

Healing Traditions

Healing Traditions

The Mental Health of Aboriginal Peoples in Canada

Edited by Laurence J. Kirmayer and Gail Guthrie Valaskakis



UBC Press · Vancouver · Toronto

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16 15 14 13 12 11 10 09 5 4 3 2 1

Printed in Canada on acid-free paper

Library and Archives Canada Cataloguing in Publication

Healing traditions : the mental health of Aboriginal peoples in Canada /
edited by Laurence J. Kirmayer and Gail Guthrie Valaskakis.

Includes bibliographical references and index.
ISBN 978-0-7748-1523-9

1. Native peoples – Mental health – Canada. 2. Native peoples – Mental health services – Canada. I. Kirmayer, Laurence J., 1952- II. Valaskakis, Gail Guthrie

RC451.5.I5H44 2008 362.2'08997071 C2008-906205-1

Canada

UBC Press gratefully acknowledges the financial support for our publishing program of the Government of Canada through the Book Publishing Industry Development Program (BPIDP), and of the Canada Council for the Arts, and the British Columbia Arts Council.

This book has been published with the help of a grant from the Canadian Federation for the Humanities and Social Sciences, through the Aid to Scholarly Publications Programme, using funds provided by the Social Sciences and Humanities Research Council of Canada.

UBC Press
The University of British Columbia
2029 West Mall
Vancouver, BC V6T 1Z2
604-822-5959 / Fax: 604-822-6083
www.ubcpres.ca

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Foreword

GEORGES HENRY ERASMUS

When one considers the material consequences of Canada's century-long policy of state-sponsored, forcible assimilation, a simple fact emerges: for generations, opportunities to live well *as an Aboriginal person* have been actively frustrated. Successive governments, committed to the notion that Aboriginal cultures belong only to the past, have made no provision for the well-being of these cultures in the present and future. In the arrangement of Canada's social affairs, only the assimilated Indian has been offered even the prospect of wellness. For those who resisted or refused the benefits of assimilation, government policies assured a life of certain indignity. That is the essence of life in the colony: assimilate and be like us or suffer the consequences.

But to go on blaming government for our problems is, as we know, to stop short of solutions. Canada has responsibilities, articulated in treaties and in other formal agreements with Aboriginal people. Canada furthermore has a role to play in the present work of healing and reconciliation. However, our healing and well-being are and ought to be our own responsibility. What Wilfred Pelletier wrote of freedom is true also of wellness: "It is not something government can give you. Government does not have it, you have it, and when you realize this you exercise it responsibly" (*No foreign land* 1973, 149-50). The task of securing our well-being and that of our children is the ultimate task of our cultures. As noted in one of the contributions to this volume, "culture is treatment, and all healing is spiritual."

For many years now, Aboriginal people have been on a healing journey. We began to address the conditions of our communities even before the demise of the government-managed Indian residential schools. Focusing on addictions and a renewed commitment to traditional Aboriginal teachings, the healing movement in its early days embraced a holistic view of individual and community wellness. Perhaps the most dramatic example of community healing to date has been Alkali Lake (Esketemc First Nation), in British Columbia. The return of this society from a state of near-universal addiction became the subject of a video, *The Honour of All: The Story of Alkali Lake*. The case of Alkali Lake, which achieved a 95% rate of sobriety, demonstrates hope and potential when even one dedicated person is committed to the goal of community wellness.

Fortunately for us, there are today thousands of committed Aboriginal people across Canada and indeed across the world. Their strength and resilience is a source of much-needed encouragement. Every year many more rise, take the first uncertain steps, and add to a growing momentum that we hope will carry us forward.

Since 1998 the Aboriginal Healing Foundation has encouraged and supported community-based healing initiatives that address the intergenerational legacy of physical and sexual abuses suffered in Canada's Indian residential school system. We know today that the residential schools have contributed to unresolved historical trauma and that the healing of this trauma is critical to our ability to address other pressing social concerns. And so, like the authors, the Aboriginal Healing Foundation looks forward to a time when Aboriginal people have addressed the effects of unresolved trauma in meaningful terms, have broken the cycle of abuse, and have enhanced their capacity as individuals, families, communities, and nations to sustain both their well-being and the well-being of future generations.

This collection challenges many common assumptions, as it should. The terrain of mental health is broad, varied, and incompletely seen from any one vista. In the following pages, mental health is considered from a variety of critical perspectives that subject even the notions of mental illness and Aboriginal healing to constructive analysis. What these writings bear in common is a commitment to the principle that we as Aboriginal people must take possession of our wellness. This principle includes the freedom to critique, to debate, and, one hopes, to arrive at a constructive consensus of the definitions of healing.

This collection will contribute to just such a discussion.

Masi.

Preface

This is the first book dedicated to bringing together research and reflection on the mental health of Aboriginal peoples in Canada from a wide range of perspectives, with contributions from psychiatry, psychology, anthropology, women's studies, sociology, and education. This is not a handbook of practice but a resource for thinking critically about current issues in the mental health of indigenous peoples. Thus there is an emphasis on cultural analysis of the concepts, values, and assumptions that shape mental health theory and practice and on the nature of Aboriginal identity and experience. Understanding the multiple meanings of Aboriginal identity requires an appreciation of history and contemporary and political realities. This book examines some of these contexts and cultures – and traces their implications for mental health. Although the focus is necessarily on social suffering and affliction, we have tried to strike a balance between looking unflinchingly at the problems faced by Aboriginal peoples and recognizing their equally evident well-being, resilience, and renewal. We believe this approach will be useful for a wide range of readers in Aboriginal communities as well as in the general population, including health professionals, community workers, planners and administrators, social scientists, researchers, educators, and students.

Our title, *Healing Traditions*, has several potential meanings. First, it refers to recovering and applying traditional methods of healing. Aboriginal peoples had a wide range of methods of healing that served to integrate the community and provide individuals with systems of meaning to make sense of suffering. These traditions were displaced and actively suppressed by successive generations of Euro-Canadian missionaries, governments, and professionals. Restoring these traditions, therefore, makes available a great variety of potentially effective forms of healing that may fit especially well with the values or ethos of contemporary Aboriginal peoples.

More broadly, the recovery of traditional healing involves ceremonies and practices that engage not just individuals but also families and communities in ways that can promote solidarity, social support, and collective transformation. Many indigenous ways of understanding the person include an ecocentric sense of self that contrasts with the individualism that underwrites most contemporary mental health theory and practice. For most Aboriginal peoples, traditional subsistence activities (e.g., hunting, fishing, trapping)

were deeply integrated with spiritual beliefs as well as with family and community relationships. Returning to the land to take part in these activities may then have healing value for both troubled individuals and whole communities.

Traditional healing is also healing through tradition. The recovery of tradition itself may be healing, both at individual and collective levels. Efforts to restore linguistic, religious, and communal practices can be understood as fundamental acts of healing. Retrieving and transmitting the knowledge associated with healing practices reaffirms core cultural values and maintains the historical continuity of Aboriginal cultures.

Finally, traditions themselves need to be reconfigured to meet the challenges of the contemporary world. The effort to reassert cultural traditions results in individuals and communities taking political action to claim their place in the larger world, at the levels of regional, national, and global society, and this too may have positive effects on health. Establishing legal claims to traditional lands and self-government may also be viewed as crucial elements of reasserting the autonomy that was central to traditional culture, even when the forms of social life, community, and governance necessarily reflect contemporary political structures.

Notions of mental health and illness cover a broad territory that includes well-being, everyday problems in living associated with bodily symptoms of stress and anxiety, mild depression, and seasonal fluctuations in mood and energy, as well as more severe psychiatric disorders, such as major depression, bipolar disorder, schizophrenia, and other psychotic disorders. There are several reasons for collecting such a diverse group of conditions under the broad term “mental health”: they all involve processes of behaviour and experience related to mental or psychological functions; there are overlapping causes, symptoms, and, in some instances, similar treatments that work to ameliorate many of these conditions, promoting health, resilience, and recovery; and finally, these all fall under the domain of the “psy” professions in contemporary health care – psychiatry, psychology, social work, family therapy, and so on.

Concepts of mental illness and psychiatric disorder focus on problems and pathology. The clinical professions are committed to trying to understand and help those who are obviously ill, suffering, and disabled by offering specific forms of therapy, marshalling appropriate resources, and engaging in social advocacy. At the same time, we recognize that mental afflictions are part of the human condition: we all have difficulties at times, and we are all striving for better functioning, greater well-being, and positive life attitudes and experiences. Recognition of the universal importance of mental well-being suggests that we focus not only on mental illness but also on mental health. A focus on health, well-being, and resilience draws attention to what works, to what can be learned from those who are healthy despite adversity – those who find creative solutions to life’s challenges.

The term “mental health” is therefore both less stigmatizing and more positive than mental illness, which is likely why it is preferred by many individuals and organizations.

There is the risk, however, that in focusing on the positive, on solutions, and on the milder end of the spectrum, we ignore those who are carrying the heaviest burden of illness, whose behaviour and experience may be more out of the ordinary, strange, and disturbing, and who may be blamed, stigmatized, and scapegoated. We therefore think it is crucial to retain this broad and flexible use of the term “mental health,” which encompasses the whole range of human problems, in an effort to reduce the stigma attached to mental illness and to signal a commitment to address all forms of suffering.

Although psychology and psychiatry tend to focus on the individual, many of the problems people face involve interactions with others – in couples, families, communities, or wider social networks, including governments and global economic systems. As the contributors to this volume emphasize, what is distinctive about Aboriginal mental health is the shared history and social predicament that has made many communities vulnerable to a range of social problems that, in turn, increase the risk of emotional suffering. The challenge for mental health theory and practice is to develop perspectives that are deeply informed by an understanding of this social and cultural history and current political and economic contexts.

The book is divided into four sections: an introduction to the mental health of indigenous peoples; origins and representations of social suffering; transformations of identity and community that contribute to resilience; and traditional healing and mental health services. However, all of the contributors discuss issues that span these divisions, so the book is structured more like a spiral that returns to core questions again and again in ways that can enlarge our understanding. The cross-cutting themes make it possible to pursue many paths through the book, to follow discussions of the impact of colonialism, sedentarization, and forced assimilation; the importance of land for indigenous identity and an ecocentric self; the notions of space and place as part of the cultural matrix of identity and experience; the processes of healing; and the importance of spirituality as a counterbalance to the competitiveness and materialism intrinsic to urban industrialized societies and consumer capitalism.

In the introductory chapter, Laurence Kirmayer, Caroline Tait, and Cori Simpson outline some of the historical background and current context needed to understand what is distinctive about the mental health of Aboriginal peoples. The diverse indigenous cultures of North America developed many unique ways of life and rich cultural traditions reflecting the ecological contexts in which they lived. These were radically challenged and transformed by European colonization and the policies of forced assimilation adopted by governments. Although it is difficult to prove a direct causal link, it is likely that the collective trauma, disorientation, loss, and grief caused by these short-sighted and often self-serving policies are major determinants of the mental health problems faced by many Aboriginal communities and populations across Canada.

In the second chapter, Mason Durie, Helen Milroy, and Ernest Hunter note the similarities in experiences of Anglo-settler colonialism in Australia, Canada, New Zealand, and

the United States. Their discussion of Aboriginal and Torres Strait Islander Australians and of Māori New Zealanders provides an illuminating set of comparisons to the situation in Canada. Despite the parallel history, there are important differences between the countries in demography, culture, and politics. The high proportion of indigenous people in the population of New Zealand has contributed to a new era of bicultural national identity that bodes well for the health of Māori. In Australia the more fragmented and marginalized Aboriginal population has continued to struggle with devastating social problems and, until recently, a lack of basic recognition and restitution from government.

