ability to respond to treatment ... The self-esteem of individuals who reported not having a history of physical and sexual abuse improved more with treatment than did that of individuals who reported such abuse" (p. 1780).

Gutierrez et al. (1994) also found that acculturation issues were related to treatment outcome. A higher treatment completion rate was found for women who indicated that they practiced traditional activities while growing up and during the year prior to entering treatment. Over 50% of those completing treatment also viewed themselves as traditional women. It is therefore essential that treatment programs with Native American women clients adopt an intervention approach that addresses the unique cultural characteristics of their clients. The program also has to be responsive to the problems the women bring with them by seeking to uncover and confront issues related to violence in their client's past.

Adult women carry the scars of personal violence experiences well into adulthood and often throughout their entire lives. Because the issue of violence and its effects has become a central theme in their lives, even if many abused women are unaware of the relationship between their current problems and their early experiences with personal violence, it is important to plan ahead to ensure that this topic remains in focus throughout the continuum of care provided.

It is imperative that sexually abused women continue to explore related issues after inpatient treatment, during transitional care, in outpatient treatment, and during aftercare. This effort is particularly important because women are much more likely to seek help for the consequences of abuse, rather than deal with the abuse itself.

Many of the issues women need to address after treatment are the same issues that existed before treatment (e.g., low self-esteem, self-stigmatization, lack of social support, and the need for supportive services such as child care). Continuing to participate in group counseling after residential treatment would help these women stay focused on these issues. The impact of violence on their children, with an emphasis on identifying cases where violence occurred, and on obtaining an immediate therapeutic intervention for abused children, also needs to be addressed.

Counselors have to be aware that dealing with abused women presents a formidable challenge. The task becomes even more complex when working with Alaska Native women. Within Native populations, and to a similar extent in others, there is a cultural "taboo" against discussing incest, sexual abuse, and child sexual abuse. This taboo is not, however, primarily directed at denial that these acts occurred, but rather at avoiding the intense "shame" associated with these behaviors. From these women's perspective, such matters are better left undisclosed. This

creates a situation where violence-related issues become even more troublesome when attempting to address them in a treatment context.

Not only are the clients reluctant to disclose information, but the counselors may also experience difficulty dealing with such issues. It is essential that an increased understanding of the problem become a vital part of solving it. Sexual abuse and other violence-related experiences, despite social customs, are issues that need to be introduced and dealt with for the good of the women. Heightened awareness of sexual abuse and other forms of violence will help lessen the effects of such phenomena, contributing to a better treatment outcome for drug abusing women who experienced personal violence.

The above discussion emphasizes the importance of examining how victimization experiences and substance abuse are linked. As described earlier, one explanation is that the experience of victimization is so traumatic that it contributes to the onset of a post-traumatic stress disorder (PTSD). Childhood sexual abuse is thus an important risk factor for PTSD.

Women with substance abuse-related PTSD were found to be more likely to report childhood victimization than women with only a primary substance abuse diagnosis (Brady et al., 1994). It was also found that the most predictive factor for lifetime PTSD among women from a Southwestern Tribe was the experience of physical assault (Robin et al., 1997). These findings reinforce the link between sexual abuse and substance abuse in women.

Treatment programs must begin to develop components that help abused Alaska Native women identify and resolve chronic stress in order to decrease the probability of relapse. It is also important, as mentioned above, to adopt traditional cultural methods that help women overcome their difficulties. Assisting these Native women in gaining a sense of self-worth and self-efficacy is a fundamental premise on which treatment must proceed.

D. Why Treatment Often Fails for Alcoholism and Other Drug-Related Problems for Alaska Natives

Many Alaska Natives grow up in small villages, speaking their language, following their own norms for behavior, including drinking behavior and remain fairly isolated from the main stream of non-Native society. Thus, it is necessary that alcohol programs with substantial Native clientele develop treatment approaches based upon understanding the Alaska Native social and cultural background. Today, many of us Native people are becoming aware of the drinking problems that confront us. But at the same time, social and cultural patterns are recognized as key determinants of individual drinking behavior as well as individual response to the prevention or treatment approaches. Leaders from our Native communities are emphasizing the need for our people to attack the problem, to assert our right to self-determination and confronting it. This undoubtedly means that our people will begin developing more of our own programs staffed by Native personnel in the immediate future.

-Anonymous Alaska Native

Current treatment approaches are mostly based on implicit assumptions about human behavior and the nature of alcoholism. These beliefs are chiefly derived from the behavior and value systems espoused by the dominant culture, and reflect a way of thinking that is largely representative of a European heritage. Beliefs about alcoholism are widely accepted and generalized to people of different ethnic or cultural groups. Such thinking excludes consideration of or tends to minimize social and cultural differences. A void thus exists with respect to culturally relevant treatment for people apart from the dominant culture, such as Alaska Natives. It is thus important to determine what is an appropriate or culturally relevant treatment approach for Alaska Natives. The following discussion, which addresses this issues, is largely based on the thinking of Ernie Turner, an Alaska Native and a pioneer in the treatment of alcoholism among American Indians and Alaska Natives. His thinking was formalized in a paper jointly written with Bernard Segal (Turner & Segal, 1995) and presented in Anchorage in late summer of 1995 during a conference on alcoholism in Alaska.

1. Culture-Related and Culture-Specific Treatment Issues

Alaska Native people have believed in the personal power of a "Healer," and the techniques they used were simple, yet powerful. For the Natives, the Healer possessed the greatest power in the world, the power of the mind and spirit in action. They knew a mind in harmony with the environment and the Creator was the nucleus of all life.

Alaska Native people were intensely involved in their traditional spiritual beliefs. As a force, the spiritual content of the people, along with tribal rule of the culture, formed what is often referred to as the "sovereignty" that held people together. To the individual, deep spiritual feelings and respect for all of creation were as much a part of their being as their physical features and personality. Spiritual power flowed like energy from their bodies, guiding their thoughts and actions throughout their lives, endowing them with values and a world view that gave meaning to their existence. Alcohol disrupted this spiritual flow.

As a result of these beliefs, a spiritual movement toward sobriety has been recently started in traditional Native areas. Spiritual retreats are held, using traditional religious practices that strongly advocate sobriety through the use of Native customs. This approach endorses the values and beliefs of the culture and the family system.

Many Natives in recovery, however, point out that cultural identity and cultural conflict, and the indifferent attitude in their communities by non-Natives toward traditional values, interfere in their recovery. They further assert that most non-Native counselors in traditional facilities, where they received treatment, did not understand their unique customs, values, and needs, and that they were asked many times to participate in activities that were contrary to their beliefs. These issues are important factors that need to be dealt with if Alaska Natives are to benefit from treatment for substance abuse.

Many Alaskan alcohol treatment programs hire mostly non-Native recovering alcoholics as counselors, depending on their experience as alcoholics to help clients in the recovery process. Yet there is very little training to help them understand the

nature of the alcohol problem in Alaska, particularly as it affects Alaska Natives. There is also little exposure to cultural relevancy. Some programs employ Natives, believing that they are in fact providing culturally sensitive treatment. With some exceptions, little effort has been made, however, to educate counselors about creating culturally relevant environments and programs that are conducive to recovery for Alaska Natives. Moreover, most programs attempt to facilitate change by imposing western values.

Few programs attempt to provide education on Alaska Native history or on the impact of alcoholism in Alaska Native communities. Treatment programs tend to disregard the feelings of the clients in relation to their culture, their world view, important values, spiritual beliefs, cultural conflicts, and where and how they see themselves in relation to society as individuals. Programs do not discuss Alaska Native drinking practices, nor do they provide information on traditional healing methods.

On a personal level, Alaska Natives with alcohol problems often bear an emotional burden linked to their being a Native and an alcoholic. As Natives, they have experienced a social stigma resulting from many years of government paternalism and the culture shock that occurs when a small culture is forcibly absorbed into a larger technologically advanced society. As alcoholics, they have experienced the stigma and problems associated with their drinking.

Adding to the complexity of treatment is the fact that society has generally developed an institutionalized opinion concerning Alaska Natives, which has resulted in the creation of a social distance between western society and Native cultures. Consequently, the effectiveness of a non-Native counselor working with Native clients, who they frequently believe to have socially unacceptable values, may not be an appropriate context for treatment. This is only one aspect of the counselor-client relationship, but when such a heavy social stigma is associated with the "Native" problem, the social distance phenomenon cannot be ignored. Native clients, having become accustomed to the social distance, can easily sense rejection by the counselor. Clients are thus often referred to counselors as "hostile," "unmotivated," and "hard to reach." Part of this attitude may be due to the "alcoholic's" disturbed condition, but the client's reaction to a counselor is highly dependent on the counselor's ability to demonstrate cultural acceptance.

For example, many traditional alcoholism treatment programs pressure Alaska Native clients to admit that they are an alcoholic, and call a refusal to admit such "denial." However, how can one admit to being an alcoholic when one does not know what an alcoholic is? It is most likely that such clients would not admit to being an alcoholic until s/he knows what alcoholism is.

Generally, people with drinking-related problems come to the attention of authorities primarily when the community cannot control their behavior, not with the realization that they may be developing a "drinking problem." Many Alaska Natives entering treatment would view their behavior from a different set of expectations than those held by the treatment agency. The drinker wants to know how to redeem themselves within the community while the treatment counselor wants to confront the person with his or her "alcoholism."

Alcohol abuse and alcoholism, nevertheless, do exist, and they are significant problems, as emphasized throughout this document. Native communities, however, have their own standards by which they define the problems associated with the consumption of alcohol. Thus when interventions are made, they have to account for the Native cultural perspective.

Many counselors are not working within, nor are they familiar with, the cultural framework of the client's background. When clients and counselors do not understand each other, alcohol problems will not be solved; cultural differences contribute to such misunderstandings.

When working with Native clients, non-Native and Native counselors must understand that they are usually witnessing a person with tragically low self-esteem and a sense of incompetence that may have resulted in part from a feeling of cultural or racial inferiority imposed by the dominant society. Many Alaska Natives also experience difficulty adjusting to the demands of the dominant society, which are seen as alien. Significant conflict exists because demands are made for them to assimilate into the larger society. Some of the conflicts between different cultural value systems are contrasted below:

- Harmony with Nature vs. Mastery over Nature
- Extended Families vs. Nuclear Families
- Environmental Education vs. Academic Education
- Spiritual Conviction vs. Missionary-Induced Religions
- Native Language vs. English Language
- Native Food vs. Western Foods
- Native Customs vs. Western Customs

In accordance with such thinking, treatment should be based on the client's situation. It is difficult for clients to recover unless they feel good about themselves as persons; they need community support and role models to follow, and their values and beliefs must be incorporated into the recovery process.

Because some Alaska Natives entering treatment for substance abuse may have lost or never developed their cultural identity, it is important to work with them so they do not feel "shame" or "guilt" concerning their lack of cultural identity. Such individuals must be helped to achieve a sense of cultural identity, and the challenge is to help them feel good about their accomplishments.

2. Culturally Relevant Treatment

Treating the alcoholic or alcohol-abusing Alaska Native client requires a culturally relevant intervention. This intervention must begin with a decision as to whether it will be culturally sensitive or culturally competent. Cultural sensitivity refers to a treatment orientation that acknowledges cultural diversity in the following ways: by using the other person's language (often through translators or by hiring bilingual staff), by working within the culture's community, by creating a culturally appropriate environment, and by demonstrating cultural awareness.

A culturally competent intervention, while incorporating the above features, builds its strategy on the cultural values, beliefs and practices of the population the program is trying to reach. This is not an easy task. In Alaska, for example, a culturally competent intervention necessitates that counselors acquire a basic understanding of the fundamental fabric of the people that they are trying to serve. Non-Native counselors have to learn about all Alaska Native groups while Alaska Native counselors must gain an appreciation of different Alaska Native cultural groups.

While a detailed study of the different cultures may be impractical, exposure to them is necessary, and consultation can be sought to aid in developing appropriate interventions. Before any intervention is made, however, it is important to assess first the level of acculturation or the degree to which the client has adapted to or assimilated the dominant culture's values and customs. In other words, it is essential to learn in which world the person functions, or if he or she is caught between two cultures.

Assisting the client to achieve a sense of identity is an important step in treatment. Counselors must understand the nature of acculturation to help the client establish a cultural identity and function in the dominant society. Acculturation represents learning who one is with respect to her/his cultural identity, establishing self-pride and a sense of self-efficacy, and using these as a basis for interacting with the dominant culture. Counselors also have to understand the effects that acculturation stress has on the character of relationships within the families and communities, and on the beliefs, traditions and values of a given cultural group.

Following a culturally competent treatment framework also requires that fundamental core concepts or central values of a cultural group be understood and utilized appropriately in the treatment process. To date, little has been published about such values and their utilization in treatment. Appropriate application of these values, such as spiritualism, could facilitate interacting with Alaska Native clients.

3. Spiritualism in Alcohol Treatment

Spiritualism refers to the belief that all life processes have their beginning in spiritual creation. A vital aspect of this belief is that the practice of spirituality acknowledges a "Creator" who is looked to for guidance. Spirituality has been a uniting force among Native people, and can be a critical factor in healing. Spirituality is sometimes confused with religion. Spirituality represents a dimension of belief that is not part of any particular formal religious institution

Culturally competent treatment must take into account the individual's present world view and spiritual conviction. As noted earlier, it would be helpful to incorporate indigenous healing systems into the recovery procedure. As Ernie Turner relates, "My grandfather told me our spirit is our deepest self. He said spiritual activities are ways in which we relate to all life. It helps to enlarge our life and to understand the purpose of life itself. Our spiritual self can cure us of all of our ills." Using this belief system as a basic premise in treatment, programs must incorporate the positive factors of the Native culture into counseling, including motivating clients to regain a sense of cultural identity.

Skilled Native counselors, who are sensitive to their client's predicament, can communicate effectively to convey both understanding and acceptance of the client's situation. Many non-Native counselors are not effective because they maintain a social separation from Alaska Native clients, and are unable to incorporate the subtleties of the culture into their counseling relationship. Rupert Ross (1992) expressed a need for traditional healing methods:

When we encounter Native people who do not take to our predominant form of healing, who refuse to open themselves up in our way, we believe we see people who are not interested in healing themselves or, worse still, who are incapable of so doing. These are the unwritten conclusions of many of the psychiatrists, psychologists and other therapists who prepare reports for our courts to assist them in finding an appropriate sentence; the message between the lines is that the Native cannot or will not help himself. In our conceit, we assume that he who doesn't choose our way is left with no way. We fail to ask the simplest of questions, such as "Do you want to turn your life around, to heal yourself?" and "If you do, how do you think such healing might best be accomplished?" In fact, the history of Native people in our jails shows that when they have asked to be able to bring appropriate healing measures into play we have scoffed at their requests. It is only recently that prison officials are permitting, or encouraging, Elder visitation and pipe ceremonies, sweet-grass and sweat-lodge ceremonies.

I don't believe that we have to understand how such spiritual healing works...For thousands of years of a very harsh existence Native people coped successfully with their inevitable sorrows and stresses. Not only have they survived, but, as we are slowly coming to appreciate, they retain as a people an impressive dignity and a strong sense of self-worth. It seems clear that they did not psychoanalyze themselves into that state so there must have been other mechanisms. Why is it, then, that we so regularly fail to make the connection when we hear repeated requests for pipe ceremonies, sweat ceremonies and the like from Native people in our hospitals, jails and treatment centers? Why do we want to write those practices off as hocus pocus instead of recognizing that they have healing potential?

There is a remarkable resurgence in the use of traditional ceremonial healing not only within Native communities but within Native-run treatment centers for those with substance-abuse or other problems. Obviously, these traditional practices are not instituted to serve as tourist attractions, for there are no tourists present, only Native people in search of help from other Native people. They are instituted because they are considered appropriate and productive.

At the same time, such treatment programs also incorporate some aspects of our healing techniques, for there is an increasing focus upon talking, upon sharing grief and sorrow verbally with other loved ones, and upon disclosing the traumas of the past in an effort to finally leave them

behind. From what I have seen thus far, this combination of intellectual and spiritual healing seems to be a potentially powerful tool. I have watched the most dysfunctional of families return from such centers with new insights and new faith. Part of their apparent success comes from the Native insistence that the whole family be involved, that it be a "holistic" approach which recognizes that all must know what each suffers so that all can contribute towards comfort and help instead of unwittingly contributing towards making things worse. Another part involves putting a stamp of approval on the disclosure and discussion of private feelings and past traumatic events, together with learning how to speak of such things. The third part involves the use of traditional ceremonies (which may also be new to many Native people, thanks to our efforts to eradicate them) and the capacity of those ceremonies both to "cleanse" each individual and to then prompt him or her to a solemn re-dedication towards helping other family members in need. (pp. 146-147)

It is clear that the series of problems associated with abusive drinking and other drug use are quite severe among Alaska Natives. However, rather than identifying ethnicity as the only variable contributing to the predicament of Alaska Natives, the focus should also be on sociocultural factors, such as racism and cultural loss, if progress is to be made in overcoming substance abuse. Concentrating only on the classification of "Alaska Native" detracts from understanding and identifying the conditions that are related to the current predicament. Within this context, Alaska Natives are the people most capable of understanding their dilemma, and what can be done about it.

In large part, the solution to the problem of alcohol abuse rests with the Alaska Native community. Many Alaska Natives, however, are ambivalent about how to react to the problems associated with drinking. This conflict is expressed in many different ways. For example, family standards about acceptable and unacceptable drinking practices may vary and appear to be inconsistent. The younger generation, growing up in the present environment, may receive mixed messages about drinking.

One approach that has arisen to "take control" over the problem is the formation of a traditional "Sobriety Movement" to help Native people confront drinking within their own communities. The Sobriety Movement (discussed in greater detail in Chapter XI) seeks to reduce alcohol-related problems by urging individuals to take control over their life by returning to traditional values.

