Inuit Concepts of Mental Health and Illness: An Ethnographic Study

Laurence J. Kirmayer, M.D., FRCPC

Christopher Fletcher, B.E.S.

Ellen Corin, Ph.D.

Lucy Boothroyd, M.Sc.

Culture & Mental Health Research Unit,
Institute of Community & Family Psychiatry,
Sir Mortimer B. Davis—Jewish General Hospital,
4333 Chemin de la Côte Ste-Catherine,
Montréal, Québec H3T 1E4
514-340-8210/FAX 514-340-7503

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Division of Social & Transcultural Psychiatry,
Department of Psychiatry, McGill University

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Laurence J. Kirmayer
Christopher Fletcher
Ellen Corin
Lucy Boothroyd

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Inuit Concepts of Mental Health and Illness

SUMMARY

The concepts of mental health and illness of the Inuit of Nunavik (Northern Québec) were studied through ethnographic interviews, participant observation and a questionnaire survey. The aim was to document Inuit knowledge and practices in order to inform mental health workers and planners working in Nunavik of the range of different perspectives and identified needs. The research involved the participation of the community in the selection of survey sites and the identification of appropriate problems for study. Three communities differing in their existing resources and average level of acculturation were studied.

Three types of research interview were conducted, corresponding to distinct parts of the project: (1) problem identification interviews with Inuit health care and community workers identified the range of problems in the community and the usual terminology used to describe them, resulting in a list of specific registers of potentially problematic behavior; (2) problem register interviews with key informants from the community identified the perceived prevalence of problems in the community and the typical signs and symptoms associated with each type of behavior or problem; (3) case history interviews with key informants reconstructed detailed accounts of cases with which they were personally familiar.

Major findings of the study include:

- There is no general term for mental health or illness in Inuktitut. When pressed, informants either used an English term ('mental health problem') or offered two terms with different connotations: *Isumaluttuq* and *Isumaqanngituq*. *Isumaluttuq* implies thinking too much while *Isumaqanngituq* means 'having no mind' or not thinking at all.

- According to informants, the most prevalent mental health problems were alcohol and drug abuse, family violence and abuse, and suicidal behavior.

- Most people were not very familiar with mental health problems. Although many had heard of demon possession, only a small number of cases were actually described.

- Although some people who completed suicide were described as withdrawn, isolated, depressed, having heavy thoughts, low self-esteem or hating themselves prior to their suicide, in many cases their suicide came as a complete surprise even to close friends and relatives.

- Inuit recognized four broad types of causes of mental health problems: (1) physical and environmental; (2) psychological or emotional; (3) demon or spirit possession; and, (4) culture change and social disadvantage. In many cases, multiple causes were offered for the same problem.

- The presence of hallucinations or bizarre behavior prompted people to think of mental illness or demon possession.

- Violence, drug abuse and suicide were all commonly attributed to abuse and neglect in childhood or to ongoing family violence.

- Inuit tended to label behaviors or states of mind rather than individuals. This left open the possibility that someone who had an affliction or troublesome behavior could change and improve.

- People tended to be very tolerant of others' unusual behavior. This may improve the integration and prognosis for people with psychiatric disorders. It may also, however, delay the recognition of depression, psychosis and suicidality.

- Talking with others was widely recognized as a good way to prevent and/or resolve mental health problems.

- Religious exorcism was viewed as an appropriate treatment in cases of demon possession by people who believed this was a cause of unusual behavior or illness.

From the interviews and survey, a model of indigenous concepts of and attitudes toward mental health and illness was developed. An Inuktitut/English lexicon of mental health related terms was also prepared. The model and lexicon can be used in future research on the prevalence, causes and consequences of specific social and psychiatric problems.

The research also has more immediate implications for the design and delivery of mental health care among the Inuit, including community education programs to improve the recognition, treatment and rehabilitation of people with major psychiatric disorders and community and professional interventions for people facing life crises.

Concepts de santé et de maladie mentales chez les Innuits

RÉSUMÉ

Les concepts de santé mentale et de maladie chez les Inuits de Nunavik (au nord du Québec) ont été étudiés à l'aide d'entrevues ethnographiques, d'observation par des participants et d'une enquête par questionnaire. La recherche impliquait la participation de la communauté dans la sélection des sites de l'enquête et dans l'identification de problèmes appropriés pour l'étude. Trois communautés se distinguant par leurs ressources et leur niveau d'acculturation ont été étudiées.

Trois types d'entrevues ont été faits, correspondant à des sections distinctes du projet: (1) des entrevues d'identification de problèmes auprès d'Inuits, préposés aux soins de santé et individus travaillant pour la communauté, ont identifié l'étendue des problèmes dans la communauté et la terminologie habituelle employée pour décrire ceux-ci. Il en a résulté des registres spécifiques de comportements problématiques; (2) des entrevues d'enregistrement de problèmes auprès d'informateurs-clés provenant de la communauté ont identifié la perception par rapport à la prévalence des problèmes dans la communauté et les signes typiques associés à chacun des comportements ou problèmes; (3) des entrevues d'histoire de cas auprès d'informateurs-clés ont permis de recréer les récits détaillés avec lesquels ils étaient familiers.

Les résultats principaux de cette étude incluent:

- Il n'y a pas de terme général afin de décrire la santé ou la maladie mentale en Inuktitut. Forcés, les informateurs utilisent soit un terme anglophone ('*mental health problem'*) soit deux termes ayant des connotations différentes: *Isumaluttuq* et *Isumaqanngituq*. *Isumaluttuq* implique le fait de trop penser tandis que *Isumaqanngituq* voulait dire 'having no mind ' ou le fait de ne pas penser du tout.

- Selon les informateurs, les problèmes de santé mentale les plus fréquents étaient l'abus d'alcool et de drogues, la violence familiale, une famille abusive et les comportements suicidaires.

- La plupart des gens n'étaient pas familiers avec les problèmes de santé mentale. Bien que plusieurs aient entendu parlé de possession démoniaque, seul un petit nombre de cas a été décrit.

- Malgré le fait que certaines personnes s'étant suicidées étaient décrites comme retirées, isolées, dépressives ainsi qu'ayant des idées lourdes, une estime de soi basse et haïssant leur propre personne et ce, juste avant leur suicide, dans plusieurs cas leur suicide était tout à fait inattendu même pour les amis-es proches ou la famille.

- Les Inuits reconnaissent 4 grands types de causes des problèmes de santé mentale: (1) les causes physiques et environnementales; (2) les causes psychologiques et émotionnelles; (3) le fait d'être possédé par un démon ou

par un esprit; (4) les changements d'ordre culturel et les désavantages sociaux. Dans de nombreux cas, de multiple causes étaient offertes pour le même problème.

- La présence d'hallucinations ou de comportements bizarres étaient associés à la maladie mentale ou à la possession démoniaque.

- La violence, l'abus de drogues et le suicide étaient tous fréquemment attribués au fait d'avoir été victime d'abus et de négligence étant enfant ou à de la violence familiale perpétuelle.

- Les Inuits avaient tendance à étiqueter les comportements ou les états mentaux plutôt que les individus. Ceci rendait possible le fait qu'un individu atteint d'une maladie ou d'un trouble de comportement puisse changer et s'améliorer.

- Les gens avaient tendance à être très tolérants face aux comportements inhabituels des autres. Ceci pourrait bien améliorer l'intégration et le pronostique des individus atteints de troubles psychiatriques. Par contre, ceci pourrait également retarder l'identification des problèmes de dépression, de psychoses et de tendances suicidaires.

- La fait de parler avec les autres était largement reconnu comme un bon moyen afin de prévenir et/ou de résoudre les problèmes de santé mentale.

- L'exorcisme religieux était perçu comme un traitement approprié dans le cas où les gens possédés par le démon étaient des gens qui croyaient que ceci était une cause possible du comportement inhabituel ou de la maladie.

A l'aide des entrevues et de l'enquête, nous avons développé un modèle de concepts indigènes d'attitudes envers la santé et la maladie mentale. Un lexique inuktitut/anglais de termes reliés à la santé mentale a également été préparé. Ce modèle ainsi que ce lexique pourra être utilisé dans des recherches ultérieures sur la prévalence, les causes et les conséquences de problèmes sociaux et psychiatriques spécifiques.

Cette recherche possède également des conséquences immédiates sur la façon de développer et d'administrer les soins de santé mentale à la population Inuite, incluant des programmes communautaires d'éducation ayant pour but d'améliorer l'identification, le traitement et la réhabilitation des individus atteints de troubles psychiatriques majeurs ainsi que des interventions auprès de la communauté et des professionnels afin d'aider les gens faisant face à des crises au cours de leur vie.

1. INTRODUCTION

This report concerns an ethnographic and experimental study of Inuit concepts of mental health and illness and attitudes toward those afflicted with mental illness. Fieldwork was conducted in three communities of Nunavik from 1991 to 1993. The research reported here is part of a larger program concerning the expression, course and outcome of psychiatric disorders, emotional distress and social problems among the Inuit of Northern Quebec. Since little is known at present about the mental health needs and attitudes of these communities, the overall program has three consecutive phases:

(1) ethnographic and attitudinal research to identify the concepts of mental health and illness in the community;

(2) epidemiological research, using measures for the types of problems identified in phase 1, to determine the prevalence and social correlates of (a) major psychiatric disorders, (b) milder forms of emotional distress and (c) social problems;

(3) development and assessment of intervention programs, i.e. evaluation research of the effectiveness of social and psychiatric programs developed to promote mental health and the rehabilitation and integration of people with mental illness.

Each of these phases of research builds on its predecessor. The design and evaluation of intervention programs depends on accurate knowledge of existing problems. Meaningful epidemiology depends on knowledge of the ways in which symptoms and syndromes vary within the population.

The present report concerns only the first phase of the research program. The specific goals of this project were threefold:

(1) to examine the Inuit identification of and attitudes toward individuals with mental health problems;

(2) to identify the bases of the Inuit recognition of individuals as having mental health problems, emotional distress or psychiatric illness;

(3) to identify the types of explanations (explanatory models) offered by the Inuit for forms of deviant behavior associated with psychiatric disorders.

Psychiatric disorders, emotional distress and social problems cannot be sharply distinguished *a priori* and so must be studied together to cover the potential domain of Inuit mental health concepts. As a result, the research project examined a broad range of forms of behavior and emotional distress that can be related to mental health problems.

1.1 Outline of Report

In the remaining sections of this introductory chapter of the report, we summarize the current social conditions in Nunavik, previous work on the epidemiology of psychiatric disorders and historical and contemporary concepts of mental illness. Chapter 2 provides a detailed description of methods and sample characteristics for the ethnographic component of the study. The next four chapters summarize the major findings of the ethnographic research on concepts of mental health and illness. Chapter 3 presents the analysis of symptoms, signs and behaviors that indicate deviance from social norms and specific types of mental disorder. Chapter 4 outlines Inuit ethnopsychology and ideas about the causes of mental illness and the sources of mental health. Chapter 5 considers the social course of mental illness—that is, the way in which problems unfold over time, in interaction with others, to give rise to restitution and recovery or chronicity and disability. Chapter 5 also collects and analyzes accounts of treatment whether informal and administered by self or family or in the context of religious ritual or professional medical, social work or psychiatric care. Chapter 6 presents the rationale, methods and results of an experimental questionnaire study of attitudes toward the mentally ill. The concluding chapter summarizes the major research findings and some of their implications for future research, clinical care and public health measures.

1.2 The Inuit of Nunavik

The Inuit of Nunavik (Northern Québec) currently number about 7500 people living in 14 settlements situated along the coasts of Ungava Bay, Hudson Strait and Hudson Bay (Blanchet et al., 1992). The settlements range in size from about 200 to more than 1000. The settlements are predominantly Inuit, although Kuujjuarapik (Great Whale) is situated at the border between Cree and Inuit territory and has a mixed composition.

The history of contact between the Inuit of Nunavik and Canadians of European descent parallels that of many, if not most aboriginal communities in this country only the time frame is greatly compressed. Until the turn of the century contact between most Nunavik Inuit and southerners was limited to brief and often accidental encounters. In the 1920s trading posts were established on the Hudson Bay and Ungava Bay coasts.

Early missionary efforts among the Inuit were intermittent and unsystematic but the trading posts were soon followed by Anglican and Catholic missions charged to convert the Inuit. The arrival of missionaries coincided with drastic reductions in staple food species, particularly caribou, and widespread epidemics of measles and tuberculosis. The missionaries who came north had some basic medical training and brought some medical supplies, which were replenished annually by ship. On their arrival, they found a quite desperate situation and they began to care for the ill, the dying and the dead. They also preached salvation through baptism. The missionaries subtly—and at times openly and coercively—shunned

traditionalist members of the bands, particularly shamans. The relatively quick conversion of the Nunavik Inuit to Christianity should be seen in this context of widespread illness, food deprivation and large numbers of deaths, which in some cases were so extreme that there was no one capable of burying the dead. The position of power that the missionaries had in dealing with the outside world, in their apparent immunity to illness and their control over medicine, were all likely strong motivations for the Inuit to convert.

Little changed in Northern Québec from the 1920s until the early 1960s when, after repeated efforts by missionaries and international embarrassments largely as a result of the work of the American military in the north during the cold war, the provincial and federal governments began to show concern for the welfare of the people in this forgotten part of Canada. At this point the modern community began to develop rapidly.

The Inuit today are devoutly Christian. Some communities have three churches: Catholic, Anglican and Pentecostal.[1] Pentecostalism is a relatively new and popular phenomenon in the north. Its success can be at least partially explained by the use of local ministers who speak Inuktitut and the polarity of its theology of good and evil personified by Jesus and Satan through which all behavior and events can be judged. Few people have any expressed interest in a return to the ways of the past and many are wary of speaking of their past spirituality. Nevertheless certain cultural practices and traits specific to the Inuit, their belief system and cosmology do remain very much intact. This fact has often been overlooked or considered extraneous to the delivery of health services in the region.

In 1975, the James Bay and Northern Québec Agreement transferred authority from Federal and Provincial agencies to the Inuit for many aspects of justice, education, health and environmental protection. The Inuit of Nunavik currently have a level of regional political autonomy rivaling that of most other Native peoples in Canada.

Most wage-earning jobs in the communities are related to municipal or regional services and administration. A number of middle-aged or older men devote full-time to hunting. A small number in most settlements work as stone carvers. Most others are partially or sporadically employed as wage-earners for one of the town services (Prattis and Chartrand, 1990). More women than men are employed in services related to health and social welfare; i.e. by the school or hospital. A majority of people receive government subsidies or other forms of social welfare (Irwin, 1989). Many use this income to subsidize traditional hunting activities that are not in themselves profitable in a cash economy. Hunting and fishing remain very important activities within the local economy and supply at least 30% of the nutrition (calories) consumed in the communities

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[1] Although we refer to the church as 'Pentecostal', in most cases there is no formal affiliation with a Pentecostal church in the south and people retain close ties to the Anglican church, participating in additional prayer meetings and identifying themselves as 'born again Christians'.

(James Bay and Northern Québec Harvesting Research Committee, 1976). Hunting is subsidized by an assistance programme, in which meat is both stored and distributed within the community to those who are unable to obtain it by hunting themselves.

The population of Nunavik has grown rapidly in the last few decades, although the rate of growth is slowing (Duffy, 1988; Duval and Therien, 1985). From 1973 to 1979, the birth rate averaged 36.2/1000 for Inuit compared to 15.4 and 14.6 for Canada and Québec respectively. From 1983 to 1984, the birth rate averaged 34/1000 among the Inuit compared to 12/1000 for Québec as a whole. The age structure of the Inuit population differs from southern Canada in that the proportion of young is much larger and still increasing. In 1986, 56% of the population was less than 20 years old and only 2% were over 65 years old (Blanchet et al., 1992).

The crude death rate among the Inuit of the East Coast of Hudson's Bay averaged 8.0% from 1982-86, compared to 6.8% for Québec as a whole; when adjusted for age, the Inuit death rate rises to nearly twice the Québec rate. The most frequent causes of deaths are accidents in the young and circulatory diseases in the old. The three most important causes of morbidity are respiratory diseases, accidents (especially among males) and infectious diseases. An unknown proportion of psychiatric morbidity is hidden in the accident statistics. Consultation and hospitalization rates in Nunavik are as high or higher than the rest of the province suggesting that the increased rates of specific health problems are not related to a lack of access to or use of medical care but to other environmental, nutritional and social factors.

Psychiatric care for the Inuit is provided by nurses, community workers and family physicians. Each settlement has a nursing station. Depending on the size of the town, there are usually two or three nurses. The nurses are invariably southerners who usually spend 1 to 3 years in the North. Many of the nurses have some interest in Inuit culture and language but no special preparation for cross-cultural work and their work load leaves them with little time for study. Few have specific psychiatric or psychotherapeutic expertise.

Attached to each nursing station, although under separate administrative jurisdiction, are one or more Inuit community workers and interpreters. The community workers deal with social problems and attempt to provide support and counseling. They receive in-service training provided through the Kativik Regional Board of Health and Social Services and the McGill School of Social Work. Like the nursing station interpreters, the community workers are frequently in an awkward position dealing with social problems that directly affect members of their own family or kin. Although the community workers protect confidentiality, clients are sometimes reluctant to talk about problems because they fear it will become common knowledge in the village.

Two large villages (Povungnituk and Kuujjuaq) have ultramodern hospitals with acute and chronic care beds, minor surgical and obstetrical suites, radiographic instruments, cardiac monitoring equipment, and other laboratory facilities. These are staffed by family and community physicians who also travel periodically to

the nursing stations in the other settlements to see patients and supervise treatment plans which are carried out by the nurses. The hospitals have larger social service units that provide training and supervision for the community workers in all settlements.

Until recently, psychiatric care was provided entirely by the local physicians or by transferring severe cases to a hospital, principally to the Montreal General Hospital or the Douglas Hospital Center in Montreal. As hospital services have developed, a wide range of specialists have been invited north. Several years ago, Dr. Louis Couture, a child psychiatrist from the CHUL (Centre hospitalier université Laval) began doing consultations and other psychiatrists have made sporadic visits or provided telephone consultations to the north. In 1987, one of us (LJK), at the invitation of the Director of Professional Services at that time, Dr. André Corriveau, undertook to provide regular psychiatric consultations for the Inuulitsivik Health Center in Povungnituk, which includes in its catchment area 7 settlements with a combined population of about 4000 people. More recently, Dr. Michelle Larose and other mental health staff have provided services for both hospitals. A full time psychiatrist for Nunavik attached to the Montreal General Hospital, has been approved by the Ministry of Health but no one has been hired yet for the position. This clinician will be optimally situated to provide continuity of care for Inuit in their communities and on the few occasions where patients require psychiatric hospitalization in Montréal.

1.3 Psychiatric Epidemiology Among the Inuit

There is evidence from epidemiological studies that the major psychiatric disorders identified in standard Western psychiatric nosology can be identified in Inuit populations. A brief review of this work will provide a backdrop against which to consider the origins and impact of cultural beliefs and practices pertaining to mental illness among the Inuit of Nunavik.

Early epidemiological studies among the Inuit used nonspecific indicators of emotional distress like the Cornell Medical Index or the Health Opinion Survey (Murphy and Leighton, 1965; O'Nell, 1989). Studies using specific diagnostic criteria have, with few exceptions, been confined to patients seen in consultation and have used older diagnostic criteria that may be unreliable and inconsistent with contemporary nosology.

Early authors claimed that forms of mental disorder other than hysteria (i.e., *pibloktoq* or 'arctic hysteria' and related conversion or dissociative symptoms) were rare among the Inuit. However, current psychiatric consultation work confirms that most of the diagnoses in current psychiatric nosology can be readily found among the Inuit. In a number of cases, however, there are culture-specific features of the form or content of distress.

Bloom (1972) reported on DSM-II diagnoses of 103 psychiatric referrals of Alaskan Eskimos. One quarter involved psychoses and 16% neuroses (mainly depressive with only 2% dissociative). The remainder covered the range of

psychiatric disorders and stress-related problems in living. Men had significantly more psychoses and women more neurosis and personality disorders, but this may have reflected a referral bias due to the fact that men with milder disorders are often handled by the criminal system owing to associated violent behavior or drinking.

In a survey of 93% of the adult population of a Baffin region settlement in the NWT (Nunavut), Sampath (1974) found that over one third of those interviewed had a mental disorder according to DSM-II criteria. High prevalence rates were found for schizophrenia (28/1000), affective psychoses (46/1000), neuroses (116/1000) and personality disorder (177/1000). On a measure of global distress, the Health Opinion Survey questionnaire, women reported more symptoms than men and an increase in severe symptoms with age. In contrast, men showed a decrease in severe symptomatology with age. Sampath (1976a,b) attributed these differences to differential effects of modernization. Among those with personality disorders 70% were found to have a hysterical personality often with dissociative symptoms which Sampath related to *pibloktoq*. Sampath did not find any individuals with psychophysiological disorders or transient situational disturbances although he considered that this might reflect difficulties in working with interpreters. The supply of alcohol was limited and alcoholism was not common.

The Baffin Island Case Register contains ICD-9 diagnostic information on 453 adults seen in psychiatric consultation between 1974 and 1983 (Hood et al. 1985). Primary diagnoses include: schizophrenic psychosis 9%, affective psychosis 10%, other psychotic conditions 6%, neurotic disorder 20%, personality disorder 17%, adjustment/stress reaction 19%, depressive disorder 4%, substance abuse/dependence 3%, mental retardation 2%. Secondary diagnoses were made in 35% of patients. While alcoholism or substance abuse was a primary diagnosis in only 3% of cases it was seen as a contributor to psychiatric problems in one third of patients.

Seltzer (1980) emphasized the role of socioeconomic and acculturative stress in the development of depressive and paranoid symptomatology among the Inuit. In a later paper, Seltzer (1983) described three Inuit cases of spirit possession seen in psychiatric consultation in the NWT. There was no evidence of thought disorder in any of the cases and patients had partial amnesia for many or most of the spirit encounters suggesting a dissociative process. The characteristics of the spirits were consistent with traditional Inuit lore although they also reflect concerns about the stress associated with rapid modernization and the intrusion of Euro-Canadians.

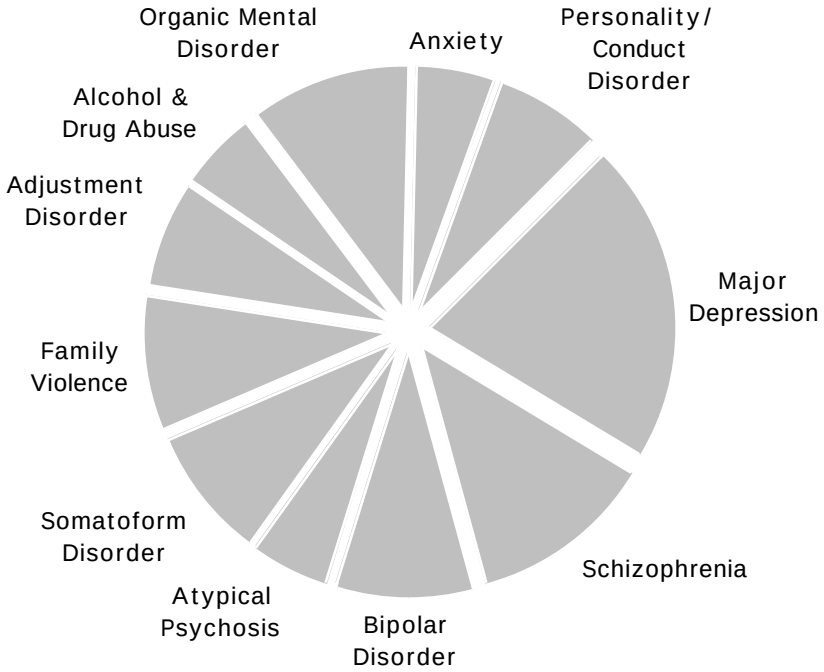

Figure 1-1. Principal DSM-III-R Diagnoses of 100 Consecutive Inuit Patients Referred for Psychiatric Consultation (1987-1992).

In a series of 100 cases referred for psychiatric consultation to L. Kirmayer from 1987 to 1990, the single most common DSM-III-R diagnosis was major depression with melancholia (See Figure 1-1 & Table 1-1.) The loss of significant relationships, the presence of great burdens of care due to illness of dependents and persistent family violence were the main stresses associated with the onset or maintenance of depression in women. Among men, the most common stresses were lack of meaningful work and, particularly for young men, the breakup of couple or sexual relationships. The lower rate for depression among men may reflect a difference in community prevalence. While at present men appear to be suffering much more from acculturation stress owing to their inability to find valued work, women are much more likely to be the victim of abusive relationships that promote a pervasive sense of helplessness, futility and personal vulnerability. This may make problems of anger and impulse control more common in men and anxiety and depression more common in women. The different rates of disorder in men and women may also reflect help-seeking behavior since many men who are depressed may avoid coming for medical help. Men may mask or cope with their depression by drinking or by going off hunting. When they become aggressive and self-destructive, they are more likely to enter the legal system. The very high degrees of coexisting social problems and dual diagnoses in this series (see Table 1-1) indicates the need for a comprehensive approach to mental health that goes beyond enumerating diagnostic categories.

Table 1-1. Psychosocial Comorbidity with Psychiatric Disorders

1° Diagnosis	N	%	Alcohol Drug	Antisocial Conduct	Family Violence	Sexual Abuse	Suicide Attempt
Organic	6	11%		1	2		
Alcohol/Drug Abuse	3	5%	3	2	1		1
Conduct Disorder	2	4%		2	1		1
Family Violence	5	9%		1	5		
Personality Disorder	2	4%					
Adjustment Disorder	4	7%				1	
Anxiety Disorder	3	5%					
Major Depression	12	21%	2		3		4
Bipolar Disorder	5	9%			1		
Schizophrenia	7	12%	1	1	1		2
Atypical Psychosis	3	5%	2	1	1	1	1
Somatoform	5	9%					
Total (N)	57		6	8	15	2	9
(%)			11%	14%	26%	4%	16%

Alcohol and substance abuse including sniffing solvents, glue, gasoline, and in some communities cocaine, is far more common than figures based on nursing station visits would suggest (Brody, 1981). Foulks (1985) argued that traditional hysterical expressions of stress or psychopathology had been transformed in recent times into impulsive behavior and substance abuse. As indirect evidence for this theory, Foulks noted that 49% of a random sample of Alaskan Eskimos reported “blackouts” while drinking. He suggested that drinking serves both communal conviviality and also for the release of intense emotion with consequent violent acts. In traditional times, the angry or aggressive Inuit would be viewed as “a child out of control.” In places where it is readily available, alcohol (or other intoxicants) has replaced traditional dissociative practices as a means by which one can escape intolerable psychological pain (Kraus and Buffler, 1979).

A number of observers have noted a pattern of “easy” suicide for seemingly minor or trivial reasons (e.g. "I’m bored."). While some have claimed this may have roots in a traditional pattern (Balikci, 1961), the profound acculturation stress experienced by youth must play a major role in the elevated suicide rates reported (Berry, 1985; Duffy, 1988; O’Neil, 1983, 1986; Vallee, 1972). Our own survey of 100 Inuit youth in Povungnituk identified extremely high rates of suicide attempts associated with solvent abuse, a history of physical abuse and parental substance abuse (Malus, Kirmayer & Boothroyd, 1994).

1.4 Traditional Concepts of Illness

In traditional Inuit culture, illness was viewed as accidental, due to the breaking of taboos, soul loss and/or the action or intrusion of evil spirits. These modes of

explanation were not mutually exclusive. Treatments included physical manipulations, medicines and the intervention of shamans (*angakok*) (Avataq Cultural Institute, 1985; Balikci, 1989).

Certain illnesses were attributed to interactions between the spirit of a person, place or thing and the individual (Merkur, 1991). Shamanic practices involved spirit journeys to confront the hostile evil spirits and placate or defeat them with the shaman's own spirit allies. Many individuals had some shamanic experiences and powers and a wide range of unusual experiences and behaviors were tolerated and interpreted as the result of spirit communications. Spirits (*mitilit*) might pay brief visits or live for an extended time with individuals, who, if they were not impaired in their social functioning, were not viewed as deviant or afflicted.

With the transformation of traditional culture, the nature of illness experience and explanation has changed. Beginning concertedly in the last century, most communities were subject to several waves of Catholic and then Anglican missionary work. In the last decade, the Pentecostal church is growing rapidly in popularity. It has certain similarities to traditional shamanism with its emphasis on ecstasy and singing. In contrast, the Catholic and Anglican traditions seem to many Inuit to be excessively verbal and formal. Demonic possession continues to be a popular explanation for psychosis and Christian exorcisms, inspired by television and videotaped presentations of southern practices, are not infrequent.

1.5 Contemporary Concepts of Mental Health and Illness

Older ethnographic accounts of Inuit mental health centered on *pibloktoq* (arctic hysteria or kayak-angst), a culture-bound syndrome consisting of running about wildly and risking life and limb (Wallace, 1960). Although there has been a substantial literature proposing various cultural and biological explanations, published accounts of *pibloktoq* are few and pay little attention to the social context and meaning of the behavior (Aberle, 1952; Brill, 1913; Foulks, 1974; Freeman et al., 1978; Gussow, 1960; Landy, 1985). The term '*pibloktoq*' probably derives from Inuhuit (Greenland Inuit) dialect for 'drum dance trance'. Behavior attributed to *pibloktoq* may have arisen from enthusiastic shamanic practices occurring at times of personal and social stress for individuals. Some of this stress probably came about from the negative impact of Arctic explorers' activities on Inuit communities and relationships (Dick, in press).

While Foulks (1985) has argued for a psychological and historical continuity, in which the dissociative phenomena of pibloktoq and spirit possession have been transformed into the blackouts and loss of control of alcohol and solvent abuse, the classic accounts of exotic culture-bound syndromes bear little resemblance to the current psychiatric problems of the Inuit. Indeed, in his study of traditional Inuit beliefs about mental illness in the sixties, Vallee (1966) could find no knowledge of *pibloktoq* among the elders in Northern Québec. Instead, Vallee suggested that a variety of mental disorders have been common for at least three generations among Inuit both with and without intensive contact with Euro-

Canadian society. In interviews and case studies conducted in Povungnituk, Inukjuak and Kuujjuarapik in 1963, Vallee was able to characterize four commonly recognized patterns of mental disorder. His results are probably indicative of traditional knowledge in the first half of this century, since, at the time of his survey, only about 10% of Inuit could read and write in English, although all were literate in Inuit syllabics. Vallee's results will be described in some detail since his study remains unique in the anthropological literature on the Inuit and is close to the concerns of the present study.

Finding no general indigenous concept of mental or psychiatric disorder,[2] Vallee (1966: 57) chose as his basic criterion of mental breakdown: "incapacity of the person to perform some or all of his normal roles accompanied by behavioral oddity, as defined by the informants, and where the incapacity and oddity are attributable to the head rather than to some other body organ." He thus directed informants to talk about "happenings in which people were rendered incapable of performing in their everyday capacities and where there was no obvious physical cause for this inability, and where the individuals behaved in an unusual, although not necessarily unpatterned, manner."

With an open-ended ethnographic interview method, Vallee (1966) identified four distinct patterns of emotional / behavioral illness, which corresponded roughly to epilepsy, "simple hysteria" (i.e. isolated episodes of conversion or dissociation), withdrawal with acute melancholy, and "mania with paranoia." The terms were attached to states, not categories of persons. After the condition had passed the person was no longer in that state and was not labeled sick. However, chronicity could be denoted by an infix meaning "usually."

I. Epilepsy (*qiirsurtuq* : "he is having an epileptic fit"; *qiirsugattartuq* : "he usually has epileptic fits"). This was viewed as a "sickness of the head." It might be linked to unusual powers in divination and spirit communication. The person was possessed only while unconscious (*illisimangerpuk*), in contrast to more awesome forms of possession that occur while the person is conscious. It does not call for special treatment and is not contagious. Vallee found at least one patient diagnosed as epileptic and psychotic in the south who was not viewed as *qiirsurtuq* but as *quajimaillituq*. Others were afraid of him and did not want him returned to the camp after his recovery in hospital. Vallee suggests this rejection

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[2] According to Vallee there are no precise terms for mental disorders in Inuktitut. A variety of idiomatic expressions describe "relatively benign, commonplace behavior" which is odd, silly or evidence of stupidity. The nearest word translating "mental illness" is *niaqureriyuq* : "he has an illness of the head". (Kp from *niaquq* = head of man or animal [cf. Schnieder (1985): *niaqulirivuq* = to have an illness in the head (that causes one to lose one's balance)] [*niaqunguvuq* = he has a headache] applied to any organic malfunctioning of the head.) See also: *quajimaillituq* - he does not know what he is doing, which however has a more restricted application.

is the functional equivalent of killing or banishment in traditional times and may drive the victim deeper into his illness or promote suicide (p. 63).