In his contribution, anthropologist James Waldram critiques the ways that the notion of Aboriginality itself has been constructed and construed in mental health research. He identifies four main approaches in quantitative research that define Aboriginal identity in terms of blood quantum, legal status or self-identification, geographic region or culture area, and individual cultural orientation or acculturation. Each approach raises problems because it overgeneralizes, essentializes, and stereotypes identity in terms of sets of traits or qualities that do not characterize any single individual.

Psychologists Grace Iarocci, Rhoda Root, and Jacob Burack provide an overview of developmental approaches to understanding social competence and mental health among Aboriginal youth. They discuss integrative developmental models that include the interactions of individuals, families, and communities with culture, social context, and the ecological environment. They review research on resilience among inner-city youth and ethnic minority groups as well as the much smaller quantity of research on Aboriginal children and youth. These studies make it clear that resilience is not a single global trait or fixed characteristic of individuals but an ongoing process of adaptation based on diverse processes of growth and transformation. Individuals may show strength and resilience in one domain while having difficulties in other areas. Iarocci and her co-authors draw out the broad implications of a developmental perspective for mental health promotion and future research.

The contributions to the second section look more closely at the predicaments of particular communities, major historical changes, and specific types of mental health problems to trace the origins of the social suffering experienced by many Aboriginal communities. At the same time, they look at the prevalent social representations of these problems. The ways that Aboriginal peoples and communities are represented in popular mass media, as well as in academic writing and government reports, can play an important role in improving or aggravating their predicaments.

Colin Samson describes the Innu predicament in terms of the metaphor of the double-bind. In Gregory Bateson's formulation, the double-bind is a no-win situation in which one is faced with inescapable contradictions and is prohibited from leaving the situation or talking explicitly about the paradox. Samson describes the profound social changes brought by sedentarization and forced relocation for the Inuit. Mental health professionals tend to emphasize individual agency and culpability and do not see the sociopolitical and historical "big picture," so they end up blaming individuals for social suffering, pointing

to unhealthy parents, corrupt leaders and undersupervised and misguided children. Governments also tend to downplay or ignore the historical context because it allows them to sidestep their own responsibility. As a result of ignoring this larger context, even well-intentioned interventions tend to aggravate existing problems.

Jo-Anne Fiske explores another form of silencing and marginalization: the refusal to see the oppressive effects of the residential school system mandated by the Canadian government, which carried out a regime of forced assimilation for almost one hundred years. Fiske shows how the residential school was divided into gendered places: the outdoor fields where boys laboured and the indoor workshops where girls learned domestic skills. This symbolic organization of space was motivated by another powerful and pervasive dichotomy between the domestic and the wild, or between modern civilization and primitive savagery. The residential school as a whole was viewed as a domestic space, which served effectively to hide its political functions of containment, assimilation, and elimination of indigenous peoples through the education of their children. This elision of colonial history persists today and causes some to doubt on the claims of survivors of residential schools that they have suffered violent cultural oppression as well as physical and sexual abuse. Their claims of abuse are viewed as incredible – or at least, hard to credit – because they challenge the underlying assumption that a benevolent nation and church bestowed the gifts of civilization on backward peoples.

Dara Culhane describes the situation of urban Aboriginal women in Vancouver who are struggling with drug addiction, HIV infection, homelessness, and loss. Her interviews with these women reveal how their predicaments emerge from a cascade of events that reflect their poverty, marginalization, and disempowerment as Aboriginal women. Although the women themselves emphasize their own bad choices in life, it is clear that they have been choosing from the limited range of options created by bureaucratic systems and the exclusionary practices that affect Aboriginal people in both rural and urban society. Despite the harshness and desperation of their lives, the women emerge as struggling for a moral stance and presence in others' lives.

Drawing from his fieldwork in a Cree community in Manitoba, Ronald Niezen focuses on the phenomenon of suicide clusters. He details the historical changes faced by this community, including residential schools and the social impact of hydroelectric development, mining, and other forms of large-scale resource extraction. Like Samson, he notes the “inherently contradictory efforts to impart autonomy and self-sufficiency through the imposition of alien values.” The fact that suicides have tended to occur in clusters in some Aboriginal communities may tell us something important about the dynamics of suicide and other forms of self-destructive behaviour. Suicidal youth may be those who suffer estrangement from family and community, resulting in a lack of connection across the generations, and fall back on a small subgroup of similarly suffering and disaffected youths who reinforce each other's risky behaviour, impulsivity, and desperation, limiting their ability to imagine life-affirming alternatives or ways out of their shared quandary.

Caroline Tait examines recent concerns about an “epidemic” of fetal alcohol syndrome (FAS) among Aboriginal peoples. The pre-existing association of Aboriginal people with alcohol and drug abuse, coupled with new evidence about the potential effects of maternal substance use on the developing fetus, has led many to assume that problems related to fetal alcohol exposure are endemic in Aboriginal populations. However, this assumption has occurred in the absence of actual clinical diagnosis. Once FAS was identified as a potential problem, resources were made available to support intervention. This has encouraged communities to self-label in ways that fit the funding priorities. Tait points to the risk that, in this case, individuals and communities are accepting a label that implies permanent disability, and this may ultimately undermine collective aspirations for autonomy.

The third section continues the discussion of the impacts on mental health of the history of internal colonialism, sedentarization, and forced assimilation, but the emphasis shifts to consider notions of resilience – that is, what processes account for the fact that many individuals and communities have done well despite historical and contemporary adversities.

Michael Chandler and Christopher Lalonde present their influential work on the social correlates of suicide in Aboriginal communities. This research was originally inspired by Chandler’s work on the development of adolescent identity and sense of personal self-continuity, but they have extended this to a community-psychology approach that seeks correlations between health outcomes and social factors at the level of region, band, or community. Although most of their work to date has focused on suicide, more recently they have begun to examine outcomes like the frequency of accidents or school completion. Their developmental theory frames this in terms of individual and cultural continuity, yet continuity is not simply about preserving the past but equally about forging strong commitments to the future. They end with a plea for more effective knowledge transfer and suggest that encouraging communities to share their knowledge “laterally” with other communities may avoid some of the problems associated with the culture of experts, which tends to reproduce the colonial hierarchies of dominance and the devaluing of indigenous knowledge.

Reflecting on his work with the Cree of Mistissini over three decades, Adrian Tanner describes the social suffering brought about by sedentarization. However, he emphasizes the ways that the community has responded to this predicament by political engagement and by developing new healing practices. Individuals within Cree communities are exploring traditions that include pan-Indian spirituality, Pentecostalism, and Cree animism to create the diverse strands of what Tanner calls “the healing movement,” which involves annual gatherings and other collective activities aimed at cultural renewal and collective solidarity. Of course, there are significant differences of opinion over the right direction, and the community must contend with new tensions and conflicts between groups following divergent paths. Nevertheless, the active engagement with these healing activities constitutes a source and expression of vitality in the community.

In her chapter, Naomi Adelson also addresses the varieties of religion, tradition, and healing in Cree communities in Quebec. She reviews some of the history of Christian missionizing among the Cree, which led the community to make the religion its own. Based on interviews with church Elders, she provides a different point of view on the dilemmas posed by the new Native spirituality, which is rooted in pan-Indianism or in the recuperation of specifically Cree traditions. These dilemmas take on a particular dynamic in the light of generational differences, particularly given the experiences of youth with new levels of mobility and their connections to a global network.

The Inuit in Canada's North have faced one of the most rapid and dramatic changes in way of life of any people. In a chapter based on ethnographic fieldwork and clinical experience in Nunavik, Laurence Kirmayer, Christopher Fletcher, and Robert Watt describe Inuit concepts of mental health and illness. Contemporary understandings of mental health problems draw from popular psychology, Christian religious ideas, and more specifically Inuit notions of both spirituality and an ecocentric self. The person is seen as intimately connected to the land through diet, activities, and values. Mental health and healing can be powerfully influenced by eating country food, hunting, and camping on the land. These indigenous notions of an environmental, or land-based, psychology offer an important complement to current models of the person in mental health.

Inuit mental health and well-being are also the topic of the chapter by Michael Kral and Lori Idlout, who discuss the transformations of identity and community in Nunavut. The creation of Nunavut itself, as a political entity, has been an important milestone, affording the Inuit a greater measure of authority in their own land. Despite this political advance and government programs promoting "healthy communities," many settlements have continued to suffer high rates of suicide, domestic violence, and other social problems. Some Inuit communities have done well, and Kral and Idlout explore possible reasons for these regional differences. They discuss the factors that may contribute to a sense of collective agency and *nunalingni silatuningit*, or community wisdom.

The last section considers issues of treatment intervention, illness prevention, and health promotion with discussions of Aboriginal healing and the provision of mental health services.

Rod McCormick outlines contemporary approaches to psychological counselling grounded in Aboriginal values and perspectives. These approaches start with the recognition that substance use and related mental health problems are not only symptoms of individuals' distress but also efforts to cope with untenable social situations brought on by a history of collective oppression.

Gregory Brass presents an ethnographic study of healing and identity in a residential therapeutic program for a diverse group of Aboriginal men in the correctional system. The treatment program used a generic construction of Aboriginal identity, emphasizing pan-Indian spirituality, combined with standard methods of counselling and psychotherapy, to create hybrid forms of group and individual therapy. This hybrid Aboriginal identity and therapeutic practice was meaningful to many clients, who differed from one

another in cultural, linguistic, and personal backgrounds. However, some participants found the pan-Indian symbolism or the psychological idioms strange and uncomfortable.

At present, more than half of all Aboriginal people live in cities. Mary Ellen Macdonald examines the predicament of urban Aboriginal residents in the Montreal region seeking mental health services. Most Aboriginal people in the city are expected to make use of mainstream services, where there is virtually no attention to issues of Aboriginal identity and culture. Community organizations like the Native Friendship Centre provide some counselling and support but are not well integrated with other resources. Unlike Toronto, Winnipeg, and some other cities in Canada, Montreal has no specialized clinics or services for most Aboriginal people. However, Macdonald's interviews with members of the Aboriginal community in Montreal reveal caution and ambivalence about the potential to develop ethnospecific services, with many expressing concerns about confidentiality, stigma, and further marginalization.

Cornelia Wieman describes the unique mental health services developed at the Six Nations reserve in Ontario. The community is large enough to sustain its own comprehensive mental health clinic with psychiatric nurses, social workers, psychologists, and several part-time psychiatrists. The aim is to provide quality mental health care that is respectful of local values and traditions. Their links to the community give practitioners inside knowledge and understanding of how to mobilize social networks and supports to enhance care. At the same time, conflicts over jurisdiction and funding force staff to engage in constant struggles in order to ensure a secure future for the service.

Writing from his perspective as a Native American clinical psychologist, educator, and researcher, Joseph Gone discusses the perils of academia and professional education. Education provides credentials needed to achieve a social status and to command the power and resources to effect change. At the same time, education involves acquiring a set of identities, practices, values, and ways of knowing that belong to the "whiteman." Psychotherapies provide languages of selfhood rooted in Euro-American culture that have particular moral and political implications – some of which may be at odds with indigenous values. Gone suggests, therefore, that Aboriginal communities should be more cautious in adopting the latest popular psychological theory or treatment fad. Although some indigenous scholars have been deeply suspicious of the value system inherent in science, Gone makes the provocative argument that "scientific knowing is *probably all that recommends psychology as a profession.*" The epistemology of science allows a kind of systematic inquiry and verification that goes beyond commonsense knowledge, and this approach should be claimed and used by indigenous scholars and practitioners.

In the concluding chapter, Kirmayer, Brass, and Gail Guthrie Valaskakis examine some of the implications of the many forms of healing and diverse interpretations of tradition presented throughout this volume. Healing is a universal human experience built out of symbols, metaphors, and actions that are grounded in specific traditions. Recuperating these traditions is, thus, a way to restore cultural riches that belong to a people and that,

through them, are of significance to all of humanity. “Tradition” is a term of veneration, linking contemporary knowledge and identity to a valorized past. But all living traditions undergo constant renovation and reinvention. To recognize the ways forward for Aboriginal peoples in Canada, we need to understand this process of inventing the present by simultaneously respecting the past and imagining the future.

