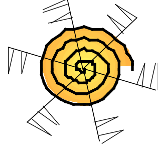

Culture & Mental Health Research Unit

Report No. 2

REVISED FINAL VERSION

Emerging Trends in Research on Mental Health Among Canadian Aboriginal Peoples

A Report Prepared for the Royal Commission on Aboriginal Peoples

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PREFACE

This report was prepared at the request of Dr. Dara Culhane Speck, Deputy Director of Social and Cultural Research for the Royal Commission on Aboriginal People. Our mandate was to review the scientific literature in order to identify emerging trends in research on mental health among Native peoples in Canada. In this report we do not directly address the issue of suicide as this was the topic of an earlier report for the Royal Commission prepared by our group. We do review some of the work on alcohol and substance abuse because, while these are the topic of other reports to the Commission, we feel they are closely related to mental health and we want to counter the fragmentation of research and care that seems to plague Native mental health.

Published literature was searched by Medline, PsychINFO and SocLit. Unpublished research reports were solicited from research teams in Canada and the United States as noted in Appendix B. The literature was reviewed by an interdisciplinary team of clinicians and scholars from psychiatry, anthropology and sociology. It was assessed for scientific validity, assembled and integrated by the senior author. Where methodological flaws or limitations affected the data this is noted. In many areas, however, there is a paucity of research and we have had to rely on the consensus among Native peoples, researchers and scholars.

This is not a comprehensive report. An enormous amount of information is held by a variety of agencies in the form of surveys, reports, position papers and recommendations that are not readily accessible. For example, NNADAP, Nechi Institute, Northern Health Research Unit, Canadian Center on Substance Abuse (CCSA), Statistics Canada and the Medical Services Branch all have extensive holdings of information on Native mental health and substance abuse. In some instances, despite formal requests to these agencies, information was not received. The Royal Commission office and the CCSA were the most helpful and responsive agencies in providing information.

In many ways the problem of information gathering we have experienced mirrors the problem of the Aboriginal peoples. There are many different agencies involved and a tremendous number of programs—with little coordination of the effort. This experience points to the need for some sort of clearinghouse for information on Aboriginal issues that can gather together and hold all previous research and reports.

In assembling this report we were able to draw from literature reviews and research results of the Native Mental Health Research Group (cf. Appendix A) of the Culture and Mental Health Research Unit of the Department of Psychiatry, Sir Mortimer B. Davis—Jewish General Hospital. This unit receives support from the Fonds de la recherche en santé du Québec as part of a priority research team grant on "Culture and Somatization." The Native Mental Health Group has received research grants from the Conseil québecois de la recherche sociale and the Kativik Regional Board of Health and Social Services. This work, however, was not done under the auspices of any of these agencies and they bear no responsibility for its content.

This report was revised on the basis of external reviews obtained by the Royal Commission. A few recent publications not included in the original review were added. The most important changes concern the section on physical and sexual abuse where we have taken into consideration the reports of the Canadian Panel on Violence Against Women and the Ontario Native Women's Association. We would like to thank Dr. Clare Brant, Ms. Joan Glode, and Dr. Jacques Kurtness for their helpful comments on the earlier version.

Laurence J. Kirmayer, MD, FRCPC
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& November 26, 1994

1. INTRODUCTION

As requested by the Royal Commission on Aboriginal Peoples, our aim in this report is to review the scientific literature on the mental health problems of Canadian Aboriginal peoples to identify emerging trends in research themes and methods. The topics to be covered include the following:

(1) an overview of epidemiological data on Aboriginal mental health in Canada;

(2) a critical review of existing literature on the topic of prevention and treatment among Aboriginal peoples in Canada;

(3) a comprehensive discussion of emerging trends in this field;

(4) guidelines for future research.

This report is organized in accordance with these themes. We have endeavoured to include specific material on women, status and non-status Indian, Inuit and Métis peoples. Unfortunately, in most cases there is very little information available. Given that the problems we address cut across groups, we have not created separate sections for each important subgroup. The index provides a way to track down specific mention of groups, geographical regions or other specific interests. The index can also function as a glossary since many technical terms are defined on their first occurrence.

In this introductory section, we provide definitions of technical terminology and offer some general comments on research methods to orient the reader. The second major section addresses basic epidemiological statistics on common psychiatric disorders. The third section summarizes research issues on alcohol and substance abuse, particularly as they relate to other psychiatric disorders. The fourth section considers traditional and contemporary healing practices and addresses problems in the assessment of helping interventions. The fifth section identifies emerging trends in the field. Finally, we present a summary of the major conclusions and guidelines for future research based on our reading of the literature.

1.1 Mental Health, Mental Illness and Social Problems

Psychiatry is concerned with disturbances of feeling, thinking and acting that cause suffering. Most psychiatric problems are not diseases in the sense that they do not have identifiable physiological abnormalities associated with them although it is suspected that for many types of problems such underlying processes will eventually be found. Most psychiatric diagnoses are made on the basis of clusters of symptoms called *syndromes*. When it is assumed that there is some common underlying disturbance of psychological mechanism in these syndromes, they are considered *disorders*. Current psychiatric classifications of

disorders in use in North America are the DSM-III-R (American Psychiatric Association, 1987) and the ICD-10 (World Health Organization, 1992). The fourth revision of the DSM, published in 1994, incorporated material designed to encourage culturally-sensitive diagnosis (Mezzich et al., 1993).

Although the dualism of Western culture tends to treat them as separate realms, there is ample evidence for the close relationship between physical and mental health. Garro (1993) notes the emergence of diseases of westernization among Aboriginal peoples in recent times including diabetes, cancer, heart disease and high blood pressure. For Canadian Aboriginal peoples as a whole, "the single most important group of health problems in terms of morbidity and mortality" are accidents and violence, often involving alcohol (Young, 1988, p. 54). Physical disease, violent death and substance abuse are all linked to social problems—especially loss of community, social support and shared meaning in life—and resultant psychological and emotional problems.

Psychiatric disorders are often associated with social problems: inability to perform one's social roles, conflict in relationships, breakdown of communal ties and order. In much research with Native peoples the emphasis has been more on substance use and social problems rather than on psychiatric disorders. Most work on children's mental health does not use conventional diagnostic labels but focuses on social problems. For example, in a comprehensive review of health and social services for communities in Northern Quebec on the Hudson Bay Coast—covering all aspects of the health care system and done in the context of local initiative and control over health care service delivery and programme development—no mention is made of mental illness while significant attention is given to "social deviance," family violence, infant neglect and "psychosocial" health programmes (Proulx, 1988).

Social problems may be caused or aggravated by psychiatric disorders in individuals. The psychiatric perspective tends to see social problems as caused by individual pathology and approaches treatment at an individual level. Consequently, diagnostic schemes and treatment resources are designed and directed toward individuals.

Clearly, social problems have much wider and more substantial origins in social and economic circumstances. Social problems may themselves be the cause of psychiatric disorders. Armstrong (1993, p. 224) believes that "chronic stresses of daily life rather than diagnosable psychiatric disorders, account for Native Indians' high rates of arrest, homicide, suicide, incarceration, wife and child abuse and violent death." For the public health worker, social organizer or politician, it is more natural to focus on issues affecting whole communities and to attribute all problems to these broad forces.

Both individual and social perspectives have something to contribute in understanding the origins and alleviation of suffering. The tendency to focus on social problems may leave those with identifiable discrete disorders under-serviced and understudied (Thompson et al., 1993, p. 218). A focus on just psychiatric problems ignores the fundamental historical and social causes of

illness that may, in themselves, offer the best hope for change and healing. Exclusive focus on the individual or the social dimension gives a distorted picture. Indeed, there can be no sharp division between mental disorder and social problem unless problems are taken out of context.

Whereas psychiatry focuses on psychopathology, risk and vulnerability factors and the causes and treatment of distress, the notion of mental health entails not just the absence of illness but positive conceptions of well being, personal and social harmony. Mental health is characterized not by a total absence of suffering, since all people face loss, pain and conflict in their lives, but by resilience, the capacity to adapt and pursue personal and social values. There is a scientific literature on health and hardiness but this is largely framed in terms of the individualistic values of Euroamerican culture which assess health in terms of wealth, power, independence, rationality and control (e.g. Antonovsky, 1987; Kobasa, Hilker & Maddi, 1979; Maddi, 1988). Conventional notions of well being are tied to a specific economic and social system. Some of these values do not correspond to cultural notions of well being among Native groups. There is a need, therefore, for local definitions of health and wellness that embrace culture-specific visions of the good life.

1.2 Research Methodologies

There are three broad strategies for studying the mental health problems at the level of communities: clinical, epidemiological and ethnographic. Each has strengths and limitations. Clinical research is focused on groups of people already identified as ill or seeking help and uses the observational skills and techniques of the clinician to probe the underlying nature of problems. Epidemiology can be used in clinical or community settings and examines the characteristics of larger groups of people with standardized questionnaires and statistical techniques. Ethnography involves intensive interviewing of key informants and participant observation to understand the lived experience of a community.

Clinical and ethnographic methods often produce qualitative data—descriptions, typologies and narrative accounts of the meaning and relationships of events and processes. Qualitative research is often viewed as less precise, reliable and generalizable than the quantitative methods used by epidemiology. Quantification demands that researchers pose questions in a clear, operationalized way and submit their hypotheses to statistical tests. It is generally viewed as more objective, that is, as less liable to the biases and preconceived notions of the researcher. Quantitative research emphasizes reliability and replicability—the ability to obtain the same results on different occasions when the same methods are used. Both quantitative and qualitative methods have virtues and drawbacks and both are certainly vulnerable to biases.

These methods tend to produce different forms of knowledge. While epidemiology and clinical research aim to find general truths about health and illness that can be applied across the whole population or fit to the particular

characteristics of a group, ethnography is more concerned with local knowledge. Local knowledge pertains to the beliefs and practices of specific groups or communities and a specific historical moment. As such, it may have limited generalizability, although it offers a deepening of understanding that may inform thinking about new situations.

The most valid and useful information about mental health and illness that we have comes from approaching problems with multiple methods. When different methods converge, we can be more confident of the solution. The integration of these forms of knowledge is an ongoing challenge in the field of mental health. Individual researchers have strong commitments to one or another approach based on training, professional orientation and personal values. For many, the different epistemologies implicit in these approaches make them incommensurable and impossible to integrate.

Discussion of the relationship between qualitative and quantitative, and epidemiological and ethnographic research can be found in: Kleinman, 1987; Corbin & Strauss, 1990.

In what follows, we briefly discuss some of the methodological issues raised by the type and site of research.

1.2.1 *Clinical Observation and Clinical Epidemiology*

Most studies are conducted in clinical settings where problems are recognized and where professional staff are present to collect information. Most of these studies are anecdotal or impressionistic and the larger social context and biases of the observers are rarely described.

Clinical studies can identify potentially important risk and protective factors but cannot determine their prevalence or relative contributions to mental illness in the general population. Clinical studies usually only involve people who come for help. Therefore, they cannot provide information on those in the community who are suffering but who do not come for help or who, while they may have signs and symptoms of mental illness, do not view themselves as ill. Clinical studies also cannot address people who have successfully dealt with stresses, traumas, or illness episodes. Because they focus on people who have come for help, clinical studies may confound factors that influence help-seeking with those that contribute to specific psychopathology. This may introduce a statistical bias ("Berkson's bias") into estimates of the co-occurrence of problems.

Studies of mental health in the community indicate that many individuals never come for help or use alternative family and community resources. Those that do contact the professional health care system are seen primarily in primary care, (that is, the first line of medical treatment—usually family medicine, general practice, nursing stations, community clinics or hospital emergency rooms) and not in psychiatry or other forms of specialty mental health (Regier, Goldberg & Taube, 1978). Primary care has, therefore, been recognized as a crucial site for psychiatric epidemiology and research (Shepherd, 1987). This emphasis on

primary care is obviously relevant to the Canadian Aboriginal population, both for those living on reserves or in isolated communities and for people living in metropolitan centers with ready access to tertiary care. However, for the reasons mentioned above, primary care studies are less suited to identifying how people cope successfully with challenges—that is, the ingredients of restitution, recovery and mental health. It is therefore necessary to conduct surveys to identify problems in the community in order to determine their true prevalence and to study the effectiveness of family and community resources as well as professional interventions (Goldberg & Huxley, 1992). Studying the pathways to care may also identify problems in recognition of distress and in differential treatment and so improve the delivery of appropriate care (Rogler & Cortes, 1993).

1.2.2 *Community Epidemiology*

Epidemiological surveys offer the best means of identifying risk and protective factors that function at the level of the vulnerable individual, as well as factors at the levels of family, social network, cultural community, society or nation that affect whole populations. Epidemiological studies require large numbers of subjects to permit multivariable statistical analysis. They require highly structured and standardized interviews or questionnaires to allow aggregation of data. Epidemiology makes the assumption that the internal variation in populations can be captured with a few questions or categories. For example, ethnicity is usually treated as a simple categorical variable rather than a complex multidimensional construct which varies over time in different ways for different individuals. Epidemiology also assumes that similar problems and processes occur across different communities so that they may be aggregated for analysis.

Current psychiatric epidemiological methods emphasize structured diagnostic interviews and systematic recording of details of personal history and experience. Interviews have been devised that must be administered by skilled clinicians who can interpret specific behaviours. The best known of these are the PSE, SADS, SCID and most recently, the SCAN (Wing et al., 1990). Instruments have also been devised that can be administered by trained lay interviewers, permitting larger scale surveys to be undertaken (Eaton & Kessler, 1985) . The most widely used of these interviews in North America, the Diagnostic Interview Schedule developed by the US National Institute of Mental Health to conduct the Epidemiological Catchment Area Study (ECA) (Robins et al., 1991) has evolved into the Composite International Diagnostic Interview which yields both DSM-III-R and ICD-10 psychiatric diagnoses. The CIDI has been adapted for cross-cultural work in conjunction with the World Health Organization (Cottler et al., 1991; Robins et al., 1991; Wittchen et al., 1991). These structured interviews were developed to improve the reliability of surveys and to allow the approximation of clinical psychiatric diagnoses with data collected by lay interviews (Helzer & Robins, 1988). However, these instruments have not always proved as reliable as initially claimed particularly in estimating lifetime prevalence of disorders. This inaccuracy occurs because memory, even for personally salient events, is surprisingly poor and recall is biased by present concerns and conceptions

(Rogler, Malgady & Tryon, 1992) . These factors set limits on the reliability of any psychiatric survey.

Self-report measures of symptoms also identify psychiatric distress. Many people have significant levels of distress but do not fit discrete psychiatric diagnostic categories (Goldberg & Huxley, 1992) . There is ongoing controversy in psychiatry about which types of problems are best understood as belonging to a continuum of severity and which represent distinctly different categories of distress. The use of symptom measures allows us to examine distress along a continuum and to look for discontinuities which may mark a threshold to developing a more serious or different type of disorder (Grayson, 1987; Grayson et al., 1987). Analysis of patterns of co-occurrence of symptoms on symptom measures may also reveal dimensions of distress which may vary cross-culturally. The use of symptom measures, while canvassing distress in a broad way, does not address specific psychiatric disorders for which specific treatments are available and for which health resource allocation can be estimated. Accordingly, a specific level of symptoms or other criteria may be chosen as definitions of caseness, to identify individuals who are likely to be cases by conventional clinical diagnostic methods. Where the cutoff should be made, however, is a matter of disability or functional impairment and distress rather than being intrinsic to a symptom cluster or the definition of a disorder and so is influenced by other social, economic and psychological factors that contribute to disability.

Much research involves collecting information at a single point in time and so is termed “cross-sectional.”A general problem for cross-sectional epidemiological research is that factors found to correlate with an outcome do not necessarily cause it. Studies that simply report correlations between risk factors and mental illness, while they may be useful in developing indices of prediction, may be misleading in attempts to determine the causes of mental illness. Longitudinal studies permit greater confidence in identifying antecedents and consequences of factors presumed to contribute to illness. Ultimately, however, ascription of causality depends on models of the pathway from cause to consequence. These models are usually derived from social or psychological theory, clinical experience, and detailed knowledge or case studies of communities. In the public arena, if a model is widely accepted, there is a temptation to treat every correlation as further confirmation of it when, in fact, the causal connection has still not been established. Further, research tends to examine only those factors that already have credence or are easy to measure and so tends to reproduce the conventional wisdom. In particular, with existing methods, social factors are generally much harder to identify, quantitate and study comparatively than are individual factors. Consequently, the research establishment tends to reproduce the emphasis on individual explanation rather than situational explanations implicit in Euroamerican folk psychology (Ross & Nisbett, 1991).

Basic methodological problems in the epidemiology of Aboriginal mental health include:

(1) combining data from different communities means very different groups and milieus are being aggregated;

(2) studying smaller, more homogeneous communities means that small numbers of cases exert a large effect on reported results which may be of no statistical significance or of limited generalizability;

(3) the definition of who is an Aboriginal person is often problematic due to people living on or off reservation, mixed parentage, style of living, self-identification, etc.;

(4) census data may be biased by problems of ethnic identification and sampling which in turn will alter population prevalence rates;

(5) Aboriginal people in some settlements may be much more closely studied or scrutinized than neighbouring rural communities, leading to a more complete reporting of cases (e.g. of suicide) and hence, the impression of a higher prevalence of problems where none exists;

(6) studies do not take into account ongoing culture change;

(7) in small scale communities there may be a significant problem of reactivity in research: that is, the researcher may have substantial impact on the community which both threatens the validity of findings and introduces new factors into the system.

1.2.3 *Ethnography*

Ethnographic case studies consider the meaning of events and actions to the individuals and groups involved. They examine actions as *situated*—that is, having a particular salience, pragmatic force and meaning in a specific social context. While older anthropological traditions were pre-eminently concerned with belief systems, contemporary psychiatric anthropology focuses on the local construction of meaning through action (Kirmayer, 1992; Kleinman, 1986; Kleinman, 1988; Littlewood, 1990). Culture is not an homogeneous medium that affects everyone identically—it emerges from processes of invention, transmission, negotiation and contestation of shared beliefs and practices.

Anthropological perspectives insist on the coherence and uniqueness of local worlds of meaning which give shape to individual suffering, symptom expression and the interpersonal processes, course and outcome of psychiatric disorders. From this perspective, it is necessary to approach each group anew, with an effort to discern local patterns of illness experience and expression as well as local methods of coping and healing. Although this is a *sine qua non* of ethnographic research or intensive case studies, it is much more difficult to achieve in larger epidemiological studies.

1.2.4 *Necessity for a Combined Approach*

For obvious methodological reasons, there is little information that bears directly on the question of the relative importance of cultural, historical and biopsychological contributors to mental disorder. When dealing with culturally distinctive groups, it is tempting to attribute any special features as due to cultural difference. As Thompson and colleagues (1993) note, such “cultural” explanations have been used against Native peoples to treat their mental health problems as consequences of history, environment or social situation and so to stop the search for other contributors and treatments (p. 197).

There is a tendency to attribute any difference to distinctive cultural or historical features, but economic problems and issues of scale (i.e. the size of communities and the degree of infrastructure) may also account for observed differences. Hence, comparative studies with statistical techniques that control for other possible explanations are needed. The most valid methods of determining the level, nature and correlates of distress involve integrating epidemiological and ethnographic methods but this has rarely been accomplished (Kirmayer, 1989a; Kleinman, 1987; 1988; Manson et al., 1985) .

With these cautionary statements in mind, we will summarize what is known about Native mental health within the scientific paradigm and what can and ought to be done given current methods. Throughout this report our emphasis will be on refining both methods and questions through interdisciplinary cross-fertilization and cultural critique.

2. RESEARCH ON PSYCHIATRIC DISORDERS

2.1 Demography

Canada's Aboriginal peoples comprise four main groups: status Indians registered under the Indian Act of Canada; non-status Indians; Métis and Inuit. Although some demographic data are available for all four groups, systematic health data collection systems for non-status Indians and Métis do not exist (Norris, 1990) .[1] Since some Aboriginals who have integrated into the dominant society may no longer identify themselves as Aboriginal, existing statistics do not provide a complete picture of the evolution of health care problems in this group.

The demography of the Aboriginal population is distinct from that of the general Canadian population in several important respects. Due to a later demographic transition in the 1940s to 1960s to the pattern of fewer children per family (which occurs as a response to reduced infant mortality), a greater proportion of the Aboriginal population are young (Norris, 1990) . The rate of growth of the Aboriginal population is currently decelerating, but the birth rate remains at about twice that of the general population. Aboriginal groups have significantly higher mortality levels resulting in a life expectancy about 10 years shorter than that of the average Canadian. The 1986 Census indicated that 37% of all status Indians had less than grade 9 education, more than twice the total Canadian rate of 17% (Medical Services Branch, 1991) .

Over 75% of the Aboriginal population reside off reserves (Valentine, 1992) . In Eastern Canada, Aboriginal peoples living off reserve tend to resemble the local general population in demographics, employment and prosperity, while in Western Canada, there continues to be a large gap between the economic status of the local general population and Aboriginals even when they leave the reserve.

Although most Aboriginal communities face similar problems of rapid cultural change, there are substantial variations in the type and frequency of social problems. There is great cultural diversity among Aboriginal groups with some 596 bands located on 2284 reserves and Crown land, 10 different languages and more than 58 dialects (Frideres, 1993) . The communities are situated across a great diversity of geographical locations and coastal, mountain, prairie, arctic and sub-arctic (boreal) ecosystems. Communities vary in their distance from cities. Urban and rural reservation environments differ along dimensions of economy, subsistence patterns, educational opportunities, practice of traditional lifestyle, transmission of language and culture, and experience of minority status and discrimination. This diversity is a challenge to any effort to provide a

[1] Throughout this document we will use "Aboriginal" and "Native" interchangeably. We will also use the term "Indian" when referring to status or non-status Indians in Canada or Native American Indians in the U.S. Similarly, we will use the terms non-Aboriginal, white and Eurocanadian or Euroamerican as equivalents, although we prefer the latter two terms as they are cultural rather than quasi-racial designations. To avoid confusion, the choice of term will parallel the particular literature we are citing or reviewing.

comprehensive portrait of Native health. In the past, statistics associated with one or a few groups have been over-generalized to apply to the entire Aboriginal population. There were and are enormous cultural differences between Amerindian groups that certainly equal or exceed those between people from neighbouring European countries. Speaking of Aboriginal peoples in the collective then, is a way of acknowledging shared values, historical experiences of contact with European societies, and common political concerns and aspirations in the contemporary scene. This shared reality is a source of political strength and positive ethnic identity; it should not, however, obscure the reality of great diversity and, correspondingly, different problems, needs and solutions.

