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- February 15th for the Spring Issue.
- May 15th for the Summer Issue.
- August 15th for the Fall Issue.

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# A Message from the President

by  
David Lambert



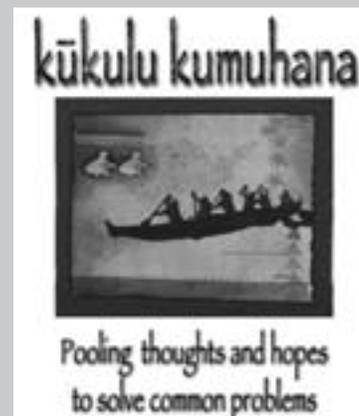
NARMH's annual conference "The Changing Faces of Rural Mental Health" in Boulder, Colorado was a resounding success. Nearly 250 persons attended from 36 states and Canada, including students, consumers and family members. The presentations were great, the discussions provocative, and people had a very good time. Sergio Aguilar-Gaxiola had flown in from California to present the second afternoon plenary session "Translating Research into Services: Closing the Gap in Mental Health Utilization in Mexican Americans." Dr. Aguilar-Gaxiola had planned to fly back to California early the next day, but found the conference so interesting and friendly, he changed his plans and stayed in Boulder an extra day. Kathryn Powers, Director of SAMHSA's Center for Mental Health Services, also flew in from California (on her way home) and took time from her very busy schedule to present a stimulating lunch-time talk.

The conference was so good, it is hard - and definitely not fair - to spotlight just one part. However, where I think this conference broke important new ground was in the multi-cultural competency panel followed by concurrent sessions on ethnic population specific cultural competency training. Time constraints limited discussion to four population groups - African Americans, National Asian American Pacific Islanders, First Nations, and Latinos. The plenary and concurrent sessions clearly demonstrated the need and challenge to "contextualize" evidence-based and promising treatment to both

people and to place. This is a conversation that we in rural mental health communities must continue to pursue - with federal and state policy makers, with providers, with consumers, and with other rural citizens.

Finally, I am pleased to announce that NARMH is undertaking a major redesign of its web site. The goal of the redesign is to help make NARMH become the "go-to" place for rural mental health. You will find information about NARMH, about rural mental health, about "news that you can use", and helpful links to other web sites and resources to be more accessible and complete. Look for the new-look NARMH web site (same address - [www.narmh.org](http://www.narmh.org)) to be done by late fall.

Join us in  
Honolulu, Hawaii  
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August 4-7, 2005



## Notes from the Field

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by Deborah Carmen

There are not enough words to express my appreciation for the availability of a program to assist people during a time of personal crisis. In 2002 I became seriously ill with a spinal infection. I had mounting bills and a pending foreclosure and was a single mother of a five year old son. Troubled with thoughts of suicide, I contacted the Farm Resource Center. I had recently purchased a small farm in a rural community and was unaware of the resources available. The FRC outreach worked orchestrated a plan to assist me in organizing my priorities. She also led to the available community resources. I quickly sought a counselor for depression and help with the foreclosure.

FRC does not attempt to take the place of a counselor but is a referral service offered to help those in crisis. FRC deals with suicide threats and other crises through outreach workers who understand the rural culture and are knowledgeable about community resources. Some people might just need someone to talk with at their kitchen table. Their presence can change the split second a person has made up her/his mind to commit suicide. FRC re-

fers people who need help to licensed counselors and physicians.

President Bush established the President's New Freedom Commission on Mental Health in April 2002 as part of a commitment to eliminate inequality of Americans with disabilities. He directed the commission to identify policies that could be implemented by local, state, and federal governments to maximize existing resources, improve coordination of treatment and services, and to promote successful community integration for adults and children with a serious mental illness.

President Bush identified the fragmented mental health service delivery system as one of the three obstacles which presents those with mental illness from getting quality care. The Commission in their Interim Report to the President declared the mental health system to be "fragmented and in disarray." The extent of unmet needs and barriers to care included the "lack of national priority for mental health and suicide prevention."

The goals of a transformed mental health system would include the following:

- Americans understand that mental health is essential to overall health

- mental health care is consumer and family driven
- disparities in mental health service are eliminated
- early mental health screening, assessment, and referral to services are common practice
- excellent mental health care is delivered
- research is accelerated
- technology is used to access mental health care and information.

These are the values that the FRC endorses and already implements

If much of the President's New Freedom Commission's sub-committee report is implemented, programs such as the FRC would be available when Americans need help. I now proudly serve on the Farm Resource Center's Board of Directors and will continue to work to see that FRC is able to continue to provide rural mental health outreach. I also encourage other consumers to get involved in building a strong mental health system.

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*RMH welcomes the comments of other consumers of the mental health system in terms of services and policy.*



Photos by Michael Hill

## Malawi AIDS Orphans: A System of Care Model

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by Michael Hill

### Introduction

Mai Kalindawala, who looked in her seventies, strained to stand as her visitors arrived. They were from the new group in the area, the Malawi Children's Village. Her mud home with a thatched roof now had many leaks during the raining season, but the framed, glassed windows spoke to prosperous days when her husband still lived ten years ago. In the past three years she had also lost her five adult children to AIDS—although none spoke of “the thin disease”. Their eleven children were now her responsibility. Too feeble to hoe and weed another garden alone, her young granddaughters would have to quit the government's free school to help her

plant and bring water. She knew the girls' futures would be hard without good English and math skills. Her guests from MCV, she had heard, had helped other families, but in the past others had failed in their offers of help. Another's promise cannot be held, even with both hands.

Any visitor to a village served by Malawi Children's Village (MCV), or any other area in Malawi, might have a similar experience to this one from 1998. This paper will describe the impact of the AIDS epidemic on children and communities in Africa, the southern African country of Malawi and specifically in the Mangochi area on the southern-most shore of Lake Malawi. This context of the pandemic's proportion is important in understand-

ing why a “system of care” model was selected for these families like Mai Kalindawala's. The effectiveness of this MCV model will be discussed and compared to another model, the community-based organization (CBO) that is widely practiced in Africa and often recommended by international aid agencies.

### The Nature of the Problem: the Crisis

Malawi Children's Village is located in the Mangochi District of the south central African nation of Malawi. The Malawi National AIDS Control Program has estimated that HIV prevalence is 30-50% in the 15-49 age group. Sub-Saharan Africa hosts 92%

of the world's AIDS orphans and 70% of all people infected by HIV. In Malawi about 36% of all children under the age of 15 are orphans, according to *Children on the Brink* (Hunter & Williamson, 1998). "A generation of children are being left behind to be raised by their grandparents" (UNAIDS/WHO, 2001).