This book has had a long gestation, and many people have contributed to bringing it to completion. At various stages in its development, the co-ordinators of our Québec Aboriginal Mental Health Research Team and the National Network for Aboriginal Mental Health Research have done background research and managed the logistics. Deepest thanks to Gregory Brass, Aimee Ebersold, Shannon Dow, Tara Holton, Cori Simpson, Caroline Tait, and Marsha Vicaire. Dianne Goudreau generously contributed her editorial expertise and Robert Lewis ably copy-edited the final manuscript. Kay Berckmans and Antonella Clerici provided administrative and secretarial support and facilitated the meetings and conferences that led to this publication. Darcy Cullen of UBC Press shepherded the manuscript through the editorial and production process with tact and creativity.

This book has been published with the help of grants from the Aboriginal Healing Foundation and the Canadian Federation of the Humanities and Social Sciences, through the Aid to Scholarly Publications Programme, using funds provided by the Social Sciences and Humanities Research Council of Canada. Preparation of this volume was also supported by grants from the Canadian Institutes of Health Research (CIHR), the Institute of Aboriginal Peoples’ Health, and the Institute for Neurosciences, Mental Health and Addictions. We thank Jeff Reading and Remi Quirion for their vision in fostering the National Network for Aboriginal Mental Health Research. The Aboriginal Healing Foundation supported Gail Guthrie Valaskakis’ co-leadership of the Network and participation in this book project. The Department of Psychiatry and the Lady Davis Institute for Research of the Sir Mortimer B. Davis – Jewish General Hospital in Montreal have supported our work in Aboriginal mental health since its inception.

The National Network for Aboriginal Mental Health Research, founded with a grant from the CIHR Institute of Aboriginal Peoples’ Health, is a vehicle for training and fostering collaborative, community-based research that can contribute to improving the mental health of Aboriginal peoples. This volume is one fruit of this ongoing collaboration. This book has many Aboriginal voices, but there are still too few involved in the fields of mental health research and practice. It is our hope that these essays will inspire others to take up the challenge of rethinking mental health and healing from diverse perspectives.

Laurence J. Kirmayer
Gail Guthrie Valaskakis
2007

With great sadness, I note the untimely death of my friend and colleague Gail Guthrie Valaskakis. Her creative vision, wise counsel, and steadfast commitment made the National Network for Aboriginal Mental Health Research a reality. Although she was not able to see this book in print, it stands as a testament to her belief in the value of socially relevant research and collaboration among researchers from diverse disciplines and backgrounds as a means to further the health and well-being of indigenous peoples in Canada and throughout the world.

Laurence J. Kirmayer
2008

PART 1

The Mental Health of Indigenous Peoples

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The Mental Health of Aboriginal Peoples in Canada: Transformations of Identity and Community

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Around the world, indigenous peoples have experienced colonization, cultural oppression, forced assimilation, and absorption into a global economy with little regard for their autonomy or well-being. These profound transformations have been linked to high rates of depression, alcoholism, violence, and suicide in many communities, with the most dramatic impact on youth (Waldram, Herring, and Young 2006; Warry 1998). Despite these challenges, many communities have done well, enjoying high levels of health and well-being and continuing to transmit their cultural knowledge, language, and traditions to the next generation. This book brings together scholars, researchers, and clinicians from a range of backgrounds and perspectives to consider some key issues in the mental health of Aboriginal peoples, particularly in Canada.

In this introductory chapter, we provide an overview of the social and historical context that underpins current mental health disparities found among Aboriginal peoples of Canada. We first outline the profound changes in the material, social, and political conditions of life for Aboriginal peoples brought about by European colonization. Although it is not easy to prove causality when describing the unfolding of large-scale historical events, it seems clear that intensive interactions with colonizers and settlers as well as with the economic, bureaucratic, and technocratic institutions of Canadian society have been major determinants of the social distress experienced by Aboriginal communities today. We then review the clinical information available on the type and prevalence of mental health problems in Aboriginal populations. Next, we consider some of the ongoing transformations of individual and collective identity as well as the forms of community that have persisted despite adversity and that hold the seeds of resilience and renewal for Aboriginal peoples. The concluding section explores some implications of an emphasis on identity and community for mental health services and health promotion.

Aboriginal Peoples in Canada

According to the 2006 census, 1.17 million people self-identify as Aboriginal in Canada, representing 3.8% of the total population (Statistics Canada 2008). First Nations constitute

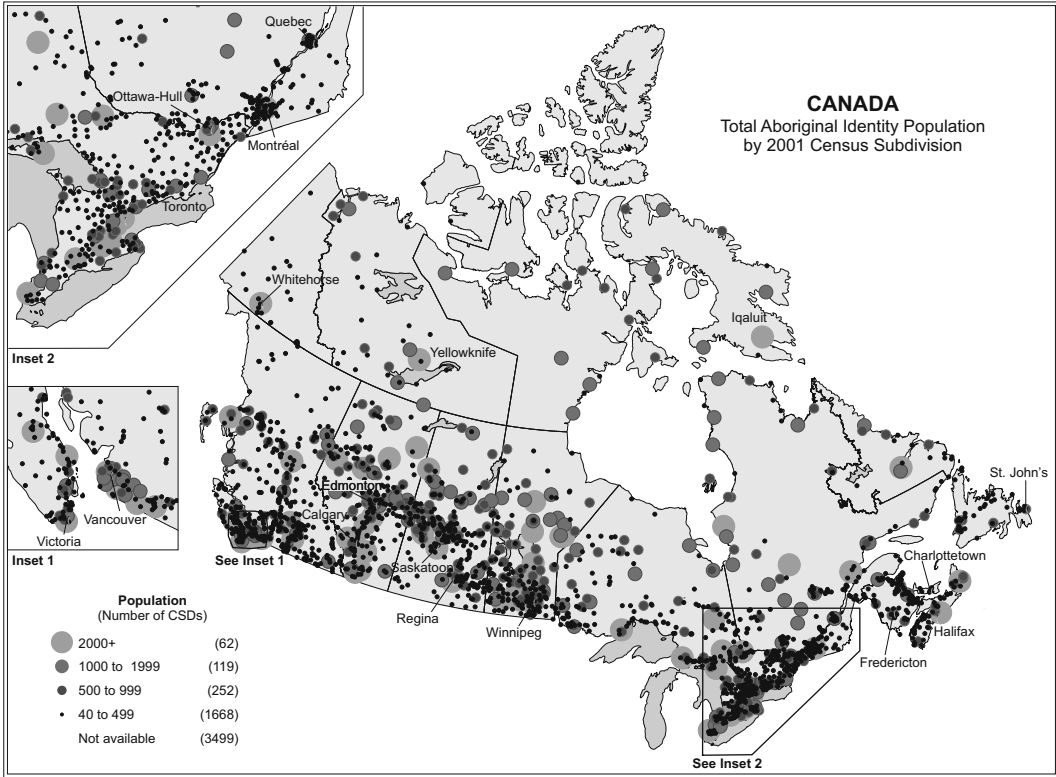


FIGURE 1.1 Geographic distribution of the Aboriginal population in Canada. Total Aboriginal population in Canada by census division, 2001. *Source:* Statistics Canada, 2001.

about 60% of the Aboriginal population, Métis 33%, and Inuit 4%.¹ First Nations are administratively divided into status and nonstatus Indians under the federal Indian Act (Imai 2003). In 2006, 698,025 people identified themselves as First Nations, of whom 564,870, or 81%, were registered as status Indians. The 2006 census estimated the Inuit population at 50,485, and there were 389,785 Métis. The nonurban population is distributed across many small communities that include 615 First Nations bands and 2,284 reserves and 52 Inuit communities (Frideres 2004; Government of Canada 2006; Statistics Canada 2008). More than half (54%) of Aboriginal people live in urban centres. About 60% of First Nations people live off-reserve, 3.4% of them in urban areas. Almost 70% of Métis live in urban areas. Fully 80% of Aboriginal persons live in Ontario and western Canada, with the greatest concentrations in the North and on the Prairies (Statistics Canada 2008). Most Inuit live in small settlements in the northern regions of Canada, mainly Nunavut (50%), Nunavik (northern Quebec) (19%), Nunatsiavut (northern Labrador) (4%), and the Inuvialuit region of the Northwest Territories (6%); about 17% of Inuit live in urban areas across Canada.

Demographically, the Aboriginal population is substantially younger than the general Canadian population: almost half of the Aboriginal population is under 24 years of age, making the mean age 27, compared to 40 for the non-Aboriginal population (Figure 1.1).

Indigenous people in Canada come from very diverse backgrounds, with greater cultural and linguistic differences between some groups than those that distinguish different European cultures. Broad culture areas have been described based on the importance of local ecology for traditional subsistence activities that were at the centre of social organization and cultural values (Figure 1.2). There is great linguistic diversity within this population, with more than 55 languages in 11 major language groups (Figure 1.3). In addition

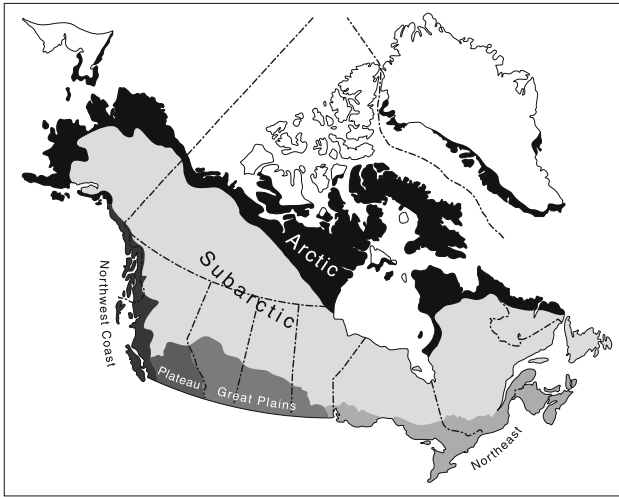


FIGURE 1.2 Cultural-ecological regions. *Source:* Natural Resources Canada.

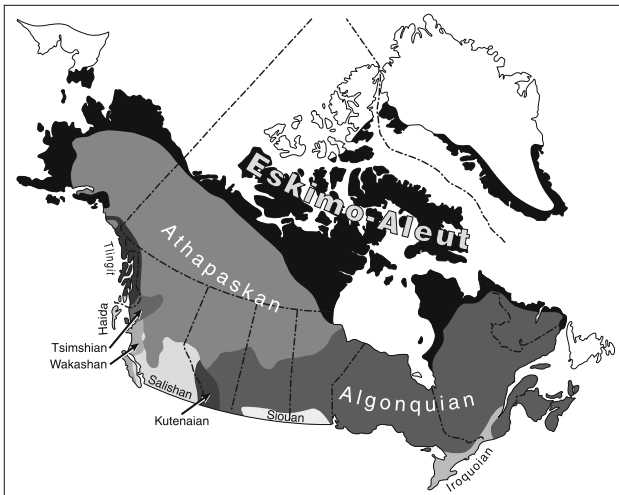


FIGURE 1.3 Language groups. *Source:* Natural Resources Canada.

to the social, cultural, and environmental differences between groups, there is an enormous diversity of values, lifestyles, and perspectives within any community or urban Aboriginal population. This diversity makes lumping groups together under generic terms like “Aboriginal” or “indigenous” misleading (see Waldram, Chapter 3). Nevertheless, although First Nations, Métis, and Inuit each have a unique historical relationship with European colonization and Canadian governments, they do share a common social, economic, and political predicament that is the legacy of colonization. This shared predicament has motivated efforts to forge common political fronts (i.e., the Assembly of First Nations and the Métis National Council) and, to some degree, a collective identity across diverse groups (e.g., the National Aboriginal Health Organization, the Native Women’s Association of Canada, and Quebec Native Women). Globally, there are also striking parallels in the histories of indigenous peoples around the world, suggesting that although biological, social, cultural, and political factors vary, there are common processes at work (Durie et al., Chapter 2; Kunitz 1994; Stephens et al. 2005).