Further, prevention must be emphasized. Such efforts need to be based on an understanding of the influence of cultural factors on initiation to drinking and drug-taking. The different factors that reinforce such behavior also need to be identified. If a prevention effort is to be successful, it must be a long-term multigenerational effort that targets these factors and utilizes procedures that are culturally relevant..

The deepest roots of the current crisis lie in the pattern of destruction caused by alcohol. The Alaska Native community sees alcohol abuse and alcoholism as a threat to its entire way of life. This crisis particularly affects women and children. A sound prevention effort must focus on educating people about alcoholism and alcohol abuse,

and culturally effective treatment and prevention programs will help contribute to the healing process.

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CHAPTER VII

FETAL ALCOHOL SYNDROME: PRENATAL EXPOSURE TO ALCOHOL AND OTHER DRUGS

In Memoriam: Roy Kirk, 1972-1986. The anger cornered 14-year-old Roy Kirk in a concrete cell 400 miles from his home in Stebbins. Kirk was in McLaughlin Youth Center in Anchorage, facing a sexual assault charge he denied. His future was frightening and uncertain, his past unsettling. The night of Oct. 30, 1986, he was locked in a cell, alone, to cool down after an argument with another boy... Sometime between 8:30 and 9 p.m. - guards said it happened during an eight to ten-minute stretch between routine checks - Roy Kirk pulled the lace out of his right tennis shoe, tied it to a window grate, knotted the other end around his neck and leaned forward until he fell unconscious...

Kirk first came to the attention of the State Division of Family and Youth Services because of his mother's drinking. Kirk told a psychiatrist in Anchorage that his parents often went to Nome to drink and didn't come back for as many as five days at a time. "There is a question if Kirk received any consistent supervision when living in Stebbins," wrote the psychiatrist in a report requested by the court after Kirk's arrest. "Inconsistent parenting has been the norm." (Dougherty, *A People in Peril*, Anchorage Daily News, 1988, p. B8.)

The memorial to Roy Kirk recounts a horrible tragedy; a 14-year-old boy driven to the depths of despair and suicide. But perhaps even more tragic, are the questions that were **not** asked in this account of young Roy's death: "Did he really intend to commit suicide?" "Did he know that losing consciousness would result in his death?" "Or did he perhaps suffer from fetal alcohol syndrome which impaired his judgment and caused him to act impulsively?" Seldom were these questions asked when Roy's memorial was published in 1988, and far too often they go unasked and unanswered for many young people in Alaska today.

Some important questions are: What role does prenatal exposure to alcohol and other drugs, over several generations, play in the ongoing spiral of alcoholism, drug abuse, injury, suicide, domestic abuse and child neglect or abuse? Are many, if not all, of these tragic conditions exacerbated by the conditions of parents and grandparents, who may themselves suffer from the physical, cognitive and behavioral impairments caused by fetal alcohol syndrome (FAS) or fetal alcohol effects (FAE)? The purpose of this chapter is to examine the issues related to these questions. The sections that follow review the state of the science concerning what is known about

fetal alcohol and other drug exposures, raising questions that are critical to the survival of the Native people of Alaska.

A. Defining Fetal Alcohol Syndrome and Effects

Fetal alcohol syndrome (FAS) was formally named by a group of researchers at the University of Washington in 1973 (Jones et al., 1973). Although the condition had been suspected and described by earlier reports (e.g., Lemoine et al., 1968), it was not widely publicized or studied until the 1970s. Fetal alcohol syndrome is a term that refers to a “constellation of birth defects” caused by exposure to alcohol during gestation (Clarren & Smith, 1978). One component of this constellation of effects involves physical symptoms while the other part refers to cognitive and behavioral symptoms.

1. Facial Characteristics of Fetal Alcohol Syndrome: Implications for Alaska Natives

When fetal alcohol syndrome is mentioned as a medical diagnosis, many people look first for characteristic facial features described in books or journals. These features are important to the diagnosis, but they are only one component. The features can only be identified through specific physical measurements made by a developmental pediatrician (also called a dysmorphologist) or other trained physician. The professional looks for the proportion between the eye openings (called palpebral fissures) and the space between the eyes. The palpebral fissures are particularly small in children with FAS, because during fetal development, the eyes grow directly from the tissue of the brain. Alcohol prevents the brain from developing properly or completely, so it also impedes growth of the eyes to normal size.

In addition to small eye openings, a dysmorphologist evaluates a child’s face for a flat midface, a thin upper lip, and a smooth philtrum (i.e., the space between the nose and upper lip). Less common features include epicanthal folds (i.e., folds in the corner of the eyes), ptosis (or drooping eyelid), high arched eyebrows, and a short upturned, nose (Clarren & Astley, 1995).

Clarren and Astley, in a broadly accepted guide for assessment of fetal alcohol syndrome, caution that, “No two individuals with FAS have exactly the same combination of features or the same level of expression of each feature” (1995, p. 3). This is particularly true for people of different racial backgrounds. Physicians who attempt to make diagnoses must be aware that epicanthal folds and a flat midface are quite characteristic of persons of Asian descent, some Alaska Natives, and some American Indian groups. In these cases, such facial features would not be considered indicative of FAS. Errors based on lack of experience, poor judgment, or even sub-conscious biases could lead to false positive diagnoses of FAS and inflated estimates of the condition among particular racial groups. This has made diagnosis difficult in Alaska because some physicians are familiar with the natural features of the many different racial groups that are commonly called “Alaska Natives,” while other are not. It is crucial that the true pattern of facial characteristics of FAS among various groups

of Alaska Native people be determined and applied uniformly across the state to prevent “over diagnosis.”

Another problem that arises in using facial characteristics as a necessary criterion is that the face changes as a child matures. “The FAS facial pattern often diminishes with age. It tends to be most clearly expressed between the ages of 2 and 10 years” (Clarren & Astley, 1995, p. 3). This can represent a diagnostic problem, because early childhood is also the time of life when children with FAS tend to function best behaviorally (Burgess & Streissguth, 1992). Alaska Native children, as a result, in both urban and rural areas, may not be referred for diagnosis until their educational or social difficulties become critical. When they are finally seen by a doctor, the adolescent’s facial features may have changed so significantly that definitive measurements are impossible to obtain. Some physicians are skilled enough to supplement their assessments with childhood photos, but in many cases, pictures may not even be available to the parents or adult patient. In cases where extended families are involved, admittance to a mother’s heavy drinking during pregnancy may be withheld. These circumstances can prove frustrating for all involved, making diagnosing the condition extremely difficult.

2. Growth Criterion for Fetal Alcohol Syndrome

A second criterion necessary for a diagnosis of fetal alcohol syndrome is deficient growth, pre- and/or postnatally. Some children with FAS are born prematurely. They are small in both size and weight. However, even when the newborns are carried to full term, they are typically far below average in height and weight according to expectations based on the size of their parents and averages for their racial groups. It has been established that the growth deficiencies are related to exposure to alcohol. “Growth problems are generally not treatable in FAS. That is, growth failure is not due to poor or inadequate nutrition, metabolic problems, hormonal disorders, or malabsorption” (Clarren & Astley, 1995, p. 6).

Some children improve in weight compared to their peers as they reach puberty. Girls, in particular may gain weight at puberty, although others continue to be quite small throughout life (Streissguth, LaDue, & Randels, 1988). The change in growth patterns may complicate the diagnostic process based on the age of the child or young person when he/she is first referred.

Birth weight is another physical manifestation related to racial background. Some indigenous peoples of the United States have newborns that are typically smaller than infants of Anglo-European descent, while others are characteristically larger. Physicians and other professionals must be sensitive to these differences in evaluating children’s health conditions. We cannot apply standards designed for the predominant Anglo-European culture to children of Alaska Native heritage.

Specialists in the field have recently identified a new dilemma related to the growth criterion. Clarren and Astley (1995) described alcohol-exposed children as having the physical, cognitive, and behavioral features of FAS, yet having “normal” growth. When a child has normal growth patterns, his/her mother may have decreased her drinking during the third trimester of pregnancy -- the one most critical for fetal growth. Perhaps increased public education programs have influenced the decline of maternal drinking

during the third trimester. What could result is a relatively new growth phenomenon in children with FAS. This hypothesis needs to be tested.

3. Cognitive and Behavioral Characteristics of Fetal Alcohol Syndrome

Facial and growth features are important to the diagnosis of FAS. Damage to the brain and central nervous system must be documented because such damage can impair a broad spectrum of cognitive and behavioral skills. The central nervous system is the part of the body most vulnerable to the effects of alcohol during gestation because it develops throughout the entire nine months of pregnancy, and continues to develop even after birth.

Structural brain damage during fetal development can result in microcephaly (i.e., small head and brain size), and may occur with other anatomic problems that interfere with a person's ability to think, learn, and behave appropriately. Problems may also occur in brain functions. Clarren and Astley (1995) described several types of anomalies linked to structural brain damage: seizures, abnormalities of muscle tone, tremors or marked dyscoordination, decreased hearing of neurosensory origin and visual problems stemming from the small size of the eye (nearsighted, far sighted)

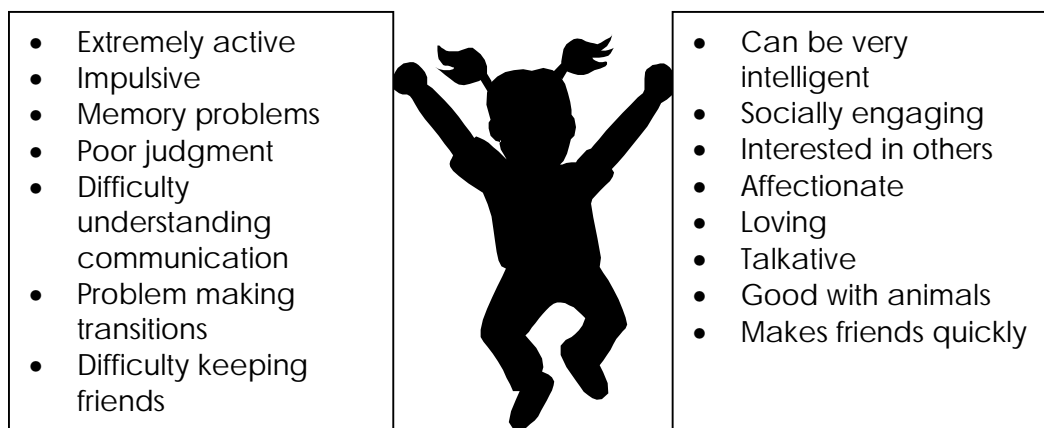
If these impairments are diagnosed without recognition of the true cause (i.e., prenatal exposure to alcohol), the child may not be treated correctly or effectively. When children enter school and other social situations, their disabilities can be misunderstood, and they may even be punished for neurological problems over which they have no control (Streissguth, 1997).

The most common myth about individuals with FAS is that they are all mildly mentally retarded. Research has shown that students with FAS can have intelligence scores (IQ) ranging from above average to severely mentally retarded. One of the pioneering studies reported a range of IQ scores from 95 to 25 (Streissguth et al., 1996). IQ scores for students with FAE are similar.

The most important effects of brain and nervous system damage are changes in behavior. These changes are sometimes subtle and are extremely difficult to diagnose. Behavior problems may represent the greatest challenge to individuals with FAS because they can be difficult, though not impossible, to change.

FAS-related behavior problems that persist throughout life usually include hyperactivity, distractibility, impulsivity, poor judgment, superficial communication skills (i.e., lack of real understanding of what is being discussed) and poor social skills. Individuals with FAS may experience learning problems and/or developmental delays. Only a small percentage of individuals with FAS actually have mental retardation. As with the physical symptoms, no two people show exactly the same pattern of behaviors. The typical behavior profile found in fetal alcohol syndrome is shown in Figure 7-1 on the following page.

Figure 7-1. Behavior Profile of FAS and FAE (adapted from Burgess, Lasswell, & Streissguth, 1992).



The behavioral characteristics used in assessment and diagnosis of FAS/FAE are typically the negative or problematic behaviors, but it must be stressed that each person has strengths and individual talents as well. If FAS is recognized when a child is young, there is much that can be done to help him/her overcome any physical, cognitive, and behavioral obstacles. It is only society's lack of attention and willingness to face difficult taboos about substance abuse during pregnancy that leave many children, adolescents, and adults struggling to understand why they are so "different."

B. Defining Fetal Alcohol Effects

Perhaps the most controversial issue among professionals is trying to understand fetal alcohol effects (FAE). At present, there is debate over what to do with children, adolescents, or adults who are referred for diagnosis and have some, but not all, of the symptoms of FAS. "What is this condition called?" What is recommended to families and professionals attempting to understand the day-to-day problems?

When individuals have some of the characteristics of FAS and a definite history of maternal drinking during pregnancy, the most common label used is "possible fetal alcohol effects" (PFAE), shortened to fetal alcohol effects (FAE). Unlike FAS, FAE is not a recognized medical diagnosis. Without all the physical, cognitive, and behavioral criteria for FAS, the "cognitive/behavioral dysfunction cannot be definitively linked to the prenatal exposure in any one individual" (Aase, Jones, & Clarren, 1995). In many cases, doctors and other professionals try to clarify this label by reporting that a patient has "brain damage with possible fetal alcohol effects due to maternal consumption of alcohol during pregnancy" (Burgess, personal clinic notes, 1997). The disadvantage of such a description is that it may or may not qualify the affected individual for educational, medical, and/or social service benefits.

In 1996, the National Institute of Medicine recommended dividing possible fetal alcohol effects into categories with titles such as, "FAS with Confirmed Maternal Exposure to Alcohol," "FAS without Confirmed Maternal Exposure to Alcohol" and

“Partial FAS with Confirmed Maternal Alcohol Exposure” (Stratton, Howe, & Battaglia, 1996). Further, the committee subdivided the third category into "alcohol-related birth defects (ARBD)" and "alcohol-related neurodevelopmental disorder (ARND).”

Unfortunately, literature in the field has become confusing because writers have used the terms “PFAE,” “partial FAS,” “ARBD,” and “ARND” interchangeably. When they are used correctly, diagnosticians choose either the phrase “possible fetal alcohol effects” or “fetal alcohol exposure” to describe the situation in which a patient shows some, but not all, of the diagnostic criteria for fetal alcohol syndrome. For simplicity, this paper will simply use the terms FAS and FAE to describe individuals who experience physical, cognitive, and/or behavioral problems as a result of prenatal exposure to alcohol.

1. Characteristics of FAE: The Danger of Misdiagnosis

A crucial point to make is that FAE is not less serious nor less debilitating than FAS. Although young people and adults with FAE do not have all of the physical symptoms specific to FAS, they usually have some or all of the cognitive and behavioral deficits. This can make FAE more debilitating than FAS because sufferers have no medical diagnoses to describe their conditions. If they look “normal,” they are expected to behave “normally.” When the children begin to have problems learning, or they become hyperactive and impulsive, they may be misdiagnosed as having attention deficit disorder. Unfortunately, many are medicated with drugs that have not been studied extensively with this population of children.

For young adults with FAE, the challenges can be even greater. If their attention problems, memory deficits, and lack of judgement are not diagnosed, they may be labeled “lazy” or “maladjusted.” They can become disillusioned with school, because they do not understand why they have social and academic problems. Many of these youngsters get into trouble because they are easily victimized by their peers who take advantage of them (Streissguth, 1997). One social worker explained that, “Unfortunately, these kids make perfect gang members; they follow the crowd and do whatever they’re told so they’ll fit in” (personal communication, 1990). They often end up spiraling downward through alternative schools and the juvenile justice system without any recognition of the root cause of their problems. Perhaps this was the fate of 14-year-old Roy Kirk who took his own life at McLaughlin Youth Center.

Adults with FAE face lifelong problems. When their peers and communities expect them to conform, they may lack the judgment required to choose good role models. They can fall into a lifestyle of drinking, accidental injuries, and personal violence because they do not have the support and skills needed for productive living. The following sections examines what needs to be done to answer questions faced by these individuals.

C. Estimates of FAS in Alaska

By the mid-1980s, the Indian Health Service (IHS) had appointed a Fetal Alcohol Syndrome Coordinator for the State of Alaska. Due to the growing body of research and the work of the coordinator, cases of diagnosed or suspected FAS and FAE

among Alaska Natives served by IHS were systematically tracked. No such effort was initiated for non-Native women. Estimates of FAS/FAE were derived only for Alaska Native women. Because the rate of FAS among non-Native women giving birth in Alaska is unknown, caution must be taken when comparing the rates of FAS and FAE between Alaska Native women and other women in the state.

In 1994, the Alaska Natives Commission (1994) quoted the rate of FAS as two times the national rate, or approximately 5.1 per 1,000 live births. The Commission found that in some areas of the state, for example, the Copper River Basin, the prevalence of FAS was estimated to be 350 per 1,000 live births, or 35% of the children born to Alaska Native mothers (Alaska Section of Maternal, Child and Public Health, 1990, AK Commission V. 2, p. 26).

Since that time, the Centers for Disease Control (CDC) conducted a statewide prevalence study of FAS among children born between 1977 and 1992 (Egeland et al., 1998). The CDC study used five strict criteria for a diagnosis of FAS, and of 630 potential cases, 145 individuals were identified as having the full syndrome. Not surprisingly, "the Indian Health Service case files identified the largest proportion of cases (56%), followed by the regional Native health corporations (19%), and the state's genetics clinics (12%)" (Egeland et al., 1998, p. 784). Of the children classified as having FAS, "83% were Alaska Native, 12% were White, and 4% were Black" (Egeland et al., 1998, p. 782). To give credence to such dramatic numbers, however, it is important to examine the methods by which they were established and compare those to strategies used to estimate prevalence in other populations.