2.2 Epidemiology

The overall prevalence of psychiatric disorders among American Indians has been estimated at between 20-63% of adult American Indian populations (Robin et al., *unpublished*). Estimates vary widely due to the number and type of diagnoses canvassed and the inclusion of symptom measures of distress as indicators of caseness. Most estimates of prevalence are based on service utilization records and so give an indication of treated cases, not the true prevalence of disorders which includes many undetected and untreated cases in the community, even for serious disorders (Robins et al., 1992). Since many people never come for treatment, service utilization is at best only a lower bound on the true prevalence of distress in the community and at worst, serves to distort the picture due to inequities of access and availability of appropriate services.

Young and colleagues (1993) reviewed records on 581 referrals for psychiatric consultation in the Baffin region. The mother tongue was Inuktitut in 88% of cases; 345 cases were women. Reasons for referral were: depression (27.9%), suicidal thoughts or attempts (24.4%), relationship or family problems (14.7%), grief reactions (10.5%), violent or abusive behaviour (9.5%) and psychotic or bizarre thinking (7.5%). There was a high prevalence of concurrent social problems, the most frequent of which were interpersonal conflicts (47.7%).

In our own clinical case study from the Inuit of Northern Québec, of 100 consecutive cases referred for psychiatric consultation, the single most common DSM-III-R diagnosis was major depression with melancholia (Kirmayer et al., 1993). Co-occurrence of social problems for the first 57 cases is presented in Table 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. In men, the most common stressors 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 men appear to be suffering from their inability to find valued work, women are much more likely to be victims of abusive relationships that engender 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 behaviour: 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. At the same time, much physical and sexual abuse likely remains unreported as victims are frightened or embarrassed to seek help.

Table 1.
Psychosocial Comorbidity with Psychiatric Disorders Among Inuit Patients

Primary Diagnosis	N	%	Alcohol / Drug Use	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	**57**		**8** **14%**	**8** **14%**	**15** **26%**	**2** **4%**	**9** **16%**

To date, only four community epidemiological studies of psychiatric prevalence rates among North American Indians have been published—two of these in Canadian populations (Roy et al., 1970; Shore et al., 1973; Sampath, 1974; Kinzie et al., 1992). Results for the first three studies are summarized in Table 2.

Roy examined the prevalence of “active cases” of psychiatric disorders on 10 Indian reservations (9 Cree and 1 Salteaux) in Saskatchewan with a total population of 4,763. A search for active cases was made through hospital and clinic registers, key informants and personal interviews by the project director. A comparison was made with non-Indians in the 18 rural municipalities in the same geographical area, with a total population of 28,096. Table 2 presents the prevalence rates for diagnoses made by the clinician interviewers based on ICD criteria. In all, 129 individuals received a psychiatric diagnosis for a prevalence of

10.6% in the interviewed sample (n=1218). If the figure is treated as the prevalence of “active cases” in the population as a whole, this gives a prevalence of 27.3/1000 for the Indian population compared to 15.2/1000 for the non-Indian population. Schizophrenia and mental deficiency accounted for a greater proportion of cases in the Indian group. As the authors note, their method could not yield a true community prevalence of psychiatric disorders. As well, alcoholism was underestimated because alcohol use was endemic but did not conform to conventional abuse patterns. Among the many methodological problems with this study were unsystematic case finding that depended on clinical files and general practitioners, and unstructured interview techniques with vague diagnostic criteria.

The study by Shore and colleagues (1973) involved a community on the Pacific Northwest Coast with a population of 200 adult Indians. A sample of 100 subjects were assessed by two psychiatrists who conducted field interviews over a six-month period.

Table 2.
Epidemiological Studies of Psychiatric Diagnosis among Native Peoples

Study	Sample	Diagnostic Method & Criteria	Diagnoses	Prevalence %
Roy, 1970	Indians of Northwest Saskatchewan n=1,218	Clinical diagnosis from chart review by ICD criteria	Neurosis Mental deficiency Schizophrenia Functional psychoses Epilepsy Alcoholism Organic Psychosis	3.2 2.5 2.2 1.3 0.8 0.5 0
Shore et al., 1973	Adult Indians of the Pacific Northwest Coast, n=100	Psychiatrist interview using DSM- I	Alcoholism Psychoneurosis Psychophysiological reactions Personality Disorder	27 18 15 5
Sampath, 1974	Adult Inuit of Baffin Island n=214	Psychiatrist interview using DSM-II and HOS	Neuroses Affective Psychoses Personality Disorders Schizophrenia Organic Brain Syndrome	11.6 4.6 3.8 2.8 0.5

The levels of psychiatric impairment and alcohol abuse were very similar to those found among the general population in the Stirling county study in Nova Scotia (Murphy et al., 1988). Psychoneurosis and psychophysiological syndromes were much more commonly found in women than men in this community (female to male ratio =17:1), while the majority of subjects with alcohol impairment were men (male to female ratio = 1.7:1).

The authors found that alcoholism was "the major psychiatric problem, if not the major health problem" in this settlement; however, they noted that it was impossible to compare their figures with prior studies of alcoholism rates among Native Americans because "distinctions between culturally approved norms of drinking and non-normative drinking have not been clearly made" (p. 77).

Sampath (1974) interviewed 214 adults (15 years old and over; 97 males and 117 females) of "Oxford Bay," a pseudonym for a Southern Baffin Island settlement with a population of 550. This sample represented over 93% of the adult population. Sampath found that while women were on average more symptomatic than men, they were less likely to report severe symptoms except in the 45-64 year old age group. Fully 37% (n=80) of the individuals interviewed received a diagnosis of mental disorder. This figure translates into a period prevalence rate of 373 per 1000. This is almost twice that found in the ECA study in the U.S. (Robins & Regier, 1991). Whether this is truly an elevation in prevalence or reflects methodological problems is not possible to determine. The study used DSM-II criteria which had low reliability. The interviewer worked through a translator. The study did not diagnose psychophysiological disorders, transient situational disturbances or alcoholism—all of which would be expected to be quite common and which may have confounded the reported diagnoses.

Most recently, Kinzie and colleagues conducted a 1988 follow-up study of the North West Coast village originally studied by Shore and colleagues in 1969 (Shore et al., 1973). This study was able to take advantage of the significant advances in psychiatric epidemiology since the earlier work. It employed a structured psychiatric interview for skilled clinicians, the Schedule for Affective Disorders and Schizophrenia Lifetime version (SADS-L) which generates diagnoses based on the DSM-III-R. The researchers included a section on Post-traumatic Stress Disorder (PTSD). Subjects were matched to the 1969 sample for sex and age. The results of this study are presented in Tables 3 to 5.

In all, 31.4% of subjects met a current DSM-III-R diagnosis. As shown in Table 3, a marked sex difference was observed with nearly 46% of men affected and only 18.4% of women ($p<.002$). Most of those fully employed (88%) had no diagnosis of mental disorders. However, the presence of a diagnosis was not related to marital status, age or educational level. A lifetime diagnosis of mental disorder was also highly related to sex (82% of the men, but only 58% of the women).

Table 3.
Prevalence of Psychiatric Disorder in an American Indian Village (N=131)[a]

	Point Prevalence (%)			Lifetime Prevalence (%)		
	Men	**Women**	**Total**	**Men**	**Women**	**Total**
Alcohol Disorders						
Alcohol dependence	32.8	6.2	18.8	72.9	31.0	50.8
Alcohol abuse	3.6	0.8	2.1	3.6	8.4	6.1
Total	36.4	7.0	20.9	76.5	39.4	56.9
Substance Abuse	2.2	-	1.0	7.4	-	3.5
Affective Disorders						
Major, single	-	1.6	0.9	8.9	11.4	10.2
Major, recurrent	2.2	4.7	2.9	8.1	14.8	11.0
Dysthymia	1.5	2.3	1.9	1.5	6.2	4.0
Cyclothymia	0.9	1.7	1.3	0.9	1.7	1.3
Bipolar	-	-	-	-	2.8	1.5
Total	4.6	10.3	7.0	19.4	36.7	28.0
Organic Disorders						
Dementia	1.4	0.8	1.1	1.4	0.8	1.1
Organic Anxiety	0.9	-	0.4	0.9	-	0.4
Organic Mood	-	-	-	1.4	1.1	1.3
Organic personality	4.4	-	2.0	4.4	-	2.0
Schizophrenia	4.4	-	2.1	4.4	-	2.1
Anxiety Disorders						
Generalized anxiety	-	-	-	-	0.8	0.4
Simple phobias	-	1.1	0.6	-	1.1	0.6
Panic without agoraphobia	-	1.1	0.6	-	1.1	0.6
Agoraphobia	-	-	-	-	1.7	0.9
PTSD	4.5	-	2.1	6.8	3.3	5.0
Personality disorders	3.0	-	1.4	3.0	-	1.4

[a] Weighted for age and sex
Source: D. Kinzie et al. 1992.

Table 4 presents a comparison of diagnoses in 1969 and 1988. In 1969, 59% of the subjects studied met criteria for a current DSM-III-R diagnosis (62% of men and 52% of women). In 1988 only 31.4% had a diagnosis (46% of men and 18.4% of women); 19% had a current alcohol-related disorder. In 1969, 22 subjects were reported to have psychophysiological reactions (a category in DSM-I). None of these met any DSM-III-R diagnostic criteria in 1988. No PTSD cases were diagnosed in 1969 because the diagnosis was not in use at that time.

The most impressive finding in 1988, as in the 1969 study, was the high rate of alcohol-related problems. Lifetime rates of alcohol dependence of almost 57% of the villagers were the highest reported in the literature to the authors' knowledge and may be compared with the rate of 13.3% in the ECA study. The current dependency and abuse rate is 21% for the village compared with a

prevalence of 2.8% in ECA study. At some time in their lives, 76% of the village men had a diagnosis of alcohol dependence or abuse compared with 39% of the women. Although high, these rates were actually less than those found in 1969. Possible reasons for the decrease in prevalence include: drug education and treatment programs; influence of churches; and higher educational attainment. Alcohol dependency is increasingly a problem of the younger population, ages 20-29. Substance abuse other than alcohol was relatively low in the 1988 study showing a lifetime prevalence of 3.5%.

Table 4.
Comparison of 1969 and 1988 Surveys of a Northwest Coast American Indian Community

Diagnosis	Prevalence (%) 1988 (n=131)[a]	1969 (n=100)
Alcohol Disorders		
Dependence	11.9	36
Partial remission	6.9	3
Total	18.8	39
Substance Abuse	1.0	-
Affective Disorders		
Major, single	0.9	5
Major, recurrent	2.9	-
Dysthymia	1.9	4
Cyclothymia	1.3	-
Total	7.0	9
Organic Disorders		
Dementia	1.1	2
Anxiety	0.4	-
Personality	2.1	-
Schizophrenia	2.1	-
Anxiety Disorders		
Generalized anxiety	-	6
Panic disorder	0.6	-
Simple Phobia	0.6	-
PTSD	2.1	-
Antisocial Personality	0.4	-
Other Personality	1.0	5

[a] Weighted by age and sex.
NB. 1969 diagnoses by DSM-I criteria; 1988 diagnoses by DSM-III-R
Source: D. Kinzie et al. 1992.

In general, lower prevalence rates of mental disorders were found compared with the previous study in 1969. However, the rates were much higher than those found in the general U.S. population with the ECA data as shown in Table 5. The current prevalence of affective disorders (1988) was not especially high compared to that found in the ECA study, but the lifetime prevalence was remarkably greater with recurrent major depression being the most common

disorder. The authors conclude that both alcohol-related disorders and affective disorders are major mental health problems in this Indian community. Commenting on the difficulties of cross-cultural diagnosis, they note that clinicians must be experienced in cross-cultural psychiatry to adequately recognize the respondents' nonverbal and often subtle responses.

Table 5.
Comparison of Prevalence of Psychiatric Disorders in an American Indian Village with ECA Data [a]

	Indian Village		ECA	
	Current	Lifetime Prevalence	1 month	Lifetime Prevalence
Any Disorder Both Sexes	31.4	69.4	15.4	32.2
Alcohol Dependence/Abuse	20.9	50.9	2.8	13.3
Affective Disorders	7.0	28.6	5.1	8.3
Any Disorder Except Alcohol Dependence/Abuse	19.6	42.4	12.8	22.1

[a] From Regier et al., 1988.
NB. Indian village study used SADS with experienced clinician interviewers; ECA used DIS with lay interviewers.
Source: J. D. Kinzie et al., 1992.

Chester, Mahalish and Davis (1993,*unpublished*) conducted a community-wide mental health survey among American Indians on a Northern Arizona reservation. Among 156 adults surveyed with a Personal Problem Checklist, the most common problems reported included family emotional problems (39%), anxiety (39%), sleep disturbance (39%), physical abuse (25%), drugs and alcohol abuse (16%) and suicide in family members (14% attempted, 13% completed). In a sample of 28 youth, the most common problems were troubling nightmares, association with bad companions, truancy and alcohol and drug use. In a sample of 50 children, the most common problem again was nightmares (40%). This survey confirmed the under-reporting of problems in client files found in previous studies. Much lower levels of self-reported psychological symptoms and behaviours were found on intake forms used by patients at the community health clinic than when people were asked similar questions by local interviewers. For example, while 31% of the adult sample reported problems with alcohol or drug use by self or spouse, only 14% of the adult clinic patients reported such use; whereas 38% reported depression in the community survey, only 10% of the adult clinic sample self-reported such feelings. Clinic patients were drawn from the same population as the interviewed sample, therefore it is unlikely that their emotional distress or use of alcohol would be lower than the interviewed sample. Indeed, since the clinic patients were seeking medical help, we would expect their reported levels to be higher. Clearly, problems are extremely prevalent and significantly under-reported in the clinic setting.

Data pertaining to Native children's mental health are scant (Beiser, 1981). Opportunities to collect information have been lost because of the difficulties of preparing culturally appropriate instruments. For example, in the Ontario Child Health Survey, it was decided to exclude Native communities owing to the lack of standardization of instruments on these populations (Armstrong, 1993). This is currently being rectified with studies conducted by the same researchers in some Native communities (Wattie, 1993).

Indian adolescents have almost five times greater risk for emotional disorder than do their non-Indian counterparts in the general population (Beiser & Attneave, 1982). In addition to bearing much of the brunt of culture change, adolescents have been exposed to specific stressors which have a negative impact, both during adolescence and in later life. The profoundly negative effects of boarding schools on Native American mental health have been increasingly recognized in recent years (Harvey et al., 1976; Kleinfeld & Bloom, 1977; Lomawaima, 1993).

A health survey of Indian boarding school students was launched by the U.S. National Center for American Indian and Alaska Native Mental Health Research (NCAIANMHR) in 1988 to determine the incidence and prevalence of symptoms of depression, anxiety, suicidal behaviour and substance abuse among Indian students living away from home. It also aimed to clarify the relative contributions of coping strategies, social support, and self-esteem to symptomatic distress (Dick et al., 1993; King et al., 1992). Subjects were screened with the Suicidal Ideation Questionnaire (Dick et al., *in press*). Diagnoses were ascertained by interview with the DISC (version 2.1c) in a subsample of the youth who scored in the first and third quartile on the self-report questionnaires. The most common diagnoses were conduct disorder (18%), major depression (15%) and alcohol dependence (13%). In both high and moderately distressed groups, 25% of respondents indicated they had made a previous suicide attempt and 40% of these had made an attempt within the last 6 months. More than 60% of students reported they had witnessed or experienced at least one traumatic event, although these most often involved someone other than the respondent.

The Flower of Two Soils Study (Beiser et al., 1993; Sack et al., 1987; *in press*) was designed to examine the relationship between school performance and emotional distress among children in four Indian communities, representing a range of cultural areas: Northern Plains, Southwest, Eastern Woodlands and Northwest Coast. Two of the communities are in Canada. The study design involved the longitudinal collection of self-report measures from children, as well as observational reports from teachers and parents. Measures included depression, anxiety, attention deficit disorder, conduct, self-esteem, community allegiance, intelligence (WISC), achievement, developmental histories and social and family background. This study obtained an exceptionally rich corpus of data, much of which apparently has not yet been analyzed or published.

The Flower of Two Soils Reinterview study was conducted by the NCAIANMHR in 1991 with the 251 Northern Plains children who took part in the earlier study. At the time of the initial study they were aged 8-10 and for the reinterview 11-18

years. Unfortunately, only 109 children were successfully followed up (i.e., 43%). Subjects received the DISC at time 1 and the DISC 2.1C with a PTSD module on follow-up. Fully 43% of the respondents received a diagnosis of at least one DSM-III-R disorder. The most frequent diagnoses were disruptive behaviour disorders 22% (including conduct disorder 9.5%), substance use disorders 18.4% (including alcohol dependence, 9.2%), anxiety disorders 17.4%, affective disorders 9.3% (including Major Depression, 6.5%), PTSD 5%. Rates of comorbidity were very high with almost half of those with behaviour or affective disorders meeting criteria for a substance use disorder. Almost 2/3 of respondents reported having experienced a traumatic event and of these, 2/3 had experienced two or more such events. The most frequent events were car accidents (25/109) and death or suicide (29/109).

2.2.1 *Discussion*

Most of these reports do not include standardized diagnostic assessments, or else use older, less reliable diagnostic criteria, and consequently do not meet the scientific standards of current epidemiology. As O'Nell (1989) noted, the discrepancies found in prevalence rates between the early studies may reflect: (1) true differences across the populations; (2) distortion produced by unreliable measures; (3) the result of culturally invalid standards and methods of assessment. Recent epidemiological surveys undertaken by the Province of Québec among the Cree and Inuit have used a brief measure of generalized emotional distress, questions about suicidal ideation and attempts, and a few questions about people with chronic mental illness within the family. These methods can give only a very crude estimate of the level of distress in the population and provide little information about specific disorders or service needs.

These studies also do not provide a sense of the connections between Western-based psychiatric diagnosis and local understanding of disorder and impairment, the usual concomitant of mental illness. This type of information about social context and course is crucial to evaluating possible contributing factors to distress and developing appropriate intervention strategies (Good, *unpublished*; Kleinman, 1988). More recent studies have made a greater effort to assess and convey features of the social context of distress but the techniques of epidemiology are ill-suited to giving this fuller portrait.

2.3 Specific Psychiatric Disorders

In this section we summarize information pertinent to the study of specific psychiatric disorders among Canadian Aboriginal peoples. Although forms of distress commonly co-occur (often referred to as "comorbidity"), a focus on specific disorders is useful because of the considerable effort within psychiatric research to develop specific treatments for specific types of problems. Accordingly, we will briefly summarize current opinion about the range of treatments viewed as useful and appropriate for these disorders. In most cases, very little has been done on these problems within the Native population so that we draw on the wider cross-cultural literature to suggest areas likely to be important for future research.

2.3.1 *Schizophrenia*

The prevalence of schizophrenia was probably overestimated in early clinical and epidemiological studies because of the tendency for North American psychiatrists to misdiagnose bipolar affective disorder as schizophrenia. This bias changed in the seventies due to the influential results of a British–U.S. comparative study (Cooper et al., 1972). However, diagnostic biases with specific ethnic groups may still exist (Good, 1993b; Littlewood, 1993; Lopez, 1989). Since the standard treatment for schizophrenia is neuroleptic medication which carries a risk of tardive dyskinesia (a syndrome of involuntary movements), while the treatment for bipolar disorder is usually lithium (with less risk of serious side effects), the possibility of any diagnostic bias in this area is of considerable practical importance.

While schizophrenia is now generally held to be found in most populations, cross-national studies have revealed important cultural differences in symptomatology, course and outcome (Jablensky et al., 1991). In some cultural groups, somatic symptoms may be common presenting complaints of schizophrenia and harbingers of relapse. Leff (1988) has argued that the catatonic form of schizophrenia which is more common in South Asia represents a sort of somatization of psychosis.

Most striking is the finding that schizophrenia has a better outcome in developing countries compared to industrialized nations (Jablensky et al., 1991). This may be related to social factors in the developing world: (1) a greater prevalence of brief reactive psychoses with good outcomes; (2) better social integration and less stigmatization of psychotic individuals; (3) less competitiveness and materialism in everyday lifestyle; (4) less emphasis on wage earning employment; and (5) availability of religious interpretations and practices that allow integration of psychotic experiences (Lin & Kleinman, 1988).

Hostility, criticism or negative expressed emotion within the family are known to contribute to the risk for relapse in young male schizophrenics (Leff & Vaughn, 1985). Psychoeducational treatments are aimed at mitigating this family environment. Most recently, it has been proposed that cultural differences in the interpretation of schizophrenic illness may lead families to adopt a less critical,

more accepting stance toward the afflicted member who thus experiences less negative expressed emotion (Jenkins & Karno, 1992).

The adaptation of people with schizophrenia has much to do with their ability to reconstruct a coherent sense of self (Davidson & Strauss, 1992). Corin (1991; Corin & Lauzon, 1992) has shown how this may occur in an urban context where individuals lack a traditional framework to integrate their psychotic experiences. Cultural factors may influence insight in psychosis and so affect willingness to comply with treatment (Kirmayer and Corin, *in press*). In particular, spiritual, religious or moral explanations for psychosis may be more prevalent in some communities and offer interpretations at variance with biomedical views. This may lead clinicians to attribute a greater degree of psychosis or personality dysfunction to the schizophrenic individual. On the other hand, socially shared explanations for psychosis may also give meaning to inchoate experience and help to protect the afflicted individual from the damaging effects of having an inexplicable illness.

Notwithstanding a general tendency for acceptance and non-interference, tolerance of psychotic behaviour probably interacts with social roles and gender in most communities. For example, among the Navajo, Levy (1983, reported in Kunitz, 1983) found that men with schizophrenia tended to be hospitalized when they were threatening violence while women were brought to hospital when they became withdrawn and unable to perform their household chores.

There is evidence that social stigma adversely affects the course of schizophrenia. Raybeck (1988; 1991) has suggested that stigma may be less in small communities where people are reluctant to label and reject others. In the case of Native peoples, this stigma may differ markedly among Native communities based both on their size, history, structure and cultural beliefs and practices (Thompson et al., 1993). It is further complicated by the functions that deviant roles may play in the social cohesion and transactions of small-scale communities (Savishinsky, 1991). Potential stigma may be compounded for those Native people with psychiatric disorders living in urban settings who face racism and stigmatization as a visible minority.