Although there have been improvements in recent years, there continues to be a significant gap in life expectancy between Aboriginal peoples and the general Canadian population. According to Health Canada, in 2001 the average life expectancy for First Nations men was 70.4 years, compared to 77.1 for the general population; the corresponding figures for women were 75.5 versus 82.2.² Among Inuit, the figures for 1999 revealed an even greater disparity, with life expectancies of 67.7 for men and 70.2 for women. Aboriginal peoples suffer from a wide range of health problems at much higher rates than other Canadians (MacMillan et al. 1996; Waldram, Herring, and Young 2006). They have 6 to 7 times greater incidence of tuberculosis, are 4 to 5 times more likely to be diabetic, 3 times more likely to have heart disease and hypertension, and 2 times as likely to report a long-term disability. Injuries and poisonings are the main cause of potential years of life lost; Aboriginal peoples have 1.5 times the national mortality rate and 6.5 times the national rate of death by injuries and poisonings. The potential years of life lost before age 75 due to accidents or health problems is about 50% higher in geographic regions with a high proportion of Aboriginal residents (Allard, Wilkins, and Berthelot 2004). Almost 40% of these years lost are due to injuries, mainly suicide and motor vehicle accidents. The regions with the highest levels of premature years lost and lowest expectancies of living free of disabilities are characterized by being remote and rural and by having the sparsest population, high levels of unemployment, low educational attainment, and low household income. Social problems are also common. In a recent survey, fully 39% of Aboriginal adults reported that family violence is a problem in their community, 25% reported sexual abuse, and 15% reported rape (Health Canada 2002). The incarceration rates of Aboriginal adults are 5 to 6 times higher than the national average, and Aboriginal people account for fully 18.5% of the federal prison population (Brzozowski, Taylor-Butts, and Johnson 2006).

These health disparities and social problems are paralleled by elevated rates of mental health problems in some communities (Petawabano et al. 1994; Waldram et al. 2006). Age-standardized suicide rates of Aboriginal youth are 3 to 6 times that of the general

population (Kirmayer et al. 2007). In 2001 survey rates of emotional distress reported were about 13% among First Nations individuals living off-reserve, compared to 8% in the general population (Government of Canada 2006, 164). The rates may be higher on some reserves. Although these problems affect individuals, both their high prevalence and the great variability across communities underscore the need for a social perspective if we are to understand the sources of illness and suffering as well as resilience and healing.

Social Origins of Distress

Despite creation stories rooted in a timeless past and notions of cultural continuity, traditional Aboriginal societies in North America were not static over their 15,000 years or more of migration and development throughout the Americas, nor were they entirely free of disease or social problems (Ray 1996). However, a dramatically accelerated process of cultural change began in the sixteenth century through interactions with European outsiders, which included those on fishing expeditions, explorers, itinerant traders whose ships put in for provisions, missionaries, fur traders, and colonists. In addition, there were encounters with Mesoamerican and Caribbean Natives who accompanied European expeditions (Trigger and Swagerty 1996).

The origins of the elevated rates of mental and social distress found in many Aboriginal populations are not hard to discern. Aboriginal peoples in Canada have faced cultural oppression and social marginalization through the actions of European colonizers and their institutions since the earliest periods of contact. Culture contact brought with it many forms of depredation. Economic, political, and religious institutions of the European settlers all contributed to the displacement and oppression of indigenous people.

Early missionary activities focused on saving heathen souls through religious conversion. In many cases, this involved suppression or subversion of indigenous spiritual beliefs and practices that were integral to subsistence activities and to the structure of families and communities. Although Aboriginal peoples engaged in trade to further their own interests, early trade and military alliances with Europeans were generally arranged without regard for Aboriginal cultural values or relationships. With colonization, these sporadic encounters took on a new scale and intensity, resulting in escalating levels of violence against Aboriginal peoples – violence driven by fear and avarice and justified by ideologies that viewed the indigenous peoples of the Americas as “savages” and that declared the entire continent *terra nullius*, “no man’s land,” a land unclaimed and free for the taking.

The history of the European colonization of North America is a harrowing tale of decimation of the indigenous population by infectious disease, warfare, and active suppression of culture and identity, an undertaking that was tantamount to genocide (Stannard 1992; Thornton 1987). Despite the escalating levels of violence toward indigenous peoples, the greatest killers were new diseases brought by the colonizers, including smallpox, measles, influenza, bubonic plague, diphtheria, typhus, cholera, scarlet fever, trachoma,

whooping cough, chicken pox, and tropical malaria. Estimates of the indigenous population of North America prior to the arrival of Europeans range upward from about 7 million.³ Close to 90% of these people died as a result of the direct and indirect effects of culture contact. For example, the population of northern Iroquoian peoples is estimated to have dropped from about 110,000 in the early seventeenth century to about 8,000 by 1850 (Trigger and Swagerty 1996).

Colonization did not end with the creation of new nation-states. Over the past century, Canadian and American government policies have continued the process of destruction of indigenous cultures and ways of life through forced sedenterization, creation of reserves, relocation to remote regions, residential schools, chronic underfunding and poor resourcing of essential services such as health care and education, and bureaucratic control (Miller 2000; Neu and Therrien 2003; Richardson 1993). For example, the crowded, poor-quality housing in most Aboriginal settlements increased the risk of transmission of contagious diseases, including tuberculosis, which necessitated prolonged hospitalizations, further subverting the integrity of families and communities (Grygier 1994). Increasing reliance on European foodstuffs contributed to the growing dependence of indigenous peoples on European market economies. The negative health and social effects of this shift in diet and lifestyle are evident today, with problems of obesity and diabetes now endemic in many Aboriginal communities (Waldram et al. 2006).

Although the process of sedentarization began with the response of indigenous peoples to the presence of fur traders and missionaries, it took new form with the systematic efforts of the government to police, educate, and provide health care for remote populations. The location of virtually every Aboriginal settlement was chosen by government or mercantile interests rather than by the Aboriginal peoples themselves (Dickason 2002). In some cases, this resulted in arbitrary groupings of individuals or families with no history of living together in such proximity. Groups of people were essentially forced to improvise new ways of life and social structures. In many cases, Aboriginal peoples were relegated to undesirable parcels of land out of the way of the settlers' expanding cities and farms. When new land was needed for the settlers, Aboriginal communities were pushed still farther to the margins. Other forced relocations took place for more complicated political reasons. The disastrous "experiment" of relocating Inuit from Nunavik to the far North to protect Canadian sovereignty was a late chapter in this process of forced culture change that revealed the government's lack of awareness of basic cultural and ecological realities crucial to survival (Marcus 1992; Royal Commission on Aboriginal Peoples 1994; Tester and Kulchyski 1994).

These policies served the economic, social, and political interests of the dominant non-Aboriginal society and were supported by both explicit and subtler forms of racism and discrimination. Active attempts to suppress and eradicate indigenous cultures were rationalized by images and arguments that portrayed Aboriginal people as "primitive," "savage," and uncivilized (Titley 1986). This discounting of Aboriginal peoples' ways of life justified legislation that prohibited traditional religious and cultural practices like

the Potlatch or Sun Dance (Hoxie 1996). Aboriginal peoples were viewed as incapable of understanding and participating in democratic government, thereby motivating efforts to “civilize” and assimilate them into mainstream Canadian society.

Aboriginal children, particularly First Nations children, became the central target for assimilation strategies through their forced attendance at residential schools and out-of-community adoption into non-Aboriginal families. These efforts were part of an orchestrated plan of forced assimilation that emerged at roughly the same time in Canada, Australia, and New Zealand in accordance with British colonial policy (Armitage 1995).

The Canadian government informally recognized indigenous communities of Canada as peoples or nations, but they were viewed as uncivilized and hence unable to exercise rights as citizens in a democratic polity. The Bagot Commission Report (1844) argued that reserves in Canada were operating in a “half-civilized state” and that in order to progress toward civilization, Aboriginal peoples needed to be imbued with the principles of industry and knowledge through formal education. This report began a shift in Indian policy in Canada away from the principle of protection and toward active assimilation. This shift was reinforced by the Davin Report (1879), which recommended a policy of “aggressive civilization.” Aboriginal adults and Elders were described by this second report as having “the helpless mind of a child.” To be integrated into the emerging nation, therefore, Aboriginal children had to be separated from their parents and “civilized” through a program of education that would make them talk, think, and act like mature British Canadians.

From 1879 to 1973 the Canadian government mandated church-run boarding schools to provide education for Aboriginal children (Miller 1996). Following the recommendations of the Davin Report, residential education for Aboriginal children in Canada was modelled after the system of boarding schools for Native American children in the United States (Miller 1996; Milloy 1999). Although portrayed as places of education and enlightenment, most of the residential schools in fact functioned as “total institutions” (Goffman 1961) or “carceral spaces” (Foucault 1977) – enclosed places of confinement with a highly regimented social order apart from everyday life. The schools were located in isolated areas, and the children were allowed little or no contact with their families and communities. There was a regime of strict discipline and constant surveillance of every aspect of their lives, and cultural expression through language, dress, food, and beliefs was vigorously suppressed.

Over the span of 100 years, about 100,000 Aboriginal children, mainly First Nations, were taken from their homes and subjected to an institutional regime that fiercely denigrated and suppressed their heritage. At their height, there were 80 residential schools operating across Canada, with a peak enrolment in 1953 of over 11,000 students.⁴ Although some families welcomed the opportunity for formal education of their children, others desperately tried to avoid sending their children to the schools (Johnston 1988). The extent of the physical, emotional, and sexual abuse perpetrated in many of the residential schools has only recently been acknowledged (Haig-Brown 1988; Knockwood and Thomas 1992; Lomawaima 1993; Milloy 1999). Beyond the impact on children of abrupt separation

from their families, multiple losses, deprivation, and frank brutality, the residential school system denied Aboriginal communities the basic human right to transmit their traditions and maintain their cultural identity (Chrisjohn, Young, and Maraun 1997).

Intensive surveillance and control of the lives of Aboriginal peoples in Canada went far beyond the residential school system. Assimilation of Aboriginal peoples was the explicit motivation for the removal of Aboriginal children to residential schools. Aboriginal parents were not necessarily seen as “unacceptable” parents, only as incapable of educating their children and passing on “proper” European values (Fournier and Crey 1997; Johnston 1983). Beginning in the 1960s, the federal government effectively handed over the responsibility for Aboriginal health, welfare, and educational services to the provinces, despite remaining financially responsible for status Indians. Provincial child and welfare services focused on the prevention of “child neglect,” which emphasized the moral attributes of individual parents, especially mothers, and on enforcing and improving care of children within the family (Swift 1995). In the case of Aboriginal families, “neglect” was mainly linked to endemic poverty and other social problems, which were dealt with under what social workers referred to as “the need for adequate care.” However, improving care within the family was not given priority, and provincial child-welfare policies did not include preventive family counselling services, as they did in the case of non-Aboriginal families. Since there were no family reunification services for Aboriginal families, social workers usually chose adoption or long-term foster care for the Aboriginal children they took into care, resulting in Aboriginal children experiencing much longer periods of foster care than their non-Aboriginal counterparts (MacDonald 1995).

Beginning in the 1960s, as a result of heightened surveillance and concerns about child welfare, large numbers of Aboriginal children were taken from their families and communities and placed in foster care. By the end of that decade, between 30% and 40% of the children who were legal wards of the state were Aboriginal – in stark contrast to the rate of 1% in 1959 (Fournier and Crey 1997). By the 1970s about one in four status Indians could expect to be separated from his or her parents; rough estimates on the rates of nonstatus and Métis children apprehended from their families show that one in three could expect to spend his or her childhood as a legal ward of the state. Eventually, many of these children were adopted into non-Aboriginal families in Canada and the United States. Termed the “Sixties Scoop,” this practice lasted almost three decades – and statistics indicate that there is still an overrepresentation of Aboriginal children in the care of non-Aboriginal institutions and foster families (Gough et al. 2005).

