TWO ESKIMO VILLAGES ASSESS MENTAL HEALTH STRENGTHS AND NEEDS

BARBARA A. MINTON, Ph.D. and SUSAN SOULE, M.A.

Abstract: Due to a growing consensus of the inadequacy of the current mental health system in rural Alaska, an assessment of mental health strengths and needs was conducted in two Eskimo villages. Respondents were 216 Eskimos who completed a structured interview. Results document perceptions of problems and strengths unique to the village cultures and settings. To increase effectiveness, programs must take into account the perspectives expressed by village people.

Two Eskimo Villages Assess Mental Health Strengths and Needs

The literature on rural mental health has documented several unique characteristics of rural settings that impact the effectiveness of community mental health services. One of these characteristics is large geographic catchment areas (Bloom & Richards, 1976; Dolan, 1975; Clayton, 1977). To reach their clients, mental health workers in rural settings spend more money on transportation and more time traveling than their urban counterparts (Flax, Ivens, Wagenfeld, & Weiss, 1978). A second characteristic is the harsh physical environment found in many rural areas. The profound effect of weather on everyday life presents a special challenge to those from urban areas who take jobs in rural settings (Keller & Murray, 1982). In addition to these physical challenges, mental health workers are often not prepared for the different attitudes and value systems of those living in rural areas (President's Commission on Mental Health, 1978). The resulting "culture shock" has been one explanation given for the short length of stay of many mental health workers in their rural jobs (Keller et al., 1982).

Alaska epitomizes the characteristics which make rural mental health delivery unique. The state has a small population that is widely dispersed over a vast land mass (U.S. Bureau of the Census, 1989). The state's physical terrain, while breathtaking, impedes transportation. Extreme weather conditions are common. Eight native cultural groups have been identified in the state, each with its own language, values, and cultural

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heritage. These groups include Inupiaq and Yupik Eskimos; Athabaskan, Tlingit, Haida, Tsimshian, and other Indians; and Aleuts (Alaska Blue Book, 1989).

These characteristics suggest the need for a service system that is culturally sensitive and accessible to small groups of people in remote areas. However, Alaska's first mental health centers were established using national guidelines developed for urban and suburban areas outside the state. Catchment areas were defined on the basis of population, and professionals were hired to perform a variety of services including education, prevention, and treatment.

The system of mental health care which resulted from adopting this national model has not been optimal for people living in rural areas of Alaska. Mental health workers frequently spend more time travelling to an area than they spend in actual consultation or treatment. This excessive travel time results in workers presence in villages only one or two days every few months. Establishing rapport and maintaining ongoing treatment plans is extremely difficult under these constraints. In emergency situations, the mental health worker may be hundreds of miles away, powerless to help resolve a crisis.

In Alaska, the challenges of rural mental health delivery are often combined with that of cross-cultural work. A rural mental health worker discovers the difficulties of working in settings in which the culture and lifestyle are neither shared nor understood. Local hire is an obvious solution to this difficulty, but lack of higher education has excluded many Alaska natives from clinical positions. Professionals from outside the state have generally be recruited to fill clinical vacancies. These professionals, who are unfamiliar with the cultures and rural lifestyles, stay in their jobs an average of one year (State of Alaska, 1985). This short length of stay has led to disrupted and inefficient service delivery.

In one of the first formal statements of such problems in Alaska, a group of rural mental health center directors argued that the dominant culture service model was not working (Scott, Soule, Bill, Friendman, Collier, Walluk, Wiscinckas, & Graf, 1982). They stated that to be effective, professionals must disregard the model of services emphasized in most American graduate programs. Instead, clinicians must allow community members time to get to know them as individuals, work at a slower pace, provide services in informal settings, and view the community rather than the individual as the target for intervention.

