# IN REVIEW

# The Mental Health of Aboriginal Peoples: Transformations of Identity and Community

Laurence J Kirmayer, MD[1], Gregory M Brass, MA[2], Caroline L Tait, MA[3]

*This paper reviews some recent research on the mental health of the First Nations, Inuit, and Métis of Canada. We summarize evidence for the social origins of mental health problems and illustrate the ongoing responses of individuals and communities to the legacy of colonization. Cultural discontinuity and oppression have been linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the greatest impact on youth. Despite these challenges, many communities have done well, and research is needed to identify the factors that promote wellness. Cultural psychiatry can contribute to rethinking mental health services and health promotion for indigenous populations and communities.*

(Can J Psychiatry 2000;45:607–616)

***Key Words:*** *Aboriginal mental health, First Nations, Inuit, Métis, Cree, psychiatric services, suicide, colonialism, culture, epidemiology, ethnography*

Around the world, indigenous peoples have experienced rapid culture change, marginalization, and absorption into a global economy that has little regard for their autonomy. Cultural discontinuity has been linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the most profound impact on youth. Despite these challenges, many communities have done well. This paper will explore mental health issues of the First Nations, Inuit, and Métis peoples of Canada. We first summarize the social origins of distress among the original inhabitants of North America. We then discuss the range and magnitude of the individual and collective problems caused by a history of systematic suppression and dislocation. We also consider some ongoing transformations of individual and collective identity and forms of community that hold the seeds of revitalization and renewal for Aboriginal peoples. Finally, we outline some of the implications for mental health services and health promotion of an emphasis on identity and community.

First Nations, Inuit, and Métis constitute about 1 million people, or 4% of the Canadian population. There are 11 major language groups with more than 58 dialects distributed among some 596 bands residing on 2284 reserves, or in cities and rural communities (1,2). The cultural and linguistic differences among many groups are greater than the differences that divide European nations. In addition to inter-group social, cultural, and environmental differences, there is an enormous diversity of values, lifestyles, and perspectives within any community or urban Aboriginal population. While this diversity makes lumping people together under generic terms like "Aboriginal" or "indigenous" profoundly misleading, most groups nevertheless share a common social, economic, and political predicament that is the legacy of colonization. This shared predicament has motivated efforts to forge a common political front and, to some degree, a collective identity among diverse groups. Indeed, striking parallels in the mental health problems of indigenous peoples around the world suggest that, while biological, social, cultural, and political factors vary, there are common processes at work (3–5).

## Social Origins of Distress

Despite myths of a timeless past and cultural continuity, traditional Aboriginal societies were not static, nor were they entirely free of disease or social problems (6,7). In the 16th century, however, the process of cultural change accelerated

Manuscript received August 2000.

[1]Professor and Director, Division of Social and Transcultural Psychiatry, McGill University; Director, Culture and Mental Health Research Unit, Sir Mortimer B Davis–Jewish General Hospital, Montreal, Quebec.

[2]Formerly, Coordinator, Aboriginal Mental Health Research Team, Culture and Mental Health Research Unit, Sir Mortimer B Davis–Jewish General Hospital, Montreal, Quebec; now, Coordinator/Facilitator, United Native Nations Study on Urban Aboriginal Homelessness in British Columbia, Vancouver, British Columbia.

[3]Coordinator, Aboriginal Mental Health Research Team, Culture and Mental Health Research Unit, Sir Mortimer B Davis–Jewish General Hospital, Montreal, Quebec.

*Address for correspondence:* Dr LJ Kirmayer, Institute of Community and Family Psychiatry, 4333 Côte Ste Catherine Rd, Montreal, QC H3T 1E4
e-mail: cylk@musica.mcgill.ca

dramatically with the earliest contact with European outsiders. Contacts included encounters with fishing expeditions, itinerant traders, and ships putting in for provisions, as well as direct meetings with explorers seeking to establish colonies, missionaries, fur traders, and colonists. Meetings with Mesoamerican and Caribbean Natives accompanying European expeditions were also a feature of these contacts (8).

The history of the European colonization of North America is a harrowing tale of the indigenous population's decimation by infectious disease, warfare, and active suppression of culture and identity that was tantamount to genocide (9,10). Estimates of the indigenous population of North America prior to the arrival of Europeans range upward from about 7 million. Close to 90% of these people died as a result of the direct and indirect effects of culture contact. For example, Northern Iroquoian peoples may have shrunk from about 110 000 in the 16th and early 17th centuries to about 8000 by 1850 (8). The European settlers' economic, political, and religious institutions all contributed to the displacement and oppression of indigenous people.

Contact brought with it many forms of depredation, including infectious diseases, among which the great killers were smallpox, measles, influenza, bubonic plague, diphtheria, typhus, cholera, scarlet fever, trachoma, whooping cough, chicken pox, and tropical malaria. A growing reliance on European foodstuffs and diet also profoundly affected the health of indigenous peoples. These effects continue to the present day with problems of obesity and diabetes endemic in many Aboriginal communities (7,11,12).

Colonization did not end with Confederation. Over the last century, such Canadian government policies as forced sedenterization, creation of reserves, relocation to remote regions, residential schools, and bureaucratic control have continued to destory indigenous cultures (13,14).

Although the process of sedentarization began as a response of indigenous peoples themselves 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 all Aboriginal settlements was chosen by government or mercantile interests rather than by the Aboriginal peoples themselves (15). In many cases, this resulted in arbitrary social groupings with no history of living together in such close quarters; groups of people were thus forced to improvise new ways of life and new social structures. In other cases, Aboriginal peoples were relegated to undesirable parcels of land out of the way of the colonizers' expanding cities and farms. The disastrous "experiment" of relocating Inuit to the Far North to protect Canadian sovereignty—a late chapter in this process of forced culture change—revealed the government's continuing lack of awareness of cultural and ecological realities (16–18).

These policies served the economic and political interests of the dominant non-Aboriginal groups and were sustained by both explicit and subtler forms of racism. Active attempts to suppress and eradicate indigenous cultures were rationalized by an ideology that saw Aboriginal people as primitive and uncivilized (19). This ideology justified legislation that prohibited Aboriginal religious and cultural practices like the potlatch or the Sun Dance (20). Aboriginal peoples were viewed as unable or unready to participate in democratic government; they needed to be "civilized" to join the rest of Canadian society. Systematic efforts at cultural assimilation were directed at Aboriginal children through forced attendance at residential schools and out-of-community adoption by non-Aboriginal families (21).

