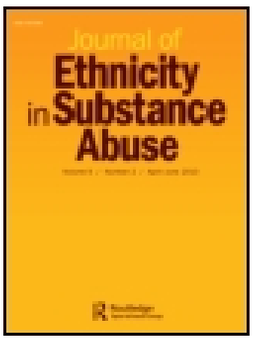

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Perceptions of alcohol misuse among Alaska native health care system stakeholders: A qualitative exploration

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ABSTRACT

Although alcohol misuse is a priority for health care systems serving Alaska Native and American Indian (ANAI) people, stakeholders' perceptions of misuse are understudied. Patients ($n = 34$), providers ($n = 20$), and leaders ($n = 16$) at a Tribally owned and operated health care system reported that alcohol misuse results from the interaction of factors, including colonization, structural factors, social alienation, social norms about overdrinking introduced at the time of colonizing contact, coping with emotions, and beliefs about ANAI people and alcohol. Childhood exposure to alcohol misuse leads some ANAI people to avoid alcohol altogether, shedding light on the high levels of abstinence observed in ANAI communities.

KEYWORDS

Alaska Native; American Indian; qualitative; alcohol misuse

Introduction

Alcohol misuse and its associated harms have been a long-standing challenge for Alaska Native and American Indian (ANAI) communities (Frank, Moore, & Ames, 2000). A recent analysis of Indian Health Service (IHS) and National Death Index data found a rate of alcohol-attributable death 3.3 times higher in ANAI people compared with the U.S. White population; the Alaska region had the highest ANAI rate and the highest ANAI female rate nationally (Landen, Roeber, Naimi, Nielsen, & Sewell, 2014). Also of note, though less emphasized in the literature, are higher rates of total abstinence from alcohol among ANAI people (Cunningham, Solomon, & Muramoto, 2016). Preventing alcohol misuse and treating alcohol use disorders (AUD) remains a high priority for many Tribal communities and for IHS.

Views of alcohol misuse and AUD among ANAI people

Despite a substantial literature describing the burden of AUD in ANAI communities, few studies have examined health care system stakeholders'

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views about alcohol misuse, which are important to consider in determining effective AUD treatment options. Studies on community perceptions of ANAI alcohol misuse have focused broadly on American Indian (AI) communities in the contiguous United States; few have focused on urban settings (Dixon et al., 2007; McDonell et al., 2016; Tonigan, Martinez-Papponi, Hagler, Greenfield, & Venner, 2013). In two large multi-site studies, AI participants living on or near reservations described physical, economic, intergenerational, social, and psychological reasons for misuse (Radin et al., 2015; Yuan, Duran, Walters, Pearson, & Evans-Campbell, 2014). In both studies, participants shared that emotional regulation; lack of financial and educational opportunities; youth exposure and easy access to alcohol; traumatic experiences including child abuse and neglect, historical loss, and reinforcement of negative stereotypes; and peer pressure and parental role modeling contributed to alcohol misuse in their communities. Among urban AI participants in Minneapolis, Spicer (1997, 2001) also found that boredom and lack of economic opportunity were related to alcohol misuse. Yuan et al. (2014) conducted a survey examining the associations of alcohol misuse and childhood maltreatment with out-of-home placement among 294 urban lesbian, gay, and bisexual AIAN adults in which 60% of males and 70% or more of females who used alcohol reported childhood physical abuse, neglect, and emotional abuse. Cultural disconnectedness has been identified as a contributor to alcohol misuse in urban-dwelling AI people in Minneapolis (Spicer, 2001) and in two large urban communities in California (Brown, Dickerson, & D'Amico, 2016). In a quantitative study of 452 parents/caregivers of youth regarding risk and resiliency factors for alcohol abuse, respondents shared that a loss of culture and perceived discrimination contributed to misuse (Whitbeck, Chen, Hoyt, & Adams, 2004). No published studies regarding the perceptions of alcohol misuse from the perspective of ANAI health care providers or leaders were located.

Present study

This exploratory study was carried out in an Alaska Native– (AN–) owned and operated health care system with the intent of informing treatment services for patients struggling with alcohol misuse and alcohol use disorders (AUD). This study was conducted to inform development of a survey of stakeholders' explanatory models of alcohol misuse, with the ultimate aim of identifying opportunities to improve AUD treatment (Buus, Johannessen, & Stage, 2012; Kleinman, 1988; Kleinman, Eisenberg, & Good, 1978). Our primary research question was how stakeholders in an

AN–owned and operated health system understand alcohol misuse and AUD among ANAI people.

Methods

Setting and participants

This study was conducted at Southcentral Foundation (SCF), an AN–owned and operated nonprofit health care organization serving 65,000 ANAI people living in Anchorage, Alaska; the Matanuska-Susitna Valley; and 55 rural villages representing 229 federally recognized Tribes. Health care finance and services for ANAI people in Alaska are organized differently from those in the contiguous United States, with IHS playing a less substantial role in many regions of the state (Rhoades & Rhoades, 2014). Southcentral Foundation is funded by a combination of IHS and third-party payers (i.e., private insurance, Medicaid/Medicare). It is a prepaid health care system in which beneficiaries (enrolled members of federally recognized Tribes) can receive health care services regardless of insurance status. In addition to primary care and some specialty services, SCF provides a variety of alcohol-related services and programs (Gottlieb, 2013). Reducing rates of substance misuse and dependence is an organizational priority.