There is also evidence that the prevalence and course of schizophrenia varies with the level of employment in a society. The high levels of unemployment in most Native communities might then be expected to contribute to a relatively poorer prognosis for schizophrenia. However, in many Native communities, individuals who are ‘unemployed’ in the wage-earning sector of the local economy, may nevertheless occupy privileged and respected positions within the community. Such roles may be sources both of esteem and stress. Research on social factors in mental illness then must attend to more locally relevant definitions of social status, occupation and integration in the community.

Treatment programs for schizophrenia involve medication, education of patients and their families and social and occupational rehabilitation aimed at maintaining integration within the community (Falloon & Fadden, 1993). Patients may require hospitalization when severely ill but benefit from day-

hospitals or supervised settings and, if these ambulatory programmes are readily available, hospitalization can often be avoided.

2.3.2 Bipolar Disorder

Armstrong (1993) claims that bipolar disorder (manic-depressive illness) is rare among Native Indian populations. In contrast, Sampath (1974) observed high levels in an Inuit community on Baffin Island. This research was conducted before criteria distinguishing between schizophrenia and bipolar disorder were sharpened in the late 1970s. Our own recent clinical experience among the Inuit of Québec indicates levels of both schizophrenia and bipolar disorder comparable to those of southern populations (Kirmayer, *unpublished data*). Note, however, that the sharp distinction between schizophrenia and bipolar disorder remains problematic because there are intermediate forms (e.g. schizoaffective disorders), familial associations, and some patients shift their diagnostic picture when followed over time (Blacker & Tsuang, 1992).

There is also evidence of significant under-diagnosis of bipolar disorder among certain ethnic groups in the U.S. due to clinicians' biases. For example, affective disorders appear to be under-diagnosed among Black Americans, perhaps because of a tendency to misinterpret paranoid ideas that simply reflect the realities of facing routinized racism and occupying a disadvantaged position in society (Loring & Powell, 1988; Neighbors et al., 1989). In some groups, hallucinations and other dissociative phenomena may be more common and may be misdiagnosed as psychotic. Among some Southwestern Amerindian groups (e.g., the Hopi), hallucinations commonly accompany grieving and may be misinterpreted as indicating psychotic depression or other disorders by uninformed clinicians (Matchett, 1972; Shen, 1986). It is possible that similar diagnostic problems occur with Canadian Aboriginal groups but there is no research to date that bears directly on this.

Since bipolar disorder appears to have the strongest genetic predisposition of any major psychiatric disorder, it is possible that local fluctuations in the gene pool of an isolated group could result in higher prevalence in some communities. Given how small many Native communities are, it would only take one or two affected families to significantly change the rate.

Both mania and depression, and milder mood fluctuations, have been linked to seasonal changes in the intensity of sunlight and the length of the day (Eastwood & Peter, 1988; Fossey & Shapiro 1992; Wehr et al., 1987). Given that many Aboriginal peoples live at higher latitudes, such seasonal affective disorder may play a significant role in triggering bipolar disorder and depression (Hansen et al., 1987; Nayha, 1985). Variations in length of day may also contribute to seasonal variations in milder mood disturbances, interpersonal conflict and disease susceptibility (Condon, 1982; 1983). This points toward the possibility of treating some mood disorders with artificial bright light to extend the effective hours of daylight—a treatment that is very appealing because its physiological rationale involves resetting a system through mimicking a natural environmental

process rather than with exogenous pharmacological agents (Hellekson et al., 1986). Parenthetically, the focus on seasonal affective disorders and the importance of light is consonant with Aboriginal values that recognize the close relationship between well being and the relationship to the environment.

Just as with schizophrenia, expressed emotion or family affective style appears to influence the course and the likelihood of recurrences of affective disorder (Miklowitz et al., 1988). Given differences in Aboriginal expressive styles and modes of explaining and responding to mental disorder, this may be a significant factor in the course of illness and should be further investigated.

2.3.3 *Depression*

'Depression' is both a lay term for any state of demoralization, discouragement and "low" mood and, as 'major depressive disorder', a specific psychiatric syndrome. The relationship between milder forms of depressed mood and the clinical syndrome of depression is complex. Distinguishing among mood, symptom and disorder is a complex issue and there is much evidence that depression is culturally shaped (Kleinman & Good, 1985).

There is general consensus that there are high rates of major depressive disorder among Native groups although epidemiological data are limited (Medical Services Branch, 1991, p. 26). A recent survey of leaders of 57 reserves in Manitoba found that 47% of respondents perceived depression was a serious problem in their community (Rodgers & Abas, 1986; cited in Armstrong, 1993, p. 224). To some extent, this may reflect the use of depression as a common term for a wide range of feelings of demoralization.

Manson, Shore and Bloom (1985) reported that the prevalence of depression in selected Indian communities may be 4 to 6 times higher than in the studies noted above. In a pilot study using the SADS-L with 86 patients from three tribes, Shore et al. (1987) identified three contexts of DSM-III major depression: (1) uncomplicated; (2) associated with alcoholism; (3) superimposed on dysthymia (chronic depression) or personality disorder. Symptoms were similar to those described for non-Native populations except for more frequent reporting of hallucinatory phenomena in some Southwestern tribes.

Research on the treatment of depression supports the value of both antidepressant medication and psychotherapy (interpersonal or cognitive behavioural therapies) (Elkin et al., 1989). However, it suggests that the chances of recurrence are substantial and prolonged treatment and follow-up are essential for a good outcome (Frank et al., 1991).

Recently, attention has been given to the many patients seen in primary care who do not fit criteria for either depression or anxiety but who suffer from a mix of symptoms. A mixed depression-anxiety syndrome has been identified and there is a need for studies on its course and appropriate treatment (Katon & Roy-Byrne, 1991).

There is much evidence that depression and anxiety are substantially under-recognized and under-treated in primary care. Only about 50% of cases of major depression are recognized as such in primary care (Schulberg, 1991). In part, this is due to a widespread tendency (among all ethnic groups) to somatize distress—that is, to express anxiety or depression in terms of somatic symptoms. Compared to patients presenting with frank psychological or social complaints, somatized clinical presentations reduce rates of recognition of depression by 1/3 to 1/10 (Kirmayer et al., 1993).

Specific instruments have been devised to measure depression in American Indian populations. These include the Depression Index Scale (Manson et al., 1985) and the American Indian Depression Scale (Shore & Manson, 1981). More recently, Manson (1991) and colleagues have validated the Center for Epidemiological Studies Depression Scale (CES-D) among American Indian groups. To date, three studies have examined the CES-D in American Indian samples (Baron et al., 1990; Beals, *in press*; Manson et al., 1990) In general, factor analytic studies suggest that depression and somatic symptoms tend to be collapsed into a broad general dimension of distress among Indians compared to the general population. This might contribute to a tendency to somatize distress. There is a need to study the effectiveness of measures like the CES-D in screening for depression in primary care among Aboriginal peoples and, most importantly, to see whether patients identified and treated truly have a better outcome. Studies of this type are underway in the U.S. (P. Somervell, *personal communication*).

2.3.4 *Anxiety Disorders & PTSD*

There is much evidence for cultural variations in anxiety disorders (Guarnaccia & Kirmayer, *in press*). The perception of an event as threatening involves cognitive evaluations which are based on cultural knowledge. In many communities, notions of spirits, witches and malign magic may still be prevalent and causes of significant fear (Carpenter, 1953; Walker, 1989). As well, conditions of disadvantage and oppression may make individuals fearful of their own safety and future prospects.

Brant (1990) has claimed that due to selective migration to the cities, Amerindians still on reservations have a high proportion of individuals who are temperamentally shy or inhibited. This would predispose individuals to social anxiety and other problems related to behavioural inhibition (cf. Kagan, 1989). Brant did not support this claim with any empirical data. It is predicated on a selective migration and isolation of populations that does not agree with the facts of frequent movement back and forth between reservations and cities, as well as intermarriage and exchange between communities. It also assumes an unrealistically short time scale for changes in the frequency of temperamental traits in populations. Finally, it is clear from the same studies that have established the heritability of temperamental traits that such traits are polygenic and highly influenced by environmental factors (Tellegen et al., 1988). This implies that such rapid modification within a population by selection is extremely unlikely. Lock (1993a) notes that these ideas, based on the biological

orientation of much current psychiatry, are reductionistic and could be used to justify discriminatory practices.

Recently, much attention has been focused on the possibility that many Aboriginal people suffer from trauma-related disorders (Manson et al., *unpublished*; Robin et al., *unpublished*). In some communities, family violence, sexual and physical abuse may be common (Fischler, 1985) and individuals have high rates of exposure to violent death which increases the risk of developing a Post-traumatic Stress Disorder (PTSD). Native communities have also faced long-standing stress in the form of suppression of traditional lifeways, dislocation of whole communities, and childhood separation from families with virtual incarceration in residential schools (Frideres, 1993; Dickason, 1992; Wadden, 1991; York, 1990). All of these factors contribute to both high levels of individually experienced trauma and a backdrop of shared cultural or communal traumatization which both intensifies and alters the meaning of individual trauma and loss. Precisely how these collective and individual problems interact is a matter requiring close study.

A series of studies by the U.S. NCAIANMHR address a wide range of cultural issues in the diagnosis and treatment of PTSD and other trauma related disorders (Manson et al., *in press*). Ongoing studies using combined epidemiological, psychometric and ethnographic methods are exploring the following issues: the definition and perception of trauma; the frequency of traumatic events in Native populations; the relevance and fit of the DSM criteria for PTSD; performance characteristics of self-report and interview schedules for screening and diagnosis; symptom patterns and prevalence of PTSD; comorbidity of PTSD with other psychiatric disorders; developmental precursors and mediators of risk for PTSD; domains of functioning and impairment; traditional and biomedical treatment and prevention strategies; and collective representations of and responses to traumatic stress. The researchers maintain that trauma-related and individual and community vulnerability models are not mutually exclusive and can, in fact, be combined to yield a more comprehensive approach that identifies and intervenes at multiple levels.

The American Indian Vietnam Veterans Project (AIVVP) was set up to study the impact of the Vietnam war on minority veterans who were not adequately addressed in the earlier National Vietnam Veterans Readjustment Study. Manson and colleagues (*in press*) note that significant issues in American Indian life experience that have been neglected in much mainstream epidemiological work with respect to PTSD include: racial discrimination, identification with the enemy, ethnic affiliation, and salience of the warrior image as an aspect of the self.

The notion of disorders as trauma-related is appealing because it performs three simplifications: (1) *scientifically*, it implies a single, unidirectional cause from trauma to specific symptoms; (2) *clinically*, it mandates a focus on recovering, disclosing, reliving and transforming traumatic memories; (3) *morally*, it absolves the individual of culpability for their problems and attributes problems to external factors (Kirmayer, *in press*; Young, 1990, *in press*). However most

research on PTSD reveals an interaction between premorbid characteristics (e.g., level of generalized anxiety or past history of depression and panic disorder, as well as personality disorder, substance abuse and other problems) and the tendency to respond to a traumatic event with persistent symptoms of intrusive images and thoughts, anxiety, emotional numbing and functional impairment (McFarlane, 1993).

2.3.5 *Somatization and Dissociation*

It has been claimed that somatization is more common in many ethnic groups including Amerindians. In fact, somatization is common in all groups; there is little evidence to support a higher prevalence of somatization or somatoform disorders in specific ethnic groups (Kirmayer & Weiss, *in press*). As noted above, factor analytic studies of the CES-D suggest that somatic symptoms of depression and cognitive-emotional symptoms are very closely related among Native peoples in a generalized distress dimension which may lead to predominately somatic clinical presentations.

Many Aboriginals living in remote communities underwent prolonged childhood hospitalizations for illness. These involved long separations from their families. Nursing and hospital staff became surrogate parents. In some cases, this may have led vulnerable individuals to experience either great hostility toward non-Native health care workers, or to view the health care providers as nurturant figures who are turned to in times of stress in adult life. In Australia, Bianchi and colleagues (1970) described the “dispensary syndrome” where Aboriginals who had received medical care in childhood were overly preoccupied with and anxious about their bodies and suffered a variety of medically unexplained physical symptoms which necessitated their turning to doctors and nurses for care and attention. This form of somatization may be one unfortunate consequence of the traumatic separations endured by Aboriginal children as a consequence of the lack of adequate local medical care. For example, “by the mid-fifties and early sixties the Inuit had the highest rate of tuberculosis in the world; according to anthropologist Robert Williamson, by 1964 more than 70% of Keewatin Inuit had been in sanatoria for periods ranging from three months to nine years” (Dickason, 1992, p. 397). This prolonged dependence on health care personnel and institutions is likely to have had adverse effects on some individuals.

Dissociative phenomena (which include functional alterations in perception, memory and identity) appear to have been a prominent part of traditional shamanistic religious and healing practices (Hultkrantz, 1992). Foulks (1980) has argued that, among the Inuit, ritually prescribed dissociation fulfilled psychological and social functions which were taken over by alcohol in recent times. Contemporary psychiatric nosology tends to view dissociation as inherently pathological and ascribes it to traumatic experiences, especially severe physical and sexual abuse during childhood (Spiegel, 1991). As such, evidence of dissociation is *prima facie* evidence of having been traumatized. In fact, however, dissociative experiences are extremely common and, in most parts of the world,

viewed as positive elements of religious practice or ritual performance. Pentecostal and other religious movements among some Aboriginal groups may encourage dissociative experiences which have an emotionally cathartic and healing function. Many traditional religious practices may also promote dissociation and use of imagery and imagination in ways that have been neglected by psychiatry. In some cases, these experiences may be misinterpreted as pathology by clinicians unfamiliar with local religious practices and with the role of dissociation.

On the other hand, in some communities, dissociative phenomena may be attributed to serious illness and carry a grave prognosis. Among the Navajo, Kunitz (1983) found that 'mind loss' characterized by faints, dissociative reactions and seizures were thought to be the final stage of all disease and hence, mental illness carried the connotations of a grave, incurable and end-stage illness. This led to reluctance to pursue or accept psychiatric treatment.

2.3.6 *Adjustment Disorders and Grief Reactions*

Prince (1993) has emphasized the importance of pathological grief reactions among the Cree of Northern Québec. He sees cultural styles of emotional expression as inhibiting the expression of grief brought on by many individual and communal losses experienced as a result of community dislocation, violence and psychiatric illness.

There is evidence for marked cultural variation in grieving practices, with many cultures prescribing elaborate and formal mourning rituals while some minimize or suppress open expression of loss (Eisenbruch, 1984). These practices vary across Aboriginal groups by virtue of past tradition and current Christian and secular psychology influences. In mental health practice, therapies directed at promoting normal grieving based on work with dying patients and bereaved families have been widely accepted (Melges & DeMaso, 1980; Worden, 1983). Although the normative models of grieving derived from this work are widely viewed as the "natural" response to loss, the impact of these on health cross-culturally may be complex. In some situations, when norms for the expression of grief contravene local norms for emotional expression, health care providers who promote what they perceive to be healthy grieving may also be provoking interpersonal and community conflicts. Models of 'grief work' that involve whole communities may fit better in some ways with traditional values. However, these approaches have their own dilemmas in that collective grieving may create shared convictions about the nature of problems that do not take into account individual variations.

Eisenbruch (1991) has argued that in the case of traumatized populations (his example is Cambodian refugees) the notion of individual grief and PTSD is inadequate to capture the social reality and lived experience. He proposes instead the construct of "cultural bereavement"—the experience of loss of cultural institutions, lifeways and communal context. This represents an ongoing loss that cannot be mastered by individuals alone; its healing requires acknowledgment of the disruption of community and, ultimately, collective

restitution and repair. He has developed a research instrument for examining the dimensions and degree of cultural loss and bereavement experience by refugee populations that could be adapted to the predicament of Aboriginal populations (Eisenbruch, 1990a).

2.3.7 *Personality and Conduct Disorders*

Personality disorders involve enduring patterns of maladaptive behaviour. They are related to exaggerations or extremes of temperamental traits which interact with social learning and environmental stress or trauma (Paris, 1993). They are currently diagnosed with operationalized criteria based primarily on specific behavioural patterns. Because they are associated with characterological traits, diagnoses of personality disorders have carried a weight of therapeutic pessimism, even nihilism. Patients with personality disorders have been viewed as untreatable and the diagnostic label has served largely pejorative and dismissive functions within the mental health care system—all too often, labelling someone with a personality disorder is a way of dismissing them as untreatable and absolving the clinician of further efforts to help.

In recent years, more focused cognitive-behavioural methods for the treatment of personality disorders have been devised and these show real promise in helping a wide range of patients heretofore considered difficult if not impossible to treat (Benjamin, 1993; Linehan, 1993). As well, milieu and social treatments for personality disorders have long been considered viable, if expensive alternatives.

There are serious difficulties with applying personality disorder constructs to Aboriginal peoples. Neligh (1988b) questioned the validity of personality disorder diagnoses among Natives. Certain behaviours which count as criteria for the diagnosis are endemic in Aboriginal communities. Antisocial behaviour, for example, defined as criminal activity, may be frequent and related as much to economic factors, substance abuse and the local norms.

Two alternative views present themselves: on the one hand, we may view the severe social problems and deprivations faced by many Aboriginal communities as resulting in a high prevalence of personality disorders. In favour of this view is the fact that many Aboriginals have endured severe traumas related to forcible separation from their families, hostile school and institutional environments and other forms of harm. Such severe treatment might be expected to leave lasting injuries in capacities for trust, self-esteem, the regulation of mood and the control of aggression and other impulses. This view would suggest that individual therapeutic interventions are likely to be of limited value when scars are so deep. Social interventions would be more likely to be of help in this situation. On the other hand, we may reject the applicability of the personality disorder label when the causes of problems are obviously social and when neither individual nor social remedies have yet been adequately tried.

People who are trapped in situations of prolonged and repetitive abuse with no possibility of escape are liable to a wide range of damaging effects including persistent feelings of helplessness, self-hatred and self-defeating and self-

injurious behaviour (Briere, 1993). Herman (1992a,b) has pointed to the apparent changes in personality that occur in such situations that impair an individual's ability to make wise choices even when opportunities for escape and healing are finally available. Countering this self-perpetuating defeated stance requires explicit attention to the problem and major efforts at remoralization which usually include renewed connection and belonging to a community that acknowledges past wrongs and is committed to supporting and empowering the individual.

This situation and prescription, described by Herman for complex PTSD, seems applicable to the predicament of some Aboriginal people who, by virtue of the isolation of their communities, poverty and lack of resources have been trapped in abusive relationships. The intensity and extent of the damage wrought by abuse is amplified by the lack of any opportunity to escape, as well as by the perception of the systematic denigration and suppression of Native cultures in the larger social world.

2.3.8 *Developmental Disorders*

Inadequate prenatal nutrition and care, and maternal alcohol use may both contribute to high rates of developmental disorders in some Aboriginal communities. The epidemiology of specific forms of intellectual handicap has relied on medical markers rather than behavioural assessments (Fryer, 1990). Fetal alcohol syndrome may be a particular problem in communities where alcohol abuse is widespread (Plaiser, 1989). The most effective prevention is undoubtedly improved prenatal care with abstention from alcohol, good nutrition, and supportive relationships (Beitchman, Inglis & Schachter, 1992a). The goals of maintaining integration in the community, supporting families as caregivers and reducing stigmatization parallel the goals for other psychiatric disorders. However, most Aboriginal peoples clearly recognize a difference between a constitutional intellectual deficit and other forms of mental or behavioural disorder. Specific programs for developmentally disabled children are best dealt with in the context of educational programs.

2.4 Family Violence, Abuse and Neglect

Using data drawn from the U.S. National Family Violence Resurvey (Straus & Gelles, 1990), Bachman (1992) examined the rate of family violence in a subsample of 204 American Indian families. In 1984, the year prior to the study interview, 15.2% of the American Indian group had experienced a violent conflict in the family and for 3.2% of respondents the physical violence was severe. This compares to 14.8% and 3%, respectively, among a white sample. When economic deprivation, age and urbanicity were controlled in logistic regression models, alcohol consumption and self-perceived stress were independent predictors of increased risk for violence. Bachman notes that these data are tentative, since they involve a small sample and imprecise measures, but suggests that the rates represent a lower bound. She quotes Straus (1986) to the effect that "what we know about Indian families is fragmented, anecdotal, descriptive, and often

overpowered by poor understanding of the particular cultures being studied" (Bachman, p. 107). From participant observer studies, Bachman describes the typical pattern of violence as a husband or boyfriend going out and getting drunk with friends, becoming angry due to "faulty assumptions," leading to a jealous rage and then assaulting his partner.

The recognition of sexually abused children in the general U.S. population increased from 6,000 reports in 1976 to 132,000 in 1986 (Conte, 1991; Gelles & Conte, 1990). For research and legal purposes, sexual abuse is generally defined along three dimensions: (1) an age difference of greater than 5 years between child and offender; (2) specifically sexual behaviour; (3) sexual intent. Prevalence estimates of sexual abuse in the general community vary widely across studies from 6% to 62% of females and 3% to 31% of males (Peters et al., 1986). Herman (1989) found that 10% of women report childhood sexual abuse and 1% report father-daughter incest.

Although some U.S. authors have suggested that levels of sexual abuse among Native Americans in most communities appear to be comparable to those of the general population (Fischler, 1985; Piasecki et al., 1989), other evidence suggests greatly elevated rates in some regions. The Canadian Panel on Violence Against Women, created in 1991, included an Aboriginal Circle team to address violence among status and non-status Aboriginal women. The problem of violence against Aboriginal women was examined through discussions with individuals in 139 communities across Canada in 1992 and the receipt of 800 submissions (Ministry of Supply and Services, 1993). Despite the lack of studies on the prevalence of abuse among Inuit women, police, hospital and social service reports indicated an extremely high rate of violence against women and children. The Northwest Territories (NWT) RCMP witnessed a 30% increase in wife abuse complaints between 1989 and 1990; the occupancy rate at Iqaluit's women's shelter has tripled in the past five years. These findings do not seem to be solely the result of increased reporting of abuse, as Inuit elders have testified that wife abuse has increased in prevalence when compared to the past. A NWT survey reported that nearly 50% of abused women in the north suffer the abuse in their own homes. The Canadian Panel reports that "sexual assault reports [in the NWT] are 4-5 times higher than in the rest of Canada." Those at highest risk for sexual abuse in the north, according to a study released in 1991, were females from 13-18 years old, followed by girls aged 7-12 years; almost all assailants were known to the victim. Another study reported that the average age of child abuse victims in the north was 9.7 years, while that of the abusers was 29 years.