From 1879 to 1973, the Canadian government mandated church-run boarding schools to provide education for Aboriginal children (22). Over 100 000 children were taken from their homes and subjected to an institutional regime that fiercely denigrated and suppressed their heritage. The extent of physical, emotional, and sexual abuse perpetrated in many of these residential schools has only recently been acknowledged (23–26). Beyond the impact on individuals of abrupt separation from their families, multiple losses, deprivation, and brutality, the residential school system denied Aboriginal communities the basic human right to transmit their traditions and maintain their cultural identity (27).

The assimilation of Aboriginal peoples was the explicit rational for the removal of Aboriginal children to residential schools. Aboriginal parents were not necessarily seen as unacceptable parents, only as incapable of educating and passing on "proper" European values to their children (28,29). Beginning in the 1960s, the federal government effectively handed over the responsibility for Aboriginal health, welfare, and educational services to the provinces, although it remained financially responsible for Status Indians. 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 (30). In the case of Aboriginal families, "neglect" was mainly linked to endemic poverty and other social problems which were dealt with under the social workers' rubric of "the need for adequate care." Improving care within the family, however, was not given priority, and provincial child welfare policies did not include the preventive family counselling services that were available to non-Aboriginal families. Because there were no family reunification services for Aboriginal families, social workers usually chose adoption or long-term foster care for Aboriginal children; as a result, Aboriginal children experienced much longer periods of foster care than their non-Aboriginal

counterparts (31). By the end of the 1960s, fully 30% to 40% of the children who were legal wards of the state were Aboriginal children—in stark contrast to the rate of 1% in 1959 (28).

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 (19). The cumulative effect of these policies has, in many cases, amounted to near cultural genocide (27). The collective trauma, loss, and grief caused by these shortsighted policies are reflected in the endemic mental health problems of many Aboriginal communities and populations across Canada. Framing the problem purely in terms of mental health issues, however, may deflect attention from the large-scale and, to some extent, continuing assault on the identity and continuity of whole peoples.

To these organized efforts to 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 for non-Aboriginal Canadians. Despite efforts at income assistance and community development, this gap had widened over the decade since 1980 (1). The effects of poverty are seen in the poor living conditions on many reserves and remote settlements that lead to chronic respiratory diseases, recurrent otitis media with hearing loss, and tuberculosis; in the past, these necessitated prolonged hospitalizations that further subverted the integrity of families and communities (32). Of course, the very notion of poverty is a creation of the social order in which Aboriginal peoples are embedded, an order 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 deprivation and lack where none existed. 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 adjectives useful in advertising campaigns (33).

Together with the legacy of internal colonialism these realities of globalization contribute to the continuing political marginalization of Aboriginal peoples. Some groups, however, have been able to exploit the logic of consumer capitalism to further their efforts at 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 by waging a publicity campaign aimed at influencing public opinion in the US and abroad (34). 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 likely have had a positive effect on the sense of efficacy and the mental health of many Cree. Efforts to revitalize communities and collective identities must be understood, therefore, in terms of local politics, the agendas of provincial and federal governments, and the supervenient forces of globalization.

## The Impact on Mental Health

Aboriginal peoples suffer from a range of health problems at higher rates than occur in the general Canadian population, and they continue to have a substantially shorter life expectancy (1,7). This is largely due to higher infant mortality and increased rates of death among young people by accident and suicide.

Epidemiological studies have documented high levels of mental health problems in many Canadian Aboriginal communities (7,35–37). The high rates of suicide, alcoholism, and violence, and the pervasive demoralization seen in Aboriginal communities, can be readily understood as the direct consequences of a history of dislocations and the disruption of traditional subsistence patterns and connection to the land (38–42).

Most estimates of the prevalence of psychiatric disorders are based on service utilization records, but since many Aboriginal people never come for treatment, service utilization is at best only a lower estimate of the true prevalence of distress in the community. Only a few epidemiological studies of psychiatric prevalence rates among North American indigenous peoples have been published—2 of these in Canadian populations (43,44). These studies indicate rates of psychiatric disorders varying from levels comparable to those found in the general population to up to twice those of neighbouring non-Aboriginal communities.

In the US, Kinzie and colleagues conducted a 1988 follow-up study of a Northwest Coast village originally studied by Shore and colleagues in 1969 (45,46). The Schedule for Affective Disorders and Schizophrenia Lifetime version (SADS-L), with a supplementary section on posttraumatic stress disorder (PTSD), was used to generate DSM-III-R diagnoses. In all, 31.4% of the subjects met criteria for a current DSM-III-R diagnosis. A marked sex difference was observed, with nearly 46% of men and only 18.4% of women affected ($P < 0.002$). Most of those who were fully employed (88%) had no diagnosis of mental disorders. The presence of a diagnosis was not related to marital status, age, or educational level. As in the 1969 study, the most impressive finding in 1988 was the high rate of alcohol-related problems: the lifetime rate of alcohol dependence was almost 57%, while the current dependency and abuse rate was 21%. Similar or even higher rates have been reported in other American Indian populations (47).

Data pertaining to Aboriginal children's mental health are quite limited, but there is clear evidence of high rates of problems, including suicide and substance abuse, among adolescents in many communities (48,49). The Flower of Two Soils reinterview study followed up 109 of 251 US Northern Plains adolescents (aged 11 to 18 years), who took part as children in an earlier study (50,51); diagnoses were ascertained with the Diagnostic Interview Schedule for Children-2.1C (DISC 2.1C), including a PTSD module. Fully 43% of the respondents received a diagnosis of at least 1 DSM-III-R disorder. The most frequent diagnoses were disruptive behaviour disorders, 22% (including conduct disorder [CD] 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 PTSD, 5%. Rates of comorbidity were very high, with almost one-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 CD are increasing in some American Indian communities in the US, owing to increasingly high levels of family breakdown (52). In this population, CD before age 15 years is a risk factor for adult alcohol abuse (47).