A demographic survey of MCV's thirty-seven villages completed over the summer of 1997 identified 1,053 households with a population of over 27,000. In each village there was a grandparent like Mai Kalindawala raising more than ten children. There were 2,239 orphans (we now have 3,200), of whom 615 were considered to be in severe need. Within the 0–2 year-old range, there were 130 orphans. The impact of the AIDS epidemic is profound.

*"It used to be said that in Africa, there was no such thing as an orphan.... While many orphans in Africa are still taken in by their kin, an increasing number are slipping through this traditional safety net." (Children and AIDS: the Crisis, Firelight Foundation Web site)*

Psychosocially, the trauma these children experience has been compared to that of children living in war zones. They are denied the basic closeness of the family and its love and attention. There is the prospect of sexual exploitation and loss of their parent's property. Along with health problems, orphans can exhibit symptoms such as sadness, insomnia, nervousness, depression and grief. (Subbarao, K. et al, 2001).

Communities suffer, too, as the traditional safety net becomes a fine tread with little reserve elasticity. The headman has few or no resources within the village. Orphans can become outcasts and an exploitable group. The ability of the village to monitor these orphans and vulnerable children (OVC) is lost.

Women are especially vulnerable as they cannot use devices like condoms and contraceptives without the husband's agreement. Combined with greater biological risk of contracting HIV, 20 years from now we may see southern Africa depopulated of women, said Stephen Lewis, the UN envoy on AIDS in Africa (Wines, 2004).

In the light of these facts of the devastation that the AIDS epidemic is bringing to Africa, is there a place for hope?

### **The MCV Model: a System of Care**

MCV serves 37 villages including approximately 27,000 people and 3,200 orphans in a 100 sq. km. area. It began in 1995 when a group of former Peace Corps Volunteers and concerned Malawians came together to help by providing village-based assistance to families for the care of orphans. The premise remains that the Malawian traditional extended family, although overwhelmed and resource depleted, was culturally intact. Malawi Children's Village was formed through a collaboration of the District Traditional Authority, headmen from thirty-seven villages and a dedicated all-Malawian staff. MCV is funded through donations from individuals and by foundation grants for specific projects. Total donations that supported MCV in 1996 were about \$20,000. Now donations total over \$110,000. Grants equal about \$90,000.

With Malawi and Africa's scarce resources and the growing number of orphans and vulnerable children (OVC), many villages have organized into small

groups, or community-based organizations (CBOs) to address their needs. CBO are usually able to raise very little money, so they may limit their activities to services that use a volunteer's time only, such as psychosocial support, mentoring or child care for guardians. Material support for things such as school supplies and emergency food or medicine depends on the formation of income generating activities (IGAs) such as raising poultry/livestock, a community garden or hair grooming. Small government grants are hard to acquire and are often restricted politically. CBOs are, therefore, economically limited in scope, providing assistance to a few children and covering only their fundamental needs—rarely broad enough to meet the complex needs of OVC. CBOs' advantages are significant, however, in that they reflect community ownership, utilize community leaders, utilize local resources, and have low operational costs.

A system of care as seen in the MCV model differs in its focus upon comprehensive services and the size of its organizational base—37 villages.



This approach has several advantages including strengthening the capacity of many care-givers and leaders, developing a sense of the village's ownership of the problem, enlisting collective responsibility of many villages for comprehensive OVC care and reducing village's stigma about orphans. This "a rising tide raises all boats" approach uses the entire 37 villages as the *system of care*—the safety net—needed for OVC care. The disadvantage of the *system of care* approach is that its comprehensiveness is more expensive and can risk dependence on outside funding sources. MCV has been able to keep this cost per orphan low, under \$30.

MCV was born with the collaboration of former Peace Corps Volunteers in Malawi and Chakunja Sibale, a Malawian Senior Medical Clinician, who believed in a comprehensive approach

to the needs of OVC. Early planning for the project also systematically included involvement of the District Traditional Authority and his village headmen. A needs assessment included their input, a complete census/survey and village focus groups. The model that resulted was a strength-based concept using the traditional village system to care for OVC in all 37 villages. The comprehensive components of MCV's *system of care* approach derived from this process are:

1. *The use of volunteers.* Appointed by each of the 37 headmen, village coordinators receive a bicycle and a small monthly allowance to maintain their bike and uniform.
2. *Continuing leadership support and involvement* is accomplished with regular meetings, both jointly and separately, of headmen and village coordinators.

3. *All staff are Malawian* to insure cultural relevance and self-reliance.

4. *Services are village-based* through use of an outreach team, headed by a RN, that visits each village monthly. A village coordinator is always present to direct them to orphans most in need. The team provides medications, inoculations, food, nutritional supplements, clothes, blankets and transportation to the hospital for seriously ill children. Bicycles

are used to inform staff of urgent or emergency needs of orphans or guardians.

5. *Training to update knowledge* is provided several times each year to the village coordinators. Topics include child care, early recognition of medical problems, HIV/AIDS prevention, care of AIDS patients, nutrition and other health care topics.
6. A primary health clinic and a nutritional rehabilitation center *provide both basic and critical health care, in addition to outreach.* The clinic, held each weekday morning at the center, is free of charge. The nutritional center is available for approximately 16 malnourished infants and toddlers.
7. *Community-wide preventive health education* provides an emphasis on AIDS education by a health educator. Last year thirty-five trainings were given for more than 1,000 people. AIDS Toto Clubs (No More AIDS) were begun in 16 villages and 5 primary schools.
8. *Education is the best way for OVC to escape poverty and to build resiliency.* MCV encourages guardians to keep children in school, the center's library has 20-50 visitors a day and MCV provides secondary school fees. In return for this help, students give time to MCV during their school breaks—a practice that builds self-confidence and responsibility.
9. *Building self-reliance and sustainable incomes* is addressed with irrigation projects and a vocational Training Center that give villagers, especially women, greater independence by producing income beyond a subsistence living.