II. Simple hysteria (conversion). In his sample of 31 cases, Vallee found 5 girls between ages of 13 and 16 who had transient paralyses and/or dissociative experiences with visions or hallucinations. These were not viewed as serious afflictions compared to the next two categories.

III. *Qissaatuq, quvarpuq* (*kavarpuq*: he is extremely sad, troubled, quiet). These were episodes of passivity, withdrawal and depression. In some case brief flurries of manic activity occurred but silent brooding and immobility were most characteristic. This was often associated with feeling bad and unworthy or blaming oneself for misfortunes in the community as well as self-destructive or self-injurious actions. Some individuals made suicide attempts but there were no successes (which Vallee attributed to protection of others, but which may also reflect low energy/anergia compared to high frequency of successful suicide among the non-depressed). Treatment involved relatives and friends praying for the afflicted individual to recover along with support in familiar surroundings. In his sample of 31 cases, Vallee found 9 female and 5 male cases, making this a common condition, with a female predominance. The belief was that anyone was vulnerable, usually having a single episode. Elders recalled individuals with this problem 50 or more years earlier. Men with visions during their illness who recovered might subsequently aspire to religious positions, while women would be more likely simply to return to their usual domestic activities.

IV. *Quajimaillituq*: "he does foolish things and does not know what he does" (a term also used for rabid dogs during the violent phase of their illness). In this state, individuals were hyperactive or agitated, with incoherent or disjointed speech, loose associations, paranoid suspicions and compulsive rituals. They avoided sleep, were aggressive, blasphemous and might harm self and others. The afflicted person might report messages from the devil or some other supernatural agent directing him to be wary of others who were going to harm him. *Quajimaillituq* was viewed as an infection or possession by the devil. People who were strong of head and heart were less susceptible. It was thought to be contagious but not to affect non-natives. In the view of Inuit informants, Southerners tended to be too permissive with the afflicted person since it was really the devil who was acting and not the person himself. This justified tying up the sufferer to restrain him and pummeling him when he got too blasphemous or violent. The five men and one woman in Vallee's series tended to experience the attacks in late winter often following a physical illness (flu or measles). All the men showed other signs of social impairment and had trouble finding wives.

Vallee's study remains unique in the anthropological and psychiatric literature on the Inuit. The present research was designed to use more systematic ethnographic methods to update and extend his research to the realities of contemporary Inuit community life and health care practices.

2. METHODS

The study involved both qualitative ethnographic methods and quantitative analysis of questionnaire data. This section summarizes the methodological rationale and details the procedures used in the ethnographic research. The vignette based study of attitudes is presented in Chapter 6.

The research was conducted with full attention to the guidelines of the Association of Canadian Universities for Northern Studies (1990). In particular, community residents and agencies were involved in the planning and modification of the protocol. The protocol was approved by the Kativik Regional Board of Health and Social Services, the Council of Physicians, Dentists, Pharmacists and Midwives of the Inuulitsivik Health Center and the Research Ethics Committee of the Jewish General Hospital. In addition to this institutional evaluation, the proposal was presented to community health committee representatives for their evaluation and approval.

2.1 Ethnographic Studies of the Meaning of Symptoms and Illness

The explanatory model methods of medical anthropology have demonstrated the importance of the individual's culturally shaped ideas about the cause, course and consequences of illness (Kleinman, 1980; 1986). The semantic network approach has emphasized the wider network of meanings that surround an illness concept (Good, 1977; Good & Good, 1980). These methods have been coupled with standard epidemiological practices to produce the best surveys of mental health problems among Native American populations to date (Manson et al., 1985). However, both of these approaches have been criticized for exaggerating the coherence and rationality of indigenous illness concepts (Corin, 1993; Kirmayer, 1992, 1993a; Young, 1981).

Systems of signs, meanings and behaviors do not exist as an explicitly conceptualized body of knowledge either in individuals' cognitive representations or in institutional codifications. Such social knowledge is enacted and manifested in the behavior of people when they face actual health problems (Corin, 1993). Ethnographic methods then, must be used to reconstruct the features and course of specific cases in the community. These cases can then be used as stimuli in a semi-structured interview to elucidate how people recognize, label, interpret and respond to behaviors viewed as evidence of a mental health problem.

The methods developed by Ellen Corin and colleagues in studies in Abitibi (Québec), Africa and Brazil, emphasize the ethnographic study of the systems of signs, meanings and behaviors that surround mental health problems through observations of the actual practices of people (Corin, 1993). This method extends the explanatory model and semantic network approaches in three ways: (1) by focusing on a broad range of problems (the field of mental health and illness) rather than a specific disorder, the approach avoids the artificial segmentation of

knowledge and practice, recognizing that people under ordinary circumstances must deal with problems that do not fit one single conceptual rubric; (2) by exploring the response to actual cases, the approach avoids the over-emphasis on cognitive representations that are abstract or idealized and a poor reflection of actual practices; (3) by comparing data collected with similar methods from disparate cultures, the approach situates local reactions within the social, economic and political constraints of communal life and promotes the identification of larger order social factors in mental health.

2.2 Study Sites

The choice of fieldwork and survey sites was based both on pragmatic considerations (large enough community to provide a good sample of deviant behavior) and on obtaining sufficient variation in degree of acculturation to include this as a factor in the study. Three communities were involved in the study: Povungnituk, Salluit and Kangiqsujuaq (Wakeham Bay). Povungnituk and Salluit are among the largest Inuit settlements in Northern Québec and have been the subject of previous ethnographic work (Graburn, 1969; Saladin d'Anglure, 1986). In 1988, the Inuit population of Povungnituk was 881, that of Salluit 684, while Kangiqsujuaq was home for 360. Povungnituk is the site of one of two regional hospitals and as such has experienced a relatively high degree of exposure to southern ideas of mental health care (Foggin and Aurillon, 1989). Salluit has had less direct exposure to these ideas, and there is an impression among some community members that it suffers from a higher prevalence of psychiatric disorders. Kangiqsujuaq, on the Ungava coast, is the smallest and most traditional of the three communities. Additional interviews were conducted in Kuujjuaq, Kuujjuarapik and Inukjuak as well as with informants from Akulivik and Ivujivik.

2.3 Selection of Respondents and Sampling

Respondents were selected to encompass basic sociodemographic variations in sex, age and degree of acculturation. Sex roles continue to be sharply distinguished and extend into different attitudes toward care-taking, illness and deviant behavior (Briggs, 1970; Brody, 1975; Condon, 1988). Age cohorts have experienced substantially different exposures to traditional life style, southern schooling and biomedical health care (Duffy, 1988). For the purpose of this study adult respondents can be divided into three cohorts: 18-30, 31-50, and >50. The oldest cohort grew up under more traditional circumstances and has generally not received much southern education. The middle cohort was often sent south to boarding schools for education, while the youngest cohort has been educated primarily within the community by local schools (Condon, 1988). While most individuals in these settlements have superficially adopted a southern lifestyle, and have access to television and constant interaction with representatives of southern institutions, there remains substantial variation in level of acculturation based on education, employment and language skills. Within the age cohorts,

two rough levels of acculturation can be distinguished: *traditional* (little or no English or French spoken; little or no southern education; "traditional" lifestyle); and *acculturated* (moderate to fluent English or French; education to high school; little traditional activity) (Berry, 1985).

A total of 80 interviews were conducted, each lasting from 1 to 3 hours. Since this is a convenience sample we present the demographic characteristics here in detail to give some indication of its representativeness of the community. Forty-seven percent of respondents were female. All except one spoke Inuktitut; 55% also spoke English; and 5% spoke French. The origins of the informants were Povungituk (68), Salluit (11), Kangiqsujuaq (8), Inukjuak (1). The mean age of informants was 40.2 (standard deviation (SD) ± 15.6); the age distribution is presented in Figure 2-1.

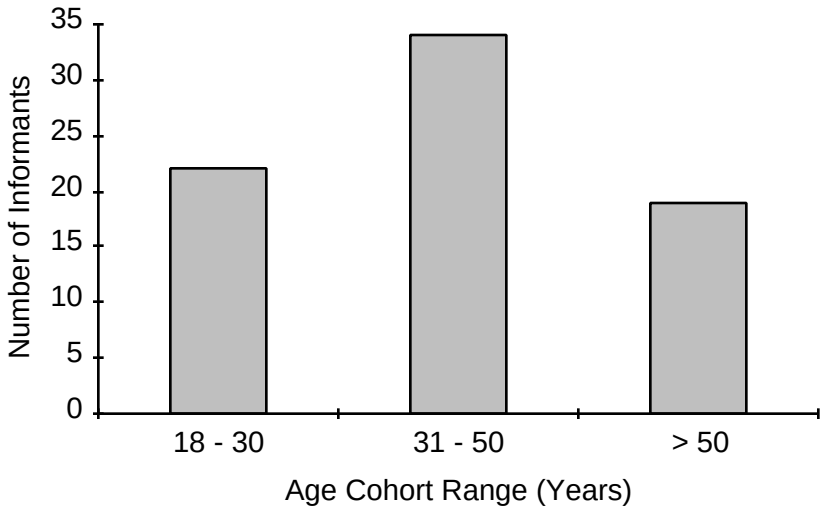

Figure 2-1. Distribution of Ethnographic Interview Informants by Age Cohort.

With regard to informants' marital status, 52% were married or living common-law with a partner, 15% were single, 6% widowed and 4% separated or divorced. The modal number of children of the informants was 4 (mean 4.5, SD ± 3.0; minimum 0, maximum 13); 11 informants had adopted from 2 to 7 children. The average years of education was 8.4 (SD ± 9.0; minimum 0, maximum 15). The distribution of education is presented in Figure 2-2.

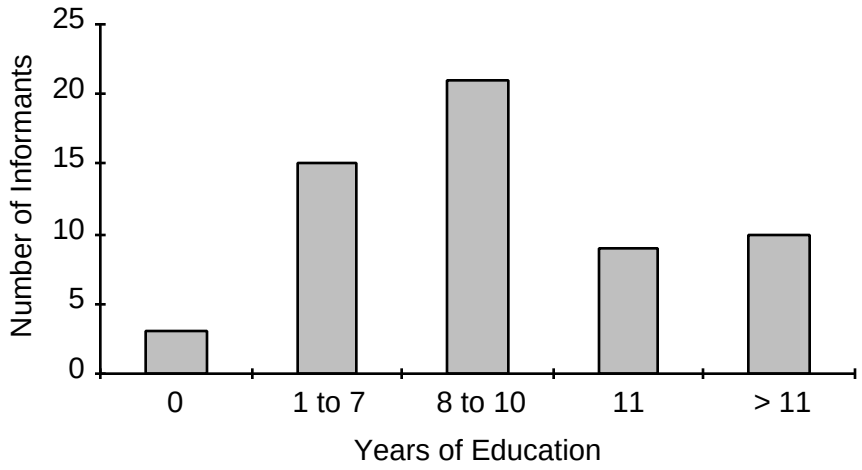

Figure 2-2. Distribution of Interview Informants by Years of Education.

Table 2-1. Distribution of Occupations in the Sample

Occupation	Number of Informants
Wage-earning	
health services	10
interpretation / translation	8
administration / secretarial work	6
education	6
traditional work (hunting, carving)	5
social / community work	5
consulting / entrepreneur	5
domestic work	4
religious work	2
Non wage-earning	
unemployed	8
student	6
homemaker*	6
retired	3

* includes "works at home", "mother", and "homemaker"
Nine people gave no response to occupation.

Informants' occupations are summarized in Table 2-1. Of those for whom occupation was noted 69% had wage-earning jobs; 20% were in the health or social services field; 15% reported traditional activities (e.g. hunter or homemaker). The frequency of church attendance among informants is summarized in Figure 2-3.

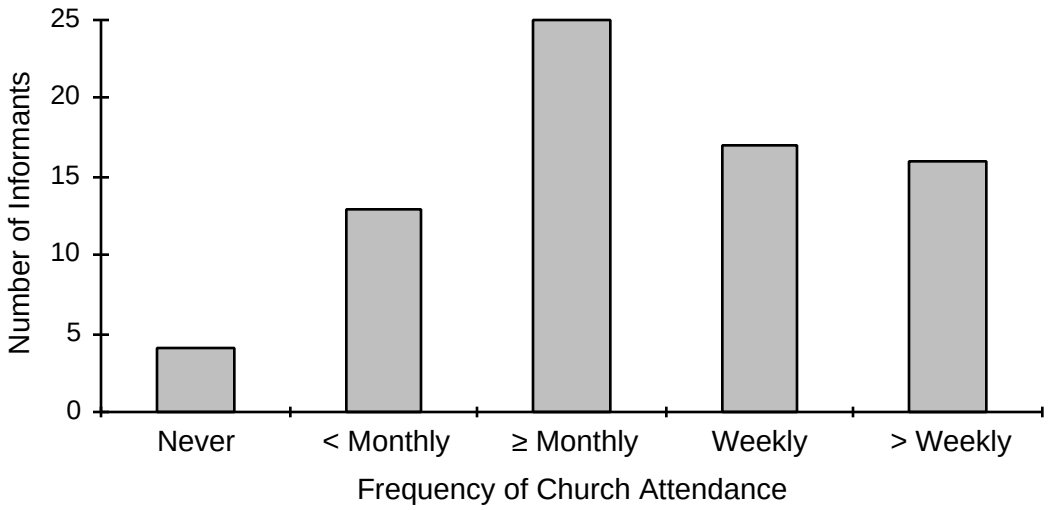

Figure 2-3. Distribution of Informants' Frequency of Church Attendance.

2.4 Procedure for Ethnographic Interviews

The primary form of data collection was semi-structured ethnographic interviews. These interviews were conducted by the investigators (LJK, CF) or by research assistants, along with a trained Inuit interpreter, in Inuktitut except when the respondent was fluent in English or French. Although it was hoped that the use of non-Inuit interviewers would increase the likelihood that respondents would talk freely of matters they might be hesitant to report directly to a fellow community member, the presence of an interpreter, who was most often from the same community, mitigated this effect. Equally important, however, the non-Inuit interviewer was more likely to notice and pursue culturally-distinctive illness concepts and to avoid the incomplete interviews that can occur when tacit cultural knowledge is shared by interviewer and respondent.

The project was explained to community members and potential participants as an attempt to better understand the range of views of the Inuit community toward mental health and illness. Informed consent for the interview and tape-recording was obtained from all participants. The consent form is reproduced in Appendix A.

Three types of interview were conducted: (1) problem identification interviews with Inuit health care and community workers to identify the range of problems in the community and the usual terminology used to describe them, resulting in a list of specific registers of problematic behavior; (2) problem register interviews with 60 respondents to identify the perceived prevalence of problems in the community and the typical signs and symptoms associated with them; (3) case history interviews with 12 key informants who each provided detailed narrative accounts of up to 3 cases with which they were personally familiar. Appendix A provides an outline of the topics covered and the flow of problem register interviews. All interviews were tape-recorded, transcribed and translated from Inuktitut to English. Additional notes were recorded by the interviewer immediately after each interview. The three types of interview are outlined below.

1. *Problem Identification Interviews.* The research began with a series of 12 interviews with Inuit health care and community workers to identify local (Inuktitut and English) terms commonly used for designating "madness", craziness and similar problems. Respondents were prompted first with general terms for unusual or abnormal behavioral and then with specific descriptions of common types of deviant behavior.

Based on work by Murphy and Leighton (1965) and Essex and Gosling (1983), Corin and colleagues identified 11 broad registers of behavior that reflect the range of psychopathological disorders:

1. Violence towards others and / or things;
2. Violence towards oneself;
3. Delusions and hallucinations;
4. Social withdrawal and isolation;
5. Speech alterations;
6. Bizarre behavior;
7. Anxiety;
8. Depression;
9. Mental deficiency;
10. Seizures, convulsions;
11. Problematic substance abuse.

Informants were asked to talk about each of these registers to identify local terms. To further elicit cultural idioms of distress, informants were asked to talk about the experience and expression of typical life stresses and developmental transitions. This information was used to augment the list of registers with culture-specific problem areas.

2. *Problem Register Interviews.* This step used the problem registers developed in Step 1. Semi-structured interviews with 60 respondents identified specific cases corresponding to each of the registers established in Step 1. When an actual case could be identified, the interviewer briefly elicited the signs, symptoms, typical behaviors and social responses associated with the register in that case. Informants were also asked how common, how serious, and how problematic for the community they perceived each register to be.

The basic registers were presented to the informant and explored by a series of detailed questions, some of which were generally applicable and some of which applied to specific registers. Open-ended inquiries were followed by progressively more specific probes to reconstruct detailed descriptions of the evolution of signs and symptoms, their indexical behaviors and the personal and cultural meanings attached to specific signs, symptoms, behaviors and contexts. The emphasis was on comparing and contrasting the different registers to uncover salient features.

3. *Case History Interview*. Individuals with detailed knowledge of multiple cases of mental illness and skill in case description were selected from among the respondents in the second step of data collection to serve as key informants. More intensive interviews with 12 key informants reconstructed a limited number of cases covering the range of problems identified with the problem oriented interview. Interviews included a detailed description of the signs, meanings and behaviors related to each case. Field work also provided additional contextual information concerning the signs and behaviors associated by the individuals and groups within the community with problems in the area of mental health, including: premonitory signs, diagnostic signs, indications of worsening or improvement, and prognostic signs; the perceived severity of the problem, including the reasons used to assess and justify a judgment of severity for the patient and for others around him; explanations and interpretations offered for actual cases including primary, secondary and hypothetical causes as well as predisposing or aggravating factors; reactions of others towards the affected person over the course of the illness including positive and negative reactions to specific behaviors as well as tendencies to label the individual in a socially dis-valued way (stigma); help-seeking behaviors taken by the individual and others around him including the full range of family, social, religious, and medical responses.

A semi-structured interview with open-ended questions was used to collect systematic data related to each case. The interview comprised 8 sections:

(1) basic demographic information about the key informant (age, sex, education, employment, marital status, place and length of residence, religious practice, languages);

(2) sociodemographic, personal and family information for the case under discussion;

(3) exploration of signs, symptoms and behaviors associated with the problem (e.g. How does the problem manifest in this case? How can one see that it is a problem? Was the person always like that? How old was he or she when the first problem occurred? What were the first manifestations? How did the behaviors evolve over the course of the problem?);

(4) specific terms or labels used to describe a problem were identified by following the introduction of any new problems, signs or behavior with

the probe: “Do you name this problem (sign / behavior / experience) in a specific way?”;

(5) etiology was investigated by the following questions: “How do you explain the origins of the problem? What are the causes? Could one have expected the appearance of this problem? Are there any factors which may have aggravated the problem? (Careful attention was given to multiple meanings and explanations.);

(6) the severity of the problem was addressed by probes: “Is it a serious problem? Has this problem modified his / her ways of being or activities? If so, how? Did the trouble lead to problems for the family and / or other people in the community?”;

(7) exploration of social reactions included information on feelings, opinions and actions provoked by the problem at different stages of its evolution. Questions addressed different categories of people (persons in the same household, other family members, neighbors, etc.) Special attention was given to reactions involving fear, anger, rejection or support, to the reasons underlying these reactions, and to their manifestations;

(8) help-seeking behaviors were assessed by probes following the sequence of such actions in each case: “What was done? Who was part of the decision making process? Why was such a decision taken? What was the result? What do you think should be done?”

2.5 Data Analysis

The analysis of ethnographic data involved four steps: (1) preliminary content analysis of the interview transcripts to identify types of symptoms, signs, behaviors, contexts, outcomes and meanings relevant to the cultural recognition and interpretation of mental health and illness (Weber, 1985); (2) computer coding and cross-referencing of the interview data by the categories identified in the preliminary content analysis to permit collecting similar instances for more detailed comparative analysis; (3) semiotic analysis to distinguish signs that serve as indices of health, illness, severity, danger and prognosis and signs that are metaphors with wider connotations grounded in cultural practices; (4) statistical analysis of the correlation of signs with specific interpretations of case histories.

The transcripts were analyzed with respect to three frames of analysis:

(1) by behavioral registers and indigenous categories;
(2) by specific cases reconstructed from multiple viewpoints;
(3) by individual narratives, examined in terms of discourse process.

Specifically, the transcriptions of recordings from the Problem Identification Interviews were subjected to content analyses to determine: (1) the types of

discrete problems described by informants; and (2) specific terms used to describe different problems. This was used to construct an augmented list of problem types based on the basic 11 registers described above.

Similarly, data from the second level Problem Register Interview based on the revised problem registers underwent content analysis to determine: the signs, symptoms and behaviors that distinguish one type of problem from another, and that indicate severity and prognosis; the causal explanations tendered for various types of problems; the typical course or evolution of illness over time and across salient social contexts and life passages; and, the treatment or management of symptoms and illness.

Third level Case History Interviews examined the explanatory models applied to the full range of problems identified in the first interview. Again, content analysis identified: specific signs, symptoms, personal characteristics and contextual factors that differentiate different problems; the modal explanatory model for each type of disorder; and, the range of variant explanations. This allowed the construction of a description of the dimensions of indigenous mental health and illness concepts, their semantic structure and practical application.

There was a basic methodological problem in adequately representing the diversity and complexity of individual views within the community while identifying common themes and collective representations. In the results section we have dealt with this by presenting extensive quotations and noting which are representative of many informants opinions and which are somewhat idiosyncratic. We have organized the passages according to the results of our analysis to represent a synthesis of the shared social representations. In later discussion, we consider the impact both of widely shared beliefs and practices and more idiosyncratic views.

3. Symptoms, Signs and Behaviors of Mental Health and Illness

In this section we summarize findings from the ethnographic interviews related to the recognition and labeling of behavior as indicating mental health or illness.

3.1 Initial Interviews—Behavioral Registers and Lexicon

The initial list of 11 behavioral registers was easily intelligible to all respondents. The first set of 12 interviews, and further literature review, led to an augmentation of this list to include patterns of deviant behavior recognized by the Inuit or described in the ethnographic literature. Given the importance of dissociative and somatoform symptoms in clinical and ethnographic accounts of Inuit illness, three registers tapping possible dissociative behavior were added: lapses of memory, periods of immobility and episodes of running wild across the landscape. The first two correspond to conversion symptoms (although they might also commonly indicate a stroke). The 'running wild' register corresponds to published accounts of *pibloktoq* or 'arctic hysteria'. 'Demon possession' covered a range of indigenous beliefs and religious practices described in detail in below.

Table 3-1. Behavioral Registers

1. Mental health problem, 'crazy'
2. Bizarre (strange, odd, weird) behavior
3. Speech alterations (not making sense or talking in a way that is hard to understand or unusual)
4. Delusions and hallucinations (i.e. believing things that are not true; seeing or hearing things that are not there or that others do not see or hear)
5. Violence toward others and/or things
6. Violence toward self (suicide, trying to kill self)
7. Social withdrawal and isolation
8. Depression (sad, low, discouraged)
9. Anxiety (fearful, nervous)
10. Mental deficiency (dull, slow, unable to learn)
11. Seizures, convulsions
12. Substance abuse (sniffing, marijuana, hash, alcohol, cocaine, drugs, etc.)
13. Lapses of memory (forgetting who or where you are or forgetting other important personal events)
14. Periods of being frozen, immobile, unable to speak or to move
15. Running wild (e.g., stripping off clothes and running into the snow)
16. Demon-possession

The initial interviews also identified specific terms which formed the basis for the preliminary lexicon of mental health related terms (cf. Appendix B). These terms were also used in subsequent interviews to elicit further comments.

Inquiries about the general concept of mental health and illness led quickly to discussions either of severe social problems (family violence, suicide, drug abuse), common mental disorders (mainly depression) or psychotic disorders. Many informants professed to have little experience with mental illness but all were familiar with family or community members with problems with violence, suicide and substance abuse.

We will discuss the symptoms, signs and behaviors associated with each of the registers below with a view to detailing the basic distinctions made by informants and the salient cues for recognizing specific types of problems.

3.2 General Concepts of Mental Illness

Inquiry about general mental health problems or 'crazy' behavior evoked responses that fit the registers of bizarre behavior, speech alterations, as well as hallucinations and delusions. Accordingly, this section will summarize results from Registers 1 through 3.

There is no generic term for mental illness or mental disorder in Inuktitut. When pressed, informants either used an English term (mental health, mental health problem, 'crazy') or offered two terms with different connotations:*Isumaluttuq* and *Isumaqanngituq*.

Isumaluttuq is a term glossed as "having heavy thoughts", "a lot on one's mind", "thinking too much", "being worried" or anxiously preoccupied. It covers a very broad range of problems and situations, ranging from ordinary worry and preoccupation to profound depression, withdrawal and behavior clinically consistent with psychosis. One informant explicitly noted it could be applied both to depressed people and to schizophrenics although the two groups clearly had different problems.

At the mild end of the spectrum, one informant stated that a hunter concerned about where the caribou are located might be *'isumaluttuq'*. More serious anxiety is implied in the following account:

> *Isumaluttuq* would be, if someone is lost, out in the tundra. The mind, the thought that the person keeps coming back to, in not, in a way that doesn't give you peace. It worries you. So…Something that keeps coming back to you, that makes you worry. Or that doesn't, doesn't imply being well, mentally well. [P002]

Isumaluttuq covers mild to moderate forms of depressed or anxious mood. It was offered as a label for behavior manifested by worried facial expression, distractibility or difficulty concentrating, confusion, dysphoric mood, and other difficulties in everyday functioning:

> When a person has a mental health problem, what I see is …the person cannot think very well, very well. The way he acts, the way he does things, and they get confused, he has… the word for Inuktitut can, we can say that it's *isumaluttuq*. Which means doesn't think positive things. [P003]

> I mean.. doing negative things. Like such as....depression, aggressive… I think that's where it starts, when they're depressed more, they're in that house, that. And they get to a point that they have no control, with their mental. [P003]

Isumaluttuq can be recognized "just by looking at the person" or, most commonly, from the content of the person's speech and the fact that they keep returning to certain concerns. This repetitive aspect of speech then mirrors the mental process of worrying. The severity of *Isumaluttuq* can be judged directly from the person's account of what's troubling them (unless they are unaware, as in the informant's reference to 'unconscious' process).

> They keep talking about it. It keeps coming back to them. And finally you will say, are you worried? Are you having a problem? And then they'll start to talk about their problems. But that is a very, it's not, it doesn't imply that the person is…having a serious problem. They will describe it as such. The kind of problem I'm talking about will not, affect them seriously. They won't give you the sense that they're really worried about it. They won't talk about it directly. They won't tell you, tell you, um, they won't really point their problem. Because they're not, unconsciously perhaps, they're not really even aware that it's bothering them. But the other kind of problem, where there is more serious, that is more serious, they'll come out and say it. They'll say that they're having a problem. [P002]

Other indications of *isumaluttuq* include trouble sleeping "because the person is disturbed." *Isumaluttuq* is essentially a psychological concept, since it implies difficulty with thought processes. As such, it can be used as an explanation of mental health problems as well as a label of specific symptoms.

Since it names a state of mind rather a characteristic of a person, *isumaluttuq* itself has no expected course or prognosis. It can change rapidly as the person's mind and experience change.

The second term offered by many informants as having broad applicability for mental health problems, *Isumaqanngituq*, implied more severe problems. *Isumaqanngituq* was glossed as "he has no mind/brain", "crazy", "doesn't know what's going on around him", doesn't know what he's doing", "acting strange".

> we usually call them not very bright with mind… *isumaqanngituq*…They will probably think that this person has no mind to think…they will do things that a normal person wouldn't do. Like facing other people with madness. They have to be different…They talk to themselves or they blame other people for absolutely no reason and they are very isolated from other people and actually some of them are quiet and one or what would you say, a pain in the neck. [P030]

This same term can be used for someone who is profoundly intellectually disabled or demented. An alternative term used by some informants as a more accurate translation of mental illness was *isumaqatsianngutuq*. This had similar connotations of "losing their mind," "going crazy," "having a mental illness." Both *isumaqanngituq* and *isumaqatsiangittuq* tended to imply a persisting condition or permanent states of affairs. A temporary mental illness was denoted with a change of infix as *isumansungittuq*.

The more severe forms of mental disorder are easy to recognize: people act strangely, talk too much and / or too loud and aggressively, talk about things that are not true or don't exist or wander about aimlessly mumbling to themselves. Alternatively, they may become too quiet and withdrawn and shun the company of others. Among the behavioral changes that may signal the onset of mental illness are being very active, very suspicious, getting angry easily, crying a lot, violence or self-destructiveness:

> It's like when, when they, they get angry very easily, and, ah, something like that. And, it's hard for them to communicate…they would, they would get, maybe, ah, angry or something like…ah, violent or something like that. When you, ah, when you are nice to them…they…I mean, when you speak to them nicely, they would, I think they would, I mean, that they would be fine. [P009]

> Their personality's changed. I mean, the person that she knows, their personality changed. That person she knew, before she was mentally sick, she used to be able to talk. Yea. She was like any other person…an elderly lady. She started talking about suicide. And she had become very quiet. …she doesn't know how exactly to describe what the changes were, but she knew there were some changes. That person wanted to commit suicide and she wanted someone to take her where there's nobody else on the land. And, she tried to injure herself. [P010]

> When they're starting to be mentally sick, their behavior changes like, I'm and I talk a lot and I'm open and everything. But all of a sudden I go quiet, I , it's like I can't hear people talking, even if they talk to me. [P032]

> I know one guy has mental health problems. Sometimes he acts crazy and ...and I just ignore him and just try to use say nice words to him.....that's it. Uh when he says something crazy like "I'm a ghost" or "I'm a dead person", I just say "Oh yea? You're alive". And sometimes he looks all right but when the time comes that he gets a little crazy sometimes…I mean in his words, not in how he acts. He doesn't show it much but...then he's having a mental problem. [P050]

> We just can see them if they have mental problem. They look different than a normal person… how they walk and...sometimes they play with things like…they are not to play with I think...And.....they're just different from normal people. Sometimes they look normal.. and ..sometimes they.. they have a lot of things in their mind. [P050]

Isumaluttuq implies thinking too much while *isumaqanngituq* is not thinking at all. Both terms can be applied for similar behaviors but carry different implications about the underlying process. For example, both can be applied to violence but *isumaluttuq* would imply the violence is not totally irrational but rather stems from brooding, anxiety, depression or nonpsychotic jealousy. In contrast, *isumaqanngituq* would imply the violent person was literally "out of his mind" and was acting destructively for completely irrational reasons or without any thought at all. The distinction meets a gray zone in explanations of delusions and hallucinations which are more often understood as 'thinking too much' rather than 'having no mind'.

Another broad class of mental health problem identified by many respondents involved people whose interpersonal behavior was difficult because they were

immature or fractious in their interactions. There was no term for this group of problems which appear to correspond to personality disorders in psychiatric nomenclature.

> There's a lady that I know who may need psychiatric help but nobody has ever done anything about it. She complains a lot about her health, but I think it's more mental than anything. Her situation is thinking that she's always left alone. She gets excited over things if people don't talk to her right away. She would make a small thing into big one. And she's very hard to get along with—only thinking of herself. More than anyone. And she has very much difficulty with her family. She' always feeling left out and needing the most attention. Sometimes she does things that adult people wouldn't do. Like forcing people to get whatever she's asking for. And she would act like a little kid and be mad at this person for a while. And there is much more. I think she does get nervous breakdowns. I'm not sure. But that's how I see her…Sometimes she would do things you wouldn't think of to do. Or say very disturbing things that would create arguments. You know, just making it up, to play mind games with some people. Very disturbing. [P007]

The relationship between behaviors as signs and symptoms, and the broad terms for mental disorder is summarized in Figure 3-1.