Seventy Tribal health care system stakeholders participated in this study: 34 patients, 20 providers, and 16 leaders. Detailed descriptions of participant demographics are provided in Tables 1–3; all patient and Tribal leader participants self-identified as ANAI. Patients were recruited by research staff at a table in the SCF Anchorage Native Primary Care Center and through flyers posted in clinic waiting rooms and lobbies. We recruited patients with self-reported history of alcohol misuse and/or related treatment; patients self-reporting behavioral health conditions and/or treatment; patients who reported both alcohol misuse/treatment and behavioral health conditions/treatment; and patients who reported neither. We included patients without alcohol misuse/treatment or behavioral health conditions/treatment on the hypotheses that (a) in light of rates of AUD in the service population, they are likely affected by AUD through experiences with friends or family members, and (b) their attitudes affect patients who are struggling with alcohol. Seventy-six percent of patient participants reported that alcohol misuse has been a concern for them personally, and 62% reported having received some form of alcohol misuse treatment, including self-help groups. Alcohol misuse had been a concern with regard to family or friends for 94% of patients in this study. Among participating patients, 68% reported that behavioral health issues have been an issue for them

Table 1. Patient Demographics.

Gender	*n*	%
Female	23	67.7
Male	11	32.3
Age	*n*	%
$\leq$ 40 years	13	38.2
$>$ 40 years	21	61.7
Race/ethnicity	*n*	%
ANAI	21	61.8
ANAI in combination with another race	13	38.2
Non-Hispanic/Latino	34	100
Type of community participant grew up in	*n*	%
Rural	19	55.9
Urban	10	29.4
Both	5	14.7
Local option (alcohol) laws in community spent most time in while growing up	*n*	%
No alcohol sales allowed but possession and importation allowed	2	6.7
No alcohol sales, importation, or possession of alcohol allowed	7	23.3
Alcohol sales in state-licensed restaurants or package stores only	8	26.7
No limits on alcohol sales, importation, or possession	10	33.3
Don't know	1	3.3
Grew up in communities with multiple types of local options laws	2	6.7
Years living in Anchorage	Range	Average
	<1–47	17.9

personally, and 62% responded affirmatively to the question "Have you ever received treatment of any kind for a behavioral health issue?"

For the provider sample, we recruited medical service providers, behavioral health providers, and substance use treatment providers through employee e-mail. For the leader sample, we recruited clinical and administrative leaders with management responsibilities in clinic operation through employee e-mail. Tribal leaders, who included executives and board members of SCF and its sister and parent organizations, as well as those holding leadership positions in the seven Cook Inlet Tribes, were recruited at a regional Tribal leadership meeting.

Procedures

Considering the problematic history of research about ANAI alcohol use and persistent racial stereotypes about ANAI people and alcohol (Coyhis & White, 2002; Foulks, 1989; Gonzalez & Skewes, 2016), we were especially careful to ensure that this research met appropriate ethical and community standards. The study was approved by the Alaska Area Institutional Review Board and the local Tribal authority for health research. All participants provided oral informed consent.

Data were collected in March 2014 through August 2015. Individual interviews were performed with patients to protect their privacy and minimize discomfort in sharing personal stories and with Tribal leaders because focus groups were infeasible. Interviews lasted approximately one hour. We conducted separate, two-hour focus groups with providers and clinical and

Table 2. Provider Demographics.

Gender	*n*	%
Female	14	70.0
Male	6	30.0
Age	*n*	%
$\leq$ 40 years	4	20.0
$>$ 40 years	16	80.0
Race/ethnicity	*n*	%
ANAI	3	15.0
ANAI in combination with another race	2	10.0
Asian	1	5.0
Black	1	5.0
White	13	65.0
Non-Hispanic/Latino	20	100
Provider type	*n*	%
Behavioral health	5	25.0
Medical	9	45.0
Substance abuse	6	30.0
Years employed in health care system	Range	Average
	2.5–23	7.8

Table 3. Leader Demographics.

Gender	*n*	%
Female	11	68.7
Male	5	31.3
Age	*n*	%
$\leq$ 40 years	8	50
$>$ 40 years	8	50
Race/ethnicity	*n*	%
ANAI	7	43.8
ANAI in combination with another race	3	18.8
Black	2	12.4
White	4	25
Hispanic/Latino	2	12.5
Non-Hispanic/Latino	14	87.5
Type of leader	*n*	%
Administrative leader	8	50
Clinical leader	4	25
Tribal leader	4	25
Health care system employee	*n*	%
Yes	13	81.3
No	3	18.7
Years employed in health care system	Range	Average
	4–25	9

administrative leaders. Interviews and focus groups were recorded and transcribed, with personal identifiers redacted. Participants completed a demographic survey and received a $50 gift card to a local retailer.

Using Kleinman's explanatory models as a conceptual framework, we designed semistructured interview and focus group guides to elicit stakeholder views of the causes, courses, and effective treatment of alcohol misuse (Kleinman, 1988; Kleinman et al., 1978). Sample questions included "Why do you think people drink alcohol?" and "How is alcohol use different in villages compared with larger communities, like Anchorage?" The semistructured patient interview guide was pilot tested with two ANAI staff members.

Analytic approach

We completed a descriptive thematic analysis of the data to identify stakeholders' beliefs and attitudes about key factors associated with alcohol misuse (Sandelowski, 2000; Sandelowski & Barroso, 2003). We uploaded the patient interview transcripts into ATLAS.ti 7, a software program that facilitates qualitative data management and analysis. The two research team members who conducted the interview reviewed the transcripts and drafted an initial codebook comprising deductive codes derived from the guides and inductive codes derived from the data. The codebook was reviewed by all authors and revised by consensus.