In the early 1980s, some communities began their own experiments to address mental health problems. In one of the most innovative approaches to service delivery, the Four Worlds Project in Canada (Bopp, 1987) began promoting self-determination and healing, with decreased dependence on professionals found outside local communities. Their approach emphasized local initiatives, integration of native traditions with self-help programs, and use of indigenous service providers with consultation from other sources as necessary. In Alaska, Inupiaq Eskimos

began a program call Inupiaq Ilitqusiat, which called on local villages to reemphasize traditional Inupiaq values and to define their own solutions to the problems of suicide, alcohol and drug abuse, and violence (Inupiaq Ilitqusat, 1982). These programs shared common themes of reliance on traditional wisdom and use of local talent as part of the healing process. Advanced degrees were not required and help was made available within the local area.

The inadequacies of the mental health system in rural Alaska and the new emphasis on local determination formed the context for the current study. If mental health care is to be improved, system changes must be consistent with cultural norms and practices. The current study had as its major purpose the documentation of local thinking about mental health problems, strengths, and sources of help. The purpose of the study was not to design a specific system of intervention for the villages. Rather, it was to begin to identify important factors that must be addressed in a culturally relevant system. To maximize cultural relevance, local participation and control was emphasized in all stages of research design, data collection, and analysis.

Method

Respondents

The State of Alaska (which provided partial support for this project) selected the geographic area in which the study was located. Their decision was based on a desire to locate the project in an area of the state that was not receiving other special project monies, as a way of helping to assure fiscal equity in local communities.

Respondents were 216 Eskimos living in two villages in rural Alaska. The villages were similar in ethnic composition and lifestyles. Respondents were randomly selected within four age groups using lists of village residents supplied by each local government. Age groups sampled were 7-18, 19-29, 30-54, and 55+. These age groups were selected by the village people in a village meeting run by an elder. The village participants labeled the age groups "young people," "young adults," "middle aged people," and "elders."

Initial sampling was 40 people within each age group. However, sample size was exceeded in most groups, resulting in a total of 216 people participating in the project. Overall response rate to requests for interviews was 92%. Approximately 30% of the respondents chose to be interviewed in their native language; the remainder were interviewed in English. Those who chose to be interviewed in their native language were exclusively in the "middle aged people" and "elders" categories. (Effects of age and language spoken are, therefore, confounded.)

Procedure

Individual meetings were arranged with regional and village leaders to discuss project participation. Once village leaders became interested, they called a community meeting to discuss the project. At this meeting, research hypotheses and design were discussed. An approach derived from Manson, Shore, and Bloom (1985) was used to determine interview questions. This approach used the community meeting to derive the initial set of interview questions. During this meeting, community members stated that the concept of "mental health" had no equivalent in their native language and was not an appropriate construct to use. Questions considered more meaningful to local people were discussed in small groups at the initial meeting. These small groups reconvened and the larger group reviewed and selected a set of questions for further refinement. Approximately 135 people attended this initial community meeting and all age groups were represented.

After the initial meeting, eight bilingual community members were chosen by village leadership to be interviewers. The first author and the interviewers discussed the questions further and refined wording. Once interview questions were finalized, interviewers were trained in standard interview techniques. Interviewers then contacted respondents, explained the purpose of the interviews, and requested respondent participation. Interview questions were presented in either English or the native language, according to respondent preference. All interviews were taped and transcribed in the villages. Interviews were then sent to the first author for analysis.

Standard content analysis was completed on all interviews. Thematic categories were derived from analysis of the first 50 interviews, and the next 50 interviews were coded into these categories by two trained raters. Resulting interrater reliabilities were .94 using the pi method (Scott, 1969) which corrects both for the number of categories in the category set and for the probable frequency with which each is used. The remaining interviews were then scored. Respondents received a score in each thematic category. Data were coded dichotomously; a one was assigned if the category was mentioned an a zero was assigned if the category was not mentioned.