In 1989, Bray and Anderson conducted an appraisal of the prevalence of fetal alcohol syndrome among Canadian Native peoples. The purpose of the study was to determine whether there was epidemiological evidence to suggest that FAS occurs more frequently in Native populations. The researchers concluded that, "The notion that there is more FAS among Native children than non-Native children is questionable. It is difficult, if not impossible, to make a valid comparison of the prevalence rates for Natives and non-Natives and draw inferences regarding higher prevalence for Natives" (Bray & Anderson, 1989, p. 44).

These researchers pointed out that applying standard diagnostic criteria across cultures is problematic. "Since anthropomorphic features of Indian children generally differ from Caucasian children, the use of facial characteristics as a diagnostic criterion is questionable." In addition, "educational assessment across cultures, especially the use of IQ tests in the evaluation of central nervous system dysfunction as a criterion, requires special attention" (Bray & Anderson, 1989, p. 44). These authors provided an important warning: "Native peoples should not be stigmatized by a condition such as FAS which is difficult to prove and may have negative impacts within the Native community. Caution is warranted before we conclude that FAS is more prevalent in any Native peoples" (p. 44).

Because it is inappropriate to compare rates of FAS and FAE among populations, the State of Alaska has not attempted to estimate exact numbers of individuals with FAS (Alaska Division of Alcoholism/Drug Abuse, [ADA] 1998). Rather, the Division has cited statistics related to the number of women who are pregnant at various points in time and the percentage of those women who report drinking heavily. For example, "Research in 1991 revealed that 21,600 Alaskan women in the childbearing ages

between 18 - 44 were heavy drinkers, and although 'alcoholic' women run the risk of producing one or more 'FAS infants,' even a small amount of alcohol/drugs consumed during pregnancy may be enough to cause harm to the unborn" (ADA Web Site, 1998, p.2). In addition, ADA found that, in a 1995 study of women who delivered babies in a single Anchorage hospital, 16.2% had urine samples that tested positive for alcohol and/or other drugs (ADA Web Site, 1998, p.2). Such statistics indicate the very serious potential for newborns in Alaska to have symptoms related to prenatal exposure to alcohol or drugs, but no studies to date have given definitive estimates of the incidence (i.e., the number of individuals who experience a given medical condition at some time during life) or prevalence (i.e., the number of individuals affected by a condition at a given point in time) of fetal alcohol syndrome in Alaska.

Some professionals have pointed out that problem drinking among women of different cultures should be examined as a risk factor for FAS because, "consumption patterns and styles vary significantly across Native tribes and consumption rates for some groups of Native women are much lower than the national average." (Levy & Kunitz, 1974). It is not appropriate to classify all Alaska Native peoples in all communities as having the same vulnerability to FAS because of their substance abuse patterns. Before any definite conclusions can be attained, research must be undertaken to determine the exact patterns of drinking and genetic risk factors that endanger Alaska Native children.

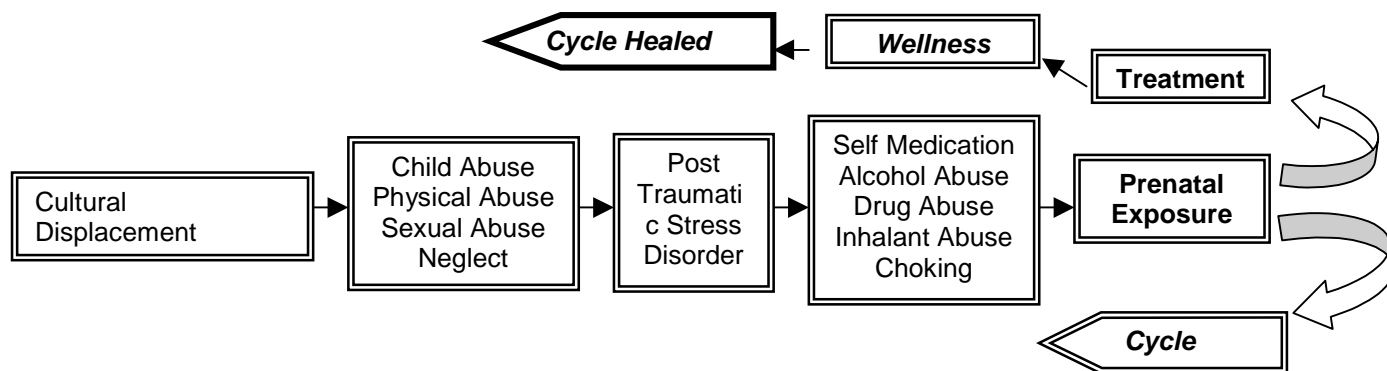
D. Searching for Solutions: What Should be Done to Find the Answers to the Problem of Fetal Alcohol Syndrome?

The most important way to begin to address the complex problems of FAS and FAE is to view prenatal exposure as a condition related to substance abuse across multiple generations. To date, most of the suggestions in the literature and other media have been directed mainly toward helping FAS/FAE children, and sometimes adolescents. For example, one of the major recommendations made by the Alaska Natives Commission (1994) was to increase funding and availability statewide of the "Healthy Start" Program to assist families at risk for having children with prenatal exposures to alcohol (Vol. 1, 1994). Although such programs are essential, it must be recognized that there are lifelong consequences of FAS and FAE.

E. Need to Recognize the Multigenerational Effects of Substance Abuse

The advantage of looking at substance abuse as an ongoing cycle through many generations is the fact that it also shows how the process can be interrupted and changed at any point in time. Intervention must occur at many different points in the cycle, across many generations of a family or community; it can be repeated and/or modified if any particular strategy is not effective. Figure 7-2 depicts the cycle of substance abuse, personal violence, and prenatal exposure to alcohol and other drugs as it is repeated across generations.

Figure 7-2. Multigenerational Cycle of Substance Abuse



In order to design appropriate treatment methods for all of the components of the model we must commit the resources to find the answers to many research questions that have yet to be explored. These issues are outlined in the following sections.

F. Need to Reexamine the Concept of Adult Children of Alcoholics

A common theme in the field of substance abuse during the past decade is the idea that, if a person's mother or father drank or abused other drugs, many problems of adulthood might be related to grief suffered from being an "adult child of an alcoholic" (ACOA). Twelve-step programs were established to help such adults come to grips with their grief and anger, and to help them put their lives on more productive paths. Twelve-step programs have been adopted in some Native communities, while other Native groups have started "talking circles," or other culturally-related interventions to help young people and adults deal with issues related to parental substance abuse. While these programs are extremely important and can be successful for many people, there is a need to go a step further.

What has not been asked in the literature, nor in most recovery programs, is the question, "To what extent are the problems experienced by ACOAs related to cognitive or behavioral disabilities resulting from prenatal exposure to alcohol or drugs?" This is not to say that every ACOA suffers from FAS or FAE; quite the contrary. Only few of the individuals whose mothers (not fathers) drank heavily during pregnancy show the characteristics of full fetal alcohol syndrome.

G. Need to Explore the Relationship between Prenatal Exposure and the Breakdown of Effective Parenting

The breakdown of nuclear families and effective parenting has been attributed to the abuse of alcohol by many writers (e.g. Napoleon, 1992). One author of the Alaska Natives Commission Report noted:

Alcohol's significant negative impacts on Native families and communities has come out quite clearly and loudly at all levels of the Commission's inquiry. The terms "dysfunctional families" and

“dysfunctional communities” have been mentioned so often that they are standard for anyone – from professionals to Native elders - who seek to adequately describe how alcohol affects Native society and culture (1994, p. 75).

It is essential to look beyond only the abuse of alcohol by the current generation and its effects on those families. What remains to be studied are the conditions among families in which one or more of the parents, or even the grandparents, are themselves affected by FAS or FAE. The questions that must be confronted are, “What role does fetal alcohol syndrome play in the breakdown of parenting skills?” “How can an individual be expected to be a good and careful parent if he or she suffers from poor judgment, impaired memory, and inadequate social skills?” Once we examine the true effects of alcohol on an individual’s ability to bear and raise children, then we can determine the level of support he/she might need to be an effective parent. Only by confronting the fact that some members of our communities may not have the cognitive and behavioral skills required to make decisions and raise children in a healthy way can we adjust expectations and provide the help they need.

H. Need to Reexamine the Idea That Fetal Alcohol Syndrome is 100% Preventable

A common sentiment in the research literature and in public awareness campaigns is that FAS and FAE are 100% preventable, which at first glance seems like a reasonable tenet. If one examines this assumption in greater detail, however, it becomes clear that the situation is much more complex. If FAS and FAE are viewed as affecting several generations, it is easy to see that a young woman with FAS might have great difficulty making good decisions about drinking if she becomes pregnant. As a result of her own cognitive disabilities, she may not have the skills to care for herself let alone her unborn child. In that case, to assume that she has the “choice” whether to drink during pregnancy is too simplistic. If everyone around her drinks, and this is the behavior she has always known, it is unreasonable to expect that she would behave differently during pregnancy. Even if she were given warnings about the effects of alcohol on pregnancy, she might not have the ability to make the abstraction that her drinking could affect her own fetus. She may simply continue habits that she had practiced most of her life with no purposeful intention to harm her unborn child.

To date, evaluation data on prevention programs that seek to raise public awareness about the dangers of drinking during pregnancy have not demonstrated any significant decrease in the rates of fetal alcohol syndrome (Abel, 1998). Referring to Figure 6-2, it makes sense that public education would not be sufficient if more than one generation has been affected by prenatal exposure. Intervention must occur at each stage along the continuum of substance abuse in order to break the cycle permanently and effectively.

A tragic illustration of the effect of FAS on the breakdown of the family unit was a phone call received by the author (D. Burgess) from the tribal judge of a small band of American Indians in one of the western states of the U.S. The judge called to seek advice about alternatives for treating women among her people who were pregnant

and drinking. The tribal judge said, "I am 56-years-old and I am the eldest person left in my band. If I don't do something about the alcohol deaths in my community, we will cease to exist as a people." This elder asked if the author thought she should jail the young women who were carrying children and continued to drink. Because no substance abuse treatment programs were available in that geographical area that would accept pregnant women, this was the only option available to the judge. We discussed the situation at great length and finally decided to explore treatment options for the women. But how many elders in our communities face this dilemma? Must we lose entire groups of peoples before we commit the resources to solving the very complex problems caused by FAS and FAE? More research on pregnancy among adults with FAS and FAE is needed to determine the level of support required to have successful and healthy outcomes.

I. Need to Examine the Idea of Alcohol as "Self-Medication"

One of the widely accepted theories of the cause of substance abuse is the concept that people who suffer from depression may be using alcohol or other drugs as a form of self-medication. This may be the case for many individuals. For children and adolescents with FAS or FAE, however, the use of inhalants, alcohol, and other drugs may be their way of "following the crowd." If they truly lack the judgment to make good choices, they may be drinking just to imitate their friends.

As described above, young people with prenatal exposures have difficulty making and keeping friends (Burgess, Lasswell, & Streissguth, 1992). They are most successful in groups when they copy the behavior of others; if others are drinking or using drugs, these youngsters are likely to do the same. And, without the benefit of good judgment, they may not know when or how to stop. On some occasions, they may unintentionally drink to excess or may suffer overdoses from inhalants or other drugs. Such events could result in death. What might have been a simple attempt to "fit in" could be interpreted by professionals as intentional substance abuse or even suicide. For this reason, it is crucial that incidents of injury and presumed suicide among children, adolescents, and even adults, be carefully examined to determine whether FAS or FAE had a role in what might otherwise have been seen as "intentional" acts.

J. Need for Studies of Prevalence Rates in the Corrections Systems

Just as young people with FAS or FAE may drink or use drugs to conform to the group around them, they may also commit criminal acts without understanding the nature of their offenses. One of the most common behavioral characteristics of FAS and FAE is poor judgment, or the inability to understand the consequences of one's behavior. Although this has been demonstrated consistently, few professionals have attempted to determine the prevalence of prenatal exposure among young people and adults involved in the justice system.

Successful interventions with youths beginning a criminal career requires exploring the extent to which their behavior might be the result of neurological deficits caused by prenatal exposure to alcohol. How can we expect to provide remediation if we are

afraid to ask the questions about the physical conditions that might influence a young person's behavior?

Likewise, it is crucial to determine the prevalence of prenatal exposure to alcohol among the population of men and women in the state's prison system. The Alaska Sentencing Commission stated that: "The Commission finds a clear connection between the abuse of alcohol and the commission of criminal offenses in Alaska. This alcohol connection is particularly strong in rural areas, and among Alaska Natives wherever situated. It is estimated that at least 75% of offenders have problems with substance abuse, and this figure is probably even higher for Native offenders" (1994, p. 73).

There is a need to go a step beyond connecting alcohol abuse, at the time of the event, to the crime in question. Professionals must begin to look further into the history of the offender to determine whether that individual was himself/herself prenatally exposed to alcohol or other drugs. If there is a positive history of exposure, the implications of the cognitive and behavioral limitations must be considered before sentencing is decided. How can a person ever be expected to improve their life skills if they are incarcerated for crimes related to central nervous system deficits? Only rehabilitation can help the individual to live a full and capable adult life. This is not to say that individuals who break the law should not "pay" for their crimes, but punishment through incarceration of persons with FAS or FAE will not prevent them from reoffending. Only instruction in skills to replace the maladaptive ones can help the individual become a functional member of the community.

K. Need to Document Relationship of FAS and FAE to Sex Offenses

Professionals must also become aware of the relationship of FAS and FAE to sex offenses, and explore avenues for remediation. It has been documented that inappropriate sexual experimentation is a characteristic of FAS and FAE (Streissguth, 1997). Unless affected adolescents are taught in a very specific and concrete manner how to relate to young people of the opposite sex, their compulsions may be expressed inappropriately. Parents may not be aware of the potential danger until someone from a school or recreational program calls one day to tell them their son or daughter was caught "behaving sexually" with a younger child. If professionals react to this situation without regard for the student's possible FAS or FAE, they might interpret such an act as violence or sexual deviance. In fact, it might be more accurate to see that the adolescent was merely acting out his/her developing sexuality, but with a younger child with whom he/she feels comfortable. Unfortunately, when this type of behavior is punished, the young person learns to be afraid or resentful and fails to learn appropriate sexual behavior toward others.

L. Need to Examine the Effectiveness of Substance Abuse Treatment for Individuals with FAS or FAE

In this document, and in current literature in the field of substance abuse, there is an appropriate emphasis on the importance of making treatment culturally meaningful and responsive. What has not been detailed is the need to make treatment effective

for young people and adults who have cognitive or behavioral disabilities from prenatal exposure to alcohol or other drugs. In fact, few if any treatment programs even investigate the prenatal exposure history of clients upon intake. Among the rare programs that collect this critical information, the authors are not aware of any that actually modify the treatment plan based on those findings. It is little wonder then that no research studies have been conducted to explore whether typical substance abuse treatment is effective for individuals with FAS and FAE. Treatment methods, including twelve-step programs, usually rely heavily on the client to gain a cognitive understanding of addiction, and then make a conscious decision to change their behavior. For individuals with FAS and FAE, whose own abilities are compromised, cognitive programs are not effective. Whether there is relationship between prenatal exposure and failure of treatment to meet the client's needs can only be answered by direct study. The need for more concrete, behavioral, and culturally appropriate treatment programs for adolescents and adults who are addicted to alcohol or other drugs is clearly indicated.

M. Need to Examine the Economic Impact of FAS and FAE Across Multiple Generations

Early studies of the economic costs related to the problems of FAS and FAE on a national level produced highly discrepant numbers. In 1980, the National Council on Alcoholism estimated the national expenses to include: "\$14.9 million for health treatment of babies born with FAS; \$670 million in total treatment costs for 68,000 FAS children under the age of 18; \$760 million in treatment costs for 160,000 FAS adults; and \$510.5 million in direct productivity losses" (National Council on Alcoholism, 1989, p.1).

At the time, these estimates were considered conservative because they did not take into account expenses incurred for all individuals with undiagnosed FAS or those with FAE. Abel and Sokol (1987) estimated the national cost of medical services alone for the treatment of FAS-related growth retardation, surgical repair of physical problems, treatment of hearing and vision disorders, and intervention for cognitive disabilities to be at least \$321 million per year.

The economic implications of FAS and FAE for Alaska is extremely difficult to estimate because the prevalence of these disorders has not been accurately established. The only available figure, and the one still cited by the Alaska State Division of Alcohol and Drug Abuse (ADA, 1998), is an estimate developed by former state senator, John Binkley. In his introduction of several bills during the 1990 legislative session, Senator Binkley estimated that each child with FAS would cost the state approximately \$1.4 million across his/her lifetime (Streissguth, 1990). There is no similar analysis for costs associated with FAE. Even if any of the cost figures are accurate, it is important to remember that they take into account only a single generation.

It is also important to look at the economic impact of prenatal exposures across generations. We must examine the impact of FAS and FAE on the disruption of families in terms of extra costs of medical and social services, and the juvenile justice and the adult corrections system. This must then be contrasted with the financial

contributions these families might have made to the community if they had not been disrupted by the effects of FAS or FAE on the grandparents, parents, aunts, uncles, and/or children. In addition, we must begin to explore the effect of undiagnosed FAS and FAE on schools at every level and on the employability of the affected individuals.

CHAPTER VIII

ALASKA'S LOCAL OPTION LAW AS A MEANS OF CONTROLLING ALCOHOL

In earlier days, village councils, supported by teachers and missionaries, by territorial law where operative, and, indirectly by limited opportunities to purchase liquor for transport to the village, could focus on possession of liquor within the village, not on liquor-related conduct. By the mid-1960s, however, liquor traffic became a fixture of regional traffic. State law was not consistent in its support of a liquor ban in the village. It had legalized private use and possession of liquor.