Each interviewer coded half of the transcripts, and every fifth transcript was coded by both researchers to ensure consistency. Disagreements and potential codebook changes were discussed in regular meetings and resolved by consensus. Transcripts were then recoded as needed (Rolfe, 2006). We ran a query to compile all the text that had been coded in the parent categories "risk" and "misuse." The first author reviewed the report and drafted preliminary results and notes for discussion with the full team. The focus group data were manually coded by two clinician team members using the codebook that was developed. Their analyses were reviewed and discussed by the full team, with disagreements resolved by consensus.

Results

Our analysis identified nine main themes, which are summarized in Table 4. Patients seldom ascribed alcohol misuse to a single cause, or even a single category of causes; rather, they considered AUD to arise from a complex web of historical, cultural, social, psychological, and biological causes. Similarly, clinical and Tribal leaders consistently described AUD etiology as multifactorial, with the contributions of different factors being interrelated and interdependent. For example, one ANAI clinical leader described the interplay between acculturative stress and social norms in the initiation of this individual's own alcohol use:

> I was just thinking back to my own personal experiences with alcohol as a teenager, and just the culture change that I had experienced in my own life—we moved to a new place, completely different people, and [we were] kids trying to fit in, and I'm pretty sure that's when I first had alcohol, was trying to fit into a social group, you know? In a new place. In my watching my own father drink alcohol growing up, to me, that was perfectly acceptable behavior. And so I think that … what you've been exposed to in your own home, what you've been exposed to in your social group of friends, what's acceptable, I think that's sort of what initiates it, and then where it goes from there, I think can definitely be, continue to be determined by your peer group or whatever. But I think there's definitely a—there could be a genetic component as well to that, to where there are people that can't moderate that at all.

Table 4. Summary of Themes.

Theme	Description
Defining alcohol misuse	Physical, cognitive, and behavioral signs and symptoms; long-term social consequences (e.g., job loss, relationship problems)
Colonialism's toxic legacy	Historical trauma; lasting harm to family and community structures through forced relocation and boarding school, policies against ANAI cultural practices and language use, loss of ANAI traditional knowledge, and the introduction of alcohol by Russian and American trappers/traders
Structural factors	Economic hardship, lack of stability, transportation challenges, and lack of employment; local option laws concerning alcohol availability; lack of sober spaces and activities
Social alienation	Feeling/perceiving a lack of belonging and connection with other people
Social norms concerning alcohol use	High prevalence of alcohol misuse and early childhood exposure; shaped by mass media and stereotypes; no culture of "knowing how to drink" in ANAI community; binge drinking associated with paydays; Alaska (not only Native) motif of "work hard, play hard"
Familial patterns of alcohol use	Intergenerational patterns of alcohol misuse; some individuals with family history of misuse/AUD purposefully avoid alcohol altogether
Coping with emotions	Desire to modulate painful emotions/experiences, often due to past trauma; can start as episodic and spiral into a continuing pattern; "self-medicating" PTSD or mood disorders
Beliefs about alcohol and ANAI people	ANAI people are uniquely vulnerable to AUD due to lack of "knowing how to drink," biology (including genetics)
Moral judgments about alcohol misuse	Individuals who misuse alcohol do so by choice (view expressed by minority of patients only)

We observed a general tendency for ANAI participants to withhold judgment about others' alcohol-related behaviors and to refrain from generalizing beliefs about alcohol misuse. They tended to frame potentially critical comments with disclaimers such as "in my opinion" or "that's just my experience." For example, one patient said,

> I'm clueless as to why other people drink … . I'm not gonna fixate on something that I don't do, and it's not my place to judge other people who do it. … [J]ust because I stopped drinking, that doesn't give me the right to judge other people who consume alcohol. That doesn't give me the right to police other people who consume alcohol. You know, if I stop drinking, then that's something that I did. It's not anybody else's business. It's not anything I have to toot my horn about. I don't view me not drinking as me having a major accomplishment. And I don't view it as me having the right to police other people.

In what follows, we further characterize the study participants and describe the themes alluded to in the preceding quotations. Words displayed in quotation marks or pulled text represent participants' verbatim comments.

Theme 1: Defining alcohol misuse

All stakeholder groups were familiar with the impact of alcohol misuse and had seen its consequences in the ANAI community. They considered AUD to be a serious issue that requires health system attention and investment. When asked to define alcohol misuse, patients often described physical, cognitive, and behavioral signs of intoxication: slurring, memory problems, stumbling, emotional lability, impaired judgment, and verbal or physical aggression were all mentioned, as were cravings, blackouts, and delirium tremens. Some patients considered alcohol misuse problematic when it has longer-term consequences, including social and economic difficulties (e.g., relationship problems, losing a job, having trouble in school) or legal problems (e.g., being charged with driving under the influence, losing custody of children). Patients distinguished drinking "a little bit but all day" from binge drinking; both were seen as misuse.

Providers' definitions of alcohol misuse tended to focus on behavior and impairment. They considered negative social and functional impacts of drinking behaviors on the individual's life and the potential for such consequences to become more severe over time. For example, a behavioral health provider said:

> Any time drinking creates a problem, regardless of what it is, you're misusing it. And so it starts with little problems. It might be relationship problems. It might be a DUI. It might be spending the rent money, and then saying, "No, I'm not gonna do that anymore." But then I think it really leads into dishonesty and legal problems and losing your kids and losing your job … .