The Canadian Panel found a "serious" lack of research on violence among Aboriginal women, particularly for Métis and women living off-reserve. The Panel reports a 1991 estimate that between 75 and 90% of women in some northern Aboriginal communities are physically abused. A survey in southern Ontario found that 71% of an urban sample and 48% of a reserve sample had been assaulted by current or past partners. A NWT survey found that 80% of girls and 50% of boys under the age of 8 were sexually abused.

A second Canadian source of abuse statistics among Aboriginal peoples comes from a survey carried out by the Ontario Native Women's Association (1989) as part of the Aboriginal Family Violence Project. A total of 104 completed questionnaires were received, nearly half from individuals residing on Ontario reserves. Eighty-four percent indicated that family violence took place in their community; an even more striking result was that 80% of respondents reported personal experience of family violence, approximately 8 times the rate estimated for Canadian women in society as a whole. The most frequently abused persons in a family context were women (88%) followed by children (51%); 84% of the time the husband was identified as the abuser. The kinds of abuse identified as features of family violence were mental and emotional (89%), physical (87%), and sexual (57%). A high percentage of respondents (78%) indicated that more than one family member suffered regular abuse.

Research in the general population indicates that the majority of sexual abuse is initiated when children are less than seven years old; 70% of abuse takes place more than once. Many offenders engage in more than one type of sexual deviancy. For example, up to 50% of fathers referred to a clinic for incest also abused children outside the home.

At present, it is not clear what factors increase a child's risk except female gender, separation from mother and poor relationship with mother (these last two may be consequences rather than risk factors). While some have characterized abused children as needy and emotionally deprived from a troubled family, Finkelhor (1988) found that abused children tended to be more attractive and intelligent than non-abused.

Physical signs of abuse include injury (often not found) and sexually transmitted diseases (which should give very high index of suspicion) (Krugman, 1991). Preschool children are more likely to present with behavioural rather than physical symptoms and disclosure of the abuse is likely to be accidental. The only relatively specific behavioural symptom is sexualization. Pathological effects of abuse span the gamut of symptoms and problems: aggression, hyperactivity, antisocial behaviour, social withdrawal, sensitivity, fear, inhibition, academic disability, immaturity, learning disability, somatic symptoms, low self-esteem or depression and symptoms of PTSD. Somatic symptoms include muscle tension, gastrointestinal and genitourinary difficulties. About 20% of abused children may be asymptomatic. Early abuse may predispose people to depression in later life (Bifulco, Brown & Adler, 1991).

Prevention programs have been developed for schools and generally consist of teaching children that: (1) they own their body and therefore can control access to their body; (2) there is a continuum of touch and different kinds of touch; (3) there are secrets about touching that should be told to others; (4) who they can and should tell (i.e., who their support system is); (5) to trust their feelings when a situation feels uncomfortable; (6) to say "No," get away from the situation, and tell someone and keep telling until it stops (this may be a cultural issue) (Wurtele, 1987). However, these programs can be distressing if not presented in a sensitive manner (Trudell & Whatley, 1988).

There is also a need to address internal and external prohibitions for perpetrators and to sensitize guardians to recognize signs of abuse and protect children from potentially abusive situations. Applying social sanctions against abusers may be problematic in some Aboriginal communities where an ethic of non-interference discourages open confrontation (Brant, 1990).

Abused children have been terrorized and rendered helpless, so they cannot say "No." They tend to blame themselves for the events and any subsequent disruption of the family (Shapiro, 1989). Treatment aims to restore their sense of safety and control (Dickstein, Hinz & Eth, 1991). Family intervention is essential to restore a sense of boundaries and safety (Everstine & Everstine, 1989). Assertiveness training has been advocated as having an important role to play in treatment and prevention. However, in many Aboriginal traditions, children are encouraged to be deferent and not to oppose adults or elders; traditional child-rearing and social control relied more on modelling than on overt social sanctions. This poses a problem for methods of therapy or intervention that are explicit and directive. Group therapy may be particularly helpful for adolescents and adult survivors and may also be used with preadolescents (Kitcher & Bell, 1989).

False accusations of abuse can occur but generally constitute less than 6-8% of cases (fewer where child's report is spontaneous; more where it is prompted by questions from a parent engaged in a custody battle or other struggle with their partner) (Yates, 1991). Young children are more suggestible than adults. There is a need to avoid excessive or exclusive interest in details of abuse since this can promote confabulation (Klajner-Diamond et al., 1987; Wehrspan et al., 1987).

Much work on physical and sexual abuse, as well as family violence emphasizes the impact of poverty, social isolation, demoralization and alcohol and substance abuse. These factors also appear to contribute to abuse in Native communities (Bachman, 1992).

In a report on 10 cases of physical abuse culled from ethnographic work among the Inuit, Graburn (1987) notes that all of the children were developmentally abnormal—either because of cultural isolation through hospitalization or an apparent congenital developmental disorder. Among the Inuit, the slow to learn or disabled usually are treated with extra kindness and attention. However, parental psychopathology and social stress in these families, combined with cultural practices of teasing, diversion of aggression and non-interference, led to persistent severe abuse.

Even where families are consistently abusive or neglectful, it is crucial to avoid taking the child out of the community if possible. A great deal of damage has been done by social welfare agencies removing children from their families and arranging foster care or adoption in distant places where there is no cultural continuity. In Manitoba, this policy amounted to virtual genocide (Johnston, 1983; York, 1990). Shore (1978) argues that when the biological family is irreparable and estranged, Native children should be placed with extended

family members rather than other non-Aboriginal foster families, so that the cultural identity needs of these children during adolescence will be looked after and the integrity of Indian families will be protected.

The emphasis on sexual and physical trauma in recent popular psychology raises special problems. Certainly, it represents a liberation movement of tremendous importance that empowers the oppressed. Attention to the wide prevalence of sexual and physical abuse of children and women has made it possible for the first time for many to confront and escape from their tormentors. It also allows individuals in psychotherapy to make sense of their emotional troubles and to reconstruct a coherent story out of a painful past.

It is important to recognize, however, that trauma does not explain everything and framing problems exclusively in these terms may lead to inadequate diagnosis and response to both individual and social problems.
There is evidence that memories of trauma can be repressed or dissociated and hence remain inaccessible to consciousness until people are ready and encouraged to confront them. There is also evidence that personal memory is inaccurate, malleable and easily confabulated. As a result, current enthusiasm for trauma explanations can contribute to personal and social confusion about the true sources of problems. In small communities, in particular, there is a significant risk of a witch-hunt in which fears and rumors about abuse snowball into accusations which are accepted as truths without material evidence. Far from leading to justice and healing for a community, such a process could harm everyone. In recent years, this appears to have happened in several non-Native communities.

This dilemma remains unresolved at present. Certainly, the likelihood of trauma and abuse going unrecognized and untreated is still much greater than the likelihood of false accusations. The movement to recognize the pervasiveness of abuse in society at large has helped Aboriginal peoples uncover and confront the terrible episodes of abuse that have plagued residential schools, religious institutions and other settings where children and adults have been made vulnerable. Perhaps, because they are less prone to adopt an adversarial view, Aboriginal communities can avoid some of the excesses of society as a whole and protect the vulnerable while preserving extended family and community bonds.

2.5 Alcohol and Substance Abuse

Alcohol and substance abuse are the focus of other reports to the Royal Commission. However, because we believe that the field of mental health should not be divided into separate problems when these are so closely related, we present a brief overview of the issues here with an emphasis on the relationship between substance use, psychiatric disorders and positive mental health.

2.5.1 *Prevalence*

It should be stated at the outset that there are numerous stereotypes and myths such that Indians and non-Indians alike tend to overestimate the proportion of

alcoholics in any given Indian community (May, 1992). In addition, since accurate prevalence data are not available, it should be noted that most of the following discussion is based on indirect estimates of rates—usually based on mortality from various causes that are known to be alcohol (or drug) related—that are likely to have varying accuracy and validity.

The actual prevalence of “alcoholism” and other “substance abuse” in most Aboriginal communities is not known. Despite the lack of clear epidemiological evidence, it has been written that American Indians have higher rates of alcoholism and alcohol-related problems than any other minority in the U.S. (Rhoades et al., 1987). Indian alcohol-related deaths occur at more than 4 times the age-adjusted rate of the general population due to increased incidence of accidents, suicide, liver disease and cirrhosis (Rhoades et al., 1987). These data have an important message: it is not only alcoholism or substance “abuse” per se that are serious issues in Aboriginal communities; alcohol and substance “use” carry high risks for mortality as well—particularly due to accidents, suicides and homicides. This appears to be true for the Canadian population as well (Statistics Canada, 1993). These risks may relate to the pattern of consumption in certain Aboriginal communities—i.e., the tendency to sporadic, high dose binge drinking. In addition, drinking by Indians appears to be typified by blackouts, as well as a high degree of violence and physical fights when intoxicated (Manson et al., 1992). However, there have been no exhaustive studies on the prevalence of alcoholism or "heavy" binge alcohol use in various tribal groups (Lex, 1987). In general, studies which do exist point to marked heterogeneity with clear differences between the sexes as well as between tribes with regard to drinking patterns and the degree of alcohol-related mortality (Christian et al., 1989; Heath, 1985). For example, studies in Oklahoma have shown that there are wide variations in alcohol-related deaths among many of the state’s Indian tribes with the Seminole people exhibiting the lowest percentage of alcohol-related deaths. This variation will be discussed in more detail below.

Estimates of the prevalence of alcohol problems in the Aboriginal population are based on mortality figures. In Canada, injury and poisoning are the leading cause of death among status Indians and Inuit. Injuries primarily involve accidents with motor vehicles which are largely alcohol-related (Aboriginal Health in Canada, 1992). Based on a 1984 report by the Federation of Saskatchewan Indian Nations, Statistics Canada estimated that alcohol abuse levels in Aboriginal peoples were between 35-40% for adults and 10-15% for adolescents. This is a rough calculation with no information on regional or tribal differences. In addition, Statistics Canada suggested that high-volume, binge drinking was the most prevalent drinking pattern for adult Aboriginals.

In 1991, Santé Québec conducted a random survey of 400 households in nine Cree communities of James Bay. Overall, only 40% of the respondents reported occasional drinking and 9% of the males and 5% of the females were regular drinkers. These survey data are at odds with information gleaned from the "Rapport du comite interministeriel sur l'abus des drogues et de l'alcool" produced by the Québec Secretariat aux Affaires Autochtones. This survey gathered information from regional organizations (social service agencies, school

boards, local police, hospitals, health clinics, mayors and Band chiefs) from numerous villages across Quebec. The report summarized information on the extent of abuse, causes of abuse and the concrete steps taken by organizations to combat drug and alcohol abuse in these communities. The responses of these organizations provide the most compelling and complete description of the problem of alcoholism and drug abuse available in the literature.

The summary findings suggest that alcohol and drugs constitute the most serious problems in northern communities and can be considered the direct cause of family violence, suicide, violent crime, accidents and accidental deaths. Other problems cited included fetal alcohol effects and poor school performance (thought to be primarily due to the use of inhalants).

In many communities, solvent or inhalant abuse (gasoline, nail polish remover, glue, etc.) constitutes a serious problem especially among children and younger adolescents (Barnes, 1985; Byrne et al., 1991; Nurcombe et al., 1970; Oetting & Edwards, 1985; Remingston & Hoffman, 1984; Sharp et al., 1992). Inhalant abuse has been observed in children as young as six years old in some communities. Sometimes this translates into later use of alcohol, cannabis or other drugs. Unfortunately, due to the addictive potential of solvents and their tremendous toxicity, considerable permanent neurological and other organ damage may be done during a transitory period of use.

It seems clear that official surveys tend to underestimate the prevalence of substance abuse. Under-reporting of alcohol-consumption levels is also apparent in the most recent data from the Aboriginal Peoples Survey conducted in 1991 by Statistics Canada (Statistics Canada, 1993). In this survey, 14% of the individuals reporting Aboriginal identity stated that they did not drink any alcohol during the past twelve months (compared to 19% of the general Canadian population). Of those who did drink during the past year, 29.4% were occasional drinkers who drank less than once per month (compared to 18% of the general Canadian population). Of the remainder, 31% drank 1-2 times per month, 19% drank once per week, 11% drank 2-3 times per week, 4.5% drank 4-7 times per week. Unemployment was viewed as the most serious social problem (68% of respondents) closely followed by alcohol abuse (61%) and drug abuse (48%). Based on these two recent surveys, it would appear that estimates of regular drinking range from 5% in Cree females up to 34.5% when the total Canadian Aboriginal population is considered together. Yet in most Aboriginal communities in Canada, alcohol and drug abuse were ranked very high on the list of social problems.

2.5.2 *Comorbidity*

The rates of other major psychiatric disorders are known to be much higher among alcohol and substance abusers. Surveys conducted in the U.S. have shown that up to 50% of alcoholics have a comorbid psychiatric disorder (primarily affective and anxiety disorders). Westermeyer et al. (1993) recently described psychiatric comorbidity in an American Indian sample. Of 100 patients diagnosed with a substance abuse disorder, the majority also received an

additional diagnosis, primarily organic mental disorder, major depression, panic disorder or social phobia.

Psychiatric patients are also shown to have high rates of alcohol and substance abuse. In a recent study, Brady et al. (1991) found that 29% of patients admitted to an inpatient psychiatry unit met criteria for substance abuse in the 30 days prior to admission. Not surprisingly, patients tended to deny drug use upon admission. The authors concluded that substance abuse was generally under-reported and under-treated. Similarly, Gogek (1991) found, upon careful interview, that 40% of psychiatric out-patients received a diagnosis of substance abuse. It is important to note that none of these patients presented with a complaint of substance abuse.

Explanations for the relationship between substance abuse and other psychiatric disorders vary a great deal. They include neurobiological explanations which posit that drugs are powerful mood altering substances that may produce temporary or permanent alterations in the neurobiological systems involved in mood regulation. In addition, mood alterations can be the result of both intoxication and withdrawal states. Other explanations include the idea that individuals with psychiatric disorders are self-medicating their depression, anxiety or psychotic symptoms through the use of alcohol or drugs.

Though the causal relationships between comorbid disorders are not well established, they have practical implications for evaluating the prevalence of mental disorders in Aboriginal populations, as well as in determining mental health service needs and treatment.

Good (1993) warns that diagnostic difficulties or misdiagnoses are particularly likely to occur among members of ethnic minorities. Powerful cultural differences in patterns of communication, care-seeking and reporting of symptomatology contribute to these problems of diagnosis. Any research into prevalence of mental disorders and comorbidity needs to be particularly sensitive to these issues.

Reliable, comprehensive diagnostic interviews must be devised for alcohol and substance abuse as well as psychiatric disorders. Most recently, Manson and colleagues (1992) have reported that a slightly altered version of the DIS may be used in Native American populations, with the caution that diagnostic criteria related to symptom duration, severity and functional impairment must be tailored to individual populations. In addition, they recommend that particular consideration be given to patients' history of physical illness and personal losses.

Potential comorbidity should be taken into consideration when evaluating the prevalence of psychiatric disorders in Aboriginal populations. In patients with alcohol and substance abuse, it is generally agreed that detoxification followed by a period of abstinence of 4-6 weeks is necessary before psychiatric diagnoses can be confirmed. Affective and anxiety disorders frequently resolve on abstinence.

Since alcohol and substance abusers are more likely to have additional psychiatric disorders, they may require psychiatric treatment in addition to addiction treatment. This should be taken into consideration when evaluating treatment outcomes, as well as in planning service needs.

Overall medical and mental health care utilization are increased considerably in patients who have comorbid disorders. In a Canadian study, patients with major psychiatric diagnoses—in addition to drug and alcohol abuse disorders—were found to require more treatment service in terms of inpatient stay and outpatient contacts (Woogh, 1990).

2.5.3 *Social Context of Alcohol and Drug Abuse*

> "The fact that Indian alcoholism has not been made a national scandal is partly attributable to the fact that we ourselves, as a national and local Indian community, passively accept alcohol as a constant feature of modern Indian life" (JoAnn Kauffman, a member of the Nez Perce Tribe and Executive Director of the Seattle Indian Health Board).

Is it true, as some have argued, that Aboriginal people passively accept alcohol and alcoholism as a feature of their lives? On the surface it would appear that this statement is not true. Surveys of Aboriginal peoples have shown that individuals possess a substantial understanding of the negative health and social consequences of alcohol and drug abuse. In addition, surveys of Aboriginal peoples have shown that individuals perceive alcohol and drug abuse as serious problems in their communities (Santé Québec Health Survey, 1991; Aboriginal Peoples Survey, 1991).

However, it is possible that while individuals acknowledge the harmful effects of drugs and alcohol and recognize problems, communities fail to respond to the problems. Surveys of many Canadian Aboriginal communities would suggest that this is the case. For example, it was observed of the Cree, Inuit and Naskapis of Québec that

> "one factor impeding their fight against alcohol abuse is the way alcohol is perceived in the community. It has become acceptable to abuse alcohol, and society is becoming increasingly tolerant of alcohol abuse." (L'abuse des drogues et de l'alcool chez les cris, les inuit et les naskapis, 1989).

Many researchers looking at the drinking habits of various cultural groups note that the presence or absence of strong community sanctions affect drinking rates. In some Aboriginal cultures, alcohol and other substances have been given positive connotations. More often, however, where there is an apparent lack of community sanctions against alcohol, this appears to reflect a broader tendency toward tolerance of others and non-interference in their activities, even when recognized as potentially harmful: "there is a heritage of independence in thought and action and a reluctance to intervene in the lives of others" (Price, 1975). Similarly, Whittaker (1979) noted in his study of drinking practices in the Sioux that there was "a striking absence of guilt about excessive drinking and

drunkenness. Even if he or she commits a crime while intoxicated...feelings of remorse are uncommon. I believe this reflects a social norm in Sioux society that prohibits criticism of one member of the society by another..." Thus, social pressure to drink responsibly was non-existent in the Sioux communities examined by Whittaker.

The strongest case for this line of reasoning was made in a well-documented examination of tribes in Oklahoma who display very different rates of alcoholism and alcohol-related mortality (Stratton et al., 1978). The Cherokee Indians displayed a very low rate of alcohol-related deaths (6/100,000 population) and arrests compared to the Cheyenne-Arapaho Indians (296/100,000). Analysis of the history and current social organization of the two tribes supported the view that traditional cultural values, tribal institutions and social organization are important to an understanding of current drinking practices. Stratton and colleagues concluded that "tribes that have traditionally emphasized communal values and have developed political and social controls to regulate alcohol use have fewer alcohol problems."

In conclusion, it is clear from a survey of the existing literature on the drinking practices of different tribal groups, and the literature on prevention and treatment approaches, that continued emphasis on informational prevention programs aimed at individuals will not solve the problems of substance abuse in Aboriginal communities. There is no deficit of information. May (1992) and others have suggested that informational programs must be combined by *active attempts to change attitudes, beliefs, values and social structures that support and reinforce the inappropriate use of substances.* The types of programs that are now considered to be the most effective in changing alcohol and drug programs are those that incorporate these ideas and involve entire communities.

2.5.4 *Community-Based Action*

> "If deviant behavior of any type is to be effectively constrained, not only must there be strong community values regarding those behaviours, but these values must be visible and clearly communicated to everyone. In the case of drugs and alcohol there is often a reluctance to openly confront the problem and deal with it on a community wide basis. Most often the problem is assigned to some office or agency and there is very little involvement on the part of community members in general" (Beauvais and LaBoueff, 1985)

Two very useful reports in the recent literature document the importance of community-based action against drinking and drug problems in Aboriginal communities. The first was produced by Beauvais and LaBoueff (1985). The second report was published by May (1992) with commentary from many other researchers and clinicians working in the area of substance abuse—who were largely in agreement with May's evaluation of the issues.

May (1992) outlined a detailed community action approach to problems of substance abuse, based on a public health perspective. He proposed that *"the most profound and permanent social changes in public health occur from value and*

behaviour shifts in primary social groups." In other words, Aboriginal communities themselves must develop comprehensive, consistent and clearly defined alcohol prevention, intervention and treatment policies, at a local level with everyone involved sharing in the responsibility for change.

Evidence to support this position comes from many areas of public health. For example, the prevalence of smoking in adult males has dropped from a high of 50.2% in 1965 (two years after the first official warnings from the Surgeon General) to 31.5% in 1987 with a concomitant drop in death from lung cancer and emphysema. This shift reflects the gradual changes in attitudes towards smoking, societal values, and laws that came about as a result of both formal and informal changes in society (May, 1992).

Proponents of sociocultural models of alcohol abuse make an important point: it is well documented that drinking patterns as well as acceptable behaviour while “under the influence” are learned and that they can be un-learned (Heath, 1991). In order to do this, May (1992) outlined a detailed, practical and comprehensive plan for communities, listing three broad areas that need to be addressed:

(1) controlling the supply of substances (and places to use them) in the community.

(2) direct shaping of community drinking practices and attitudes towards drugs and alcohol. For example, promoting alcohol-free cultural events and arranging opportunities for bringing youth into social contact with drug-free elders.

(3) reducing the physical and social environmental risks of substance use.

May (1992) suggested that Indian tribal councils and community organizers need to debate the issues and become actively involved in a coordinated, cooperative and integrated effort involving all the major institutions in the affected communities (familial, religious, social, economic, judicial, educational and health care institutions).

The need for community-based approaches to the problems of alcohol and drug abuse has been acknowledged in numerous publications on Canadian Aboriginals (Community perspective on Health Promotion and Substance Abuse, Inuit Women's Association, 1990; Tamas, 1987; L'abuse des drogues et de l'alcool chez les cris, les inuit et les naskapis, 1989; Steering Committee, 1991).

The need for coordination of services has also been repeated many times in the reports listed above. Many reports have suggested that there are too many legal and jurisdictional problems, and too many organizations involved, resulting in considerable duplication of services. This underscores the need for change to be initiated from within communities—rather than from numerous federal, provincial and municipal agencies with conflicting agendas and a manifest lack of coordination.