Results

Three questions from the structured interview were chosen for analysis. These are "What makes you sad?" "What makes you happy?" and "Where do you go when you're sad?" These questions were viewed by the interviewers as those which would be most helpful in understanding the problems, strengths, and resources of village people and were chosen for initial analysis on that basis. The other interview questions provided elaborations on these major questions (see Appendix I). The content

analysis resulted in 22 categories for the questions assessing sources of sadness, 31 categories for the question assessing sources of happiness, and 11 categories for the question assessing resources used when sad (see table 1). Sources of sadness include those documenting the impact of other people (Other People, Victim, Communication), those which are focused on self (Transgressions, Personal Inadequacy), and those which describe negative events of habits (Death, Alcohol, Sickness). Similar types of categories were discovered for answers relating to happiness. Categories mentioning other people (Interaction with People, Doing for Others, Family), self (Accomplishment, Time Alone), and specific events causing happiness (Outdoor Activities, Sports) were discovered. The question asking for resources used by respondents when sad elicited responses primarily about other people (Friends, Pastor, Parents). Definitions of each categories are provided in Appendix II.

Because some respondents gave multiple responses for a category, data were scored with two systems. In one system, multiple responses were counted and recorded. In the second system, multiple responses were counted as a single response. all analyses were performed on both sets of data. Findings were not significantly different for these two coding systems.

Table 1
Categories Derived from Content Analysis and Percent of People Whose Responses Fell in Each Category (n=216)

Questions: What makes you sad?		
Response Categories	Death	31.5%
	Alcohol	22.9%
	Other People	22.6%
	Kids	20.3%
	Miscellaneous	18.5%
	Negative Personal Emotion	16.1%
	Victim	13.0%
	Relatives	12.1%
	Communication	8.7%
	Sickness	7.0%
	Boredom	6.1%
	School	6.1%
	Drugs	6.0%
	Relgion	5.7%
	Losing a Friend	4.8%
	Lack of Contact with Friends	4.8%
	Basic Needs	3.4%
	Trangressions	3.0%
	Finances	2.2%
	Suicide	2.2%
	Personal Inadequacy	1.7%

Table 1 (Continued)
Categories Derived from Content Analysis and Percent of People Whose Responses Fell in Each Category (n=216)

Question: What makes you happy?		
Response Categories	Outdoor Activites	25.6%
	Miscellaneous	18.1%
	Kids	17.8%
	Sports	17.8%
	Relatives	16.9%
	Getting Along or Being with Friends	16.8%
	Work	15.6%
	Interaction with People	14.8%
	Religion	10.9%
	Doing for Others	9.0%
	Inside Entertainment	9.0%
	Travel	8.6%
	Other's Happy	7.8%
	Gifts	6.5%
	Anything	6.0%
	Good Daily Living	6.0%
	Escaping Bad Things	5.6%
	Doing with Others	4.8%
	Walking Around	4.7%
	Control of Drinking/Drugs	4.4%
	Good Health	3.9%
	Going to School	3.9%
	Accomplishment in School	3.9%
	Finances	3.9%
	Food	3.0%
	Nice Weather	2.2%
	Doing for Family	2.1%
	Time Alone	1.7%
	Positive Feedback	1.7%
Question: Where do you go when you're sad?		
Response Categories	Friends	59.8%
	Religion	29.6%
	Parents	27.5%
	Others (Nonspecific)	17.6%
	Relatives	16.2%
	Miscellaneous	14.8%
	Teachers	8.5%
	Elder	6.3%
	Counselor	4.9%
	Yourself	2.8%
	City Officials	2.1%

The percent of people whose responses were scored in each category give an indication of consensus about sources of sadness, happiness, and help. Sources of sadness most often mentioned are Death

(31.5%), Alcohol (22.9%), Other People (22.6%), Kids (20.3%), Miscellaneous (18.5%), Negative Personal Emotions (16.1%), Victim (13%), and Relatives (12.1%). Sources of happiness most frequently mentioned are Outdoor Activities (25.6%), Miscellaneous (18.1%), Sports (17.8%), Kids (17.8%), Relatives (16.9%), Friends (16.8%), Work (15.6%), Interactions with People (14.8%), and Religion (10.9%). Sources of help when people feel sad are Friends (59.8%), Religion (29.6%), Parents (27.5%), Others who have Positive Personal Traits (17.6%), Relatives (16.2%), and Miscellaneous (14.8%). Percentages of all response categories can be found in Table 1 above.