Tribal leaders likewise defined alcohol misuse more broadly. Asked to describe what misuse looks like, one said, "Well, homeless, out of work, dysfunctional—probably stressful—family lives, whether it causes the stress itself or there is stress that causes the drinking. Now, I guess that's the age-old question: how does one get to that point?"

Theme 2: Colonialism's toxic legacy

The continuing harms of colonialism in relation to alcohol misuse were brought up most strongly among patients and Tribal leaders, who spoke in much more personal terms. Participants related alcohol misuse in ANAI communities to historical trauma and the lasting effects of colonialism, such as harm to family and community structures through forced relocation and boarding school, policies against ANAI cultural practices and language use, loss of ANAI traditional knowledge, and the introduction of alcohol.

Patients and Tribal leaders explained that the deleterious effects of these practices extend far beyond the direct harms that were done to ANAI

people at the time of early Russian and American contact. These harms have been internalized, taking the form of a "generational curse" handed down within families and communities, a vicious "cycle that isn't broken. It just continues." This quotation from a patient captures several relevant subthemes:

> Loss of culture [is a cause of alcohol misuse]. During the so-called colonization period … the first thing that was done was to dismantle the culture completely by taking the language away, taking the values away, name calling like "heathens," taking ceremonies away, taking self-worth away, and putting in also these other factions. A lot of the people were devastated. Another thing that was used was disease, [where we lost] anywhere from 75 to 95 percent of our people. And so that left just a very few of our people, many of who were then put in institutions like sanitariums, were gathered up and sent to boarding school. And so when you lose your family nucleus and you're being bombarded by another culture to the point of breaking, breaking you to remake you in their image, it created tremendous trauma. And then this happened for generations, so you have generational trauma, and so you have often times a lot of dysfunction in a family, and it's things that have been passed down, and things that have recurred that have not been a positive or good in your culture. So it's—I think it's all of these factors, and pretty soon it becomes just a way of life.

Patients and Tribal leaders described challenges to cultural identity as a predisposing factor not only for alcohol misuse but also for gambling addictions, depression, and interpersonal and family difficulties. Patients described feeling self-doubt or being questioned by others about their cultural identity as a profoundly painful experience. For example, one patient said,

> Cultural identity … is real important. People want to know who they are, and people wanna be able to say, "This is who I am, and this is what I stand for, and this is why." And when people can't answer those questions for themselves, that's when they start looking for answers in other places … . I think whichever cultural values are important to you, being able to define them and knowing why you define them, and being able to look at others in your life who have the same one or have demonstrated the same kind of finding the values, and knowing who they are and standing on those things—I think that makes a difference, because you don't then need to go looking for a party where you can fit in and drink … . And feeling bad about the things that you are not. I think cultural identity helps you feel good about the things that you are.

Patients spoke of the deleterious effects on families of moving away from subsistence-based living and ANAI culture, including loss of traditional cultural values; secure self-identity as an ANAI person; culturally specific coping mechanisms; culturally grounded pathways to self-esteem and respect in the community; and deep, personal connections to the land and the natural world. Patients who were raised "living off the land," often in more rural communities, reported that the transition to urban living threatens

the values and activities inherent in subsistence lifeways and makes some ANAI people more vulnerable to alcohol misuse.

Participants in all stakeholder groups emphasized that alcohol was not historically a feature of ANAI lifeways and that learning how to use alcohol safely was not part of ANAI culture. For example, one patient said,

> I think in Alaska general, the Alaska Native peoples—alcohol is fairly new. I'd say within the last 150 years or so .... I think that's one of the effects of alcohol being devastating to our people, 'cause it's, I think it's fairly new. I know other cultures, they've—I'm sure they've had alcohol consumption for hundreds of centuries.

Some participants expressed the view that the Russian and American traders and trappers who introduced alcohol to ANAI communities in the 18th century also introduced social norms of overdrinking and acting out while under its influence. One Tribal leader stated:

> I think for Alaska Native people, if you go back and look at history ... . some of the things that our people went through at the hands of different people I think add to that. Again, the examples we saw weren't people sitting daintily at the table with a glass of wine. The examples we saw were the first [non-ANAI] people coming into Alaska, within our borders, probably being the excess, and utilizing what power they had over our people in that, and the trauma that our people went through because of that.

Theme 3: Structural factors

Stakeholders in all groups emphasized the role of structural factors in the use of alcohol. Compared with other stakeholders, patients spoke at a more detailed level about the lived experience of specific challenges they and people they knew had faced. They also had more to say about differences in how alcohol is used in rural versus urban settings. Providers and leaders tended to speak of structural challenges in population-level terms, emphasizing the role of policy and social services. Patients reported that structural factors such as economic hardship, lack of stable or adequate housing, transportation challenges, and lack of employment not only trigger alcohol misuse but also pose barriers to treatment and recovery. One provider observed, "Certainly [alcohol is] far more available than jobs in most of the villages that we work in."

Other structural factors included local alcohol policies and the degree to which regulations concerning alcohol possession, underage drinking, and public intoxication are enforced. Stakeholders in all groups perceived that "dry" or "damp" rural communities, in which alcohol is banned but brought in illegally, often have higher rates of binge drinking compared with communities that allow alcohol sales. For example, one patient said,

> It seems like in the villages—'specially dry ones—people tend to overindulge, and there's—I've talked about it before to people, and many think, "Oh, it's because you can't bring it in. You have to quickly have it and get rid of it." And it kinda becomes a culture, it seems like, of—that's the norm. Like you just drink it 'til it's all gone.