2.6 Summary and Conclusion

O'Nell (1989) argues that in psychiatric investigations involving Native Americans, a universalist theoretical perspective which tends to obscure the role of local interpretations in the phenomenology of psychiatric illness dominates research. Her recommendations include: (1) the direct investigation of the local meanings of the signs, symptoms, and syndromes of Western psychiatry in order to assess their significance for American Indian populations; (2) the concentrated search for potentially unique and powerful local signs of distress, some of which may appear nowhere in Western psychiatry, in order to develop a fuller picture of psychiatric distress among these peoples, and (3) the study of the culturally-constituted social processes of illness (the expression and treatment of psychiatric disorders) among Native peoples.

The amount of money spent on programs related to alcohol and substance abuse for Aboriginal peoples is impressive. For example, the National Drug Strategy specifically targeted Canada's Aboriginal peoples for prevention and educational programs to complement the already existing activities of the National Native Alcohol and Drug Abuse Program (NNADAP). In 1992-93 the annual budget for NNADAP was $53.9 million. The $500-million Brighter Futures program for Aboriginal children was initiated in 1992. In addition, numerous provincial programs are in place. There is little known about the effectiveness of these programs and the extent to which their objectives have been met. There are numerous instances in the literature where their effectiveness has been questioned. For example, in a general discussion of programs for alcohol and drug abuse, Tamas (1987) notes that “there are serious questions about the effectiveness of many programs now operating in the country.”

Lack of extensive program evaluation is the most glaring omission in the literature surveyed for this report. There have been some evaluations of NNADAP's programs (for example, the Addiction Research Foundation did carry out an evaluation of NNADAP’s programs for the Medical Services Branch); however the documentation on these was not available to us at the time this report was prepared.

It will be necessary and important to identify some programs (prevention, community action, treatment, etc.) that have been successful in Canadian communities. For example, there are anecdotal reports of the "success" of the Alkali Lake Band in British Columbia in eliminating alcohol and drug abuse in their community. They have produced a film and run a training program called “Alkali Lake's New Directions.” Analysis of the program (i.e., of the steps taken by the community, how the change was initiated, what the important factors were in producing change in the community, and so on), can be found in two Masters theses (Furniss, 1987; Johnson, 1986) but, to our knowledge, they have not been published or received critical review.

The Canadian Aboriginal population is remarkably heterogeneous, a fact that is emphasized again and again in the literature on alcohol use and problems among Indians. This variability needs to be studied and the strengths of some

communities harnessed. This can best be approached through detailed case studies that attempt to identify the salient features of both successful and unsuccessful programs. Each community has its own unique history, relationships and current political-economic and geographical situation, but enough elements are shared in common that solutions found to work in one region can be adapted to the specific needs of different communities.

In isolated communities, individuals with major mental disorders pose special demands on limited resources. Models of half-way houses, day-hospitals and supervised settings appropriate for urban settings may be inappropriate (Falloon et al., 1993). Although Thompson and colleagues (1993) descry the lack of specific programs for partial hospitalization, transitional living, or children's residential treatment in the U.S., given the disastrous history of residential education as well as the overall movement within psychiatry toward treating people in their home communities, there is little to recommend the development of centralized, treatment programs for Aboriginal peoples. Expertise could be made available to develop local programs. Models developed for rural communities in North America, Europe and Africa may be more appropriate if adapted to the needs and resources and traditions of specific communities. These generally depend on close family and community involvement in the care of the afflicted individual. Communities must explore new methods of maintaining the integration of the chronically mentally ill. To the extent that such individuals are not labelled or stigmatized—whether because of local cultural beliefs or the small scale of the community—their illness may have a better course.

3. Prevention and Treatment of Mental Disorders

3.1 Role of Conventional Medical and Psychiatric Care

In the U.S. and Canada, much more money has gone to alcohol treatment programs than to mental health (Thompson et al., 1993). The former are generally staffed by recovering alcoholics with little or no mental health training and hence, it is doubtful whether they provide even basic psychiatric care. Levy (in Manson and Dinges, 1988, p. 86) has claimed that the Indian Health Service alcohol programs are more tribal employment programs than mental health treatment programs. NNADAP programs may serve a similar job creation function in many Aboriginal communities.

Thompson and colleagues (1993) claim that primary prevention in psychiatry is not currently useful but suggest that secondary prevention (identification and clinical intervention with individuals evidencing early symptoms of specific disorders) and tertiary prevention (aftercare services) to decrease risk of recurrence are likely to be of help (p. 202). The lack of evidence of the effectiveness of prevention is used to justify the focus of psychiatry on identifying and treating mental illness rather than promoting mental health (Munoz, Chan & Armas, 1986; Newton & Craig, 1991). However, intervention with children at home, school or clinic might be considered prevention in that long-term problems can be avoided by early recognition and treatment (Beiser & Manson, 1987; May, 1980). As well, treatment of distressed adults can have a preventative effect on children and other family members who are at risk. In any event, effective psychiatric and psychological treatment for all distressed individuals must be a mainstay of effective mental health programs.

> "The often stated belief that clinical services delivered by highly trained professionals 'don't work' with Indian people is vacuous. Such services have seldom been tried, or when tried have been underfunded, understaffed, and/or delivered with little cultural sensitivity. Neither has there been any follow-up of these or any other service delivered to Indian people to judge the efficacy of such services." (Thompson et al., 1993, p. 201).

Culturally sensitive care includes giving ample time to develop rapport; time for the person to tell his or her story; probing with discretion across cultural boundaries; and gentle confrontation so as not to recapitulate abuse suffered at the hands of authorities (Thompson et al., 1993). It requires great attention to the pervasive impact of minority status, power differentials and endemic racism, not only in society as a whole but in health care institutions and even in the therapeutic relationship (Kareem & Littlewood, 1992; Pinderhughes, 1989).

Cross-cultural work with Aboriginal peoples involves attention to differences in styles of emotional and nonverbal communications. For example, while lack of eye contact is viewed as a sign of anxiety, avoidance, psychopathology or even dishonesty in Anglo-American culture, many Aboriginal peoples (e.g., Cree) are taught to avoid direct eye contact as a sign of respect and non-confrontation of others (Darnell, 1981; Darnell & Foster, 1988). Fundamental differences in the

experience of time (e.g., Christie & Helpern, 1990) and interpersonal boundaries may also lead to inter-cultural misunderstandings with potentially serious consequences in the context of psychiatric assessment and treatment.

McShane (1987) discusses why the efforts of mental health professionals to take cultural factors into account when delivering mental health services to Indian consumers have failed. He lists five major efforts which have all suffered from theoretical shortcomings as well as problems with their implementation:

(1) Although efforts have been made by mental health care professionals to change assessment instruments so that American Indian clients are not disadvantaged (e.g., misdiagnosed), a common assumption has been made of cultural homogeneity across tribal groups. Although the modified tools may select culturally-specific values, they fail to account for how behaviours are evaluated in various tribal groups. For example, "on one reservation public drunkenness is socially permissible, making alcoholism a significant public psychosocial problem; on another reservation of a different tribal group, drinking to excess occurs expressly in private. Public drunkenness is socially unacceptable" (McShane, 1987, p.98).

(2) Efforts have been made to alter and change procedures in order not to disadvantage Indian clients. For example, flexible psychotherapy sessions which start whenever the client shows up (perhaps accompanied by family members who were not expected to join the session) and ends whenever the client feels done, have been attempted. The problem with such attempts at process adjustments is that "socioeconomic, educational, and cultural differences between the white, upper middle class, college educated mental health providers and poor, little educated Indian clients, foster ineffective efforts due to ignorance, insensitivity or miscommunication. Participants who have differing belief systems and participant structure expectations may adjust in maladaptive ways and these maladaptations may stabilize over time and become expected or 'normal'" (McShane, 1987, p.98).

(3) Another attempt involved placing indigenous workers in mental health care facilities that operate according to the Protestant work ethic and the biomedical model, so that they would act as a culture brokers between the facility and Indian clients. However, this has put immense pressure on indigenous workers.

> "The cost is high in human terms for Indian workers who cannot adapt. Turnover rates are very high, and 'alienation of the marginal man' occurs. For those who adjust to non-Indian ways, there is of necessity a certain withdrawal from Indian ways." (McShane, 1987, p.100).

(4) A fourth adjustment has been to promote the natural support systems in most Indian communities. "However, certain forces (i.e., alcoholism, death due to illness and accident, migration and back-migration contributing to acculturation) have caused some deterioration in positive family and social systems so they are less effective "(McShane, 1987, p.100).

(5) The utilization of traditional healers in mental health care has also been tried. However, there are few such people to begin with, and with the disintegration of cultural systems in Indian settlements, the healing role has become disentangled from the fabric of the community. In addition, the Indian healers may approach the healing process differently, valuing “subjective” knowledge and perceptions over “objective” knowledge.

McShane (1987, p. 111) notes the following approaches to improving and adapting therapy offered to Native Americans:

(1) modifying psychotherapists’ cognitive and emotional orientation;

(2) modifying traditional treatment approaches;

(3) modifying patients’ knowledge and expectations;

(4) negotiating and facilitating shared role and relationship expectations.

McShane (p. 113) then discusses the importance of therapist education to promote a cultural paradigm shift. He also states that Native communities should have legal jurisdiction over the hiring of mental health care workers and their education in transcultural psychology, and that continued employment and licensure of a mental health care worker in a Native community could be tied to ongoing education in Aboriginal culture.

Schact and colleagues (1989) advocate home-based therapy with American Indian families who would otherwise not receive mental health care. Because of the barriers to the Aboriginal's use of mental health care services, such as distance from reservation, lack of transportation, unwillingness of Aboriginals to discuss their problems with strangers at preappointed times, etc., home-based therapy with therapists who possess an understanding of Aboriginal cultural values and the specific problems associated with Aboriginal communities would be an alternative. Therapists must be flexible with time and must receive the support of the institutions they are affiliated with for this program to succeed. In addition, therapists working with the home-based therapy model must be able to forego their expectations of western-style therapy methods and results, such as being in control of the therapy process and the therapy site. Such therapists must work closely with a support group or advisory committee at the local community level.

3.2 Training of Indigenous Workers

Few professionals are situated in remote communities and fewer still have specific knowledge of the local language or culture. As a result most services are delivered by transient personnel working in concert with local community workers who themselves are under-trained, unsupported and frequently placed in an untenable social situation while working in their own communities and

among their own kin. There needs to be more study and specific training addressed to the problems of the community worker in isolated regions. Conventional notions of professional distance and detachment may be irrelevant or even harmful and certainly do not conform to the reality and needs of this type of community worker.

One obvious solution to the lack of linguistic and cultural skills of non-Aboriginal practitioners is the training and development of more Aboriginal practitioners. Few American Indians are trained as social workers, psychologists, psychiatrists or other mental health practitioners and fewer still serve American Indians on reservations (LaFromboise, 1988, p.389).

As solutions to inadequate mental health care among Aboriginal peoples, LaFromboise (1988) proposes strategies targeted at psychology which should be expanded to include the full range of mental health disciplines:

(1) recruitment of Aboriginal peoples into careers in psychology, social work, nursing and other mental health disciplines;

(2) the revision of mental health training programs so that the curriculum would include the impact of the cultural environment and contextual effects on the Aboriginal experience;

(3) training of mental health practitioners to include a community-based practicuum internship so that networking and consultative skills can be developed;

(4) greater effort on the part of mental health care providers to build on their clients' strengths while helping their clients to maintain their memberships in social networks and remain in natural communities in the least restrictive environment.

(5) greater involvement of Aboriginal governments in regulating the quality of psychological service provision.

3.3 Traditional Healing

> "Amerindians always say that to attain reason, one must first treat the emotions with honour and respect. To gain someone's trust or cooperation, or to comfort others so as to have them participate in a shared objective, 'it is necessary to deal in the first place with the emotion [of people], to lift up the spirits so as to sit down [together] and think clearly.' At the beginning of a speech or negotiations, northeastern Natives, particularly the Wendat-Iroquois, almost invariably offered several wampums, the effect of which was meant to 'call reason back to its seat.'
>
> For five centuries, Amerindians and Whites have dealt with their emotions only very sporadically and superficially. Society's interests, as defined by the dominant governments, have never allowed them to do more. Division was the rule, so that it was essential to produce and maintain emotional confusion by instilling feelings of guilt or superiority, prophesying, and so forth" (Sioui, 1992, p. 5).

There is little scientific evidence for or against the efficacy of current treatment programs based on traditional Aboriginal healing practices. Exploration of the mechanisms and efficacy of these programs is urgently needed and could make significant contributions to the evolution of healing practices in Canadian society as a whole. Advocacy of traditional healing, however, need not rest on having results from double-blind placebo controlled studies in hand. From a mental health perspective, whatever their specific therapeutic effects, traditional forms of healing are likely to have efficacy at the levels of giving meaning to experience, giving the sufferer a renewed sense or morale and promoting community solidarity (Dow, 1986; Frank & Frank, 1991; Jilek, 1982; Jilek & Todd, 1974; Kirmayer, 1989; 1993; Waldram, 1993).

Csordas (1992) addresses the issue of evaluating the effectiveness of indigenous religious healing. He makes two important points regarding such evaluations: (1) it is necessary to take into consideration indigenous criteria for and definitions of success; (2) evidence of success or failure must be sought not simply in the moment of the healing ritual but in the wider social context and over a longer period of time, where the effects of the healing intervention gradually unfold and have their therapeutic impact. Csordas illustrates this with an account of three types of religious healing common among the contemporary Navaho: traditional healing of the medicine man using chants, sand painting, hand trembling, and crystal- or coal-gazing; Native American church healing of the roadman using peyote rituals and, increasingly of late, the sweatlodge adopted from Plains Indian traditions; and the Christian faith healing of the independent Navajo Pentecostal preacher or the Catholic Charismatic prayer group. Csordas considers traditional medicine to be based on an implicit philosophy of life as containing obstacles which must be dealt with skillfully or—when they cannot be evaded or worked with—accepted. Native American church emphasizes a philosophy of self-esteem through a personal experiential connection to the sacred. The various Christian church movements emphasize a moral vision in which renunciation of traditional religious ways is crucial to the adoption of a new identity. While the specific beliefs and healing practices differ among these

groups, all share an emphasis on the nature of healing as a process of coming to understand the nature of one's life. Csordas argues that this focus on understanding involves culture-specific notions of the nature of healing efficacy that are rooted in experiential worlds that may not be captured by standardized forms of outcome measurement.

It is important to recognize that the situation faced by many communities today is not that of a single homogeneous tradition but of special forms of pluralism. Csordas's (1992) description of the variety of forms of healing available on the Navajo reservation provides one example of this pluralism. The situation of urban-dwelling Aboriginal peoples represents another in which both traditional and biomedicine may be consulted at the same time or for different sorts of problems (Waldram, 1990).

Healing ceremonies are not just for individuals, they are for affiliated groups and whole communities. Consequently, their effects have to be measured beyond the individual. Rituals derive their efficacy not from abstract symbolic processes but through their use of evocative language, images and gestures that are deeply meaningful to people with a specific history, geography and set of current relationships (Csordas, 1992; Kirmayer, 1993). Accordingly, to be most effective, healing rituals must arise from and be tailored to the local context. When this context has not been preserved, a healing tradition must be actively re-created.

Drawing from earlier work by Csordas (1983) and Dow (1986), Waldram (1993) discusses the emergence of pan-Indian spirituality in his study of symbolic healing in prison settings. His primary findings are that participants in Aboriginal spirituality-healing come from diverse cultural, socioeconomic and personal backgrounds. They must first learn the mythic underpinning to which the healing process is attached. This places the emphasis on the healer as the bearer of tradition and the center of the healing practice. The healer must find or develop commonalities in participants' experiences and weave them together to make a coherent story, with links to tradition that can foster the interpersonal and spiritual dimensions of the healing process.

Individual-centered therapies encourage people to think of themselves as autonomous, separate, powerful agents whose natural goal is to articulate and achieve their own goals. Consequently, personal history is often reconstructed as a story of opposition and obstacles to that goal. This is in contrast to other therapeutic traditions in which, for example, family values and belongingness are central so that, far from viewing parents and others as causes of suffering through their errors or omissions, one is encouraged to reflect on their positive meaning and value in one's own identity. The best described example of this comes from Japan, where Naikan therapy has developed as a purportedly successful method of treatment for young people with conduct problems, delinquency or antisocial behaviour (Reynolds, 1983). The patient is encouraged to meditate on all he owes to his parents. Such a notion flies in the face of dominant North American cultural ideas of parents and childhood as the source of suffering. It may however, be more consonant with some Aboriginal groups' values.

The epistemology of many Aboriginal peoples allows for the validity of mythological knowledge and for forms of empirical understanding that are often discounted in a technological world that defers to scientific authority. The value of myth and story telling can be easily appreciated in terms of psychological processes of making meaning and coherence from variegated and often quixotic life experience. But it is also a social process of creating evocative stories which are circulated between and among members as tokens of identity and opportunities for participation in a shared world.

Sweatlodge practices must be examined from this point of view. The sweatlodge and associated healing practices are not only rituals for individual transformative experiences, they also have meaning for communities with particular histories. The resurgence of interest in traditional practices like the sweat lodge (and their adoption even by Aboriginal groups which never had such traditions) is part of a more global movement of re-generating Aboriginal identity and exploring the significance of an evolving tradition in the contemporary world. Of course, in some hands, Native spirituality becomes a product, open to commercialization. The relationship between this commercialization and the healing power of "authentic" tradition needs careful study. Others may try to appropriate these traditions (Rose, 1992) but no one can lay claim to have the final version since, like all traditions, these are in constant flux and evolution.

The scientific assessment of the efficacy of traditional medicine remains a vexing epistemological and social problem (A. Young, 1983; D. Young, 1988, 1989). Just as they often do in biomedicine, the criteria of success may differ for healer and patient. Perhaps, this is less likely in small communities where worlds are closely shared and the healer cannot hide behind a professional role and limited contact with the patient, and so protect himself from evidence of dissatisfaction or failure. But then too, patients' ability to confront the healer may be very limited in this situation, depending on power differentials and support for challenges to authority.

This points to the fact that Native healing movements and practices deserve scientific study not only in terms of efficacy but also with regard to their social, political and economic context. Although the renewal and development of these practices must be protected and fostered, they should not be immune from critical examination. Traditional healing practices also involve local contexts of power. While ideally rooted in spiritual values, there is no guarantee that some individuals will not take advantage of their leadership positions.

The assumption that everything associated with biomedicine, psychiatry and the dominant political system is *a priori* wrong, while everything associated with traditional practices is automatically correct, will lead to a blinkered perspective that does not serve Aboriginal peoples well. Indeed, many things done in the name of tradition are, to some extent, adaptations or even new inventions, with loose connections to tradition. In some cases, practices labelled traditional are only a few generations old. This in no way invalidates their usefulness, integrity

or experiential authenticity. It does, however, emphasize that no culture or tradition is static; all undergo constant change and evolution. Ideally, this change occurs with a degree of conscious choice and critical examination that insures that the rights and needs of the less powerful or disenfranchised (even within Aboriginal communities) are somehow represented along with those who are most powerful or successful in controlling the new regime.

This is a delicate issue given the challenges of strengthening Aboriginal traditions and autonomy. Criticism must therefore come from within the group as a sign of its health and vitality, following lines laid out by traditional social structures but allowing for challenges (from within and without) when structures become oppressive or unresponsive to contemporary Aboriginal realities. Researchers can contribute to understanding these cultural and political issues only by working in collaboration with a range of Aboriginal groups, acknowledging and exploring the diversity within Aboriginal communities and not being entirely subservient to any authority. Otherwise, the danger is that the search for truth will be suppressed by political goals and the community will lack that wider or longer range vision offered by critical study of the hidden assumptions and biases of Aboriginals and non-Aboriginals alike.

Manson (*unpublished*) has noted several key issues in clinical collaborations between traditional and Western medical practitioners based on differences in:

(1) *definitions of abnormality*: practitioners may differ in who they believe to be ill and in just what aspects of their illness or behaviour they take to be significant pathology;

(2) *forms of healing recognized as legitimate*: both traditional and biomedical practitioners may accept some of each others' practices while rejecting others;

(3) *explanations of illness and healing efficacy*: different epistemologies, ethnophysiological theories and explanatory models are used to choose and rationalize the choice of specific treatments within each system;

(4) *credibility of healer and practices*: the sources of healing authority are different in the two traditions;

(5) *reimbursement*: traditional healers must function within communal patterns of exchange or as entrepreneurs, while biomedical practitioners enjoy governmental support and reimbursement through universal health insurance;

(6) *patient expectations of healer's role*: patients have their own hierarchies of resort, and the collaboration of biomedical and traditional healing constitutes a new hybrid which may or may not fit with their needs and expectations. Biomedicine offers a

form of anonymity that, while often criticized, may also be sought by some patients.

(7) *notions of professional ethics and integrity*: practitioners derive their authority from fundamentally different systems and have different notions of their responsibilities and obligations. Social control of biomedical and traditional healers is markedly divergent.

All of these differences present potential sources of conflict and obstacles for systematic collaboration. Taken together, they tend to keep biomedical and traditional health care approaches apart.

3.4 Government Intervention Strategy: The Example of the Eastern Arctic

In eastern Arctic regions, state-sponsored intervention in cases of Aboriginal mental illness are quite recent and have largely been devoted to treating deviant behaviour. Originally, deviant behaviour was defined as a judicial matter and intervention was taken on by the RCMP. Early relief ships with limited medical personnel (Eastern Arctic Patrol) would also occasionally intervene in cases where an individual's behaviour was no longer endurable by the community or group. In the 1950s, nursing stations were established marking the true beginning of medical treatment of mental illness in the north. At this stage only people with extreme behavioural problems would be brought to the nursing station, largely with the intention of having the person removed from the community to treatment facilities in the south. This can be seen as a corollary to the earlier banishment and execution methods employed by Inuit to deal with extreme cases of deviant behaviour. The medical services system in the north and in other Aboriginal communities was developed for and oriented toward treatment of life-threatening epidemic diseases through evacuation to southern institutions. Today the northern medical system no longer deals with such large scale epidemics but has inherited the administrative and institutional structure of the past. The epidemics faced today are social and behavioural, requiring interventions *in situ*, which the system is not structured to undertake.