## Results

Here are some of the outcomes from MCV's system of care in its eight years of operation to over 1,000 households, including that of Mai Kalindawala:





- The average number of orphans per household has dropped from more than 6 to less than 2. Thus, a primary objective of the project – the distribution of the burden of orphan care – is being achieved.
- The MCV child death rate is lower than that in the District for all children, orphans and non-orphans.
- The clinic had 3,200 in 2003, up from 2,570 visits in 2002, treating the most common diseases: malaria, diarrhea, malnutrition, and respiratory problems.
- Food sustainability has begun for eight villages and over 50 individual farmers through large irrigation projects and the distribution of treadle pumps. Farmers can irrigate over five times as large an area, producing enough food for their family and OVC, plus an income from surplus crops that could mean sending their children in school (buying school clothes and paying tuitions), retaining their land and resisting exploitation.
- School attendance by MCV orphans is almost twice the attendance rate in the District. In addition, 66% of MCV orphans passed the national secondary school certificate exam (the national pass rate < 20%).
- One hundred secondary school students receive scholarships (only primary school is free), up from 55 in 2002. Two secondary school graduates are in college and two more in technical training programs. One in an irrigation program will be hired by MCV upon graduation, becoming a positive role model for other students.
- A library was opened over a year ago at our main site. The afternoon scene of fifty children checking out books is not uncommon.
- So far, over 400 individuals, many former Peace Corps Volunteers, have visited and volunteered at MCV. The impact of short-term volunteering can be dramatic: an after-school tutoring program for primary school students drew a class of 42 students (when 15 were expected!) with 81% passing their secondary school entrance exam.
- Attitudinal shifts occurred with villagers, caregivers and village coordinators. In a survey conducted by World Vision (Lopoukhine, S. et. al, 2001) caregivers reported that several attitudinal changes were noted: 1) orphans are no longer considered outcasts, but part of the village; 2) village coordinators reported that if MCV were to suddenly disappear, they would feel responsible for the orphans and continuation of their care (of our current village coordinators, 85% have been with MCV



since its beginning); 3) the village coordinators have independently formed a mutual aid committee to collect funds and support coordinators and their families in times of crisis; and 4) village headmen report that they feel their villages are connected by a sense of mutual responsibility to other villages—they do not remember this sense of cooperation prior to MCV's arrival.

- The annual cost per orphan for MCV's operation is under \$30. Although comprehensive programs such as MCV will never be able to generate enough income to fully self-sustaining, this cost is low compared many international charitable programs that report over \$250 per orphan per year.
- MCV's model has received wide recognition for its work through: designation as a Model Program by World Vision; acclaim for its comprehensiveness and effectiveness by Malawi's Minister of Women and Children; successful application of it's model in southern Tanzania with The Mango Tree Project, also serving about 3,000 OVC; and potential

adaptation in Zambia by The Special Minister to the President in his home district. There is still much to be done: expansion of skill training, the irrigation program and a bereavement peer counseling program, plus wider efforts to reach more of the 100,000 underserved orphans in Malawi alone. In the face of what devastation AIDS has wrought upon sub-Saharan Africa, it is easy to feel helpless; in fact, it is unrealistic to think that it will be possible to meet all orphans' needs. Both CBO and comprehensive System of Care models will be needed to support extended families as they help the increasing numbers of OVC.

Despite the bleak picture of AIDS in Africa, hope comes in witnessing the determination of Malawians and other Africans caring for their children one by one. At MCV, we are confident that our initial efforts have been timely and that this project is soundly designed and capable of adapting to meet needs as they emerge. In the future MCV will be used as a model for scaling up CBOs to meet the needs of Malawi and Africa's orphans.

*Mai Kalindawala had held out two hands to show respect that first day to receive two blankets. The MCV outreach team still came regularly, but their village volunteer, Mai Phiri, came very often to see what her grandchildren needed: medical care, proper clothes to return to school, or even 5kg. bags of maize during the "hunger season". It was not ever a lot, but none died. When others saw orphans being helped, they knew they could take in a child or two. MCV will help them. And the village's AIDS Toto Club has done some very funny plays on AIDS. Chief Chipoka laughs more—but laughing is the way of Malawians.*

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*Michael Hill is Director of Counseling and Community Services at Las Clinicas del Norte in El Rito, NM, and a NARMH Board member. As a MCV founder and its Board VP, he has often visited MCV. He was a Peace Corps Volunteer in Malawi (1964-66).*

## Articles for RMH

### Guidelines for submission for Model Programs and Research articles:

*Rural Mental Health* seeks manuscripts that contribute to improving services to rural communities. Manuscripts that describe the diverse nature of rural communities and mental health issues are encouraged.

### Model Programs:

Nature of the problem/population  
Description of the program  
Funding  
Evaluative information (as available)

### Research articles:

Nature of the problem/issue,  
Literature review, Methodology,  
Findings, Implications, Limitations  
and future research needs.

**Suggested length: 8-15 pages.**

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# How Much Does it Cost: A Study of Alcohol and Nicotine Dependence and Admission Rates in Long-term Care Facilities

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by John Husted, Ph.D., Kathy Konstant RNC., B.A., Wendy Husted, B.A.

It has now been forty years since the United States Surgeon General issued the first major report on smoking and health. Due to this report and public health warnings from the United States Center for Disease Control, cigarette smoking began to show a steady decline in the 1980's. Alcohol abuse, the other major cause of premature death in the United States, is also reported to be declining among the elderly for both health and financial reasons and because a significant portion of older alcoholics have already died (Hanson, Venturelli & Fleckenstein, 2004). One might ask then, what is the need for another study about drinking, smoking and long-term care? The answer to this legitimate question is that the cost in dollars and human resources directly attributable to smoking and abusive drinking continues to be so high that it is almost beyond calculation.

The impetus of this report comes from observations of the senior researcher, who practices clinical psychology in rural Western Minnesota. This practice includes many long-term care facilities. It has long been apparent that a high number of non-dementia individuals who were referred for mental health services seemed to be much younger than the average person living in the facility. From reading reports from the referring physician or social worker, it also appears that the individual referred was not only much younger, but often also addicted to nicotine or had some kind of alcohol abuse diagnosis in their medical charts.

With the assistance of two college-trained researchers, a study was developed and implemented to test whether these observations would be supported scientifically. The design also attempted to calculate the cost, in

Medicare dollars, of alcohol and smoking problems. Specifically, the study was designed to measure the average age of first admission for all individuals living in two rural long-term care facilities during the period from January 1, 2004 to January 15, 2004. This average age was then compared to the age of those living in the same two long-term care facilities over the same period of time who had a diagnosis of either alcohol abuse or nicotine addiction.

The first problem was to define alcohol and nicotine abuse in an objective manner to insure that the results of this study could be understood and replicated in other sites. To accomplish this, a categorization of alcoholism or alcohol abuse was confirmed only if it appeared in the patient's medical history as provided by the admitting physician. While it was obvious that this procedure would result in a conservative estimate of the actual number of individuals who may have been abusing alcohol, it was used because it met the criteria of objectivity. Nicotine addiction was categorized in the same way, with the additional provision that if the individual continued to smoke in one of the "smoking rooms" provided by either facility, it was also assumed that nicotine addiction was present.

Since the initial referrals from the health care professionals often involved mental health problems of an attitudinal or behavioral nature, the researchers also attempted to determine if a high percentage of these problems were in some way correlated to the group of nicotine and alcohol abusers. The senior researcher determined the presence of attitudinal or behavioral problems by asking either the social worker of the facility or one of the nurses about non-dementia patients who were physically aggressive, refused medications or meals, or

continued to make unrealistic demands on the long-term care staff. Two of these health care professionals at each facility were asked about attitudinal or behavior problem patients, and each had to independently identify the same individual for that person to be considered a behavioral problem.