Other stakeholders believed that alcohol misuse is more common in the city, where money is the only barrier to access. Among patients, we heard a perception that an individual who has had too much to drink may be safer in a rural setting, where people know each other, than in the city, where they may be more vulnerable to abuse or violence. At the same time, some patients said this very feeling of safety could contribute to overdrinking in rural communities.

In rural communities, some patients reported, "boredom" and a lack of sober entertainment—"no movie theaters, no bowling alley, no big shopping centers"—contribute to alcohol misuse. Stakeholders perceived a particular risk for young people. One patient said:

> I do think that village life—because there are fewer options, especially for kids. You know, there's sports, but—basketball. But if you're not into basketball, that's a very lonely existence for a village kid, you know? I can see why they would seek out a way to belong, like alcohol and parties. It's not like Anchorage, where you can be in YMCA, Boys and Girls Club, or you can go to the parks, or—there are just more options here for good choices.

Theme 4: Social alienation

Patients reported that social alienation—feeling a lack of belonging and connection with other people—was a primary contributor to alcohol misuse. As one patient expressed it, "Maybe [people who misuse alcohol] feel that they don't have anything to be sober for." Patients pointed to loneliness, relationship difficulties, not feeling cared for, past trauma, and lack of regular, positive interactions with others—whether through family ties, volunteering, church involvement, or employment—as increasing the likelihood of alcohol misuse. Participants also noted that these challenges seldom occur alone, but tend to cluster in ways that multiply their effects. They also noted the effects of long winters: "There are people that get really depressed during the winter. The solitude, being stuck at home all the time. You know, the sun being out four hours a day. Not getting out so much."

Theme 5: Social norms concerning alcohol use

Participants reported that social norms play an important, reinforcing role in alcohol misuse. As with other themes, participants and Tribal

leaders spoke in detail of lived experiences and family stories while providers and clinical and administrative leaders tended to speak in broad terms. One clinical leader put it this way: "I think that if, if the norm for your social group—whether that's family, village, state, wherever it might be—is excessive use of alcohol, then that's what you know. That's what you experience. That … is normal to you." One provider was struck by a culture of drinking on a return to the rural community where the provider grew up: "When I went back to visit, it was—it's so common to drink. I was back there for social events. Everybody drank, and people didn't question whether you were underage or not." Another provider noted the role of mass media in creating social norms around alcohol use, saying, "I think a lot of it has to do with what you see on TV—you get into an accident, what do you do? You turn to a bottle. You have a problem with your girlfriend? You turn to a bottle, or you go out and get drunk."

Among patients and providers, we heard a perception that alcohol misuse is an Alaskan problem, not unique or limited to ANAI people. One provider commented, "[I]t's not just the Native population. In my short time—I've only lived in Alaska two and a half years, but I lived globally and also throughout the United States. So it's shocking to me—it's … everybody. Alaska kind of has that rough-and-tumble sort of aspect, and there are lots of people, I think, that initially gravitated here as an escape [from more restrictive social norms]."

In contrast with what they perceived as the dominant culture's norms, knowledge, and skills governing the use of alcohol, participants in all groups perceived that "knowing how to drink" and "knowing when to stop" are uncommon—though not completely absent—in the ANAI community. For example, one Tribal leader said, "I do think that for some non-Native populations, you know, they could have a glass of wine at every meal or at dinner meal and it's not a big deal, and there's a culture around that." One patient participant told a story of her father introducing her and her siblings to alcohol as children, on the rationale that "[S]ince we're Indian, we needed to know how to drink, and needed to know how to take care of ourselves. That meant nobody was gonna take advantage of us if we were drunk or whatever, because we'd be able to know beforehand what was going on and how to stop it."

Participants in all stakeholder groups discerned a correlation between paydays and binge drinking. One provider commented, "When there is a flush of money, there's a flush of use." Participants reported that overdrinking can be correlated with dividends from the Permanent Fund or Alaska Native corporations or the receipt of income derived from

employment in seasonal, predominantly male industries such as commercial fishing, mining, and oil drilling.[1] One patient said,

> Like say you're in my hometown and you're a fisherman. And you're out fishing on the ocean for a two-week period of time. And during those whole two weeks, you're not drinking. You're chucking fish. But once you get into port, there's bars and there's a liquor store. I grew up in a fishing town … . I saw them play hard. I saw them—these are rough and tough fishermen. And they make money and they spend it.

Gatherings with family and friends, and particularly those associated with holidays and village funerals, were mentioned as a time when binge drinking is more likely to occur.

Patients reported that, in their experience, early childhood exposure to alcohol misuse is not uncommon in ANAI communities and can shape lifelong attitudes and behaviors around alcohol. Participants in all groups reported that peer pressure and the desire to fit in can influence drinking behavior among children and adolescents. As one patient said,

> When you're growing up, lots of times your peers will put pressure on you about it. "Here, have one, celebrate with me. It's my birthday." "Here, have one. It's your birthday." "Here, have one." Some kids are smart. Just say no. But a lot of times, the peer pressure's too much.

Theme 6: Familial patterns of alcohol use

Participants in all groups reported that familial patterns of alcohol use shape ANAI people's views and behaviors. Some patients described this as an intergenerational problem, with parents modeling the behaviors they learned from their parents, who often learned from their parents before them:

> I think you learn to see the world differently because you only know … from an alcohol viewpoint. From the alcohol family. You don't know how other families run because—or, how they run without alcohol—because you were never taught that …. Also, when it comes time to have their own family, [youth] don't know that there's another way … .

Providers also identified family patterns as a potential contributor to AUD, with young people at risk because of "growing up around it. Not just with parents, but grandparents."