In the spring of 1993, the community of Povungnituk, Québec, decided to go to the media with revelations that two community members—one Inuit, the other white—independently of each other, had sexually assaulted over eighty young boys and girls. In the weeks following this revelation, at least twenty more children went to social services in the community because they too had been abused by other community members. This number represents fully one quarter of all children under the age of eighteen in the community. Some adults also began to seek help for abuse they had suffered as children but never discussed. Community leaders, faced with the overwhelming responsibility of trying to help the abused, recognized their own inability to deal with the situation and decided to go public and solicit help from outside their community. When asked for an aid package, the initial response of a government representative was that some aid would be forthcoming but that solutions must come from

within—implying that the government had no business in the Aboriginals' social problems. In this case, the government's initial response was one of abandonment of responsibility for serious health issues in Aboriginal communities under the guise of empowering Aboriginal peoples to manage their own affairs.

Under pressure from Aboriginal political organizations and repeated media exposure of tragedies associated with inadequate government-sponsored social services programmes (i.e., abuse of Aboriginal children adopted by white families, residential schools and forced relocation programmes), there has been a shift in government policy towards what could be called "Native solutions for Native problems." This policy shift has been encouraged for the autonomy it has given some Aboriginal groups to deal with mental and social health issues in a manner appropriate to their own culture. While it is an admirable and just idea, it has not been appropriately supported in most instances with technical support and expertise, and with training for individuals who are to take over these roles from non-Aboriginals (York, 1990). Aboriginal organizations have made significant efforts at the community, regional and national levels to create networks of communication and strategies for dealing with problems such as family violence, substance abuse and suicide but are often not in the position to capitalize on the knowledge gained through these meetings and workshops once they get home (Young & Smith, 1992). Some regional Aboriginal organizations have well developed health administration departments and are making great strides in assuming responsibility for these roles and producing intervention strategies appropriate to their communities. In other regions, the structure and expertise are not yet in place and programme development is lagging. It is not possible, at present, for many Aboriginal groups to grasp and deal with all the problems faced in their communities simply because they share the same language and culture. The net effect of the policy shift has been that the government has relieved itself of the responsibility for some social and mental health services without supplying structural support to those who will deal with the problems which remain. Each community or group is obliged to create its own structures independently of others and cannot benefit from each others' knowledge and experience. It would be preferable to develop local structures and expertise in anticipation of constructive change, rather than repeat the abrupt and ill-planned transfers that have occurred in the face of some crises.

In his book *The White Man's Indian*, Berkhofer (1979) collects the themes of white imagery about North American Aboriginal people. The grouping together of all the peoples and cultures of the entire continent under the generic term "Indian" was predicated on the assumption of shared barbarism, religious idolatry and uniform lack of "civilization" of all Aboriginal peoples in the Americas. From this highly condescending, homogenizing perspective, a series of stereotyped images have arisen which shift with the fashion of the day. Positive or negative, these stereotypes retain the assumption of cultural uniformity among Aboriginal groups based on the geographic accident of occupying the same continent. This imagery, as stereotypical and wrong as it is, profoundly influenced the evolution of government structures charged with regulating the lives of American and Canadian Aboriginal peoples.

Throughout the history of Canadian bureaucracy, Aboriginal peoples have been the responsibility of single large departments. When the federal responsibility for some Aboriginal groups was handed over to Québec, parallel provincial institutions were created following the same view of Aboriginal homogeneity.[2] As government regulated services, health care has followed the same perspective. Medical programmes have been planned around the interchangeability of Aboriginal peoples, problems and communities. Uniqueness and individuality have never been the concern of the bureaucracies.

In a recent paper analyzing the Inuit disk identification system, Smith (1993) examines the role of the health care system in the governments' bureaucratic control of all aspects of Inuit life. Interactions between the state and the individual, in this case Inuit, are based on the ability of the state to bureaucratically atomize the group into equal discrete elements on which it then gathers and maintains "facts." Through the collection of facts, government claims to measure and understand society and so is capable of deciding what is good and bad for it. Smith's paper demonstrates how the collection of health care information serves implicit political and cultural agendas.

The effect of biomedical research and practice, in concert with bureaucratic political processes, is to subordinate the social context and unique experience of the individual to the demands of comparability and presumed sameness of its subjects. In discussion with Inuit and other Aboriginal people about experiences with mental health problems and service delivery, one hears many expressions of frustration at being another number or dossier to be dealt with and the often-expressed sentiment that the system in place cannot fix anything, because it has no interest in either the culture as a whole or with the individual context of the person's life. Analyses of Aboriginal perceptions of health care services reveal this sense of frustration and rage at the "structural violence" Aboriginal people experience in their attempts to receive basic health care. For example, O'Neil (*in press*) discusses how obstetrical services in the north are presented in a meaningless context. Individual and cultural expressions during the birthing process are attempts to transform the experience into a personally and socially meaningful one.

Epidemiological data are increasingly relied on to determine the needs and measure the success of community health services. These data are missing for most Aboriginal communities. Even where they have been generated by extensive (and invasive) studies, however, serious methodological issues regarding their interpretation and adequacy remain. Epidemiological methods use highly abstracted and filtered data, often without first-hand interaction with the population. In the field of mental health services, where great variations between cultures and communities are commonly seen, the epidemiological assumption of homogeneity cannot be met. The danger in not evaluating the

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[2] These responsibilities subsequently have been devolved to regional Aboriginal government organizations through the James Bay and Northern Québec Agreement (Salisbury, 1986).

lived context through first-hand ethnographic methods is most serious in small Aboriginal communities.

3.5 Community Organization and Empowerment

Community development and local control of health care systems serves not only to make them responsive to local needs but to provide a means of promoting a more general sense of self-efficacy and pride that contribute to positive mental health. Thus, Aboriginal rights, land claims and redistribution of power cannot be separated from the empowerment of individuals within communities and, hence, the health of groups and individuals (Culhane Speck, 1987).

Shkilnyk (1985) offers a dramatic portrait of the Grassy Narrows community destroyed by dislocations and disruption of traditional subsistence patterns and connection to the land. She sees escalating suicide, alcoholism, violence and pervasive demoralization as consequences of these social changes. Although she argues that these become self-perpetuating, there is evidence that they can be reversed where communities work to reconstruct their own infrastructure (Garro, 1993; York, 1990).

Contemporary mental health theory offers the metaphor of the 'sick society' to apply to communities facing social pathologies (Edgerton, 1992). Aboriginal leaders may adopt this metaphor in their efforts to gain redress from government for past wrongs and ongoing neglect. But the image of the sick community, while providing a rallying cry for social change, also conveys a pervasive sense of loss and may contribute to demoralization. It is crucial, therefore, to find and promote images and activities representative of the vitality, renewal and rebirth of Aboriginal communities and traditions.

Government responses to social pathologies of simply providing more health care avoid the more fundamental causes. Serious effort must be applied to developing meaningful employment that allows persons to achieve their potential and fits with a lifestyle consistent with cultural values and practices. This economic focus must be coupled with broader attention to supporting local efforts to preserve and enhance community and cultural esteem. The most obvious and direct way to achieve these goals is through political and social empowerment at local, regional and national levels.

Mental health promotion and prevention programmes must identify community strengths as well as weaknesses to avoid contributing further to the demoralization that hurts everyone (Levy & Kunitz, 1987) . Berry (1993, p. 18) states that:

> "Fundamental changes are required in order to retain control over lives, and through this, to return self-respect among Aboriginal Peoples. This return of control will involve advancing and withdrawing: the former on the part of Aboriginal peoples in the areas of education, health, social services, justice and

economic development; and the latter on the part of non-Aboriginal peoples in the areas of schooling, hospitals, welfare, policing and resource exploitation."

4. EMERGING TRENDS IN RESEARCH

In this section we consider emerging areas of research on the promotion of Aboriginal mental health and the prevention and treatment of mental illness. Specific issues to be addressed include cultural concepts and practices related to mental health and illness, the notion of the person, Aboriginal identity, traditional values and spirituality, models of culture change and culturally appropriate and valid research methods.

4.1 Concepts of Mental Health and Illness

Traditional Aboriginal knowledge allowed for a wide range of concepts of mental health and illness. Among the recognized causes were natural causes or accidents, human agency, supernatural agency (e.g., animals gaining revenge or elements which were not treated with respect), object intrusion and soul loss (e.g., Foulks, 1990; Murdock et al., 1978; Shweder 1985; Trimble, Manson, Dinges, & Medicine, 1984; Vogel, 1970;1990). Generally, these causes were not mutually exclusive; several could be applied to account for an illness episode or changes in its course.

In many cases, the concept of mental illness as a discrete type of problem is foreign to Aboriginal views of health. Physical, emotional, spiritual and environmental health are part of the same system of relationships. When they are in harmony, there is health and well-being; when they are unbalanced, there is distress.

For example, in northern Québec there exists no global term in Inuktitut for mental illness (Kirmayer et al., 1993). Similarly, there is no term for mental health and when a committee was formed to address these problems it chose the name "Peace of Mind Committee" to express its goal. The idea of harmonious and peaceful relationships and a calm and clear state of mind is immediately intelligible and accepted as a valid goal.

The whole emphasis of contemporary psychiatry on describing discrete categories of illness runs against the tendency in many Aboriginal healing traditions to look for connections or inter-relationships to account both for the cause and cure of distress. These connections are not just part of a cognitive system but lived out in the bonds of the family, community and in one's relationship to the natural environment. LaFromboise (1988, p. 392) notes that:

> "American Indian psychologists…tend to attach diagnostic labels to clients less frequently than non-Indian psychologists (Horowitz, 1982; Kelso & Attneave, 1981). When problems arise in Indian communities, they become not only problems of the individual but also problems of the community. The family, kin, and friends coalesce into a network to observe the individual, find reasons for the individual's behavior, and draw the person out of isolation and back into the social life of the group. The strong social and symbolic bonds among the

> extended family network maintain a disturbed individual within the community with minimal coercion.
>
> American Indians who engage in individual therapy often express concern about how conventional Western psychology superimposes biases onto American Indian problems and shapes the behavior of the client in a direction that conflicts with Indian cultural life-style orientations and preferences." (Lafromboise, 1988; p.392).

As a consequence of this emphasis on interconnectedness in Aboriginal concepts of mental health, LaFromboise argues that "traditional community and kinship networks of support may be the most effective delivery agencies" (p.391). She suggests that network therapy, which mobilizes family, relatives, and friends into a socially attentive force which can respond to emotional distress works best with both urban and reservation Indian communities (cf. Speck & Attneave, 1973). Network approaches to the treatment of alcohol and substance abuse show promise and may fit well with Aboriginal concepts of connectedness and community (Galanter, 1993).

4.2 Ethnopsychology and Concept of the Person

> "The Amerindian genius, acknowledging as it does the universal interdependence of all beings, physical and spiritual, tries by every available means to establish intellectual and emotional contact between them, so as to guarantee them—for they are all 'relatives'—abundance, equality, and therefore, peace. This is the sacred circle of life, which is opposed to the evolutionist conception of the world wherein beings are unequal, and are often negated, jostled, and made obsolete by others who seem adapted to evolution." (Sioui, 1992, p. xxi)

The notion of the cultural concept of the person and the self may provide an integrative model for sociocultural and psychological factors in mental health (Markus & Kitayama, 1991; Shweder, 1991) . Cultures vary in the concept of the person and the self (Carrithers, Collins & Lukes, 1985; Marsella, DeVos & Hsu, 1985) . While the dominant North American culture tends to be highly individualistic, valuing self-direction, individual preferences (Bellah, Madsen, Sullivan, Swidler & Tipton, 1985) and achievements as the markers of success, maturity and psychological health, many other cultures see the person more as a social being whose identity derives from family and community (Sampson, 1988) .

Despite the recent burgeoning of interest in cultural concepts of the person within the field of psychological anthropology, relatively little has been written on Canadian Aboriginal experiences of self and personhood. Smith (1989) addresses the Ojibwa experience of self. Fienup-Riordan (1986) examines the concept of personhood among the Yup'ik Eskimos of Western Alaska and Stairs (1992) explores some similar issues among the Canadian Inuit. The broad polarity between egoistic or individualistic cultures and communalistic or sociocentric cultures, which has dominated this literature, must be expanded to encompass the ethnopsychology and cultural realities of Aboriginal peoples. In

some respects, these cultures appear sociocentric in that the well-being of the family, tribe or band often takes precedence over the individual. However, this occurs not because of submersion of the individual's perspective, but more often from clearly altruistic values expressed in terms of devotion to the natural order and to personally felt ties. In many respects, then, Aboriginal peoples are better understood as more individualistic than the modern welfare state, in that traditional patterns of non-interference and respect for the individuals' own choices and action pervade the society (Brant, 1990) .

Aboriginal concepts of family involve more than the degree of biological relationship. It involves a social and emotional bond between people who share a world of experience. Once welcomed into this world as a "brother," an individual may participate in family ties quite as strong as those forged during early development. Sioui (1993) notes that traditional notions of interdependence and rationality based on equanimity lead naturally to an ethic of sharing rather than competition. Traditional values of cooperation and spiritual harmony contrast sharply with those of materialism, aggressiveness and acquisitiveness promoted by Euroamerican society. Current values are in transition but a broad ethic of non-interference continues to be a common expression of the underlying emphasis on cooperation, conflict avoidance and seeking of harmony (Brant, 1990).

In addition to the contrast of egoistic and sociocentric versions of the self, a third aspect, not adequately incorporated in current models in psychological anthropology, concerns the role of the environment in the construction of the self. For Aboriginal peoples, the land, the animals and the elements are all in transaction with the self and indeed, in some sense, constitute aspects of the self (or, better, the human self participates in these larger, more encompassing realities) (Stairs, 1992) . Damage to the land, appropriation of land, and spatial restrictions all then constitute direct assaults on the self.

> "Georgina Tobac, a sage of the Dene nation, crystallizes in one sentence the anguish experienced by the Native when the earth is assailed by modern man. 'Every time the white people come to the North or come to our land and start tearing up the land, I feel as if they are cutting my own flesh; because that is the way we feel about our land. It is our flesh'." (Sioui, 1992, p. 18)

In this light, the widespread destruction of the environment motivated by modern modes of economic production takes on a new dimension. Throughout the Far North, destruction of the natural subsistence base has proceeded far more quickly than any belated efforts at conservation or restoration (Dickason, 1992, p. 396). These environmental changes must be understood as attacks on the Aboriginal self, having psychological consequences that are equivalent in seriousness to the loss of social role and status in a large scale urban society. The result is certainly a diminution in self-esteem, but also the hobbling of a distinctive form of self-efficacy that has to do with living on and through the land. The implication is that issues that may seem purely political or territorial for the dominant society are fundamentally issues of collective and personal self-creation and well-being for Aboriginal peoples.

For most Aboriginal peoples who still practice traditional subsistence methods to some degree, the concept of the person entails notions about the creation of the body-soul-self through consumption of natural food. Traditional hunting practices are not just means of subsistence then, they are, at one and the same time, religious, moral and psychosocial practices aimed at maintaining the total health of person and community. The integrity of the food supply and cultural identity are intimately linked; indeed, in many respects they are one and the same for some groups, e.g. the Inuit (Dickason, 1992, p. 397, citing Milton Freeman). Inuit concepts of self include physical links with animals through the eating of "country food" (Borré, 1991) and may be properly considered "eco-centric," as contrasted with ego- or socio-centric views of the person (Wenzel, 1991).

Psychotherapy and other mental health interventions assume a particular cultural concept of the person with associated values of individualism and self-efficacy (Bellah et al., 1985; Gaines, 1992; Kirmayer, 1989b). These approaches may not fit well either with traditional Aboriginal cultural values or contemporary realities of settlement life. There is a need to re-think the applicability of different modes of intervention from the perspective of local community values and aspirations. Family and social network approaches that emphasize the interconnectedness of individuals may be more consonant with Aboriginal culture, particularly if they are extended to incorporate some notion of the interconnectedness of person and environment.

As Gustafson (1976) pointed out, identification with the group is crucial to identity for many Native individuals. Consequently, the individual psychotherapist's expression of empathy may seem quite insubstantial when compared to the need for the protection of a literal guardian, or a new, powerful group matrix to sustain one's life and give it meaning (McShane, 1987, p.107).

Spirits, ancestors and supernatural beings are also part of the person's social world. Putsch (1988) draws cases from three different cultures—Navajo, Salish, and Hmong—to illustrate the role of the dead in concerns and fears related to illness, depression, and suicidal behaviour. Ghosts or spirits may be viewed as being directly or indirectly linked to the etiology of an event, accident or illness. Ghost illness is well known in many North American Indian groups: among the Mohave, Sioux, Comanchee, Tewa, Eskimo, and Salish speaking peoples (p.19).

> "Similar dreams, ruminations and hallucinations of the dead have been reported to the author in suicidal American Indian patients, survivors of suicide in Alaska Native families, and by unsuccessful suicides. For all of these reasons, assessments of mental status in American Indian patients should take interactions with the dead (dreams, ruminations, and hallucinations) into careful account." (Putsch, 1988, p.23).

In summary, Aboriginal perspectives on the person suggests the importance of the environment in behaviour and experience. This may also have implications in terms of managing anger, anxiety, grief or other potentially troublesome emotions and interpersonal conflicts. Changes in community location and lifestyle have impeded traditional strategies for coping that rely on mobility,

solitude and self-regulated social distance. There is a need for environmental psychological studies focusing on the experience of Aboriginal peoples and traditional practices and wisdom about the use of the natural world to regulate mood, reflect on and cope with interpersonal conflict.

Spirituality also plays a central role in Aboriginal concepts of health and illness and must be incorporated into models of care and interventions. Contemporary spirituality has complex roots in historical traditions, Christianity and modern psychological and social insights (Hultkrantz, 1992; Vecsey, 1990). It needs to be studied and applied as a potent source of healing for individuals and communities.

4.3 Aboriginal Identity

> "In the quest to 'individualize' the tribal consciousness, federal Indian schools pressed Indian students into a strictly homogeneous mold of dress, appearance and (limited) educational opportunity. The seeming contradiction is no real paradox: federal boarding schools did not train Indian youth to assimilate into the American 'melting pot' but trained them to adopt the work discipline of the Protestant ethic and to accept their proper place in society as a marginal class…
>
> The government's failure to achieve these goals is due in great part to Indian people's commitment to the idea of themselves. As individuals and as community members, Indian people cling stubbornly to making their own decisions, according to their own values. In the process, they have created spaces of resistance within the often oppressive domains of education, evangelism, employment and federal paternalism" (Lomawaima, 1993, p. 236).

Nostalgia for a mythical past is common among Eurocanadian health care and education workers in Amerindian communities. This is derivative of older colonialist views that have pervaded white imagery of Indian cultures:

> "Only civilization had history and dynamics in this view, so therefore Indianness must be conceived of as ahistorical and static. If the Indian changed through his adoption of civilization as defined by whites, then he was no longer truly Indian according to the image, because the Indian was judged by what the whites were not. Change toward what whites were made him ipso facto less Indian" (Berkhofer, 1979, p.29).

This perspective promotes stereotypic imagery of an idyllic Aboriginal past in contrast with the corrupted present, at the same time as it devalues the contributions, actual and potential, of Aboriginal culture to the contemporary Canadian context.

Aboriginal professionals themselves are not immune from stereotyping. DuBray (1965), a Native American (Rosebud Sioux) social worker, gives a broad sketch of Native cultural values as they pertain to dilemmas of social workers providing services to Native clients. Drawing from Honigman (1961) and other anthropological reports, DuBray argues that:

> “ ... a high degree of psychological homogeneity based on common values characterizes the behavior of the American Indian. ... American Indians, considered as a separate ethnic population without regard to individual differences, valued the following characteristics: nondemonstrative emotionality, the autonomy of the individual, an ability to endure deprivation, bravery, a proclivity for practical joking, and a dependence on supernatural powers.” (Dubray, 1965, p.33).

The problem is that the creation of an ethnic identity requires elevating certain beliefs, practices or characteristics to core values or shared experiences. This naturally tends to obscure individual variation and the constant flux of cultural and ethnic definitions of self.

Trimble and Medicine (1993) discuss some implications of the recent evolution of Native ethnic identity for mental health research . Notions and experiences of being a Native involve cross-cutting historical, cultural, linguistic, geographic and political dimensions. To a large extent, they are situational—emerging out of specific encounters with others who are viewed as sharing a generalized Aboriginal heritage or a political position. As a result of this complexity, few studies of American Indians clearly define operational criteria for membership or exclusion within a given tribal group (Trimble & Medicine, 1993).

All cultures are in constant evolution, so it remains unclear just how traditional culture should be identified when it is undergoing a constant process of re-construction. Cultural and ethnic identity must be understood as an invention of contemporary people responding to their current situation (Roosens, 1989). This is not to question its links to history and tradition, nor to challenge its authenticity, but to insist that culture be appreciated as a co-creation by people in response to current circumstances—an ongoing construction that is contested both from within and without.

For Aboriginal peoples, two complex arenas of this change are the relationship of individual groups to pan-Indian political and ethnic identity movements, and the relationship of the renewal of traditional healing and religious practices and their appropriation by “New Age” practitioners.

The development of a shared identity involves particular problems for Métis who have suffered from ambiguity of status (Dickason, 1992; Peterson & Brown, 1985). In this situation, the writing and dissemination of a group’s history takes on a special urgency.

The existence of a shared history is part of investing ethnic identity with social value and contributes directly to mental health. Studies of how cultural and historical knowledge is used to construct ethnic identity and the way in which such ethnicity is then used for psychological coping, social interaction and community organization, can therefore contribute directly to Aboriginal mental health.

4.4 Traditional Values and Spirituality

The majority of researchers—even those who are trained in the social sciences—approach research on Aboriginal mental health with implicit and unquestioned assumptions about what constitutes valid research methodology, the “rational” categories of experience, the superiority of biomedical diagnosis and healing, and the centrality of the kinds of social relationships and values that are born from and help to maintain the dominant economic and political ideology. Even those articles or essays which distinguish between Aboriginal and non-Aboriginal values with the aim of educating social workers, therapists, nurses, doctors, and others planning to work with Aboriginals, fail to address the fundamental differences between Aboriginal and non-Aboriginal world views.