-S. Conn (cited in Lonner & Duff, 1983)

This chapter examines the historical antecedents and effects of the Local Option Law, focusing on two general relationships: alcohol in local communities, and State and local power.

A. Local Option

A major revision of the Indian Reorganization Act (IRA) in 1934 had historical significance related to today's efforts of community control over alcohol. The amended Act recognized tribal (village) councils as governing bodies for villages and gave councils authority over its own members. In 1936, the Territorial Legislature approved a Local Option Law permitting voters in formally incorporated communities to vote on banning liquor sales. A local option election required 50% of voters in the previous election to sign a petition to ban sales, and two-thirds of the voters had to approve the ban. The Bureau of Indian Affairs (BIA), under the new IRA authority, encouraged Native communities to vote against the sale of alcohol.

In 1953, alcohol returned as an issue for indigenous communities in the United States following Congress' repeal of the national ban on selling alcohol to Indians and Alaska Natives. It was left to their discretion to decide whether to allow alcohol on reservations, including the recognized Annette Island Reserve in Alaska. In accordance with the federal act, the Alaska Territorial government repealed all Territorial liquor laws. In 1957, the Territorial Legislature changed the procedure for granting liquor licenses and reinstated Local Option Laws. Liquor distribution licenses in unincorporated communities, under the new law, required a majority of residents in a designated radius of the liquor outlet to sign a petition approving the license.

B. The Local Option Law

In 1980, the Alaska Legislature, in response to a recognition of the severity of alcohol-related problems in the State, and in response to pleas from the entire Alaska Native community, voted to give municipalities and unincorporated places the authority

to ban sales and importation of alcohol. Limiting sales to specific establishments was also a choice. In 1986, the State Legislature gave municipalities and unincorporated locations the option of banning possession of alcohol by holding a local option election. Thus, while it may not be possible to ban sales of alcohol under the authority of tribal governance, communities with large Native populations can act under authority of Alaska legislation.

Berman and Hull (1997) reported that from 1981 to 1994, 99 Alaska communities held 148 local option elections that either added or removed restrictions on alcohol. Local options controls in about 250 communities are summarized in the following Table 8-1:

Table 8-1

Community Alcohol Control Status	Percent of Communities
Banned sale, importation or possession of alcohol	13%
Banned sale or importation	22%
Banned sale	4%
No controls and no drinking establishments or retail outlets	28%
Have a community store	2%
Have bars or liquor store	31%
Total	100%

In summary, 41% of the communities surveyed approved various controls, and 59% did not established controls. However, the situation regarding alcohol control keeps changing depending on community opinions.

The Local Option Law or local control over alcohol can be a critical factor in a community's effort to combat abusive drinking. It presents an opportunity for villages to elect one of the following mutually exclusive options: (1) prohibit the sale of alcohol unless sold under a single community liquor license; (2) prohibit the sale of alcohol with the exception of specific types of retailing; (3) prohibit the sale of alcohol; and (4) prohibit the sale and importation of alcohol.

The prohibition of sale and importation becomes potentially more powerful under the Local Option Law than under the limited authority available to villages because: (a) the Local Option Law extends village authority over all residents and visitors who previously may have denied the authority of the village governing bodies to constrain sale and importation; (b) the Local Option Law extends village authority to a five mile boundary around the village; and (c) the Local Option Law, under severe penalty, requires compliance by commercial carriers and by all statewide and regional alcohol distributors. The Local Option Law implies State law enforcement and judiciary response to violations. In practice, the option banning sale and importation is by far the

most popular choice because it follows the wishes of local communities to severely limit or prohibit access to alcohol.

C. Use of the Local Option Law

Many village inhabitants interpret local option to mean "prohibition." They (and many government agency personnel) talk about voting "dry" and having "dry" communities. To villagers, "dry" means no more alcohol, no more drinking, and no more drunks in the villages. Were it possible for village law to totally prohibit the manufacture or possession of alcohol and to search and seize persons and property for evidence, many villages would choose to do so.

Village residents correctly see the Local Option Law as having been written specifically for them, but the law failed to provide them with the tools they perceived necessary to accomplish their objectives. The new State law did not: (a) provide for real increases in police effort; (b) address the cultural, social, and situational differences among villages; (c) meet many villages' desire for prohibition of the manufacture, possession or use of alcohol; or (d) offer alternative flexibility of enactment or enforcement sought by villages in order to have the least intrusive law to solve their particular problems.

A number of villages find the Local Option Law inconsistent with their accepted modes of community problem solving. Differences occur concerning who makes decisions, how decisions are made, how interventions are made into the behaviors of others, the role of informing as a form of social control, the range of acceptable control mechanisms (e.g., embarrassment, isolation, exile, jail, internal vs. external policing), and the degree of rigidity or flexibility that is desired in community-wide laws, enforcement, penalties and rehabilitation.

The Local Option Law, while empowering villages to control aspects of their own lives, remains a western law. It was not designed or written by rural people, and its purpose, intent, powers, procedures, language, limitations, and relationships to other parts of western law and law enforcement, remain quite unclear to many rural people. Villagers also see that other, vaguely understood aspects of western law formally prohibit them from taking actions to solve the very problems for which they are turning to the Local Option Law. In order for them to realize their goals they may, wittingly or unwittingly, violate other laws.

D. Effectiveness of the Local Option Law

Communities that believe that they retain sovereign powers to control their internal affairs and their relationships with the outside world expend more energy than other communities in the construction and enforcement of local laws. Because they do not derive their authority from larger governments or bodies of law, and because they feel that they cannot depend on outside law enforcement, they must exercise their own authority. Characteristics of continuous law making and enforcement in these communities include some of the following:

- Signed commitment by each community member to support community laws and the actions of council members.
- Commitment by each community member to physically and psychologically support the law enforcement effort.
- Annual review, reconsideration, amendment, specification, rejection, and reenactment of law by the entire community.
- Creation and maintenance of local law on a wide range of daily life matters, such as loose dogs, curfews, speed limits, truancy, drug use, drunken behavior, theft, threatening behavior, family neglect, gambling, fish and game salvage.
- No assignment of enforcement to specific individuals, so that responsibility rests with each and every community member.
- Enforcement by large numbers of persons (men, women, children, elders, council members) at the same time and place, creating mutual pride and support and deindividualization of the burden.
- Formal investigation, trial, and punishment methods.
- Formal methods of exile with hoped for and encouraged returns and reintegrations.
- Semi-permanent exile of consistent violators, particularly violent persons and substance distributors.
- Increased, rather than decreased, enforcement of alcohol restrictions during major celebrations.
- Extensive monitoring of luggage and freight at point of entry into community.
- Immediate destruction of prohibited substances at point of entry, as the basic fine (rather than later trial) for attempted importation and as the basic social embarrassment.
- More intensive enforcement of repeated violators' activities within and without the village (through villagers or relatives reporting systems in other communities, particularly hubs).
- Convicting violators on the grounds of possession and use, or using possession and use as prima facie evidence of illegal importation.
- Exercising controls over visitors as well as residents.
- Illegal search, seizure, and destruction of alcohol from private homes based on observed and reported possession and use.
- Unaltered policy of prohibition, but methods and penalties of enforcement renewed or otherwise modified to meet new needs; for example, penalties may be stiffened by reducing the amount of basic physical support provided by peers.
- Non-reliance on outside enforcement entities or procedures, since these commonly result in after-the-fact actions; the village desires and achieves immediate behavior intervention and modification.

The Local Option Law is only one mechanism that encourages more community self-control. There are communities that view the Local Option Law as an unnecessary, redundant, and useless tool to reduce access to alcohol. These communities have a long tradition of controlling access through internal formal governance (i.e., law making, enforcement, trial, and punishment) and informal means (i.e., each community member sharing some of the active responsibility for controlling

access and use). Some of the means used by these communities are legitimized by community consensus, but may be illegal because they violate the constitutional rights of residents. Lack of complaint about violations is due to shared cultural community values, respect for traditional and community authority, and a desire to live within the protected confines of a healthy community.

Communities that desire greater self-determination over aspects of their quality of life, and whose traditional systems no longer suffice (for a variety of reasons) to meet these objectives, may be the most likely to look to the Local Option Law and other tools to achieve their goals. In other words, the communities that are most likely to avail themselves of the Local Option Law are those that are in transition, returning to a healthier, self-controlling state; these may be communities that have experienced a multigenerational decline in quality of life due to factors suggested earlier.

The Local Option Law by itself does not create healthier communities. Healthier communities, or communities that are becoming healthier, are the ones to benefit most from its enactment as an additional support method toward regaining local control over community life. The attributes of a community most likely to benefit from successful Local Option Law outcomes are:

- a secure, activist, and strong village or city council;
- a village council which is not itself typified by abusive use of alcohol;
- a consolidation of or unanimity among all village power bases;
- a population marked by stability, in terms of ethnic composition, migration, economy, goals, and problem rates;
- a community desire and ability to identify problems, set goals, establish priorities, establish solutions, and take action as a community; and
- other difficult goal-directed actions taken by the community
- which indicate that the community can exercise self-control.

Even in villages enacting and supporting local control, the use of western legal tools to meet community objectives is highly problematic. Contrasts exist between traditional community practices and western legal solutions. Ways have to be found to provide communities with the power to create and enforce their own tribal alcohol regulations, ones that originate from the will of the people. Tribal authority, however, will not be feasible in light of the recent Supreme court decision denying Alaska Natives tribal authority. The problem, therefore, must be dealt with at State and local levels.

Several changes, however, have been noted in relation to the Local Option Law: increased privatization of alcohol use and behaviors; altered and intermittent patterns of distribution and consumption; substitution of other substances; and a shifting of village alcohol-related behaviors and problems to regional hubs and larger communities.

Some villagers believe that the law is self-executing, that by passing the law, the reality of daily life will automatically change. This view is not totally without foundation. What appears to have happened in some villages is that the local option vote constitutes an elaborate reaffirmation of village authority and rules. The threat of external force appears to support and mobilize the internal control mechanisms of a

village, including reduced drinking and improved morale. The longevity of these positive social and health changes depends on the continuing development of greater internal village controls and corresponding improvements in the perceived quality of life. What is achieved, ultimately, by the Local Option Law, may be less formal control over alcohol than enhanced village self-control over vital aspects of community life, health, safety, and morale.

Ever since the passage of the Local Option Law, communities have repeatedly attempted to gain some consensus over the availability of alcohol in their communities. Berman and Hull (1977) indicated that "Relatively few communities have tried and failed to exercise some control under the Local Option Law. Many communities have held more than one local option election . . . and a few have held several" (p. 2).

One of the more publicized local option elections took place in Barrow, Alaska in 1994 when the community first voted dry, then overturned the vote in 1995 and reimposed it in 1996, only to be overturned again in 1997. In 1998, however, the North Slope Borough initiated a "wet/dry" Borough-wide vote, which failed, leaving Barrow and other North Slope villages open to alcohol. Although Barrow fluctuated between being "wet" and "dry," there is evidence that during the ban in 1995, even though it may have been unpopular, many residents complied with the law and tried to make it work. Some positive health effects were achieved. For example, Chiu and Perez (1998) reported that the number of alcohol-related visits to the local hospital decreased significantly from the number attained in 1993. In 1993, when Barrow was "damp," there were 1,084 visits for the 12-month period, and in 1994 there were 166 visits, resulting in a decrease of 85%. The community also saw a decrease in alcohol-related arrests, crimes, and violence.

The Alaska Local Option Law represents a strategy that can be used to combat alcohol abuse and its effects if a community is willing to support its enactment. The specific value of the local option is that it has a powerful symbolic value. It communicates to the people that they have control, and that they can exercise community standards for behavior, as well as demand their enforcement. The result has been a growth of sense of community responsibility and "control over community."

But, as discussed above, if community members choose not to honor local control, then it will not be successful. Just enacting it will not cure a community's alcohol-related ills. A concentrated effort must also be made to deal with the reasons for drinking, and to curtail the desire of some community residents to shift their drinking to regional hubs or cities where drinking is legal. Alcohol, as emphasized throughout this document, is often a symptom of other problems, and these need to be resolved as well if drinking-related problems are to be ameliorated.

Despite the havoc that alcohol has caused, many villagers believe the problems of alcohol can be overcome and the future of their culture is dependent solely on the traditional values and the caliber of new community leaders, or the young people of the community. The villages' concern with alcohol is less a preoccupation with the personal health or moral implications of ingesting alcohol than with the death of village members, particularly young men. The deaths of young men, while terrible personal and family tragedies, constitute a major cultural concern because of the loss of future leaders, culture bearers, and role models.

Before contact with western traders, drinking was regulated by community leaders and elders. Over time and through numerous mechanisms, policy control shifted from local community control to governmental control. This erosion had a detrimental effect on Alaska Native communities. The Alaska Natives Commission, in its 1994 report, recognized this situation and called for Alaska Natives to reestablish a functional social order. The report stated:

Alaska Natives are mature and capable residents of the nation and the state, but they also occupy their own cultural and political communities. Native villages and their tribal governments -- as distinct partners with the state and federal governments -- must be entrusted with the social and political decisions critical to Alaska Natives' future well-being and survival. The validity of Alaska Native cultural perspectives...must be recognized and afforded due respect...If significant improvements are to be made with respect to overall Alaska Native well-being, the Native community must take ownership of the problems and assume responsibility for the solutions. Any future attempts to regulate alcohol importation and use in Alaska Native villages -- as well as the enforcement, prosecutorial, and sentencing powers and resources without which such regulation is meaningless -- must be premised on the fundamental belief that Alaska Natives can and should have ultimate and unquestioned control . . . a continuation of historic and present approaches to the issue should be deemed unacceptable by those who genuinely care about the future well-being of Alaska Natives. (pp. 60, 64, 77)

The decision in 1998 by the Supreme Court not to uphold Venetie's tribal authority over its own lands set back efforts by Alaska Native communities to regain governmental control of their own communities. It is evident that the Alaska Native community has to resolve the problems related to self-determination, but they still retain the one element of self-governance that is within local community control -- regulation of alcohol. It is up to local people to use this authority effectively.

CHAPTER IX

ETHNICITY AND SUBSTANCE ABUSE: ARE THERE ANSWERS THROUGH RESEARCH?

...many Native people find...us [non-Natives] foreign and perplexing. Never realizing that a gulf divides us, we have never stopped to explain ourselves to them. Instead we blithely make pronouncements about what we will do for them and then impose our structures and institutions without ever explaining why we built them and how we believe they will produce the desired results. There is mutual bewilderment here, based on a mutual assumption only now being proved wrong: the assumption that both societies shared common notions of the "proper" way to relate to and treat the universe, other people, and one's own mental and spiritual health.

-Cited in Rupert Ross (1992, p. XXV)

A. Why Cultural Research Has Failed to Develop Solutions that are Applicable to Alaska Natives

Western research practices have not always helped to provide solutions to the current dilemma facing Alaska Natives. Such research has usually been based on a Eurocentric cross-cultural research perspective, an approach that is not relevant to the world of Alaska Natives because it is based on linear thinking in which the seeking of cause and effect predominate. The world of the Alaska Native is "Holistic," in which cause and effect are not primary. A non-linear or "circular" perspective prevails, in which elements of the world are dealt with both individually and in terms of their relationship to other elements. Context is crucial in this way of thinking.

Cross-cultural research does not follow a circular world view. More often, it typically represents a systematic analysis, description and comparison of human societies in an attempt to identify significant principles that may account for similarities and differences in selected behaviors, such as drinking or drug-taking behavior. There are, however, inherent problems that contribute to a lack of progress in understanding and reducing drinking and drug-taking behavior within different cultural or ethnic groups.

One of the difficulties is that most cross-cultural substance abuse studies are based on the following inherent assumption: substance abuse among different sociocultural groups stem from similar causes and follow the same course as found in the larger or dominant culture. While some similarities may exist across cultures, research in Alaska has to account for phenomena not usually present in (urban) western societies, such as conducting research in New York City. For example, in Alaska's rural areas, the supply, distribution, and consumption patterns not only differ dramatically from non-Native urban centers but also from practices followed in the Lower-48 states. In isolated Alaska communities, alcohol may not be present due to a

variety of factors: weather may prevent flights that transport alcohol; there may be a lack of money to buy alcohol; and seasonal subsistence activities, such as fishing, hunting and berry picking, may be in progress. There are also no bars in many communities to serve alcohol by the drink.

This situation implies that cross-cultural research has to represent more than an emulation of methods used in other cultures. These procedures do not account for the physical setting nor do they capture the lifestyles, beliefs, thinking styles and behaviors of the culture being studied. Cross-cultural substance abuse research must address the meaning of drinking or drug-taking behavior within a culture. Such research also needs to determine if the drinking or drug-taking behavior within a specific cultural group has a different meaning and serves different functions than any group to which it is being compared.

An example of remarkably ill-conceived cross-cultural research was the study in Barrow in the late 1970s. In order to obtain "personality and social correlates of drinking," Klausner et al. (1980) administered the Michigan Alcoholism Screening Test (MAST) to a sample of Barrow's Inupiat residents. The application of this instrument is questionable in Native communities. Further, the Inupiat's cultural system and related drinking practices are quite different from those of most American drinking groups, and the MAST items are not indicators of problem drinking when applied to an Inupiat sample.

In addition to questions concerning the validity and reliability of the MAST itself, no significant cross-cultural research had been conducted prior to its application in the Barrow study. Additionally, the scale was not translated into Inupiat nor, apparently, pilot tested. Instead, responses were taken at face value and scored accordingly as indicators of alcoholism.