[1]The Permanent Fund, established in 1976 by a state constitution amendment, is owned by the State of Alaska and comprises income-producing investments derived from mineral royalties. A portion of the Fund's investment earnings is distributed annually to Alaska residents. The Alaska Native Claims Settlement Act (ANSCA) of 1971 led to the establishment of 13 regional corporations and 198 village corporations owned by AN people through shares of corporate stock. Not all AN people are shareholders. Shareholders receive dividends, often in quarterly intervals, in varying amounts.

For some young people, alcohol misuse was both a family norm and a way to escape the negative effects of family members' alcohol misuse, as exemplified in this quotation from a patient: "My parents were drunkards, and they'd fight every weekend, until the next day. In the Saturday afternoons, I'd drink and, yeah, forget about the fights." Patients noted that although some who have been exposed to adults' overdrinking as young people fall into the same habits, others, wishing to avoid the consequences they have witnessed or wanting to spare their own families that experience, purposefully decide to avoid alcohol altogether. One shared this story:

> I think after my daughter had passed away, that's when I thought I couldn't take it. Yeah. It was just—she died overdose of alcohol. She had a liver failure or kidney failure. And yeah. It—I didn't wanna see that. For me, the wakeup call was my daughter telling me, "Mom, you don't need to drink anymore. You're gonna go down."

Theme 7: Coping with emotions

Across all stakeholder groups, the desire to modulate painful emotions, memories, and thoughts was seen as a primary driver of alcohol misuse. We heard a common understanding across the groups that alcohol misuse might begin in a time of unusual stress or challenge—for example, after the death of a relative—and spiral out of control from there.

Using alcohol to "get rid of problems" or "avoid discomfort" was a common theme among patients, as exemplified in the following:

> Why I went too far was because I did not want to think, I didn't wanna feel anything. It was all too much for me. It hurt so much. These thoughts of inadequacy. These thoughts of, "I'm not doing all the things I'm supposed to be doing. I'm not good enough. I'm ugly. I am this. I am that." And they were all negative stuff. They were all bad.

A personal history of childhood trauma—neglect, violence, physical or sexual abuse—was frequently mentioned by patients as a cause of alcohol misuse later in life. For example, one patient shared the following:

> I experienced sexual abuse very early, possibly starting from two years old. And then the physical abuse, I—I witnessed—I was a witness to my dad beating up my mom in front of me. Verbal abuse. I think mental abuse. So. And then keeping all that inside over many years' period of time made it really easy for me to see alcohol as an escape. And the first alcoholic drink I had, that's how I felt. I—for the first time, I felt—for the first time in my life, I felt free from fear.

Some patients who reported childhood trauma said that the original injury had been compounded by the failure of trusted adults to protect them or to seek redress on their behalf; some suggested that betrayal increased their vulnerability to alcohol misuse. Patients often described a

vicious cycle, in which one uses alcohol to escape problems, finds that it makes things worse, and drinks more in an attempt to escape their difficulties.

Across all stakeholder groups, mental health issues were cited as a reason some people misuse alcohol. In addition to posttraumatic stress disorder (PTSD), patient participants mentioned mood disorders as conditions that may lead individuals to "self-medicate" with alcohol. A substance abuse treatment provider described the use of alcohol for this purpose as well: "How do you cope with the depression, the anxiety, the dysphoria that go along with the problems that you're living? And then, the question comes up for some people, 'Why not drink?'" Another substance abuse treatment provider commented that a lack of mental health services to diagnose co-occurring disorders could cause patients to self-medicate with alcohol. In keeping with this observation, providers noted that identification and treatment of underlying depression or other mental health disorders was often an essential component of assisting patients with AUD.

Theme 8: Beliefs about biology, alcohol, and ANAI people

The belief that ANAI people are physiologically more vulnerable to alcohol misuse than non-Native people came up in all stakeholder groups. Distinct from comments about the prevalence of alcohol misuse in ANAI communities, this theme was grounded in the notion that ANAI people are inherently, and uniquely, "at risk" for alcohol misuse, either as part of their AIAN heritage or because of individual differences that may make some individuals more vulnerable to alcohol. Participants in all groups advanced biological, and sometimes genetic, explanations for why this might be so. For example:

> I think physically, there might be some science behind how our bodies actually can process alcohol, I don't know—I think that's part of it. (Tribal leader)

> Some people are—I think they're genetically alcoholics, and they could get addicted really easily 'cause of their genetics. (patient)

> I'd just wanna know … if they would compare Alaska Native DNA or genetics to a different culture's population, since it's—I know that with Alaska Natives, there's a lot of alcohol problems. And … with other races, there's not as much, or not—they're just—I just wanna know if there's a difference. (patient)

The idea that some people are predisposed to AUD and cannot use alcohol in a nonproblematic way also arose in the patient interviews, as in this example:

> Say it's been five years since my last drink. And I think, "Oh, well, I can—now I can drink like a normal person." Mm-mmm [*negative*]. One drink, and it's done. The

> deal is already sealed. The mathematical equation is already written out. It's done. No matter how much I try to control it … . I don't think that even if you've been clean for 20 years, you're—you take that drink, and it's not gonna stop. And then you're gonna—it picks up right where it left off.