The First Nations and Inuit Regional Health Surveys conducted across Canada in 1997 (excluding Alberta and the Northern and James Bay regions of Quebec) included questions addressing mental health and well-being, but the lack of specific diagnostic measures makes it impossible to estimate the rate of psychiatric disorders. Overall, 17% of parents reported that their child had more emotional or behavioural problems than other children of the same age (53).

Epidemiological surveys undertaken by the province of Quebec among the Cree (54) and Inuit (55), in 1991 and 1992, respectively, 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 Aboriginal populations. Many First Nations, Inuit, and Métis communities have elevated rates of suicide, particularly among youth; however, rates are in fact highly variable (35). In Quebec, for example, the Inuit, Attikamekw, and several other nations have high rates of suicide, but the Cree have rates no higher than the rest of the province (56). This variation has much to teach us about the community-level factors that affect suicide risk.

Our own research with the Inuit communities of Nunavik (Northern Quebec) has documented extremely high rates of suicidal ideation and attempted suicide among adolescents and young adults (57,58). The risk factors identified are similar to those found in other studies of Aboriginal youth and include male sex, a history of substance abuse (especially solvents or inhalants), a history of a psychiatric problem, a parental history of substance abuse or a psychiatric problem, feelings of alienation from the community, and a history of physical abuse. Protective factors identified in this research include good school performance and regular attendance at church. It is striking that young men are not only much more likely to complete suicide but also more often attempt suicide. This fits with the perception that there has been greater disruption of traditional roles for men, resulting in profound problems of identity and self-esteem.

While the Cree population in Quebec does not have an elevated suicide rate, other psychological problems stemming from substance abuse and family violence are prevalent (56). In a secondary analysis of the Santé Québec Cree health survey, we found that higher levels of psychological distress were associated with younger age, female sex, early loss of parents or a relative, and a smaller social network (fewer than 5 close friends or relatives) (59). More negative life events, serious illness, or a drinking problem in the last year were also associated with greater distress. Surprisingly, education past the elementary school level was also associated with greater distress; this effect was seen more clearly among women. In the middle-aged group, this finding of a negative effect with greater education may reflect the impact of residential school experience. For younger women, another explanation is required: it may be that younger women with more education experience greater role strain because they are required not only to work or study but also to carry child-rearing and other family and household responsibilities. Reporting a good relationship with the community and spending more time in the bush were associated with less distress. The beneficial effect of time in the bush was clearest for men. The Cree population continues to practice traditional hunting activities that provide not only an important source of food but also a way of life with significant social and spiritual meaning, which contributes to well-being (60).

Studies in which the level of analysis is the individual may not identify factors that account for differences among communities in the prevalence of suicide and other problems. This requires systematic comparisons of communities, but this type of research poses ethical dilemmas because of the potential negative effects of findings on individual and community self-perception. Nevertheless, such analysis is essential to guide effective mental health promotion.

A recent study by Chandler and Lalonde identified a clear link between levels of community control or autonomy and

suicide rates among Aboriginal peoples in British Columbia (61). These authors examined 6 indicators of what they termed "cultural continuity" but which might more accurately be called local control: community control of police and fire services, education, health, local facilities for cultural activities, self-government, and involvement in land claims. The presence in the community of each variable was associated with a lower suicide rate compared with communities that lacked such local control. An index created by summing these factors was strongly negatively correlated with suicide rates across the 196 bands in the study—clear evidence for a strong association between lack of local community control and high suicide rates.

Although most attention has been given to the common mental disorders (depression, anxiety, and PTSD) which are endemic in Aboriginal communities, psychotic disorders make distinct demands on small, remote communities. Small communities may be more tolerant and less stigmatizing of some forms of unusual behaviour in individuals who are well known and intimately related to many members of the community (62). Our own studies of Inuit concepts of mental health and illness and attitudes toward deviant behaviour suggest that cultural factors play a role (63,64). Inuit tend to label states rather than people, allowing for the possibility that someone whose behaviour is bizarre today may be ordinary tomorrow (65). There may be other features of Inuit ethnopsychology that promote better adaptation and outcome of psychotic disorders (66). Longitudinal outcome studies are needed to examine this possibility.

### Transformations of Identity and Community

The wide variation across Aboriginal communities in suicide rates and other indices of distress suggests that it is important to consider the nature of communities and the different ways in which 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 (67–71). These, in turn, are strongly influenced by collective processes at the level of band, community, or larger political entities.

All cultures constantly evolve, and cultural and ethnic identity must be understood as inventions of contemporary people responding to their current situation (72). This is not to question the authenticity of tradition but to insist that culture be appreciated as a co-creation of people responding to their circumstances—an ongoing construction that is contested from within and without. For Aboriginal peoples, 2 important arenas for this contestation and change are the relation of individual groups to pan-Amerindian political and ethnic identity movements and the relation of traditional healing practices to cosmopolitan medicine and religion, as well as their appropriation by "New Age" practitioners.

Notions and experiences of being a Native cut across historical, cultural, linguistic, geographic, and political dimensions (33,73). 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 (74).

The very notion of Aboriginality is a social construction that, as a "dividing practice," both marginalizes and unites. The discourse of Aboriginality was used originally by colonial powers when confronting "the others" whose territory they conquered (75–77). Over centuries of colonial contact, however, the paradigm that justified the rapid and often violent usurping of indigenous lands, followed by more encompassing forms of neocolonial bureaucratic control over remnant populations, has evolved into a powerful notion that there exists a distinct category of peoples in the world distinguished by having been sociopolitically marginalized.

Colonial history and anthropological writing about Native American cultures and peoples have had a powerful effect on their representations in contemporary North American society. Berkhofer, for example, discusses how the construction of stereotypical images impacted on Native Americans' self-image (78). Since anthropological investigations began in the 19th century, Native Americans have been the objects of a Euramerican cultural gaze that creates an "Other" and then polices its cultural identity (79). The resulting 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 forging of identity (33).

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. A shared history invests ethnic identity with social value and contributes directly to mental health. Studies of how cultural and historical knowledge are used to construct ethnic identity and the way in which such ethnicity is then used for psychological coping, social interaction, and community organization can therefore contribute directly to Aboriginal mental health (74). For example, the development of a collective identity has posed particular problems for Métis, who have suffered from ambiguous status (15,80). In this situation, the writing and dissemination of a group's history takes on special urgency

(81): to be effective, the expression of collective history and identity requires a public forum.