A total of 112 medical charts were surveyed in the two facilities, 70 in one and 42 in the other. The average age of first admission from these charts was 83.1 years. Twelve of the 112 patients met the predetermined criteria for alcohol or nicotine abuse. Four of these were women. Nine were determined to be both alcohol and nicotine abusers. The average age of first admission of the 12 smokers and/or drinkers was determined to be 71.3 years. A statistical procedure (the t test) was then employed to determine the certainty with which the researchers could conclude that these two samples represented different populations. ( $t=4.52$ ,  $df>25$ , confidence level  $>p.001$ ). The statistic strongly suggested that the people from the smoking and drinking group tended to be admitted at a younger age.

The health care professionals working at the facilities identified a total of seven residents as having attitudinal or behavior problems. Of these, only two did not come from the alcohol and nicotine group. Although the sample size is too small for a formal statistical analysis, the fact that over 70% of the attitudinal or behavioral problem group was part of the alcohol and nicotine abuse group, which comprised only 10% of the overall population of 112 patients, certainly points to a connection between smoking, drinking and behavioral problems.

From the survey taken at both facilities, it can be concluded that individuals who either drink or smoke heav-

ily tend to be admitted to long-term care facilities at a much earlier age. The difference in average age of first admission was 11.8 years. The hypothetical percentage loss of non-institutional years over a lifetime was a little over 14% (11.8 divided by 83.1). The actual cost in health care dollars is harder to estimate. The average daily cost per patient of the two facilities was \$135.00 per day. If one multiplies this daily cost by the number of people identified as smokers and drinkers and by the 11.8 years average difference in age of first admission, the total estimated cost in health care dollars would be (\$135 x 12 people x 11.8 years x 365 days) \$6,977,340 that is incurred simply because of unhealthy habits. To illustrate how much cost this is to rural communities, the entire county budget is 4.1 million dollars for roads, social services and law enforcement. The cost of one year of health care in a long-term care facility for this group is \$591,300 or more than 14% of the entire county budget for one year.

In Minnesota, the cost of care is calculated based on the severity and types of medical problems represented by each person living in a long-term care facility. Certainly those with behavioral and attitudinal difficulties would require more dollars to treat effectively than would non-behavioral problem individuals. The human cost of treating these kinds of individuals in long-term care facilities, however, in energy, emotions, family difficulties and problems with roommates is extremely high. The emotional exhaustion they seem to generate in caregivers appears immense from the perspective of a mental health consultant. To say that helping such individuals adjust successfully to a long-term care setting is difficult is almost certainly an understatement.

The primary goals of this report are to increase awareness of the effect of poor lifestyle choices prior to first admission to a long-term care facility and how these personal choices cause

a huge drain on increasingly limited health care and human resources. The above data indicates that the cost of care for persons who are smokers or drinkers is vastly higher than for other persons. If an individual decides to continue to drink abusively or smoke at addictive levels in spite of at least 40 years of medical advice to the contrary, from a policy perspective it would seem fair to ask them to pay for their increased cost of care while they are still wage-earners through taxes on the products they abuse, at or near the rate of these projected medical costs. If people in the United States people have the freedom to engage in very abusive health habits, why should the rest of society that does not engage in these behaviors end up paying for most of another's problems that are so clearly preventable? The freedom to choose and to abuse themselves should not be paid for by people who choose healthier lifestyles. Paying for another's preventable health problems is becoming increasingly intolerable in a society whose capacity to provide essential care for all the elderly is becoming more and more limited.

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*The senior author would like to thank Roy Mayeda for his editorial help with this article.*





## The Problems of Relapse in Chronically Mentally Ill

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by John Husted, Ph. D.

### Introduction

In spite of the continuing development of effective antipsychotic medications, people with persistent psychiatric disabilities continue to be rehospitalized at an unacceptably high rate. Dharwadkar (1994) reported that about 50% of all individuals with a diagnosis of schizophrenia are rehospitalized every year. Masand, Daniel, and Harvey (2003), while favorably reviewing two of the newer antipsychotics, wrote in the same article that in one outcome study, 90% of individuals with first episode (schizophrenia) were rehospitalized and 80% of this group were hospitalized at least once more in the next five years. These authors suggested that functional deficits in occupational, social, and self care continue to afflict the recovering individual. These social skills deficits are not impacted by the new medication and play an important role in rehospitalization

What seems to be happening is that something other than the classical schizophrenic symptoms of fragmented thinking and auditory hallucinations are preventing recovery. Other factors, such as attitudes toward success and learned adaptive behaviors, not impacted by antipsychotics seem to be involved in relapse. It is becoming increasingly clear that for individuals diagnosed with schizophrenia to have a chance to recover from catastrophic mental illness, much more than advances in medicine need to take place. A fundamental new direction needs to be developed and implemented.

This paper addresses the issue of a new therapeutic approach. The focus is on personality factors, such as lack of confidence, passivity and pessimism, which so often accompany psychiatric disabilities rather than symptoms and their remission. This approach is based on the assumption

that lack of confidence is caused by the lack of opportunity to succeed in everyday living. Such lack of opportunity, which is a secondary characteristic in major psychiatric disability, is the primary cause in the 50% annual rehospitalization rate. The therapeutic approach to be described in this paper directly addresses this deficit.

Lack of success and resulting loss of confidence often result in people with psychiatric disabilities assuming that their disability is so limiting that they are unable to perceive themselves as capable of functioning independently. Their inability to perceive themselves as fully independent individuals is due to having had little or no successful experience in these areas. This paper will suggest that it is the perception of incapacity rather than the symptoms themselves which results in relapse. The paper will also present a new

*continued on page 14*

# The Changing Faces of Rural Mental Health



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Boulder, Colorado



system of psychotherapy designed for both the physician and therapist to gradually change this perception. The goal of this therapy is to change the recovering person's set of beliefs about themselves (identity) from a person beset with persistent problems to a person one who can solve them. This new approach is called "identity change therapy."