The majority of non-Aboriginal Canadians tacitly accept such assumptions as the notion that nature is pre-eminently a source of raw material of little intrinsic worth, waiting to be fashioned into human artifacts of greater value. Nature presents us with unqualified abundance, to be reaped and transformed by enterprising humans. In this view nature exists apart from—and often in opposition to—human physical and spiritual life. Even when ecological awareness is promoted, it is usually justified in terms of capitalist values as facilitating a more rational means of maintenance, allocation and distribution of raw resources. Within the capitalist system, nature and the natural world is capital and property, subservient to and beneath human-human and human-God relationships. The notion of property thus conditions both attitudes toward the natural world and the cultural concept of the person (Nedelsky, 1990).

Aboriginal peoples’ cosmologies, on the other hand, accept nature as sacred as well as mundane, in an ongoing dialogue with humans (Hultkrantz, 1992; Vecsey, 1990). As such, nature cannot become the property of humans. All other relationships of exploitation that follow from the original exploitative relationship between humans and nature (within the capitalist system) are therefore also challenged within Aboriginal cosmology.

These differences in perspective lead to different causes and different manifestations of anxiety. Among non-Aboriginals, living entirely within the capitalist system, everyday anxiety is often related to the scarcity of resources, time, commodities and money, as well as the scarcity of affection, respect and other basic human needs. This scarcity is, in some respects, an illusion but it is an illusion necessary for the maintenance of an economic system based on relentless work. Arguably, the economic system depends on people who will work harder, more efficiently and faster for a limited number of material goods which they believe they need to be happy. People thus live with a constant sense of lack or deprivation.

Aboriginal culture does not have this “lack” in its cosmology, yet when Aboriginals offer their beliefs to non-Aboriginals, they may be perceived as “lacking” in their understanding of the demands of the white world. Perhaps the real lack or the absence of comprehension of the rules of the world rests with the non-Aboriginals, for the values and practices of Aboriginal cultures may indeed

hold some answers for the crises of the environment, capitalism, and faith in the contemporary world.

A broader view of health and mental health issues, which takes into account the different cosmologies of Aboriginals and non-Aboriginals, would perhaps yield more viable solutions. Most of the concepts which we use to define and qualify the various interactions of an individual with society—such as leisure, work, employment, recreation, profit, power, well-being, relaxation, loneliness amd ethnic identity or cultural belonging—have different meanings and values in Aboriginal cultures and should not be taken automatically to refer to the same thing in Aboriginal and non-Aboriginal worlds. Such concepts should not be applied indiscriminately in evaluating the mental health status or social adjustment of Aboriginal patients.

Across many Amerindian traditions a recurrent image is the great circle—representation of a spiritual world that contains animals and the environment along with people. These images have much to offer a capitalist society increasingly adrift with a loss of communal values. However, to contemporary critical consciousness they also appear very romantic. Talk about the 'laws of nature' is always suspect, for—given the tremendous diversity of the modern world—who is to declare what these laws are? Sioui's solution appears to be a radical form of individualism: "In the Amerindian's world of plenty, no one is required to believe in the ideology of another. Each person is a vision, a system, a world" (Siou, 1992, 103). This ethos may work well for a people dispersed across a great territory with material abundance relative to their wants and needs. It seems less credible in the global context of a world woven together by telecommunications and economic interdependence—a world to which Aboriginals, no less than other Canadians, must ultimately adapt.

4.5 Culture Change: From Acculturation to Creativity and Contestation

Acculturation is a term for the accommodation of individuals from one cultural background to the encounter with a new culture. In the case of Aboriginal peoples, this process has been driven both by their own economic interests and by tremendous external pressure from government, economic, educational, medical and religious institutions at various points of their history. This process of cultural confrontation and change has usually proceeded at a pace dictated by interests outside the Aboriginal communities. Hence, it is appropriate to speak of *forced acculturation.*

Berry (1993) notes that at the level of the group, acculturation may involve many types of changes: (1) changes in *physical environment* including location, housing, population density, urbanization, environmental degradation and pollution; (2) *biological* changes in nutritional status and exposure to communicable diseases; (3) *political* changes, transforming or dissolving existing power structures and subordinating them to the dominant society; (4) *economic* changes in patterns of subsistence and employment; (5) *cultural* changes in language, religion,

education and technical practices and institutions; and (6) changes in *social* relationships, including patterns of inter- and intra-group relations.

Berry (1976; 1985) described four different patterns of response to acculturation: integration, assimilation, separation and marginalization. The choice (or emergence) of a particular response to acculturative stress is based on two variables: (1) whether traditional culture and identity are viewed as having value and are therefore to be retained; and (2) whether positive relations with the dominant society are sought. In general, integration and assimilation are viewed as positive outcomes by the dominant society—the former involving a form of biculturalism while the latter amounts to abandoning one's identification with one's culture of origin for the dominant culture. In fact, active efforts to maintain traditional culture may be protective against the depredations of culture change.

The pattern of acculturation reflects the ideology of the dominant society as well as the pattern of assimilation and accommodation adopted by the traditional group (Berry, 1993) . Canada currently has an explicit policy of promoting multiculturalism which should encourage individuals to maintain both their cultures of origin and acquire new skills, values and practices derived from the dominant society. Historically, however, government interventions have been based on policies of assimilation or segregation. Thus, despite recent changes in official policy and a less explicit ideology of assimilation, Aboriginals in Canada face similar problems to those encountered by their counterparts in the United States.

Changes have been particularly profound for Aboriginal groups that were hunter-gathering societies organized at the level of extended family, bands or tribes. In most cases, these groups were used to large territories, low population densities and relatively unstructured social systems. The process of sedentarization has changed all of these parameters leading to larger communities composed of unrelated individuals, living in high density dwellings, with complicated new political and institutional structures that restrict freedom of activity.

It is important to note, as well, that the very notion of poverty is a creation of a new social order in which Aboriginal peoples were embedded. Dickason (1992, p. 398) quotes Abe Okpik, NWT council member to the effect that "poverty had no place in the traditional lifestyle… [it begins] when a person is bewildered and has no way to impose his way in a completely new environment."

Berry and colleagues (1987) summarized the results of a series of studies conducted between 1969-1985 on acculturative stress experienced by immigrants, refugees, Aboriginals, sojourners, and ethnic groups in Canada. They defined acculturative stress as "a reduction in health status (including psychological, somatic, and social aspects) of individuals who are undergoing acculturation, and for which there is evidence that these health phenomena are related systematically to acculturation phenomena" (Berry et al., 1987, p.491). They list the following symptoms of acculturative stress: lowered mental health status (specifically, confusion, anxiety and depression), feelings of marginality and

alienation, heightened 'psychosomatic' symptoms and identity confusion. They note that those who are involuntarily involved in the acculturation process (e.g. refugees and Aboriginal peoples) may experience greater difficulty than those who choose to migrate or otherwise expose themselves to a new culture. The results of their studies testing a model of four patterns of acculturation (Assimilation, Integration, Separation, and Marginalization) indicate that for all Aboriginal groups studied, "those favoring Integration (the mid-path between Assimilation with attendant culture loss, and Separation with resistance to further contact) experience less stress, while those preferring Separation tend to experience greater stress in all but two samples" (Berry et al., 1987, p.505).

Among the many problems intrinsic to acculturation models are:

(1) Existing measures of acculturation are often based on only a few items and so are psychometrically inadequate.

(2) The multidimensionality of acculturation is often ignored; culture change may proceed in different ways and at different rates in spheres of work, play, friends and family.

(3) Acculturation is treated as intrinsic to the person rather than as arising out of specific social situations and opportunities.

(4) Acculturation is framed in terms of a unidirectional notion of culture change which ignores the ways in which the subdominant culture may appropriate, modify, influence and subvert the dominant culture in creative ways.

(5) Models present an overly homogenous view of peoples' culture of origin, which itself is held to varying degrees and in idiosyncratic ways by members, and which may be the object of intracultural challenge and contestation.

Acculturation models usually assume that a dominant culture absorbs, overwhelms or replaces a subdominant or less powerful culture. The acculturation model, as applied in many cross-cultural psychological studies, freezes the past into a static and stylized "tradition." This ignores the sense in which Aboriginal culture is itself viable and can be seen to adapt to and incorporate elements of other cultures with which it comes in contact. Cultures are constituted not just of economic power but of circulating ideas, beliefs and practices. Further, cultures are not homogenous systems but consist of individuals with different social positions who each may adopt a different mix of old and new ideas. Culture is actively created and contested as it evolves. What happens in acculturation (which is sometimes described as a process of deculturation and reculturation into the dominant culture) is, in fact, a process of adaptation, negotiation and exchange that is impossible to describe along a single dimension.

What is needed then, is more detailed analysis of the ways in which incorporation and adoption of elements from other cultures occur and, with

specific reference to mental health issues, studies of the role of existing cultural methods of recognizing and dealing with behavioural, emotional and interpersonal problems.

The acculturation literature tends to minimize profound social problems that eclipse the niceties of culture change and adaptation. The current that runs through all the acculturation studies from the original immigrant studies to the contemporary Aboriginal interests is that people faced with acculturative stress are all being disempowered by the dominant culture. Isolation from the structures which were used to understand and determine power is the single common element. Whether the isolation is geographic, as in the case of immigrants, or administrative and political as in the case of Aboriginal peoples, they all face the erosion of control over their own lives. Change has occurred not through a gradual process of engagement and exploration but in a series of powerful economic and political moves. It is these aggressive acts on the part of European-Canadian business, religious, educational and governmental institutions that have led to the stresses of culture change for Aboriginal peoples. This historical reality challenges the implicit assumption of acculturation models that social and mental health problems are inevitable when two cultures of differing degrees of "primitiveness" or economic and technical "advancement" collide.

Forced relocations were a particularly profound form of stress as they involved a complete change in circumstances, often for reasons that were completely arbitrary to the individuals involved. The location of virtually all Aboriginal settlements was chosen by government or mercantile interests rather than by the Aboriginal peoples themselves (Dickason, 1992). Hence, not only the fact but the manner in which lifestyle shifted from nomadic hunter to sedentary village has been dictated from outside the local culture. The "experiment" of relocating Inuit to the Far North to protect Canadian sovereignty was just a late chapter in the process of forced culture change (Dickason, 1992, p. 396; Marcus, 1992). Unlike fleeing from persecution or war to a safer place, or choosing to migrate to find a better life, these government organized dislocations had the effect of simultaneously disenfranchising individuals and communities, and undermining their trust in any overarching political authority or "just" world.

Dislocations and culture change have also been driven by the ravages of infectious illness (Dickason, 1992; Sioui, 1992; Thornton, 1987). In many ways, the effects of this brute biological fact have been of greater magnitude than the planned genocidal activities of successive generations of governments. Sioui (1992) holds out an olive branch to Euroamericans by playfully shifting the blame for the Amerindian holocaust to the bacteria and viruses carried by the European invaders. He also raises the ironic question, though, of what it was about the unhealthy lifestyle of the Europeans that bred (and still breeds) such virulent strains of microorganisms!

It is also misleading to speak of the active efforts to eradicate traditional beliefs by missionaries, politicians and educators as "acculturation." These practices, perpetrated in the name of religion, "civilization" or political expediency, have

amounted to something approaching systematic genocide (York, 1990). Two to three generations of Aboriginals

> "were forcibly taken from their families and placed in church-operated residential schools between the ages of six and sixteen. They often lost their language, religion, culture, values, links with their family and village, even the ability to parent. Many adopted the values of their residential schools, which were more like prisons than homes. Later, many of these schools' inmates seemed to be more comfortable in prisons than in any other social institution. Virtually all were abused psychologically and physically, and recent evidence indicates that many were abused sexually." (Armstrong, 1993, p. 221).

The extent of abuse and violence perpetrated in many of these residential schools and other "welfare" institutions is only now coming to light (Haig-Brown, 1988; Johnston, 1988; Knockwood, 1992). Less overtly brutal—but just as important in its effects on identity and self-esteem—is the systematic denigration of traditional values and cultural identity in these efforts at educational and moral "improvement" (Lomawaima, 1993). Both segregated and integrated schools, as well as other social welfare institutions, exposed Aboriginal youth to overt racism, open denigration of their traditions and contradictory expectations with little hope for real integration, even if they were willing to forsake their background (Johnston, 1983). To the present, Aboriginal children continue to be exposed to the prejudice of the dominant society and may come to view themselves in a negative light (Aboud, 1988).

Hammerschlag (1982) argues that mental health problems of U.S. Native peoples can be explained by their political disenfranchisement. In the U.S., Native Americans have only been full citizens since 1934 with the passage of the Indian Reorganization Act, and only since 1978, with the passage of the Native American Religious Freedoms Act, have they had the right to practice their traditional beliefs without interference. In Canada, Aboriginal peoples have only been able to vote since 1960 and continue to lack power to direct their own economic, health and educational programs. Where transfer of power from governmental institutions to local groups has been arranged, it has usually occurred without any effort to prepare local leaders to manage the complex systems and resources involved. This lack of preparation and orderly transfer of powers has resulted in confused situations and has required long periods of time to set right.

Hammerschlag also notes that it is crucial to speak of illness in psychohistorical terms. The mental health problems of Aboriginals can then be understood in terms of internalized defeat, hopelessness about the future, and psychological vulnerability to the racism and oppression of white society. Current health delivery systems, in their denigration or peripheralization of traditional cultural values and practices can then be seen to emphasize dependency and reinforce illness.

Aboriginals have been forced to be obedient in exchange for subsistence living. They have been forced to give up what has been life sustaining for generations in order to survive within the culture of those that have defeated them. The

solution then is to cultivate a renewed sense of connectedness to Aboriginal culture.

As Hammerschlag puts it:

> "The most important thing I've learned in my experience with Indian people is that to survive in health you need to be connected to something other than yourself, something which gives you a proud, strong, positive sense of self meaning. That sense of connection is the crucial variable in maintaining psychological health." (Hammershlag, 1982, p.35.)

This view is entirely consonant with contemporary health psychology research which emphasizes the central importance of meaning in life and community solidarity and participation in all forms of well-being and longevity (Antonovsky, 1987; House et al., 1988).

LaFromboise (1988, p. 388) summarizes evidence that the majority of mental health problems in Indian communities stem from extensive and chronic social and economic problems. Stresses, such as an average of 30% unemployment on most Indian reserves, high dropout rates from school, substandard housing, malnutrition, inadequate health care, shortened life expectancy, high suicide rates in small communities, and forced acculturation to urban living are crucial factors in Aboriginal mental health.

Sporadic efforts by government to rectify the economic disadvantage of Aboriginal peoples have not had the salutary effects anticipated when they subverted traditional practices of exchange that served to maintain family and community solidarity. Where monies have been integrated into existing social structures, they have, at times, strengthened communities.

For example, Miller (1990) analyzed the U.S. federal War on Poverty programs of the 1960s and the 1970s—specifically, two of the constituent programs, Comprehensive Employment and Training Act (CETA) and Indian Community Action Projects (ICAP)—and discussed their hidden effects on the Coast Salish Indians. These projects provided employment and training opportunities for Natives who in turn provided aid to many extended family members. Miller notes that this enhanced group cohesion and solidarity:

> "Families frequently are structured around and actively depend on leadership from members with relatively large and stable incomes who can provide aid to family members. This aid frequently takes the form of balanced reciprocity. For example, small sums of money are provided to family members for important purposes such as keeping a car operating. The favor may be returned by chopping wood or carrying out other useful tasks. Also, family members make loans at strategic times that are returned when the crisis is weathered and can be repaid. In Coast Salish communities this movement of capital through gift or loan may be enough to enable family members to meet the expenses of operating fishing boats or to keep homes heated in winter." (p.62).

> "Salaries received during training periods under CETA and other federal programs helped maintain and foster expensive cultural practices that are

> essential to family cohesion, individual well-being, ceremonial life, and the work of traditional curers. Traditional practices, such as giving children Indian names and conducting potlatches, and conducting traditional funerals, and winter Smokehouse dances, while never dormant, received a major boost following a quiet period." (Miller, 1990, p.67).

Ethnic group subordination continues to occur at all levels of societal institutions including law, education, policy, and economy (Anderson and Frideres, 1981; Harjo, 1993). However, efforts to counteract these inequities may backfire if they feed into prejudices within the larger society. Anderson and Frideres (1981) trace how educational curricula specially modified for Aboriginal students lead to differential access to employment and economic opportunities in the dominant culture because potential employers or higher education authorities will not give such degrees equal consideration.

Taylor (1992) argues that to have a positive ethnic identity, which may be a crucial feature of the sense of self, a group must have public celebrations, ritual enactments and opportunities to valorize and have others acknowledge their traditions. In the case of minority groups, this may require special efforts to create and protect situations where ethnic identity can be enacted and confirmed. From this point of view, the collective representations and images of Aboriginal people in the dominant society become part of Aboriginal peoples' own efforts to re-invent themselves, and to rebuild self- and group-esteem damaged by the oppression of religious, educational and governmental institutions.

The metaphor of trauma is currently gaining currency as a way of talking about the long-standing collective and personal injuries suffered by Aboriginal peoples. As mentioned above in the section on abuse, this perspective has rhetorical power but raises complex issues for healing and mental health promotion. But the emphasis on recovering conscious awareness of traumas is problematic because many forms of violence against Aboriginal people are structural or implicit and so cannot be pointed to by the individual. The impact of personal traumas and collective historical events can be partially tapped through individual's self-reports and narratives, although they may be difficult for individuals to remember and disclose because they are avoided, dissociated or repressed due to their painful implications. It is tempting, therefore, to focus only on the stories that can be told about explicit traumatic events and use these to explain all of the perduring inequities. But these historical events also have implicit effects that people may not be able to describe because they were never fully aware of their impact. These damaging events were not encoded as declarative knowledge but rather "inscribed" on the body, or else built into ongoing social relations, roles, practices and institutions. Social analysis is necessary to delineate these forms of violence and oppression and so to aid efforts to resist and change structural problems (Lock, 1993b).

4.6 Culturally Appropriate Research Methods

Armstrong (1993, p. 224) flatly states that "reliable and valid measures of Native mental disorders have never been constructed." Robin and colleagues (*unpublished*) cite the following factors related to misdiagnosis of psychiatric disorders and alcoholism among Native American Indians: linguistic, conceptual and taxonomic differences (Manson & Shore, 1981; 1983); unique patterns of drinking (Levy & Kunitz, 1974); tribal variations in grief reactions (Miller & Schoenfield, 1973; Shore & Manson, 1981); different cognitive styles (Rhoades, 1989); and lack of trust between clinicians and Indian patients (Sue, 1992).

Part of the problem is that, given the great diversity of Aboriginal cultures and communities, no measure is likely to work everywhere. The amount of labour involved in designing and validating new instruments mitigates against creating culture-specific instruments for each group. It argues in favor of using standardized instruments but addressing their limitations and possible sources of invalidity; for example, by adding culture-specific items, building in the possibility for using alternative diagnostic criteria of thresholds for caseness post hoc, emphasizing locally significant measures of disability and distress as outcome measures and combining epidemiological studies with parallel ethnographic research targeted at specific questions of validity and interpretation. On the other hand, some basic commonalities in mental health and illness are recognized and provide anchor points for studies that seek to include local cultural knowledge and expressions within their purview.

Nevertheless, there have been some significant recent efforts to adapt existing measures to Aboriginal populations. For example, the Foundations of Indian Teens study of the NCAIANMR is aimed at devising culturally appropriate and valid assessment methods. It involved three phases: (1) focus groups with teens to discuss the nature of trauma, elicit examples of traumatic events and review a screening instrument; (2) a self-report survey with screening instruments for PTSD, depression, problem-drinking, anxiety, and conduct disorder, which was administered to 297 adolescents attending a high school in a Southwestern community; (3) a second stage clinical interview of 65 adolescents who reported traumatic events on the screening, using a current version of the DISC (version 2.3). Half of the respondents (51%) reported they had experienced a traumatic event.

This study identified problems with the definition of the traumatic event in the standardized PTSD interviews. In many cases, the events viewed as traumatic by adolescents involve violence to someone who is not a close relative, or involve some illness or loss that would not ordinarily be viewed as an acute traumatic stressor. In Indian communities where there is a strong sense of connection or family ties to most members, traumas affecting superficially unrelated individuals may have severe impact. Clearly, the judgment of what is a severe stressor is culture-dependent.

The interactional style of many Indian groups tends to involve taciturnity, limited disclosure and stoicism. This may be perceived by others as a lack of emotionality (e.g., Darnell, 1987). This could mask significant distress or, less

likely, be confused with emotional numbing said to be characteristic of PTSD (Manson et al., 1993).

Self-report questionnaires, while easy to administer, suffer from many shortcomings:

(1) Most have not been validated for Aboriginal populations. To date, only the CES-D has been validated with clinical populations (Manson et al., 1987). The MMPI-2 was normed and validated on a large group of the general population including a single sample from a Northwest Coast tribe (Butcher & Pope, 1990). This is only a start and the question remains whether, and to what extent, scales can be universally valid (Trimble & Medicine, 1993).

(2) There may be many recording errors when subjects are not familiar with the process of filling out forms. There is a "culture" of responding to structured questionnaires that is often taken for granted by researchers.

(3) Respondents' acquiescence ('yea-saying') set may lead to bias. This may be particularly common in Aboriginal groups where custom and politeness dictate efforts to cooperate and be agreeable. It is further complicated by attitudes toward authority.

(4) When survey questions are about deviant or embarrassing behaviour, individuals may not answer truthfully. Less often, some individuals may wish to exaggerate their distress for strategic purposes. Actually, these biases are probably worse with face-to-face rather than anonymous self-report interviews. In fact, efforts to circumvent such embarrassment have led to the development of computerized interviews that can be self-administered (Binik et al., 1988). These could be adapted to epidemiological research and delivery of psychoeducational treatment in Aboriginal communities.

(5) Respondents may not understand the questions and there is no check for comprehension or completion.

(6) Questions may be understood but interpreted differently. Cross-cultural research has demonstrated that even apparently simple questions about concrete behaviours (e.g., "Have you been crying a lot in the past week?") may have profoundly different meanings for different peoples and, even within a culture, their interpretation may be highly context dependent (Kortmann, 1990; Kortmann & Horn, 1988; McNabb, 1990a,b).

Problems with the cross-cultural use of standardized interviews then include:

(1) *Comprehension*: even with careful translation, words or terms may be rarely used in everyday parlance or have different connotations or even denotations;

(2) *Acceptability*: certain questions may be too sensitive to be broached except in special contexts or relationships;

(3) *Relevance*: certain questions may not be relevant given differences in culture or social structure (e.g., nature of family, social support, role of work, religion, etc.). Manson and colleagues (1993) give the example of a social support question that asks 'how often have you visited with friends in the last month (don't count relatives)?' In many communities, not counting relatives would leave no one since everyone is either a blood relation or viewed as family, exactly by virtue of the closeness of friendship. For some groups, friends who are not considered family may not exist.