The large-scale removal of Aboriginal children from their families, communities, and cultural contexts through the residential school system and the “Sixties Scoop” had damaging consequences for individuals, families, and whole communities. Much like former residential school students, who often returned to their communities in a culturally “betwixt and between” state, Aboriginal children relegated to the care of the state or non-Aboriginal families have experienced problems of identity and self-esteem growing up at the margins of two worlds. Physical and sexual abuse, emotional neglect, internalized

racism, language loss, substance abuse, and suicide are common in their stories (Fournier and Crey 1997; York 1990).

The intense governmental surveillance and bureaucratic control of the lives of Aboriginal peoples in Canada was mandated and institutionalized by federal Indian policy (Neu and Therrien 2003). Some of these policies were well intentioned, but most were motivated by a condescending, paternalistic attitude that failed to recognize either the autonomy of Aboriginal peoples or the richness and resources of their cultures and communities (Titley 1986).

The Indian Act (1876) was the most comprehensive piece of federal legislation directed toward the management of Aboriginal peoples in Canada. Although established over a century ago, this document continues to play an integral role in the lives and juridical identities of Aboriginal peoples. The Indian Act defines First Nations people as wards of the Crown, subjects for whom the state has a responsibility to provide care (Imai 2003). The broad application of the Act has included prohibiting participation in cultural activities such as the Potlatch and the Sun Dance, restricting movement by means of the pass system, creating social categories of identity such as “status” and “nonstatus Indians,” and exempting status Indians from taxation (Tobias 1976; Miller 1990).

The Indian Act has been the focus of great conflict and contestation in many First Nations communities, which have been forced to reconcile local notions of membership, citizenship, political participation, and structure with imposed legal sanctions and controls (Lawrence 2004; Sissons 2005; Valaskakis 2005). For example, until quite recently, the patrilineal descent recognized by the Indian Act resulted in the removal of Indian status from many First Nations women (and their children) who married non-First Nations men.

Acknowledging the colonial nature of the Indian Act and its negative consequences in communities across Canada, government officials have made some efforts to replace the Indian Act with a more modern document defining a more contemporary arrangement. In 1969 the federal government produced its “White Paper,” which asserted that existing Indian policies were discriminatory and argued that removing special status by abolishing the Indian Act would end this discrimination. However, the liberal philosophy behind the White Paper did not address some of the most basic values, concerns, and aspirations of Aboriginal people (Turner 2006, 29ff): it did not consider the legacy of colonialism and other institutions of forced assimilation that created a persistent pattern of inequalities and marginalization; it did not acknowledge indigenous rights as a unique form of group rights, not merely another instance of ethnocultural minority rights in the framework of Canadian multiculturalism; it failed to recognize the contested legitimacy of the initial formation of the Canadian state, in which Aboriginal peoples were incorporated into the new state with loss of land, power, and autonomy; and most critical for the process of creating a viable political arrangement, the White Paper was produced without the participation of Aboriginal peoples themselves. Far from being perceived as a positive step toward political equality, the “ex cathedra” manner in which the White Paper was produced, its paternalism, and its lack of recognition of the autonomy of Aboriginal peoples

created a sense of betrayal that has made leaders wary of subsequent efforts at reform (Turner 2006). In 2001 the Liberal government proposed the First Nations Governance Act (FNGA), which also met with considerable opposition since there was great concern that this legislation would disempower First Nations peoples and communities. The proposal was dropped, and debate continues on ways to rework the formal relationship between the government and Aboriginal peoples.

The Indian Act confers official status only on some First Nations individuals. Other Aboriginal peoples, including nonstatus Indians and Métis, have no official status. This has significant consequences for their relationship with government institutions. Along with nonstatus Indians, the Métis were denied access to programs such as the Non-Insured Health Benefits Program (which provides free medical services to status Indians and Inuit who are not covered by provincial health-insurance plans). Programs provided by the federal government to status First Nations and Inuit under the umbrella of the Medical Services Branch – more recently renamed the First Nations and Inuit Health Branch (FNIHB) – such as health centres, federal alcohol- and drug-abuse programs, initiatives for at-risk children, and a healthy-babies program, are not available to Métis and nonstatus First Nations, many of whom live in communities adjacent to the First Nation reserves that are served by these programs. Despite facing the same social and health problems, none of the provincial or territorial governments has yet to offer parallel programming for Métis and nonstatus First Nations (Chartrand 2006, 23).

The history of urbanization in Canada is also the history of the displacement and marginalization of Aboriginal peoples. The sites upon which many Canadian cities are built were traditional meeting places used by indigenous peoples as gathering spots or settlement areas (Newhouse and Peters 2003, 6). Prior to the mid-1990s, a variety of policies ensured Aboriginal peoples were excluded from urban centres. These policies reinforced an image that Aboriginal culture and identity are incompatible with urban residence. Urban migration has therefore often been interpreted as a decision by Aboriginal people to leave their rural communities *and* cultures in order to assimilate into mainstream society. Of course, there is no reason why an Aboriginal person cannot maintain and develop a distinctive identity and community in urban settings. By the 1980s, however, the focus of concern over Aboriginal urbanization had shifted from questions of cultural adaptation to the impact of poverty. By extension, the presence of indigenous people in cities came to be viewed as detrimental to the moral and physical conditions of both Aboriginal peoples and the urban community, providing another rationale for the further removal of indigenous people from city areas.

Over the past 50 years the percentage of indigenous people living in Canadian cities has risen to approximately 56% of the total Aboriginal population (Siggnor 2003, 16). The most urbanized groups are nonstatus Indians and Métis, with 73% and 66%, respectively, living in urban areas (Norris and Clatworthy 2003, 51). It remains relatively easy for Aboriginal people to move back and forth between rural or reserve communities and the city.⁵ Although indigenous peoples face some of the same challenges as other migrants,

many indigenous people are travelling within their traditional territories and expect that their indigenous rights and identities should make a difference to the ways that they are able to live their lives in urban areas (Norris and Clatworthy 2003, 6).

“Residential instability,” which is marked by frequent migration back and forth from cities as well as by high mobility within cities, may diminish the well-being of urban Aboriginal populations (Norris and Clatworthy 2003). High mobility may weaken social cohesion in communities and neighbourhoods where large concentrations of indigenous people live. Residential instability is associated with family instability and with a high proportion of female lone-parent families with low incomes that may experience high rates of crime and victimization. High mobility also makes it more difficult to deliver services such as schooling and housing to this population, and it destabilizes organizations such as Friendship Centres that provide health, employment, and education outreach and social services (Norris and Clatworthy 2003, 69-70). As a consequence, individuals and families living in these areas exhibit greater social problems (e.g., poorer education attainment, divorce, crime, suicide), which in turn leads to even greater levels of social disintegration. Therefore, a major challenge for indigenous peoples living in cities is to maintain social cohesion through collective activities and community strategies that reinforce indigenous cultural identity and develop urban institutions that reflect indigenous values.

To the organized efforts to assimilate, regulate, or destroy Aboriginal cultures are added the corrosive effects of poverty and economic marginalization. In 1991 the average income for Aboriginal people was about 60% of that of non-Aboriginal Canadians. Despite efforts at income assistance and community development, this gap had widened over the decades since 1980, and it has continued to grow (Frideres 2004). In the 1996 census 43.4% of Aboriginal people lived below the poverty line; in 2001 the figure was 55.9%. The effects of poverty are seen in many ways, including the poor living conditions on many reserves and in many remote settlements. A government survey in 2001 found that two-thirds of Aboriginal reserves had water supplies that were at risk for contamination.⁶ In the 2001 Aboriginal Peoples Survey, 34% of Inuit living in the North, 19% of Aboriginal people in rural areas, and 16% of those in urban areas reported that there were times in the year when their drinking water was contaminated. Aboriginal people are much more likely than the non-Aboriginal population to live in crowded housing. The 2006 census found that 31% of Inuit lived in crowded conditions, compared to 15% of First Nations people (26% of those living on reserves), and 3% of the non-Aboriginal Canadian population (Statistics Canada 2008). Aboriginal people are also much more likely than non-Aboriginal people to have a home in need of major repairs.

Of course, the current notions of poverty are the creation of the social order in which Aboriginal peoples are embedded, one that has economically marginalized traditional subsistence activities while creating demands for new goods. The presence of mass media even in remote communities makes the values of consumer capitalism salient and creates feelings of relative deprivation and lack where none existed before. Even those who seek solidarity in traditional forms of community and ways of life find themselves enclosed and

defined by a global economy that treats “culture” and “tradition” as commodities or useful adjectives in advertising campaigns (Krupat 1996).

These realities of globalization, together with the legacy of internal colonialism, contribute to the continuing political marginalization of Aboriginal peoples. Some groups, however, have been able to exploit the logic of mass media and the market to further their efforts to regain local control and stewardship of their land and people. For example, the Cree of northern Quebec have successfully fought against hydroelectric development in their territory through publicity aimed at influencing public opinion in the United States and abroad (Salisbury 1986). They have appealed to a global audience through moral arguments and suasion to achieve an influence beyond their local political or economic power. These manifest successes in challenging the Quebec provincial government, achieved on a global stage, likely have had a positive effect on the sense of efficacy and mental health of many Cree. This example illustrates the extent to which efforts at revitalization of communities and collective identities must be understood not only in terms of local politics or of the agendas of provincial and federal governments but also in terms of the forces of globalization that reach into even the most remote communities in contemporary Aboriginal Canada.

Mental Health Consequences of Cultural Suppression and Forced Assimilation

The terms “mental health” and “mental illness” cover a broad domain that encompasses personal growth and well-being, everyday problems in living, such common mental disorders as anxiety and depression, and severe mental disorders like schizophrenia or manic-depressive illness. Many social problems, including interpersonal violence, child abuse, alcohol and drug abuse/dependence, gambling, and antisocial behaviour, are also prominent mental health concerns because of their causes and consequences.

Qualitative ethnographic and epidemiological studies have documented high levels of mental health problems in some Canadian Aboriginal communities (Kirmayer 1994; Government of Canada 2006; Royal Commission on Aboriginal Peoples 1996; Waldram 1997a; Waldram et al. 2006). However, there are many gaps in knowledge and a great need for further systematic research to identify the prevalence, causes, and effective responses to specific mental health problems as well as the factors that contribute to health and well-being in many communities.

Epidemiological Studies of Mental Health

Older studies of mental health problems used symptom checklists or clinical impressions of individuals’ overall level of distress and impairment without distinguishing different types of problems. Contemporary psychiatric epidemiology uses structured interviews

administered by clinicians or trained lay interviewers to elicit reports of the specific symptoms, behaviours, and experiences. This information can then be used to make diagnoses following the diagnostic criteria of the World Health Organization (1992) or the American Psychiatric Association (2000). This gives a more detailed picture of the prevalence and co-occurrence of specific types of disorders, which may require different types of treatment intervention and have very different courses and outcomes. Psychiatric epidemiology faces many challenges in cross-cultural application because of differences in how people experience and express distress (Kleinman 1987; Kirmayer 1989; van Ommeren 2003). Generally, the way to address these limitations is to begin with careful qualitative ethnographic work in order to understand local models of illness and idioms of distress (Manson, Shore, and Bloom 1985; Canino, Lewis-Fernandez, and Bravo 1997; de Jong and van Ommeren 2002; Beals et al. 2003; Waldram 2006). This understanding of local cultural knowledge and practice can then be used to revise interviews, questionnaires, and criteria in order to ensure that they make sense and capture the relevant dimensions of illness experience.