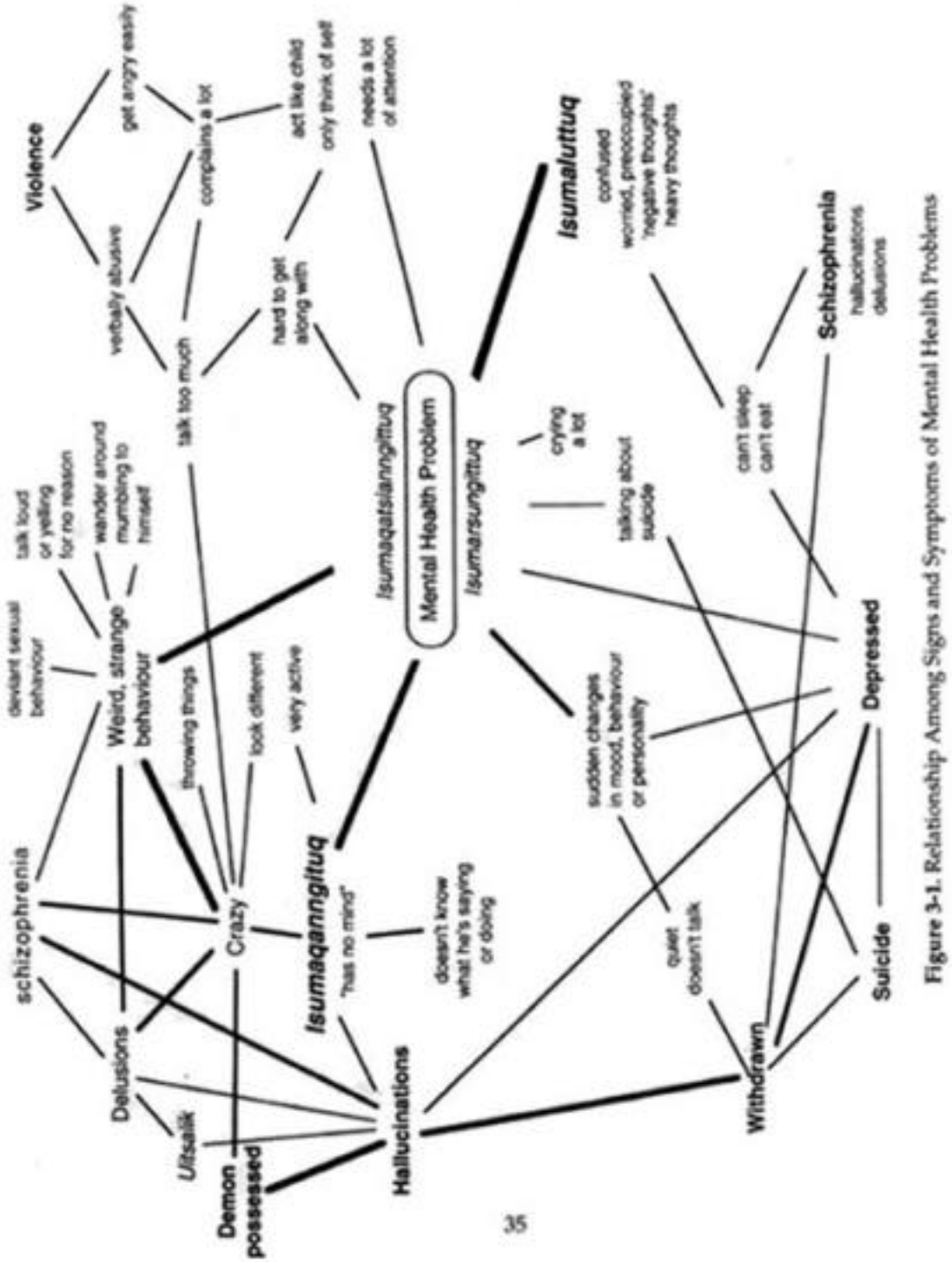

Figure 3-1. Relationship Among Signs and Symptoms of Mental Health Problems.

3.3 Hallucinations and Delusions

Informants readily gave instances of individuals with hallucinations or delusions. The Inuktitut terms for these are purely descriptive: "seeing (or hearing) something that is not there," "believing something that is not true." These are commonly recognized as indication of something wrong; however, opinions differ markedly on the nature of the problem. In some cases, hallucinations were clearly related to a pre-existing or emerging mental illness:

> That's usually is for the mental cases. Here, they say its a bad spirit. I think it's a hallucination. Their mind is working so hard that they actually see and do what they can hear without us hearing it. [P030]

> She was, she heard about her mother-in-law, when she was like that. She was (saying) things like, um, that she and her son, her husband, were going to jail. And everywhere she went she was saying that and that's when they became aware that she was not herself and she was…And when she was watching television she saw that, um, she saw the television the other way that people were not seeing. She was seeing things on it that they weren't. She didn't exactly say what she was seeing. But she was saying that she saw that was a different. [P010]

Similarly, delusions could reflect an identified psychiatric disorder:

> I know one person who used to be like that. From what I know, this person used to be, like in his mind it was set. Like that's the way it is. In his mind. And even though it wasn't so that way, it was—he believed that in his mind, that whatever it was that he thought he did, was what happened.....he thought that, someone was trying to get him arrested? And it even got to the point where he was almost, ah....physically hitting the person. The idea came from the time he was busted for selling [drugs]. When they wanted him to go to court, he thought that person there was trying to get him behind bars. From what I knew, that was not to the case. But he thought otherwise. But he was really thinking in his mind that it was happening to him that way. The way that it was going in his mind....the way his mind was working. Paranoid? Ah, for me it would be like, like you were saying, having delusions. [S004]

For most informants, however, hallucinations were strong evidence of demon possession.

> Inuit people they never heard of such a thing as hallucination. you know? Even the ones who are completely healthy in mind, they can hallucinate but they think that it's an evil doing it, you know? evil taking…[P030]

> Those crazy people, they're talking a lot, pushing people, but those who's hearing things, they seems to be staying at home. But they come to nursing station when they really need help. And we ask them what it is and they talk and feels better after. Very serious. They even told us what they were hearing—I mean music, rock and roll music. Some of them sniffing [solvents]…[P033]

> My small daughter. Four year old. I have experienced that, uh, seeing? we couldn't see. Like she was crying for a whole ten minutes straight. Even though

> we thought it was…At first we thought it was just her, ah, sickness. Like, headache, or stomach ache. But since she started to, ah, cry, ah, and, saying a small word. Some kind of 'look'. So it's like she's seeing something. 'Look.' And she couldn't even, she could even face it. So it was in our hands. Even though the head was facing to our body, even the eyes. She, she couldn't handle it. A little, when she opened her eyes, even just a small bit, she asked, she was pointing that, that she see. But since it was so hard to handle that, um, we didn't have an idea what to do. But, since it was too long, I started to, I, we need the group to pray for that girl. That's where we saw it was the demon possession. It wasn't mere hallucination. It was stronger than hallucination. [P003]

'Delusions' might also indicate demon possession, particularly when they involved an 'imaginary husband' or 'wife' (*uirsalik*; see section on demon possession below).

Whether viewed as mental disorder or some form of possession (or often both), hallucinations were considered serious problems and associated with a wide range of other symptoms including: "shouting and dancing for no reason"; being really depressed or down; wandering around back and forth; not talking, eating or sleeping; withdrawal and wanting to be left alone; suicidality; talking a lot; and / or hitting things.

3.4 Interpersonal Violence

Violence was viewed as a prevalent and serious problem in the communities by most informants. The most common form of violence described was spouse abuse although vandalism by adolescents was also frequently noted. Men were usually the perpetrators although several informants noted aggressive women, or discussed the role of verbal provocation by women in marital conflicts. Verbal threats were included as a form of violence by many informants.

Although interpersonal violence is clearly very common in Nunavik communities, it was never viewed as 'normal' or acceptable by any informant. Violent individuals were uniformly viewed as troubled, if not with mental illness then with a difficult upbringing and with ongoing personal problems.

Violence was almost always associated with alcohol or, among youth, solvent abuse. When people were not drinking, they were usually not violent and indeed, were likely to be guilty and contrite. However, jealousy, possessiveness and a tendency to dominate other people were also cited as antecedents of family violence:

> The only people that I know when they are uh drunk.. they're violent towards their family—their wives, their relatives—when they're drunk only. Other than that I think they're OK when they're sober. Before, people get to be like that, their possessive, pushy. You know they used to be he big boss, you know. I think there's not a few people like that today. I don't know maybe one or two. They control their families so… [P052]

> You can talk to them or you can walk with them, or when they have been taking some substance, their personality changes. Like, you can notice people, when they smoke [cannabis]. When they have been taking some drugs, sometimes they become violent or violently physical…sometimes they will become very physical and they can become easily mad. Or do something that he cannot do when he's not, when he's not taking…before he take anything. But their personality changes when they have been—before they take some or after they have taken some. And, when they become physical or violent that they hurt themselves, and also, um, they hurt the other people.[S006]

In a few instances, violence was associated with individuals who had mental disorders. For example, a man who was being treated for schizophrenia by the doctors and for demon possession by the church was suffering from hallucinations:

> He was being told things. And he would talk by himself or. He was really, really violent to people. He's like, one time he said, I'm getting shot in the head, by someone who is in my head, inside my head. Someone is telling me, who is inside my head, that they're going to shoot me. Tell me, that's really, really, really, just to hear that is very violent. Because it's inside the person. It's, there's nobody provoking that, except him, inside his head. [P002]

When people were not actively violent there was nothing to distinguish them from other people. This was either because the violence was solely due to the effects of alcohol or drugs that left no residuum, or was due to efforts on the part of the wife abuser to present himself publicly as a mild and amiable person. Even when someone was openly violent, threatening or shooting at others with a gun, this was usually viewed as a behavior that was due to extrinsic circumstances (like alcohol, temporary illness, anger) and that could change at any time.

The most important signs of violence were found in the victims, who were likely to be fearful, depressed, discouraged and generally demoralized.

> This lady, a friend of mine, has been having many, many problems with her husband in the past…The, the man is committing adultery. He has one or two, two children, besides the ones he has with his wife. He has a serious drinking problem. He's abusing drugs. He's physically and verbally violent with his wife and his kids. And she's very affected by that. Within, I mean you can tell by her work. The kind of work she does that. She's that kind of chronic problem. It's a chronic problem with them. And it's affecting her work, the quality of her work…But, her husband wants her to work. So she's being forced to work. [S002]

3.5 Suicide

Suicide, primarily among adolescents and young adults, was recognized to be a serious problem in most communities. Individuals who completed or attempt suicide were described as often withdrawn, isolated, depressed, having heavy thoughts, low self-esteem or hating themselves. In some instances, it was easy to recognize someone who was suicidal because they talked about their troubles and feelings of misery, boredom and wanting to escape. However, such feelings were common among young people in the communities and others might be alerted only if the person talked explicitly about suicide.

> Well, when I've heard it and I've seen it before, in my brother, in my daughter and in my brother-in-law, my father has committed suicide, so for me, after my father had committed suicide, I was able to start to be able to tell who's, I mean, the way they talk. They don't say I'm going to commit suicide. It's like some are talking like Oh I'm tired of life or I'm, they start asking questions, some start asking questions about death. Well, it's happened in my brother's case and my brother-in-law, so they.... that's something kind of hard for me to talk about. But, some, some people take notes, they write notes. I've seen my brother's writing before. He wrote notes and he started writing notes. And he tried to hang himself. My daughter tried that too. She tried to hang herself. And my brother-in-law has stabbed himself. I mean, cut himself up. So, I mean, it's hard for me to say, how do you, to tell you how I can tell. But, it's just there when you, when you have to know. So for me it's just like that. I don't know if it would be the same for you. It's hard for me to explain really. I mean I'm trying. I'm trying. But I can't explain everything perfectly. [P032]

Explicit talk about suicide could be misleading, however, since those that talk most might be most manipulative or ambivalent.

> Well, some say, "I'm going to commit suicide," or "I'm going to do it." It's like some of them are just trying to scare you, or it's hard to tell whether they really mean it or whether they're just trying to scare you. My husband talks about suicide. And I myself have thought about it. Now I know I won't do it, but there are days and times that it comes to thinking about it. For me, I don't say anything to anybody. I don't say I want to commit suicide so I myself have thought about it, I never say anything to anybody about it. … you really get tired of living. I have thought of like just disappear, like I don't know if I mean by dying, or, that's something I myself can't understand. I feel like disappearing, maybe without dying or with dying, I don't know. I mean, there are times when I think about how I'm going to do it. Am I gonna hang myself? Am I gonna overdose? Do I slash my wrists? what, what, what? How will I do it? You just get tired of what's happening around you. [P032]

Indeed, in some instances suicide attempts were understood as attempts to get attention or remonstrate others. The usual precipitants of such suicide attempts are interpersonal:

> Frustrated young people, for the most part. Young people that feel that their parents don't give a damn. Or just don't understand their problems, are unsympathetic. Ah..people who fail at things that they, they want to accomplish.

> Ah, lover's quarrels. That's a very big one. Disagreements between boyfriend, girlfriend, or common-law spouse. For the most part they threaten to do so when there is someone there to stop them—knowing full well that they're going to be stopped from doing it. [S004]

> When young people get mad, eh? Real mad, they always say I'm going to kill myself. They always say that every time they get mad at somebody or have a fight with somebody. When they can't beat beat the guy or something, they always say I'll kill myself or something. Even though they won't going to kill themselves.. That's what they do. Young people. [P050]

Among young people suicide was linked to interpersonal conflicts, particularly problems with anger and dependency. The most frequent precipitants mentioned were the break up of relationships or other frustrations with family, school, or friends. Such angry suicide attempts, though, were often described as gestures. In more serious cases, suicide was preceded by silence, withdrawal and self-isolation:

> Other times, you don't know how things began. Like if someone begins to close their door in their room, lock themselves up, you don't…at first you don't notice that. That's the time when you begin to see that something is wrong with the person. That they are depressed. And creating some kind of imaginary stuff in their mind. And sometimes it's a bit late, that person has become depressed. Some of them commit suicide? And some are…they start to get help… I find there are different kinds of reasons why you can know a person is depressed. [P001]

> There's few young people who, right before they died, it seems they were so quiet, they were alone and they were acting different than usual and weird. Like there was a young guy who was so different right before he died—right before he killed himself. He was so different. He didn't talk to anybody until unless they talked to him. [P038]

Many informants noted that it was very difficult to tell that someone was going to commit suicide, even among close friends or relatives. The event then came as a tremendous shock.

> I can't tell. Every time someone I know commits suicide, I'm completely shocked. Unprepared. Caught off guard. Even if I know the person well. The one's that actually do go ahead and commit suicide. They don't really talk about it. As far as I know. At least, they don't talk about it to me. [S004]

> I didn't see any sign, but maybe some people knew—saw the difference in the way he acted. They might have seen the person differently as when you are not happy and you do not want to speak to other people, or to talk about things. That you don't want to be bothered, or like you want to be alone or you don't want to talk to anyone. But my friend, I didn't notice. But, sometimes people who commit suicide, maybe they're trying to give some sign that they have problems. Even though they're not trying to open themselves. [S006]

> There were maybe two or three people I knew, friends. The third one was not that close, but he was a relative of mine. The other two were close friends. The first one, he used to say, "I'm not so happy with my family." And he used to say,

> "I want to get out of that household." But he never talked about suicide or anything. And I'm quite sure that there were signs of what was to come. But I never noticed them. And the only time that I learned about it was—I mean how to notice these symptoms, or the signs of someone who is suicidal—when we met with social workers here. And they were talking about, "These are the signs to look for in a suicidal person." That was the only time I learned about them. And that's when I was looking back, I started to say, "So that's what was happening." And the other friend who killed himself 3 years ago—he didn't seem to have any problems at all. And yet he shot himself. But I heard, later on I heard from other people that quite a number of times, his friends came in when he was contemplating shooting himself. And he used to say: "I'm capable of using these"—showing them bullets. But those people who dropped in that time, when he was in those moods, never picked up the signals saying "I'm capable of using these bullets." And he never talked about what he thought about. What he wanted to do. He never talked about it. And the last one was this year. I was visiting his place? And he was feeling down. He was quite happy and he went out to make a phone call. When he came back in he was down. You could see in his face that he was down, after looking so happy. When he came back he was sad. And he went to his room, got onto the bed to lie down and few minutes later one of his friends looked in on him and he was lying there so he shut the door and the next day we heard that he had hung himself. Ah, but he had shot himself in the stomach, somewhere in the stomach earlier? Maybe two years before that? And all I can think is that it's sad to see his family had a chance to talk with him about his problems. But I don't think that they were listening to him. [S003]

The high prevalence of suicide among the Inuit has lead to various efforts at suicide prevention education. This has had some impact on general knowledge of the precursors of suicide:

> It's very hard. If you're just a citizen of the town, it's very hard to know. But there have been some courses offered in order to be able to recognize them. I don't know. They usually act just normal in front of other people. But they look very lonely. They usually talk about how they feel. They don't exactly say that that's what they want to do, they seem to be preparing themselves for it. Like there have been courses given out , giving information saying that this person would be giving his personal things that are precious to some people that he likes. And sometimes they would be talking about it. Talking about things, talking about themselves being lonely. [P034]

3.6 Social Withdrawal and Isolation

In traditional Inuit life people lived in small bands composed of one or a few extended families and had very high degrees of contact with each other. Nunavik communities today are larger but houses are placed close together, and people ordinarily have much contact with each other—freely visiting each other's homes throughout the day and evening. Homes are crowded by southern standards and so it is difficult to find time away from others within the settlement. Withdrawn, self-isolating behavior then, is extremely conspicuous.

> Well, some of them, if you're outside, that person is coming towards you, but when they see you they walk another direction or when you go and visit they

> just go to their room and they are very quiet...both boys and girls. Mostly young people that I know are like that. A lot of the young people do. [P032]

> They usually lock themselves in their rooms. They don't socialize, when they go out hunting they go alone all the time. They don't even go to the stores where there all the people gatherings. They just isolate themselves in their homes. [P034]

Adolescents might isolate themselves in their rooms at home. Adults might stay inside their home, coming out only at night or when urgent matters made it essential. People who did not physically isolate themselves in this manner might nonetheless become quiet and withdrawn around others.

The problems associated with withdrawal ranged from shyness and low self-esteem, through fearfulness, to depression, suicidality and psychosis.

> Those people he has spoken to who didn't want to get out of the room or go out or see anybody else, when he talks with them, a lot of them say that they lost their self-esteem. They isolate themselves because they find they're not the same as any other people. And shy. They don't want to talk about themselves. Just an idea like, "I'm so ugly I shouldn't appear anywhere. I'm stupid. I can't stay around." [P004]

Withdrawal due to shyness could also be associated with loneliness, sadness or depression.

> They don't have friends. And they're sad. They need friends, and there's no one for them. That's why they're sad and depressed. And they need someone to have fun with, and to talk to. ..*Inutukijuk* (someone who is lonely). [P009]

Some individuals might have more painful secrets they could not speak about and that caused them to isolate themselves.

> It took him two years to speak to someone about it. Now it's making him completely isolated. He has kids, the wife, and the mother, in the same house. But he's always sitting there. The only time he goes out is go around, go around their house. Don't go anywhere else. So he, something is really disturbing him…*qitsatuk*,….mentally disturbed? He's not going out. Why is he not like he was when he was young? Why is he always alone, or staying home all the time. Don't want to see nobody. He used to be really active before this happened. A very good worker too. But now there's not a thing you would make him feel like doing, even if it sounds exciting to do. He's alone. He may have his kids and wife and mother in same house, but he treats them like they were a few thousand miles from here. [P007]

Ultimately, such isolation became alarming because it involved a complete refusal or inability to take part in community life. It might also portend more serious illness or suicide:

> Well, mostly the people who I know who do that are the young people. Yeah. That's mostly the people who don't want to go around, because either they're shy, I mean shy in a way that they have ideas about other people. They're afraid

> to be seen in public. A lot of young people are like that. Because they're shy, they're afraid someone will laugh at them, they have no self-esteem. I think some of them are preparing for suicide. That's one of the things—when a young person doesn't want to be around people, or talk to other people, they let themselves be alone, that's one of the signs of suicidal people.[P032]

> It is called *isumaluttuq*. *Isumaluttuq* is worried, but in a way that is very serious. It is a serious something that really, that a person has to look into. This person needs help. I was talking about fantasies earlier. It is because this person can be living in his own world, that he believes in it so much, that he gets isolated. If each time a person gets into this withdrawn phase, it means he is scared of something we are not scared and he starts believing, he believes it so much that it's starting to affect him. That he's not living in a world where we, where we normal people live. Us being normal we have our own fears but we take this where we are now, this is life as it is. We accept it; that person is not able to accept it anymore. [S001]

Initially, withdrawal was tolerated and respected by others, and might not be viewed as a problem. This is part of a larger cultural attitude of non-interference in others' activities and lives. This may delay recognition of potentially severe problems:

> Like if someone begins to close their door in their room, lock themselves up, you don't..at first you don't notice that. (That's) time you begin to see that something is wrong with the person. That they are depressed. And creating some kind of imaginary stuff in their mind. And sometimes it's a bit late, that, that person has become depressed. Some of them commit suicide? And some, they start to get help.....[P001]

It is not withdrawal itself but the change from being normally gregarious to withdrawn that indicates a problem.

> There are people who are quiet who doesn't talk very much, but it's their own personality. And there are people who aren't like that but are starting to be like that, that's two different people, so for those who are normally, some people , they may not be worried about anything at all but still be very quiet, not very talkative, doesn't mix with lots of people, but that's normal for them. That doesn't mean they have a problem. But there were others who were not like that but starting to act like that, that's when you know there is a difference.[P032]

3.7 Depression

Depression was viewed as a 'mental problem' (i.e., *isumaluttuq*) but not as a mental illness *per se*. It is signaled by wanting to be alone, refusing to talk with others, not eating, not sleeping, crying a lot. More severe cases of depression are associated with suicidal ideation and hallucinations.

> I notice people who are depressed and want to be alone. Feel like crying or don't want to eat. Or just lying down in bed sleeping. Or staying in their room without anybody, without anybody to disturb them. And people who are depressed, sometimes they don't want to eat. Sometimes you can see when the person depressed, that he lost few pounds. [S006]

Depressed people can be recognized by their appearance and behavior, chiefly sadness, quietness and avoidance of contact with others. They don't want to look others in the face and turn away. They avoid talking to others. Several informants clearly described anhedonia—i.e., the person cannot take pleasure in usual activities and is not cheered up by a good turn of events.

Although usually associated with social withdrawal and avoidance and sleep disturbance, depression might also take an agitated form:

> *Isumaluttuq* …they would be different lots of different ways. Some can be depressed quietly. Some can be depressed violently and bother anybody they see outside of home—especially outside of home—saying a lot of bad things to any person, that she meets, blaming a person, anybody. Blaming such little small problems she sees. He or she. That's depressed. Violence and depressed at the same time. Depression and quiet is... I don't know really how to say it. Quietly a person would say she or he can not sleep over night a couple of nights because he or she had a lot on her mind. She wouldn't say she had a problem. But all she or he can say is I can not sleep for a couple of nights. So can I get anything to make me sleep. Things like that. But he or she cannot get mad at the person. They are trying to be quiet, trying to hide something.. There's a lot of women like that. [P029]

> They.. they their way of life is different. They look different, they don't act the same... I don't know. Maybe in many ways. They don't take care of themselves and sometimes they, they don't really wash themselves. So they become dirty. And.. they don't talk to you, they don't talk about funny things that would make you laugh (or things like that). [P034]

Depression is related to, but distinct from sadness. In Salluit the term used is *qitsatuq*, which is also used for grief associated with mourning.

> Depressed is very real. "*Qitsatuq*" you would call it, it's the same word being, being used for mourning. But when you're mourning it's because you have lost a loved one, a family, but when you are depressed it's something else. *Qitsatuq*, she's depressed. They are very withdrawn. They are feeling so guilty and they are guilty for nothing. Well, for something they have done but something they shouldn't dwell on for so long but they chose to dwell on it and postpartum depression is very real. It's a very real depression postpartum. I've gone through

> it a couple of times until I handled it. I had to learn how to handle it. I think that's what you call depression or you, you have very low self-esteem and when you're depressed you don't look after yourself. You look after what you have to look after, your kids, your husband, to make sure they're well dressed, well, well kept, food is on the table on the dot. You can do all these things when you are depressed. You can only see after, after a while that you are depressed because you did not take care of yourself…That's what I would call depression. [S001]

> Someone who's very, very depressed, very, very down, in Inuktitut we call it *qitsatuq*. That's more than being sad. More below than being sad (*Kavartuq*). *Qitsatuq* means, he's beyond fixing himself, and he needs a little more attention than being sad. Very low, very down. Like if one's, relatives die, and that relative was quite close to that person, that person feels really down, *qitsatuq*. You can be very depressed with many other things like divorce or separation and being looked down on by other people, being helpless. Meaning when you cannot get help from anyone. And you feel helpless. [S002]

Just as withdrawal and isolation may be tolerated and normalized, so too the slowing down and withdrawal of depression may not be recognized as a problem requiring medical or other help. In one instance, an elderly woman with recurrent seasonal depressive episodes would retire to a pallet on the living room floor for 6 to 8 weeks every year, unable to do any housework. This was accepted by the family and no help was sought for many years until an episode in which she began to hallucinate and was throat-singing with an invisible partner. This prompted the family to seek both medical help and religious intervention for possible demons. During her psychosis the woman talked of past sexual infidelities and made many lewd remarks. Her husband viewed this as punishment for his own past indiscretions. The psychotic depression resolved with medication and two years later the episode was no longer recalled by either the woman or her husband.

3.8 Anxiety

Anxiety was viewed as a less common problem than depression and even less of a 'mental health problem'. Anxiety was described as a problem of worrying a lot, usually about specific fears that people had acquired through untoward events they had experienced, including family violence, accidents and injuries. Fears cited included those of being raped, of violence, of harm befalling one's children, or of the house burning down. Most of these events are not uncommon in the settlements.

> There was one person, right now she's doing fine, but, she was really nervous, very anxiety, when her, family member drowned? And she was, ah, nervous to go out or even go canoe, or— ever since where there's been water. And she was very nervous, very nervous. [P014]

An acutely anxious person was described as jittery, jumpy, unable to stay calm, unable to be at ease, unable to sit still or stay indoors. They may talk rapidly and complain or blame others for inciting their anxiety, or as a result of their

irritability. People who had experienced anxiety themselves added other symptoms including trouble sleeping, headaches, low energy, lethargy, lack of appetite, vulnerability to colds, difficulty concentrating, and difficulty performing skilled tasks. Such anxiety was usually a very transient condition:

> Not common here. It's just, not very many people and mostly the same people are like that. well there are a lot of nervous people but it's not .. it doesn't last so long. Well it is a problem, but still its something that doesn't last too long unless ... like I said with Inuit people. I think its a problem if you're in the situation now but its something that goes away.[P032]

A few informants described people who were seen as anxious all the time for little reason. This was related to their own mental processes of worrying. They kept expecting something bad to happen. Talking and thinking about worries or irritations could make them bigger. People with anxiety tended to talk a lot about their fears and worries and this could annoy other people.

At least one informant, a health worker, had a very contemporary sounding 'psychosomatic' model of anxiety, including a description of panic attacks and cognitively mediated secondary anxiety:

> They have anxiety attacks. They have become short of breath, or, their blood pressure goes up. They're chronically ill people. Their health goes down. These people are more often sick than other people. Because their heartbeat becomes tense. I don't know really how to describe it. But are they more sick than others , or are they sick that they are sick. [P002]

In general, however, anxiety was seen as a fear reaction to concretely threatening situations, notably the threat of family violence.

> No I don't anybody who is who are like that.... jumpy you meant? I guess the only people who are like that are alone—mainly the women when the men are drunk. There's a woman that I know who is very jumpy—used to be very jumpy—because her husband was a drunk and killed a person and spent a long time in jail. When he got back her, he start all over again drinking, and he was sent back to jail and he killed himself. This person , his wife, used to be very jumpy and you know nervous and she's very old now you know she look like she's a very old person but she's not. Her hair is white, her face is wrinkled, you know I think she's just adjusting to a normal life now that her husband is dead now. That's all I know. [P052]

3.9 Mental Deficiency/Learning Disability

People with intellectual handicaps were sharply distinguished from those with 'mental illness'. They were generally recognized as having a congenital condition (often attributed to the mother having taken drugs during pregnancy) that was described as a physical disability with behavioral and intellectual limitations.

Mental retarded people were described as slow, dull, unable to function as a normal human being, childish. In some cases they were also noted to be very active, have attention problems and be difficult to control or, less often, aggressive. In general, they do not look different from other people unless they have an accompanying physical deformity or disability.

> I have a kid, he's 8 years old. He's very slow of learning at school. But very active. He's different than my kids. He's everywhere. Making my kids cry with no reason at all. He's—sometimes I get tired of it—And he's very slow at talking, writing, and things...But he, but he looks normal. [P033]

> The only people that I would know would be people who are handicapped eh? I have a daughter who is very slow in her learning, because she's quite small. She's even smaller than her younger brother. And she's very slow in her leaning in school. But I think she's normal—you know, eats a lot. She's happy to play, playful, do everything that a normal person would do. But she gets the special teachers to keep up with other children. I think there is quite few [like her] in school. [P052]

> That's people who don't learn fast. I guess the thing that I notice the most is their speech. They talk funnier than others. For instance I know of a kid, who means to say one thing but it comes out different. It's funny to hear. That's the thing I notice the most. And he's also very hyper. The other thing I notice about that is that they tend to be very violent toward other people. I suppose it's because they're teased a lot for being slow or dull witted. When they get angry they get so angry that they are willing to stab a person with scissors. Not that they did it. But, they threatened to do it. [S004]

Difficulties in learning (learning disabilities, poor school performance) were mentioned more often than frank mental retardation and were attributed to more diverse causes.

> When children didn't have enough sleep, there would be different causes and different reason why they didn't get enough sleep. I've been a teacher before in a classroom I used to recognize children who didn't get enough sleep, who are just daydreaming. They fight and there's no organization, they're hard to organize, they're hard to control. They're shouting and slapping each other, things like that. [P034]

3.10 Seizures and Convulsions

Like mental retardation, seizures were viewed as physical problems. Some knowledgeable informants distinguished between seizures which involved loss of consciousness or 'absence' and convulsions which involved jerking movements of the whole body.

> Seizures, someone who is going limp? And not coordinating as he should, but not convulsing. Convulsing is another term for, there will be spasms of the whole body. I've never actually seen, seen convulsions but seizures I can…[S001]

In most cases, the only distinguishing feature of someone with seizures was the seizure itself.

> Well in my daughter's case, she used to have lots of seizures, many times a day for weeks. And that affected her very much, her behavior. She couldn't go to school because of that, she would be tired all of the time, she would be moody, she would be scared to be alone. That changes, that changes her behavior a lot. But, I also know a lot of others who are epileptic but doesn't have seizures all of the time and they don't have any problems with other people. [P032]

In several cases, however, informants described troublesome behavior in people with seizure disorders when they were not having seizures. This included "acting childish," "saying something bad," and "throwing things."

There was at least some hint that on occasion convulsions might have been 'hysteric':

> Well, we don't get to see that much anymore, since people don't gather themselves together. When we used to have hall for recreation like, music and games, Inuit games, before. We used to see people having a fit? You know. A convulsion. And they would help. They just don't let them do it alone. [P007]

It is not clear from this account whether the fits seen during the Inuit games were more common simply because more people with epilepsy were in town or whether there was something about the excitement of the festival that engendered seizures (which may have been either epileptic seizures induced by sleep deprivation, exhaustion, etc.) or pseudoseizures.

3.11 Memory Lapses, Immobility and 'Running Wild'

The three registers tapping memory lapses, sudden frozen immobility and running wild are grouped together here because all were intended to tap dissociative behavior, said to be common in the past among the Inuit (e.g., Foulks, 1974). In fact, these registers yielded few case descriptions from informants. All three were said to be rarely encountered and tended to be attributed to organic causes (aging, stroke or substance abuse).

Memory lapses were attributed to drugs, depression, Alzheimer's disease, mental illness, old age:

> Well there had been another one, but he died because he lost his memory. That was a few years ago, I think two years ago. He drowned. He walked out there. He used to come and visit our place. He came to our place walking, he forgot that he walked and he just took our skidoo and took off. And sometimes he would be walking and forget where he is. Sometimes he would forget a lot of things. The family didn't realize his sickness, I mean they thought it was depression. But it was a kind of a disease...Well there were times when he almost drowned, before he really did. And so we know that he had Alzheimer's disease…Well, for that man that died, he was a kind of a person who was independent, so no matter what was happening to him, he still wanted to be alone. But, for the one who is still living, she's afraid to be alone. She thinks she's mentally sick. She's afraid something is making her like that. I don't know if the family knows that she has that disease. The hospital, the nursing station, knows what she has. But I don't know if the family knows, because they don't act like they know. I mean it seems like they don't know. She thinks that she is depressed or there's something that makes her depressed, she doesn't know how to say. But she thinks so hard what causes her to be like that. But still can't find answer. And she gets depressed because she still can't find the answer. [P032]

> I used to think it was mainly women who have borne a lot of children. I was experiencing this myself recently. Because just about two months ago I had a surgery in Montreal and when I came back I was forgetting things very easily. It's not fun. Like I was forgetting the teapot, the kettle on. I was making tea on the stove and I forgot all about it. And it dried out boiling and I wasn't aware of it. It's not fun to be forgetful. [P034]

> The only person I know that's actually like that is my 13 year old. Well, you ask him a very basic question and he will look at you with a blank look on his face. So you say, "Come on, come on, answer me here." It'll take like a moment for him to remember what the question even was. My Mom blames that on his natural mother having been stoned all the time when she was pregnant with him. I can't say whether that's true or not. I don't know. [S004]

There were no clear accounts of immobility or freezing behavior.

Running wild was not commonly observed but was readily attributed to alcohol or drugs. Most informants said this was the only time they had observed—or could conceive of observing—such behavior. The portrait was of an intoxicated person running about the settlement shouting and hitting anybody he was angry with. When the effects of the alcohol dissipated so too did the 'wild' behavior.