Multivariate analysis of variance (MANOVA) was performed to test for effects of village, gender, and age for response categories of all three questions. For the sources of both sadness and happiness there are main effects of age and gender. For the question assessing sources of sadness, age effects are significant at p.05 (F=1.41). Gender effects are significant at p.01 (F=2.01). For the question assessing sources of happiness, both age and gender effects are significant at p.01 (F_{age}=2.17, F_{gender}=2.07). MANOVA performed on the question assessing sources of help shows only a significant age main effect (F=1.87, p.01).Univariate tests after MANOVA were examined for clues to the categories that might have contributed to the significant main effects (Harris, 1975). For the question assessing sadness, age effects may be related to the categories of School, Victim, and Alcohol. More young people (ages 7-18) that other age groups endorsed school and victimization as sources of sadness. Alcohol use was cited less often by the young adult group (ages 19-29) than by the other age groups (see Table 2). Categories most likely related to gender effects are Death, Relatives, and Boredom (see Table 3). More females than males cited Death and Relatives as causing sadness. Males cited Boredom more often than did females as a source of sadness.

Table 2
Sad Question
Percent of People in Categories with Significant Univariate F-tests for Age
(p<.05)

Category	School	Victim	Alcohol
7-18 (n=68)	12.4	24.4	18.5
19-29 (n=52)	3.8	5.7	5.7
30-54 (n=44)	0	2.3	25.0
55+ (n=52)	3.7	11.1	44.5

Table 3
Sad Question
Percent of People in Cateogries with Significant Univariate F-tests for Gender (p<.05)

Category	Death	Relatives	Boredom
Females (n=122)	36.1	20.5	2.5
Males (n=94)	26.6	2.2	11.7

Significant univariate F tests were also examined for the question assessing sources of happiness to provide clues as to categories that may have contributed to main effects for age and gender. For age effects, categories with significant univariate tests as presented in Table 4.

Table 4
Happy Question
Percent of People in Categories with Significant Univariate F-tests for Age (p<.05)

Category	Good Daily Living	Other People Happy	Kids	Sports	Family
7-18	0	5.8	1.4	40.5	21.7
19-29	0	0	22.4	20.4	20.4
30-54	6.5	8.7	26.1	2.2	17.4
55+	18.9	18.9	28.3	3.8	7.6
Category	Religion	Walking Around	Money	Friends	Going to School
7-18	1.4	10.1	2.9	30.3	13.0
19-29	2.0	8.1	2.0	22.4	0
30-54	8.7	0	0.9	8.7	0
55+	35.9	0	0	3.8	0

Categories that increased with age include Good Daily Living, Kids, and Religion. Categories for which responses decreased with age are Sports, Family, Walking Around, Friends, and Going to School. Two categories had more complex patterns with reference to age: Other People Happy and Money. Other People Happy showed the highest response percentage from elders (ages 55+), no mention in the young adult group (ages 19-29), and intermediate values in the other two age groups. Money was mentioned most often by the middle aged group, by smaller percentages of young people and young adults, and not at all by elders. Gender effects on the question asking for sources of happiness are significant for five categories: Kids, Good Health, Religion, Family and Relatives, and Doing Things with Others. Females had a higher number of responses to all categories except "Doing Things with Others," in which males were higher (see Table 5).

