

## REJOINDER TO THE COMMENTS ON THE MISALLIANCES IN THE BARROW ALCOHOL STUDY

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The Committee on Arctic Social Sciences of the U.S. National Research Council has just published its mandated recommendations for developing a strategy for future social science research in the Arctic (Kraus, in this issue; Committee on Arctic Social Sciences, 1989). The committee focuses major attention on the issue of research ethics in Arctic communities. It recommends that a statement on ethics should be developed that not only "guides scientist, but also gives people and communities affected by research and their representative institutions a clear idea of what behaviors to expect from scientists in the conduct of research" (p. 58).

Among the questions that the committee feels should be explicitly addressed are: "Should those proposing to conduct social research in the Arctic be required to obtain a permit from local authorities prior to the initiation of their research? If so, what is the appropriate process for making decisions about requests for such permits? Should scientists working in the Arctic be required to disseminate the findings of their research to residents of the communities in which they work? What form should the dissemination of these findings take? In cases where the publication of research findings may negatively portray Arctic residents or Arctic communities, should Arctic residents have some say in the publication or timing of the release of research findings? How can requirements of this sort be made compatible with the traditional value of academic freedom?" (p. 58). The presence of guidelines which would address these questions would have obviously allowed us to design, implement, and report our research in a more congenial manner.

The commentaries from respected colleagues in this issue suggest how our research and the research of others might have been better negotiated with the community. As Westermeyer (in this issue) points out, psychiatric disorders are a stigmatized subject in our society and in most others. Unlike epidemiological studies on heart disease, for example, studies of alcohol dependency, schizophrenia, or other mental disorders are likely to threaten the self-image of a community. Because of stigma, individuals suffering alcohol dependency in our own society are often not willing or able to consider themselves as such. Rather more frequently than not, they are

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offended when family, employer, or physician suggest the possibility. In some cases, the problems created by their alcohol use become persuasive and the individual seeks treatment. In other cases, denial of the problem tragically persists because of the associated social stigma, and individuals, families, and communities are prevented from dealing with the condition in a humane and effective manner. Because of this bias, research on mental disorders must be conducted with even more sensitivity than other kinds of medical and social research.

Trimble (in this issue) points out that the levels of alcohol use and abuse in all populations, remain high in rural Alaska. Wolf (in this issue) adds that our study focused too narrowly on the sociological factors associated with alcohol use in only one community, when the pattern is problematic in other rural Alaskan communities as well. He cites new approaches at the state and local levels that mandate an examination of specific tolerance of alcohol-related and/or drunken behavior in a community. Researchers and clinicians must be sensitive to the fact that such tolerance is often based on not wanting to offend victims or their families by labeling alcohol-related behavior a disorder. In contrast, it is important to recognize that a different kind of sensitivity is utilized to identify symptoms of heart disease. Heart disease is not shameful; a mental disorder, like alcohol dependency/abuse unfortunately is.

For these and related reasons, the crux (or the Achilles-heel as Shore puts it in this issue) of our study was the manner in which it was reported. Trimble, Heath, and others (in this issue) are correct in laying the ultimate responsibility for release to the press of the research findings at the feet of the researchers. The directive from Intersect, and the concurrences of the Steering Committee and Technical Addressing Community in Barrow to do so, made sense to us at the time. We believed—as they did—that the problems of alcohol-related morbidity and mortality were not being addressed by community and state institutions, and that the release of the report might bring much needed attention to this formidable but perennially overlooked problem. In retrospect, it has become apparent that this perspective was based on the clinical approaches used with individuals suffering alcohol dependency/abuse with concomitant denial in our own society. As Guilmet and Richards (in this issue) point out it represented the biases of the biomedical model of health/disease. The model follows a format in which experts in medical and psychiatric conditions make a diagnosis based on the empirically derived categories of biomedical technology. Their subjects (patients?) receive the announced diagnosis and are expected to comply with recommended treatments. True collaboration between expert and subject in defining who and what is to be studied, how it will be studied, and for what purposes has not been obtained.

Exciting alternatives to such regrettable approaches are presented in this issue by Mohatt, Trimble, May, Beauvais, Lujan, and others. They argue for research approaches that “build the capacity of the studied communities

to become researchers of the needs of their own communities." Such involved collaboration can help a community "learn of its strengths and define its problems, thus becoming empowered and strengthened" (Mohatt, p. 64). Interestingly, parallel shifts in relationships between medical experts and their clients are also emerging. Consumer advocacy groups such as the National Alliance for the Mentally Ill are forming powerful constituencies, which may result in more negotiated approaches to patient care. The demystification of expert opinion and the enhancement of public information and sophistication has the potential to bring about a more ethical and effective delivery of services needed to manage problems of individuals and communities.

The current status of funded social science research in the Arctic, however, remains appalling. The National Science Foundation funded no projects there during 1985 and 1986, and estimates funding of just \$62,000 in both 1987 and 1988 (Committee on Arctic Social Science, 1989). It is to be hoped that the recommendations of the Committee on Arctic Social Sciences and the approaches outlined by Attneave, Richards, Shore, and others in this issue will clear the way for researchers and communities to move forward with much-needed projects in alcohol-related problems and other important issues affecting the health and welfare of Native American and Arctic peoples.

We are grateful for the opportunity to air the painful events precipitated by our research so that some of the factors and issues which have prevented progress in needed areas of research might be addressed explicitly and solutions found. I believe that the commentaries offered in this journal have provided the concepts and framework for a new beginning in social and medical science research in communities in Alaska and elsewhere.

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#### References

Committee on Arctic Social Sciences. (1989). *Arctic social science: An agenda for action*. Washington, DC: National Academy Press, 7.