The researchers failed to consider that the MAST is a screening rather than a diagnostic test, despite the cross-cultural issues involved in the use of the MAST. It can elicit a high number of false-positive responses. The researchers also failed to recognize that a score which may be indicative of alcoholism among one special population group, such as lower-middle-class White male workers, will have an entirely different meaning for a non-English-speaking Inupiat population. Other methodological errors were made, such as having a local policeman accompany interviewers to homes where interviews were conducted. Segal (1980), acting on behalf of the Barrow community, provided a detailed critique of the Klausner et al. study.

It is not surprising that the Barrow study was refuted by the Inupiat community for its claim that "70% to 80% of the adult population of Barrow is at risk for the medical and social consequences of alcoholism." While the community knew there was an alcohol problem, the nature of the research did not mobilize public opinion to deal with the impact of alcohol on the community. Rather, efforts were directed at refuting an "insult" to their community. It took years after the release of the study before researchers were permitted to work in Barrow.

The Barrow experience reinforced a strong belief in Alaska Native communities that researchers come into indigenous communities as intruders and leave without providing a sense of participation and accomplishment that could promote beneficial change. Subject populations must be involved in planning the research in their communities, and such research has to be pursued in partnership between the

researchers and the community. Any research reports must be shared and endorsed by the community before they are finalized and distributed.

In essence, unless cross-cultural researchers are sensitive to the cultural milieu of the community in which research is conducted, findings may not represent the world of indigenous people as they perceive and experience it. Researchers will, instead, report an ethnocentric study in which the data is interpreted according to their own values. Bryan MacLean expressed concern over researchers not working in collaboration with the population being studied, stating that it can “hurt” the community by deriving culturally inappropriate conclusions. He added that because of the bad precedent established by some researchers, scientists interested in conducting research within Native communities will have to overcome community resistance to being studied, and need to establish a binding partnership with the community involved in the study (Personal communication, January 18, 1998).

B. Drinking in Different Cultures

Drinking and drug-taking behavior vary among cultural groups. Differences not only exist across national boundaries, but also within given societies. In the United States, for example, patterns of drinking and drug-taking behavior within minority and/or ethnic groups differ from those experienced by members of the larger, dominant society (Rebach et al., 1992). Members of minority groups are at greater risk for drinking and drug-related problems than members of the larger society (DeLaRosa & Adrados, 1993).

People who use drugs develop expectations about what a drug will do for them, and this expectation is related to the choice of a drug and to the context of use. Krohn and Thornberry (1993) reported that the role that "alcohol and other drug use plays for the Caucasian adolescents is different from the role it plays for African-Americans or Hispanics" (p. 124). Although the relationship between sociocultural, environment and drug-taking behavior are beginning to be understood, there is a need to comprehend more fully how preferences for different drugs are related to different sociocultural contexts.

Within cultures, chemically dependent people come to share a group of values, attitudes and behaviors that are remarkably similar. Individual differences begin to blur as one's lifestyle becomes increasingly centered around seeking, using, and becoming intoxicated on chemicals. Relationships with others are impacted by manipulation and hostile dependency. Some substance using groups reflect more inter-ethnic mixtures than other groups in their society. Skid Row areas, for example, usually inhabited by representatives from all ethnic groups (Segal, 1991).

Research can serve ethnic groups better by examining: (a) the dynamic forces operating within a cultural group that contribute to and sustain drinking and other forms of drug-taking behavior; and (b) the outcomes and consequences of these behaviors. Specific measures that reflect the values of the cultural group under study, rather than translating measures from another culture, need to be developed.

C. Research within Minority Groups

When investigations are directed at a minority group within a larger society, there is a need to focus on identifying how the cultural group's values are disrupted or affected by the larger or dominant culture, and to determine the extent to which substance abuse is related to an attempt to cope with this disruption and its effects. It is also important to learn if there is a pattern of drug-taking behavior that is more common or unique among minority members that differs from drug-taking behavior within the majority group. The study of minority groups within a larger cultural group also takes on added difficulties because acculturation factors need to be addressed. Cultural change, for example, is related to crime, suicide and mental health, and other adverse consequences, many of which are discussed in Chapter VI.

D. Focusing Cross-Cultural Research

Cultural change has affected all indigenous groups. Cross-cultural researchers must comprehend how such groups survive in a changing world, appreciating how world views, derived from cultural heritage, shape belief systems and guide behavior. When working with Alaska Natives the researcher's task becomes one of understanding the nature of spiritual beliefs, and incorporating appropriate aspects of these beliefs into the research project. Further, if cross-cultural substance abuse research is to be conducted, it not only must be of value to the groups studied, but these groups must also have an investment in it. The ethnic group member's conflicts with cultural values and attitudes cannot be overlooked when seeking reasons for drinking and drug use.

An inherent feature often found in working with Alaska Native clients is that, when they find themselves in a context where they are being asked something they may not know about, they may attempt to please the inquirer by providing an answer they believe the questioner wants to hear (Turner & Segal, 1995). Response to written questionnaires are answered in the same manner. Without taking this cultural mannerism into account, any research within the Native community may result in sufficient false positive or false negative responses to render the data unreliable. Careful thought has to be given to the measures used and the procedures followed when working with an ethnic group whose perception of the research is different from that of the researchers.

Other problems that emerge within a Native community involve individuals who became chemically dependent at such an early age that they were never fully acculturated into their own ethnic group; and others may not have been provided any cultural learning experiences as they grew up. It is possible, in such instances, that feelings of shame, guilt and anger may contribute to drinking and drug use.

Progress can be achieved when researchers stop looking into a culture and develop procedures to start looking out from within a culture. What this approach entails is developing an understanding of the values and lifestyles of the ethnic group under study, and determining what within the community helps sustain the integrity of the traditional values and lifestyles, what has been suppressed or lost in those traditions, and what contributes to the disintegration of traditional values and

behaviors. Such information will aid in understanding what changes need to be made for one culture to relate to another. Dominant cultures often expect that minority cultures will adopt or adapt to a different value system. Consideration needs to be given by the larger society towards incorporating aspects of the value system of its minority groups. For example, the non-Native society can benefit from understanding and adopting the Alaska Native's attitude of "caring" toward others, a behavior which contributes significantly to maintaining harmony in group living situations.

In summary, the deepest roots of the current crisis within many Alaska Native communities lies in the pattern of destruction related to drinking and drug use. Policy and procedures to understand and confront the problem need to use the strengths of cultural groups. This can only occur when practitioners and researchers assist in the process of healing through the initiation of meaningful, culturally relevant research undertaken in partnership with, or led by, the community studied. Additionally, research begins with questions that guide the study's methods and the interpretation of findings. As stressed above, traditional cross-cultural research has begun with the wrong questions, and answers to the following questions may help provide solutions to assist in ameliorating substance abuse within Alaska Native communities:

- What are the dynamic forces operating within cultural groups that contribute to and sustain drinking and other forms of drug-taking behavior?
- What are the outcomes and consequences of these behaviors?
- How do these compare with those from other cultures?

Answers to these questions can best be derived if the research designed to address them (a) accounts for the non-linear world view of Alaska Natives, and (b) emerges as a partnership with the community in which the research is to occur.

CHAPTER X

HEALING OUR OWN: ALASKA NATIVE INITIATIVES

The winds of change are blowing across our villages, spreading hope and strengthening our Native traditions through sobriety. We are ready to take action and to take control of our lives, families and communities.

-David Mousseau, cited in Village Voices, Summer, 1966, upon celebrating sobriety with traditional ways in Bethel, Alaska

Native communities are mobilizing to overcome problems, especially those related to substance abuse. In the summer of 1996 in Bethel, for example, more than 500 people gathered to celebrate the 13th annual Rural Provider's Conference (sponsored by Rural Alaska Community Action Program) honoring Native sobriety. This chapter provides only a brief description of some of the many projects and interventions that have been designed and carried out by Alaska Native people. It does not describe all the efforts that are being undertaken. Mohatt, Hazel, and Mohatt (1998) noted that:

Communities throughout rural Alaska are creating community-based treatment and prevention methods, as well as using existing indigenous cultural resources to treat and prevent health problems and alcohol and substance abuse. Further, People In Peril (Anchorage Daily News, 1988) described a growing revolution of hope known as the Sobriety Movement, sponsored by the Alaska Federation of Natives. The Sobriety Movement stresses the need for people of the villages, not health agencies, to take responsibility for their own well-being. Yet, alcohol is just one of the health problems Alaska Native people face. Beginning with measures to control and eradicate TB in Alaska Native villages, which has been a major accomplishment, other health problems, particularly rising concerns about behavioral health risk factors, have received a great deal of current attention because they account for the major causes of mortality. A concern about how to prevent health and behavioral health problems in Alaska has focused increasingly on building personal and community competence in order to increase hope among Alaska Native communities. (p. 3)

If communities are to regain a sense of empowerment, it is critical that they have origination and control of projects, based upon locally articulated needs and strengths. Mohatt et al. (1998) stated: "What is so crucial is a deep respect for each village as a place where people grow and are nurtured. It is a place where problems exist, but the problems can only be understood and eradicated if the strengths, the positive nature, and the potential of the village and its people are understood and incorporated into . . . [the solutions]." (p. 3)

Alaska Natives are using cultural and contemporary methods to treat and prevent health problems and substance abuse in both urban and rural settings. One example of this effort, as noted above and in an earlier chapter, is the Alaska Federation of Natives Sobriety Movement.

A. The Sobriety Movement

The Sobriety Movement was founded over 10 years ago as a Resolution to control alcohol that was passed at an AFN Annual Meeting. The purpose of the Resolution is to help communities gain a perspective on drinking and drinking-related problems. It stresses the need for people of the villages, not health agencies or corporations, to take responsibility for their own well-being.

The Sobriety Movement currently depends on donations to undertake any activities. The Movement seeks to help individuals, families and communities affected by, concerned with, and working toward the prevention of alcohol and drug abuse. It is also concerned with helping people move ahead and regain control over their lives. It is primarily a campaign whose mission is to encourage and support grass roots efforts to achieve sobriety.

The goals of the Movement include encouraging and supporting the following: alcohol-free and drug-free Native families, the practice of traditional Native values and activities, cooperation with existing groups working to promote sobriety among Alaska's Natives, the formation of sobriety groups in every Alaska Native community, and encouragement and support of sober Alaska Native leaders and role models (Jim LaBelle, personal communication, December 1998). One of the activities sponsored by the Movement includes a sobriety pledge drive which helps generate awareness, attract attention, and encourage participation in sobriety. The pledge also serves to provide a numerical census of those who lead, believe in and support a sober lifestyle. Each year at the AFN Convention and other gatherings around the state, members of the sobriety movement distribute buttons with the motto "Our Spirit, Strong and Sober" to all those who make a pledge to sobriety. Red ribbons attached to the buttons proclaim "Let it Begin with Me." The Alaska Native Health Board (1994) reported that: "Sobriety Movement members can be seen all around the state, traveling to conferences and gatherings, and encouraging people to join the Sobriety Movement and live the life of sobriety, described as "a positive, healthy and productive way of life, free from the devastating effects of alcohol and drugs" (p. 22).

Mohatt et al. (1998) described another activity called the "Iditapledge for Sobriety." This undertaking involves obtaining pledge signatures, putting them on microfilm, and giving it to a drug-free Alaska Native dog sled musher who, in ceremonial fashion, carries the microfilm in the 1,049 mile Iditarod Dog Sled Race. (The race is run annually from Anchorage to Nome in commemoration of the dog team relay that carried vital serum needed to cure the diphtheria epidemic in 1925.) Symbolically, the sobriety pledge signatures represent a "serum of commitment" needed to cure the pervasive and devastating effects of alcohol and drugs.

The Movement not only consists of thousands of individuals who have pledged themselves to a life of sobriety, but also includes over 50 Charter Groups who have passed resolutions adopting the concepts and goals of the Movement. The Movement

has been recognized as a model for circumpolar indigenous communities and an effort is currently underway to bring these communities together to share their experiences and knowledge regarding sobriety efforts (Mohatt et al., 1998).

B. Community Efforts

1. *The Tanana Chiefs Conference*

Efforts to counter alcohol-related problems are pursued in many different forms. The Tanana Chiefs Conference, for example, published a special supplemental newspaper dedicated to domestic violence prevention. It featured true life stories and true life solutions, and information about domestic violence, all directed at bringing the problem into the open in an attempt to reduce domestic violence.

This publication is part of the STOP Violence Against Women campaign administered by the Tanana Chiefs Conference Family Services Department. It is federally funded by a STOP Violence Against Women Discretionary grant, and serves 37 interior villages encompassing an area of over 240,000 square miles. The 6,190 residents in the area live a mostly subsistence lifestyle through hunting and fishing and seasonal employment. Domestic violence within these communities has been high.

STOP Violence Against Women is an ongoing program staffed by two project specialists. It provides training and technical assistance in villages. The project focuses on direct services to victims of domestic violence and sexual assault and provides assistance to villages to produce village-specific services, plans, protocols and materials.

The program has made a substantial effort to increase the general public's understanding of the dynamics of domestic violence, as illustrated in its recent publication on this topic. Tribal Family Youth Specialists and Village Police Safety Officers receive training to increase their understanding of domestic violence and sexual assault. Tribal Councils, which serve as tribal courts, also receive training regarding tribal ordinances and the issuing of temporary restraining orders.

Village providers and leaders also assist in developing an inventory of local resources available to identify, intervene and prevent domestic violence and sexual assault. Safe Home manuals for volunteers were produced and distributed during training sessions. Elders from each village are actively involved in all these efforts.

This program represents an example of local communities exercising their authority in the planning and exploring of options available to them. Other communities may also benefit from adopting similar programs.

2. *The North Slope*

In 1993, the North Slope Borough published a magazine style book, Taking Control. The North Slope Borough. The Story of Self Determination in the Arctic. The text was directed at North Slope youth with the purpose of acquainting them with their heritage and challenging them to claim their future as healthy individuals proud of their Native legacy. An important part of the history that is presented describes how the people of the north were able to "take control" of a large part of their destiny through a

Home Rule Charter. What the North Slope has done can serve as a model for other communities. The preamble of the Charter reads as follows:

We, the People of the North Slope Borough, in order to form an efficient and economical government with just representation, and in order to provide local government responsive to the will of the people, and to the continuing needs of the communities, do hereby ratify and establish the Home Rule Charter of the North Slope Borough of Alaska.

C. Community-Based Suicide Prevention Program

In 1989 the Alaska State Legislature inaugurated the Community-Based Suicide Prevention Program (CBSP) to reduce Alaska's unusually high suicide rate, especially among Alaska Natives. The program is administered within the Department of Health and Social Services. The CBSP sponsors local projects designed to build community capacity and/or target prevention efforts for high risk populations. Founded on the principles and practices of community development, the program has empowered a number of villages to implement projects that they have designed locally, based on their own assessment of community strengths, weaknesses, problems and visions.

The projects vary depending on what best fits a particular context and have included the direct provision of counseling, teen centers, 24 hour drop-in centers, public education events and workshops, covering a range of topics related to wellness, community events such as potlucks and performances, after-school programs and elder/youth awareness programs. Projects aim to build self-esteem, cultural pride, respect, family bonding and wellness, coping skills, and community and individual spirituality. Many projects specifically target drug, alcohol, inhalants, and other controlled substances which affect both children and adults (Mohatt et al., 1998). The Alaska Native Commission (1994a) described CBSP's early progress:

Starting with 48 projects in 1989, the program has grown to include 60 projects serving 63 communities in 1993. Of the original group of 48 grants, 25 (52%) programs are still functioning. There are emerging indications that these projects are in fact resulting in positive change in the communities. A recent evaluation of the program has found that village projects serve as catalysts to advance other important community-based responses to self-destructive behavior. . . . As a group, the communities that have implemented their own suicide prevention projects with state funding from this program have shown a 51 percent drop in suicide. (p. 46)

Initially, it was planned that project funding would be gradually phased out and the communities would take over support of their projects. By fiscal year 1991, the CBSP shifted to a policy in which the State recognized that each project would need some base level of funding in order to continue (Forbes, 1994). Communities are encouraged to develop their own projects and are empowered to implement them with State funding (an approach which is dramatically different from other State-funded

behavioral health programs). The program supports and provides community development specialists who help communities formulate their plans and express them in proposals. This process minimizes the instances of well-intentioned communities failing to receive funds due to technical problems with their proposal (Alaska Native Commission, 1994b). In addition, regional groups are brought together at project coordinator conferences in order to share their activities, a monthly Community-Based Suicide Prevention Program Newsletter provides information on different projects as well as information about upcoming events, funding resources and changes and descriptions of innovative local, national and international projects.

D. The Road Back: A Village Based Prevention Strategy

The following section, used with permission, was written by Charleen Fisher, and appears in a description of prevention programs in Alaska by Mohatt, Hazel, and Mohatt (1998). It illustrates a village-based effort to deal with substance abuse.

The Council of Athabascan Tribal Governments (CATG) was formed in 1985 as a response by the Chiefs of the Yukon Flats region to unify their voices against the threat of opening the Arctic National Wildlife Refuge to oil exploration, thereby invading the Porcupine Caribou herd's calving grounds and threatening the existence of the herd and the subsistence lifestyle of the people. Since then, CATG began a process of increasing the quality of life in all 10 villages of the upper Yukon Flats by taking on projects that employ and empower local Athabascan people.

CATG villages are located in the Yukon River Valley between the Brooks Range and the White Mountains from the Canadian border to below the Dalton highway where the village of Rampart marks the farthest village down the Yukon River in the consortium. The villages that comprise the CATG are: Arctic Village, Beaver, Birch Creek, Canyon Village, Chalkyitsik, Circle, Fort Yukon, Rampart, Stevens Village, and Venetie. The dominant culture of the area is Athabascan including the Gwich'in and Koyukon dialects. The CATG approach to healing includes taking into consideration the economic, educational, political and social histories of the people in the region.