Table 5
Happy Question
Percent of People in Categories with Significant
Univariate F-tests for Gender ($p<.05$)

Category	Kids	Good Health	Religion	Family & Relatives	Doing Things with Others
Male	10.1	0	6.1	8.1	8.1
Female	25.4	6.5	15.6	23.8	2.5

Univariate tests after MANOVA for the questions assessing possible sources of help when people are sad indicate three categories that might be related to the significant main effect of age. These are Friends, parents, and Miscellaneous. With age, there was less mention of friends and parents as sources of help. The category Miscellaneous, which contains one-of-a-kind responses, had more items generated by the young adult and middle aged groups than by either the young people or the elders (see Table 6).

Table 6
Sources of Help Question
Percent of People in Categories with Significant
Univariate F-tests for Age ($p<.05$)

Category	Friends	Parents	Miscellaneous
7-18	71.7	45.3	3.8
19-29	75.7	24.3	32.4
30-54	50.0	18.2	31.8
55+	32.0	8.0	0

The interview data revealed several important community characteristics that should influence the design of new local mental health programs. These are: 1) long-standing, intimate human relationships, 2) developmental differences, 3) sex differences, 4) perceived areas of need and strength, and 5) acceptable sources of help. Each of these findings and its implications for program design will be discussed.

The emphasis on long-standing, intimate relationships can be seen in many of the interview responses. The respondents in this study perceive themselves as living within a web of human relationships that includes nuclear family, extended family, and friends. Most people in villages grow up with each other, live and work together as adults, and grow old together. Village families often intermarry, creating multiple extended family relationships. The resulting close relationships seem to have both positive and negative consequences. On the positive side, respondents report gaining a great deal of happiness from their children, relatives, and friends. On the negative side, children and other people were often cited as sources of sadness. Perhaps it was this high degree of social connectedness that

Scott et al. (1982) sensed when they called for community oriented strategies that mobilize this strong social network to create the context within which the problems of the individual can be solved. Effective mental health programs must take these relationships into account and work within this network of relationships to ensure lasting, positive change. Focusing therapeutic work solely on an individual may be ineffective due to the impact of the larger social network on all areas of functioning.

Another important community characteristic that should affect mental health program design involves developmental differences in values and activities. Age effects show that older people derive more happiness from religion and everyday pleasures and less from physical activities, school, and kids. These responses may reflect elders' current life situations, as they may be less involved in child-rearing, school, and activities that require physical strength and stamina. It is also possible that their emphasis on religion and everyday pleasures reflects developmental shifts as aging brings a focus on the present rather than the future and an emphasis on religion as a source of meaning.

However, a more compelling explanation for elders' emphasis on religion and everyday pleasures may be a cohort effect. Those who are elders in the 1980s grew up when there were no schools in villages and sports had not been widely introduced. Instead, the focus was on traditional Eskimo games and skills such as hunting, fishing, and skin sewing. This was also when missionaries targeted village people for Christian conversion. Therefore, elders' sources of current happiness may be an expression of the activities they learned to value when they were younger instead of developmental change associated with aging.

While it is impossible to resolve the question of whether each finding reflects true developmental change or a cohort effect, the implication is clear. Mental health programs must be designed to approach elders in a manner consistent with their values regarding religion and meaningful life activities. Programs must also take into account younger people's emphasis on sports, school, and their own children.

Developmental change in responses to the sad questions indicate several interesting patterns. First, with age there is less emphasis on school as a source of sadness. The percentage of respondents who mention this category drops dramatically at age 19. Since few villagers attend college, it is reasonable t assume that school-related problems decrease once people leave the school setting. A second developmental pattern shows both young people and elders victimized more than other age groups. These responses may reflect feelings of powerlessness and lack of control over the environment by those who are not yet given adult status and by those who are facing the consequences of aging.