Both contemporary environmental rhetoric and New Age spirituality promote the notion that indigenous peoples practised a generic form of spirituality characterized by a harmonious, non-exploitative approach to nature based on an animistic ontology (82). This obscures the historical reality of diverse cultural traditions with different mythologies, religious beliefs, and spiritual practices; it also ignores centuries of European contact and the assimilation of Christian forms of belief in syncretic religious practices (83). In most First Nations and Inuit communities, such organized religious denominations as the Anglican or Catholic churches remain influential, especially among older populations educated in the residential school system (84). Moreover, in recent years the evangelical Christian movement, primarily the Pentecostal Church, has spread rapidly in many communities (85). Pan-Amerindian spiritual practices are strongly influenced by the vibrant cultures of the northern plains of the US, but the distinctive elements of these traditions are not shared by other, equally rich, Aboriginal traditions.

The literature of cross-cultural psychology makes a broad distinction between egoistic or individualistic cultures and sociocentric, communalistic, or collectivist cultures (86). 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. This, however, occurs along with strong support for individual autonomy and independence. For peoples like the Inuit, who traditionally have lived in small groups of 1 or 2 extended families, the notion of a sociocentric or communalistic self is misleading because there has been no social group larger than the family. Traditional notions of Inuit family relations have been extended to the new situations of large settlements (87–89).

Many Aboriginal peoples have what might be better termed an "ecocentric" concept of the person in which other people, the land, and the animals are all in transaction with the self and indeed, in some sense, constitute aspects of a relational self (89,90). Damage to the land, appropriation of land, and spatial restrictions all, then, constitute direct assaults on the person (81). Traditional hunting practices are not just means of subsistence, they are sociomoral and spiritual practices aimed at maintaining personal and community health (60). For example, Inuit concepts of self include physical links with animals maintained by eating "country food" (91). In this light, the widespread destruction of the environment motivated by commercial interests must be understood as losses to 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; it is also the hobbling of a distinctive form of self-efficacy that has to do with living on and through the land (92).

Notions of health, illness, and healing are central to the discourse of Aboriginal identity in many communities. In her careful ethnographic study, Naomi Adelson has shown how the Cree notion of "being alive well," *miyupimaatisiiun*, serves both to organize social life and create a sense of collective identity (93,94). Contemporary Cree communities have various healing practices drawn from Christianity, Cree traditions, pan-Amerindianism, and popular psychology that provide settings and symbols to articulate social suffering and narrate personal and collective transformations (95,96). In some cases, there are conflicts among adherents of different traditions, but all are concerned with achieving wellness through living a morally upright life, defined not only in religious or spiritual terms but also in relation to the land.

In recent years, pan-Amerindian healing movements have enjoyed increasing popularity in Aboriginally run treatment centres. Waldram discusses the emergence of a form of pan-Amerindian spirituality in his study of symbolic healing in prison settings (97). Participants in Aboriginal spirituality and healing practices come from diverse cultural, socioeconomic, and personal backgrounds. Often, they must first learn the mythic underpinning to which the healing process is attached (98). This emphasizes the healer's role as not only the ritual expert but also the bearer of tradition. The healer must find or develop commonalities in participants' experiences and weave them together to make a coherent story with links to tradition that can foster the interpersonal and spiritual dimensions of the healing process.

Some of the dilemmas of the homogenizing discourses of Aboriginality and pan-Amerindian healing are evident in Brass' ethnographic study of an Aboriginal-run halfway house and treatment centre, located in Quebec, for men in the correctional system (99). Clinical staff integrated a generic construction of Aboriginal identity, largely spiritual in nature, with standard methods of Western psychotherapy to create hybrid forms of group and individual therapy that would be meaningful to a large population of Aboriginal clients who differed from one another in cultural, linguistic, and personal backgrounds. This syncretic approach aimed to provide local idioms of suffering and healing through which residents could narrate their traumatic memories and sources of emotional pain. However, these psychotherapeutic approaches were not always well received. Inuit residents, for example, voiced concerns about the strangeness of the centre's "Indian things," while residents from Aboriginal groups with distinctive traditions or political stances found the emphasis on a psychological idiom of healing inappropriate.

The metaphor of trauma has gained currency as a way of talking about personal and collective injuries suffered by

Aboriginal peoples (100). This perspective has rhetorical power but raises complex issues for healing and mental health promotion. The emphasis on narrating personal trauma in contemporary psychotherapy is problematic because many forms of violence against Aboriginal people are structural or implicit and so may remain hidden in individual accounts. It is tempting to focus only on the stories that can be told about explicitly traumatic events and use these to explain persistent inequities, but these individual events are part of larger historical formations that have profound effects for both individuals and communities—effects that are harder to describe. These damaging events were not encoded as declarative knowledge but rather "inscribed" on the body or else built into ongoing social relations, roles, practices, and institutions (101,102). Social analysis to delineate these structural forms of violence and oppression is needed to aid efforts to resist them and to promote change.

Communities created by government fiat and expected to respond to programs aimed at promoting a "healthy community" face another set of dilemmas. In her ethnographic study in Igloolik, Nunavut, Kristiann Allen has shown how terms like "community," "participation," and "empowerment" are given different meanings by individuals within a single community to create personal and collective continuity with the past and effectively position themselves in the emergent self-government (103). Here again, models based on individualism and bureaucratic rationality confront relational notions of the self.

## Implications for Mental Health Services and Health Promotion

The most striking fact about the recent history of most Aboriginal communities is the rapidity with which social and cultural change has occurred, introducing the forces of globalization to even the most remote communities. Rapid change has challenged Aboriginal identity and resulted in dramatic generation gaps between youth, adults, and elders. These changes affect the whole population; therefore, mental health services and promotion must be directed at both individual and community levels. However, conventional models of service and health promotion require rethinking to be consonant with Aboriginal realities, values, and aspirations.

In most urban areas, mental health services have not been adapted to the needs of Aboriginal clients and this is reflected in low rates of use (104). As well, Aboriginal communities have distinctive features that make it difficult to deliver conventional mental health care and prevention programs. Compared to the urban centres where most models of care have been developed, Aboriginal communities are small, and many are remote. This results in fewer material resources for medical and social services and multiple roles being assumed by a few individuals. These practical constraints have been exacerbated by government policies that lead to insufficient support for mental health services for Aboriginal communities.