Theme 9: Moral judgments about alcohol misuse

This theme came up only in the patient interviews. A small minority of patients attributed alcohol misuse to a lack of self-control, responsibility, or self-knowledge, which was viewed as especially risky for people who may be vulnerable to alcohol misuse because of family history or life circumstances. Patients who held this view used the language of priorities, choices, not wanting to take responsibility, selfishness, and "not wanting [sobriety] enough" to describe what they perceived to be the reasons individuals misuse alcohol. These participants often expressed anger, and sometimes contempt, toward those who, in their view, choose to misuse alcohol:

> I get really angry … I live in a day-to-day society where I'm not in treatment or any of that. I live in a day to day. I live in a normal society. And you know, it's not the alcohol that's causing an alcoholic to drink. It's the alcohol consumer that's making the decision to consume the alcohol … . I walk by liquor stores every day. I see drinkers every day. But that doesn't change the fact that I'm not going to drink. You know? There's nothing the alcohol is doing to make me drink. And I think that's the same way with alcoholics. The alcoholic himself or herself is—there's a point where it's like, dude, that's your choice … . It's like, taken out in that realm where the alcohol is pulling them into alcohol. [expletive deleted] That's not happening. At some point, they're making the choice.

Discussion

The question of why people misuse alcohol was central to our inquiry. Stakeholders in this study articulated a complex web of contributors to alcohol misuse among ANAI people, in which the interaction of different factors—for example, cultural dislocation and historical trauma combined with economic hardship, childhood abuse, biological factors, and social norms around alcohol consumption—shapes the way a person uses alcohol and his or her risk of developing AUD. This finding suggests that multilevel interventions may be more appropriate for ANAI people seeking to overcome AUD.

Across groups, there was agreement about the kinds of factors that contribute to alcohol-related difficulties, with some differences in emphasis by stakeholder group. Participants, and particularly patients, identified social alienation as both a cause and an effect of alcohol misuse. They emphasized the importance of connectedness and purpose: feeling that you matter

to other people, you have a place in the world, and others care about you and rely on you. The sociocentric worldview expressed by patient participants, in which personhood and individual well-being are shaped by and within the context of community, is shared by many Indigenous cultures; it is markedly different from the individual-focused, pharmacology-heavy paradigm that underpins most of Western medicine and much AUD research and treatment (Goodkind, Gorman, Hess, Parker, & Hough, 2015). Expanding on the phenomenon of "having something to be sober for," and the factors that protect urban-dwelling ANAI individuals from AUD (including those who use alcohol), will be the subject of our next analysis of these data.

Participants in this study pointed to the legacy of colonization of ANAI peoples and lands as contributing to the development of AUD, both at the individual level and within the ANAI community. Although prior research has described this association, and several theorists have made a strong case for the causal role of historical trauma in AUD (Brave Heart, 2003; Brave Heart, Chase, Elkins, & Altschul, 2011; Ehlers, Gizer, Gilder, Ellingson, & Yehuda, 2013; Enoch & Albaugh, 2017), few prior studies have asked whether or how patients and other health care system stakeholders perceive this link. Our finding that loss of cultural practices and identity challenges could predispose a person to misuse alcohol is consistent with a recent study that found that one element of ethnic identity—affirmation, belonging, and commitment—may have protective effects against alcohol consequences for ANAI college students (Skewes & Blume, 2015). Emerson and colleagues found that PTSD is significantly associated with AUD in both ANAI people and non-Hispanic Whites; their data also suggest that the AUD burden borne by ANAI people with a lifetime history of PTSD is greater than among non-Hispanic Whites with similar trauma exposure (Emerson, Moore, & Caetano, 2017). Prior research suggests that individuals' attempts to self-medicate mood symptoms (noted as a cause of alcohol misuse by our participants) can increase the risk of developing AUD and increase its persistence (Crum, La Flair, et al., 2013; Crum, Mojtabai, et al., 2013; Lazareck et al., 2012); available evidence suggests that concurrent treatment of mood disorders and substance use disorders is optimal (Turner, Mota, Bolton, & Sareen, 2018). Taken together with our findings, these results suggest that interventions that are culturally grounded and trauma-informed may hold greater potential for success for ANAI people with AUD. Our study also lends support to prevention and treatment programs for ANAI people that include cultural revitalization strategies (e.g., traditional values, language, art, subsistence food activity) (for example, see Herman-Stahl, Spencer, & Duncan, 2003; Rasmus,

Charles, & Mohatt, 2014), as well as treatment approaches that make use of community reinforcement and peer support.

The view of AUD as a moral failure was expressed only by patient participants, and very few of them. Although providers and leaders articulated the harmful effects of alcohol misuse on people other than the individual misusing, they did not attribute alcohol misuse to insufficient willpower, selfishness, or lack of caring for others. It is possible that these stakeholders held such views but did not voice them, but the overall tenor of their comments is inconsistent with the idea that alcohol misuse and AUD are essentially volitional. Those who articulated the moral failure view still drew a distinction between judgment and intervention, in keeping with ANAI norms of self-determination and noninterference with others' choices and activities (Good Tracks, 1973; Wark, Neckoway, & Brownlee, 2019). In many Indigenous cultures, respect is a central value: judging others' behavior is considered rude and inappropriate (Brant, 1990). Participants emphasized the causal role of colonial abuses, which strike directly at autonomy and respect, in escalating AUD risk for ANAI people. Our findings support prior research suggesting that treatment approaches built around behavioral judgments, comparisons, or unsolicited advice, as well as those with a heavily didactic tone, may be counterproductive for ANAI people (Brant, 1990; King et al., 2009).