(4) *Salience and completeness*: looking at the symptoms, problems or diagnostic entities from within the culture, are the most important issues, beliefs and practices addressed? Many of these may be left out of models and measures developed from the researchers' own implicit cultural perspective.

As a result of these limitations of both self-report and structured interviews, it is essential to conduct ethnographic work using key informants and participant observation to explore cultural idioms of distress. Another technique being used with success employs focus groups in which specific questionnaires are explored and critiqued by Aboriginal community members.

5. Research Guidelines

Research methods and substantive questions are closely related. Even the most pressing questions from clinical or social policy perspectives may not be adequately addressed unless appropriate methods are available. The relationship between research methods and questions goes deeper than this, however, in that the existence of specific methods implies a way of looking at situations that makes certain questions "thinkable" while others, that might challenge the implicit frame, are never raised. For these reasons, we strongly favour a plurality of methods. In particular, ethnographic, case study and critical social science methodologies try to examine existing conceptual frameworks to discern their limits and, to some degree, step outside them and offer new ways of looking at problems.

Similarly, the relation of research to policy, service structure and health care delivery is exceedingly subtle and complex. Research is conducted on problems that are perceived to be important for cultural, economic or scientific reasons, and the very existence of a body of research then serves to make these problems more salient and significant. For example, much research has been done on drug treatments in psychiatry, not only because of their demonstrated efficacy but also because of powerful financial interests at work in the pharmaceutical industry. This work confirms the value of certain drug treatments even as it obscures the potential efficacy of other modalities. In addition to its self-conscious agenda to understand and describe pathology so that healing methods may be improved, medical research limits the universe of possibilities for action, generates relative utilities within that universe, and offers rationalizations for value choices through the rhetoric of science.

5.1 General Recommendations

Although we have criticized centralization as a method of controlling health care that must be locally adapted, we do think that there is a place for a central agency that has as its main function coordination and dissemination of research information and expertise. One centralized agency should be involved in advising Aboriginal communities on the development of research programs and services related to mental health as well as substance abuse (alcohol and drugs) and social problems. The agency should have these additional functions:

> *Promotion*: Active promotion and funding of comprehensive, community-based programs that have a research and evaluation component. By offering evaluation services, this agency could identify the ingredients of successful programs and the causes of failures.
>
> *Liaison*: The same organization could serve as a liaison between Aboriginal communities and "experts" or resource people who could serve as consultants for emerging Aboriginal-run research, prevention and treatment programs.

> *Information*: This agency could also serve as a national clearinghouse for information on Aboriginal mental health issues. By collating and ensuring free access to information, this agency could provide Aboriginal leaders and communities with the information necessary to find solutions to local problems and conduct health care planning.
>
> *Training*: This agency could promote active recruitment of Aboriginal peoples for training in research, mental health intervention and community development.

As we see it, this agency would differ from the MSB in that its primary responsibility would not be service provision but information dissemination. This might reduce potential conflicts of interest. Research priorities need to be determined by the individual communities. Research questions that are likely to be priorities are:

> What are the prevalence rates and specific types of mental disorders in the community? This should be geared not to official record keeping but to identify community problem areas and the need for specific health care and community resources.
>
> What are the consequences of mental disorder for the community—in terms of disability, mortality, school drop-outs, unemployment, alcohol and substance abuse, the prevalence of fetal alcohol syndrome, etc.?
>
> What is the history of culture change and problem solving with the community relative to devising and supporting interventions for current mental health problems?
>
> What prevention and treatment programs have been shown to be successful (if any) in other similar communities?

At the policy level, government mental health intervention has been criticized in the past and, as a result, has moved towards Aboriginal controlled and oriented intervention strategies. At the research level some parallel movement has begun to take place. Traditionally, research orientation and design were undertaken by the person or group seeking the funding—almost always urban academics. The researcher would define the research question, methodology and design as well as control the dissemination of results. With increasing Aboriginal administrative control over health services has come increased participation in research design and orientation. While few Aboriginal controlled health service facilities are equipped to undertake specialized research roles, they have increasingly become partners in the research process, defining objectives and orientations according to the perceived needs of the communities they serve. O'Neil and colleagues (1993) have developed a participatory health research methodology whereby flexibility is built into the research, permitting results to reflect the interests of the

communities and the health care institutions which serve them. Results are shared openly with Aboriginal political and medical organizations so that they may use them to further their own objectives. Research associates are hired from the communities and are given a status closer to advisor and colleague than the traditional role of interpreter. The associates are expected to play a role commensurate with the position they are given. They participate in the evaluation of the research orientation and approach. As well, they are expected to act as liaisons between the communities and the other researchers. The ultimate objective is for people within the community and evolving administration to develop appropriate research skills.

An example of this participatory process is described by Minton and Soule (1990) in a study that sought to identify factors important in the development of culturally relevant health care in Alaska. It took its initiative from the Four Worlds Project based at the University of Lethbridge, Alberta (Bopp, 1985). Open-ended questions ("What makes you happy?" "Sad?" and "Where do you go when you are sad?") were used to elicit local perceptions in a sample of 216 residents. Responses were grouped into 22 categories for sadness, 31 for happiness and 11 for resource use. Statistical analysis showed that sadness and happiness were affected by age and gender. Children and adolescents (ages 7-18) judged school and victimization as sources of sadness more frequently than other age groups while citing alcohol less frequently. Women cited death and relatives as sources of sadness while males cited boredom. Adults over 30 years of age expressed daily living and other people being happy as sources of happiness, while young people rarely cited these. The reverse age pattern was found for the categories of sports and family as sources of happiness.

In this study, the questionnaire design and administration was influenced by the community's participation. The concept of mental health was considered by the community to have no direct correlate in the local language. 'Sad' and 'happy' did make local cultural sense and so were used in the questionnaire. The data suggest a variety of characteristics which should be considered in the design of community-based mental health problems including: the social network of the individual, developmental differences, gender differences, perceived areas of need and strength, and acceptable sources of help.

What is most important to note here is that the community was not treated as a homogenous entity with a single "culture" to be characterized. A variety of life influences affect the mental health and coping strategies of different segments of the population. There was also a refreshing lack of insistence on a global culture change model. Instead, the authors point out concrete events which have in fact changed over time and which, in turn, likely affected the outlook of individuals.

This community-based approach has not yet been widely incorporated into mental health research among Aboriginal groups. What little research that has been done comes from either academics, government agencies or from small scale community-based research projects (e.g., the type fostered by the Brighter Futures Programme). Among the problems with the latter are that they sometimes lack the technical expertise and rigor to yield valid results, and they

tend to be undertaken without consideration of regional health service objectives so that they do not lead to enduring changes in programs and service delivery.

Researchers in other disciplines are experimenting with and adopting new models for research and application of results. It should be possible to develop an approach to Aboriginal mental health that supports the local interests of communities and regional objectives, while maintaining the methodological rigor and global perspective demanded by high quality research.

5.2 Principles of Culturally Sensitive Research

Beiser (1981) outlined general principles for epidemiological studies of Native American children as follows:

(1) psychological dysfunction should be assessed along multiple dimensions;

(2) studies should target vulnerable age groups with age-appropriate measures;

(3) data should be collected from multiple observers (e.g., child, parent and teacher);

(4) in addition to characterizing negative attributes, risk factors and psychopathology, attention should be given to positive attributes, protective factors and indicators of health and successful adaptation;

(5) measures should be culturally appropriate.

These principles, which have guided Beiser's own studies of the development and adaptation of Native children, are as pertinent today as they were a decade ago. What recent epidemiological research has added to this is a renewed emphasis on discrete diagnostic categories defined by operational criteria (Klerman, 1989).

Dimensional measures are able to tap levels of distress that, while they do not reach diagnostic criterion level (in frequency, intensity or pattern of symptomatology), nevertheless contribute to significant clinical and social pathology (Mirowsky & Ross, 1989). These forms of research are not mutually exclusive, although major epidemiological instruments like the Diagnostic Interview Schedule (DIS) and the Composite International Diagnostic Interview (CIDI) have, unfortunately, abandoned dimensional measures of symptomatology entirely in the pursuit of hierarchical diagnoses (Robins, 1989).

Both self-report and interview measures may suffer from ethnocentric biases or lack validity when used across cultures. Thus, it is important to develop culture specific instruments or to ascertain that extant measures are indeed valid in the new context. A major issue for the development of culture-appropriate measures

in research is how far to go in creating local measures that are not directly comparable to cross-cultural instruments in common use. Local measures based on the culture's own vocabulary and concepts of illness (termed 'emic') are likely to be more reliable and valid since they are put in terms of the local culture's vocabulary and categories of experience. However, if they are not comparable to measures used elsewhere, results are difficult to link to existing bodies of work. To avoid this dilemma, it is possible to combine both approaches, that is, to include 'etic' measures standardized on large heterogeneous populations and local 'emic' measures that tap culture-specific symptoms, attitudes and local idioms of distress. It is then possible to study the effect of alternative diagnostic criteria or dimensional measures of distress and outcome to determine which best fit local realities.

However, given the great diversity of languages and peoples involved, and the small size of many communities, it may be too difficult, time-consuming and intrusive to attempt to re-develop and re-validate instruments in each population "from scratch." This argues in favour of working to modify and validate existing scales rather than starting from scratch each time.

At this point in the development of Aboriginal mental health research, it is imperative that all epidemiological research include an ethnographic component. This should use key informants and participant observation to explore cultural idioms of distress, as well as focus groups in which the proposed questionnaires are explored and critiqued by community members.

5.2.1 *Community Participation*

Active involvement of local collaborators is crucial for successful research. Participation of the community can lead to more effective designs, culturally appropriate measures, immediate practical applications and, in the process of conducting research, reinforce a sense of community control and solidarity (Manson et al., 1981). Use of non-local interviewers may undermine the validity of research data due to lack of linguistic skill, cultural knowledge and trust. Unfortunately, use of local interviewers may also be problematic at times because of an unwillingness to divulge sensitive material, their own biases and the vulnerable position they are placed in when such material is disclosed.

Aboriginal groups are increasingly aware of how to use anthropology, and other research disciplines, as tools to achieve political goals (Dyck & Waldram, 1993). O'Neil and colleagues (1993) describe some of the projects undertaken by the Northern Health Research Unit at the University of Manitoba and the role that Aboriginals in the various communities studied have played in helping to define the research questions. Such community-based research methodology is an important innovation in that it helps negate the perception that research is irrelevant and driven more by the careers of researchers, than out of any concern for the welfare of the people served. It also reveals how limited existing structures are for supporting community-based research and researchers.

5.2.2 *Sampling Strategies*

Most research on Aboriginal mental health uses clinical or convenience samples. These are influenced by the structure of the community and the local health care system and are open to many forms of systematic bias that limit the validity, representativeness and generalizability of any findings. Random sampling is the most credible way to ensure representativeness and avoid biases in research. However, random sampling techniques based on population survey methods are difficult to employ in Aboriginal communities for many practical reasons (e.g., inaccurate census information, remoteness of regions, and seasonal variations in population activities) (Manson et al., 1981).

Factors that impede sampling in Aboriginal communities include:

(1) frequent travel out of the community and into the bush;

(2) different perceptions of time and structures of daily routine making appointments unreliable;

(3) geographical distance and transportation access;

(4) traditional activities and religious cycles;

(5) caretaker responsibilities (especially for woman);

(6) suspicion of outside researchers or burden of too much surveillance and previous research participation, resulting in low response rates.

Random sampling also ignores local community dynamics that may be crucial both to the conduct of a study and to its validity and translation into useful intervention. Trimble (1977) found that a nomination technique within randomly selected household clusters produced comparable samples across different American Indian communities.

5.2.3 *Measures*

Translation of test instruments with checks for semantic equivalence by blind back-translation is basic to developing valid cross-cultural self-report instruments and standardized interviews (Brislin, 1986). Recent work in item response theory offers a more rigorous approach to the psychometric assessment of functional equivalence between measures.

Culturally sensitive instruments require identifying indigenous concepts of symptoms and disorders, illness lexicons and taxonomies, and evaluative dimensions. Efforts must then be made to achieve each of several types of validity (Flaherty et al., 1988).

Criteria of existing interview instruments must be modified to fit local situations. For example, Robin and colleagues (*unpublished*) discuss four key areas in the Schedule for Affective Disorders and Schizophrenia-Lifetime version that require adjustments for sociocultural and economic factors in the Southwestern Amerindian groups they are studying.

Depression: The SADS-L sets 90 days as the upper limit of time normal for grieving over the death of a close relative. If prolonged after this period grief is diagnosed as major depression. However, in many Native groups, periods of mourning up to a year are considered normal or even prescribed (Miller & Schoenfeld, 1973). Other societies may exhibit little or no grief publicly in the belief that this would be harmful to self or the community. Robin et al. elected to lengthen the grief exclusion criterion for major depression to 12 months.

Alcoholism: SADS-L criteria for alcoholism require continuous drinking for at least one month. This poorly captures the episodic nature of much drinking by Aboriginal peoples (Levy & Kunitz, 1971).

Psychosis: Experiences with the supernatural or “ghosts” are common and normal in some Aboriginal groups but could be misinterpreted as psychotic symptoms (especially with structured interviews like the DIS) (Walker, 1989). Hallucinations after death of a loved one are common signs of grieving

behaviour rather than psychosis in Southwest Indian groups (Shen, 1986; Matchett, 1972).

Antisocial personality: SADS-L criteria require adjustment for high rates of unemployment and related problems of job access, and for high contact rates with law enforcement agencies. Aboriginals typically have more close-knit family networks; hence, the standard criterion of lack of close relationships is *less* likely to be met.

5.3 Research Themes and Questions

In this section, we summarize the crucial research themes and questions identified in this review, along with some comments on appropriate methodologies specific to these questions. Given the nascent state of most mental health care and psychiatric services, research on health promotion and intervention cannot be entirely divorced from more basic questions about the nature of illness and the effective ingredients of change and healing.

Among the questions to be addressed at the level of psychological processes are:

- How are depression, anxiety and demoralization expressed and coped with within Aboriginal communities? Expressions of distress vary widely cross-culturally so that psychiatric diagnostic categories may give a very incomplete picture of local forms of distress (Kirmayer, 1989a) . We need to know more about cultural variations in the expression of distress so that treatable disorders can be recognized. We need to understand the social response to problems so that helpful strategies can be supported and maladaptive responses modified.

- What role do culture-specific notions of the self and the person play in the cognitive and behavioural processes that contribute to depression, anxiety and other mental disorders?

- How do some individuals resist the damaging effects of widespread social problems and political disempowerment?

- Traditional values of non-interference may sometimes be viewed as "non-intervention," especially when compared to the mental health practitioners' training and impulse to actively intervene wherever possible. However, non-interference often reflects respect for others and may be coupled with subtler forms of influence not immediately apparent to outsiders. The circumstances under which denial and avoidance are adaptive strategies and under which they are themselves the cause of harm, are the focus of current controversies in health psychology and must be studied in the Aboriginal context.

- How must psychotherapy, family therapy and network interventions be modified to fit the social and cultural situation of Aboriginal peoples? We

need to develop culturally appropriate forms of psychotherapy and intervention that reflect the cultural concept of the person and cultural values (Kirmayer, 1989b) . Most psychotherapy is individualistically oriented and aimed at self-efficacy. To respect traditional values of family, community and spirituality, psychotherapy may need to be altered, or at least occur with a large measure of openness to alternate conceptions of the self.

Social processes affect the whole community and demand different research strategies to examine their impact. Important social questions for understanding and promoting Aboriginal mental health include:

- What accounts for the substantial variation in rates of mental disorders rates across communities?

- What is the effect of changing configurations of the family on parenting, the psychosocial development of children, and social supports for adults? (cf. Stack, 1992) .

- To what extent are economic factors (poverty, unemployment, and rate of growth) sufficient to account for differences in rates of mental disorders?

- How can we understand local variations in the relationship between ethnic identity, acculturation and mental health?

- How do community attitudes toward mental health and illness affect the course of psychiatric disorders?

Specific gaps in the research literature identified by this review include:

- Epidemiological research using structured interviews to ascertain the rates and correlates of psychiatric disorders in Aboriginal groups.

- Systematic comparisons across regions and tribal groups to identify variations and social correlates (e.g., Bachman, 1992) . The use of multivariable statistical techniques (e.g., logistic regression) allows determination of the contribution of specific risk factors, while the effects of other factors are held constant.

- Little mental health research has been done specifically for Aboriginal women and much of what exists is anecdotal or purely descriptive (Jilek-Aall, 1986). This is disturbing given the obvious differences in the impact of specific dimensions of culture and community change on men and women (Abbey et al., 1991). Some Aboriginal societies which were traditionally matriarchal became more patriarchal in response to contact with the political, economic and religious institutions of Canadian society. Both men and women are re-examining their roles in the context of history, religion and contemporary social realities. In many communities, women are emerging as leaders and significant change agents. This involves shifts and accommodations in traditional roles (McElroy, 1975). The impact of these progressive influences

on traditional concepts and practices needs to be examined so that it can be more openly and consciously debated by those who are directly involved.

- There is evidence for variations in the metabolism of psychiatric medications in different ethnic populations (Lin, Poland & Nakasaki, 1993). We need studies of the pharmacokinetics, pharmacodynamics and efficacy of major classes of psychiatric medications among Aboriginal peoples.

- We need studies of the comparative efficacy and styles of practice of primary care in Aboriginal communities. There is a lack of integration of psychiatry with primary care in many biomedical settings which gets carried over into health care delivery for Aboriginal peoples. Young (1988) argues that paraprofessionals may be more easily deployed to provide comprehensive primary care on reserves. We need information on the workings of interdisciplinary teams where conventional hierarchies are altered and inappropriate.

- We need further study of forms of community change and empowerment as potential responses to social problems and mental illness. Community development and local control of health care systems serves not only to make them responsive to local needs but to provide a means of promoting a more general sense of self-efficacy and pride that contributes to positive mental health.

- We need studies of the nature of the stigmatization of deviant behaviour and labelled psychiatric patients in Aboriginal communities. The level and type of stigmatization of mental disorders varies widely across different Aboriginal groups (Thompson et al., 1993). Stigma may contribute to the course and outcome of a wide range of social problems and psychiatric disorders, from schizophrenia to alcohol and substance abuse.

- We need information on hierarchies of resort both within Aboriginal communities and in urban settings. People in Aboriginal communities often use both traditional and Western style medicine. They may adopt very pragmatic assessments of what works.

- We need studies of misdiagnosis. Clinician biases may lead to over-diagnosis of psychosis, under-diagnosis of affective disorders and errors in treatment prescription. Uncooperativeness or reluctance to divulge information, or pervasive mistrust on the part of Aboriginal patients, may be readily misinterpreted as impairment by clinicians, when it may be an appropriate response to prior violations of personal and community integrity.

- There is a need to study the issue of ethnic matching with respect to Aboriginal practitioners.

- There is a need for studies on problems of translation and culture brokerage in mental health. This involves broadening the perspective from a focus on

the patient to the clinician-patient dyad, the translator-patient-clinician triad and beyond to the family and community context of health care interactions.

- There is a need for more research on the predicament of the community worker in remote and small scale communities. Mental health disciplines and techniques have evolved in larger scale urban contexts where distance, anonymity and limited technical roles are feasible. These assumptions of the professional role are unrealistic in most Aboriginal communities. The consequence for outside health care providers working in Aboriginal communities may be that they hold themselves aloof from the community in ways that are unhelpful. Aboriginal workers in their own communities face a uniquely difficult, if not paradoxical, situation in applying conventional mental health professional roles and models to their own kin and neighbours. Just as more attention must be focused on the predicament of indigenous community workers, there is need to study the role of the outside consultant, or itinerant professional health care worker.

5.4 Implications for Intervention

Previous working groups have clearly set out the broad agenda for Aboriginal mental health (Steering Committee, 1991). The basic principles include: a holistic approach to health (that is, avoiding the segmentation of care and narrow focus of biomedicine to encompass biological, psychological, sociocultural and spiritual dimensions of health and well-being); the coordination of multidisciplinary services; a continuum of care from promotion to prevention, treatment, support and aftercare; mental health training of existing workers; the development of specialized indigenous training centers; a focus on child and family; experiential learning; and the development of indigenous models. While embracing these principles, we offer the following specific implications of extant research for promoting mental health and providing care for mental illness among Aboriginal peoples; there is a need to:

- provide basic biomedical and psychiatric care; train primary care providers to better detect and treat major depression, panic disorder, and other psychiatric disorders

- develop and improve access to treatment programmes for substance use

- develop cadres of Aboriginal workers with skills in counselling

- develop culturally sensitive approaches to psychotherapy

- address problems at community and political levels as well as at the individual level; specifically, to promote empowerment of individuals and communities so that people come to feel a greater sense of coherence and control over their lives

- promote active transmission of traditional language and life skills from elders to young people

- support and develop symbols and symbolic enactments of group and community pride

- develop culturally appropriate educational programmes for youth and parents that address problem solving, dealing with substance abuse, depression, anger, relationship conflicts and other life events

- develop new models of mental health practice that are more deeply rooted in traditional and emerging concepts of community.

Finally, we note that there are certain problems not of culture but of scale, that affect the applicability of mental health programmes designed for urban settings. In small communities, identifying vulnerable individuals may have damaging effects on their social status and integration, further aggravating their situation. As well, in small communities there are no secrets so that usual guarantees of professional confidence may be more or less meaningless. The development of interventions must thus proceed with the participation of community members, experts on social process and cultural practitioners and not by mental health practitioners, who simply transplant models of care appropriate to their familiar settings to Aboriginal communities.

In accord with previous reports, we believe that the fragmentation of mental health programmes into substance abuse, violence, psychiatric disorders, suicide prevention and so on is not the best way to proceed (Steering Committee, 1991). There is great overlap between the affected individuals, the professional expertise and the appropriate interventions. Indeed, in many cases, it is not helpful to single out the specific problem as an explicit focus at the public or popular level because focusing attention exclusively on the problem, without attending to its larger context, can do more harm than good. We therefore advocate that a comprehensive approach to mental health and illness be integrated within larger programmes of health promotion, family life education, community and cultural development and political empowerment.

APPENDIX A

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