Because of the size and scale of Aboriginal communities, there is little opportunity to maintain the anonymity that protects the practitioner's professional role in large cities. This anonymity has both ethical and practical uses: it provides privacy and safety for clients who wish to talk about embarrassing matters, and it allows the helper to have some respite from being constantly "on call." In small communities, helpers are often related to the people they are helping and have no way to step back from their role; this can rapidly lead to burnout. As well, to date few Native people have had the opportunity to pursue professional training in mental health.

Language is a basic conveyor of culture, and people are in general most readily connected to their emotions and intimate thoughts in their first language. Yet, few health professionals working in Aboriginal communities have made the effort to learn local languages, and little mental health information has been translated. Culture, however, is a much broader issue than language: it includes notions of how people work (ethnopsychology), patterns of family and social interaction, and basic values—the recognition of which must be central to any mental health program. A new generation of practitioners is emerging—people able to combine local knowledge about health and healing with the most useful aspects of psychiatry and psychology. Aboriginal heritage is, however, no guarantee that a professional will be culturally sensitive, both because of the diversity of traditions encountered and because of the implicit cultural values and assumptions of psychiatry itself. A cultural critique of psychiatry is necessary to open up a space for creative reformulations of theory and practice.

For example, psychotherapy and other mental health interventions assume a particular cultural concept of the person, with associated values of individualism and self-efficacy (105–107). These approaches may not fit well either with traditional Aboriginal cultural values or with realities of contemporary settlement life. There is a need to rethink the applicability of different modes of intervention from the perspective of local community values and aspirations. Family and social network approaches that emphasize the relational self may be more consonant with Aboriginal culture, particularly if they are extended to incorporate some notion of the interconnectedness of person and environment (89,108,109).

The epistemology of many Aboriginal peoples allows for the validity of mythological knowledge and for forms of empirical understanding often discounted in a technological world that defers to scientific authority (33,110). The value of myth and storytelling can be easily appreciated in terms of psychological processes of making meaning and coherence from often chaotic life experience. But traditional stories and myths

are also emblems of identity that circulate among Aboriginal peoples, providing opportunities for mutual understanding and participation in a shared world.

The many forms of traditional healing that are currently undergoing a renaissance and spreading across diverse cultures and communities must be considered from this larger perspective. The resurgence of interest in traditional practices like the sweat lodge (and their adoption by Aboriginal communities that never had such traditions) is part of a more global movement to regenerate Aboriginal identity and explore the significance of an evolving tradition in the contemporary world (111,112). Of course, in some hands, Aboriginal spirituality becomes a product, open to commercialization. Neoshamanism has become the subject of weekend workshops for middle-class Americans (113). The relation between this commercialization and the healing power of "authentic" tradition needs careful study. To a large extent, traditional healing draws its efficacy from its rootedness in a local community with a shared social life. The traditional healer is known to the community, and his or her efficacy and moral conduct are open to scrutiny. Traditional healing practices involve local contexts of power that should not be immune from critical examination.

Government and professional responses to social pathologies—providing more health care or supporting traditional forms of healing—while essential, do not address the most fundamental causes of suffering. Community development and local control of health care systems are needed, not only to make services responsive to local needs but also to promote the sense of individual and collective efficacy and pride that contribute to positive mental health. Ultimately, political efforts to restore Aboriginal rights, settle land claims, and redistribute power through various forms of self-government hold the keys to healthy communities (114).

## Conclusion

Aboriginal peoples of North America, like indigenous populations in other parts of the world, have experienced profound disruption and alteration of their traditional life ways 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, increasingly pervasive bureaucratization, 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.

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 be linked to its sense of local control and cultural continuity. Recent successes in negotiating land claims and local government, along with forms of cultural renewal, hold out hope for improvements in health status. Attempts to recover power and maintain cultural traditions must contend with the political, economic, and cultural realities of consumer capitalism, technocratic control, and globalization.

### Highlights

- Aboriginal populations have a high prevalence of mental health problems that can be related to the effects of rapid culture change, cultural oppression, and marginalization.
- There is evidence that local control of community institutions and cultural continuity may contribute to better mental health.
- Psychiatric practice must be adapted to local cultural concepts of the person, self, and family that vary across Aboriginal communities.

Issues of equity in health and well-being for Canada's Aboriginal peoples are important to any vision of a just society. Research on the problems that Aboriginal populations face has important implications for health service delivery, for mental health promotion, and for social psychiatric theory and practice in general. Research and program development must be fully collaborative through broad-based partnerships with Aboriginal communities (115).

A cultural perspective can contribute to developing forms of mental health services and health promotion that respond appropriately to the dilemmas created by this complex history and social context. In turn, the local knowledge, values, and wisdom of Aboriginal peoples hold up to the larger Euro-Canadian society a mirror that can generate a bracing critique of dominant cultural assumptions and preoccupations.

## References

1. Frideres JS. Aboriginal peoples in Canada: contemporary conflicts. Scarborough: Prentice Hall Allyn and Bacon Canada; 1998.
2. Morrison RB, Wilson CR, editors. Native Peoples: the Canadian experience. Toronto:McClelland and Stewart; 1988.
3. Hunter E. Aboriginal health and history: power and prejudice in remote Australia. Melbourne: Cambridge University Press; 1993.
4. Kunitz SJ. Disease and Social diversity. New York: Oxford University Press; 1994.
5. Spencer DJ. Anomie and demoralization in transitional cultures: The Australian Aboriginal model [editorial]. Transcultural Psychiatry 2000;37(1):5–10.
6. Ray AJ. I have lived here since the world began. Toronto: Lester Pubishing Limited; 1996.
7. Waldram JB, Herring DA, Young TK. Aboriginal health in Canada: historical, cultural, and epidemiological perspectives. Toronto: University of Toronto Press; 1995.
8. Trigger BG, Swagerty WR. Entertaining strangers: North America in the sixteenth century. In: Trigger BG, Washburn WE editors. The Cambridge history of the native peoples of the Americas: Volume 1, North America. New York: University of Cambridge; 1996. p 325–98.
9. Thornton R. American Indian holocaust and survival: a population history since 1492. Norman: University of Oklahoma Press; 1987.
10. Stannard DE. American holocaust: the conquest of the New World. New York: Oxford University Press; 1992.
11. Young TK. Health care and cultural change: the Indian experience in the central subarctic. Toronto: University of Toronto Press; 1988.