### **How Deficits in Social and Self Care Develop and Lead to Rehospitalization**

William Glasser, a psychiatrist and author, long ago warned that effective treatment was more complicated than adherence to a medical model of symptoms and solutions. In his 1971 book (*The Identity Society*), he argued for teaching each person with persistent psychiatric disability more effective coping skills and increased positive involvement with others. Glasser's focus on coping skills becomes even more crucial when persistent psychiatric disability is involved. Inheriting a genetic code that results in catastrophic psychiatric disability creates a whole cluster of significant and frightening symptoms. Often by the time these are recognized and treated with medication, damage to self esteem and loss of confidence have already occurred. In other words, developing this kind of psychiatric disability creates an outlook in which the possibility of affirming, confidence-producing experiences may have disappeared. People with psychiatric disabilities' beliefs about themselves are much more likely to involve concepts such as sick, passive, and unsuccessful. These people fail to make progress because they have insufficient prior experiences in independent living which they remember as successful. Depending on the age of onset of the first psychiatric illness, individuals may simply not have had the opportunity to develop effective coping skills. This lack of confidence and/or experience in effective adult living is in place regardless of how successful the antipsychotic medication is in reducing symptoms. This lack of

opportunity for success may help explain why individuals with early onset generally have a poorer prognosis for recovery (Husted, J. & Fick, K., 1997). People who are older before getting sick would have had more opportunity to develop coping skills and thus have more positive memories of successful independent living.

People who believe that they cannot cope effectively because of their psychiatric disability would view the process of recovery with ambivalence at best. Their assumptions and beliefs about themselves would be incompatible with success in independent living. Without adequate treatment they would not even be able to imagine what success would be like. People with psychiatric illnesses continue to identify with their symptoms because this explains who they are and what has happened to them. As they progress through conventional therapy toward believing that they are capable of coping, problem-solving and have the potential for success, resistance in the form of hesitation, anxiety, and self-defeating (in their view, self-protecting) behavior can tend to develop. This resistance can develop because the therapeutic journey toward competency in independent living simply does not define who they are.

### **The Specifics of Identity Change Therapy**

The goal of this therapy for the person with a persistent psychiatric disability to change self beliefs from one who is overwhelmed by problems into one who can overcome them. The following are suggestions to bring about this change. To carry out this approach, psychiatry need to accept the premise that no matter how modern and effective their medications are, medicine cannot change their patients' learning histories or beliefs about themselves. Psychiatry must then give up reliance on a medical (disease) model to include these concepts of learning, attitude, and identity. Such an understanding recognizes that elimination

of symptoms through medications does not result in permanent positive change. Psychiatrists need to de-emphasize symptoms and emphasize learning. Cognitive issues such as appropriate goal setting, positive behaviors, and volitional control need to be discussed. Psychiatry's starting point in any treatment model needs to emphasize this power of volition. Psychiatry is also by far in the best position to help clients differentiate between their inheritance of a genetic code that results in an illness in which clients choice is non-existent from their current personal choice over which individuals can exert genuine power.

For individual therapists, the concepts of empowerment and choice to change also need to be stressed using a skill building approach. More specifically, working together, client and therapist need to develop very simple, realistic treatment goals based on existing deficits in coping. These goals, developed from a functional assessment of that individual's independent living skills, would involve procedures to increase competence and confidence in cooking, cleaning, budgeting, social, and medication compliance areas. These deficits and resulting treatment goals would then need to be broken down to the simplest level at which learning is most easily accomplished. For example, hygiene might be getting up at 7 a.m., soap and warm water hand-washing, shower for two minutes, shampoo, towel off, etc. Social interaction might begin through role playing to focus on when to say "hello" and "good-bye." These basic coping behaviors would then be learned and over-learned to the point at which they would come automatically. Nothing more in therapy should be added until each stage is completed.

As each individual begins to feel more confident and begins to change the underlying belief system in the direction of one who can solve problems, resistance is likely to occur. These

self-defeating behaviors and negative attitudes usually go unrecognized by the client or can be reported as an onset of psychotic symptoms. When resistance does take place, the therapist should stop and address only the anxiety and ambivalence that take place when someone begins to change basic assumptions about them and about life. Such fundamental change in beliefs about the self (even in the context of beginning to master simple tasks) needs a strong trusting relationship with a therapist.

### **Toward the Development of a More Comprehensive Theory of Recovery**

As a new approach to therapy, identity change does help explain at least in part the dismal rate of rehospitalization of the persons with persistent psychiatric disability. Identity change attributes much of the high relapse rate to the loss in confidence caused by insufficient opportunities for success. The development of a belief system as one who is incapable of progress in independent living is forged through lack of opportunity for success and thus explains why late onset individuals generally do better since they have more time as an adult to experience success.

Identity Change therapy also explains in part another new finding: that of lower rates of rehospitalization in sparsely populated areas. Researchers at the University of Minnesota, Morris, located in rural Western Minnesota, consistently found a much lower rate of rehospitalization. When individuals participated in an in-home therapy, relapse rates were only 6 to 7%. This figure was consistent over a ten-year period. The control group, which received no therapy, still had a low rehospitalization rate of 20% (Husted, J. & Wentler, S., & Longhenry, D., and Allen, G., 2001). Since it was obvious that something more than therapy was suppressing relapse rates, the researchers explained the impact of the sparsely populated area by suggesting that relationships, roles, and resulting belief systems tend to be

very well defined in rural areas. In these communities, one belongs to a family, is someone's brother, sister, son, or daughter, works at a specific job at a specific location, and repeatedly encounters people, locations, and activities which reinforce this identity. This content provides a stable identity embedded in these relationships and patterns of daily living. This capacity to anchor visually and experientially who one is and where one lives seems to assist the individual in centering and focusing so that when relapses come, they are more easily recognized and effectively resisted. In other words, people who know where they belong and where help is tend to be more resistant to rehospitalization. It may also be that those once developed are less subject to the rapid changes and thus more durable than in urban settings.

Finally, new approaches to treatment are valuable not only if they explain existing data but also if they result in desired outcomes. For example, in the ten-year longitudinal study, the rate of rehospitalization was between six and seven percent each year when this new treatment strategy was employed. This is compared to the fifty-percent relapse rate that is usually reported. This approach identifies a pattern of attitudes and self-defeating behaviors that paradoxically seem to occur after most of the actual symptoms of the mental illness have become manageable. Identity Change Therapy explains this regression as being caused by a lack of confidence which has created an identity in individuals as one who copes by having symptoms. The relapse is caused not by the symptoms of the illness itself but because the illness precludes sufficient opportunity for successful living so that confidence cannot develop. The new therapy directly addresses this lack of confidence by asking psychiatrists to change from a medical to a medical-teaching model and by therapists to stress programs that over-learn very basic coping skills while at the same

time work through the client's resistance. By identifying the underlying cause of much of the 50% annual rehospitalization rate and addressing it directly as personal choice in learning new confidence building behaviors, Identity Change Therapy aims for success by addressing and changing each client's beliefs about themselves from one who has insolvable problems to one who can change them.

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*The 2004 Howery Award is presented to Gerald Mohatt by his brother, Dennis Mohatt.*

## What I Have Learned About Healing From Native People

*by Gerald V. Mohatt*

I want to begin with a story of resilience. This is the daughter and niece of a young woman that my wife and I were close to in Rosebud in the early 1970s. She was a tenacious, strong child who had suffered much. She left the reservation, struggled, was supported and helped by key individuals in and out of her family system, met a man who she married who nurtured her strengths and she became a strong, tenacious woman who has the highest expectations for her children and loves them and supports them without reservation or limits.