Most estimates of the prevalence of psychiatric disorders in Aboriginal populations are based on clinic- or service-utilization records. Case reviews based on psychiatric consultation in Aboriginal communities indicate high rates of depressive disorders in some communities (e.g., Abbey et al. 1993; Armstrong 1993). However, since many people never come for treatment, service-utilization studies are usually at best only a low-end estimate of the true prevalence of distress in the community and may not give an accurate profile of problems in the community.

The few community surveys of prevalence rates among North American Aboriginal peoples indicate rates of psychiatric disorders that vary widely from levels less than the general population to levels twice those of neighbouring non-Aboriginal communities. This variation likely reflects both methodological difficulties in accurately assessing mental health across cultures and real differences among populations and communities that may provide important clues to the social origins of distress.

In the United States, Kinzie and colleagues conducted a 1988 follow-up study of a Northwest Coast village originally studied by Shore and colleagues in 1969 (Shore et al. 1973). In all, 31.4% of subjects met criteria for a current psychiatric diagnosis (Kinzie et al. 1992; Boehnlein et al. 1993). A marked sex difference was observed, with nearly 46% of men being affected, compared to only 18.4% of women. The presence of a psychiatric disorder was not related to age, marital status, or educational level, but men were much more likely to be affected (46%, compared to 18.4% of women). The surveys in both 1969 and 1988 found a very high rate of alcohol-related problems, with a lifetime rate of alcohol dependence of almost 57%, and an abuse rate of about 21%. Similar or still higher rates have been reported in other American Indian populations (Kunitz et al. 1999a).

More recently, Beals and colleagues have published results from the first large-scale epidemiological surveys of rural Indian reservations in the United States, conducted as part of the American Indian Services Utilization, Psychiatric Epidemiology, Risk and

Protective Factors Project (AI-SUPERPPF). The project involved surveys of a total of 3,084 members of two Tribes living on or near their home reservations in the Southwest and on the Northern Plains. These community surveys, conducted from 1997 to 2000, found that the overall rate of psychiatric disorders in the two Tribes was roughly comparable to that of the general population, but the rates of specific diagnoses differed (Beals et al. 2005a; Beals et al. 2005c). Compared to the general population, alcohol dependence and post-traumatic stress disorder were more frequent in the American Indian communities (Spicer et al. 2003).

Major depressive disorder was actually substantially less frequent in the American Indian samples (the 12-month prevalence was 3.8% for men and 7.9% for women) than in the general US population (6.1% for men and 11.0% for women) (Beals et al. 2005a). The researchers found this hard to reconcile with the prevalence of social problems and evident distress in the community, and they reasoned that this low rate might reflect methodological difficulties with the version of the Composite International Diagnostic Interview (CIDI) used in these studies. The CIDI asks individuals about the two cardinal symptoms of major depression: depressed mood and anhedonia (loss of interest or ability to take pleasure in ordinary activities). The interview has a “skip-out” so that if respondents have not had either of these two key symptoms, they are not asked about other symptoms of depression. As a result, individuals who have other culturally mediated or inflected ways of expressing depression may not be identified by the survey (Kirmayer and Jarvis 2005). In the AI-SUPERPPF surveys, Northern Plains Tribal members were much less likely to report either depressed mood or anhedonia than the Southwest Tribe or the general population (Beals et al. 2005b; Beals et al. 2005c). The authors speculated that this might be due to local cultural attitudes that regard admitting to feelings of depression as a sign of weakness; it may also reflect specific cultural idioms of distress that lead individuals to express depressed mood in terms of loneliness, boredom, or anger (O’Neil 1996 and 2004; Jervis et al. 2003).

To diagnose a discrete episode of depression, the CIDI also asks respondents to indicate whether their symptoms co-occurred during a two-week period. This proved difficult for survey participants from both Tribal groups. To salvage the data from this survey, the authors tried an alternative method of scoring, relaxing the criteria for co-occurrence of symptoms. With these modified criteria, the rates of depression were higher than those in the general population, but it is difficult to know how to interpret these results.

Rates of exposure to potentially traumatic events were very high in these communities, up to 67% for males and 70% for females (Manson et al. 2005). This compares to levels previously reported in the general population in the United States of 61% for males and 51% for females. The rates for women in particular were very elevated, reflecting increased levels of sexual and domestic violence.

Data pertaining to Aboriginal children’s mental health are limited, but there is clear evidence of high rates of problems, including suicide and substance abuse among adolescents in many communities (Beiser and Attneave 1982; Gotowiec and Beiser 1994; Beals

et al. 1997). The Flower of Two Soils Re-Interview Study followed up on 109 of 251 Northern Plains adolescents (aged 11 to 18) who had taken part as children in the earlier study (Beiser et al. 1993; Sack et al. 1994). Fully 43% of the respondents received a diagnosis of at least one DSM-III-R disorder, with the most frequent diagnoses being 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%); and posttraumatic stress disorder, 5%. Rates of co-morbidity were very high, with almost half of those with behaviour or affective disorders meeting criteria for a substance-use disorder. Almost two-thirds of respondents reported having experienced a traumatic event; the most frequent events were car accidents and death or suicide. There is evidence that rates of conduct disorder are increasing in some American Indian communities in the United States owing to increasingly high levels of family breakdown (Kunitz et al. 1999a). Conduct disorder before age 15 is a risk factor for adult alcohol abuse in this population (Kunitz et al. 1999b).

Surveys using symptom measures suggest high rates of common mental disorders, with as many as 25% of individuals in some communities suffering from current depression, but the lack of specific diagnostic measures makes it difficult to judge the reliability of these estimates (Haggarty et al. 2000). The 1997 First Nations and Inuit Regional Health Surveys, conducted across Canada, found elevated rates of depression (18%) and problems with alcohol (27%) (First Nations Information Governance Committee 2007).⁷ The 2002 Regional Health Survey found that 30% of First Nations individuals had experienced a period of two weeks or more in the previous year when they were sad, blue, or depressed, a cardinal symptom of depression. Data from the Canadian Community Health Survey in 2001, which used the CIDI, indicate that 12% of First Nations people living on-reserve had an episode of major depression, compared to 7% of the general population.

Surveys undertaken by the Province of Quebec among the Cree in 1991 (Clarkson et al. 1992) and among the Inuit in 1992 (Boyer et al. 1994) and 2006 (Kirmayer, Paul, and Rochette 2007) used brief measures of generalized emotional distress, specific questions about suicidal ideation and attempts, and a few questions about people with chronic mental illness within the family. Again, these methods give only a very crude estimate of the level of distress in the population and provide little information about specific disorders or service needs.

Suicide is one of the most dramatic indicators of distress in the Aboriginal populations. In many communities, First Nations, Inuit, and Métis have elevated rates of suicide, particularly among youth; however, rates are in fact highly variable (Kirmayer 1994; Kirmayer et al. 2007). In Quebec, for example, the Inuit, Attikamekw, and several other nations have very high rates of suicide, while the Cree have a rate comparable to that of the general population of the province (Petawabano et al. 1994). This variation has much to teach us about the community-level factors that affect suicide risk.

Compared to the general population, a smaller proportion of Aboriginal people consume alcohol (79% versus 66%, respectively) (First Nations Information Governance Committee

2007). However, the rate of problem drinking is higher in the Aboriginal population, with 16% of First Nations individuals reporting heavy drinking on a weekly basis, compared to 6.2% in the general population. The Northwest Territories Health Promotion Survey found that 33% of the territories' Aboriginal persons were considered heavy drinkers, compared to 16.7% in the non-Aboriginal population (Northwest Territories Bureau of Statistics 1996). In the same survey, use of cannabis was also greater for Aboriginal persons (27.3%) than for non-Aboriginal persons (10.8%). The survey also asked about the history of solvent use and found that the percentage of Aboriginal people who had used solvents was particularly high (19.0%), compared to 1.7% among non-Aboriginal people.

A survey of drug use in Manitoba assessed Aboriginal (Indian and Métis residents off-reserve) and non-Aboriginal adolescents over four consecutive years from 1990 to 1993 (Gfellner and Hundleby 1995). The Aboriginal groups had consistently higher rates of use of marijuana, nonmedical tranquilizers, nonmedical barbiturates, LSD, PCP, other hallucinogens, and crack. For both LSD and marijuana, the average rate of use for Aboriginal adolescents was over 3 times higher than the corresponding non-Aboriginal rate. In the same survey, glue sniffing was more frequent among the Aboriginal group than among the non-Aboriginal groups.

Inhalant use (e.g., gas, glue, solvents) is an increasing problem among young people worldwide but is much more common in some Aboriginal communities than in the general population (Howard et al. 1999; Neumark, Delva, and Anthony 1998; Weir 2001). In a survey of Inuit youth in one community in Quebec, 21% reported having used solvents at one time, and 5% had used them within the past month (Kirmayer, Malus, and Boothroyd 1996). Individuals who had used solvents were 8 times more likely to have made a suicide attempt. The 2004 Nunavik Health Survey found that 5.9% of respondents had used solvents in the previous 12 months; for those 15 to 19 years of age, the rate was 13.5% (Muckle et al. 2007).

Qualitative Ethnographic Research

Whereas epidemiological research identifies the magnitude and distribution of mental health and social problems of Aboriginal peoples in Canada, qualitative studies implicate the collective exposures of Aboriginal peoples to forced assimilation policies as prime causes of poor health and social outcomes. The policies of forced assimilation have had profound effects on Aboriginal peoples at every level of experience, from individual identity and mental health to the structure and integrity of families, communities, bands, and nations.

Narratives and life histories suggest that the residential school experience has had enduring psychological, social, and economic effects on survivors (Haig-Brown 1988; Milloy 1999; York 1990). Of course, the links between events and outcomes made by individuals in their narratives do not prove causality, but they give a clear picture of how suffering is

understood and can identify plausible connections for more systematic study. Transgenerational effects of the residential schools identified through such qualitative research include the structural effects of disrupting families and communities; the transmission of explicit models and ideologies of parenting based on experiences in punitive institutional settings; patterns of emotional responding that reflect the lack of warmth and intimacy in childhood; repetition of physical and sexual abuse; loss of knowledge, language, and tradition; systematic devaluing of Aboriginal identity; and, paradoxically, essentializing Aboriginal identity by treating it as something intrinsic to the person and thus static and incapable of change. These studies point to a loss of individual and collective self-esteem, to individual and collective disempowerment, and, in some instances, to the destruction of communities.

The legacy of the policies of forced assimilation is also seen in the current relationship of Aboriginal peoples with the larger Canadian society. Images of the “savage” and stereotypes of the “drunken Indian” continue to recur in popular media. Racism is still widespread, if sometimes subtle, and beyond active discrimination there is a continuing lack of historical awareness of the experience of Aboriginal peoples with colonization and the enduring impact on their well-being and social options. Governmental, bureaucratic, and professional tutelage and control continue to undermine Aboriginal efforts at self-direction.

The impact of local control on mental health has been strikingly illustrated in the studies by Michael Chandler and Chris Lalonde (1998; see also Chapter 10; Chandler et al. 2003) that compare the rates of completed suicide in 80 bands in British Columbia. There was wide variation in rates, with some communities exhibiting no suicides, while others suffered very high rates. Each community was scored on seven measures of what was termed “cultural continuity”: self-government, involvement in land claims, band control of education, health services, cultural facilities, police services, and fire services. The rate of suicide was strongly correlated with the level of these factors. Communities with all seven factors had no suicides, while those with none of the factors had extremely high suicide rates. Of course, it is possible that some of these factors are markers for healthy communities and that the link to suicide is through other co-varying but unmeasured factors, including collective self-efficacy and self-esteem, better infrastructure or community organization, and more job opportunities or active roles for youth. Labelling these factors as “cultural continuity” is also questionable, as the involvement of Aboriginal people in contemporary institutions like municipal government or formal school systems can hardly be viewed as cultural traditionalism. “Local control” seems a more accurate term, and it is a factor that probably reflects cultural adaptability and pluralism rather than the maintenance of tradition. Nevertheless, this study provides compelling evidence for the impact of community-level factors and should encourage other studies of determinants of mental health that are based on careful analysis of the history, structure, and dynamics of communities.