A Center for Substance Abuse Prevention (CSAP) Community Prevention Coalition Demonstration grant was awarded to the CATG, and "The Road Back: A Village Based Prevention Strategy" was started. This five year demonstration project has three goals: (1) form a community alcohol and drug abuse prevention coalition at regional and local levels in the Gwich'in Athabascan villages of the upper Yukon drainage. The coalition consists of existing and new partnerships and involves the expansion of long range comprehensive, multidisciplinary community wide and regional substance abuse prevention programming; (2) to further develop and enhance culturally competent preventive education and training programs in the proposed partnership area; and (3) to expand and enhance culturally competent substance abuse prevention programming across an expanded geographical area through partnership development and local prevention linkages.

Each of the village's Tribal Councils acts directly as supervisor of the prevention programs, providing its direction. Some of the villages use the coalition building process as a priority for prevention programs. Others concentrate on prevention in the

school or using and enhancing cultural practices and knowledge. In all cases the village prevention program is part of community

In Arctic Village, for example, Kenneth Frank (prevention worker) coordinated three different student age groups for three camping trips to climb the surrounding mountains. The mountains around the village are 2,500, 3,000, and 6,000 feet high. Some students had lived in the village all of their lives but none had climbed the mountains before. Once on the mountain peaks the youth ate and discussed their sense of accomplishment. Pride overcame their fear and helped them reach their goal. Prevention workers in Rampart (Margaret Moses), Stevens Village, and Venetie have sponsored similar prevention activities involving camping, moose hunting, and trips involving subsistence activities.

In Beaver, Francine Henry (prevention worker) worked with the Beaver Tribal Council to facilitate the Fourth of July festivities. Beaver has an active youth group that meets to sew, have slumber parties and to discuss alcohol, tobacco and other drug abuse issues. Arctic Village started two sweat lodge groups, a women's and a men's group which include both youth and older adults. In the sweat lodge, traditional customs are practiced and sobriety dates are celebrated.

In Chalkyitsik, Minnie Salmon (prevention worker), together with the village Tribal Council and Indian Child Welfare Act worker, facilitated a camp on the Black River with 15 students. The majority of the time was spent on cultural activities. They made a caribou hide boat and dog pack, along with lessons on how to knit a fish net. The fish net was not completed at the end of the week long camp but plans were made to finish it over the winter. In addition to the cultural activities, lessons on drug and alcohol addiction were provided. The camp ended with two of the oldest students, both young women, paddling the skin boat down river to the village. When they arrived, the village residents and everyone from the camp were waiting on the bank to greet them. Cultural camps were also held by prevention workers in Canyon Village (Delma Fields) and Venetie.

In Circle, Margaret Henry John (prevention worker) collaborated with the Tribal Council to open a community center. The youth received a pool table and organized games with prizes. There is an outdoor volleyball net for all who want to play. The Fort Yukon Prevention Worker, Kimberly Carlo, initiated a traditional Native dance group for teenage youth who later performed at the annual Festival of Native Arts in Fairbanks, and at Quyanna night during the Alaska Federation of Natives' annual convention in Anchorage. The Quyanna night event was broadcast over the rural TV system and was viewed by over 200 villages. Richard James, in Birch Creek, combined resources with the school district and sponsored a youth Native dance group at the Festival of Native Arts.

Stevens Village youth, with the help of Cheryl Mayo-Kriska (prevention worker) and the school and village Tribal Council, toured one of the Trans-Alaska Pipeline's pump stations, and a local fish camp and museum. In Venetie, Judy Erick (prevention worker) said, "as a result of camping and spending quality time with each child, the kids I work with are more close to me, have trust in me and are not afraid to talk to me about anything."

All prevention workers are employed directly by the Council of Athabascan Tribal Governments. Also employed is a Counselor Supervisor, Floris Johnson, and a Project

Director-Evaluation Coordinator, Charleen Fisher. The Counselor Supervisor provides technical support and acts as a resource for the prevention workers and Communities. The Project Director works with the Counselor Supervisor and the prevention workers on reporting and evaluation activities that keep the project in compliance with grant requirements, along with basic administration of the project. All the employees of "The Road Back" program are Alaska Natives recruited from the villages in which they work.

The Road Back program represents an empowerment approach to prevention. Achieving empowerment involves the following steps:

- Step 1: Careful specifications of the target group by the prevention worker in collaboration with the community.
- Step 2: Prevention workers present two alternative proposals related to drug and alcohol abuse to their communities for discussion and selection.
- Step 3: Selection of a representative group of participants to be interviewed.
- Step 4: Prevention worker conducts and documents the prevention activity.
- Step 5: Prevention worker conducts interviews with selected participants on effects of the activity soon after the activity is held.
- Step 6: Schedule and conduct a follow-up interview with the target group participants at a later date, if possible.
- Step 7: Interviews are transcribed and reviewed for essential common patterns.
- Step 8: Report writing making sure that the information presented is valuable to the community.

The results are then published and distributed to the villages as a way to celebrate healthy activities. The Council of Athabascan Tribal Government's prevention efforts are an innovative approach. This prevention program illustrates how Alaska Native people are working to determine their own destiny preventing substance abuse youth.

E. Spirit Camps

Many Alaska Native families continue the tradition of summer fish camps to harvest and prepare fish for the winter. Catching, cutting, drying, smoking, and packaging hundreds of fish for storage involves the extended family. Camp members also harvest berries and hunt for meat.

During the early 1980s, the Northwest Arctic Natives Association (NANA) began to invite elders to meet and articulate the central values associated with being an Inupiat. The NANA spirit movement evolved and carried through with a commitment to transmit to young people these values in order to safeguard the survival of Inupiat culture and to prevent alienation, alcohol and drug abuse and suicide.

One way that elders could teach subsistence activities and convey cultural traditions is through a cultural camp. These camps concentrate on youth and adolescents rather than young and middle aged adults. NANA leaders felt they needed to focus on the health of the youth in order to assure strength for the future (Mohatt et al., 1998).

Meanwhile, Donald Peter, Director of the University of Alaska Fairbanks' Alaska Native Human Resource Development Program, initiated a similar process with tribal

elders primarily, but not entirely, from Athabascan tribal groups through the Respiritualization Task Force. They generated the idea of sponsoring spirit camps as a place where tribal elders could transmit their knowledge and values both through talking to participants and through the rhythm and the activities of the camp. The camp would be a healing place.

Camps vary in type, some are youth oriented, others family oriented, and some engage in alcohol detoxification and recovery. The idea of spirit camps has been embraced by tribal groups throughout Alaska and is frequently being utilized for alcohol treatment. Two of the most well known camps are the Ga'alleya Spirit Camp of elder Howard Luke, and the Old Minto Cultural Heritage Camp led by Robert Charlie and elders from Minto. (Also located at the Old Minto village site is a recovery camp which is operated by the interior tribal corporation, Tanana Chiefs Conference.)

The typical framework for spirit camps, such as Ga'alleya, is for participants to come for a one week stay. They live in tents or log houses and work with tribal elders on wood gathering, building structures, processing fish and berries, and other traditional fish camp activities. The group gathers for talking circles several times a day. These circles are modeled after American Indian ceremonial structures, such as healing ceremonies and purification rites, in which individuals sit in a circle and each person speaks without any interruption.

Talking circles typically demand that individuals remain in the group until it is finished. A sacred object, such as an eagle feather, is passed from person to person which they hold while they speak. No topic is forced on the speaker. They talk and participants listen respectfully. During these periods, participants may tell personal stories of their struggles and growth. Elders may share their personal stories or particular cultural stories which belong to them or to their group. Howard Luke often speaks to the participants about *Alleya* (luck) and the weasel who would come to visit the people's homes. The weasel would knock on the door, look into the home and examine it to see if the residents live in harmony and respect. Was it a clean home? Were the animals who were hunted prepared in a respectful way? Did the people speak to each other with respect and love each other, especially the children? If the weasel saw a respectful house, *Alleya* would enter and stay with them.

Such stories dramatically teach the participants about deep cultural meanings concerning how one should live. They both inspire and teach. In the Old Minto camp, such events occur frequently. Elders speak strongly about cultural values and rules for how to conduct oneself within the family and community.

In the NANA region, people with health and other problems were brought to camps to meet with traditional healers. Although no formal studies are available concerning the effectiveness of spirit camps for alcohol recovery, case studies have shown how such camps strongly affect its participants. It has been stated that Spirit camps provide:

a foundation for community development. An individual community member could have a substantial effect on community healing by working with others to identify traditional sources of strength and implement projects based on these traditions. These models are valuable not only because they connect us with the traditions of the people and our true

selves but also because nature is a sacred and healing place that helps us to be wise and creative as we work towards our future. (Hampton et al., 1995, p. 263)

F. Native Pathways to Education: Alaska Rural Initiative

The Alaska Federation of Natives, in cooperation with the University of Alaska Fairbanks received funding from the National Science Foundation and the Annenberg Rural Challenge to implement the Alaska Rural Systemic Initiative/Rural Challenge (AKRSI/RC). The purpose of AKRSI/RC is to bring people together from throughout the State to implement a series of initiatives to systematically document the indigenous knowledge systems of Alaska Native people, and develop educational policies and practices that effectively integrate indigenous and western knowledge through a renewed educational system. The program's emphasis is on renewing Native pathways to education so that traditional knowledge systems (ways of knowing and world views) can be more effectively utilized as a foundation for learning all subject matter, particularly in the context of rural and Native Alaska. Overall guidance is provided by a series of Elders' Councils and the Alaska Native/Rural Education Consortium, constituted of partner organizations from throughout the State. The following initiatives were sponsored by AKRSI/RC: S.P.I.R.A.L. Curriculum Framework, Cultural Documentations/Atlas, Cultural Standards, Village Science Curriculum applications, Native Educator Associations, Native Ways of Knowing, Elders Academies, AISES Chapters/Native Science Fairs, Math/Science Unit-Building Workshops, Math/Science Performance Standards, and Alaska Native Science Education Coalition. The AKRSI promises to play an important role in linking schooling to the cultural and physical environment in which students are situated.

G. Rural Alaska Community Action Program and the Rural Providers Conference

Before our time, we did not have individualism, but family and community cooperation was stressed. Effective methods to deal with any kind of problem should be approached with cultural traits that are meaningful to our people. Today we have programs that are meaningful to our people and these examples could give you good ideas on how to deal with our problem. The benefits for the future of our children are rewarding. All we need to do is get off our easy chairs and get busy.

-John Pingayak (P 13, VPC '93 Summary report RurALCAP)

The Rural Alaska Community Action Program, more commonly known as RurALCAP, is a private, nonprofit corporation whose mission is to protect and improve the quality of life for rural Alaskans through education, training, direct services, advocacy and strengthening rural people's ability to advocate for themselves. RurALCAP has worked with villagers to help them break the cycle of alcohol abuse and gain control of the changes affecting their lives since 1965. Service and technical assistance programs focus on child development (such as Head Start and Parent-Child programs), alcohol and drug abuse prevention, energy and weatherization projects, and protection and advocacy of natural resources needed to support a subsistence economy..

Beginning in the 1970s, RurALCAP sponsored a counselor-training program to address Alaska's need for village-based alcohol and substance abuse services. This program eventually evolved into independent programs sponsored by regional health corporations. To assist local efforts, RurALCAP maintains a statewide network of mutual support through teleconferences, an extensive library and resource center of information and reference materials, and a monthly newsletter. RurALCAP also provides two manuals, Nation Building and Paths of Discovery, designed to support the AFN Sobriety Movement. The manuals serve as personal and community empowerment guides for people working in rural Alaska.

Additionally, the Alcohol Prevention Program provides specific support and technical assistance through Beginning Alcohol, An Addictions Basic Education Studies (BABES) and a FAS/FAE Training Specialist. BABES is a primary prevention program using puppets to help children develop positive living skills and provide them with information that enables them to make healthy choices about alcohol and other substances.

RurALCAP has been the impetus behind the annual Rural Providers Conference (RPC) for over 300 village-based substance abuse prevention and intervention workers. The conference now includes family members and others who come to learn new skills and celebrate their own sobriety. The RPC is planned and facilitated by conference participants with logistical support from RurALCAP, co-sponsoring organizations, and the host community. The conference has been primarily hosted by rural communities, including Soldotna, Nenana, Glennallen, Bethel and Sitka.

Workshop sessions address suicide prevention, inhalant abuse, Native spirituality, and traditional story-telling. Workshops allow participants to learn about new and traditional approaches to community-based prevention programs designed to combat alcohol and drug abuse. Evening events, such as a potlatch dinner, fiddle dancing, and a cultural sharing night, renew energy and connect service providers. The conference closes with a Staking Ceremony, a tradition borrowed from the Lakota Sioux and adapted so that participants may honor and symbolize their personal commitment to the fight against the use and abuse of alcohol (Mohatt et al., 1998).

A new ceremony, using a Tlingit blanket robe, was introduced in Sitka in 1998. "In a very moving display of love, hope and rejuvenation, the healing blanket ceremony took the conference to a heightened level of spirituality. The purpose of the ceremony is to get wrapped in the blanket and be prayed for to help heal whatever crisis one might be facing" (p. 12, RPC '97 Summary report RurALCAP).

The RPC was again held in Sitka in 1998. A new Tlingit blanket robe was prepared called "Emergence." "Support and caring was offered to all who stepped forward to be wrapped in the robe. A large part of the RPC is about healing, so the Healing Robe is a natural part of that process. It gave a chance to release problems, regain perspective and internalize tranquility. But most of all, it embraced all with love and hope" (p. 12, RPC '98 Summary report RurALCAP).

H. Initiatives for Women

1. *Tundra Women's Coalition*

The Tundra Women's Coalition (TWC) is a domestic violence program in Bethel. It was established in 1978 by a group of women from the Bethel area concerned about the escalating incidences of rape and other violent crimes against women. This community of concerned women formed this grass-roots level organization to assist abused women. Today, TWC provides services to 56 villages in the Yukon-Kuskokwim Delta region, encompassing over 100,000 square miles with a population in excess of 25,000 people.

The services consist of an emergency shelter for women and children, a 24-hour crisis line, peer counseling, parenting support, adult and child sexual assault advocacy, and other activities. Initial funding came from the State Legislature and the Law Enforcement Assistance Agency. Funds are presently provided by the Department of Public Safety and the Council on Domestic Violence and Sexual Assault.

Similar programs can easily be started in other communities. The Emmonak Women's Shelter is an example of a program based on the TWC, serving four surrounding villages: Alakanuk, Kotlik, Sheldon Point and Mountain Village. A shelter built in the spring of 1984 is currently in use.

2. *Bristol Bay Women's Conference*

The Bristol Bay Women's Conference is another "grassroots" effort that combats domestic violence, sexual assault, and other crimes against women. This group met in November 1998 to implement plans at the tribal and village level to deal with abused women's issues. The conference was organized by the Safe and Fear-Free Environment, Inc. (SAFE), funded through the Bristol Bay Native Association (BBNA).

Both SAFE and BBNA believe that women in the region are empowered to stop domestic violence and sexual assault in their homes, villages, state and nation. These groups believe that their recommendations for stopping violence in a woman's personal life and home can be progressively applied to larger groups, and that violence against women can be stopped. Their recommendations fall into four categories: personal lives and homes; villages and region; state; and nation. They are presented in Appendix A.

3. Other Women's Treatment/Intervention Programs

Substantive achievements have been made in the treatment of women who are victims of violence. Programs exist in both urban and rural communities, some of which are described below.

"Jake's Place" in Dillingham is a facility dedicated to assist pregnant women. The program, opened in 1992, has 12 residential beds. It provides comprehensive services, such as counseling, physical exercise, and craft work, and tries to include elders as part of the program. Aftercare services are also provided.

There is a close relationship between Jake's Place and village-based family service workers and counselors. Twenty villages in the region are staffed with counselors who are cross-trained in alcohol and mental health counseling. Jake's Place is also involved in a "Wellness Conference," which brings together villagers to define problems, derive solutions and prioritize efforts.

Two women's programs are administered by the Fairbanks Native Association (FNA). One is the Women and Children's Residential Program (WCRP). WCRP's mission is to empower women to achieve continued sobriety, physical and emotional health for herself and her children, skills for nurturing, effective parenting and healthy family relationships, cultural and spiritual identity, education and employment, and a sense of place in the community.

The treatment program is divided into three phases. Phase I is initiation into treatment, and is described by WCRP as a stabilizing period. Several days after admission, and encompassing a period lasting several weeks, a comprehensive assessment of the client begins, obtaining both clinical and baseline data; children are also assessed if admitted with their mother, and treatment plans are formulated. Shortly thereafter, individual counseling begins, alcohol and drug education efforts initiated, parenting and family classes established, group processes started, and participation in culturally-related activities inaugurated.

Phase II concentrates on treatment, providing individual, group and family counseling. It also focuses on relapse prevention, problem/conflict resolution, the parent-child relationship, and other personal and life issues.

Phase III emphasizes resolving personal issues and establishing ties to the community. Transitional care and aftercare are integral components of this treatment phase, along with educational and occupational efforts.

FNA's other program is called "Lifegivers," a residential program for pregnant and postpartum teens. In addition to pre- and postpartum services, Lifegivers' fundamental purpose is to help the youth in residence move away from drug-taking behaviors into a drug free lifestyle. An emphasis on reestablishing cultural ties is an integral part of the program.

a. Cook Inlet Tribal Council Programs

The Cook Inlet Tribal Council (CITC) is intensely engaged in providing services to Alaska Natives residing in Anchorage. One of its foremost programs is the Ernie Turner Center, a comprehensive substance abuse treatment program. Part of its

recovery process is to help clients learn about and use the strengths of their culture to restore self-esteem. Other CITC health-related programs include:

- Transitional Services, a national model program for comprehensive welfare-to-work services that offers pre-employment training, case management, supportive services, and employment and community service placements for welfare recipients transitioning into the workforce.
- Supported Work Services, offers training to help participants gain employment.
- Family Services, addresses childcare for working parents.
- Family Preservation, provides intervention services to keep families that are identified as high risk from abuse or neglect together.
- Social Services, a program that provides counseling, information, referral and advocacy services.

b. Southcentral Foundation

The Southcentral Foundation (SCF) provides services to Alaska Natives and American Indians. SCF is arranged into several divisions: (a) a Human Services Division, which consists of the Behavioral Health Department that oversees numerous programs; (b) the Anchorage Primary Care Center, which encompasses many health sub-units, (c) the Alaska Natives' Master of Public Health Collaborative Project; and (d) the Certified Nursing Assistant Program.