Very few participants seemed to be aware that rates of abstinence are higher among ANAI people than in the general United States population. The belief that ANAI people are at increased risk for AUD was prevalent across all stakeholder groups; participants attributed causality to sociocultural and historical factors as well as biological factors. However, recent surveillance data challenge stereotypes of ANAI people's alcohol use. A 2016 study using data from the National Survey on Drug Use and Health and the national Behavioral Risk Factor Surveillance Study (BRFSS), for example, found lower or comparable rates of alcohol misuse among ANAI respondents compared with Whites (Cunningham et al., 2016). In the 2015 Alaska BRFSS, 19.8% of AN adults reported binge drinking in the past 30 days, compared with 16.3% of all U.S. adults; and 11.6% of AN adolescents reported binge drinking in that period, compared with 17.7% of all U.S. adolescents (Alaska Department of Health & Social Services, 2016). This information should be included in outreach and education efforts aimed at AUD prevention.

The connection between beliefs about ANAI vulnerability to AUD, the creation and maintenance of both descriptive drinking norms (perceptions of peer drinking behavior) and injunctive drinking norms (perceptions about acceptability of drinking behavior), and the persistent stigma regarding AUD among ANAI people demands careful attention (Foster,

Neighbors, & Krieger, 2015; Lewis et al., 2010). The fact that recent surveillance data challenge the common claim that alcohol use is more common among ANAI people, and demonstrate a higher-than-average level of abstinence among ANAI people, may be an important counter-message to convey within the health care system and an effective step toward addressing stigma (Livingston, Milne, Fang, & Amari, 2012; McGinty, Goldman, Pescosolido, & Barry, 2015). Public health messaging may also be able to leverage the understanding, commonly held among stakeholders in this study, that norms of overdrinking and alcohol-related violence use are a product of colonization and not part of traditional ANAI lifeways, to support culturally grounded strategies for avoiding alcohol misuse (Beauvais, 1998). In addition, it should be noted that rates of alcohol use and misuse are relatively high in Alaska as a whole: the state ranks 10th nationally in prevalence of binge drinking among adults and fifth in intensity (Centers for Disease Control & Prevention, 2016). These rates cannot be attributed solely to ANAI people, who account for 22% of the state's population (U.S. Census, 2017).

Across groups, participants proposed biological explanations for ANAI peoples' struggles with alcohol. We were especially struck by assertions that genetic differences underlie ANAI alcohol misuse and AUD, particularly in view of participants' clear articulation of other important sociohistorical causes. These assertions speak to a mismatch between persisting cultural beliefs and genetic research. Family studies across different populations confirm that genetic factors contribute to AUD susceptibility (Deak, Miller, & Gizer, 2019), but a study in eight contiguous AI reservations found that AUD heritability was either the same or lower than that reported in other populations (Deak et al., 2019; Wilhelmsen & Ehlers, 2005). Molecular studies indicate that the genetic contribution to AUD occurs through the cumulative effect of many gene variants of small effect, although gene–environment interactions make definitive studies challenging (Deak et al., 2019; Duncan, Pollastri, & Smoller, 2014). Multiple efforts to identify gene variants that could account for a greater susceptibility to AUD in Tribal communities have been unsuccessful (Ehlers & Gizer, 2013). In short, while genetic factors appear to contribute in all populations to individual susceptibility to AUD, they do so through gene–environment interactions that are likely complex, and there is no evidence of greater susceptibility to AUD in ANAI populations.

Participants reported that alcohol misuse among ANAI people in Alaska increases during the winter, citing shorter days, boredom, and less social interaction as potential causes. Although some evidence suggests that untreated depression may play a causal role in the development of AUD and increase both persistence and risk of relapse (Sher, 2004), our search

of the literature did not yield any studies specific to the possible role of untreated seasonal affective disorder (SAD) in AUD among ANAI people dwelling in the circumpolar region. Further biomedical research could elucidate whether SAD is a contributing factor.

In contrast with the findings of People Awakening (Allen, Mohatt, Beehler, & Rowe, 2014)), a large qualitative study of alcohol use and sobriety among AN people in rural southwest Alaska, our participants said that healthy drinking is less likely, and perhaps impossible, for most ANAI people. The bimodal distribution our participants described among people who had been exposed to alcohol misuse as children—i.e., that they tended either to replicate those patterns in their adult lives or to avoid alcohol altogether—is consistent with People Awakening's findings and gives important context to epidemiological results that show higher rates of both AUD and abstinence among ANAI people (Hensel, Haakenson, & Mohatt, 2003; Mohatt et al., 2004).

This study has certain limitations, beginning with the fact that study participants opted into the research. Their views may not be representative of all stakeholders in the SCF health system, much less of ANAI people overall, especially given the broad service area SCF covers; the diversity of cultural and other experiences, beliefs, and values found in these communities; and the variations in alcohol misuse patterns that have been previously reported in ANAI communities (Cunningham et al., 2016; Young & Joe, 2009). Sixty-nine percent of participants were women; the views of men may differ and be incompletely represented in this inquiry. Although conducting the patient interviews in English could potentially have excluded some participants, most ANAI people in the Anchorage area are fluent in English. Finally, because this study was carried out by and within the Tribal health care system, this sample may not represent those who are not accessing health care services.

To better characterize stakeholders' explanatory models and assess their distribution, we are using these results to adapt Broadus and Evans's (Broadus & Evans, 2015) Public Attitudes about Addiction Survey for use across a wider sample of SCF stakeholders. This survey will incorporate views about sobriety and will, we hope, provide results that can guide the design and prioritization of alcohol prevention and treatment services for ANAI people in Alaska, as well as provide a standardized instrument to help other Tribal health organizations optimize their AUD prevention and treatment programs.

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