Cultural continuity remains an interesting construct and one that is important in the light of ongoing efforts of Aboriginal peoples to recuperate and reclaim traditional knowledge and values as an explicit basis for collective identity and community cohesion. Cultural continuity can be expressed in many ways, but all depend on a notion of culture as something that is potentially enduring or continuously linked through processes of historical transformation with an identifiable past or tradition. To some extent, it is precisely this notion that has been challenged by recent critical writing on the idea of culture itself that emphasizes its constant contestation, invention, and renegotiation by members of a community in dialogue with other cultures and with global systems of knowledge and practice.

Transformations of Identity and Community

The wide variation in rates of suicide and other indices of distress across Aboriginal communities suggests the importance of considering the nature of communities and the different ways that groups have responded to the ongoing stresses of colonization, sedentarization, bureaucratic surveillance, and technocratic control. It is likely that the mediating mechanisms contributing to high levels of emotional distress and problems like depression, anxiety, substance abuse, and suicide are closely related to issues of individual identity and self-esteem (Chandler 1994; Chandler and Ball 1989; Phinney and Chavira 1992), which in turn are strongly influenced by collective processes at the level of band, community, or larger political entities (Tester and McNicoll 2004).

All cultures are in constant flux, so cultural and ethnic identity must be understood as a construction of contemporary people responding to their current situation (Niezen 2003; Roosens 1989; Sissons 2005). This is not to question the authenticity of tradition but to insist that culture be appreciated as a co-creation by people in response to current circumstances – an ongoing construction that is contested from both within and without. For Aboriginal peoples, two important arenas for this contestation and change are the relationship of individual groups to movements founded on pan-Indian political and ethnic identity and the relationship of traditional healing practices to cosmopolitan medicine and religion, including their appropriation by “New Age” practitioners.

Notions and experiences of being a Native involve cross-cutting historical, cultural, linguistic, geographic, and political dimensions (Krupat 1996; Vizenor 1999). 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 (Trimble and Medicine 1993). Of course, Aboriginal identity is also embodied and linked to behavioural and physical attributes (e.g., brown skin, brown eyes, black hair), but these attributes too are shaped by cultural scripts (e.g., braided hair, choice of clothing) that determine how people identify or fail to identify each other as Aboriginal.

The very notion of Aboriginality is a social construction that serves as a “dividing practice” that both marginalizes and unites. Over centuries of colonial contact, the rapid and often violent usurping of indigenous lands – followed by more encompassing forms of neo-colonial bureaucratic control over remnant populations – has given way to a powerful notion that there exists a distinct category of peoples in the world distinguished by having been sociopolitically marginalized from nation-state populations. This discourse of Aboriginality was used originally by colonial powers when confronting the “others” whose territory they conquered (see Waldram 2004; Chapter 3). Colonial history and anthropological writings about Native American cultures and peoples have had a powerful effect on their contemporary representations in North American society. Berkhofer (1979) discusses how the construction of stereotypical images impacted the self-image of Native Americans. Since anthropological investigations of Native Americans began in the nineteenth century, they have become the objects of a Euro-American cultural gaze that creates an “other” and then polices its cultural identity. The resultant discourse on Aboriginality circulates within the wider society, including the media and popular culture, and creates commonly accepted social facts about ethnic identity and tradition. Recognizing a practice as traditional marks it off from the everyday practices of a people or community. This labelling, essentializing, and commodification of tradition are all features of modernity that pose dilemmas for the recuperation of history and the forging of identity.

The creation of an explicit ethnic identity requires that certain beliefs, practices, or characteristics be elevated to core values and claimed as shared experiences. This naturally tends to obscure individual variation and the constant flux of personal and social definitions of self and other. It also leads to the privileging of groups identified as being more “authentically” close to the ideal ethnic image while simultaneously marginalizing and even stigmatizing those groups or individuals who fail to embody this image.

A shared history invests ethnic identity with social value and thus contributes directly to mental health. Studies of how cultural and historical knowledge is used to construct ethnic identity and of the way that such ethnicity is then used for psychological coping, social interaction, and community organization can therefore contribute directly to Aboriginal mental health (Trimble and Medicine 1993). For example, the development of a collective identity has posed particular problems for Métis, who have suffered from ambiguity of status (Dickason 2002; Peterson and Brown 1993). Building a national identity of a “Métis nation” from social groups that have experienced prolonged suppression and fragmentation of their ethnic identity has proven to be a challenge. In this situation, the writing and dissemination of a group’s history takes on special urgency (Sioui 1992). To be effective in welding a group together and advancing its interests and collective well-being, the expression of collective history and identity requires a public forum.

Inequality *within* indigenous communities receives significantly less attention than does inequality *between* indigenous and non-indigenous groups (Culhane et al. 2003). Because many indigenous peoples in Canada live as small, scattered minorities within polities

where significant and powerful sectors of majority populations hold and exercise racist and exclusionary ideas and practices, the effects of internal group inequalities are largely ignored. Although divisions and debates within majority populations are taken as evidence of vibrancy and growth, similar conflicts within indigenous communities are frequently interpreted as signs of chaos, disorder, and political immaturity and thus deemed to legitimate ongoing external governance and administration. The burden of distress and despair wrought by generations of colonial oppression commonly renders relationships and social cohesion within and between indigenous communities fragile, and internal critics face tremendous challenges in their efforts to develop modes of constructive social and political criticism. However, ignoring or minimizing internal inequalities risks perpetuating injustices paid for in terms of poor health and high levels of social suffering among those who are most marginalized and exploited: women, Elders, youth, two-spirited people (i.e., gay or lesbian), and the disabled and ill. Indigenous women have been courageous in struggling with the personal and intimate legacies of colonialism within their families and communities, in placing issues of gender and class inequalities on the agenda of indigenous and other government bodies, and in working toward change for future generations (Culhane et al. 2003).

Despite concerted efforts at forced assimilation, Aboriginal cultures have persisted. Although at least 10 Aboriginal languages became extinct during the past 100 years and many others are endangered, several languages remain viable, with large enough numbers of speakers to ensure their long-term survival, including Inuktitut, Cree, and Ojibway (Norris 2007). According to the 2001 census, about 1 in 4 Aboriginal people are able to converse in an Aboriginal language, and about 18% use an Aboriginal language regularly (Statistics Canada 2003). Only 13% speak an Aboriginal language most often in the home. However, the learning of Aboriginal languages as a second language by young people is increasing (Norris 2007). Many communities are currently engaged in cultural immersion programs geared toward strengthening Aboriginal languages and identity. Aboriginal languages are official languages in the Northwest Territories and Nunavut, the latter being a vast region of Canada's North that on 1 April 1999 was recognized as a new territory with an Inuit-led government (Bennett and Rowley 2004).

Beyond the diversity of languages, there are distinctive cultural concepts of personhood and community among many Aboriginal peoples. Whereas the Euro-American notion of the person has been characterized as egocentric or individualistic, many Aboriginal peoples retain notions of the person as defined by a web of relationships that includes not only extended family, kin, and clan but, for hunters and other people living off the land, also animals, elements of the natural world, spirits, and ancestors. Aboriginal concepts of the person thus may be relational or communalistic as well as *ecocentric* (connected to the land, animals, and the environment) (Tanner, Chapter 11; Kirmayer, Fletcher, and Watt, Chapter 13; Tanner 1979) and *cosmocentric* (connecting the person to an ancestral lineage or to the spirit world) (Hultkrantz 1987). Although these forms of personhood have wide prevalence, it is important to recognize the great diversity of Aboriginal individuals,

cultures, and communities, which is sometimes obscured by images in the popular media or by Aboriginal peoples themselves when they seek to make common cause in developing political and cultural institutions.

The literature of cross-cultural psychology makes a broad distinction between egoistic or individualistic cultures and sociocentric, communalistic, or collectivist cultures (Triandis 1995). Many Aboriginal cultures appear sociocentric in that the self is defined relationally and the well-being of the family, band, or community is given central importance; however, this occurs along with strong support for individual autonomy and independence. For peoples who lived in small groups of one or two extended families, such as the Inuit, the notion of a sociocentric or communalistic self is misleading since there was no social group larger than the family by which to define the self. Traditional notions of Inuit family relations have been extended to the new situations of large settlements (Dorais 1997).

Many Aboriginal peoples have a concept of the person that might be better identified as ecocentric, for they see other people, the land, and the animals as all being in transaction with the self and, indeed, in some sense, as constituting aspects of a relational self (Drummond 1997; Stairs 1992; Stairs and Wenzel 1992). Consequently, damage to the land, appropriation of land, and spatial restrictions all constitute direct assaults on the person (Sioui 1992). Traditional hunting practices are not just means of subsistence but also sociomoral and spiritual practices aimed at maintaining the health of person and community (Tanner 1979). For example, Inuit concepts of self include physical links with animals through the eating of "country food." In this light, the widespread destruction of the environment motivated by commercial interests must be understood as attacks on Aboriginal individuals and communities 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 (Brody 1975, 2000).

Both contemporary environmentalism and New Age spirituality promote the notion that indigenous peoples practised a generic form of spirituality characterized by a harmonious, nonexploitative approach to nature based on an underlying animistic ontology (Hultkrantz 1987). This obscures the historical reality of diverse cultural traditions that have different mythologies, religious beliefs, and spiritual practices; it also ignores centuries of European contact and the assimilation of Christian forms of belief into syncretic religious practices (Vecsey 1990). In most First Nations and Inuit communities, organized religious denominations, such as the Anglican or Catholic churches, remain influential, especially among older populations, whose members were educated in the residential school system (Treat 1996). Moreover, in recent years the evangelical Christian movement, primarily the Pentecostal Church, has spread rapidly in many communities. Pan-Amerindian spiritual practices are strongly influenced by the vibrant cultures of the Northern Plains of the United States, but these traditions involve distinctive elements not shared with other, equally rich, Aboriginal traditions.

Whereas older anthropological writing conceived of cultures as closed, homogeneous, and sometimes static systems, contemporary ethnographers view cultures as local worlds that are constantly in flux. There is great variation in knowledge, practice, and attitudes among individuals within a cultural group, resulting in significant conflict, resistance, and contestation of dominant values. Local worlds are embedded in larger global systems that bring diverse peoples together through migration, mass media, and other forms of contact and exchange. As a result, most individuals have access to and participate in multiple cultures. Individuals use this multicultural background to navigate, communicate, and provide rhetorical supplies and discourses within which to locate and construct socially and psychologically viable selves.

These social realities of cultural diversity, hybridization, flux, and change exist in some tension with Aboriginal claims for a pan-Indian cultural identity rooted in a timeless mythic past (Nabakov 1996). The reality is that, like all cultural identities, Aboriginality is not “in the blood” but emerges from and is sustained by forms of life that exist at the confluence of historical currents and contemporary forces (Waldram, Chapter 3). Aboriginal identity is nurtured within families and communities, but it is also imposed by the larger cultural surroundings. Aboriginal peoples are engaged in an ongoing process of re-articulating themselves in the modern world in ways that honour their ancestors, maintain links with crucial values, and creatively respond to the exigencies of a world simultaneously woven together by electronic media and riven apart by conflicts of culture and value.