12. Young TK. The health of Native Americans. New York: Oxford University Press; 1994.
13. Miller JR. Skyscrapers hide the heavens: a history of Indian-White relations in Canada. Toronto: University of Toronto Press; 2000.
14. Richardson B. People of terra nullius: betrayal and renewal in Aboriginal Canada. Vancouver: Douglas and MacIntyre; 1993.
15. Dickason OP. Canada's first nations: a history of founding peoples from earliest times. Toronto: Oxford University Press; 1997.
16. Tester FJ, Kulchyski P. Tammarniit (mistakes): Inuit relocation in the eastern arctic 1939–63. Vancouver: University of British Columbia Press; 1994.
17. Marcus AR. Out in the cold: the legacy of Canada's Inuit relocation experiment in the high arctic. Copenhagen: IWGIA; 1992.
18. Royal Commission on Aboriginal Peoples. The high arctic relocation: a report on the 1953-55 relocation. Ottawa: Minister of Supply and Services; 1994.
19. Titley EB. A narrow vision: Duncan Campbell Scott and the administration of Indian affairs in Canada. Vancouver: University of British Columbia; 1986.
20. Hoxie FE. The reservation period, 1880–1960. In: Trigger BG, Washbrun WE, editors. The Cambridge history of the Native peoples of the Americas. Volume 1, North America. Part 2. New York: University of Cambridge; 1996. p 183–258.
21. Armitage A. Comparing the policy of aboriginal assimilation: Australia, Canada, and New Zealand. Vancouver: UBC Press; 1995.
22. Miller JR. Shingwauk's vision: a history of native residential schools. Toronto: University of Toronto Press Inc; 1996.
23. Haig-Brown C. Resistance and renewal: surviving the Indian residential school. Vancouver: Tillacum Library; 1988.
24. Johnston B. Indian school days. Toronto: Key Porter; 1988.
25. Knockwood I. Out of the depths: the experiences of Mi' kmaw Children at the Indian residential school at Shubenacadie, Nova Scotia. Lockeport (NS): Roseway Publishing; 1992.
26. Lomawaima KT. Domesticity in the federal Indian schools: the power of authority over mind and body. American Ethnologist 1993;20(2):227–40.
27. Chrisjohn R, Young S, Maraun M. The circle game: shadows and substance in the Indian residential school experience in Canada. Penticton (BC): Theytus Books; 1997.
28. Fournier S, Crey E. Stolen from our embrace. Vancouver: Douglas and McIntyre; 1997.
29. Johnston P. Native children and the child welfare system. Ottawa: Canadian Council on Social Development; 1983.
30. Swift K. Manufacturing "bad mothers": a critical perspective on child neglect. Toronto: University of Toronto Press; 1995.
31. MacDonald JA. The program of the Spallumcheen Indian Band in British Columbia as a model of Indian child welfare. In: Blake B, Keshen J, editors. Social welfare policy in Canada: historical readings. Toronto: Copp Clarke; 1995. p 380–91.
32. Grygier PS. A long way from home: the tuberculosis epidemic among the Inuit. Montreal and Kingston: McGill-Queen's University Press; 1994.
33. Krupat A. The turn to the native: studies in criticism and culture. Lincoln: University of Nebraska Press; 1996.
34. Salisbury RF. A homeland for the Cree: regional development in James Bay, 1971–1981. Montreal: McGill Queen's Press; 1986.
35. Kirmayer LJ. Suicide among Canadian Aboriginal peoples. Transcultural Psychiatric Research Review 1994;31(1):3–58.
36. Kirmayer LJ, Gill K, Fletcher C, Ternar Y, Quesney C, Smith A, and others. Emerging trends in research on mental health among Canadian Aboriginal peoples. Montreal: Sir Mortimer B. Davis–Jewish General Hospital; 1993.
37. Royal Commission on Aboriginal Peoples. Choosing life: special report on suicide among Aboriginal people. Ottawa: Supply and Services; 1995.
38. Shkilnyk AM. A poison stronger than love: the destruction of an Ojibwa community. New Haven: Yale University Press; 1985.
39. LaFromboise TD. American Indian mental health policy. Am Psychol 1988; 43(5):388–97.
40. York G. The dispossessed: life and death in native Canada. Boston: Little, Brown and Co; 1990.
41. Richardson B. Strangers devour the land. Post Mills (VT): Chelsea Green; 1991.
42. Waldram J. The Aboriginal people of Canada: colonialism and mental health. In: Al-Issa I, Tousignant M, editor. Ethnicity, immigration, and psychopathology. New York: Plenum Press; 1997.
43. Sampath HM. Prevalence of psychiatric disorders in a Southern Baffin Island Eskimo settlement. Canadian Psychiatric Association Journal 1974;19:363–7.
44. Roy C, Choudhuri A, Irvine D. The prevalence of mental disorders among Saskatchewan Indians. Journal of Cross-Cultural Psychology 1970;1(4):383–92.
45. Shore JH, Kinzie JD, Hampson JL, Mansell E. Psychiatric epidemiology of an Indian village. Psychiatry 1973;36(1):70–81.
46. Kinzie JD, Leung PK, Boehnlein J, Matsunaga D, Johnson R, Manson S, and others. Psychiatric epidemiology of an Indian village: A 19-year replication study. J Nerv Ment Dis 1992;180(1):33–9.
47. Kunitz SJ, Gabriel KR, Levy JE, Henderson E, Lampert K, McCloskey J, and others. Alcohol dependence and conduct disorder among Navajo Indians. Journal of Studies on Alcohol 1999;60(2):159–67.
48. Gotowiec A, Beiser M. Aboriginal children's mental health: unique challenges. Canada's Mental Health 1994:7–11.