A third developmental difference shows alcohol abuse cited most frequently as a source of sadness by elders and least frequently by young adults. The high frequency of responses from elders may reflect beliefs related to personal experiences of life during times when less alcohol was

available, strong religious sanctions existed against its misuse, and the fact that during their lifetimes survival often depended upon having a clear mind to cope with a harsh, unforgiving environment. It is also possible that condemnation of alcohol use could be a reaction to guilt over behavior now discontinued. The young adult group, on the other hand, did not report this category with great frequency though it is this age group, statewide, for which alcohol abuse is the highest (State of Alaska, 1989). These findings lend credence to the argument that denial of the negative impact of alcohol is highest among those most involved in its abuse. It should be noted that responses in this category included a broad definition of alcohol-related concerns and were not limited solely to one's own use.

The developmental differences related to sadness suggest several important variables for program design. Programs must take into account the importance of school for young people and their relatively high feelings of victimization. Interventions might be oriented to learning practical ways of coping with school-related problems as well as increasing respondents' sense of power and control in personal and social relationships. Programs should also explore age-related difference in attitudes about whether or not alcohol is a major problem in the village, and should design interventions that take into account these varying perceptions.

Significant sex differences also have program implications. In this study, women focused more on family concerns, health, and religion, while men emphasized outdoor activities with other people. These emphases appear similar to those found in western culture, with women traditionally focused on home and families and men oriented outside the home (Henslin, 1988; Huber, 1988). This finding may show socialization received from the white culture. It may also be related to the traditional Eskimo male role of hunter and the traditional Eskimo female role of family caretaker. Interventions must take into account the different role demands and preferences of the sexes.

Sadness and "bad" feelings were different than those a mental health practitioner might assume. The areas of sadness most often mentioned in all age and gender groups were death and alcohol. Most dominant culture mental health interventions do not focus on the problem of death. This finding may be related to several factors. First, the many intimate involvements reported by respondents suggests that the number of deaths of loved ones is higher in Eskimo communities than it is in communities with more diffuse social relationships. Many respondents reported that deaths of cousins, aunts, and friends were as emotionally devastating as deaths of spouses or children. Second, respondents reported often being called upon to provide support for bereaved friends and family members, even when the death was of someone not well known to them. Third, contributing to the impact of death may be the fact that Alaska natives have a high death rate in general; death rates for accidents, sudden infant death, homicide, and suicide are significantly higher than the national average (Alaska Federation of Natives, 1989).

It should be noted that suicide was mentioned rarely as a source of sadness. This is in contrast to assumptions made on the basis of statistics that point to the high suicide rate of Alaska natives compared to other groups (State of Alaska, 1988). Several explanations may account for this phenomenon. The first is that the base rate of suicide remains very low for Alaska natives even though their rate compared to other ethnic groups is high. Therefore, suicide remains a rare occurrence and does not frequently impact a village population. Second, it is possible that respondents were reluctant to mention suicide in the interviews due to feelings of embarrassment or shame. Third, it is possible that suicides were not directly identified as suicides but were mentioned as deaths. Anecdotal data from the interviewers suggests that several instances of this did occur. Therefore, it is likely that some of the responses coded within the death category were suicides. However, interviewers (most of whom knew how deaths had occurred) did not feel that a significant number of suicides were miscoded into the death category. Thus, it seems reasonable to conclude that death itself is a source of concern for a large percentage of the village population regardless of its specific cause. While suicide is a problem, the data indicate mental health programs need to become aware of all deaths among village people and help them develop healthy ways of dealing with the associated stressors.

Alcohol use was cited second most frequently as a source of sadness. Currently, the State of Alaska differentiates between alcohol and mental health programs and provides independent funding and monitoring of programs. These data strongly suggest that villagers do not make a distinction between alcohol and mental health problems. Instead, they view all these problems as part of a general class that creates sadness in the village. A mental health or alcohol worker must understand that programs designed to separate the two areas may not be easily understood or appropriate in these village contexts. The high concern overall about alcohol abuse suggests that programs must address this concern and that age-related differences in attitudes must be taken into account.