Re-Articulating Tradition

In recent years a series of important events has begun to reverse the cultural marginalization and oppression endured by Canadian Aboriginal peoples. It is shocking for Euro-Canadians, who have been profoundly unaware of the social realities of Aboriginal peoples, to be reminded that it was only in 1967 that Aboriginal peoples gained the right to vote. A pivotal event in public consciousness was the Oka Crisis of 1990, in which the Mohawk communities adjoining Montreal confronted local and federal authorities to defend an ancestral burial ground, which was to be appropriated to extend a municipal golf course (York and Pindera 1991). During this crisis, Canadians witnessed overt acts of racism and violence against Aboriginal people and had to confront a complacent self-image as a nation of tolerance. This led directly to the 1991 Royal Commission on Aboriginal Peoples (RCAP). The public hearings held by the RCAP uncovered the widespread abuses of the residential school system. In 1993 the Royal Canadian Mounted Police (RCMP) – the federal police force long involved with law enforcement in remote regions, including Aboriginal settlements – established a Native Residential School Task Force to investigate residential schools from 1890 to 1984. The RCAP addressed many dimensions of Aboriginal health

and produced special reports on suicide (1995) as well as volumes on the needs of urban Aboriginal peoples and on healing (1993). The RCAP Final Report included a volume titled *Breaking the silence*, which detailed the abuses in the residential school system (Royal Commission on Aboriginal Peoples 1996).

In 1998 the government responded to the RCAP report with *Gathering Strength: Canada's Aboriginal Action Plan*, which was intended to begin a process of reconciliation and renewal (Minister of Indian Affairs and Northern Development 1998). Several new Aboriginal organizations were created, including the Institute for Aboriginal Peoples Health (1 of 13 Canadian Institutes of Health Research replacing the Medical Research Council) and the National Aboriginal Health Organization.

A crucial component of *Gathering Strength* was the establishment of the Aboriginal Healing Foundation (AHF), a federally funded, Aboriginal-run, nonprofit organization created in March 1998 to support community-based healing initiatives of Aboriginal people affected by physical and sexual abuse in residential schools, including intergenerational impacts (i.e., "the Legacy"). The AHF received \$350 million over 10 years to fund projects that address the legacy of the residential schools. The funded projects included healing centres and services; community services; conferences, workshops, and gatherings; cultural activities; material development; planning; research; traditional activities (e.g., programs for living on the land); and a variety of educational and training programs (Aboriginal Healing Foundation 2006).

Aboriginal people have also sought other avenues for reconciliation and reparation. An out-of-court program for dispute resolution organized by the federal government had resolved only 147 claims by July 2005, with almost 2,000 more cases awaiting hearing or adjudication.⁸ As of September 2005, 12,455 tort claims had been filed and several class action suits were pending. Legal proceedings often involve retraumatization, and Aboriginal organizations continue to explore alternative dispute-resolution methods, including establishing a Truth and Reconciliation Commission similar to the process developed in post-Apartheid South Africa. Efforts at reconciliation are consonant with the values in many Aboriginal communities, which emphasize maintaining family and community ties and repairing breaches of trust by a public ritual of confession, expiation, and recommitment to the community. In 2006 a Residential Schools Settlement Agreement was reached between the federal government and the legal representatives of many school survivors, the churches involved in running the schools, the Assembly of First Nations, and other Aboriginal organizations. This \$1.9 billion agreement will support a series of measures intended to contribute to a "resolution of the Indian Residential Schools legacy," including a Common Experience Payment to every former student; an alternative dispute-resolution process for dealing with claims of physical and sexual abuse endured at the schools; expanded access to mental health support programs (e.g., counselling by mental health professionals, trained Aboriginal health providers, and traditional healers); and a Truth and Reconciliation Commission, mandated to promote public education and awareness

(Brant Castellano, Archibald, and DeGagné 2008). Additional funds will pay for commemorative events and memorials as well as support the continued work of the Aboriginal Healing Foundation. The churches will also contribute resources for healing initiatives.

In an effort to respond to local problems in ways that affirm Aboriginal values and perspectives, communities have experimented with various forms of alternative dispute resolution and restorative justice, including sentencing circles for healing and reintegrating offenders who might otherwise be ostracized and dealt with entirely within the penal system (Drummond 1997; Ross 1996). Other therapeutic examples of meeting in circles include talking circles, in which people speak openly and listen to others' stories in order to begin to become aware of original hurts; sharing circles, in which a high degree of trust is established and people express painful emotions; healing circles, in which people can work through memories of painful experiences; and spiritual circles, in which people develop trust in their own experiences of spirituality as sources of comfort and guidance. The rules of these circles vary with their goals, but all have in common an emphasis on each person's commitment to change, an etiquette that honours the individual's voice and experience through respectful listening, and a process of reaffirming collective and communal solidarity.

The past century has seen the emergence of various forms of pan-Indian spirituality, in which practices associated with specific cultural groups have been widely adopted and have served both as effective healing rituals for groups and as symbols of shared identity and affiliation. The elements of this common spiritual tradition include a focus on the Creator, the symbolism of the medicine wheel, the use of the sweat lodge and traditional plant medicines, Pow-Wow costume dances, drumming, and tobacco offerings (Bucko 1998; Hall 1997; Waldram 1997b).

In parallel, increased awareness of the historical predicament of Aboriginal peoples has become a rallying point. In the United States the attention to trauma among Vietnam veterans provided a context to reconsider the collective trauma of American Indians (Manson et al. 1996). For Canadian Aboriginal peoples, the revelations of the evils of the residential schools have made the notion of individual and collective trauma salient (Haig-Brown 1988). Some Aboriginal people have made use of communal settings to tell the story of their suffering. In these accounts, individual traumas and losses may be explicitly linked to collective traumas. This serves to make sense of suffering and to valorize it as part of a larger collective struggle. At the same time, the metaphors of individual and collective trauma have both positive value and limitations. On the plus side, the metaphor of trauma draws attention to the severity, shock, and violence of the physical and psychological injuries inflicted on Aboriginal peoples. It locates the origins of problems in a shared past and thus motivates the reconstruction of historical memory and collective identity. Ideally, this history would insist on the importance of social and political events and thereby avoid "psychologizing" what are fundamentally political issues (Chrisjohn et al. 1997).

However, like any partial truth, the metaphor of trauma also has limitations and unwanted connotations (Kirmayer, Lemelson, and Barad 2007). Current trauma theory and therapy tend to focus on the psychiatric disorder of posttraumatic stress disorder and give insufficient attention to the other dimensions of experience that may be profoundly transformed by massive trauma and abrogation of human rights. These include issues of secure attachment and trust, belief in a just world, a sense of connectedness to others, and a stable personal and collective identity.

For Aboriginal peoples, historical events have exerted their noxious influences at many levels and in diverse ways, only some of which are captured by the concept of trauma. Indeed, an emphasis on the most overt and dramatic forms of aggression and abuse may make it harder to recognize more subtle, indirect, and insidious effects of residential schools and other forces of assimilation on individuals and communities. The location of the origins of trauma in past events may divert attention from the ongoing effects of a chaotic and constricted present and a murky future – which are the oppressive realities for many Aboriginal young people living in demoralized communities. Finally, an emphasis on past trauma as an explanation for current suffering ignores the pervasiveness of everyday, routinized practices of exclusion and marginalization.

Conclusion

Aboriginal peoples of North America, like indigenous populations in other parts of the world, have experienced profound disruption and alteration of their traditional ways of life through culture contact. This has involved diverse processes, including epidemics of infectious disease, systematic efforts at religious conversion, colonization with forced sedentarization, relocation and confinement to reserves, prolonged separation from family and kin in residential schools and hospitals, gradual involvement in local and global cash economies, political marginalization, and increasingly pervasive bureaucratic and technocratic control of every detail of their lives. This history has had complex effects on the structure of communities, individual and collective identity, and mental health.

Although mental health problems are reflections of ordinary human vulnerabilities and can be found in every population, the elevated rates of suicide, alcoholism, and domestic violence and the pervasive demoralization seen in many Aboriginal communities can be readily understood as both direct and indirect consequences of this history of colonization, cultural oppression, loss of autonomy, dislocations and disruptions of traditional life-ways, and disconnection from the land. Framing the suffering that has resulted from these historical conflicts in terms of mental health issues may command attention from politicians and health authorities and support ongoing efforts to obtain resources and to rebuild healthy communities. At the same time, exclusive attention to individual mental health problems may deflect attention from the larger social structural problems that

persist and thus risk continuing the assault on the identity and vitality of Aboriginal peoples. Understanding the personal and collective processes of resilience that have emerged despite these adversities can play a crucial role in finding ways forward that support both individual autonomy and cultural survival and renewal.

Ongoing transformations of identity and community have led some groups to do well while others face catastrophe. In many cases, the health of the community appears to be linked to the sense of local control and cultural continuity. Recent successes in negotiating land claims and local government as well as forms of cultural renewal hold out hope for improvements in health status. Attempts to recover power and to maintain cultural tradition must contend with the political, economic, and cultural realities of consumer capitalism, technocratic control, and globalization.

Issues of equity in health and well-being for Canada's Aboriginal peoples must be central to any vision of a just society. The wounds of racism, abuse, and cultural oppression, inflicted through colonization's infernal machinery of residential schools and state control of the lives of Aboriginal people, have marked survivors, perpetrators, and bystanders as well. Redressing past wrongs, protecting human rights, and respecting the aspirations of Aboriginal peoples both as individuals and as members of distinct nations are all crucial for the health, well-being, and moral order of Canadian society as a whole.

Acknowledgments

Portions of this chapter are adapted with permission from Kirmayer and colleagues (2000, 2003). Preparation of this chapter was made possible by grants from the Fonds de la recherche en Santé du Québec and from the Institute of Aboriginal Peoples Health and the Institute of Neurosciences, Mental Health and Addiction of the the Canadian Institutes of Health Research.

Notes

- 1 The remaining 3% of respondents in the census either identified with more than one Aboriginal group or were registered Indians or members of a First Nation but did not identify as Aboriginal (Statistics Canada 2008, 9).
- 2 Treasury Board of Canada Secretariat (2005). *Canada's performance report 2005 annex 3: Indicators and additional information*. Ottawa: Treasury Board of Canada Secretariat. http://www.tbs-sct.gc.ca/report/govrev/05/ann304_e.asp (accessed 2 January 2007).
- 3 Including Central and South America, the indigenous population of the Americas prior to European contact was probably over 100 million.
- 4 Although most Métis and Inuit did not receive any formal education services, some did attend residential schools (Chartrand 2006, 21). In cases where Métis parents were given a choice about whether they would send their children to residential schools, many kept their children home, choosing to teach them the history, songs, dances, and values of their people.
- 5 A number of "push" and "pull" factors influence rural-urban migration patterns among indigenous peoples (Norris and Clatworthy 2003, 66). The push factors that prompt individuals to move from reserve and settlement communities include the lack of employment opportunities and resulting difficult social conditions; poor economic conditions; marriage and family formation; boredom and low quality of life; lack of housing, health facilities, and educational opportunities; and band politics. Factors pulling indigenous people back to reserve and rural communities include the inability to find employment or to otherwise

adjust to life in the city and lack of access to affordable or acceptable housing. Reserve and rural communities are also commonly viewed as providing a better quality of life than urban settings for raising children because of lower crime rates and less alcohol and drug abuse (Norris and Clatworthy 2003). Stronger social networks that include support from extended families, friends, and culturally appropriate activities and services are also important factors that pull indigenous peoples from cities.

- 6 Indian and Northern Affairs (2003). *Background—Water quality and First Nation communities*. Ottawa: Indian and Northern Affairs. CBC News Online (2006). *The state of drinking water on Canada's reserves*. http://www.ainc-inac.gc.ca/nr/prs/m-a2003/02304bk_e.html (accessed 2 June 2008). See also <http://www.cbc.ca/slowboil> (updated 20 February 2006; accessed 18 January 2007).
- 7 The Regional Health Surveys excluded Alberta and the northern and James Bay regions of Quebec.
- 8 From the website of the International Center for Transitional Justice, citing official statistics: <http://www.ictj.org/en/where/region2/513.html> (accessed 15 January 2007).

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