49. Beiser M, Attneave CL. Mental disorders among Native American children: Rates and risk periods for entering treatment. Am J Psychiatry 1982;139:193–8.
50. Beiser M, Lancee W, Gotowiec A, Sack W, Redshirt R. Measuring self-perceived role competence among First Nations and non native children. Can J Psychiatry 1993;38:412–9.
51. Sack W, Beiser M, Baker-Brown G, Redshirt R. Depressive and suicidal symptoms in Indian school children: Some findings from the Flower of Two Soils. American Indian and Alaska Native Mental Health Research 1994;4:81–96.
52. Kunitz SJ, Gabriel KR, Levy JE, Henderson E, Lampert K, McCloskey J, and others. Risk factors for conduct disorder among Navajo men. Soc Psychiatry Psychiatr Epidemiol 1999;34(4):180–9.
53. MacMillan H, Welsh C, Jamieson E, Crawford A, Boyle M. Children's health. First Nations and Inuit regional health surveys, 2000. Ottawa: Assembly of First Nations; 2000.
54. Clarkson M, Lavallée C, Légaré G, Jetté M. Santé Québec health survey among the Cree of James Bay: Features. Québec: Ministère de la Santé et des Services sociaux, Gouvernement du Québec; 1992.
55. Santé Québec. A health profile of the Inuit: report of the Santé Québec health survey among the Inuit of Nunavik, 1992. Montréal: Ministère de la Santé et des Services Sociaux, Gouvernement du Qu33bec; 1994.
56. Petawabano B, Gourdeau E, Jourdain F, Palliser-Tulugak A, Cossette J. Mental health and Aboriginal people of Québec. Montréal: Gaëtan Morin Éditeur; 1994.
57. Kirmayer LJ, Malus M, Boothroyd LJ. Suicide attempts among Inuit youth: a community survey of prevalence and risk factors. Acta Psychiatr Scand 1996;94:8–17.
58. Kirmayer LJ, Boothroyd LJ, Hodgins S. Attempted suicide among Inuit youth: psychosocial correlates and implications for prevention. Can J Psychiatry 1998;43:816–22.
59. Kirmayer LJ, Boothroyd LJ, Tanner A, Adelson N, Robinson E, Oblin C. Psychological distress among the Cree of James Bay. Transcultural Psychiatry 2000;37(1):35–56.
60. Tanner A. Bringing home animals: religious ideology and mode of production of the Mistassini Cree Hunters. Newfoundland: Memorial University of Newfoundland; 1993.
61. Chandler MJ, Lalonde C. Cultural continuity as a hedge against suicide in Canada's First Nations. Transcultural Psychiatry 1998;35(2):191–219.
62. Freilich M, Raybeck D, Savishinsky J, editors. Deviance: anthropological perspectives. New York: Bergin and Garvey; 1991.
63. Kirmayer LJ, Fletcher C, Corin E, Boothroyd L. Inuit concepts of mental health and illness: an ethnographic study. Montreal: Sir Mortimer B Davis–Jewish General Hospital; 1994.
64. Kirmayer LJ, Fletcher C, Boothroyd LJ. Inuit attitudes toward deviant behaviour: a vignette study. J Nerv Mental Dis 1997;185(2):78–86.
65. Nuttall M. States and categories: Indigenous models of personhood in northwest Greenland. In: Jenkins R, editor. Questions of Competence: culture, classification and intellectual disability. Cambridge: Cambridge University Press; 1998. p 176–93.
66. Kirmayer LJ. Is the concept of mental disorder culturally relative? In: Kirk SA, Einbinder S, editors. Controversial issues in mental health. Boston: Allyn and Bacon; 1994. p 1–20.
67. Phinney JS, Chavira V. Ethnic identity and self-esteem: an exploratory study. Journal of Adolescence 1992; 5:271–81.
68. Petrie K, Brook R. Sense of coherence, self-esteem, depression and hopelessness as correlates of reattempting suicide. Br J Clin Psychol 1992;31:293–300.
69. Chandler M. Self-continuity in suicidal and nonsuicidal adolescents. New Directions in Child Development 1994;64:55–70.
70. Chandler M, Ball L. Continuity and commitment: a developmental analysis of identity formation in suicidal and non-suicidal youth. In: Bosma H, Jackson S, editors. Coping and self-concept in adolescence. New York: Springer-Verlag; 1989. p 149–66.
71. Chandler MJ, Lalonde CE. The problem of self-continuity in the context of rapid personal and cultural change. In: Oosterwegel A, Wicklund RA, editors. The self in European and North American culture: development and processes. Dordrecht: Kluwer; 1995. p 45–63.
72. Roosens EE. Creating ethnicity: the process of ethnogenesis. Newbury Park: Sage Publications; 1989.
73. Vizenor G. Manifest manners: narratives on postindian survivance. Lincoln: University of Nebraska Press; 1999.
74. Trimble JE, Medicine B. Diversification of American Indians: forming an indigenous perspective. In: Kim U, Berry JW, editors. Indigenous psychologies: research and experience in cultural context. Newbury Park: Sage; 1993. p 133–51.
75. Hollinsworth D. Discourses on aboriginality and the politics of aboriginality in urban Australia. Oceania 1992;63(2):137–55.
76. Beckett J. The past in the present; the present in the past: constructing a national aboriginality. In: Beckett J, editor. Past and present: the construction of aboriginality. Canberra: Aboriginal Studies Press; 1988. p 191–217.
77. Archer J. Ambiguity in political ideology: aboriginality as nationalism. Australian Journal of Anthropology 1991;2(2):161–70.
78. Berkhofer RF. The White Man's Indian. New York: Random House; 1978.
79. Lattas A. Essentialism, memory, and resistance: aboriginality and the politics of authenticity. Oceania 1993;63:240–67.