A few informants gave more elaborate accounts.

> Like taking off their clothes, wanting to make, to make love to anybody. Person doesn't really know what she's doing. When a person is in that situation, it's hard for us to—is it demon possession, or is it the mental health problem, or is it the way she is trying to express his feelings. But it's hard for me to describe why a person is doing this. [P003]

> I never had experience myself seeing that, even in the olden days. But I know we had to be really careful with this certain person. But now he's not alive anymore. He was very close to us. A friend of ours. Who always had that. So someone will have to be with him, at least 24 hour a day. That's all I know. There's hardly any, that I've heard, of these type of people. [P007]

> She doesn't know, she hasn't really heard anything about… Not from here, somewhere else. She heard about someone who undressed and got lost in the tundra and froze to death. [P010]

In a few cases it was clearly related to a mental disorder:

> Running wild is for people who are called schizophrenic. Who go through life like that. Who go through these stages that one day they'll be completely sane the next they'll be completely wild. [S001]

> I know one person who has....I heard one person happened like this, that he stripped without thinking. Or he was thinking but, I think he would be mentally ill, or physically ill. As well as, if the person is using alcohol, smoke, or sniffing. [S006]

The fact that all three of these types of behavior were most closely associated with organic medical conditions shows both that dissociative symptoms are probably not as common as has been claimed in the past and/or that when they do occur they are most likely to be attributed to drugs, alcohol or a medical disorder. If they do occur, attributing dissociative symptoms to medical disorders would serve to legitimate them as valid forms of illness behavior and would probably contribute to increasing their frequency and persistence.

3.12 Drug, Alcohol and Solvent Abuse

Alcohol, drug and solvent (inhalant abuse, commonly called "sniffing") were among the most common problems raised spontaneously by informants in connection with youth suicide and violence. Much federal support has gone into local alcohol, drug and addiction counseling programs (NADAP) so that most informants have been exposed to standard information on substances of abuse and their effects.

Substance use can be recognized when one sees the individual acutely intoxicated—they will look red or pale in the face, their eyes may be glassy, they may stagger around and have the smell of the intoxicant or inhalant on their breath—otherwise, it is recognized more by its effects on behavior and relationships with others.

> Well, with drugs sometimes they get very calm and relaxed. But with alcohol sometimes they're very pale on their face. [P014]

> Well, it depends what you're taking. If you're taking alcohol and you get drunk, some people don't get drunk, some people do. Some get violent, some start talking a lot, some get very quiet, some people fall asleep. And when you're

> sniffing, that's another thing, you can be violent, you can have hallucinations, you can be so quiet, I mean, you can look frightened, like you're scared of something. Your looks, your eyes, they're red like they're popping out of your head, those I've seen. And you smell of substances. And for me it's scary to be near those people because you never know what's going to happen. They can become violent, some of them get the strength they don't usually have. Especially dope that I know, my brother for an example, he , when he when he wanted to smoke dope and there was nothing, he would get angry, I mean become violent. And, also, not only that, I mean, my other brother, I'm talking about my older brother, now I'm going to talk about my younger one. I think only once I've seen him taking hash. Because those two brothers of mine they're very shy to be in front of me when they take those things. They change their personality like to the opposite. [P032]

In general, drinking alcohol was strongly associated with violence, particularly wife abuse; sniffing of solvents was less often associated with violence and suicide but was more consistently linked with confused behavior and hallucinations; cannabis use was associated with 'glassy eyes', slowing down and indolence, but rarely violence. All cause changes in the person's behavior and, for those informants who used the term, changes in 'personality'. Solvents in particular are believed to cause permanent changes in a person's body and brain that are reflected in their appearance and ability to learn. For some informants, however, it was the absence of drugs and the craving or irritability associated with not having it that precipitated violence.

> Marijuana, hash, cocaine. They change a person completely. If they have some drugs somewhere, they are very good happy people. When the stuff is gone they start being violent. when it's not available anymore, that's when they get angry very easily. I know that very well. Because my close relative is one of them. It completely changes a person. And they are addicted. It's hard for them. I always understand them. It's not them. It's a drug. [P023]

> They look pale and they don't address you as a normal person. They can address you as if you don't exist or as or just say something loudly to you or some strange behaviors. The one who are using the substances? Sniffing? How does it affect them did you say? We're being told that their brain cells are damaged. Every time they sniff, there are a few brain cells go damaged and more and more until they are hooked or they take it every day. They're hard to control. [P034]

> Most husbands are abusive to their wives to get some drugs or alcohol. I've known some husbands selling their wives to get drugs and any kind of alcohol. It's happening to mostly young people. I've never known older people selling their wife to get drugs. I've known only a few years now maybe 3 or 4 years and I couldn't believe what I heard. [P050]

People who are acutely intoxicated sometimes tend to avoid contact with others because they are ashamed that they are 'under the influence'. Several informants noted that the biggest problem associated with substance use was the economic drain it represented for the family since alcohol and other drugs were costly. This was offered as one reason why youth use solvents which are more readily available.

Another serious effect of drugs and alcohol frequently mentioned was the impact on pregnant mothers who could then have deformed or intellectually disabled babies. Accounts of many different sorts of problems, including hallucinations, mental retardation, and violence, emphasized this prenatal effect of substances.

3.13 Demon Possession

Among informants of all levels of education, occupation and acculturation, demon possession was a common explanation for many forms of aberrant behavior especially hallucinations or bizarre behavior. The predominant form of demon possession was a Christian version strongly resembling southern Pentecostal and 'born-again' sects. It was most often called *anirnilunik illumittuq*—"a spirit (Satan) dwelling inside." Other forms of demon possession more strongly influenced by traditional Inuit ideas included *uirsalik* (spirit husband) and *uuttulutaq*, a more general term. These forms are discussed in more detail in Chapter 4. In this section, we will focus on the most Christianized form of demon possession since most informants referred either to this model or to exemplary cases that had been handled by church representatives.

Demon possession was associated with people not acting like themselves, strange or bizarre behavior, and with a wide range of special powers and fantastic events including sudden changes in facial appearance, speaking with a different voice, transformations into an animal, teleportation, telekinesis, levitation, clairvoyance, clairaudience and superhuman strength. Many of the accounts of demon possession were clearly influenced by the popular film *The Exorcist*, which was treated more like a documentary than a fiction.

> They were different. Like they changed, and they would do, they would float around, or something. Like they were okay before, and they were, and then they were possessed by the demon, or something. And, they would—my belief is, they would, they don't believe in God, or something like that. I mean, our God. And there is no God for them. They don't believe in anything. They don't go to church, or something like that. And they would be possessed and do bad things about people who go to church, or priest, or they are against them. [P009]

> She's heard about it, but she's never seen it. Um, she heard about someone who was demon possessed, who was just in bed all the time. She just heard that woman was in bed, but the bed was shaking by itself. That's all she heard about that person. [P010]

> Back in the early days, like the 60s? When I was less than teenager, I used to know one person. People used to say that she was possessed by devil? I used to hear about that, a lot. Through all the people that I heard her personality has changed a lot. She's [Inuk term] means something, something inside something inside the body. [P014]

> They act like they're possessed by demons. Well, my husband was the one who, who was like that. And he at that time, first he had .. well kind of a flying thing. He was off the ground about an inch. And he was talking in a way, not in his voice you know, and when he talked his face changed, I mean like it goes

> crooked, in all shapes. So, that's the only one I've seen who's demon possessed, but there have been others been said to have demon possession in the village. I think one or two other people, but I've never really seen that in a way as much as I can I don't want to see it again. And they're different, I mean different from being mentally sick, completely different. All kinds of things, things that don't make sense. [P032]

> She / he can become scary, smell bad, act like she / he is frozen, act very strong, be silent, become weak, act like she / he doesn't hear a thing, act like she / he is flying, or that person can act like a dog or a wolf when trying to be scary, or she / he can move like a snake, she / he can become scary to a point of giving up on her / him because that's what the possessor wants. You also have to be aware that this person possessed with demons can act like a Christian such as quoting from the Bible, and also be praying. If this person really does have demons inside, she / he can do all those things, she / he could also be doing other little things. People who are possessed by demons in the past have had different behaviors according to the Bible, you have to know that this person may act in different ways and you shouldn't be surprised by it because it is not her / him doing that, it the demons inside that are doing that. This possessed person can even say that she / he knows what's happening in another community and know what they are doing even if she / he's not there. No wonder—Satan is a spirit and able to do all things. [S012]

Initially, however, even very bizarre behavior might be attributed to illness. The shift from mental illness to demon possession occurred when someone had or reported an uncanny experience regarding the afflicted person. Hallucinations, in particular, were likely to evoke thoughts of demon possession. Dramatic changes in the person's tone of voice were also consistently mentioned as clear proof that another being was inhabiting the person. In other cases, a religiously inclined person might raise the possibility or authoritatively reinterpret recent events and behaviors as indicating demon possession. In some instances, it was the afflicted person himself who introduced the possibility by reporting dreams, fantasies or hallucinations with explicitly religious content or by confessing that they had prayed to the devil to solicit help. Such confessions were usually treated as definitive evidence. Often, however, the afflicted person was unaware that he or she was demon possessed until it was diagnosed by others and his / her odd behavior was retrospectively reinterpreted.

> It's pretty hard to describe. My best girlfriend, she was kind of strange when she died. She told me that when you are, when you have something like this, you're the last person to know. Meaning that when she had demon inside her, she did not know that she had demon inside her. And I wondered about that. She was kind of strange too. The way she used to think. Well I remember what she used to do at one time she went, the truck was moving along and she just stopped right in front of her like she wanted to be killed or something. And she was very scared of a certain person. She had been going around, going around with this lady's boyfriend and that made her really scared afterwards. She couldn't go out. She was always inside the house. [S002]

Demon possession could be distinguished from depression or other mental disorders because in the latter the person remained him or herself and could talk intelligibly about the affliction.

> The difference in between the depressed person and the demon possessed, you can tell the difference in, because the depressed person can talk to you about their problem. They can say what's going on. If they have their own personal problems, or if they're having problems with other people, or anybody. Although some may have a hard time, but they can talk about their problems. But in a demon possessed case, that person can't even talk on their own. They don't have their own voice any more. They don't talk on their own. [P004]

Informants who had more intimate experience with mental illness, particularly with a relative who had been labeled schizophrenic, were faced with the problem of reconciling attributions of demon possession and psychiatric disorder to the same person and same behaviors. In some instances they simply accepted both explanations. In other instances, they attempted to partition the behavior between mental illness and demon possession on the basis of how they felt with the other person. This feeling is tied to the afflicted person's behaviors and responses to other people.

> Demon possession, you can feel. It's like, in the air. And you can see the person is really not controlling itself. But, in my brother-in-law's case. it's more comfortable. I mean, it's uncomfortable, but it's more comfortable. And you know. It's a different feeling. Some people think, some people who don't really know the difference. Some think that he is demon possessed. Or being tempted, or something. It's not like that. But, he's not like that. And so is my sister-in-law. It's different too. They're both schizophrenics? And they act about the same way. Different feelings. Different. But they act the same way. I mean a depressed person, you can tell. They're looking sad. When a depressed person looks sad, and too quiet. Not like their usual self. You can tell that a person is depressed. And I think, in my case, I think a depressed person or someone who's just worried about something—like my son is lost in the tundra. They have to search for him. Maybe he's…—that kind of depression, and worrying, and schizophrenia. I find there two different things. Also, schizophrenia and demon possession are two different things. I mean, I'm trying to explain to you, the best I can, about the difference between demon possession and schizophrenia. I think that's how far I can go in trying to explain. [P001]

Although the most characteristic sign of demon possession was hallucinations, talk of the devil and strange behavior, in several cases withdrawal and isolation were attributed to possession. It is unclear what lead to this specific attribution but in most cases the withdrawn person was described as 'crazy'. In some cases it seemed that:

> Time and again there are people who are said to be [demon possessed]. Not long ago there was this lady who, ah, was sent here because, she was, you know, crazy. I don't exactly know her case history. What I heard was that she was very depressed. Probably she was very depressed. She wouldn't talk, she wouldn't eat, she wouldn't associate with people. She wouldn't do anything. She had isolated herself and when somebody becomes like that it's very, very difficult for people to handle. [P002]

The ability to recognize demon possession was also conferred by the observers' religious knowledge and experience or by a direct connection with the power of Jesus. This power informs the person through feelings in their body or 'just

knowing'. When informants doubted that they had sufficiently conveyed the authority of these feelings they mentioned uncanny behaviors, especially bodily transformations.

> There is a difference between a demon possessed person and a depressed person. And he [the person from the church] can tell which is demon possession and which is not.…usually the way he can know is… he can know that a person is demon possessed. He knows that, he has guide from someone he cannot see—that mean God or Jesus. And he has seen and he can, he can tell. He can feel. And there are times he has seen a demon possessed person who grew… who didn't have chest hair, but all of a sudden they grow hair…and nails grow long. [P004]

There was also a basic empirical test for demon possession: the mention of Jesus, prayer or other religious activity will be disturbing to the possessed person. The person will show fear, consternation, or take action to oppose the effect of the prayer, by trying to leave or by repeating prayers backwards or substituting the name of Satan for Jesus.

> When he talks to a demon possessed person, he talks about Jesus. And when he does the person, um, the thing in the person, the spirit frightens him. [P004]

The appropriate response to demon possession was uniformly held to be exorcism through prayer and laying on of hands. The afflicted person's response to this intervention also served to confirm the diagnosis.

> One of the things that happened, that he has seen, is that when a demon possessed person, when the demon is cast out, the demon comes out. You can't see it, but you know the demon comes out. And when it does the person falls on the floor and sometimes isn't even breathing. After it happens. And when the person wakes up, like everything is new for that person. Everything changes. And everything is beautiful for that person. [P004]

Demon possession may exist for years unrecognized and its origins only be determined when it finally declares itself by abnormal behavior.

> Sometimes it takes some time to get into that thing. A person may be possessed for many years and not be, there may not be any indication whatsoever that he is possessed unless he actually goes crazy, if this person has never been sick, has never had a mental illness, and then he starts acting crazy, that's what I would called demon-possessed that's what I also believe in. [S001]

If left untreated, demon possession could pass into a chronic condition in which the afflicted person is permanently changed. If exorcism failed and the person continues to exhibit bizarre behavior, he or she might be viewed as chronically possessed or more likely as having a mental illness.

As noted above, in addition to the common references to this Christianized form of demon possession which follows a formula well laid out in Christian literature and popular media, many informants interwove ideas from quite different notions of spirit possession. One of these ideas concerns a spirit 'husband' or 'wife', termed *uirsalik* and *nuliarsalik*, respectively.

> The first one I remember was when I was eleven, twelve or thirteen years old. When my cousin was going through that. There was a lot of people involved in that exorcism, I think you would call it but I only know from the stories they gave. I knew her. She was very outgoing, very outgoing,; in a way she was promiscuous. And she had a stepmother who started to notice something strange about her. But, then she was always telling her she's strange. She's the stepmother, she's not the actual mother. So she felt that there was something wrong with this girl and it was, in a way, now that I look at it, true you know. What actually happened was true. I only know one incident that—not what actually happened. Well, I only know one story that she had many babies not from her own, not from another man but from a spirit. She was with, she had relations with—that's one story I know. Her children, they were make believe like—for her it was so true, for her they were alive but other people could not see them. *Uirsalik*, it's someone who has a spirit for a husband. [S001]

Opinions differ as to whether demon possession is on the increase or was more prevalent in the past. This variation in opinion is tied to the informants' participation in the church and religious beliefs.

> There have been many. I mean that's just one example I'm giving of people who have been diagnosed as being possessed by demons. It was quite common. Right now we don't hear of it as much. But it was quite common in the past. [P002]

> There's even a woman who has been said by people to have been taken by spirits? Or, you know, there's a legend in the Inuit history, in the Inuit legends. Men, or invisible men, who come and take a woman, who is alone or who is lost on the land. They come and take her. They make her disappear for several days, or weeks, or months, or years. And then, ah, and then she comes back. She's disoriented and she's never, she'll never be normal. Because they take something from her. There's been people who say that they are explorers or the ghosts of explorers, adventurers. People who are *Qallunaat* geologists, or. People who are studying the land or the environment. But without going into the community. They used to be considered like humans who have certain powers, especially toward women. [P002]

> I guess it can happen just to anybody. It's not that common, just once in a while. Well, I remember, when I was still working at the old nurse's station, I was 16 then, half of my life, a long time ago. There used to be more. I remember that, the nurses and I would go and see those people. Well, to see what could be done, to see how they can be helped. Well, it's not us that did the helping it was the people, the natural helpers in town. [P032]

Although demon possession was very common in the accounts collected for this study—indeed, more common than any other single type of 'mental health problem'—only a very few distinct episodes of demon possession were actually described. Nor was belief in demon possession universal:

> Well there's two different ways of, two different types of possession in Inuktitut. There's the good possession and the bad possession. The good possession is where you start going "babababa" in church, and things like that. Speaking in tongues. I don't know what it's really called. I don't go to church that very often. That kind of thing turns me off. I don't know. I've never actually been involved in so called possession cases. The only thing I ever came close to that might have

> been construed as being possession was when I went to a party in Ottawa and the couple that we went to visit, that gave us the party, it was only, let's see, 5 of us in all, they were already really drunk when we got there. And I remember all the hairs standing up on my body and when the woman started going, "There he is, there he is. It's the devil right there." I was looking over here and all the hairs on my body standing on end. I got out as fast as I could. That's the—I don't know what to make of that. .I know it says in the bible that it happens. And people feel it's happened here but I've never seen anybody reacting the way they did in *The Exorcist*, or things like that. I heard of people putting cigarette butts out on various parts of their bodies with no indication of pain. But, there are psychologists that can explain that. Just block out the pain. I don't know. I guess, to be on the safe side I'll say I believe in that. Just in case it happens to be true. [Laughter] [S004]

Clearly, skeptics subscribed to a more social-psychological model of the phenomena and, although they were still Christian, tended not to participate as enthusiastically in church and avoided the Pentecostal or 'born again' group.

3.14 Other Problems

Several types of troublesome behavior not presented in the study behavioral registers were introduced by informants as related to mental health and illness. These had to do primarily with difficulty controlling anger, excessive interpersonal sensitivity and with antisocial behavior. These reflected what could be termed personality or character problems (or personality disorders in psychiatric terminology) and although they were not viewed as illnesses, some informants included them within the broad domain of mental health.

> Not being able to take comments or what we call ribbings. Not being able to handle…acting obnoxious. Well, the only thing that I can think of is when they are irritated? Like I used to be short tempered myself, whenever I got irritated I was I couldn't be with people. Anyways… I think another characteristic would be not being able to accept what the person is saying about that person. [S003]

> [Referring to people with repeated criminal activity.] Well, on the surface they seem quite normal. Um, you talk to them, you wouldn't know they have a problem. But you do know they have a problem. Ah, during the day they're just like everybody else they do normal things. They go home and eat when it's time for meals, they watch television. They show an interest in hunting or things like that. But come night time, knowing full well that they're going to get caught, they go and, break and enter into a place, steal food, clothing. Ah....ah....and things like that. [Why do they act that way?] ..Beats the hell out of me. I suspect, ah, again this is pure speculation, but I suspect it might have something to do with the upbringing in their family, in their home. Oh, various, ah, various things. Most prominent of those is the lack of discipline. A lack of instruction in respect for their fellow human beings. A lack of respect for people's property, but generally speaking, a lack of guidance in the family. [S004]

> Well there's people that I know that can't perceive themselves as being wrong, about anything at any time. I think that might be a form of mental illness. They'll tell you my hat is black even though it is blue. But one person I know, well he's,

> it takes a lot, but sometimes he'll admit he's wrong only after a lot of proof. He's what I would term a power tripper. Another person is, again, highly placed in our community. It's nearly impossible to change his mind once it's made up. There's no give and take. There's only take, they don't give. Unless they're feeling really good that day. They'll give you something without you even asking for it. People like these tend to equate themselves with, international figures only on a smaller scale. [S004]

Most of these descriptions came from a few informants who were clearly exceptionally sophisticated and astute observers of human behavior and who had adopted contemporary psychological models in much of their thinking about personal relationships as well as social and political conflicts.

3.15 Discussion

As we noted at the outset, there is no general Inuktitut term for mental health or illness. The idea of mental illness in the generic sense is not an indigenous concept to the Inuit (Vallee, 1966; Kirmayer et al., 1993). When presented with the necessity of creating a suitable term, as in the case of translating reports into Inuktitut, translators have created a term which simply means to be unwell in thoughts and even this must be tempered with a qualification about duration. They therefore arrive at two terms for mental illness in general, *Isumaqatsiangittuq* and *Isumansungittuq*, which refer to permanent and temporary states respectively. This need to create terms to satisfy the descriptive needs of the medical profession is quite common and extends to many different fields. It does not reflect a lack of awareness on the part of the Inuit towards mental health and illness but rather a perception of illness events as an experience which is expressed differently by each individual. The emphasis of the medical system on abstract classificatory categories of illness is not shared by the Inuit who tend instead to describe the particular behaviors and states of mind of the individual and relate them to details of that person's life history and current social context.

These ethnolinguistic differences reflect another semantic reality of Inuit concepts of illness which has important implications for labeling and stigmatization of the mentally ill. In Inuktitut, disease is a state experienced by the person not, as in western conceptions, a characteristic attached to the identity of the individual. For example, a person suffering from schizophrenia in the south *is* a schizophrenic—they become their disease. Inuktitut does not provide for this type of labeling and diseases are events which are not in existence when the person is not exhibiting the associated behavior. Unless otherwise qualified, disease states are usually considered to be transitory and independent from the individual. As a result, compared to Anglo-American cultures where disease labels become something intrinsic to the person, among the Inuit there is less tendency to place responsibility for managing the illness on the individual.

Two terms used by many informants for mental health problems were *isumaluttuq* and *isumaqanngituq*. *Isumaluttuq* referred to a state or process of thinking many worrisome or 'heavy' thoughts. It covered a wide range of mental

health problems including depression, anxiety and the sort of brooding and suffering that could lead to violence or suicide. Individuals who had psychotic behavior that was not wild or bizarre might also be described in these terms, invoking a notion of 'too much thinking' as both a cause and manifestation of their problems. Since it covered such a broad range of problems and referred to a state of mind, *isumaluttuq* seemed to convey a relatively benign, or at least uncertain, prognosis.

The second term offered by many informants, *isumaqanngituq*, referred to more severe mental disorders characterized by greater impairment of the capacity to think and act as a normal adult. The term literally means "having no mind" and was applied most concretely to individuals with profound mental retardation. By extension it was also used to describe individuals with severe psychoses whose behavior was erratic and bizarre. It was also applied to individuals who were violent with no reason (whether because of underlying mental disorder or intoxication)—perhaps, this extension was actually a metaphoric use of the term.

Senseless violence and extreme withdrawal were the most disturbing forms of deviant behavior according to most informants. Violence was closely associated with intoxication and substance use. Withdrawal might also reflect substance abuse but was more often related to shyness, low self-esteem, and depression. Withdrawal was more tolerated than aggressive behavior. When withdrawal was associated with hallucinations or other bizarre behavior, however, it was cause for alarm.

Hallucinations, sudden personality changes and bizarre behavior all raised questions of possible demon possession. Once introduced as a possibility, a great many behaviors are treated as further evidence of demon possession. In case accounts, it is possible to see the mutual shaping of symptoms and signs going on among the afflicted person and his or her interlocutors. Although not recognized by informants, internal evidence from their accounts suggests that the experience of behaviors as uncanny and therefore, as indicating demon possession was influenced by the label of the affliction as 'demon possession'.

Explanations in terms of demon possession commonly co-existed with other explanations—that is, the demon possession may cause depression, schizophrenia or other disorders. If so, the implication was always that eliminating the demon possession (by prayer or exorcism) will resolve the illness.

Indeed, a striking finding from the present study is the co-existence of multiple explanations for many informants based on the same sets of signs, symptoms and behaviors. The distinction between different types of problems is tied to pragmatic concerns about how others in the community are affected and whether there are any specific coping resources, from the range available in the community, that can be applied to ameliorate the situation.

4. ETHNOPSYCHOLOGY AND CAUSES OF MENTAL ILLNESS

In this chapter we consider Inuit cultural concepts of the person and the self. Every culture has an implicit notion of how people 'work' that could be called their ethnopsychology. This is intimately tied to notions of the causes of mental illness and the determinants of mental health.

Informants recognized three broad classes of causes of mental health problems: physical or organic, emotional or psychological, and spiritual through spirit possession. In sections that follow, we will first summarize some Inuit ethnopsychological concepts expressed in our interviews and described in other ethnographic literature and then consider major concepts of the causes of mental health problems.

4.1 Role of Traditional Food in Well-Being

A generalized feeling of ill health was strongly associated by informants with a lack of country foods. This nameless syndrome included physical feelings of weakness, lassitude and tiredness, and extended to emotional states of irritability, uncooperativeness, lack of interest in daily events, indifference towards children and generalized depression. Interviews by C. Fletcher on subjects other than mental health have elicited spontaneous descriptions of these feelings. For example, in Kuujjuarapik in 1993, a man in his mid-thirties who was not a regular hunter and expressed a lack of interest in the hunting lifestyle explained that the only times he went out hunting were when he was feeling depressed and lazy because of the lack of country food in his system. (He referred to his "system" in general but was rubbing the veins on his forearm while talking, implying his circulatory system.) At these times, he would go seal hunting in order to replenish himself and would always feel much better for some time afterwards.

Borré (1991) found remarkably similar sentiments among Inuit of Clyde River, NWT. She describes the case of a woman who was feeling depressed, nauseous and experiencing headaches. The woman declared that she needed seal meat to feel better and upon receiving some,

> "The next day her headache and nausea were gone, and she was working as usual. She explained that her blood had become weak from the lack of seal meat and that she needed seal meat for the next few days to be sure she was well" (p. 56).

Other Inuit in Borré's study reported that depression was a common occurrence when they were unable to consume seal meat for extended periods of time.

In Nunavik, elderly Inuit reported a need for beluga whale skin (a highly valued food) with a similar rationale. It seems that the beluga also alleviates feelings of depression experienced by elderly people which can occur when they are no

longer able to participate in camp life or in hunting. Consuming beluga rejuvenates them through its effect on the blood and hence the body and mind.

The beluga whale is perhaps the most important animal on a symbolic level to the Inuit. Beluga travel in family groups, are highly social, follow a leader, are highly intelligent and, like Inuit, can carry their young on their backs (*amaut*). The capture and consumption of beluga are very meaning-charged events. The captured beluga reconstitutes the human physically and mentally and imparts some of its intelligence and social qualities to the person through the consumption of blood, fat and skin. To be without beluga as food is to be slowly drained of an essential element of the identity of the Inuit person. One informant stated that:

> Il y a une des choses que tu devrais savoir, et il faut que tu saches aussi, c'est que le sang c'était très important au niveau de la santé et les Inuits mangeaient plus la viande parce qu'il y a du sang et ça aidait beaucoup mieux pour la personne que celui qui mangeait de la viande avec du sang un peu... et la personne va être plus en santé mais son sang serait encore plus ... plus fort. Ça paraissait même sur les joues.. les joues c'étaient mêmes rouges on disait...[dans le passé] S028
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> *There is something you should know, it is the blood that is very important for the health and Inuit eat mainly meat because it has blood in it and that helps the individual very much, more than meat with little blood ... and the person will be in better health, his blood will be more ... stronger. It's visible even on the cheeks, the cheeks were redder we say (in the past)*

The widespread awareness of these feelings and their cause, as well as first hand experience with them, show them to be an important element in the cultural model of mental health maintenance among the Inuit.

The close linkage between food, blood and mental well-being among Inuit informants counters the tendency in Western biomedical views to separate mind and body illness (Kirmayer, 1988).

For the Inuit, the brain is considered the seat of consciousness but it does not seem to be ascribed any unique qualities that other organs do not possess. The brain, like other organs, is nourished by blood and it is blood that transports healthy materials throughout the body. The quality of blood is directly affected by the quality of food consumed and more weakness associated with the impoverishment of blood quality or quantity is best remedied by consuming raw meat containing a lot of blood (seal, ptarmigan) or blood itself. It is for this reason, according to informants, that Inuit who are removed from their communities for hospital treatment in the south become weak and depressed over time—they are being fed essentially bloodless southern food.

4.2 Environmental Quality and Mental Health

Several informants mentioned environmental factors as causes of mental health and illness. Participant observer research, as well as previous ethnography, emphasize the central role of the physical environment in Inuit concepts of the normal functioning of the person. For example, in Salluit, an informant attributed the perceived higher prevalence of mental disorders to the fact that the settlement was ringed by mountains on three sides. This setting could make people feel 'closed in' and uncomfortable. It is natural for people to live with wide open spaces over which they can range freely. Indeed, being cooped up in an office may make people ill. This is particularly a problem for men who traditionally covered large territories hunting. Women were more accustomed to confined spaces, since they would spend much time together at the family camp. This traditional use of space persists in notions that one way for a man (or woman) to control anger or other difficult feelings is to go out on the land. Anything that prevents this use of space may then contribute to illness.

The environment is not impersonal but closely linked to personal memories. On the plane coming into a settlement, a young man remarked, "I know that coast like the back of my hand," his eyes tearing with pleasure at returning home after a long absence. The sense of place is very strong and tied to highly valued activities like hunting that are the basic sources of self-esteem for many men.

Of course, the environment also includes animal and plant life. Animals, in particular, have held a central place not just in Inuit subsistence patterns but in religious belief, mythology and artistic expression. Although traditional notions of the transformation of people into animals and vice versa have been largely subsumed by Christian demonology, Inuit retain a strong sense of admiration and respect for animal life.

Returning to the theme of Inuit food sources, blood quality and mental health, we must underline the potential threat to the well-being of people faced with major environmental change resulting from environmental contaminants such as PCBs and development projects, specifically the proposed Hydroelectric development in Kuujjuarapik. Whether or not these projects will pose any direct physical risk to health, they already constitute a threat to well-being due to prevalent beliefs in the close links between the environment and people's physical and mental health.

Data collected for another study[3] by C. Fletcher in Kuujjuarapik in 1993 on perceptions of environmental risk, indicate that people are concerned that the proposed project will permanently rupture their hunting practices by affecting game populations and movements. There is also a widespread sentiment that even if the game remains in the region, it will be inedible because of

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[3] The study on environmental risk perception was part of a project conducted by Prof. J. O'Neil of the University of Manitoba for the Royal Commission on Aboriginal Peoples.

contaminants in the food chain resulting from mercury discharge from reservoirs into the marine ecosystem. Scientists have tried to reassure the Inuit of Kuujjuarapik that mercury will be a localized problem with little or no effect on the wildlife consumed by the Inuit, the only possible exception being fish from the reservoirs. The Inuit do not accept this position based on their own intimate experience with ecosystem dynamics in which all wildlife is interrelated in some manner. They do not accept the idea that some level of contamination is acceptable and not harmful. The animals are either good or bad and people have no interest in eating food that is contaminated to any degree. From this perspective the people themselves are a part of this system and are therefore as much at risk as the animals, unless they abandon totally the Inuit diet which, as has been demonstrated above, is intrinsically linked to sense of well-being, health and identity. For many Inuit, the Hydro project threatens to end their distinctive way of life through forced assimilation to southern ways. Hydro-Québec has not examined these issues; indeed, human health issues warranted less than one page in the 279-page impact statement summary (Hydro-Québec, 1993:126).

4.3 Physical or Organic Causes of Mental Illness

Organic mental health problems are generally recognized to be those which a person is born with. Epilepsy, mental retardation, Down's syndrome and other emotional/mental problems evident at birth or from a young age are considered by most people to be organic in origin. They can be caused by environmental factors, mother's behavior during pregnancy (particularly drug and alcohol use), trauma encountered during pregnancy, problems encountered during parturition, accidental trauma at a young age and biological variability. One person in Kuujjuarapik explained that just as some animals are born with birth defects, so too can human children be born with a variety of defects, including defects in the brain which cause the individual to be unusual. In Kangiqsujuaq, an individual who had experienced life-long seizures, personality problems and extreme antisocial behavior was thought to have been born that way, although her condition was aggravated by continuous physical abuse during childhood.

A great variety of problems were attributed to the mother's taking of drugs during pregnancy. This often carried a degree of moral censure of the mother. The implication of this prenatal vulnerability is that pregnant mothers must take special care to ensure their children turn out normal.