### Unnecessary suffering

- Causes: Poverty, social injustice
- Solutions: A focus on children and prevention.

I was so struck in Rosebud with how much of the suffering: suicide, homicide, and alcohol abuse, early mortality that caused so much suffering was and is unnecessary because it is prevent-

able. The roots of the problems are in social injustice, in poverty, in crowding and poor housing, in unemployment, and in institutional and individual racism and oppression. It was this type of oppression that allowed me to deal on a car to get a lower price but if a Native person tried the same tactics they were considered uppity and the salesman would refuse to deal and haggle. I strongly believe that Psychology and mental health professions need to refocus on prevention, on children's issues, on policy and advocacy, on parity for mental health as a right not a privilege, on access and availability rather than prescription privileges for psychologists and to foster a synergy that multiples services rather than a professionalism that limits and excludes.

For the majority of this talk I want to turn to lessons that I have learned from Lakota, Alaska Natives, and Canadian First Nations people over the past 40 years since my first contact with Native people. These lessons or principles are what guide my work and contrast with many of those that guide our

systems of care. I believe if we grapple with ideas that come from the people whose land this is and has been, who are the first people of this land we can serve them better. I also think that the knowledge we gain will help us see avenues for working with all people in a deeper and more respectful manner.

### The healing process

- Hutkan—the root of the problem

Rick Two Dogs, an Oglala healer taught me about Hutkan. The healer diagnoses in a ceremony, receiving his knowledge from his helpers who are of the other that we do not see—the spiritual world. His power comes from them not because he or she is blessed with brilliance but because of special and unique powers that he or she has inherited or been gifted with. When a person comes for help from the healer they receive a diagnosis that describes simply the root of the problem, i.e. the child has lost their spirit because of sexual abuse. The person is troubled because they were abandoned. Our system of the DSM-IV makes little

sense to the healer in its trying to describe an entity within the person without stating the root, the Hutkan. We have moved too far to description, to saying that the problem is the way we talk to ourselves or think about something or an unknown biological disharmony. We need to examine carefully and conceptualize what the root is, what goes deep inside of the person and family and social system.

### **A singleness of desire**

- “The power seldom came to the ceremony, only once in a great while and when it did anything could be healed. Too often too many people wanted too many things.” Joe Eagle Elk.
- To heal we must become developers of a community of concern in the person and the family—a singleness of desire.

The healing process is communal in nature because whether it is you and I sitting in an office, with a family, or working with a community, fragmentation and splitting exists if pathology is

there. This is our enemy, while consensus, focus, and singleness of desire is our friend in the healing process and our task to develop. When we talk about the development of a healing process that recognizes the root causes and the need to form a single focus on healing and resilience we must look backwards.

### **Okapha—The transgenerational nature of pathology and healing.**

- We need to look backwards to other generations for what was left undone.

*— I had an American Indian client that I worked with for four years. She had few stable relationships and her children and she were in crisis. Over time she discovered in her history that both Grandparents killed their spouses and then were ostracized from the community. It lives on for four generations. Each generation has a responsibility for healing it until it is gone and no one suffers from an unspeakable silence.*

This is a picture of Dennis, Dick, and my Grandpa and Grandma Mohatt. Our family had great suffering at times, loss to cancer, alcohol, car accidents, madness, not unlike many of us.

In seeking the ultimate cause the Lakota and Native Alaskans have told me that one must look beyond today to the history of many generations. The Lakota call this Okapha. Rick Two Dogs explained this word to me again.

For my client this family history of death and being pushed from the

community and how it was repeated in her family from generation to generation needed to be spoken, represented, and ritualized in our sessions and in her community. She had both our therapy and her indigenous rituals. In Native communities there were and are rituals that allow people to cleanse themselves and reconnect with others, the make of the Yup'ik, the Inipi of the plains tribes, the sacrifice of the Sun Dance. What are our rituals that allow for this healing of what families or societies can do, for how reconciliation becomes part of healing in our work?

### **The Healer**

- Know why we wish to heal.

To facilitate what I have been discussing a person needs an expert, an expert in human relationships and who has the power to be a tool with the client, family, and the community to heal. What does it take to become such a person?

One must ask themselves and continue to ask why am I doing this work. From where do my power, motivation, and desire come? Healing is long and arduous work, hard, hard work that demands the highest standards for training and continued education. As a healer told me:

- “Today people want to be medicine men just like it was instant coffee. This is not instant coffee.” Joe Eagle Elk

### **Wokigna—to comfort**

As healers we must comfort and leave the person with a sense of peace and safety.

The Lakota have taught me that when we meet the person with expertise that they are comforters, that when we are with them and when we leave that we always should feel comfort. Joe Eagle Elk, Rick Two Dogs, Richard Moves Camp, Rita Blumenstein were and are



this type of person. You are safe and respected.

### **One's sicun, the gift that is ours.**

□ "Everyone has something to give, is here for a purpose, and they need help to find that. Whether they are a drunk or in prison they have this gift. That's why the college is here." Stanley Red Bird

In comforting one must have a deep belief in the other person, know that they have a gift and a potential that the family was to nurture and that we, as a healer, are now in the place to nurture. When Stanley said this about us creating a college on the reservation he saw that healing goes beyond the person and is social in nature. Creating a new setting to provide opportunity and hope is as much about healing as psychotherapy.

### **Choice and therapeutic methods**

□ Never persuade or coerce, never violate human choice.

"This is wonderful to learn so much about my health. Everyone should be interested but then it is their choice." Alaska Native Elder

We are doing research on diabetes and obesity. The quote is after she had her blood drawn and much information given and her results given back to her. She wanted us to know how important choice was.

Too often in our work when we speak of involving stakeholders or of building a sense of control with and in clients the process involves persuasion, suggestion, disputation, and convincing. Much of this leads to interventions that manipulate and direct. For Native people in almost all contexts in which I have worked choice is paramount. Fostering options and alternatives, stimulating reflection and reflexivity, creating a mindfulness and awareness

of our impact on others and the world around us that Yup'ik speak of as El-langneq, should become a goal of our treatments or prevention programs.

### **Nothing is free.**

□ We must see healing as a circle. If you receive you return.  
□ We give. We thank. We give back. We spread out the healing so it is truly synergistic. It does not end.

I have spoken of healing as hard work. The Lakota speak of this process as full of risk and benefit. If we benefit then we must pay back, not with money but with a life change. If we don't then the healer bears it. We talk about self-care and that is critical for us as healers but we are bound together with our clients. Unfortunately, some are likely not to follow through. The Lakota have rituals that allow them to let go of the madness and illness of their clients that they have contained in their own bodies. We need our own rituals of therapy or of spiritual practice to balance ourselves that go beyond exercise but to letting go.