80. Peterson J, Brown JSH, editors. The new peoples: being and becoming Métis In North America. Winnipeg: University of Manitoba Press; 1993.
81. Sioui G. For an Amerindian Autohistory: an essay on the foundations of a social ethic. Montreal: McGill-Queen's Press; 1992.
82. Hultkrantz A. Shamanic healing and ritual drama: health and medicine in Native North American religious traditions. New York: Crossroad; 1992.
83. Vecsey C, editor. Religion in Native North America. Moscow (ID): University of Idaho Press; 1990.
84. Treat J, editor. Native and Christian: indigenous voices on religious identity in the United States and Canada. New York: Routledge Inc; 1996.
85. Fletcher C, Kirmayer LJ. Spirit work: Nunavimmiut experiences of affliction and healing. Etudes/Inuit/Studies 1997;21(1–2):189–208.
86. Triandis HC. The psychological measurement of cultural syndromes. Am Psychol 1996;51(4):407–15.
87. Briggs JL. Socialization, family conflicts and responses to culture change among Canadian Inuit. Arctic Medical Research 1985;40:40–52.
88. Dorais L. Quaqtaq: Modernity and identity in an Inuit community. Toronto: University of Toronto Press; 1997.
89. Drummond SG. Incorporating the familiar: an investigation into legal sensibilities in Nunavik. Montreal: McGill-Queen's Press; 1997.
90. Stairs A. Self-image, world-image: speculations on identity from experiences with Inuit. Ethos 1992;20(1):116–26.
91. Borré K. Seal blood, Inuit blood, and diet: A biocultural model of physiology and cultural identity. Medical Anthropology 1991;5(1):48–62.
92. Brody H. The people's land: Eskimos and Whites in the eastern arctic. Middlesex: Penguin Books; 1975.
93. Adelson N. Health beliefs and the politics of Cree well-being. Health 1998; (1):5–22.
94. Adelson N. "Being Alive Well": health and the politics of Cree well-being. Toronto: University of Toronto Press; 2000.
95. Adelson N. Re-imagining aboriginality: an indigenous peoples' response to social suffering. Transcultural Psychiatry 2000;37(1):11–34.
96. Tanner A. The healing movement, environment consciousness and adaptation to rapid social change. Paper presented at 6th International Interdisciplinary Conference on the Environment; 2000; Montreal.
97. Waldram JB. The way of the pipe: Aboriginal spirituality and symbolic healing in Canadian prisons. Peterborough (ON): Broadview Press; 1997.
98. Dow J. Universal aspects of symbolic healing: a theoretical synthesis. American Anthropologist 1986;88:56–69.
99. Brass G. Respecting the medicine: narrating an Aboriginal identity [master's thesis]. Montreal: McGill University. 1999.
100. Manson S, Beals J, O'Nell T, Piasecki J, Bechtold D, Keane E, J and others. Wounded spirits, ailing hearts: PTSD and related disorders among American Indians. In: Marsella AJ, Friedman MJ, Gerrity ET, Scurfield RM, editors. Ethnocultural aspects of post-traumatic stress disorders: issues, research and clinical applications. Washington (DC): American Psychological Association; 1996. p 255–84.
101. Kirmayer LJ. Confusion of the senses: implications of ethnocultural variations in somatoform and dissociative disorders for PTSD. In: Marsella AJ, Friedman MJ, Gerrity ET, Scurfield RM, editors. Ethnocultural aspects of post-traumatic stress disorders: issues, research and clinical applications. Washington (DC); American Psychological Association; 1996. p 131–64.
102. Kirmayer LJ. Landscapes of memory: trauma, narrative and dissociation. In: Antze P, Lambek M, editors. Tense past: cultural essays on memory and trauma. London: Routledge; 1996. p 173–98.
103. Allen K. Negotiating health: the meanings and implications of "building a healthy community" in Igloolik, Nunavut [master's thesis]. Montreal: McGill University. 1999.
104. The Royal Commission on Aboriginal Peoples. Aboriginal peoples in urban centres: report of the National Round Table on Aboriginal Urban Issues. Ottawa: Canada Communication Group; 1993.
105. Kirmayer LJ. Psychotherapy and the cultural concept of the person. Santé, Culture, Health 1989;6(3):241–70.
106. Gaines AD. From DSM-I to III-R: Voices of self, mastery and the other: a cultural constructivist reading of US psychiatric classification. Social Science and Medicine 1992;35(1):3–4.
107. Bellah RN, Madsen R, Sullivan WM, Swidler A, Tipton SM. Habits of the heart: individualism and commitment in American life. Berkeley: University of California Press; 1985.
108. Speck RV, Attneave CL. Family networks. New York: Pantheon; 1973.
109. Trimble JE, Manson SE, Dinges NG, Medicine B. American Indian concepts of mental health: reflections and directions. In: Pederson P, and others, editors. Mental health services: the cross-cultural context. Beverly Hills: Sage Publications; 1984. p 199–220.
110. Nabakov P. Native views of history. In: Trigger BG, Washburn W, editors. The Cambridge history of the Native peoples of the Americas. Volume 1. North America, Part 1. New York: University of Cambridge; 1996. p 1–59.
111. Bucko RA. The Lakota ritual of the sweat lodge: history and contemporary practice. Lincoln: University of Nebraska Press; 1998.
112. Washburn WE. The Native American renaissance, 1960 to 1995. In: Trigger BG, Washburn WE, editors. The Cambridge history of the Native peoples of the Americas. Volume 1. North America, Part 2. New York: University of Cambridge; 1996. p 401–74.
113. Atkinson JM. Shamanisms today. Annual Review of Anthropology 1992;21: 307–30.
114. Warry W. Unfinished Dreams: Community healing and the reality of Aboriginal self-government. Toronto: University of Toronto; 1998.
115. Macauley AC, Commanda LE, Gibson N, McCabe ML, Robbins CM, Twohig PL. Participatory research maximises community and lay involvement. British Medical Journal 1999;319:774–8.

## **Résumé—** La santé mentale des peuples autochtones : transformations de l'identité et de la communauté

*Le présent article examine certaines études récentes sur la santé mentale des Premières nations, des Inuits et des Métis du Canada. Nous résumons les preuves des origines sociales des problèmes de santé mentale et illustrons les réponses actuelles des individus et des collectivités à l'héritage de la colonisation. La discontinuité culturelle et l'oppression ont été liées à des taux élevés de dépression, d'alcoolisme, de suicide et de violence dans nombre de communautés, et l'effet le plus radical s'est fait sentir chez les jeunes. Malgré ces problèmes, de nombreuses communautés s'en tirent bien ; la recherche est nécessaire pour déterminer les facteurs qui favorisent le bien-être. La psychiatrie culturelle peut contribuer à redéfinir les services de santé mentale et la promotion de la santé chez les populations et les communautés autochtones.*