> When you're pregnant, I think it's very important that you take care of yourself. Sleep well and have a lot of rest, and get consultations from one of the older people. Then your baby can be very healthy in mind and in physical. When I was pregnant my mother was preparing me for it. I had to do certain things: get up early, get a good sleep, get good rest, try to do things rapidly so that they will not linger on in your mind all the time, try to get things done fast. [P034]

> Before birth, I guess if the woman is involved with drugs or alcohol that is mostly likely that a person or a child will be like that in her life. Mostly today it would happen. More often than in past because in the past we didn't have

> anything eh? Today, there's everything. Maybe in the future we will see lots of people are like that—you know, they could be like handicapped or they would have a mental illness caused by these drugs. Other than that, if the mother is healthy and she doesn't fool around with these other things I think a child would be very normal. [P052]

Difficult and prolonged labor can also cause behavioral problems in children related to developmental disabilities:

> In your labor, it might take a long time to for the baby to get out. I did not believe that for a little while but then I told myself it can be true because it can follow your personality and everything. It might have a personality that's not very likable, who's not saying, who's not listening to other people. [P034]

Among the physical reasons for mental illness are drug use, sleep deprivation, or some other bodily problem. People can also experience a wide range of mental health problems as a result of head trauma at any age.

Aspects of the physical environment were also mentioned, not so much as causes of mental illness but as precipitating or aggravating factors. Several informants commented on the effect of the phases of the moon (the full moon as a time for 'wild' behavior) and the tides as influences on mental illness, sometimes precipitating bizarre or violent behavior or drinking binges even among otherwise normal people, or regulating the periodicity of aberrant behavior in people known to have an episodic problem.

4.4 Psychological or Emotional Causes of Mental Illness

As noted above, many informants expressed the notion that mental health problems could follow from too much thinking (*isumaluttuq*) or being completely unable to think because of 'having no mind' *(isumqanngituq*). This points to an ethnopsychological model of the workings of the mind (*isuma*) as the cause of emotional and behavioral problems.

Most informants also had clear notions of the positive effects on mental health of kindness and open communication among parents and children. One elder in particular—who spoke only Inuktitut and hence, might be expected to have had less direct influence of current 'pop' psychology and Anglo-American ideals of child-rearing—eloquently described her vision of healthy child-rearing:

> What she thinks, she's not sure, but what she thinks is that parents who always treat their children, or make them feel low, are those who don't really care about their children. And she thinks that they don't think about their future. Like they're young, they're growing up and their mother is taking care of them. Even as they grow, a parent should care. Even if the kid is an adult, that they should care and be willing to help their child. But she thinks that they parents who, they take care of their children, but when it comes to doing something bad, they criticize them because they don't really care about them. [P011]

The negative effects of negative family relationships, harsh words and abuse were even more emphatically stated. Family conflict was regularly invoked as the major cause of the complete range of mental health problems (with the partial exception of those disorders viewed as predominately organic like mental deficiency or seizures, although even here the family's response to the illness was recognized as an important determinant of the course of the illness).

Unfortunately, physical and sexual abuse and neglect in children, rape and spousal abuse have all occurred in Nunavik and informants were unequivocal on the harmful consequences of these forms of violence:

> For me, it could be child abuse, sexual abuse, rape, and other things. In my case, I feel I have, because I have been raped, because I have been abused, because I lost my mom at a young age, it has made me think a lot how I can help someone who's in that stage. But in my brother's case, he became abusive. He started abusing, I mean he was sick, he took to drugs, he turned to drugs and started abusing even when he had them. His girlfriend, he started abusing her. When he was still living with us and I had my kids, he used to beat them up. I tried to stop him, he would get worse. Well one day I asked him, why do you do that? He tells me, "Why shouldn't I, I've been treated like that before." He had it in his mind all the time, all the time, most of the time. And he gets, when he thinks about it he couldn't do anything then, at that time, it's too late to do something because my father is already dead. He gets frustrated, he gets mad and he takes it out on the kids. So, in a way, he was sick. I mean, he's an adult and he should know by now that it's not my kids' fault, it's not my fault, it's not his fault either. And, I don't know if I can say it's my father's fault, well he's the one who beat him—I don't know if I can say. And, in my daughter's case, she had been raped. She thinks about it, she's scared. She can't even trust other women, because she's afraid. When someone she gets close to, sometimes she's scared of other women too. Like my, her own family she's scared of her own father, that he might try to do something, although on the other side, she knows that he won't do anything. She gets paranoid. I guess that's why I said that she's a bit like a part of her father's side of the family, mental illness. Now I don't want to think of her as mentally sick, but I can say it has just a touch on her. I guess because she grew up watching it too. And she's always scared that she's going to turn out like that part of the family. And I guess that's why she's nervous, she's more nervous. And small things upset her. I don't want to think of her as being mentally sick. [P032]

> When they were, when their behaviors were getting to be strange, we didn't know why. I mean we didn't even try to think what why—what happened to them in their childhood. But we're finding that it's coming from their childhood, what happened. We find lots of cases who have been sexually abused as children. When they are trying to be parents they have difficulty raising their own kids and how to manage their own home. Usually tending to let children go astray—I mean stay out as late as they want, even though they talk to them that they shouldn't. And, we're finding why there are so many young people who are not well oriented, who are not very well how do you say that? Who are not raised properly. There's a problem in each house of some kind. When these parents, when they turn to alcohol and drugs in front of the kids. They don't feel at ease at home. That's our main problem in alcohol and drugs. But that's usually caused by what's behind, what happened in your past. You abuse alcohol because of what may have happened to you in your life. [P034]

Emotional trauma suffered as a result of abuse, particularly sexual abuse, is a potent source of mental health problems according to many informants. Recent revelations of widespread sexual abuse in Povungnituk have led people to re-evaluate what the cost of abuse is, in terms of mental suffering. People interviewed suggested that the cycle of abuse from victim to perpetrator was an important factor in the abuse occurring throughout the north. Some older informants suggested that the abuse cycle started, for many, at the hands of non-Inuit. In the 1940s and early 50s Inuit suffered severe hardship as a result of disease, poverty, government policies and game shortages. Their desperate situation was taken advantage of by several non-Inuit, who were becoming more numerous in the region at that time. Stories abound of school administrators, priests and other people who abused women and children with impunity. These people had control over the allocation of goods, the few jobs available and relations with the outside world, all of which gave them a great deal of power over the lives of the Inuit and led to many instances of coercive and violent sexual relationships involving women, children and non-Inuit.

Granted not all intimate relationships between Inuit and others at this time were unwanted, but measures of social control and justice were only marginally in place and unevenly applied. Inuit had little or no recourse in these events and many abused people, some of whom are now in their sixties and older, were only recently given the opportunity to talk openly about what they had experienced. Some of these people, abused at the hands of powerful non-Inuit, went on to abuse others. Social, political and juridical outlets for dealing with these cycles of abuse are only now becoming more widely available and for many are still not adequate to address the emotional problems suffered by numerous people. In particular, the judicial system was perceived by many as unresponsive and uncaring to victims and far too lenient towards perpetrators.

Other sources of emotional trauma which put the individual at risk for mental health problems and / or unacceptable behavior come from the sphere of interpersonal conflict and communication. Several interviewees described the importance of forgiveness of unpleasant interactions in maintaining personal emotional health. In discussions, some people described how unresolved negative feelings and hurtful experiences can become causes for bizarre behavior.

> *Elle a commencé à dire, il y a deux, en générale il y a deux affaires qui causent et qui peuvent faire entrer surtout dans la maladie mentale d'après elle. Premièrement c'est par les sniffing qui vont entrer, par les drogues, mais ça c'est la même chose. La deuxième, c'est que, si on se parle et un moment donné on est pas d'accord, et moi j'étais pas d'accord avec toi et moi je vais peut-être allé sortir ou peut-être parler à du monde que ce n'était pas ma faute, peut-être dans le fond c'était peut-être ma faute mais je vais dire que c'est ta faute, on s'entend pas entre nous, c'est là où les choses commencent pour le pire. Par exemple tant que je regarderai pas moi-même ce que j'avais fait pour cette personne je vais rentrer dans ces situations avec le temps. Si j'avais trop regardé dans mon cas et puis je t'avais pas pardonné, ou je t'avais pas dit, ou bien je me pardonne pas ce que je t'avais dit... Quand les deux personnes ne sont pas d'accord, c'est là où des choses ce passeraient.*

> She started to say that there are in general two things that cause mental illness to enter [begin]. The first is sniffing which will make it enter, by drugs, but that's the same thing. The second, it is if…if we speak and at some point we do not agree, and I did not agree with you and I might leave and maybe tell people that it was not my fault, maybe at the bottom it was my fault, but I will say that it's your fault. We don't agree between us, it's there that things can start to go bad. For example while I am not looking [inside] at myself what I did for this person I will enter into these situation [mental illness] with time. If I looked too much at my own case and I did not pardon you, or I did not tell you...When two people are not in agreement that's when things happen.
>
> *Et puis moi, je te pardonne pas ce que tu avais dit.,et puis je te laisse pas pardonner, moi par année ça devient de plus en plus pire ce que j'ai dans le coeur, c'est là où je peux avoir des problèmes, je peux commencer à être impatient, ou je peux commencer à avoir des problèmes dans la vie, parce que j'avais pas dit, ou bien parce que je n'avais pas regarder moi-même, dans le fond si je regardais mieux c'aurait été plus facile.*
>
> And me, if I don't pardon you for what you have said, and I leave you unpardoned, me by a year [over time] it becomes worse and worse what I have in the heart. It's there that I could have problems, I could start to be impatient, or I could start to have problems in life, because I did not say or because I did not look at myself, in the end if I look better [harder at myself] it would have been easier. [S013]

The proper and healthy course of action is to confront the individual and forgive them, or to simply forgive them in one's heart. Unlike southern norms where the onus is on the offending person to ask for forgiveness of the one he has hurt or risk unresolved guilt, for many in the north, the situation is reversed. If you have been hurt and are unable to forgive the individual who caused the pain you may become worse off.

> I start to say that this spirit is trying to put me down, trying to get me down. This bad spirit using this person. So what I do, I would pray for that person and for me too, I would ask God forgive me and forgive that person. Forgive us for this. And I, I'm - when I do that I have no bad feeling toward that person no matter what they say, when I do that. And few days, few weeks, few months, a year later, those people are coming back for help. Because I never fighting back eh? I never fight them back. And that's another belief that we have that should pointed out, which would be looked upon [by non Inuit] as, just a little person who doesn't even defend themselves, and you know, a fool. [KJ01]

In addition to the psychological and interpersonal factors described above, social factors such as isolation, unemployment, and poverty were also very commonly invoked as explanations for such problems as drug abuse, depression, suicide and violence among adults.

> It's hard to answer you this question. I think it would have—a person who is isolated or drinks too much, takes drugs too much—it could easily turn to have these kinds of problems. A person who doesn't have a job, who doesn't have anything or, who don't have any equipment to hunt. I guess it goes to these people to feel get tired of life. I guess that's mostly the causes. [P052]

For many Inuit, social circumstances were described as difficult to change or implacable and so an emphasis on personal psychological, moral and religious factors (to be discussed in the next section) may have seemed to lead to more useful potential for response.

4.5 Spirit Possession and Mental Illness

As noted in Chapter 3, spirit possession was offered as a potential cause in many cases of bizarre and aberrant behavior.[4] As this is an important aspect of contemporary Inuit understandings of mental illness, we conducted extensive interviews on the subject of possession and methods for relieving or exorcising spirits. We focused on Inuit understandings of how possession is thought to occur, specific forms of possession, behaviors displayed during possession and the extent to which possession beliefs explain deviant behaviors that may be associated with psychiatric disorders. The following summary of findings is preliminary and based on only part of the corpus of data we have collected.

There was no single criterion or method for determining whether someone had become possessed, although it tended to be considered a likely possibility when a person's attitude and behavior changed suddenly, with no warning and no previous occurrences. People who were known to have been possessed in the past and began again to exhibit bizarre behavior were usually presumed to be possessed again. Some informants stated that the symptoms of mental illness could be essentially identical to those of possession. As noted above, mental illness could be caused by a physical or organic problem, an emotional problem, or possession—these explanations were not mutually exclusive and, in many cases, a problem was labeled mental illness and still attributed to possession. Each case must be evaluated individually and one must talk to the person in order to determine what is the cause. Some informants said that they could know if someone was possessed only by looking at them.

During interviews many types of unusual or socially unacceptable behavior were attributed to demon possession. Such possessions can influence a wide range of behaviors of varying severity, including substance abuse, argumentativeness, violence and florid psychotic states. It is possible that some informants used the term 'demon possession' as a generic term for a disturbed person. However, in most accounts the details suggested a more literal view of the process of possession.

In part, the emphasis on demon possession seems to be a result of the growing popularity of the 'born again' or Pentecostal movement in the north with its

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[4] Some authorities make a distinction between soul possession and spirit possession (Merkur, 1991). The former is associated with possession by an entity with no known physical form while the latter normally has a physical embodiment, although this may be in another realm of existence.

emphasis on explaining troubles in everyday life in terms of the struggle between good and evil, Satan versus Christ. However, on closer examination, informants frequently made reference to events and concepts which were less obviously related to current Christian demonology and soteriology and which may, in fact, reflect the persistence and recrudescence of traditional Inuit shamanistic beliefs.

According to traditional Inuit culture some illnesses were considered as phenomena caused by the interaction between the soul of a person, place, or thing and the individual affected by the illness (Merkur, 1991). In his work on traditional Inuit shamanism and cosmology, Saladin d'Anglure (1977, 1986, 1988) has demonstrated that the Inuit have a cyclical and multidimensional sense of time and space. In this cosmology, humans are considered to be the amalgamation of three types of souls: the name-soul, the life breath (*souffle vital*), and the '*shadow soul*' (Saladin d'Anglure 1977, 1986, 1988). Each type of soul was in the past subject to manipulation by shamans (*angakok*) to cure disease.

In our ethnographic interviews and observations, certain types of abnormal behavior and mental illnesses were attributed to the interaction between souls and spirits of other dimensions with humans in the everyday space-time. In particular, we identified three types of interactions, corresponding to different (although overlapping) discourses on possession: *Uuttulutaq*, *Nuliarsalik / Uirsalik* and Christianized 'Satanic' possession. The signs and symptoms of 'Satanic possession' have already been discussed at length in Chapter 3 and we will return to it below, where we present a detailed case. First, however, we summarize findings on the two forms of possession that appear to be more closely linked to traditional ideas.

4.5.1 *Uuttulutaq* possession

Etymologically the word "*Uuttulutaq*" derives from the root *Uuttuq*, "to try"; together with its stem, the word means "The one who is tried." An *Uuttulutik*, then, is a tempter.

In some ways, all negative behavior and mental health problems can potentially be caused by *Uuttulutaq*. It seems that *Uuttulutaq* is an ever-present force in the world which waits for individual weakness—from whatever cause—and enters the person's existence changing their behavior.

One woman described her experience with this *Uuttulutaq* as something which comes to a person when they are in a state of weakness, morally, physically or mentally. It is an opportunistic spirit of no determined sex or form which "tries" the person when he or she is vulnerable. If it is successful in its attempts, the person may become physically or mentally ill. In this case, the woman was already physically ill and had spent a week in bed, weak and barely able to get to the bathroom. While in her room, she first sensed a presence, then felt it and recognized it as *Uuttulutik* and knew it wanted to make her ill in some way and was preventing her from recovering from her original illness. After some days, it began to speak to her. Once when it was speaking, her husband was also in bed and he became paralyzed, unable to move or to speak. The *Uuttulutik* was not trying him but making it harder for his wife to resist.

In another informant's interpretation, the *Uuttulutik* was actually offering to relieve her original symptoms and make her feel well again. Ultimately, one is forced to make a decision whether to accept the *Uuttulutik* or to deny it. In this case, the woman refused the spirit, by telling it she did not believe in it or accept it. Once she had done this she was immediately healthy again.

Another informant gave a similar account but said that the *Uuttulutik* would present itself when a person was feeling guilt over something he/she had done. The example she gave was the theft of some item which was then carried on the person. The *Uuttulutik* would recognize the thief by the item he or she was carrying and then begin to try the person through his or her guilt.

Initially, these accounts appeared similar to a Christian type of demon possession, particularly because of their emphasis on temptation and wrong-doing as causes of possession. According to several informants, however, the *Uuttulutik* is not something which only believers of 'born again' religions recognize. Indeed, religious activity has no effect on *Uuttulutik* nor is it something which is treated within the church. It can affect believers and non-believers alike. One informant stated that anyone could be affected, even children. At the age of 12, during a period of famine, this woman's husband stole a piece of bannock and a piece of meat. People noticed that this small amount of food was missing and asked where it had gone. He was too hungry to admit that

he had taken it and no one ever discovered who it was that took the food.[5] He spent his entire adult life without telling anyone what he had done and consequently, spent his life under the influence of *Uuttulutik*. He thought of this event every time he ate and never said anything about it. As an old man, he finally unburdened himself and died shortly afterwards. He had accepted the temptation of the *Uuttulutaq* and subsequently it remained a part of him until his death.

The death bed confession in this story repeats a common theme in accounts of the deaths of elderly people. It seems that cultural notions of a "proper" death often include some form of near death testimonial which has some parallels with Catholic rituals of last rites, although they are not necessarily related. Many Inuit are especially saddened when older people die in institutions in the south, unattended by family and friends. This sadness is not only because the person died alone in an alien culture, but also because they were not able to unburden themselves before death by making a declaration or testimonial, if they so wished. Not all people make such testimonials, but when they do, their death is a less painful event and people are happy for them. It seems likely that these near death testimonials are important for the soul of the person in the transition to whatever afterlife awaits them.

Other than the influence of *Uuttulutaq* on death, a person of any age can be influenced in a variety of ways by this phenomenon. It is felt that sniffing, drinking and drug abuse can all be ascribed to *Uuttulutaq* in some cases. The insistence on the individual's role in accepting or denying the spirit entity is interesting because the ultimate responsibility for the illness then rests with the individual. This contrasts with notions of accidental or environmentally caused illness.

4.5.2 *Uirsalik/Nuliarsalik*

The *Uuttulutaq* form of possession described in the previous subsection is a broad general source of possession which can affect a person's behavior and health status. In comparison, the *Uirsalik/Nuliarsalik* possession complex is a much more specific form that causes certain behaviors. Rather than being a formless force or power as in *Uuttulutaq*possession, the possessing entity of *Uirsalik/Nuliarsalik* manifests itself in a human form, making it a type of spirit possession.

Men and women who occasionally or regularly experience auditory and / or visual hallucinations, among other symptoms, are said to have a *Nuliarsalik* or *Uirsalik*, respectively. These are gender specific terms for fiancé and together form a concept in which the affected individual lives a life in another dimension

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[5] The central moral dilemma of stolen food is, of course, reminiscent of a wealth of Inuit legend related to hunger and the importance of food sharing (cf. Freuchen, 1961; Millman, 1987).

with a mate and possibly even children. The unusual behavior of the individual is a result of his or her communicating with this person.

The *Uirsalik/Nuliarsalik* phenomenon has its origin in an obsessive longing of the affected individual. The person affected begins thinking continually about an idealized mate, who is occasionally someone actually living in the community but more often is an imagined character. This imaginary person represents everything they desire in a life partner and they fantasize constantly about life with them. With time, the content of the obsessive thought is recognized by a disembodied soul who then enters it and takes on the characteristics of the desired imaginary person. What was imaginary becomes real, although it exists in another dimension. The individual who has an *Uirsalik* or *Nuliarsalik* begins to live a second parallel life with this entity. While the affected person is the only one who can see and communicate with the *Nuliarsalik* or *Uirsalik*, in some cases their interactions with the spirit partner can be seen by other Inuit. Hence, the person's bizarre behavior is a direct result of having another life in an invisible realm.

Indications that a person has an *Uirsalik* included: auditory and visual hallucinations, lack of concentration, constant nervousness, constant moving about, an unusual desire to be alone, excessive staring at nothing, sweaty palms, a distinctive odor and general weakness of the body. Despite these symptoms people may not know about an individual's *Uirsalik* or *Nuliarsalik* until she or he confesses it to someone or when the person becomes suddenly dangerous to others. People affected generally know that their *Uirsalik / Nuliarsalik* is invisible to others and try to hide the fact that they have this type of relationship. Usually, a person will acquire a *Uirsalik* in late adolescence, although children may also be affected. Occasionally, it happens later in life, after the loss of a husband or wife.

While outwardly they look quite normal to the person experiencing them, *Nuliarsalik* and *Uirsalik* do have some unusual physical characteristics. They have extraordinary beauty in most cases (which makes sense since they have taken over the idea of perfection in a mate), they do not have an umbilicus and hence, were not born. If you look in their ear, you will see out the other side and, in the female version, the hood of the *aumautik*, or woman's coat, is turned inside out creating a bump on the back.

Stories of people in Nunavik who were said to have had or to still have an *Uirsalik* or *Nuliarsalik* were common among informants. One man had been obsessed with a young woman in town. When he was out hunting, he began to hear her talking to him although she was not there, which he found pleasant but distracting. Later, he was following some caribou when he saw the woman in the distance. She walked towards him until she was quite close. The man realized that this could not be her because he knew she was still in the community. She began to beckon him to her and he became scared. While he was drawn to her, he knew she was not real and that if he went to her his life would not be the same again. He pointed his rifle at her and told her to go away; she kept calling to him and he shot at her. He fired several shots with no effect. The woman turned and quickly disappeared. He went to the spot where she had been and there was no evidence of her. He then ran about eight miles back to the

community to find the woman he had been obsessed with where she had always been. He told his story to the appropriate people and was never bothered again by any apparitions.

In another case a woman was thought to have an *Uirsalik* because she was always wringing her hands and making strange movements with them. After being gently questioned by another woman, who is now a community worker in her late sixties but who has always had a role as a person who helps others with problems, she admitted to be knitting and sewing clothes for her *Uirsalik* because she wanted him to be well dressed.

Although the symptomatology of *Uirsalik/Nuliarsalik* was similar to that of several other forms of mental illnesses with hallucinations, 'delusions', strange actions, and withdrawal, it usually was not viewed as an illness in itself. An informant with much experience as a community worker reported that individuals troubled by *Uirsalik* or *Nuliarsalik* were not normally sent to see the nurse or doctor because the health professionals do not believe in it and therefore have no idea what to do about it.

Although not an illness, *Uirsalik/Nuliarsalik* possession was nevertheless seen as a serious problem—indeed, more serious than *Uuttulutaq*—because the person affected was unpredictable and potentially dangerous. They might struggle to maintain their relationship with the unseen partner and could become violent if pressed too hard to reveal what they were experiencing. The only way to get people to abandon their spirit partner was to talk with them until they rejected it themselves. Often, the *Uirsalik* or *Nuliarsalik* would be telling the person not to listen and trying to make them break off the conversation or leave the area all together. (In this respect, this form of possession resembled Satan possession.) The affected individual would have a difficult time knowing which aspect of their experience was real and it might take some time to get them to understand that their spirit partner was dangerous to them. People with this form of possession were at risk of wandering off on their own and never returning. The *Uirsalik* and *Nuliarsalik* were constantly present with the individual affected even if there were no outward signs. The affected person might be counseled by the spirit on how to act naturally so that others would not be suspicious.

4.5.3 *'Satanic' Possession*

'Satanic possession' here refers to the form of demon possession that is more explicitly Christianized. We have discussed the signs, symptoms and behaviors of this form of possession at length in Chapter 3. As we noted there, the beliefs and practices surrounding this problem follow conventional southern Christian models, although even here there is some admixture of traditional ideas or subtle forms of syncretism.

Appendix D presents guidelines for the recognition and management of spirit possession through fasting and prayer. These were prepared by Martha Samajuali, a community worker from Salluit, in consultation with others, in response to her experiences in helping people afflicted by possession.

Demon possession was closely linked to a moral discourse. It was often triggered when the afflicted person prayed to Satan for supernatural powers to influence others or escape intolerable circumstances. If the powers were intended to be used for selfish purposes, then the person was to blame for his or her own affliction, to some extent. Many accounts of demon possession involved commentary on the 'sinful' life of the possessed person that lead to his/her affliction. This discourse on sin bridged psychological and spiritual explanations since the effects of bad actions could be understood through either type of mechanism.

> Inuit people believe that whoever is mentally sick or insane—they will talk about what that person has done in their past time, their past life. Which is like having a sex with a man or a woman without being married is sinful. And how many times you sin yourself with that, amount to give you a mental sickness. Or stealing, or disobeying, things like that. These are the things that Inuit believe—that they go mentally sick because they are sinful. They do things too many, too many different things behind peoples' backs without talking to nobody to solve it. You lost your virginity, since then they think that it's a sin to have a man without being married. Or stealing or lying, or never going to church, like me or laughing at other people-all that together makes the mental sickness according to people. Or they did something like maybe killing a baby without someone knows, knowing about it, having, a woman having a miscarriage on purpose, you know? These are the things that Inuit believe it goes to the mental health problem. [P030]

Similarly, some accounts of demon possession picked up another southern theme, linking its prevalence to youths' listening to heavy metal music which, according to some informants, contained hidden messages about Satan that could have a powerful effect on the mind and spirit of the listener. Parents and church groups have at various times responded by destroying recordings of rock music, cutting off their children's "rat tail" hair style and holding prayer vigils with and for young people. This is not to say that young people do not share in this belief system. In some cases the people interviewed who were able to give the most articulate descriptions and explanations of possession beliefs and their interaction with states of mental illness were young people.

If, as was sometimes recognized by informants, the person asked for Satanic help in order to deal with intolerable feelings or living circumstances, then the moral significance of possession was more ambiguous. In some instances, the person involved may have been the victim of wife abuse or other family violence. The attribution of demon possession then may have served to shift the focus from the terrible personal circumstances, which tended to be viewed as unchangeable and inescapable, to the spirit realm where certain practical actions can be taken. The exorcism and subsequent participation in church activities did offer the afflicted person catharsis, respite and reintegration into a more active or engaged community group. These effects might be just as important for those practicing religious healing and exorcism as they are for the afflicted person since they serve to reinforce community ties and commitments.

Finally, although demon possession was a common theme in the interviews, it should be noted that several informants did not believe in demon possession in any form:

> Yeah, demon—this I do not believe. Maybe it's the people that get things long enough to disturb their mind, that their mind is playing tricks on them because they're left feeling alone. Or they have difficulty in life and they have family problems. They cannot talk to each other. That's what I think, because I never had this kind of thing happening to me. [P007]

Skeptics tended to have more education, more income and were less affiliated with the church. For the most part, however, even skeptics kept their options open.

4.6 Impact of Culture Change on Child-Rearing and Mental Health

Many informants introduced historical awareness of recent social and cultural changes as important causes of mental health problems, especially substance abuse, suicide, family violence and child abuse and neglect. The Inuit of Nunavik have experienced profound changes in their lifeways in just two to three generations. This sort of rapid culture change, and the specific demands that have come with it, was widely recognized by informants as a contributor to the range of mental health problems. This did not take the form of a vague nostalgia for times past, but involved explicit links between mental health, child rearing, life circumstances and changes in the scale and configuration of the community, the family and the economic and educational systems. Traditionally, Inuit lived in small migratory bands composed of one or a few extended families. They congregated at certain times of the year in larger camps but spent much time in relative isolation. In camp life, parents' activities were usually the most interesting thing happening and children would naturally gravitate to watch and learn by modeling and imitation. Periodic larger gatherings were times of celebration and conflict would be solved by elders mediation (Minor, 1992) and, ultimately, by dispersing again into smaller groups back on the land.

> All she can remember about her childhood is that when she was a little girl, as she was growing, they always used to go camping. Either in a few nights, or really go camping in the summer. She was always there with her parents, with her mother, and she feels she was never separated from them. When she had her mother and she was living with her mother when she was still a young person, she had nothing to worry about. But as an adult with growing children, she started to worry about things. Worry about her children. [P011]

Methods of child-rearing and social control of deviant or troublesome behavior that were effective in the traditional context are often found not to work in the current communities (Matthiasson, 1992). These communities have created new forms of social segmentation and stratification by age and economic level. Along with this have come other social changes that have challenged the central role of the family. In current communities, children are sent to school—which parents expect to replace much of their own socialization efforts—or else, wander about the community freely, in continuation of the *laissez faire* approach that fit camp life but which now seems to some community members to border on neglect.

> The kids went to school. They were out of their parents' sight from 9 to 3 in the afternoon, 3:30 or 4 in the afternoon. And parents didn't have to deal with that anger any more. I mean the parents didn't want to take the time to teach their child any more. They were told that the teacher would teach the child everything. How to live, how to earn money, how to grow up, how to be, everything. They trust that all these books are, the kids are learning all that, how to be a human being. They don't understand that they've lost control of their position. That's why they get angry. They can't understand why there are so many dropouts. Why the school system is failing. They don't want to deal with that anger any more. [P002]

> For me it always goes back to experiences people have as children, while they're growing up. It may be any kind of trauma or grief, that they have not let themselves experience, or because they're having so many problems with their husbands but do not want to take their own blame. They're trying to blame their husband, or something. Or they had to take too much responsibility as children. They didn't have time to grow up. They had to become adults too fast. Because their parents weren't around, or they were neglected as children and had to take care of other little kids, their siblings. Many have to grow up really fast, either because they're having their own problems, or because they're…In the past, when the community was just forming, and people were not used to associating with other people or having any kind of social life, that's all they wanted. They just wanted to live a social life. They didn't want to take care of their family any more. It was exciting, it was new. They just wanted to go to bingo games. They wanted to play cards all day, and visit all day. And never mind the kids, they're going to school anyway, from 9 to 4 in the afternoon. They were thrown, thrown together. With nothing, just houses. That's all. Nothing. Many houses ended up being gambling casinos. And the kids, never mind them. They can sleep anywhere on the floor. You can open the door, in the middle of 40 degree winter, you can open the door and let all the blast in, because it's too hot. There's too many people. There's too much smoking. And never mind that the children are on the floor. That's the kind of existence people had in the, in the 50s and 60s. They just wanted to dance and socialize. [P002]

Camp life still allows families to regain some of the comfort and harmony of traditional life where ideas about relationships fit the context.

> Well, when you're away on your own, personally speaking, when I am out camping, I let my kids go and do whatever they like. There's nothing really they can do wrong. There's nobody else there. There's no property to damage. There's no other kids to fight with. Nothing to steal. And, well, it's harder to keep them outside at the camp. It's as hard to keep them outside at the camp as it is to keep them inside at the village. Do you know what I mean? They tend to stay inside to see what you're going to cook up next, or what kind of neat thing you're going to do. What their mother's going to do. [In the settlement] they see other kids horsing around outside, they want to take part. And when it's time to come in it's harder to bring them in [than] in the past. And that maybe some of the traditional ways of child rearing fit that situation very well. [S004]

The shift from hunting and a subsistence based economy to a status hierarchy based on wage-earning and ability to successfully negotiate with local and distant bureaucracies has left many men, young and old, feeling marginalized and ineffective. There are, in fact, few jobs and it takes truly exceptional ability to succeed with the limited opportunities available.

> For people in the north, there isn't much work . Only a good person, or positive people who can work well, because we don't have higher education. We don't have diplomas. We don't have certificates. We didn't have long term schooling. Because there was no high school in the north. Even though we tried to go to high school down south. People get homesick. People get tired of living down south. Where the drugs and the alcohol are. We miss the nature of our home. But when we get home there's hardly anything to work for. We try to apply for good jobs, but only the good person can be hired. [P003]

In the absence of traditions that fit the current social context, people have to fall back on their own devices in child-rearing, thinking through the alternatives they are exposed to from popular media, church, school and health services. Sometimes they invoke a mythologized past that may reflect their own idiosyncratic experiences or idealization.

> Well, I'm kind of caught between being a strict disciplinarian and being a lenient father who advises his children against things that are wrong. The lenient approach is, on the extreme, allowing your child to do whatever he wants, up to a certain point. Not allowing him, or her, to be outside past a certain hour at night. And expecting him to be there when it's time to go home. But if he's not, saying "well don't let it happen again." Whereas, a strict approach, using the same example, would be to, preach to your child, in a fire and brimstone way, as to how not to behave. And if you catch your child behaving like that, or hear that your child has behaved that way, administering corporal punishment, as it's termed in the schools. With physical punishment. Personally I try not to, punish my kids every time with the flat of my hand. If I feel they deserve it, I'll yell at them but then if they've been exceptionally bad I won't think twice about putting them over my knee and spanking them. [S004]

Corporal punishment was little used in the past, with adults relying on the strong attachments and moral authority intrinsic to family life. Some adults who

were sent to residential schools or who endured prolonged hospitalizations for TB may have experienced or witnessed corporal punishment and other harsher sanctions, and have incorporated notions of strict discipline into their ideas about 'ideal' child-rearing.