The categories documenting sources of happiness reveal a community oriented toward the outdoors and other people. The happiness category mentioned most frequently, "Outdoor Activities," included responses such as going hunting, picking berries, and riding snow machines. These responses indicate that outdoor activities, both traditional and nontraditional, are important as a way of improving mood. participation in sports was the second most frequently mentioned source of happiness. Within this category, there were many references to basketball, one of the few indoor sports available in these villages in the winter. Other categories mentioned frequently as causing happiness involved maintaining positive relationships with other people and observing as others maintain positive relationships. The importance of living in a harmonious community is supported by these responses.

The findings documenting sources of happiness provide two valuable pieces of information. First, they provide a menu of pleasurable activities and experiences that can be used to increase positive feelings in both prevention and treatment programs. Second, this information gives clues about the types of experiences that might be missing for those who have problems. Rather than relying on majority culture definitions of pathology, one could examine the aspects of "happy" functioning that are missing and use these as guidelines in devising a treatment program for an individual or group.

When feeling sad, subjects placed great emphasis on other people and religion as sources of help. The finding that people in these villages do not perceive counselors as sources of help is not surprising, given their lack of access to mental health workers. Additionally, several negative experiences with professionals were cited in the interviews and were apparently discussed widely among village residents. Interestingly, use of other people as sources of help decreased with age. While it is possible that older people chose more dependence on religion and less on other people, it is more likely that their opportunities to rely on others diminish as cohort members die. The fact that the young adults and middle aged groups used a variety of strategies coded under miscellaneous indicates more individualized solutions to finding sources of help then in the other two age groups. A typical response in this category was "going to the city and driving around." These types of responses indicate more exposure to opportunities than younger and older age groups and the means to pursue them.

Overall, the patterns of data in this study suggest that it is a mistake to look at village people as homogeneous groups with the same stressors and supports. Rather, this study suggests that village people have a multiplicity of concerns, pleasures, and sources of supports. These dimensions also vary in complex ways according to age and gender. To be effective, any comprehensive mental health program will have to take into account the patterns of differences among people. For example, a program to address concerns about death might involve separate approaches for women and men. While both approaches might emphasize use of outdoor activities and religion, the women may benefit from family visits while men may benefit from going hunting with friends. These types of interventions are more holistic and community-based than the standard solution of individual counseling sessions one or two hours per month. They also rely on organizing the community to create interventions rather than asking an outside agency to visit the community and solve the problem.

One of the most intriguing findings of this study came to light during the design of the interview questions and was serendipitous in nature. In the initial community meeting to discuss the project, village people rejected the concept of "mental health" as having meaning in their culture. "Mental health" was viewed as a concept invented and promoted by "white people." Discussion focused on the fact that many terms used by the dominant culture to describe emotional problems (such as "depression") do not have

an equivalent in their native language. While no formal data were collected on these issues, an important message was given regarding the cultural relativity of diagnostic labels and concepts. Thus, the involvement of local people in the initial phases of the study caused the design of the interview questions to be radically different than they would have been otherwise. For interview questions, villagers preferred the use of the terms "happy" and "sad" because they were matched in meaning with Eskimo terms relating to emotional difficulties and emotional health. It appears that labels learned by professionals in most graduate schools are inadequate to conceptualize and communicate about emotional problems in these villages. More careful research is needed to systematically document the conceptual differences in terms used to describe emotional states.

The importance of looking at local conceptualizations of mental and emotional difficulties has been emphasized in this study. The outcomes support alternative ways of thinking about problems, strengths, and sources of support for Eskimo people. Because of the differences in through between these villages and a typical dominant culture mental health professional, it is likely that the professional will have great difficulty providing effective services at the village level. Village people themselves, who understand the cultural conceptualizations, will be more effective at designing services. In addition, village people will more likely be effective at mobilizing the social network that appears to be a strong determinant of health. Looking at local conceptualizations and involving local people will allow programs to be more sensitive to cultural variation, and will thus, enable them to more effectively serve those who need help.