### **Humor**

□ We need to learn to make fun of ourselves.  
□ Every session has a joke or a pun or a little incongruity.

Usually, I joke more or maybe I have and didn't know it. I do sort of forget at times. I have been lucky to have brothers and friends who tease me unmercifully and let me do the same. With rural Native people and most rural people that I have lived with they love to tease and "put on" a person. Stanley Red Bird told me that I need only two things to live well: humor and strength of mind, perseverance and patience. In sessions I typically always have a pun or joke. Can't help it. It breaks the tension and is also an interpretation if used correctly, but most of the time they just come out. I

learned early from community work this lesson. I learned to speak Lakota, the western Sioux dialect. Well, I often gave talks at community meetings and for a long time I thought I was saying that I came to talk about the college and the college was there to help people. I mispronounced the words for help and they came out as I would like to chase your girls. Everyone laughed and no one told me what I had said so I would repeat it at another community meeting. I guess the people wanted to share the humor. Finally, I was told the truth and made the correction.

### **A sense of place—pictures of Alaska**

All of what I have discussed is related to place. We who are rural are bound to a place. Wendell Berry talks of knowing every blade of grass and hill or contour of his homeland. Fred George of Akiachak knows how to find his way on the tundra without a compass, just with the stars and the contour of the tundra grasses.

It is these places in Alaska and South Dakota and Ontario in which First Nations people have always welcomed my family and me. I say thank you to all of the people who are part of this. The list is too long to mention everyone but I will always be indebted to the Native people who have welcomed me to their homes and villages. I thank the National Association of Rural Mental Health for the Victor I. Howery award. I am greatly appreciated and accept it in honor of my family, friends, colleague, and the many Native people who have been my teachers and supporters.

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## Meet NARMHs New Board Members — Art McDonald and Ann Schumacher

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### **Art McDonald**

I was born and raised on the Pine Ridge reservation where I am an enrolled Tribal member. I grew up on a very isolated starvation cattle ranch that was RURAL! I joined the USMC during the Korean conflict and spent a little over two years overseas from 1953-1955. After I was discharged in 1956 I went back to the reservation but the best job offer I had was the G I Bill. I spent the next eight years in school, receiving my Doctorate in 1966. At that time I was only the second enrolled Indian to earn a Doctorate in Psychology. I took a job in Psychology at Montana State University and was the recipient of a NIMH Grant that attempted to train Reservation Mental Health Para-professionals. I did that for five years and decided to stay on the Reservation and see if I could survive. I have. During that time I have trained 17 pre-doctoral students here on the reservation, including former Board member Dan Sturgill and his wife, Tiffany. I have served as non-Clinical supervisor for a number of Doctoral level interns as well. The short version is that I have been frustrated throughout with the lack of understanding and commitment by all of the University departments to training for service delivery to the Rural communities. Students understand, but faculty don't (or can't, or don't want to).

All of the above has led me back to NARMH as the professional group or group of professional service providers that do understand and can provide leadership to the development of a meaningful academic program that will start producing service providers that are well trained and focused on real problems. My major hope for being on the Board is to gain knowledge and help from those that know and to recruit as much help as possible in teaching a new generation of Rural Mental Health Professionals.

*Editor's Note. Art McDonald received the Victor Howery Award in 2003 for his outstanding career contributions to Rural Mental Health.*



### **Ann Schumacher**

I am a Licensed Specialist Clinical Social Worker with over 13 years of experience in providing mental health services in a wide variety of settings in rural Kansas. I have worked with the culturally and economically diverse population of the agriculturally based rural and frontier communities of Western Kansas.

After growing up in Kansas City I have lived in rural Western Kansas for over 15 years. I received my bachelors in social work at Kansas State U. and my MSW at the U. of Denver. I live in Leoti, KS with my husband

Todd, and three children, Megan (12), Miranda (9), and Matthew (5). We are representatives of the declining rural population of Kansas. We are farmers and ranchers and live in a frontier region. I hope my children have the opportunity to make their living in agriculture and to appreciate the rural way of life. One of the overriding reasons young adults choose not to return to rural life is lack of services, including mental health services. I am aware that many people in rural areas find it difficult to access mental health services in a timely manner and am committed to helping find ways to bridge this gap.

As a Behavioral Health Provider in a medical clinic I have become passionate about the value of this model of service because people are more likely to use general medical services for their mental health needs. I truly believe that integrated behavioral health is an excellent model for providing quality care, increasing access to care, and improving the health of our people. I believe the mental health needs of the rural population are deserving and unique. NARMH is an incredible vehicle by which to be heard and to make a difference in rural communities.

As a NARMH board member, I will be both a voice and a listening ear to your ideas, interests, and concerns. I believe change is possible through working together with the NARMH board and its members to achieve its mission in "linking voices to promote rural mental health".



## “Conducting Culturally-Sensitive Practice in Research” A Case Example from Athabascan People in Rural Alaska

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by Marianne Rolland, M.S.W., PhD.  
and Valerie Stella, M.S.W.

Historically it has been a challenge to engage rural communities in meaningful research that contributes directly to the development of effective social service and mental health programs. Cultural sensitivity is an important ethical and clinical goal in the field of social work and mental health. It is especially important for non-Native practitioners who wish to collaborate effectively with Native people. The field of social work recognizes an ethical responsibility to implement culturally appropriate research, treatment, and program development (Green, 1982). All cross-cultural encounters can be viewed as potential learning experiences that may result in the discovery of new information or enhanced understanding that can serve to increase program effectiveness.

Systematic learning cross-culturally depends on the worker’s willingness to shift from being a worker-as-help-provider to assuming the role of worker-as-learner (Green 1982). This application applies to both the individual encounter, as well as to the larger picture where whole group or community-wide change is desired.

It has been recognized for close to a century now that the delivery of human services should be shaped to fit clients’ “cultural expectations” as opposed to the client having to adapt to the “culturally different” worker (Goldstein, 1981). Basic social worker values, such as respect for the individual, the commitment to see the world from the standpoint of the client, and a holistic understanding of “person-in-the-environment” are consistent with this perspective.

Awareness of one’s own values, assumptions, and behaviors is

necessary for developing the skills that facilitate empathic interaction and appreciation of culturally different others. It is also important to understand the larger cultural values that relate to the practitioner’s self-awareness. Many mental health professionals are influenced by Western values that emphasize competition, winning, and individual achievement. These values promote ranking and stratifying and do not encourage respect for uniqueness or contrasts. The values carry the meaning of “better than” and thus emphasize differences in levels of power within individuals.