> When a child was caught stealing something, without realizing they were actually stealing, they were just taking something they wanted. Nothing really belonged to anybody. Speaking of food, for example. A hunter's harpoon is more or less sacrosanct. You didn't touch that, it belongs to that guy. It's taboo to take that away. It's taking away food from his family. But, let's say I had a full meal just a few hours before, and this family, had nothing to eat all that day. And their parents, my friend's parents brought home a small piece of dried meat from another household. And I took that small piece that was intended for my friend. Well, my parents would most likely reprimand me. "You already had something to eat; it's that child's turn. We'll get something else for you to eat tomorrow." That kind of thing. [S004]

> Another thing that comes to mind, actually, is that if a child hurt another one, was mean by picking up a rock, throwing it, and hitting the other child, chances are, traditionally speaking, that child would only be told, "Don't you do that again, okay dear." And that was it, that was that. Not having been a parent at that time, parents must have thought that their child will grow out of it eventually. And in most cases it's true. [S004]

> Discipline is an idea that's taken hold in the last, what, 30 years? Maybe? Thirty, forty years. No matter what, what part of the world you're from, there are situations where your parents are going to reprimand you and they'll reprimand you in a severe fashion. Depending on what you did. And the Inuit are like that as well. Particularly if there was a tough fight between siblings and one got hurt pretty badly, the other, the kid that inflicted the damage, was quite likely to get a smack in the head, or something like that, from the father. Not often, but, once in a while. They were really good at making you feel guilty. They didn't even have to say much. It was just the way they looked at you. The way they talked to you. Talking to you like, "that's one of the stupidest things I have ever seen, anywhere, anytime." You know, somebody says that about you, you feel pretty small. You're not going to do it again if you can help it. Like if you're a boy and it's your Dad that told you that, or if you're a girl and it's your Mom that told you that—words carried a lot of weight. All it took was a look from my parents to know that they were displeased. [S004]

Teasing has been described as an important part of traditional child-rearing aimed at establishing interpersonal control and preparing children for uncertainty (Briggs, 1983, 1985, 1987; Lantis, 1980). In the present study, when asked about it explicitly, most informants did not report teasing as an intentional or conscious aspect of child-rearing and many mentioned the emotionally damaging effects of unfair or excessive teasing.

> Generally speaking people only tease children, more often, if it's your brother's child, let's say. You might tease the kid. You're the uncle, the child is the nephew, you might tease the kid in a friendly way. Without making them feel bad. Without undermining their sense of self worth. A lot of the time, children were named after immediate family members, and particular traits of the senior person, were used as a way of teasing the kid. If your uncle tended to sneeze a

> lot and you carried his name, chances are, "You're going to sneeze again are you?" That kind of thing would come out. "Let's have something to eat here. Don't you sneeze." You know, that kind of stuff. But that's, sneezing is not, ah, not a usual thing that happens. It's mostly the way they speak. The way they carry themselves. [S004]

The change in the nature of youth culture is of concern to many people who view it as an intrusion of non-Inuit values through the various media and a source of suffering for young people and parents alike. Reactions among some factions within communities to the apparent problems of the young reflect beliefs which maintain elements of traditional culture and newer religious beliefs. As mentioned above, in Povungnituk, Salluit and some other communities popular music is seen as being a source of temptation to demonic possession among young people.

> Before 40 years ago, nobody in our community thought of committing suicide. I guess people were respecting themselves, they were respecting each other. But today it's a different story. Young people are committing suicide—I guess the cause would be neglect. They [are] neglected by their family. They're doing their own things. Listening to rock and roll music. I think it has to do with our way of life now. Some people are not looking after their children. Like before I met some people who were camping all night, drinking a lot, I guess that affects their children, how they see their parents and that causes them to be thinking about suicide. And in some cases it has to do with the music. Heavy metal. [P052]

Several informants raised issues related to Inuit/*Qaullunaq* (white person) relations. There is a tendency to view light skin and *Qaullunaq* features as more attractive. This is an extremely delicate and embarrassing subject for informants to speak of but it reflects the impact of subtle forms of racism that may contribute directly to low self-esteem and identity confusion and hence, to mental health problems (cf. Aboud, 1993).

> There's a couple of people who are half Inuk half *Qaullunaq* which I think their personality seems to be the same, even though they're male and female because they are half *Qaullunaq* and half Inuk. I don't know why but I can tell that they have the same mental problem. I see them every day and sometimes like when it's full moon they're worse. They just talk and talk and sometimes yell and maybe if they're younger they would have been abusers like physically. Well, I grew up with my Mom, she's half and I don't remember being hit. [P038]

These accounts make it clear that social and cultural change figures prominently in Inuit accounts of mental health problems, particularly as these shade over into everyday problems in living shared by the majority of the population.

4.7 Discussion

The Inuit concept of the person has been called 'ecocentric' in that it gives a central role to environmental factors in the make-up, health and well- being of the person (Stairs, 1992, after G. Wenzel). This is reflected in ideas about the

importance of country food and nutrition on the quality of the blood, and the importance of the physical environment.

As a hunting people living in rugged conditions, intimate knowledge of the land, weather and wildlife was essential for Inuit survival. Despite exposure to North American ideas of individualism and images of the urban world, the central importance of the land and animals in Inuit concepts of the person and well-being persist today.

Mental health problems were attributed to four broad classes of explanation: (1) physical or organic effects of the environment or human behavior; (2) psychological or emotional factors related to child-rearing, interpersonal relations, and mental functioning; (3) various forms of spirit possession or intrusion; and (4) cultural change and social disadvantage. People readily employed multiple explanations to some mental health problems, the choice of explanations and their relative emphasis reflecting pragmatic concerns that shift over time.

Congenital problems were widely interpreted as physical disorders linked to accident, environmental or hereditary influences, and, especially, to the prenatal care taken by the mother. Maternal drug abuse was most often mentioned as a cause of problems through physical effects prenatally.

For childhood problems, the emphasis in causal explanations shifted to the quality of parenting and the atmosphere in family life. Children who were treated harshly or neglected were seen to grow into adults with mental health problems. There was much diversity, conflict, uncertainty and confusion of opinion over appropriate child-rearing, reflecting the dramatic changes in Inuit life style in recent decades that have rendered traditional methods difficult to apply or frankly ineffective.

Among adolescents, rapid culture change, lack of educational success and vocational opportunities, drug abuse and the ‘youth subculture’ were all invoked for the widely-recognized increased prevalence of suicide, depression and related mental health problems (cf. Kirmayer, 1994b). Depression in adults was more likely to be attributed to loss of parents or significant others, marital conflict and abuse, and childhood emotional neglect and abuse. Verbal and physical abuse were mentioned especially as having impact on children and adults (women).

Most informants were very ‘psychologically minded’ by the standards of mental health practitioners in psychiatry. (While this may have reflected a sampling bias with an over-representation of health care workers, it should be noted that some of the most traditional, least acculturated individuals, who spoke only Inuktitut, offered extremely sensitive and sophisticated accounts of psychological processes underlying emotional suffering and models of child-rearing, based on the importance of clear communication, expression of love and empathy for another’s feelings.) There was a clear concept of the role of mental processes in well-being and in suffering. The psychological concept of repression of painful emotional events with various health sequelae was shared by many informants.

There was a general consensus that people exhibiting bizarre, antisocial or disturbed behavior as a result of emotional trauma are not aware of the underpinnings of their own behavior and are often not aware that the behavior itself is aberrant. The painful events were forgotten or suppressed. This awareness of repressed memories as a cause of mental health problems has a precedent in the cultural belief system surrounding possession. Psychological explanations overlap the moral domain. Bad actions within the family give rise to painful thoughts and feelings which in turn lead to further bad actions in subsequent generations.

Three forms of possession were identified. *Uuttulutaq* involved disembodied spirits attacking individuals when they were vulnerable. The spirit was experienced as a force, feelings of the uncanny, or through its symptomatic effects. It could be dispelled by refusing to traffic with it, or by acceding to its influence. This form of 'possession' is probably related to traditional notions of spirit intrusion or attack, although no natural agency or malevolent shaman is identified as being behind the *Uuttulutaq*.

A second form of possession, which also seems to derive from traditional beliefs, called *uirsalik* or *nuliarsalik*, involves the acquisition of a spirit husband or wife (respectively). This can occur when individuals have intense longing for an idealized mate and think, daydream or obsess about him or her constantly. In response to this concentration of thinking, a free spirit may be attracted to the individual's thoughts and come to inhabit him/her. The person can see and interact with his/her spirit partner. This accounts for such phenomena as hallucinations and otherwise senseless or delusional actions, like knitting socks for non-existent children. People may live peacefully with an *uirsalik* or *nuliarsalik* for many years and this does not, in itself, constitute an illness. However, since most affected individuals are withdrawn, "strange," hallucinating or have other interpersonal difficulties, it often constitutes a social problem.

The model of *uirsalik/nuliarsalik* possession makes it clear how close the link is, for the Inuit, between psychological processes (desiring, longing, obsessing) and the spirit world. Just as psychological processes have an obvious moral dimension referring to the individuals' harmful or selfish actions, so the activity of spirits is mediated through psychological processes.

The third form of possession closely followed the prototype of Christianized demonic possession found around the world. While it is tempting to view this as simply an importation of southern Pentecostal Christian practices, it is probably more accurate to see all three forms of possession as syncretic belief systems in which traditional forms of possession are integrated with Christian beliefs to provide a credible explanation for aberrant behavior. Conviction in the possession diagnosis is grounded in bodily experiences of the uncanny and the interpretive authority of individuals aligned with the church or evincing personal power and charisma. The possession model leads to specific treatments in which many community members can participate.

5. Social Course and Treatment of Mental Illness

In this section, we present findings related to the social response to deviant behavior and individuals with labeled problems or psychiatric diagnoses. We examine the course of illness, not as a feature of a 'natural history' claimed to be intrinsic to some abstract disease entity, but as a socially constituted reality. This perspective on the social course of illness is increasingly popular in psychiatric anthropology and also fits well with Inuit views. An essential aspect of the course of illness is, of course, the various therapeutic responses and treatments sought and delivered. We will consider Inuit informants' views on medicine, psychiatry, social work, Christian healing, 'natural helpers' and other community sources of assistance.

5.1 Response to the Mentally Ill

As noted in Chapters 3 and 4, Inuit tend to view mental health problems as states of mind and behavior rather than as fixed or enduring characteristics of individuals. Informants also tended not to view those afflicted with mental illness as having special personal traits or characteristics aside from their evident problem. These views supported the frequent statement that people with mental health problems should be treated just like anyone else, i.e., with the same consideration, care and concern. Since Inuit culture also mandates a high degree of respect for the autonomy of others' actions, this also means that one should not interfere with others' lives unless their behavior is immediately threatening.

> Take care of them and let them know what's going on, and be friends with them. I mean if there's no medication for that illness, I think it's the best thing to do for a person like that, is befriend them like a normal person; like you have a friend and I have a friend, so be friendly with a person like that. So I think that's the best way to let them behave like a normal person. [P009]

There was a discrepancy, however, between ideal and actual behavior. While most informants tended to report their own behavior as conforming to this tolerant and accepting ideal, they noted that others often were ridiculing, rejecting or ostracising the mentally ill. Traditional culture was, in fact, highly tolerant by all accounts unless behavior was extremely burdensome on others or frankly threatening. In such situations, the troublesome person would be dealt with by ostracism, abandonment or, in some cases, execution. The advent of local police authority and medical care constrained options for dealing with troublesome or disruptive behaviour and transformed ostracism into efforts to have the afflicted person taken care of by southern institutions.

> What they used to do before the hospital ever popped out. They used to put these people in an isolated room. You know, it wasn't very beautiful to see, it was unnatural for Inuit to do, but they say that it was for the best, for the best for her, to try and make her talk. All of the ones that they think they're mentally sick, they would put them in one corner or put them in an isolated house and question them with any kind of questions what caused this sickness, but today it's not like

> that— people treat them just like ordinary others, they're not involved in the work. There are made welcome in the community, as far as I remember. I never seen anybody sending that person to another town just because they are mentally sick. But those days, they sent them to Douglas Hospital in Montreal. The ones that come here, they stay here for a few weeks in order for the relatives to rest a bit and then they go back without being cured to their settlements. [P030]

> It's very serious. We used to be a very small settlement and everybody used to be affected by that person. These days we don't hear people who are who are crazy. But in the past it used to be it used to affect the whole community. They used to have people looking after that person day and night. In the past they used to put that kind of person in an isolated place like an empty tent. And have some somebody to look after them. But but these days I guess people like that goes to the hospital to get help. And sometimes people ask Christian people to exorcise these people, to turn themselves to God so they could be healed. And some people ask them down South, to get help. And, I think there are those who spent some time down South and they come back and they're OK then. I don't know how, I don't know how they cure them or- they're not cured though but they always come back to that stage you know, mental sickness, I don't know, every year. These days, I think it's no longer a threat to a community because there's a group of people who can help these kind these kind of people with the mental health illness. [P052]

The close knit structure of traditional bands meant that withdrawn or depressed behavior was likely to be met immediately by attention and nurturance from others.

> In the past it was very well understood. Much more than it has been recently. We had a custom that taught us to visit people. When you're growing up, when you're a girl or a boy, and you're growing up, you go and visit people. You go and help them out with anything they have to do. You go and get water for them. You do things for them. You work together in the community. If there's something to do you work together. The moment you wake up, you go out, see what the weather is like. Even before you have any breakfast. Then you come back in and you prepare your breakfast, and you do your chores. But you do it with other people. You are around other people all the time. It was a community of sharing. There would be, there was, there was no withdrawing. Or if there is an element of that depression, there are people who are very wise to come speak with them. If there is something bothering them. [P002]

Some problems have more impact on the community. Withdrawal, isolation or depressed mood were less alarming than violent or aggressive behavior. Inuit have lived with much loss through accidental death and most informants were matter-of-fact about dealing with the attendant grief.

> If a family member or a friend, a close friend, dies, I know that person is not coming back. I am very sad and depressed over it. But as time goes, I'll get over it but I'm not able to bring back the dead, you know what I mean? That's a problem, depression which can be dealt with but can't ever completely go away. You know what I mean? You have to learn to accept it, to live with it. Most people are. Well Inuit people, I think they're very strong. They have lived through dying, I mean like .. like they were starving before, they were, they had

> to live in igloos and they lived in just a few groups of people and they had to learn to deal with things so they'll survive. And I guess that's how they gained their strength. [P032]

> Mourning is for people who have lost their, part of their family. And it's permanent. This only time will heal. This is something that they actually have to live with. The Inuit have a way of dealing with mourner, mourners. They go to the people's home, the mourners' home and stay there for as long as they are needed, give it a week, about a week or two weeks and then they gradually start going back to their normal lives. If these people cannot sleep, they stay up with them, sleep with them, be sad with them, cry with them. But as time goes on they can start joking. When there is mourning, there's always jokes around too, always, This is a way they are saying, there is nothing we can do to bring back a dead person. A dead person is a dead person. Let's leave it at that and try to get on with our lives. Something very dear, that person was something very dear to us and we may be leaving them, that person is leaving a big part of his life or her life. So it can be very dramatic like the person who is leaving might have been an idol, a father or mother, but you have to help this person get out of this depression, this mourning. Everybody helps out, they clean their home, if there are changes to be made there will be changes made in the home. [S001]

In contrast, people who were angry or aggressive would generally be avoided or given a wide berth. Intrafamilial violence tended to be avoided by people not directly involved in social services. In contrast to public violence, against the 'community', it was not usually viewed as a matter for the police. This reflects traditional attitudes of non-interference (Minor, 1992). Violence against women, however, which was perceived as very common, was seen as becoming less tolerated than it may have been in the past as awareness of the problem grows and models presented in the mass media are integrated into people's thinking.

> Maybe like down South they realize it's not good doing this and that it's like in the past it was worse everywhere it seems but now it's less than before it seems. Or since the village is growing, we don't know much what's going on. There's less abusing I guess, or they're abusing the people behind everybody's back or we don't know what's going on. In the past there were lot of people abusing in public when they're drunk. Most women realize that they have no right to be abused so they're more strong I think. Well I am. And people are realizing, especially women, they're realizing that nobody has the right to be abused. It hasn't been long since they started to drink alcohol maybe 20 years. And that's the time people were so violent in public or fighting or stuff like that.[P038]

5.2 The Value of Conversation for Mental Health

A recurrent theme in many informants' accounts of both the causes of mental health problems and the effective methods of helping, was the value of confiding in others. Open conversation between parent and child and with a trusted friend was viewed as a key to mental health and as a powerful means of resolving conflicts and healing the wounds acquired from difficult family circumstances and traumatic experiences. This view was not simply a reflection of American 'pop' psychology as presented on network television. Similar views were eloquently expressed by elders who spoke no English nor French and adhered to a relatively traditional lifestyle. For example, one elder gave the following account of the value of open communication in child-rearing and preventing or dealing with mental health problems:

> She wants to talk now about the way she helps her children, young people. How to help them not to get depressed. When a young person is doing something wrong—like they break in, or break the law, something like that—that shows that the young person has some sort of problem. And when she learns that her kids have done something wrong, she waits until they're very aware of what they have done? And waits, not right at the time that it happened, but wait till they think a little bit about it, and then she talks to them. Not criticizing them or saying "you're no good." It's not to talk to them like that, but to talk to them clearly with care and love. And when you talk to a young person who is creating problems, tell them with care that what they did, it's wrong, and they must realize that. But it's always better not to do it again. You talk to them, but calmly and clearly and carefully; to show them that you care. And help them. That's when they learn to say they're sorry and they try to go in the right direction. But if they have committed a crime and you talk to them harshly, you're angry at them, that's telling them that they're no good. They begin to think that they're no good, and they keep that to themselves. And they know that they're not good in the sight of people, and they begin to think low of themselves. And that creates depression and sometimes up to committing suicide. [P011]
>
> She use herself for an example and it's her that in her own mind that she (learned) to do that, with her kids. And she has grown children? All adults now. And, she had to help, had to help her children. And, to show them that she cares. And, sometimes she thinks that, she sees other kids who are mistreated by their parents; who are not cared for and they feel as nobody cares, their parents or anybody. They become depressed and even up to suicide. So, seeing both sides of the problem, that's how she learned to deal with her children. [P011]

Within each community, there are people who have been identified as 'natural helpers' who may appeal to religious principles. Depending on skills and inclination they may encourage the people they are helping to talk about their problems. There are also informal helping networks based on friendship. These forms of help may be extended to the most deviant individuals, provided these individuals are not threatening or violent.

> I usually have friends drop by to talk about what's on their mind. And later on they say, when they are about to leave, "Thanks for listening to me." I guess someone who is able to listen would be a good way of letting out what they're

> thinking. Because when people are thinking so much and they don't let them out, it builds up to the point where they think that they can't handle it any more. Like the weight is too much. And even if, I'm quite sure, even if they try to say, "I have a lot on my mind. I want to talk.." The person would be saying, "Yea, yea, what is it?" It would have to be someone wanting to listen. I usually have quite a few friends. Even some friends, or some people who I consider not close to me, if they have something on their mind, they will let it out. And if they see that I'm listening, then they will reveal some things that I never thought I could hear from them. Aside from who I call my close friends. [S003]

This cultural concept of the value of open expression of emotions, conflict and confession for problem solving is not universal, however, and is opposed by cultural values of self-control and by the shame and embarrassment associated with revealing personal failings or experiences of abuse. Compared to women, men have more difficulty talking about personal or emotional matters and tend to keep things bottled up inside.

> I think the Inuit men are taught to be tough which I do not agree with. Because when they are told to act tough or [not] be a coward, they use it the wrong way. They abuse their wives. There's so much abuse. So many horror films because the husband is in power and they don't show emotions. But I am sure they are hurting really bad inside. I can tell they really hurt. [S001]

But women too, have felt at times that their emotions are a burden to others and should be hidden or suppressed:

> Any other emotion is not accepted. It is not accepted to grieve. The general belief, or the old belief is that people shouldn't grieve. If you are grieving, it's because you weren't a good child. You had problems to that person, person who was alive. Whether it's your father, your mother, your brother, or anybody who was close to you. Because you were bad. Or that the person went to hell. No matter what kind of relationship you had. [P002]

> In a way you want to respect older people, because you're taught to respect them. Ever since the day you were born, you have to respect older people. But on the other hand, there is this new understanding of the ways of grief— possibility that if you don't grieve it comes back to you. You know. It will affect you later on in your life. You have to go, it's something you have to go through. Some people have always understood that. When I, when my brother died, some maybe 15 years ago, it took me a year to get over it. But I didn't even realize that I was grieving. The day, the day I stopped grieving, I could tell. Suddenly I saw the bright blue sky and the sun and the snow. I could, finally it was like—for a year it was dark, I couldn't see anything. [P002]

Notions of conversation and confession were embedded in a moral discourse that often returned to religious ideals of right and wrong in human conduct. Many interviewees believed that lack of forgiveness of others can cause mental illness. There was thus considerable pressure on those who felt wronged to move past their anger and extend forgiveness to the wrong-doer. At the same time, there was an expectation for the other party to also do something about their actions to acknowledge that they had been hurtful towards the aggrieved person and to the community at large. People's acceptance of their wrong-doing and

commitment to change often took the form of public or semi-public testimonial with expression of remorse and willingness to change. The church was seen as the appropriate place for this by many, as the centre of the spiritual life and the source of strength for people in conflict, although the family, friends, colleagues and even the community radio were also used for these purposes on occasion.

When it was impossible for the aggrieved persons to forgive and continue on they sometimes faced considerable emotional stress both as a result of their traumatic experiences and as a result of their inability to recover according to cultural norms. Social pressures and sanctions against those who do not forgive the perpetrator could contribute to their suffering. In one case a woman who had decided to leave her husband after a number of years of sadistic physical abuse was pressured relentlessly by her own family to forgive her husband and go back to him. This she could not do because she knew that the abuse would continue and was worried as well for her children who were also being abused. She felt that she was placed in an unbearable situation and was being given no choice by her family. She ultimately considered suicide the only recourse remaining to her and was preparing herself for it when social services intervened on behalf of her children at the request of the school. She was given a new avenue of escape, through her children, changed communities and moved on. Interestingly, the community response, once the children were removed from the household because of the father's behavior, was finally to force him to leave the community.

In some cases then, the pain and emotional conflict experienced by victims of violence and abuse was aggravated by the expectations of community members, causing them to be isolated while they are suffering or hiding the way they feel so as to appear to have forgiven. In discussing her experience of prolonged sexual abuse by a family member one woman said:

> People think now that I forgave and forgot what happened [but] I cannot forget, cannot forgive what happened. Even some people say you are lucky that you forgave and forgot, I don't say anything. I cannot forgive or forget. I think he is an animal. [KQ01]

In this discussion of sexual abuse we have used the terms victim and perpetrator to distinguish the people involved for expediency. The roles implied by the terms are the functions of a particular moral/juridical view of family violence that cannot necessarily be simply extended across cultures or imposed on an individual's own constructions of experience. In the more than two hour long interview of the citation above, the term "victim" was not used once. The interviewee instead referred to her personal experiences as a contest and she spoke of herself as the winner of this contest because the abuser ultimately went to jail for his crime. She had broken his hold over her life and proved her inner strength to prevail to be greater than his to subjugate. This in no way diminishes the pain and suffering she experienced but points to the importance of elucidating local meanings if we wish to fairly represent the sufferers' experiences of themselves.

5.3 Views of Biomedicine and Psychiatry

As noted above, psychological notions were widely accepted by informants. Psychotherapy and counseling were therefore generally viewed positively, although their efficacy was not always endorsed to the same degree.

Despite generally positive and benign views of medicine and, by extension, psychiatry, several informants had strong opinions about medication for the mentally ill. Many people felt that medication was counterproductive and tended to make a bad situation worse. One clear exception to this view was in the case of organic mental health problems evident from birth. In some of these cases, informants noted that medication seemed to be the only way to control the afflicted person and, in some cases, averred that it helped them. Epilepsy, which is not really considered a mental illness by the Inuit but a physical affliction of the body, was one case in which the use of medication was consistently viewed as beneficial. To some degree, the negative view of medication may reflect that lack of provision of concomitant counseling and psychotherapy, which may have occurred because of linguistic and cultural barriers or lack of appropriate resources.

> But I will say for a fact even when I was in a mental hospital I never had any counseling, and all they did was feed me pills and sometimes I would be so drowsy and I would be skipping breakfast day after day after day. And the pills I was taking, they were making me mentally sick. Before I went in I was all right, but all they [did] was fed me pills. Nobody asked me what my problem was. [S010]

In this citation we have two common themes: that pills can aggravate or even cause mental illness; and, that discussion of mental health problems is the preferable recourse. These sentiments were echoed by the following informant:

> *...cette personne qui est en nervositée ou bien en stress, parce qu'on se pardonne pas, et puis parce qu'il a gardé tout ses problèmes c'est ce qui empire lui-même, et puis en général on va à l'hôpital pour avoir des médicaments justement parce qu'on est en stress. Et puis, ces médicaments-là, nous autre même on a dit pour la deuxième fois, après l'autre entrevue qu'on avait eue, c'est la même chose qu'ils ont dit, que le médicament n'aide pas la patiente, n'aide pas cette personne qui est en stress, il la rend de plus en plus bizarre. Eux, ont remarqué que la personne devient pire qu'avant.*
>
> The person who is nervous or stressed, because we cannot pardon each other, and because he has kept all his problems inside becomes worse, and also we generally go to the hospital [nursing] to get medication because we are stressed. What's more, these medications, as we have said before in the other interview, the medication does not help the patient, do not help this person who is stressed, it makes him more bizarre. They have remarked that the person becomes worse than before [under medication]. [S013]

Medication was seen as an appropriate treatment in severe cases, as a last ditch effort to keep an individual in their community when the alternative was institutionalization. In some extreme cases, most informants felt that an individual should be institutionalized in the south even if he or she could be

maintained in the north. These cases usually involved people who were extremely disruptive to the community at large and were too great a burden for the general population to deal with. This strategy of trying to have people sent to southern health care institutions has parallels to the marginalization or ostracism of disruptive individuals in the past, as discussed by one elderly informant:

> Et puis, il a dit que la personne qui ne peut pas vraiment comprendre assez vite et bien c'est une personne qui est un peu différente des autres personnes un petit peu, puis c'est très dur à expliquer [ce qu'il dit].. s'il ne peut pas s'améliorer autant que eux voudraient qu'il améliore, alors il doit toujours de côté à condition qu'il va aidé tout le monde tant qu'il n'aura pas réussi à s'améliorer comme il voudrait qu'il le fasse, si non il va rester un petit peu de côté …c'est une personne peut-être pas bizarre mais c'est une personne qui à de la misère à se mettre à la place. [S028].
>
> He has said that a person who cannot really understand quickly and it's a person who is a bit different than other people, it is very hard to explain [what he is saying]. If the person cannot improve as they would like him to, then he is always pushed to the side on the condition that he will help people as long as he has been able to improve as they would like him to, if not he will remain a bit off to the side. It's a person who is perhaps bizarre it's [also] a person who has difficulty to put himself in the right place [to act properly]. [S028]

In another interview, an informant described two murders which occurred in past times because the people were not able to conform to the expectations and needs of the larger group. Their murders were discussed by all the members of the camp and their families were informed of the decision before their death. These were exceptional cases where the larger community was at risk from the aggressive and dangerous behavior of the individual. All other methods had been attempted before the final actions were taken.

5.4 Name-Soul and the Management of Grief

In this section, we discuss the *Saunik* name-sharing tradition which may contribute to the regulation of social relationships and the management of grief. The abstract concept of the name-soul is given meaning for most people through the *saunik* name-sharing tradition (Graburn, 1969; Merkur, 1991). *Saunik* is characterized by giving newborn infants the name or names of people in the community with the belief that they will take on certain characteristics of the personality of the people they are named after. The names usually come from respected elders, alive or recently deceased. This practice serves multiple purposes: through the giving of the name the memory, personality and skills of an elder are perpetuated through the newborn. The newborn receives the qualities of his or her homonym permitting existence to begin.

In a practical way, the system works as follows: a child named Peter, for example, would share this name with someone at least one generation above him who would in turn share his or her name with an equally older person. The personality of the elder *saunik* is transmitted to the younger through the name

and the younger *saunik* assumes the elder's societal and kinship position. In contemporary Inuit communities, this practice is used in almost all births and in some cases is actually used to aid the mother in producing a healthy child. In some instances, when the health of the fetus or the mother are in question a respected elder will name the child before it is born, with the counsel of the pregnant woman's family. This was said to encourage the child to be born healthy because it knows that it is wanted and it is already infused with an identity and personality through its name. Some adult people were effectively reborn through being renamed. Sometimes, when an individual was ill and close to death, an attempt would be made to revive the person by giving him or her a new name. With this system, names are recycled from one generation to another permitting family and community history to permeate the lives of those in the present.

The name given a child plays a large part in determining his or her social relationships with others in the community and is incorporated into the complex kinship recognition structure of the Inuit. A living elder person who has a child named after him or her will greet the person as *saunik* and vice versa. Since more than one child can be named after a single individual, they will share the same namesake and some personality traits; they too will address each other as *saunik*. However, two people with the same name from different individuals will not address each other as *saunik*, as they do not share the same namesake, just the same name.

When the younger person's *saunik* is dead the family will address the living *saunik* with the kinship term appropriate for the dead person. Hence, a newborn named Robert, after his grandfather, will be addressed as husband (*ui)* by the deceased Robert's wife, father (*ataata*) by his children, grandfather (*atatsiaq*) by his grandchildren, and so on. Since names often come from outside the extended family and kinship terms are used as if there were an actual biological link between the *saunik* and the family, there is the effect of intergenerational mixing and inter-familial kinship recognition where none exists—a situation which may be confusing to the outsider.

To properly conceptualize the role of the name in the creation of the individual we must consider the linguistic particularities of Inuktitut as opposed to English. In English, to name something is to objectify it—'It *is* a table', 'that person *is* John'. In Inuktitut, however, to name is to evoke the essence of what something is—that is, 'It exists as a table', 'he becomes John'. In a sense then, an infant is not so much identified by the name given to him or her as *realized* by it.

Guemple (1994) discusses the relationship between naming and the traditional Inuit conception of the soul. In his formulation, the Inuit see the world as containing a finite number of souls which can be neither exhausted nor added to but which are transferred continually between the young, the old, the dead and newborn and in special cases, usually associated with shamanism, between species. Animals share in their own finite quantity of souls and the recycling within each species. Even disease, which releases souls through death, has a constant presence in the cosmos which gravitates from species to species and region to region; hence, epidemics in one species may coincide with health and

abundance in others. The name-soul is not reincarnated as much as it is repeatedly introduced into new individuals through the name. Unlike the Christian soul concept where, after the body's death, the soul rises or sinks to reside in heaven or hell in perpetuity, the Inuit soul simply loses its physical manifestation for the time being but exists always in close proximity. Souls—and spirit representations of them—inhabit an invisible world and can occasionally intrude on the present world through possession or dreams, as described in the *uirsalik/nuliarsalik* possession beliefs above. (Informants also reported more mundane experiences with spirits, usually while out on the land, where they might feel the presence of a spirit and be tormented or played with by the spirit in a way that was not dangerous but nevertheless frightening. Some informants described these experiences as being taunted by spirits for their own amusement.)

As stated at the outset of this section, the *saunik* tradition was observed to help mitigate the grief felt on the death of loved ones. C. Fletcher recorded the following observation in an Ungava coast settlement.

> Walking across town a friend, he asked to borrow my camera because he had to go to family X's house because it was his sister's birthday. He has several sisters so I asked him which one was having her birthday. His response confused me because he said it was Mary's birthday. Mary his younger sister had been killed two years earlier in a freak accident. She was four years old. The house he was going to was that of a family totally unrelated to his own and one which I knew or at least thought he was not comfortable with. It seems he had never gotten along with the teenage son of that family. This was all very confusing and it was not until later that he explained that he and his entire family had gone to the birthday of the child named after his sister since her death. He had in fact been going to his deceased sister's namesake's house. What was striking about this was the normalcy and concreteness of this person's stated relationship to the child, his interaction with this one year old infant and his reversed feelings towards the family of the baby as a result. [C. Fletcher, field notes]

In another case, a young woman in her early twenties, who we will call Annie, died suddenly of some form of seizure. Her life had been unhappy. Born with an undetermined organic mental disorder, she had endured a lifetime of abuse, first at the hands of her unstable mother and later by adolescents in the community. She was prone to fits of rage and violence during which she would hurt small children, break windows in the community and inflict wounds on herself. Her death was sudden and unexpected and reaction to it within the community was quite intense and sorrowful. People who had cared for her as a child and young adult, when she could not be kept with her family or when she had been hurt, were genuinely saddened by her death. One woman said that while she was saddened by her death she was also happy for Annie, as she was now free from her affliction and the abuse she had suffered. It was clear that what she was saying was that in effect Annie still existed, but that her body was dead. In this community no one has subsequently reinvoked the essence of Annie by naming a newborn after her. Perhaps this is because of the problems she experienced as a child, and perhaps because of the social relatedness this would create between the family of the newborn and Annie's. The existence of Annie is not in question but her reinvocation by naming has not yet taken place.