University of Alaska, Southeast
School of Education
Liberal Arts & Science
11120 Glacier Highway
Juneau, AK 99801

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Appendix 1
Interview Questions

- What are the things that make you happy? What else makes you happy? (Repeated until respondent has no more responses).
- What do you do when you feel happy?
- How do you tell when a person is happy?
- What are the things that make you sad? What else makes you sad? (Repeated until respondent has no more responses).
- What do you do when you feel sad?
- How can you tell when a person is sad?
- Where do you go for help when you feel sad?
- Would you be willing to help someone that is sad?

Appendix 2
Response Category Definitions

Happy Definitions

- Outdoor Activities - activities that take place outside such as hunting, fishing, berry picking, riding sno-go.
- Kids - any mention of children, including having kids, being with kids, when kids are happy, healthy.
- Sports - includes playing sports as well as watching sports; includes swimming and dog racing as well as basketball, football, baseball, etc.
- Family - having a family, being with family. Does not include doing things for family or getting along with family, which is a separate category.
- Interaction with People - being with people, talking, visiting.
- Work - includes household work as well as paid employment. Does not include school work (homework).
- Religion - religious beliefs (God, Jesus, the Bible, etc.) and religious activities (going to church, praying).
- Travel - self-explanatory.
- Doing for Others - does not include doing things for family, but for people outside the family.

- Inside Entertainment - indoor activities such as listening to music, singing, sewing, knitting, playing video games.
- Other People Happy - when other people are happy and/or living happily.
- Anything & Everything - includes vague answers such as, "Anything makes me happy."
- Good Everyday Life - when everyday living goes smoothly.
- Gifts/Getting Things I want - self-explanatory.
- Riding Around/Walking Around/Staying Out - self-explanatory.
- Good Health - includes others as well as self.
- Accomplishment - attaining goals, getting done what needs to be done, doing a good job. Does not include accomplishment in school, which is a separate category.
- Controlling Drinking and/or Drugs - when one stops or moderates intake of alcohol/drugs. Includes self as well as others.
- Going to School - self-explanatory.
- Food - includes any mention of food (having it, preparing it, eating it).
- Doing Things With Others - self-explanatory.
- Accomplishment in School - doing homework, getting good grades, etc.
- Escaping Bad Things - includes answers such as "coming out of surgery well," avoiding arguments with friends, etc.
- Money/No Financial Worries - having money, having no bills to pay, etc.
- Nice Weather - self-explanatory.
- Time Alone - self-explanatory.
- Positive Feedback - receiving sympathy, understanding, and compliments from others.
- Doing Things For/Getting Along With Family - self-explanatory.
- Getting Along With Others - does not include family.

<u>Sad Definitions</u>

- Religious and Spiritual Concerns and Interpretations - active evil spiritual religious forces working in the village, lack of fulfillment of Christian beliefs, or "being in the last days."
- Negative Personal Emotions - negative emotions in reference to self such as "when I feel I'm a bad person."
- Personal Inadequacy - not living up to self-expectations.
- Basic Needs - lack of food, heat, or other basic physical needs.
- Kids - problems with ones own children of any age.

- Other People - when something negative happens to others or others are doing something negative (including conflict among others).
- Relatives - negative things happening to or experienced by relatives (excluding death, which is scored under Death).
- School - doing poorly academically or in sports or not liking school (including homework).
- Lack of Contact With Friends - self-explanatory.
- Victim - someone else doing something bad to you - first-hand experiences.
- Own Transgressions - person themselves does something wrong to others or breaks a rule.
- Communication - rumors, miscommunication.
- Lack of Direction From Adults - self-explanatory.
- Misc. - miscellaneous.
- Drugs - self-explanatory.
- Alcohol - self-explanatory.