The preceding program descriptions only survey some of the numerous projects and interventions that have been implemented by Alaska Native people. There is evidence that programs are working. Mohatt et al. (1998) stated, ". . . it is clear from epidemiology reports that social indicators have not gone from bad to worse in all cases. In problem areas where target intervention programs have been at work long enough to see summative changes, we do see indications of progress in harm reduction, e.g., in accidents and drowning. In regard to suicide prevention, evaluations of the small demonstration grants indicate progress in those villages which have focused their efforts on prevention... These results suggest that targeted... efforts which build upon local knowledge and strengths are making a difference" (p. 25).

Despite this progress, significant gains are not as apparent in other areas, such as in alcoholism and alcohol-related violence (e.g., domestic violence). Although there is a long history of intervention in alcohol abuse, treatment can be strengthened when indigenous knowledge is incorporated into the planning and operation of preventive and treatment-oriented interventions. Most treatment models and strategies are based on western thinking and have historically been imported into Alaska.

The following recommendations, based on the work of Mohatt et al. (1998) (cited with permission), should be considered in developing programs dealing with health, behavioral health, and alcohol and substance abuse issues in Alaska:

1. Know the context, particularly its rural nature

Alaska, especially rural Alaska, is a complex and diverse setting. Rural means different things in different parts of the United States, and even in Alaska consideration must be given to distinguishing between living in "remote," "rural," "semi-rural," "semi-

urban,” and “urban” communities. As illustrated in Chapter I, distance, weather, and the pace of life demand that programs be designed to be responsive to these conditions.

2. Local communities present special challenges to the approach undertaken in developing programs responsive to community needs.

Alaska Native villages are kinship communities. Individuals relate through kinship and have long memories and significant experience with each other. This both facilitates and hampers change. Program personnel must know their communities and take the time to build relationships and trust. People and communities are the authors of their lives. Community-based helpers must work with the community to find and develop its ability to choose and compose the solutions to its problems rather than choosing and composing for them.

3. Interventions should arise out of and connect to indigenous knowledge bases and foster choice.

There is an important intellectual and cultural movement among Alaska Natives to revive and reclaim their culture, and to base programs, interventions, and processes of change on traditional ways of knowing. In order to accomplish this connection, any prevention program personnel must identify the elders and local experts who are the keepers of wisdom and use them as resources to articulate a knowledge base that allows the intervention to proceed in a culturally consistent way. Hild (1987) noted that: “Native communities have their own standards by which they define the problems associated with the consumption of alcohol. If interventions are made, or alcohol studies undertaken, then they have to account for the Native cultural perspective” (p. 85).

Native cultures have their own concepts of health, disease, and prevention and healing. At times, western and Native traditions and approaches can be synthesized. They may also operate in a parallel fashion. When program developers or workers fail to recognize potential cultural differences in the way in which personal choice is understood, they risk intervening in ways that lead to resistance rather than commitment.

4. Western knowledge can be utilized effectively if it is contextualized within a culturally and community relevant framework.

Programs need to articulate local knowledge and create bridges to western knowledge. Mohatt et al. (1998) cite the following example: “A rural leader once told us that she wanted to have experts in suicide come to the village rather than just be asked to figure out the solutions and have a facilitator present. She said, ‘What do they think? If we knew what to do we would have done it and prevented this from happening in the first place. Sometimes we don’t know and we need expertise we don’t have’” (pp. 28-29). Behavioral health and alcohol program staff must think

through these same issues as they try to use western knowledge so that it can help communities eradicate the persistent problems confronted by rural villages.

In summary, each of these innovations fosters personal and community choice. Program interventions in Alaska must arise out of an analysis of the particular Native community's sense of history and cultural views of health and illness. The interventions described above follow these principles to maximize community potential.

This chapter illustrates some of the many actions taken by Alaska Natives to address substance abuse and related problems. Each project represents a rededication to finding effective solutions for Alaska Natives by Alaska Natives. Ranging from local initiatives to large, formal programs, all recognize the nature and extent of substance abuse-related problems, and seek to reduce abuse and help victims to recover. The critical element of these efforts, however, is that they are based on Native cultural values and controlled by Native people.

¹Some of the content of this chapter is derived from the report by Susan LaBelle, titled: Report on Selected Alaska Native and Native American Programs in the Area of Alcohol and Drug Abuse, Domestic Violence, Suicide Prevention and Selected Readings and Recommendations for Alaska Federation of Natives. August, 1998.

CHAPTER XI

HEALING OUR OWN BY LEARNING FROM OTHERS

Some Native Elders continued their traditional practices, but they were careful to keep them secret. As an unfortunate result, many of the Native languages have come very close to extinction. It is not that the traditional ways were forgotten, because as Walter Austin told us, "Again we have to remind you that the children of today, who were raised by grandparents, have all the knowledge conveyed by their grandparents that they alone can turn into wisdom." Walter said "What I tell people is that you must go back to your roots to your language and relearn your language...Native people have all the answers, all the solutions they need to survive in this era. They also have the life skills and survival skills passed down from the ancestors. It is all there."

-Key Informant Interviews (cited in Saylor & Henkelman, 1998)

This report has stressed how Alaska Natives were impacted by the colonization of their land by people with different traditions and a dramatically distinct world view. The effects of change continue, but it is time to transform such effects from negative to positive. This will happen only as Alaska's Native communities heal themselves from the effects of past traumas and meet the future prepared for change. Yet such achievements cannot occur without the participation of the non-Native community. The majority community has to recognize its historical role in the transformations that occurred in Alaska and make amends. It also has to support Native initiatives.

This chapter provides information, for both Alaska Natives and non-Natives, about progress being made by aboriginal cultures in other parts of the world to overcome cultural loss and the adverse effects of drinking. The illustrations might be adapted by Alaska Natives, as appropriate, to regain control over their communities.

A. Pathways To Healing

Rupert Ross is a Canadian attorney interested in discovering how Canadian Natives can build a nation that acknowledges and accommodates both Native and non-Native societies. He stated (Ross, 1992):

...and what bearing does the adherence to traditional views and customs by North American Indians have upon their relationships with this country's governments, agencies and institutions? How does the adherence to tradition bear upon the provision of government services and programs? How does adherence to traditional values bear upon national and provincial dreams and plans? How does adherence to the "old way" affect the North American Indian's entry into and participation in this country's business and academic affairs?

Of course, these questions must be faced not only by Natives but by Canadians of European ancestry. How does the general unwillingness of white society to acknowledge that North American Indians have different values and institutions that have not lost their relevance and application despite five hundred years of cultural and technological advances, bear upon their affairs with First Nation's peoples?

The answer is clear: as long as the government and the agencies of this country fail to recognize that many original people of this country still cling to their different values and institutions, and so long as they insist that the original people abandon their ancestral heritage and embrace European culture, so long will penalties be unconsciously imposed upon the Native and injustices and injuries be committed. And as long as the government and the officials of this country continue to act as if the original peoples are the only ones in need of instruction and improvement, so long will suspicion and distrust persist.

But if modern Canadians of European heritage were willing to grant, as their ancestors should have done two to three hundred years ago, that North American Indian values and institutions are substantive, and have the potential to add to the well-being of this country, then not only would Canadians of European ancestry benefit but everyone would gain. (p. ix)

Herein lies a large part of the solution – accommodation. Rupert Ross (1992) wrote further, “My wish is to underline, at least, the fact that we have not approached Native people with the expectation of difference which is essential for communication and understanding to commence. Not having perceived that a gulf divides us, we have never truly tried to bridge it. Unless we do, it is my fear that we are doomed to increasing mutual frustration . . . as we have already seen. . .” (pp. XXIII, XXIV).

To date, accommodation has been a one-way street for Alaska's Native people. It is time for it to become a “two-way” street. Alaska Natives must also face the challenge of taking control of their own destiny. The non-Native community's responsibility is to recognize and support this process of change. It can respond with sensitivity when asked for help, and then advocate for implementation of solutions. Accommodation by the non-Native community has to involve acceptance of Alaska Natives' ability to resolve their own problems.

Healing efforts by Alaska Natives will benefit from creating a common bond across their communities. Spirituality may be the common denominator. The role of Spirituality in regaining cultural pride was emphasized by The Four Worlds Development Project, a program dedicated to eliminating alcohol and drug abuse in Canadian Native Societies. Members of this project wrote:

Native people have suffered many forms of oppression – physical, economic, political...but perhaps worst of all, spiritual oppression. The essential way in which people related to the Creator, the land, and to each other was disrupted, and the circle was broken, resulting in terrible damage which persists to this day. Repairing the circle means rebuilding

and renewing the spiritual heart of the people, in order that the steady beat of its rhythm can once again order our lives. Helping individuals, organizations and communities to escape from unhealthy and destructive patterns, and begin a journey towards new life-affirming ways, guided by that heartbeat, is amongst the hardest and most important work on the planet today. The journey, what some have called learning to walk the "good red road," has many parts: healing, education, political and economic development...but above all, the elders say that it is a spiritual journey. (The Four Worlds Exchange, 1992, p. 1)

Nevertheless, it is up to the Native community itself to find ways to unite itself to start healing and changing. Rupert Ross (1992) described how a Native community in Canada began to establish pathways toward healing itself:

The tiny community of Muskrat Dam in northwestern Ontario, a remote village accessible only by aircraft, has recently established a family healing center, and it is already showing very positive preliminary results. In talking with the men and women who have gone through its four-week program, I have heard encouraging things. They speak of learning about the problems of other family members, about the worries which they had not been able to share before. They also speak of how the sweat ceremony helped them to see their own family as an important thing that they now wish to make "whole" again. They speak with both a sense of relief and a sense of faith, as if they had not been able to see ways to climb out of their problems, whether they involved substance abuse, family violence, repressed trauma or fear of the future. It seems as if this treatment center, and the others I am hearing of, are finding ways to marry our confrontational and conversational techniques to their own spiritual practices. In fact, they appear to be eliminating many of the more confrontational elements in our approaches, perhaps by including the whole family and by doing so in ways which emphasize the value of each individual to the group. I would hazard a prediction that in time many of our mainstream professionals will be studying these developments with interest. Maybe, just maybe, they will admit that there is some room for improvement in our own approaches. (p. 147)

B. The Alkalai Lake Experience

Another successful community healing effort took place within the Alkalai Lake Band in British Columbia. As the people of Alkalai Lake brought their substance abuse under control, talking to each revealed deeper problems -- intergenerational histories of sexual abuse. This problem was also treated through community-instigated disclosure and discussion. Success occurred primarily because the Alkalai Lake people consciously chose to openly help each other to heal. This experience can happen in Alaska.

How a community chooses to begin to face up to histories of its problems, including sexual abuse, as Rupert Ross stated, “is another issue entirely.” If, as he wrote, a community chooses to pursue them through the criminal justice system,

...the end result will be substantial numbers of people serving long periods of time in jail. I doubt very much that this is the route they will want to pursue. Instead, I foresee them following the Alkalai Lake example once again and treating the process of disclosure as an opportunity for healing rather than for the prosecution of criminal acts. Alkalai Lake did not involve the criminal courts in handling this issue; instead, they built a healing lodge for victims and abusers alike, concentrating upon honesty, forgiveness and treatment. It remains to be seen how the white criminal justice system, with its emphasis on the jailing of sexual offenders, will choose to respond to the preferences of Native communities in my region as disclosure increases.” (pp. 153-154)

C. Hallow Water and the Sentencing Circle

With permission from Rupert Ross (personal communication, January 8, 1999), the following describes how one Canadian Native community established a Sentencing Circle, which represents a merger of traditional and western ways of dealing with sexual abuse that promotes healing. Ross cited the community’s own words describing their Sentencing Circle.

1. Background

Although we did not realize it at the time, the seeds of the sentencing circle concept were within the Community Holistic Circle Healing (C.H.C.H.) since the mid 1970s. It was at that time that a few individuals within our community began to look to traditional teachings and practices as a way of beginning personal healing journeys around the pain of victimization.

In 1984, these personal healing journeys became the seeds of a community healing process when a handful of us began sitting together to share ideas. By then, most of us had come to occupy various social program positions in the community and we talked about how we could better meet the needs of the individuals and families with whom we were involved as service providers. Eventually, we became known as the Community Resource Group. Initially we addressed health and social issues such as alcohol abuse, truancy, and suicide.

By 1987 the Resource Group came to realize that sexual victimization seemed to be at the core of the unhealthiness of most individuals and families in our caseloads. Because the trust level in the group, many of us had shared our own stories of victimization, so we knew that this was also true of ourselves. Because of the conceitedness between people in the community, we understood that this had to be true for the community as a whole. As a result, we began to look for, develop, and then implement a community healing process that would address sexual victimization. This eventually became known as Community Holistic Circle Healing (C.H.C.H.).

C.H.C.H. is our attempt to take responsibility for what is happening to us. Through the power of the circle we work to restore balance and make our community a safe place for future generations. C.H.C.H. stems from our beliefs (1) that victimizers are created, not born, (2) that the vicious cycle of abuse in our community must be broken now, and (3) that, given a safe place, healing is possible and will happen.

C.H.C.H. utilizes the principles that were traditionally used to deal with matters such as victimization. The traditional way was for the community (1) to bring it into the open, (2) to protect the victim so as to minimally disrupt the family and community functioning, (3) to hold the victimizer accountable for his or her behavior, and (4) to offer the opportunity for balance to be restored to all parties of the victimization.

It was within this context that we initially approached the staff sergeant of the nearby Royal Canadian Mounted Police (R.C.M.P.) detachment, and then eventually personnel from the larger legal system. We realized that, at least until the community mandate was stronger, the community healing process needed the support of the legal system in holding accountable those people who were victimizing others. Out of this developed what we see to be a conjunctive relationship with the legal system, and it is within this context that we now see the role and purpose of the sentencing circle.

2. Rationale

In our conjunctive relationship with the legal system we see our role as one of representing our community. We do not see ourselves “as being on the side of” the Crown or the defense. The people they represent are both members of our community, and the pain of both is felt in our community.

Until now our efforts have focused on (1) attempting to help both Crown and defense see the issues in the court case as the community sees them, and asking for their support, therefore, in representing the community’s interests, and (2) providing the court with a pre-sentence report which outlines the situation as we see it. The report informs the court of the work we are doing with the victimizer, and offers recommendations on how we see best proceeding with the restoration of balance around the victimization.

Now, however, we believe that it is time to expand the community’s involvement in this process. We believe that it is time for the court to hear directly from the community at the time of the sentencing.

Up until now the sentencing hearing has been the point at which all of the parties of the legal system (Crown, defense, judge) and the community have come together. Major differences of opinion as to how to proceed have often existed. As we see it, the legal system usually arrives with an agenda of punishment and deterrence of the “guilty” victimizer, and safety and protection of the victim and community; the community, on the other hand, arrives with an agenda of accountability of the victimizer to the community, and restoration of balance to all parties of the victimization.

As we see it, the differences in the agendas are seriously deterring the healing process of the community. We believe that the restoration of balance is more likely to occur if sentencing itself is more consistent in process and in content with the healing work of the community. Sentencing needs to become more of a step in the healing

process, rather than a diversion from it. The sentencing circle promotes the above rationale.

3. Purpose

As we see it, the sentencing circle plays two primary purposes: (1) it promotes the community healing process by providing a forum for the community to address the parties of the victimization at the time of sentencing, and (2) it allows the court to hear directly from the people most affected by the pain of the victimization. In the past the Crown and defense, as well as ourselves, have attempted to portray this information. We believe it is now time for the court to hear from the victim, the family of the victim, the victimizer, the family of the victimizer, and the community-at-large. The specific procedures of the sentencing circle are provided in Appendix B.

The sentencing circle is symbolic of many similar approaches undertaken in aboriginal or native groups to retake control over their own lives, largely in response to problems linked to cultural change and the ravages of alcohol.

D. Other Canadian Programs

Other programs in Canada involve the Crow, Cree and Ojibway Nations. Some of the more noted programs were established by the Gwich'in Tribal Council in Fort Pherson in the Northwest Territories. The Athabaskan Friendship Center, located in Alberta, works to improve the quality of life for Aboriginal Peoples in an urban environment by supporting self-determined activities which encourage equal access to and participation in Canadian society. Another program was started by Tlingit Indians in Teslin, a community in the Canadian Yukon. Teslin "has taken the healing philosophy and begun to construct an actual program faithful to it. They are putting their healing words into healing acts, and they are doing so even in cases of human trust and the most intense degradation of victims" (Ross, 1996, p. 18).

Rupert Ross conveyed that the healing tradition is being established in Native communities in Canada at a pace that exceeds Provincial Governments' ability to pass enabling legislation to legalize sentencing circles (personal communication, January 8, 1999). He indicated further that the Canadian Justice System has learned from the traditions of its Native people that punishment is not always the best way to proceed, and that the court system has adopted the concept of "healing" through implementation of sentencing circles which is being applied to all Canadian citizens – Native and non-Native alike. Mr. Ross told of a prosecution involving sexual abuse charges against a rather antisocial young man. Following the sentencing circle, however, the defendant realized the significant harm he had caused the victim and the community. He left the procedure realizing the consequences of his behavior, apologized, and asked forgiveness for what he had inflicted. All parties left the procedure with a sense of beginning to heal.