In the first case, Mary's name-soul was quickly reintegrated into the community through the birth of a new baby. When compared to the normal course of events in naming, that of intergenerational transfer of personality and status from old to young, it seems that the naming of the newborn after a deceased child is an attempt to permit that original child to continue her life. The circumstances of the original Mary's death, the reaction of the family to the new Mary and the proximity in age between the two Mary's all suggest that the new Mary is culturally recognized as being the same individual as the previous Mary, although she belongs to another family. The reaction to Annie's death is quite different. There is no new Annie. So what has become of her soul? Guemple has reported that for at least one Inuit group, some names were not reused because the individual who held the name was a social outcast, inspired fear or was a murderer, thus reducing the name pool and by extension the number of souls in evidence. This social reaction to troubled and violent individuals suggests that there is something wrong with their soul, a breakdown in the natural order and that the soul needs to be retired. It exists as it always has but is not immediately reintroduced into the community—although people feel that it will eventually return in some form.

Although the differences between the Christian and traditional Inuit soul complexes were quite profound, this seemed to pose little moral or ethical dilemma for informants. The name-soul complex permitted a great deal of flexibility in the ritual management of grief and the comprehension of birth and death. Having different strategies of managing the dead person's soul available allowed individuals facing a loss to manage their grief in the ways that suited them best. At the same time, it allowed the Inuit community to constitute itself through its idealized images of what constitutes the good person. Of course these two functions were sometimes at odds with each other. In future work we plan to explore these tensions.

5.5 Discussion

In this section, we have reviewed data on the social response to mental health problems. Traditionally, Inuit have been tolerant of personal idiosyncrasy and unusual behavior and often made extraordinary efforts to maintain the sick and infirm. When someone's behavior was simply too erratic, threatening and burdensome and constituted a threat to the survival of the group, the deviant person was ostracized, abandoned, or through a collective decision, killed (Hippler, 1984). The coming of southern authorities and the formation of communities has radically changed the efficacy and feasibility of traditional methods of social control. As well, traditional methods of healing, which involved shamanism, have been supplanted by biomedical care, social services and Christian religious practices.

There was wide endorsement among informants of the value and efficacy of talking about problems. The appropriate person to talk to was someone within one's family or a trusted friend. For some shameful or embarrassing problems, health care workers were actually preferred because of the lack of privacy associated with talking to other Inuit community members (including the social service workers). The lack of anonymity in small communities was both a source of strength and solidarity among community members and a barrier to the very confession that so many advocated on religious and psychological grounds.

The cultural importance placed on resolving emotional conflict through forgiveness and testimonial or confession had positive and negative consequences for Inuit communities and their members. On the positive side, there was a deep concern for the management of interpersonal relations and conflict resolution. It was acknowledged that many people had at times in their lives caused others pain in a variety of ways. Through the culturally prescribed method of declaring their actions and seeking change in themselves they could renew their bonds with others. The community and the people they had hurt accepted their commitment to change and encouraged them to become good people and contribute to the welfare of the community. They were not stigmatized on the basis of passed actions but were respected for having changed. The victims were also respected for having been able to forgive and help the perpetrator. Both perpetrators and victims were, in effect, rewarded for their personal strength and their adherence to social norms in the face of adversity. In many communities, there were people who occupied positions of genuine respect at least partly because of their personal transformations from such difficult situations.

On the negative side, there was a tendency for people who had performed criminal acts, violence towards others, sexual abuse, and so on, to be forgiven with no real consequences or impetus for them to change. Often they went on to repeat the behavior inflicting harm on others. Alcohol or drug abusers and perpetrators of family violence or abuse, for example, may repent publicly through the church or with family members and make some effort to change but return to previous behavior patterns once the seriousness and urgency of the original event have faded. It is possible that some people are aware of the

benefits of public declarations of self-reform and manipulate them in order to avoid prosecution or other negative repercussions. Other people may genuinely be trying to reform themselves but are unable to because the causes underlying their behavior are not being addressed.

While both psychological and spiritual explanations were linked to moral discourses, they involved the person in different social circles with different consequences. Attribution of problems to family and emotional factors lead to an effort to talk things out, seek help from social services, the nursing station or hospital or other formal helpers. Explanations in terms of possession implicated the afflicted person and his or her entourage in the church not so much in terms of formal activities but through individual members identified as 'natural helpers' or church members with special knowledge, skills, conviction and charisma.

Unlike people living in large urban centers of Canada, for many of the Inuit of Nunavik there is no 'away' where troubled people can be sent or to which frightened and victimized women and children can escape. Along with cultural values of family harmony and conflict avoidance, this keeps the onus for change squarely on the victim. While consonant with cultural values, the focus on the afflicted person's bad actions, sin and possible spirit possession may have deflected attention from intolerable and abusive relationships and prevented more direct confrontations and personal and political action for social change.

6. ATTITUDES TOWARD PSYCHIATRIC DISORDERS

In this chapter we report a questionnaire study designed to examine the effects of deviant behavior and labeling on Inuit attitudes toward the mentally ill. The first section summarizes the historical evidence on Inuit management of deviant behavior and briefly reviews the literature on labeling, stigmatization and attitudes toward the mentally ill in small scale societies. Section 2 summarizes methods of measuring attitudes toward the mentally ill. Section 3 describes the methods used in the present study, and Section 4 presents the results. A concluding section discusses the interpretation and implications of the findings.

6.1 History of Inuit Responses to Deviant Behavior

It is the general impression of the physicians working with the Inuit of Québec that some individuals with anxiety, substance abuse or family conflict are helped by their active participation in the church. However, some patients with florid psychoses, whether schizophrenic or manic, appear to have been distressed by efforts at religious healing: both because the practices involve insistent claims that the individual is possessed by the devil, and because, when these exorcisms fail, the individual may be further rejected or ostracized. Indeed, in our ethnographic interviews with people diagnosed with schizophrenia or bipolar disorder, several mentioned their perplexity and alarm at being told they were demon possessed and undergoing subsequent exorcisms, to little avail.

As discussed in Chapter 5, in traditional times, extremely threatening and intolerable behavior was dealt with by ostracism or execution (Hippler, 1984). The precarious balance of subsistence and communal life did not allow constant supervision of someone unable to care for himself or constant negotiation with someone who created hostile confrontations. Outside of total dependency or disruptive hostility, however, there was probably wide tolerance of eccentricity—which could be readily explained by supernatural means (Briggs, 1970).

In modern times, the imposition of southern law and the availability of health and social services have made the old solutions untenable (Duffy, 1988). However, the same pattern of behavior has persisted in some communities: unusual behavior is tolerated, and attempts are made to ignore, minimize or explain away individuals' inappropriate or inadequate behavior (Briggs, 1985). When behavior exceeds tolerable limits it does so in two principal ways: by constituting an excessive burden on family and kin for caretaking and supervision, or by representing a significant and recurrent threat of violence or aggression on members of the community. Under these circumstances, the tendency is to bring the deviant individual to the southern authorities and ask them to take him away (Hippler, 1984).

6.2 Social Responses to Deviance[6]

The recognition of and response to deviant behavior and distress can be thought of as following a sequence from perception through labeling to action. While Edgerton (1969) suggested that these three processes may be studied independently, in practice they form an integrated whole, with available labels and courses of action providing schemas that influence perception. Individuals may be perceived as afflicted for one of several over-lapping reasons: they evidence a degree of pain, suffering or emotional distress that commands attention; their behavior is troublesome or threatening to others; their behavior fits a pre-existing category of distress; and/or their behavior contravenes group norms or is sufficiently unusual to provoke a re-examination of existing norms. While the first two forms may often be recognized cross-culturally, the latter two depend crucially on knowledge of cultural categories and expectations.

The major psychiatric disorders involve sufficiently dramatic changes in mood, thinking and behavior that they appear to be recognized as singular events in every culture (Murphy, 1976). For milder disorders, where experience and behavior are not so bizarre or unusual to demand response, it is possible for societies to minimize or ignore deviance. While tacit recognition or perception may occur, explicit labeling may be avoided if its consequences are undesirable. Alternatively, experiences and behaviors that are imperceptibly different to outsiders may be given great significance when they fit indigenous categories or confront crucial social norms.

The recognition and labeling of distress can be thought of in terms of a series of levels or thresholds: distress may be entirely ignored; acknowledged and responded to without specific labeling; labeled as a transient state; or labeled as a chronic or permanent state or trait of the person. If labeling is restricted to the lay or professional diagnosis of a chronic illness or condition, the label may be discarded when the patient improves. Alternatively, labeling may be attached to some “intrinsic” aspect of the person—their physical constitution, family background, personality or fate—in which case the label is likely to persist even if there is obvious recovery. In either case, labeling the person as deviant may have persistent effects due to changes in social role and status that are difficult to reverse (Link et al., 1987).

A lack of recognition of distress may mean a lack of treatment but it will also mean a lack of stigmatization, and this may contribute to a better long term prognosis. Conversely, the labeling or diagnosis of a psychiatric disorder may increase chances of treatment but it is also more likely to confer disabling stigma. The negative effects of stigma may outweigh the positive benefits of recognition (Warner et al., 1989) in situations where no effective treatment is available.

The stigma attached to psychiatric disorder and emotional distress stems from many sources (Cumming and Cumming, 1957). The content of symptomatic

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[6] This review is reproduced from Kirmayer (1989). We use the term “deviance” in the technical sense of deviating from social norms.

experience and behavior may be viewed as strange, uncanny or bizarre. Others may fear the unpredictability and real or imagined violence of the afflicted individual. The sufferer may constitute a drain on limited material or psychological resources. According to ethnopsychological ideas, there may be a danger of contagion. To the extent that the disorder is held to be hereditary, or to reflect moral wrong-doing, there may be a sort of "guilt by association." Finally, the sick individual is a constant reminder to others of their own vulnerability and may activate psychological defenses. These multiple sources ensure that stigma will be a problem in every society.

Stigma manifests in a variety of ways including loss of social status and resources, negative emotional response and rejection by others, a "spoiled identity" and a damaged sense of self. Each of these aspects may adversely affect psychiatric disorders and exacerbate emotional distress. Once provoked, stigma contributes to the creation of a new social role that can perpetuate itself. What is needed is a comprehensive view of the social-psychological and cultural dynamics of stigmatization (Kirmayer, 1989).

In an attempt to introduce a more anthropological perspective to the study of labeling and stigmatization, Raybeck (1988) compared ethnographic accounts of the response to deviance in small-scale social units (camp, band, village, etc.) to the response in larger industrialized societies typically studied by labeling theorists. In large scale, industrialized societies (cities, states, nations, etc.), pluralistic, poorly integrated, and often conflicting values contribute to a confusion of norms. Labeling of mild forms of deviance is a common means of social control and can abruptly result in marginalization or rejection. Small-scale societies are characterized by highly integrated and interdependent relationships with relative equality among members and a consistent value system. In such groups, the explicit labeling of behavioral deviance poses a threat to the integration of the group and mild deviance is often tolerated with little overt reaction. To maintain high levels of cooperation, deviance is minimized by strong pressure to conform in areas crucial to group survival. At the same time, in areas less immediately important to group needs, flexible norms and tolerance for deviance allow peaceful coexistence. When a limit is exceeded, social pressure to conform may be exerted by shaming and ridicule but, in general, efforts are made to re-integrate the deviant person as soon as appropriate expiation or reparation has occurred. In a small, tightly interdependent group, the social cost of ostracism is enormous. For individuals who belong to the group, the explicit labeling of deviance occurs reluctantly and only after prolonged efforts at re-integration. In contrast, outsiders who commit deviant acts in large-scale societies are quickly labeled and ostracized. As a result of the greater tolerance of deviance, Raybeck argues that the sort of socially constructed career of deviance studied in labeling theory is uncommon in small-scale societies. In large scale societies, the relative independence and anonymity of members allows their social role to be reduced to the caricature of the deviant label. The Inuit situation provides an opportunity to examine Raybeck's theory.

Cultural factors, including modes of emotional expression and concepts of illness, may mediate the family's level of negative emotion. Culturally prescribed restraint in emotional expression may limit stressful confrontations within the

family. This may have a significant impact on the course of schizophrenia and bipolar affective disorder. On a community level, interpretations of the symptoms of schizophrenia that do not stigmatize the individual with the designation of a chronic, progressive, disabling condition may allow a greater return to premorbid functioning after exacerbations (Waxler, 1979). Contrariwise, cultures that ascribe moral blame to the psychotic person with no opportunity for redress may promote chronic disability. Explanations of psychotic symptoms in terms of sorcery, witchcraft or other invisible malign forces may foster paranoid ideation that persists in the absence of active psychotic thought processes. The demonic possession theory of mental illness, held by some Inuit, may thus contribute to the form and outcome of psychiatric illness.

Crucial for the social implications of any mental or emotional disorder is whether the problem is viewed as a transient and exogenous state or a chronic and intrinsic problem of the person. Attributing a condition to some enduring aspect of the person threatens his/her social personhood. Chronic disorders may eventually lead to disqualification of the person and ejection to the margins of society. Cultures that attribute mental illness to constitutional factors may be more likely to view mental conditions as permanent and to ostracize the afflicted individuals. The Inuit preference for characterizing problems in terms of the immediate situation and the corresponding reluctance to label individuals with traits may reduce the chronicity of mental disorder.

6.3 Measuring Attitudes Toward Mental Health and Illness

The best known and most widely emulated approach to the measurement of attitudes toward mental illness is that of Star (1955), who developed a series of case vignettes to evoke subjects' views of the mentally ill. Similar vignettes have been used by others to explore community responses (Cumming and Cumming, 1957; Dohrenwend and Chin-Shong, 1967; Rabkin, 1974) and have been adapted for cross-cultural studies (Wig et al., 1980).

The community mental health movement increased the demand for self-report measures, and a variety of instruments and indirect measures of attitudes and social distance were developed (Corin et al., 1989; Link et al., 1987). Recently, Beiser et al. (1987) have developed a brief self-report measure of the way in which respondents view the mentally ill and apply the sick label. This measure has good internal consistency and construct validity and uses simple descriptors that may be more easily translated cross-culturally than more complex questions or vignettes.

Rabkin (1980) emphasized the importance of using indigenous categories to study community attitudes toward the mentally ill. She argued for a greater focus on actual behavior toward the afflicted and their families and on the evolution over time of family and community responses. Finally, noting the paucity of valid and reliable instruments for the measurement of attitudes in this domain, Rabkin called for the development of new measures. Corin et al. (1989) reviewed the literature on the cross-cultural study of attitudes toward the

mentally ill. Responding to Rabkin's critique, they proposed a case-centered ethnographic approach to the measurement of attitudes. This approach has been adopted by the World Health Organization in projects conducted in Mali and South America. The ethnographic work reported above is based on this approach.

Most recently, Littlewood (1990; *personal communication*) developed a vignette based measure of psychiatric stigma for use in a cross-national comparative study. His vignette contained many elements that would be irrelevant or meaningless to Inuit respondents (e.g., the man in the vignette worked in a factory). However, the attitudinal questions canvas most of the themes identified in the literature on psychiatric stigma and provided a source for the items used in the present study. There is some recent evidence that hypothetical vignettes can capture some of the effects of labelling (Socall & Holtgraves, 1992).

6.4 Method of Questionnaire Study of Attitudes

The study was designed to examine the interaction of behavior and labeling in attitudes toward individuals with deviant behavior that might indicate a psychiatric disorder. Subjects were presented with hypothetical vignettes of a person's behavior and asked to rate their attitudes toward the person in the vignette on a series of scales. The vignettes and questionnaires were translated into Inuktitut and checked for semantic equivalence with the English original by back translation. Discrepancies were resolved by discussion with the translators. The questionnaire is reproduced in Appendix C.

Vignettes. We devised six brief vignettes which varied by deviant behavior (withdrawal or threatening behavior) and label (*isumaluttuq*, mental illness, or demon possession; see Table 6-1). The vignettes were constructed to tap two forms of potentially deviant behavior. Withdrawal, self-isolation and taciturnity are conspicuous behaviors in small closely knit communities. We hypothesized that traditional Inuit values of non-interference would make people reluctant to intrude on a person who is keeping his distance. On the other hand, such behavior was regularly identified in the ethnographic interviews as indicating depression, mental health problems or even suicidality. In contrast, violent threatening behavior is extremely problematic in Inuit society where the traditional emphasis has been on the tight control of anger and aggression toward others (Briggs, 1970). Consequently, we expected that respondents would wish to keep greater distance from the person with violent behavior than from the person who simply withdrew. Based on the ethnographic research described in Chapters 3 to 5, we also expected that *isumaluttuq* would be a less stigmatized label since it covered state of mind that ranged from preoccupation to more anguished conditions.

Table 6-1. Vignettes Used in Attitude Survey

staying by himself and not talking/demon possession:
There is a 24 year old man. Last year he was acting strange. He was staying by himself all the time and not talking. People said it was demon possession.

staying by himself and not talking/mental illness:
There is a 24 year old man. Last year he was acting strange. He was staying by himself all the time and not talking. People said it was mental illness.

staying by himself and not talking/isumaluttuq:
There is a 24 year old man. Last year he was acting strange. He was staying by himself all the time and not talking. People said it was isumaluttuq.

threatening/demon possession:
There is a 24 year old man. Last year he was acting strange. He was threatening and fighting with people for no reason. People said it was demon possession.

threatening/mental illness
There is a 24 year old man. Last year he was acting strange. He was threatening and fighting with people for no reason. People said it was mental illness.

threatening/isumaluttuq:
There is a 24 year old man. Last year he was acting strange. He was threatening and fighting with people for no reason. People said it was isumaluttuq.

Attitude Measures. Attitudes were measured by 12 Likert-type items, with response categories from 1 to 7 ("not at all" to "extremely"). The scales tapped the following dimensions:

Social Distance Scale. Social distance was measured with a 7 item scale adapted from a longer questionnaire devised by Littlewood (1993). For each type of vignette, the respondent was asked to indicate how willing he/she would be to have the man as a friend, live next door to him, go hunting, work, or live in the same house with him, and have a daughter or sister marry him. To form the Social Distance Scale, where a higher score means more distance, the responses were recoded so that a response of "1" meant the respondent was more willing to enter the relationship (wanted less distance) and a "7" meant that the respondent was less willing to enter the relationship (wanted more distance).

Causal Attribution. Three items tapped respondents' own causal attributions to illness, sin or demon possession. Subjects were asked to indicate to what extent

they thought the vignette subject's behavior was due to illness, to something bad that he did, or to spirits or demons.

Recovery and Familiarity. The final two items of the questionnaire asked respondents to indicate to what extent they thought the vignette subject's behavior would return to normal, and how well they knew someone with this kind of behavior.

Sample. Interviews with 142 individuals were conducted between June 10 and July 11, 1993 by four interviewers. Each respondent received only one of the vignettes. Each vignette was followed by 12 questions addressing social distance, causal attributions, and familiarity with this type of behavior. A facesheet obtained sociodemographic data from the respondents and provided instruction on how to complete the questionnaire. Respondents were asked to read the vignette and answer all of the questions regarding the person described in the vignette. In some cases questionnaires were administered to a group and the interpreter then read through the questionnaire with respondents as they filled out the forms.

Data Analysis. Scales were examined for internal consistency and factor structure. Associations between responses on the distance scale and gender, behavior in the vignette (threatening or isolation), vocational training (yes or no), ability to speak English (yes or no), ability to speak French (yes or no), and occupational category (waged versus other) were examined with t-tests for independent samples. Pearson correlations were computed among all scale items as well as the distance scale response and age, years of schooling, and the questions about recovery, causes of the behavior, and familiarity. One-way ANOVA was used to test for association between the distance scale and label in the vignette (3 levels: *isumaluttuq*, demon possession, mental illness) and occupation (6 levels).

6.5 Results of Questionnaire Study of Attitudes

A total of 130 persons were interviewed in Povungnituk, while 12 were interviewed in Kangiqsujuaq, resulting in 137 completed questionnaires. Characteristics of the sample are summarized in Table 6-2. Fifty-seven percent of respondents were female. The mean age of 140 respondents was 32.8 years ± 13.6 SD (minimum 16; maximum 78; mode 20). The mean number of years of schooling was 7.7 ± 3.4 SD (minimum 0; maximum 15; mode 9; N=136). Twenty-nine percent of respondents had some vocational training (41 / 136).

Table 6-2. Sociodemographic Characteristics of Attitude Survey Sample (N=142)

	%
Female gender	57
Occupational status	
wage-earning	40.1
unemployed	39.4
traditional work	6.3
part-time work	4.9
housewife	4.2
student	3.5
Languages spoken	
Inuktitut only	13.4
Inuktitut and other*	85.9
No Inuktitut	0.7

*English and / or French

The vignettes were distributed in the following manner:

	Label		
	Isumaluttuq	Demon possession	Mental illness
Behavior			
Threatening	25	25	22
Isolation	23	23	24

Scale Psychometrics. The Social Distance Scale had good internal consistency, with a Cronbach's alpha of .79 (N=137; cf. Table 6-3). The mean score on the scale was 37.5 ± 8.0 SD. The modal response to each of the social distance items was 'not at all willing' which may indicate some response set bias; however, each item showed good variability.

Table 6-3. Descriptive Statistics for Social Distance Scale

To what extent would you be willing to...	Mean response* ± SD	Alpha if item deleted
Be friends	4.5 ± 2.1	0.738
Work with him	4.5 ± 2.0	0.763
Go hunting	5.0 ± 2.0	0.764
Be neighbours	5.1 ± 1.8	0.758
Live in same house	6.0 ± 1.4	0.784
Have sister marry him	6.1 ± 1.3	0.774
Have daughter marry him	6.2 ± 1.2	0.761

* where 1 = extremely and 7 = not at all

Factor analysis (principal components followed by varimax rotation) of the social distance items resulted in two factors with eigenvalues greater than 1 accounting for 61% of the variance (cf. Table 6-4). Factor 1 was interpreted as involving extra-familial relationships, while Factor 2 involved family relationships. Interestingly, hunting loaded on both factors suggesting that hunting relationships shared qualities with both family and extra-familial relationships.

Table 6-4. Factor Loadings of Social Distance Scale Items

Item	Factor 1	Factor 2
work with	0.85	
neighbor	0.78	
friend	0.72	
hunt	0.52	0.47
sister marry		0.80
daughter marry		0.78
live with		0.68

The most common (modal) response to the causation questions was “extremely,” once again suggesting response set bias; however, all items showed good variability and the modal response to familiarity was “not at all familiar.”

Table 6-5. Descriptive Statistics for Questions on Causality, Recovery and Familiarity

Statement	Mean response* ± SD
Man will recover	5.4 ± 1.7
Behavior due to bad action	4.9 ± 2.0
Behavior due to spirits or demons	4.5 ± 2.2
Behavior due to illness	4.1 ± 2.1
Familiar with this kind of behavior	2.9 ± 2.1

* where 1 = not at all and 7 = extremely

Intercorrelations of Measures. Table 6-6 presents the bivariate Pearson correlations among study variables. Greater social distance was associated with female gender (females: mean = 39.7 ± 7.6, n=77; males: mean = 34.6 ± 7.8, t=3.85; df=135; $p < 0.001$), younger age and more years of schooling. Among the respondents, age and years of schooling were negatively correlated with each other so that older persons tended to have less schooling; there was no gender difference in mean age.

Table 6-6. Correlations of Sociodemographics and Attitude Scales (N=140)

	Age	Education	Illness	Bad Action	Demon	Recover	Familiar
Social Distance	-.30***	.34***	.00	-.18*	-.14	-.36***	-.37***
Age		-.71***	.22*	.21*	.14	.07	.23**
Education			-.07	-.26**	-.18*	-.08	-.20*
Illness					.11	.12	-.16
Bad Action					.59***	.30***	.14
Demon/Spirit						.31***	.00
Recovery							.10

* $p < .05$, ** $p < .01$, *** $p < .001$

There were no significant ($p < 0.05$) bivariate associations of the Social Distance Scale with the vignette behavior, the vignette label, respondents having been to vocational school, occupation, and ability to speak English or French. Respondents who wanted more social distance rated the person in the vignettes less likely to recover, were less likely to attribute the behavior to bad action and were less familiar with this kind of behavior.

With respect to responses to the questions about recovery, causes of behavior, and familiarity, those who thought the man in the vignette was more likely to recover tended to ascribe the behavior to bad action and to spirits or demons. The tendency to ascribe the behavior to bad action or spirits/demons was highly correlated. Those who were more likely to think bad action was a cause tended

to be older and had less schooling. Those who were more likely to agree that demons were a cause also tended to have less years of schooling. Ascribing illness as a cause was correlated with older age. Persons who were more familiar with the behavior tended to be older and had less schooling.

Effect of Vignettes on Social Distance. Table 6-7 presents the mean values for the distance scale for each of the three vignette labels, grouped by the two vignette behaviors. The standard deviations for the six means varied from 6.7 (for threatening / *isumaluttuq*) to 11.2 (threatening / mental illness), so that the 95% confidence intervals for the six means overlap.

Table 6-7. Social Distance Scale by Vignette

Behavior	Label	Mean	Standard Deviation
Withdrawal	Isumaluttuq	37.47	7.88
	Mental Illness	36.85	8.26
	Demon Possession	36.97	7.45
Threatening	Isumaluttuq	37.82	6.69
	Mental Illness	35.89	11.18
	Demon Possession	39.62	6.75

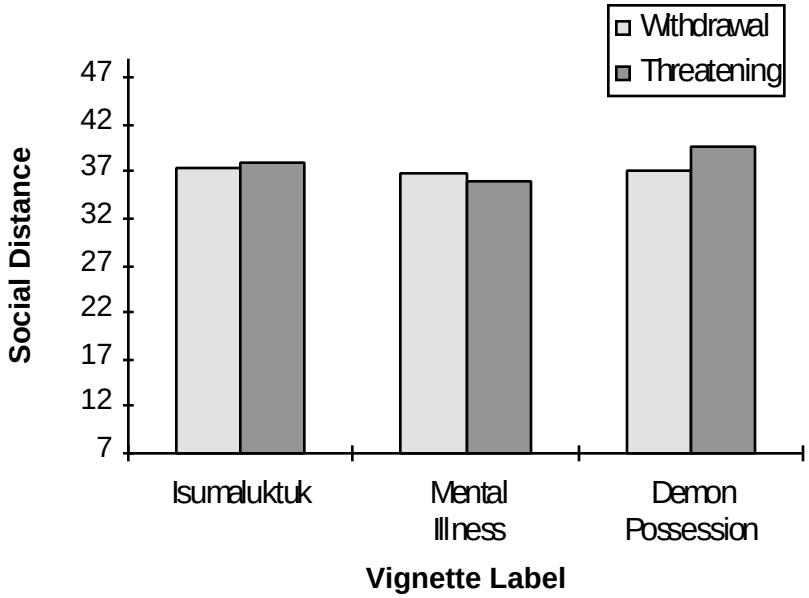

Figure 6-1. Social Distance Scale by Vignette

A 2X3 ANOVA was carried out with the Social Distance Scale as the dependent variable, examining the main effects of the vignette behavior and label and the interaction of behavior with label (N=137). Results are shown in Table 6-8. There were no significant effects of vignette label, behavior, or the interaction of behavior and label on distance scale response.

Table 6-8. ANOVA of Effects of Vignettes on Social Distance Scale

Source of variation	Sum of squares	df	Mean square	F	p
Main effects					
Behavior	15.78	1	15.78	0.24	0.63
Label	85.77	2	42.89	0.65	0.52
Interaction					
Behavior x Label	75.65	2	37.82	0.58	0.56
Explained	180.79	5	36.16	0.55	0.74
Residual	8591.16	131	65.58		
Total	8771.84	136	64.50		

Effect of Causal Attributions and Attitudes on Social Distance. Using the Social Distance Scale as the dependent variable, multiple linear regression analysis was carried out with 8 independent variables including age, gender, years of schooling, and the responses to the questions about causes of the behavior (“bad action”, “illness”, and “demons”), about recovery (“recover”), and familiarity with the behavior (“familiar”). The variables which were not significant predictors of distance scale response were eliminated one at a time, resulting in a final model which contained four highly significant independent variables ($F = 17.2$, df= 4,119, $p < 0.0001$) and accounted for 37% of the variance in scores on the Social Distance Scale.

The results for the final model in Table 6-9 remained essentially the same when additional independent variables were considered including vignette behavior category, vignette label category, ability to speak English or French, occupation (wage or other), and vocational training.

Table 6-9. Multiple Regression Model of Determinants of Social Distance

Variable	r	B	β
Variables in final model			
gender (0=female, 1=male)	-0.31***	-4.31***	-.27
years of schooling	0.34***	0.59***	.26
recover	-0.36***	-1.23***	-.26
familiar	-0.37***	-1.08***	-.29
(constant)		44.72	
R^2			.37***
Variables not in final model			
age	-0.3		-0.07
illness	0.003		0.02
bad action	-0.18		-0.02
demons	-0.14		-0.06

r = Pearson product moment correlation; B = unstandardized regression coefficient; β = standardized regression coefficient. ***$p < 0.001$

Effects of Vignettes on Causality, Familiarity and Recovery. The main effects of the vignette behavior and label and the interaction of behavior with label were analyzed by 2X3 ANOVA for each of five remaining dependent variables: the three questions on causality, as well as the scales on recovery and familiarity. There were no significant effects of the vignettes on causal attributions or familiarity with the type of behavior. Table 6-10 shows the ANOVA results for the "recover" variable. The main effect of the label given to the vignette was significant: when the *isumaluttuq* label was used, the recovery scale response was significantly lower than when *mental illness* or *demon possession* were given as labels (mean distance scale = 4.81 ± 2.04 for *isumaluttuq*; 5.67 ± 1.62 for mental illness; 5.72 ± 1.39 for demon possession).

Table 6-10. ANOVA of Effects of Vignettes on Recovery Scale

Source of variation	Sum of squares	df	Mean square	F	p
Main effects:					
Behavior	2.90	1	2.90	0.99	0.32
Label	22.85	2	11.42	3.91	0.02
Interaction:					
Behavior x Label	3.96	2	1.98	0.68	0.51
Explained	30.68	5	6.14	2.10	0.07
Residual	382.52	131	2.92		
Total	413.20	136	3.04		

6.6 Discussion

In this study we attempted to examine the effects of labeling on attitudes toward individuals with behavior that might indicate psychiatric disorder. A convenience sample of 142 adults from two communities in Nunavik were given a brief vignette and questionnaire. All of the vignettes involved a 24 year old man who was described as "acting strange." Some respondents were told that he was staying by himself and not talking while others were told he was threatening and fighting people for no reason. For either behavior, respondents were given one of three labels: *isumaluttuq*, mental illness or demon possession.

The scale devised to measure social distance had good internal consistency and face validity. Its factor structure suggested that respondents thought of social distance in terms of two spheres: (1) relationships in the community (working, friendships, neighbors) and (2) relationships within the family (living in same house, marrying a sister or daughter). Interestingly, hunting straddled the two spheres of relationship perhaps indicating its centrality in Inuit life and the level of trust needed for such a relationship.

The variation in vignette type did not influence respondents' ratings of social distance or causality. This lack of effect may indicate that the vignettes were too sketchy or hypothetical to direct respondents' thinking. In some cases, a vignette may have elicited a respondent's knowledge of a particular person who then served as a basis for answering the questions. However, the mean level of familiarity with the behavior depicted in the vignettes was low and many subjects indicated they had no familiarity at all with the specific type of behavior.

In general, respondents indicated they would keep a high level of social distance from the person depicted in all 6 vignettes, although there was greatest variance in the responses for the vignette of the threatening man labeled 'mental illness'.

Women would keep greater distance than men across all behaviors and labels. Higher ratings of social distance were associated with younger age and more education. There was a weak association between less social distance and the tendency to attribute the vignette behavior to bad action and a trend in the same direction for attribution to spirits or demons.

Although the vignette behaviors and labels failed to influence ratings of social distance, the respondents own ratings of greater likelihood of recovery and familiarity were strongly associated with less social distance. Multiple regression analysis confirmed that female gender, more schooling, less likelihood of recovery and less familiarity all predicted greater social distance. These factors accounted for over a third of the variance in the Social Distance Scale. In the final model, age and causal attributions were not significant predictors, once other factors were included.

This model suggests that the bivariate effect of greater age on decreasing social distance was mediated by education (since age and education were highly negatively correlated), and familiarity (since older individuals are likely to have had more experience with different types of deviant behavior). The effect of attributions to moral ('bad action') causes on decreasing social distance may be due to the implication of a greater likelihood of recovery.

Contrary to our original expectations, withdrawal was perceived no less negatively than threatening behavior. Also contrary to expectations, the vignette label of '*isumaluttuq*' did not lead to less social distance and actually was significantly associated with less expectation of recovery. In contrast, labels of mental illness and demon possession were associated with a greater expectation of recovery. *Isumaluttuq* can denote a wide range of states of mental preoccupation, worry, and 'heavy' or bad thoughts. While mental illness and demon possession would seem to be more serious conditions, both have appropriate treatments (biomedical and religious, respectively) and hence, may carry a more benign prognosis.