Alaska Native and American Indian cultures present their own unique requirements for cross-cultural counseling, social work, and mental health activities (Dinges, et al, 1981). Until a practitioner develops understanding, sensitivity, and respect, working with Native clients will

be ineffective and unsatisfactory. Universal as well as tribal-specific values must be considered. Native people are influenced by their tribal heritage. The degree of identification with that heritage along a continuum of traditionalism is an equally important variable to understanding (Smith, 1977). One common element found among most tribal groups is a holistic view of the person (mind, body, spirit), and of the person in relation to nature. Other commonly held values relate to the concepts of non-interference, self-determination, sharing, patience, generosity, and circular time (Good Tracks, 1973). The notion that the concept of wealth should be founded in physical and spiritual well being, not material possession is another commonly shared value among tribal groups. The Athabaskan people of Alaska have a worldview in which achieving balance in life was always the goal; therefore, any course of action to correct a problem needs to combine a physical prescription with a spiritual one (Keating, 1989). Another important value for the Athabascans as well as other Native groups is the respect attributed to the elders. While describing some themes, it is always important not to over generalize from one nation to another.

James Green proposes a positive approach to social work in Native communities that has value for both practice and research. Such an approach must include the demonstration by the non-Native worker of patience and a willingness to do humble helping tasks until such time as the worker is accepted for “more intimate involvement in Native concerns” (Green, p. 24). The burden of proving one’s value to the Native community is placed on the worker and Native people should always be encouraged to become their own advocates and intervention agents (Green, 1982).

Research concerning the mental health and social status of American Indian and Alaska Native peoples is intended to delineate areas that need improvement or change, to assess the effectiveness of programs. For results to be meaningful, members of the Native community must be involved (Ryan, 1980). In the past, research in Native communities did not always consider the importance of values, customs, language, and other cultural attributes. Results were also not normally reported back to the community or tribe in a meaningful way and were, therefore, not useful to those individuals they were designed to help (Trimble, 1976).

## Important role of elders in research

In Native communities, elders can play a significant role in achieving the goal of initiating community-owned change. Understanding the traditional roles elders played in tribal society and awareness of the value and respect they carry today provides a source of insight and understanding to social work and other mental health practitioners seeking specific wisdom to guide their practice (Rolland & Stella, 2004). Elders have vast knowledge that can help focus on strengthening and revitalizing the spirituality within Alaska Native peoples (Keating, 1989). They can also assist researchers in conducting meaningful research.

Approaching and consulting elders is one way for social workers and other mental health professionals to gain insight into the worldview of a Native cultural group, to acquire the necessary knowledge and cultural understanding to comprehend and address specific problems. This article describes ways to use ethnographic interviewing methods to explore directions for culturally grounded, culturally acceptable and culturally “owned” research as a basis for the future design of new interventions in Native communities. In this article, the topic was the very sensitive issue of sexual abuse as described in Rolland & Stella, (2004) but such a methodology could be used to study other issues as well.

So much of what a cultural group knows is woven unconsciously into the language, the traditions, and the way “thing are done” that it is often difficult for members of that group to realize how much knowledge they have and to explain it to others. It is also sometimes difficult for people to realize how useful, even essential, the knowledge they have is for the development of community programs (Bopp & Bopp, 1985). Finding ways to elicit this knowledge is important in research and practice.





*Lena Charly with beaded mittens photo by Marianne Rolland*

In times past in tribal communities, consulting elders was the natural and automatic response to challenging situations. “We didn’t have chiefs in our communities.” The oldest of the elders were called spokespersons. The spokesperson was responsible for decisions made for the clan. He/she negotiated with other clans when it came to problem solving and insured those that followed after his/her death understood stories, knowledge and right action correctly. Parents sent their children to elders to receive a general education of the stories and history of their people (W. Porter, Yakutat Tlingit Tribe, personal communication, March 2002).

Historical events have led to drastic lifestyle changes among all Alaska Native tribes that have altered the role of the Elder. While elders are still consulted to varying degrees in many communities, their traditional and modern roles may look vastly different. Despite these transitional roles, the value attributed to elders remains intact. Diversity exists in the way elders are treated by tribal members and not all elderly people are acknowledged for being carriers

of wisdom on the basis of age. Among many tribes, age is only one factor figured into the equation when considering who is an elder. “Age itself does not determine whether or not you are an elder within the tribal structure. A very young person who has been schooled in traditional lifestyle could be recognized” (TR. Borbridge, Sitka Tribe of Alaska, personal communication 2000).

Building effective and meaningful communication with elders requires visiting them in their own homes. Generally elders prefer this form of visiting as opposed to attending formal meetings. Sitting down for tea or in a story-telling circle poses an excellent opportunity to listen to the stories and wisdom all elders have to offer. In conducting the study regarding sexual abuse described in Rolland & Stella (2004), the researchers spent numerous hours in the homes of elders doing this prior to approaching them for consent to participate in a formal interview session. In considering the time involved, it is important to understand

that one of the authors had extensive experience working with members of these communities and thus entered this process with a level of trust and acceptance by some of the elder informants.

One can best characterize such a study as a participatory research design in which the role of “researcher” and “subject” do not exist in the traditional research sense of these terms. The researcher may in fact be a member of the group being studied. All participants collaborate with one another on equal terms, as a team, to share what they know toward the development of acceptable solutions to mutually recognized problems. The methods used are rooted in the oral tradition of the Athabascan people. Interviews with community elders use ethnographic rather than traditional structured or semi-structured data collection measures.

In this study, the goal of the research in the data collection was to first identify and then to extensively interview Athabascan elders about child sexual abuse from their own cultural perspective. The challenge was to create a situation that was comfortable for the elders and which would facilitate open discussion and learning.



*Yupik Elder*

*photo by Sandy Kleven*

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Athabascan Elder, Fred Ewan  
photo by Marianne Rolland

From an ethnographic perspective, in order to accomplish this, interviewers must first admit to limited knowledge about the lives of the persons whose backgrounds are culturally, racially, and ethnically radically different from their own (Leigh, 1994). The elders are the experts on their lives and life experiences, and the researchers become the student (Green, 1982).

Ethnographic interviews might best be thought of as a series of friendly conversations into which the researcher slowly introduces new elements by posing a host of carefully timed questions. Two complementary but distinct processes occur during the interview—developing rapport and eliciting information (Spradley, 1979). The person being interviewed becomes an “informant.” Some experts in the field of social work have referred to this person who possess special knowledge and is willing to share information specific to his or her children, as the “cultural guide.”

Drawing upon the wisdom of the elders through such an ethnographic approach enabled the researchers to obtain valuable information about child sexual abuse and ways to address it. Enlisting elders as cultural experts can be a valuable part of effective research within Native Alaskan communities.

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Mt. Sanford in the Wrangell Range

photo by Marianne Rolland

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