The tradition of teaching and healing is a philosophy that is present in many aboriginal societies but, as with Alaska Natives, it has been supplanted or suppressed by the cultural values of people colonizing their lands. Many aboriginal people are beginning to return to their cultural teachings and pursue activities that help their

people gain cultural identity and a positive sense of self. For example, the Tulalip Tribes in Washington started a recovery home, similar to a halfway house that was designed to help clients reintegrate back into their community. The Confederated Tribes of Warm Springs in Oregon operate the Warm Springs Community Counseling Center, which provides mental health and substance abuse services to tribal members.

E. The Navajo Experience

The Navajos are returning to their ways. Although they have had their own tribal court system, it was based on traditional western thinking and practices, but change occurred when the Navajos returned to the traditions of “harmony with others and the community.” In 1982 the Peacemaker Court was created by the Navajo Judicial Conference, which described this system as follows:

This unique method of court-annexed ‘mediation’ and ‘arbitration,’ . . . uses Navajo values and institutions in local communities. Today, it struggles to overcome the effects of adjudication and laws imposed by their U. S. government. The alien Navajo Court Of Indian Offenses (1892-1959) and the Bureau Of Indian Affairs Law And Order Code . . . made Navajos judge each other, using power and force for control. That arrangement is repugnant to Navajo morals. (Bluehouse & Zion, 1993, p.328)

The following illustrates key cultural differences:

The English words mediation and arbitration do not accurately reflect how Navajos feel about their justice ceremony. . . . The peacemaking ceremony has stages and devices to instruct and guide disputants. . . . There is a stage where the peacemaker explores the positions of the parties in the universe, verifying that they are in a state of disharmony, deciding how or why they are out of harmony. . . . It is similar to diagnosing an illness to find causes. There are lectures on how or why the parties have violated Navajo values, have breached solidarity, or are out of harmony. Lectures are not recitations or exhortations of abstract moral principles, but practical and pragmatic examinations of the particular problem in light of Navajo values. The peacemaker then discusses the precise dispute with the parties to help them know how to plan to end it. (Bluehouse & Zion, 1993, p.328)

The major element in the Navajo system is creating healthy relationships among people involved in disputes, and creating harmony between the mental, emotional, physical and spiritual dimensions of each of them. “Nourishing those relationships, the teachings seem to suggest, is the best way to help the parties create both their own solutions to the immediate problem and their own capacities for avoiding or settling disagreements in the future” (Ross, 1996, p. 28).

F. The Māori People of New Zealand

New Zealand's indigenous people, the Māori, have been subject to the same acculturation stress as other aboriginal people. The Māori people came from other Polynesian Islands in a series of planned voyages some eight or nine hundred years ago. These early settlers lived in tribal contexts. Since World War II they began living in urban communities, but maintained tribal affiliations. Dr. M.H. Durie, a Māori psychiatrist, stated:

Although economic progress and improved standards of living are important to Māori and constitute important principles for positive Māori development, of equal if not greater importance is the principle of cultural affirmation. The retention and revitalization of Māori language has been a major goal over the past fifteen years and along with it has been a corresponding emphasis on the recognition of Māori custom to modern life. This has not reflected any great desire to turn back the clock or to deny global advances. But it has suggested a strong desire to retain those values and beliefs which underlie a Māori identity. Moreover, a refocus on Māori arts, music, song and dance has created a surge of enthusiasm about being Māori which has itself led to major lifestyle changes and the incorporation of Māori icons and practices into the institutions of contemporary society.

In common with other indigenous peoples, Māori have placed considerable importance on greater autonomy and self determination, tino rangatiratanga. While both concepts have different shades of meaning, ranging from total independence and a separate nation state to simply a greater say in decision making at national and local levels, there is a measure of agreement that at the very least self determination can be said to be about the right of Māori people to exercise authority in the development and control of resources which they own or are supposed to own and to interact with the Crown according to their own needs and inclinations.

Second, and to an increasing extent, self determination has come to mean the right of Māori, collectively and at a national level, to determine their own policies, to actively participate in the development and interpretation of the law, to assume responsibility for their own affairs and to plan for the needs of future generations. (Durie, 1998, p. 4)

The introduction of alcohol into the Māori culture has been essentially similar to that experienced by Alaska Natives. The use of alcohol in Māori society, also strongly influenced by non-Natives, has been contentious since the early 1840s. While most historians have commented on Māori misuse of alcohol -- judged by the extent of drunkenness and financial indebtedness -- the dynamics of alcohol use were much more complex. Chiefs were often caught in the dilemma of trying to ensure Māori access to alcohol and controlling consumption.

Māori control of liquor licensing was recognized in the Outlying Districts Sales of Spirits Act 1870, and Native assessors were given authority to approve liquor licenses in their own communities. Their authority was often undermined by 'bush' licensees and the issue of access to alcohol gave way to one of prohibition. In some regions prohibition was actively promoted by Māori leaders. However, in most areas alcohol quickly became associated with status and hospitality and was incorporated into the evolving culture in much the same way as new technologies were assimilated (Durie, 1988).

The Māori recognize the potentially harmful effects of alcohol, and are concerned about the patterns of use and the rising incidence of alcohol-related hospital admissions, accidents, and domestic abuse. Drug and alcohol abuse and psychoses, the main reasons for first admissions to a psychiatric ward or hospital, constituted 32% of all Māori first admissions in 1993. In addition, Māori requiring treatment for alcohol problems are more likely to be admitted into a hospital setting than to be managed in a community clinic.

Significant differences between Māori and non-Māori drinking patterns have been identified. Māori, for example, frequently reported not having a drink in the week prior to the survey. On the other hand, of those who did drink, Māori were more likely to be heavy drinkers. The study confirmed the suspected tendency for Māori, especially young adults, to drink less often than non-Māori but to consume more alcohol (approximately twice the volume) on each drinking occasion (Durie, 1988).

1. The Range of Māori Solutions

Durie (1998) indicated that over the years three broad approaches for overcoming alcohol misuse among Māori have been suggested: (a) One focuses on the individual and leads to treatment or health promotional messages targeted towards potentially problem drinkers, usually young adults; (b) The second approach is community based and leads to community initiative and leadership; and (c) The third is a national approach, linked to public policy and the law. The first two are population-based approaches. Their aim is to guarantee that the majority (not just those at risk) adopt low-risk drinking behaviors.

Durie (1988) believes that "all three approaches are important though none will have success if Māori themselves are not active participants. There is some historical evidence that far from being passive consumers, Māori tribes and communities last century were active participants in the regulation of alcohol at local levels and successfully mediated between industry marketing and tribal well-being. "When Māori were not able to participate because of the law, or lack of access to public policy making, alcohol use rapidly became misuse" (p. 9).

In New Zealand, over the past decade, treatment programs for Māori alcohol problems have recognized the relationship between culture and health. Durie (1988) stated that:

It has become generally accepted that services should have policies and procedures in place enabling the delivery of culturally appropriate services to Māori. The components of culturally appropriate services

include an assessment process which takes into account cultural values, whnau (extended family) participation, use of Māori language and custom, outcome measures which are relevant to Māori understandings of health, and a Māori workforce with both professional and cultural competence. The Mental Health Commission has recommended that 'kaupapa Māori programs' (i.e., programs specifically set up for Māori clients), should be established on a regional basis according to population ratios. But some mainstream services have also established Māori programs alongside other programs. . . . Some clinical challenges, such as dual diagnosis, are of particular significance to Māori and have not been adequately addressed. (p. 9-10)

In 1989, New Zealand's government passed the "Children, Young Persons and Their Families Act," based on Māori traditions. This legislation supported a new process called the Family Group Conference (FGC), which applied to all youth – Māori or other – from ages fourteen to sixteen charged with criminal offenses other than the most serious, or purely "indictable" ones. The only requirement for participation in the FGC was that offenders accept responsibility for what they had been charged. Judge F.W.M. MacElrea of the Auckland District Court described the following Māori values as inspiring the creation of the FGSs:

First, the emphasis was on reaching consensus and involving the whole community; second, the desired outcome was reconciliation and a settlement acceptable to all parties, rather than the isolation and punishment of the offender; thirdly, the concern was not to apportion blame but to examine the wider reasons for the wrong . . . ; and fourthly, there was less concern with whether or not there has actually been a breach of the law and more concern with the restoration of harmony. (Cited in Ross, 1996)

TGC brings the offender's family and supporters together with the victim's family and supporters with the aim of achieving social harmony, putting right the wrong, and making reparation instead of concentrating on punishment. FGC's strength is that it does not stigmatize or degrade the offender as a person. It emphasizes that the act itself is shameful. The FGC success has led to its implementation in Australia.

The message from the experiences of others is that indigenous people can take control over problems affecting their community. Each group described above has reclaimed a sense of cultural pride when it began to use its cultural teachings to deal with criminal acts and to confront alcohol-related violence. The approach taken has to be restorative to offenders, not punitive. It is possible to learn from and adapt the experiences of others to rediscover or reclaim one's traditions in order to begin turning to traditional practices to promote healing. However, non-Natives have a responsibility to understand and assist in this process.

CHAPTER XII

ACHIEVING SELF HEALING: ALASKA NATIVES UNITED FOR THE 21ST CENTURY

...good health is not simply the outcome of illness care and social welfare services. It is the outcome of living actively, productively and safely, with reasonable control over the forces affecting everyday life, with the means to nourish body and soul, in harmony with one's neighbor and oneself, and with hope for the future on one's children and one's land. In short, good health is the outcome of living well.

-Royal Commission on Aboriginal People Vol. 3, pp.34-35

Good health and healing mean using traditional ways to recover from the effects of one's cultural ways being oppressed over generations. It is a process of developing the capacity of people and communities to overcome detrimental health, social, and economic conditions, and to regain patterns of living that sustain well-being. This chapter addresses self-healing, and concludes with recommendations to help healing occur.

Achieving "well-being" for Alaska Native people must go far beyond money and program-based solutions. Such "well-being" involves community and individual "empowerment" — the ability to take responsibility for one's behavior in order to control one's destiny — and being part of the process that makes decisions affecting individual and community life.

Empowerment begins by recognizing and gaining the strengths and resources necessary to take control to offset what is happening to individuals and communities. Empowerment takes commitment and requires assuming responsibility on a personal and community level. It is worthwhile to re-state a quote presented earlier to illustrate what healing is about and how it is achieved:

Healing is also about taking responsibility. It is about re-learning how we are supposed to be. Without knowing what traditional responsibilities are, then the right to self-determination really means nothing. Healing is about learning to act in a good way. (Patricia Monture-Angus, a Mohawk Indian lawyer, cited in Ross, 1996.)

The journey to healing involves moving to a positive perspective about the world in which we live. The Four Worlds Institute for Human and Community Development stated that:

Solving the critical problems in our lives and communities is best approached by visualizing and moving into the positive alternative that we wish to create, and by building on the strengths we already have,

rather than on giving away our energy fighting the negative. Whatever we think about expands. . . . If we think about how sick or weak or incapable we are, we give strength and endurance to the very weakness we wish to escape. If we think about all the things we don't like about another person, those are the very things we see and reinforce (whether negatively or positively) in our interactions with them.

Likewise, in community health development work, it is much more fruitful to focus energy on building the alternative than it is to try to oppose and undermine what we do not like. This in no way implies that we should allow injustice or unhealthy conditions to continue. The principle of moving to the positive suggests that we should clearly visualize what it is we wish to achieve in terms of positive conditions (health, prosperity, social justice, racial unity) and begin building that. Instead, many people focus their program energies on trying to eliminate the perceived obstacles to the things they wish to achieve.

Consider the example of disunity in a community. One approach to solving this problem might be to identify the people we believe are the source of the problem and to attempt to convince them to change. Unfortunately, when confronted with a challenge to one's character or personal behaviour, many people become defensive. A usual response includes one or all of the following: (a) deny that there is a problem, (b) discredit the person who challenges you, (c) blame someone else for the problem, or (d) justify the behaviour for which one is being criticized and increase it.

Another approach to disunity would be to gather together those people who want unity and to begin to behave toward each other in a unified way. The result of this strategy is that you have created unity. Other people can join this new pattern, but if they wish to partake of its benefits, they will need to behave according to the principles and rules that produce unity.

While this may be a somewhat simplified example, it is in fact a very powerful community healing and development strategy. Many North American tribal communities have already created sobriety movements that will eventually end the terrible burden of community alcoholism using this strategy. Recovering alcoholics and non-drinkers formed core groups and worked on their own healing as well as the creation of healthy human relations between them. Gradually these islands of health attracted others, and the core groups grew in strength and influence until a critical mass was reached and whole communities were transformed. (Community Healing and Aboriginal Social Security Reform, 1998, pp. 40-50.)

Another element involved in healing is a re-examination of people's basic beliefs about themselves, or creating a "post-trauma self." It was noted that:

Trauma has such a profound effect on people that it often shakes their view of themselves, of their self-worth, of their purpose for living and of their capacity to be loving, creative, intelligent beings. Creating a new self can involve re-learning what it means to be an ordinary, healthy human being because the victim's sense of such things as appropriate intimacy boundaries as well as appropriate emotional expressions can be distorted as a result of the trauma. It involves changing both beliefs and values as well as behaviour. It also usually means moving past a definition of oneself as a victim, forever powerless and fearful. It means accepting responsibility for the future and taking important first steps to become constructive members of society and to develop one's mental, emotional, physical and spiritual potential.

As this new self is being born, the individual healing from trauma must begin developing trusting, caring relationships with others. This process often begins through a deep relationship with a healer of some sort, whether trained through western medicine or through traditional processes. This is one reason why healers must behave in completely honorable ways which will enhance the capacity of the traumatized person to build appropriate relationships built on the new, 'post-traumatic self'. The relationship of trust, mutual respect and confidentiality which begins with the healer can then be extended in appropriate ways (i.e., while honoring appropriate boundaries) to others in society. It is through these relationships that people can express and exercise such capacities as autonomy, courage, intimacy, and initiative. It is at this point that the victim is ready to work toward seeking justice or compensation for the harm or loss incurred and toward forgiveness for the abuser, not because the act that was committed is excusable, but because of a deep appreciation for our common humanity. (Community Healing and Aboriginal Social Security Reform, 1998, pp. 49-50)

With the above as a foundation, individuals and communities can regain faith in themselves and in their leaders and proceed to heal. The steps a community must go through in order to heal -- to move out of a vicious cycle of violence, blaming, despair and self-destructive behavior -- can be summarized as follows:

A. Community Healing Steps and Conditions

1. **A safe environment** must be created for individuals to do their own healing work and for families and the community as a whole. A safe environment allows the community to deal with painful issues at a pace it can handle and provides the support required to ensure that issues can be dealt with in a way which leads to healing rather than to further traumatization.
2. This process requires **leadership**. In most instances, this leadership comes from two sources:

- a. courageous, role-model leaders from within the community who are willing to persevere in their own healing journey, and who are willing and able to take tough stands concerning the dysfunctional relationships and behavior keeping the community trapped in a state of denial or in patterns of violence, apathy, substance abuse and disunity.
 - b. outside helpers who provide support to the inside leadership and who are able to bring badly needed resources, such as learning processes, connection with other communities that have successfully dealt with the same issues, and a neutral outside perspective that can be trusted by community members.
3. Different types of **processes** need to be set up to allow **people to tell their stories and to process feelings**. Examples of some of the tools that can be used for this purpose are personal growth workshops, support circles, community theatre, video or other types of art projects, traditional ceremonies and counseling sessions.
 4. **Bonds of trust and mutual aid must be re-established** within families and between community members. This can result from people sharing and processing feelings together through the types of experiences described above. It can also be a conscious step which people take as they come together to tackle some of the critical challenges they face, such as reducing youth substance abuse or preventing youth suicides. At some point, community members must realize that they will be unable to move forward without learning to trust each other and to create a foundation of unity. Building these new relationships will not just happen. It will require dedicated effort to overcome the old patterns. It will also require facing up to and moving past old hurts and grievances.
 5. **Organizational healing processes** may be needed. In all likelihood, dysfunctional communities will have dysfunctional community organizations and agencies (whether professional or volunteer). The formal and informal institutions in the community need to be transformed in accordance with life-preserving and life-enhancing principles and processes.
 6. **A new pattern of individual, family and community life must be built**. This step requires community consultation, often over many months or even years. Core principles must guide the development process (based on a deep understanding of cultural values and identity) in order to articulate a common vision for the future. In other words, the community must come together to decide:
 - What is the future we want -- for children, youth, men, women, elders and families? in the political, economic, social and cultural dimensions of life?
 - What are the steps we must take in order to build that future?
 - What are our strengths and what can we learn from our past that can serve as a foundation for the task of creating a new future together? What can we learn from others to do this work?

The community's political, economic, education, health, recreation, and social service systems, as well as its informal associations, can then be re-created in ways which will lead to on-going well-being.

7. The community must keep **learning**. Individuals, families and communities who are traumatized often have a reduced capacity to learn. Their struggle to control strong feelings of anger, fear, helplessness or hopelessness has not left them much energy for creativity and learning, and personal and cultural identity and perceptions about self-worth have become distorted. Through the healing process, these feelings are released and the individual and community is ready to adopt a new, "post-trauma" identity (see the section above on healing from personal trauma). This will require new information, skills and attitudes related to many issues: personal well-being, interpersonal relations, leadership, and dealing with critical social and economic development issues.
8. **The community must establish healthy relationships with other communities** around it on the basis of its "post-trauma" identity. These renewed relationships are a necessary part of establishing viable economic, social, political and cultural patterns in the context of regional, national and inter-national forces.