Taken together, these results suggest that explaining deviant behavior in terms of moral or religious causes tends to make people believe the afflicted person is more likely to recover and leads to less avoidance or rejection. Formal education may make these moral and religious explanations less plausible while increasing the tendency to attribute deviant behavior to illness. This shift in explanations, however, leads to a tendency to keep greater distance from the afflicted person and to less confidence that they will recover. On the other hand, familiarity with people who have had deviant behavior or the specific labels attached to them may reduce the tendency to avoid individuals exhibiting strange behavior.

Attributions of causality are likely to reflect the presence of specific signs and symptoms which were not included in the study, as well as respondents' experience with prototypical cases (Kirmayer, Young & Robbins, 1994). Attributions may reflect respondents' interpretation of what is expected of them in the interview situation. Finally, it is important to note that self-reported attitudes usually do not correlate very highly with actual social behavior

(whether labeling or maintenance of social distance) which is strongly determined by contextual factors.

While the use of hypothetical vignettes in the present study is an indirect method of assessing attitudes that may be only weakly related to actual behaviors, our results suggest caution in promoting biomedical rather than moral-religious explanations for deviant behavior. Moral-religious explanations may protect afflicted individuals from some of the stigmatizing effects of psychiatric labeling. Increasing familiarity with people with unusual behavior may, however, reduce social stigmatization and rejection. Appropriately designed public information programs may therefore improve the social integration of psychiatric patients with unusual behavior.

7. CONCLUSION

In this study, we examined contemporary concepts of mental health and illness and attitudes toward deviant behavior and psychiatric disorder among the Inuit of Nunavik (Northern Québec). Based on extensive interviews with 80 informants from three settlements in Nunavik, we explored the range of models and metaphors for mental illness. We have attempted to outline the major themes shared by the majority of informants as well as those ideas that, while idiosyncratic, may nevertheless have important implications for the community as a whole.

Three types of research interview were conducted, corresponding to distinct parts of the project: (1) problem identification interviews with Inuit health care and community workers identified the range of problems in the community and the usual terminology used to describe them, resulting in a list of specific registers of problematic behavior; (2) problem register interviews with key informants from the community identified the perceived prevalence of problems in the community, and the typical signs and symptoms associated with each type of behavior or problem; (3) case history interviews with key informants reconstructed detailed accounts of cases with which they were personally familiar.

Much of the knowledge we have assembled is not held by any one person but is distributed across networks of relationships through which people do their thinking and acting. In any given case, people draw from a wide range of possible epistemological positions, illness models, labels and interpersonal stances to construct an interpretation of events to serve their own current needs, as well as the needs of their immediate social circle.

In synthesizing informants' knowledge as cultural models, prototypes or exemplars, there remains a danger that we have exaggerated the coherence of beliefs which, in many instances, are fragmentary, tentative and undergoing constant change on the basis of new information and salient experiences (Kirmayer, 1993a; Kirmayer, Young & Robbins, 1994). In directing informants to consider together a broad range of behaviors they did not always see as related, we may have encouraged them to create superordinate categories and abstract schemas that may not have existed in their thoughts before our inquiry, and may not be relevant to their methods of handling real life problems. This problem—common to all interview based research driven by models and concerns extrinsic to a society—is particularly important among the Inuit, because in Inuktitut there is a strong tendency not to label people with discrete labels and not to develop corresponding elaborate models or theories of disease semiology. Instead, Inuit tend to describe behaviors. The pathological significance of behaviors, the semiology of symptoms and signs, and their ultimate prognosis then depends much more on the historical particulars and current context of behavior. To a considerable degree, it also depends on an unknown and unknowable future and so, for the Inuit, a healthy measure of agnosticism with regard to the diagnosis and outcome of deviant behavior or experience is only wise and appropriate.

There is no general Inuktitut term for mental health or illness. People tended to label behaviors or states of mind rather than individuals. When pressed, informants either used an English term (mental health, mental health problem, 'crazy') or offered two terms with different connotations:*Isumaluttuq* and *Isumaqanngituq*. *Isumaluttuq* implied thinking too much while *isumaqanngituq* meant 'having no mind' or not thinking at all. Since it covered such a broad range of problems and referred to a state of mind, *isumaluttuq* seemed to convey a relatively benign, or at least uncertain, prognosis. This benign effect was not, however, born out in our experimental vignette study (see below).

Informants viewed the most prevalent mental health problems in their settlements as alcohol and drug abuse, family violence and abuse, and suicidal behavior. Most were not very familiar with other forms of deviant behavior or psychiatric diagnoses. Informants working in health care or social service settings had more extensive knowledge of biomedical and psychological perspectives which they held in parallel with folk theories.

Although interpersonal violence is clearly very common in Nunavik communities, it was never viewed as 'normal' or acceptable by any informant. Violent individuals were uniformly viewed as troubled, if not with mental illness then with a difficult upbringing and with ongoing personal problems.

Individuals who completed suicide were described as withdrawn, isolated, depressed, having heavy thoughts, low self-esteem or hating themselves. In some instances, it was easy to recognize someone who was suicidal because they talked about their troubles and feelings of misery, boredom and wanting to escape. Among young people suicide was linked to interpersonal conflicts, particularly problems with anger and dependency. The most frequent precipitants mentioned were the break up of relationships or other frustrations with family, school, or friends. Such angry suicide attempts were often described as gestures to get attention or a reaction from others. In more serious cases, suicide was preceded by silence, withdrawal and self-isolation. In many cases, however, suicide came as a complete surprise to the informant even when the person was a close friend or relative.

Alcohol, drug and solvent (inhalant abuse, commonly called "sniffing") were among the most common problems raised spontaneously by informants in connection with youth suicide and violence. Problems associated with social withdrawal ranged from shyness and low self-esteem, through fearfulness, to depression, suicidality and psychosis. Initially, withdrawal was tolerated and respected by others, and might not be viewed as a problem. This is part of a wider cultural attitude of non-interference in others' activities and lives which may delay recognition of potentially severe problems, including suicidality, depression and psychosis.

Four broad types of causes of mental health problems were recognized by informants: (1) physical and environmental (e.g. congenital or hereditary causes of mental retardation); (2) psychological or emotional (anxiety due to excessive worry, fear due to traumatic experiences and grief due to losses); (3) demon or spirit possession (at least three forms with differing connections to Christianized

beliefs); and, (4) culture change and social disadvantage. In many cases, multiple causes were offered for the same problem, depending on the aspect of the problem being discussed and the available sources of help.

During the prenatal period, physical or organic factors were the most important causes of mental health problems (e.g., mother's drug abuse during pregnancy injuring the fetus). In childhood, the parents' care of the child and their marital relationship were the crucial causal factors. Kindness and open communication in child-rearing were viewed as essential to mental health. Physical and verbal abuse were important causes of mental health problems across the life span.

In general, informants were very 'psychologically minded'. A wide range of behaviors were attributed to troubles with mental processes and most informants emphasized the importance of thoughts and feelings in causing, maintaining and healing mental health problems.

Among informants of all levels of education, occupation and acculturation, demon possession was a popular explanation for many forms of aberrant behavior, especially hallucinations or bizarre behavior. Hallucinations, in particular, were likely to evoke thoughts of demon possession. Initially, even very bizarre behavior might be attributed to illness. The shift from mental illness to demon possession explanations typically occurred when someone had or reported an uncanny experience regarding the afflicted person. Explanations in terms of demon possession commonly co-existed with other explanations—that is, the demon possession may cause depression, schizophrenia or other disorders.

At least three forms of demon or spirit possession were described: *Uuttulutaq* and *Uirsalik/Nuliarsalik* and Christianized 'Satanic' possession. *Uuttulutaq*involved spirit influences or intrusion without the spirit taking an embodied form. The spirit could attack anyone who was already weakened by physical illness, emotional distress or moral wrong-doing. The attack would cease if the person clearly rejected the spirit. There was no need for more elaborate religious healing.

Uirsalik/Nuliarsalik referred to a spirit husband or wife who could be acquired through the person's excessive longing or obsessive desire for an idealized mate. Free spirits would be attracted by the person's thoughts and come to inhabit them. This model provided an explanation for some individuals with hallucinations, odd or eccentric behavior and social withdrawal.

The third form of spirit possession was the most explicitly Christian and involved possession by 'demons' or Satan as a result of praying to Satan for powers or other evil actions. A wide range of behaviors associated with other mental health problems could also indicate demonic possession. Demon possession could be distinguished from other mental disorders because in the latter, the person remained him or herself and could talk intelligibly about the affliction. In demon possession, the afflicted person's voice, face, personality and behavior were said to change radically. Informants who had more intimate experience with mental illness, particularly with a relative who had been labeled

schizophrenic, were faced with the problem of reconciling attributions of demon possession and psychiatric disorder to the same person and same behaviors.

If left untreated, demon possession could pass into a chronic condition in which the afflicted person is permanently changed. If exorcism failed and the person continued to exhibit bizarre behavior, he or she might be viewed as chronically possessed or more likely as having a mental illness. The appropriate response to demon possession was uniformly held to be exorcism through prayer and laying on of hands. The afflicted person's response to this intervention also served to confirm the diagnosis.

Several informants with psychiatric disorders described the experience of having been labeled demon-possessed and subjected to exorcisms. In most cases, they found this deeply confusing and disturbing. When the exorcism did not resolve their problems, they were left alone, and public opinion seemed to shift toward viewing them as having a physical or psychological illness.

It is also important to note that, in some cases, there was external evidence that the person afflicted with demon possession (most often a woman) had been or still was a victim of physical abuse. Demon possession may provide a means of protest or temporary escape from intolerable personal and family circumstances. It may also, however, deflect the attention of helpers and other community members from the social sources of distress.

We also examined attitudes toward psychiatric disorders with the use of a questionnaire survey given to 140 people in two communities. Each respondent was presented with one of six different brief vignettes describing a 24 year old man with "strange" behavior (either 'threatening' or 'withdrawal') and labels given to the behavior (either '*isumaluttuq*', 'demon possession', or 'mental illness'). Respondents were then asked a series of questions about their willingness to live, work or hunt with this person and allow him into their family. These questions made up a scale measuring 'social distance'. Respondents were also asked to rate how much they thought the actions of the person in the vignette were due to illness, 'bad actions on his part', or demon possession. Other questions asked how likely they thought the person was to recover and how familiar they were with this type of problem.

In general, the respondents tended to indicate desire for a high level of social distance from the person depicted in all six vignettes. The strongest predictors of greater social distance response were female gender, more schooling, less familiarity, and respondents' rating of the person as less likely to recover. There were no significant effects of behavior types and labels given in the vignette on the social distance response; however, likelihood of recovery responses were influenced by the vignette label, such that '*isumaluttuq*' was associated with less chance of recovery. Ascribing strange behavior to bad action ('sin') and spirits or demons was highly correlated, and was associated with less schooling.

Taken together, our results suggest that Inuit have multiple and complex models to explain deviant behavior. Most people participate in several cross-cutting forms of explanation through physical, psychological, spiritual and social

discourse. Religious and moral explanations may be less stigmatizing than psychological or psychiatric labels, in part because they imply a person is more likely to get better, particularly through talking to others, confession or, in the case of demon possession, through exorcism.

Characterizing Inuit cultural variations in symptom expression and recognition is a necessary preliminary to accurate epidemiological studies that address not only problems that fit southern categories and conventional psychiatric nosology, but other forms of distress that represent substantial problems in the North. Understanding Inuit explanatory models and attitudes is also crucial to planning clinical and community programs for the prevention of mental health problems and for the treatment and reintegration of patients.

The analysis of Inuit concepts of mental health can provide the basis for the development of culturally-sensitive guidelines for clinical psychiatric practice. These guidelines can then be taught to physicians, psychiatrists, nurses and community workers to promote a higher standard of care, and to ensure continuity of care in a setting where frequent changes in personnel can lead to inconsistent approaches.

This research has implications for those in the community who must cope with mental health problems or who wish to help others who are burdened or afflicted. Traditional Inuit values of non-interference and concerns with the welfare of the community can be reconciled when there is a clear understanding of the effects of different community responses on the mental health of others. Religious and moral explanations appear to play a significant role in Inuit concepts of mental health. Understanding the effects these attitudes have on the recognition and response to mental illness may enable communities and health care providers to identify those attitudes that promote and those that hinder positive health and social outcomes.

Inuit acceptance of the value of talk, confiding and confession as methods of resolving emotional pain and moral predicaments fits well with contemporary mental health models in psychology, social work and psychiatry. This method could be reinforced by making counseling, group work and family life education more readily available and transferring the appropriate skills to Inuit health care and community workers. These workers, however, should not be simply given a southern professional model to emulate, but must be encouraged to critically examine both professional and local practices. Only through such critical thinking and creative innovation can practices be developed that respond to the current social and cultural realities of Inuit life.

Clearly, there is an urgent need for vigorous public education campaigns aimed at reducing family violence, marital abuse and child neglect. These must be directed not just to the victims, but to the perpetrators. To be effective, they must adopt local modes of explanation and point to effective action that people can take. Effective intervention can begin with ‘externalizing’ attributions that help people to see the social origins of their actions and predicaments. The perpetrator too, is in some ways a victim of circumstances beyond his (or her) control.

Interventions must also address the social contributors to violence including lack of meaningful work, social disadvantage and cultural denigration.

Inuit communities are currently undergoing rapid change and acculturative stress. In the span of two generations, Inuit have been forced to reinvent their culture and society to adapt to new constraints and opportunities. In a state of flux, the Inuit communities of Nunavik are creatively exploring ways to live together in a radically new situation. The problems they encounter, and the solutions they devise, may provide models for other groups undergoing rapid culture change.

APPENDIX A

Consent Forms and Interview Protocols

Inuit Mental Health Project

Consent

You are invited to participate in a project to learn more about Inuit ideas about mental health, mental illness and social problems. We need to know more about what the people think about these problems in order to understand and help in ways that are best for these communities. The results of the research will be given to the hospital and to the Committee on Peace of Mind to be presented to the communities. Some results will also be published in medical and scientific journals to help people working with other native communities.

This study is being done by Dr. Laurence Kirmayer from Inuulitsivik Health Centre and the Jewish General Hospital in Montreal. Assisting him are Dr. Ellen Corin of the Douglas Hospital in Montreal and Dr. André Corriveau of Inuulitsivik. The project is funded by the Conseil québecois de la recherche sociale. The project is being monitored by the "Peace of Mind" Committee of Kativik Regional Health and Social Services.

If you agree to participate we will ask you questions about what you think about different sorts of mental health and social problems. We will ask you about examples of each problem you know about. This interview will take about one hour. This interview will be tape-recorded so that we can review it later. Your own privacy and the privacy of the people you tell us about will be carefully protected. All information we collect will be summarized and presented anonymously—that is, any details that would identify a specific person will be removed or disguised so that no one else can know who the people involved are.

Whether you agree or do not agree to participate in this project will have no effect on your care at Inuulitsivik or any other hospital or agency. It is purely voluntary.

By signing below you certify that you have read and understand this consent form and agree to participate in the project.

Date: _____ Signed: _____

Witness: _____

Interview

For each term / register / case example ask:

1. Are there any special words or way of describing people who...?

2. Does this word / term mean anything else? (Is it used in any other way?)

3. Can you think of an example of a person with this problem?

   A. How can you tell that they have this problem?

   B. How do they act?

   C. Do they have any specific characteristics?

4. Are there any other ways of acting, thinking or feeling that would be a sign of this problem?

   Can you think of an example of a person who acts like that?

5. What do you call their way of acting / thinking / feeling?

6. What caused them to act / think / feel that way?

7. Are there any other causes of this type of problem?

8. Are there situations or events before birth that can make people vulnerable to or cause this type of problem? [infancy, childhood, adolescence, old age; for men and for women]

9. How did / do people react to X / people who have this type of problem?

10. Are there any things that make X / people with this type of problem worse?

11. Are there any things that make X / people with this type of problem better?

12. What happened to X? What usually happens to people with this type of problem? (Do they get better, worse, change, stay the same?)

APPENDIX B

Glossary of Mental Health Related Terms

During interviews subjects were asked to give the Inuktitut name or term for a variety of behaviors considered unusual or bizarre. The terms which were collected were transcribed and compiled into a list which was subsequently retranslated by Harry Okpik, an experienced translator in the health field, as well as by Robert Watt. The objective was to get a sense of the range of linguistic possibilities available to the individual in discussing mental illness and to identify the variability of terminology within and between the predetermined categories of behavior used in the interview grill. When discussing categories and terms of mental illnesses, however, it is important to remember that the terminology will vary depending on the individual's intention, linguistic abilities, dialect and comprehension of the question.

Several factors are important to note when collecting data of this type. Inuktitut is an agglutinative language in which root ideas or terms, which are not necessarily correlates of the linguistic concept of word, are modified by the addition of one or more suffixes or infixes. The fact that any root concept may be modified to produce an exact meaning dependent on the speaker's intention has often been misconstrued as indicative of a very rich vocabulary. This is not so. Just as in English, French or any other language, meaning in Inuktitut is developed through the use and juxtaposition of elements of the syntax and vocabulary. The number of words or root concepts is irrelevant. The classic Inuktitut example is the number of words for snow used by Inuit which varies from tens to hundreds and upwards depending on the source. In fact, because the speaker can modify the root concept of snow (*aputik*) with as many suffix modifiers as he or she wishes there are an innumerable number of "words" for snow. There are an innumerable number of ideas which can be expressed by the speaker which are associated with snow while there are very few roots that contain the concept of snow (c.f. Martin, 1986).

A second caution is in the area of the semantics of the terminology and language associated with disease and mental health. A term can be translated only if the translator can arrive at a corresponding concept in the second language. This is essentially a question of negotiation between cultures and their respective semantics. It also implies that meaning is structured for the reader or listener based on the translator's comprehension of the two cultures. If meaning is negotiated then it is also corrupted to some extent by the translation process. This is often a problem in medical interviews where many pragmatic issues influence the translation offer in a particular context. Further, because it is generally the foreign health specialist who is asking for the translation, entire fields of potential meaning are lost because of a too quick assimilation of a term with different connotations to the biomedical or psychiatric concept.

The Interpreter's/Translator's Word List Book (Arctic College, 1993) includes some terminology touching on the mental health field, summarized in Table B-1.

Table B-1. Inuktitut Terms Related to Mental Illness

Term	Translation	Meaning
Psychiatrist	*isumaliriji*	The one who deals with thoughts
	niaquliri	The one who deals with the head
Psychologist	*isumaliriji*	The one who deals with thoughts
Seizure	*qaujimanani sajuttuq*	
Depressed	*nikallungajuq, numaasuttuq*	
Mental retardation	*isumaqatsianginniq*	

There is surprisingly little information on terminology associated with mental health in this otherwise very complete listing of words and their translations. Even among the few words listed there are considerable differences between the Nunavik dialect and that of the Baffin region dialect (Seizure = *qaujimanani sajuttuq* in Baffin region and *qirsuniq* in Nunavik) which is echoed in differences we encoutered between communities within Nunavik. Work on a standardized nomenclature of mental health terminology would be an important public health education effort. CLSC and hospital interpreters should be trained in the standardized terminology.

GLOSSARY OF MENTAL HEALTH RELATED TERMS

Much of the terminology encountered has one of several roots to which are appended a variety of suffixes which modify the meaning:

Isuma- to think
Qauji- to know
Tuki- to understand
Niaquq- the head
Taku- to see
Tusaq- to hear
Ili- to learn

Terms using the *Isuma* root far outnumber the others while *niaquq* is only used in a single term. This would seem to show that the process of thought is key to the behavior rather than the physical head. Interestingly, the brain, *qaritaq,* is never used as a root term.

Aangajarnaturtusuuq	Takes drugs
Aangajaanirlutuq	When a person is drunk and causes problems (e.g. breaks things, gets angry)
Aangajarnimik nurqaqajanngituq	Drug addiction (lit. someone who can't stop taking drugs)
Aangajugasuarniq	Substance abuse
Aangajartuq	Drunk, intoxicated
Aangajartik	Alcoholic; someone who always gets drunk
Ajugaittumik aturtuq	Person who is acting weird
Aliasulijunnangittuq	Constant unhappiness
Anirnilunik illumittuq	Person who is demon possessed
Aulajijairunniq	Memory blanks (no memory of a period of time, could be hours, days, years.)
Aulajirqajanngituq	Person who cannot remember things
Aulataujuq	Something that is being worked on; caused by
Auparialik	Believing things that are not true (Pov)

Ilitsiqajanngituq	Person who cannot learn something
Ilitsisariittuq	Person who is a slow learner; unable to learn
Imminiarasuguniutuinarialik	Violence toward self (suicide, self mutilation)
Imminirasuartuq	Person who tries to commit suicide
Inirtuumajuq	Person who wants to do something but is afraid to do what he wants to do; fearful
Inummik isumagijaqainnalinoarniq	Obsessive thinking about one person
Inunnut mangatsiluarniq	Constant talking about other people (gossip)
Inunnut sulinngitumik mangatsiraliluarniq	Constantly saying things about other people that are not true
Inutuarurtisimajuq	Social withdrawal and isolation
Inutuguumajuq	Person who wants to be alone
Inutuutijuq	Person who feels left out; lonely one; Wanting to be away from people; thinks no one wants to have anything to do with him (Pov)
Irqisijuq	Person who is scared
Irsinartuq	People are scared of him (Inukjuak); Someone who is dangerous
Irsinarsigunnatuq uvvaluunniit kappianasigunnatuq	Violence towards other people or things
Irsiujuq	Scared watching something
Irsiumaartuq	Scared of something happening
Isumagijaqainnalimaarniq	Obsessive thoughts (always thinking and talking about one thing; death, war)
Isumaijartuq	Person who talks about what he or she could not talk about for a long period of time
Isumairsitartuq	Lapses of memory (forgetting who or where you are, other important events)
Isumairurtuq	Person who lost his or her brain / mind
Isumajaarni	Anxiety (fearful, nervous)

Isumakittuq	Person with a small brain; stupid
Isumakkut qanimajuq	Person who is sick mentally (or in brain, e.g., tumor)
Isumaluttuq	Person who is not thinking right; someone who is worried; who has many thoughts he can't express
Isumaminut	—because of his or her mental state / mind
Isumaminut pinailutalik	Person with mental problem
Isumanga	His or her thought
Isumamigut	Through their thoughts
Isumannaaniq (mut) pinailutaujuq ilunnaagut	Mental health problem in general
Isumaqanngituq	Person with no brain
Isumaqastianngituq	Person who is mentally disturbed; someone who does not think clearly; mentally retarded (Akulivik)
Isumaqatsiangittuq	Mental illness - permanent
Isumansungittuq	Mental illness - temporary
Isumatsiangittuq	Person who is not thinking straight
Isummapallianiq iqqaluanngituq	Mental deficiency (slow, dull, unable to learn)
Isurinngituq	Person who is not feeling well; someone who is uncomfortable, either physical or mental
Kappiasuttuq	Person who is afraid
Kappianiq	Fear
Kappianartuq	Someone or something dangerous; someone to fear
Katalungajuq	Person who is down, low
Kavartuq	Person who is sad, depressed

Kukujartuq	Nervous in sense of not being sure he'll make it; apprehensive or doubtful about getting something done or done right
Mumittuq	Obsessive religious conviction
Niaquqatsiangittuq	Person with an abnormal brain; head not completely right
Nirukittumiirqajanngituq	Claustrophobia; "one who cannot be in a narrow place"
Niurtuq	Something that is inhaled by a person
Nullangarqajanngituq	Person who cannot do what he or she is told to do; nervous, restless
Nuliarsalik	Man who has imaginary / spirit wife
Nurqaqajunnangittuq	Repetitive behavior (always checking something, always washing hands, etc.)
Piunngiturtaumajuq	Demon possession
Piusirlutuq	Person who is handicapped or physically disabled (e.g., mental retardation with physical problem)
Piusirsungittuq	Person who is not acting normal; not oneself
Puigurtatuq	Person who is forgetful
Qajanngituujurijuq	Person who thinks he or she cannot do anything; discouraged
Qaujimailijuq	Person or animal who loses their brain (e.g., rabid dog); crazy
Qaujimailingajuq	Person or animal doing something but not remembering what they are doing; person who runs wild or crazy (Akulivik)
Qirsuniq	Seizures, convulsions
Qitsatuq	Depression, mourning
Quarsaangajuq	Person who is afraid and irritable about it; nervous (Inukjuak); something frightening that makes the heart leap

Sinnavinnganiq	Extreme jealousy
Sinirqajanngituq	He / she can't sleep
Sulinngitumik uppirijalik	Person who believes in something that is not true
Sutaittuq	Something that seriously happened to a person; [old word for 'down' (Inukjuak)]
Takunnagalik	seeing things that others don't see (visual hallucinations)
Takunnanguatuq	Person who seems as if he / she was looking at something
Takurngatuq	Doesn't go to social events; shy
Timimigut qikartuunarunnangitjutilik	Unusual movements (ticks, uncontrollable body movements, nose picking, noise)
Tukiiruttuq	Person who goes out of control
Tukiittulijuq uvvaluunniit mumittuq	Running wild (loss of control over actions, erratic behavior)
Tukiittulijuq	Speech alterations (temporary)
Tukiqatsiangittuq	Speech alterations (long term)
Tukiqanngituq	Person or something that does not make sense
Tukiqanngitumik uqausilik	Person who talks making no sense
Tukiirugiakallasuuq	Suddenly loses control, gets wild
Tukisinanngituq	Person talking that cannot be understood
Tusaagalik	Person who hears things that are not actually there (auditory hallucinations)
Tusangnuatuq	Person pretending to be listening
Uimangajuq	Person who is jumping to conclusions; moving around alot, sleeping little, doings things fast, rushing (Akulivik); someone who is anxious, restless
Uirsalik	Woman who has imaginary / spirit husband

Uqausilik	Person talking about something
Uqumailiurtuq isumamigut	Depression
Uuttulutaq	Person who is tried by demon activities

APPENDIX C

Attitude Survey Questionnaire

There is a 24 year old man. Last year he was acting strange. He was staying by himself all the time and not talking. People said it was demon possession.

1. How willing would you be to have this man as a friend?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

2. How willing would you be to have your sister marry this man?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

3. How willing would you be to live next door to this man?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

4. How willing would you be to go hunting with this man?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

5. How willing would you be to have your daughter marry this man?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

6. How willing would you be to work with this man?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

7. How willing would you be to live in the same house as this man?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

8. Do you think that this man's behavior will return to normal?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

9. Do you think that this man's behavior might be due to an illness?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

10. Do you think that this man's behavior might be due to something bad that he did?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

11. Do you think that this man's behavior might be due to spirits or demons?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

12. How well do you know someone with this type of behavior?

Not at all Extremely
1..... 2..... 3..... 4..... 5..... 6..... 7

APPENDIX D

Concerning Evil Spirits and Fasting[7]

by Martha Samajuali (Salluit)

References from the Holy Bible concerning people with evil spirits (demons).

There are different kinds of demons and the way they possess a person is different, if a person says that there is a demon inside him or her, it has to be evaluated first how a demon had entered the person.

Check if the person has ever prayed to Satan for help. If the person has ever prayed to Satan, ask since how long the person has been doing that and how strong is the possession. And check how much work will need to be done.

A person possessed with demons has to be well prepared for, decide who will work on this person possessed of demons, decide who will be praying and decide in which house they have to work in. There will have to be fasting in this kind of work and a lot of praying will have to be done, only those who have agreed well together will have to work together, by Christians.

Those that will be working have to believe strongly on the power of Jesus Christ and that there is nothing impossible in him and they have to pray fervently because they will not battle against the evil spirits by themselves, they will be using the name of Jesus Christ to do the battle and they have to believe in Him strongly that He is able to do powerful things. Satan has no choice but to listen to you when you use the name of Jesus Christ of Nazareth, even if he doesn't want to he has no choice but to obey because the name of Jesus has so much power, one has to really believe because it is the one way to battle against demons.

You also have to know that if you are going to be involved in casting out demons from a person that Satan will be talking to you using the person's voice and controlling that person's body. You also have to understand that that person doesn't want to be possessed just like you don't want to and that it is out of that person's control, that person's controlled by the possesser and also that person's voice is being used to say awful words you don't even want to hear, hurtful words, words that make you feel like giving up and strong words.

You also have to know that the demon will let that person possessed know what you are trying to do even if she/he didn't hear you planning on what to do, she/he can even tell you not to hurt her/him. You can ask that person how many demons are inside her/him, what are their names and if they say who they are, you can demand them by their names to go out of the person one by one using the name of Jesus Christ. You also have to understand what exactly they do because each demon could be doing something different using that person. You have to believe that the demon has been casted out of the person if you tell them to go out calling them by their names and what they do using the name of Jesus Christ and by His blood.

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[7] This document was distributed by Martha Samajuali in Inuktitut and English versions at a training workshop for Inuit community workers held at McGill University School of Social Work, October 18, 1994. It is reproduced here for research purposes with the permission of Martha Samajuali.

You have to know and to be prepared if the person becomes scary and physically strong even to feel like giving up and that the name of Jesus Christ doesn't give up. You also have to believe that you have been given power by the Holy Spirit if you have Jesus Christ in your heart, and if you have been filled with the Holy Spirit.

Once the demons have been cast out from the person, that person who was possessed have to accept Jesus in her / his heart afterwards so that the demons don't go back in her / him. If the person doesn't know how to say the sinner's repentant prayer, you have to let that person repeat a prayer after you, the words are important. You have to make it clear to the person that Jesus and Satan cannot be inside a person at the same time, and that if she / he asked Jesus into her / his heart that He is in her / his heart.

Once the demons are cast out from the person and that person is not worried anymore, the demons should be told to get out of the community in the name of Jesus by those people who have been doing the praying and those involved in the exorcism, believe in your words and drive them out of town to the wilderness. You should not rejoice since Satan is listening to you, instead you should rejoice that your name is written in the Book of Life in heaven.

You can refer to these scriptures from the Bible.

Mark 5:9	What is the name of the demon.
Mark 1:23-26	The demon knows very well who Jesus is.
Mark 9:38-39	An exorcism cannot be done other than through the power in the name of Jesus and the blood.
Luke 10:19-20	Jesus has given power.
Ephesians 6:12	We have to fight with many wicked powers.
Mark 9:29	They can be cast out only through prayer and fasting.
Matthew 6:17-18	Fasting should be used towards God and not towards man.
Mark 7:25-30	Jesus had cast out demon even though he wasn't there.
Acts 8:7	Demons went out with a voice.
Luke 10:1	When Jesus appointed He appointed them by twos.
Matthew 18:18-20	The power of agreement.
Matthew 12:43-45	The demon that have been cast out have to be replaced by Jesus Christ to avoid it from going back.

Discuss the truth in these scriptures and study them because they are the only weapons against demons.

Guidelines for those that will be doing the exorcism on a person possessed by demons:

1. The christians should get together for prayers, they should agree together on fasting, the time and place they will be praying.

2. Discuss on which scriptures they will be basing their work on and pray and ask God about who will be attending the exorcism on the person, two or three people should attend if that is what God wants.

3. The people that will be doing the prayers should agree ahead of time about the fasting and the prayers that will have to be done fervently, they will have to submit themselves totally to fasting and prayers.

4. Those that will be praying will have to do their prayers in another building. They have to be ready on call for the actual prayers whether it is at night and whether if they have to be together. They have to agree together so that they can work closely together.

5. They have to understand that there is power in prayers when it is done whole heartedly and in belief, it also have to be understood that they are battling against demons and that those people that are praying also have to understand that they are strengthen the exorcisers as if they are the muscles to those exorcisers.

6. The people that will be doing the praying will have to pray for the exorcisers by laying hands on them before they go to the building where the work will take place.

7. The people that will be attending the person with the demons will have to pray first in the building before the exorcism takes place. Children are not allowed in the building that will be used during the exorcism and there shouldn't be any visitors who are just visiting so there won't be any disturbance.

8. The people involved have to understand that they should not be scared no matter how the person is behaving.

Once the demons have been cast out from the person it would seem like the person is just waking up, being relaxed and her/his life will be changed, or if the person had been possessed for many years and once the demon that have been controlling the person is cast out that person could seem restless as if she/he is mentally disturbed for a while. When the demon that have been controlling the person is cast out, the person may be restless once she/he starts to think for her/himself when the demon who was been there telling her/him is not there anymore. Once the person that have been possessed is freed from the demon, she/he has to be well cared for and prayed for and not to be left alone shortly after. If you were involved in the exorcism and you cannot sleep, you can request for sleeping pills from the clinic for your body to rest.

Everyone who have bee involved in the prayers and exorcism have to have thanksgiving by praising the miracles of Jesus once all is done. This could also be shared in the community to tell them that only through Jesus is the healing done.

Praise the Lord Jesus Christ for we have victory through Him, He even has given us power through the Holy Spirit while we are here on earth.

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