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The Mental Health of Indigenous Peoples

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Preface & Acknowledgement

This report presents the proceedings of a conference on “The Mental Health of Indigenous Peoples” organized by the Aboriginal Mental Health Team of the Culture & Mental Health Unit, Sir Mortimer B. Davis—Jewish General Hospital in Montreal May 29-31, 2000. The conference was organized in conjunction with the Annual Summer Program in Social and Cultural Psychiatry of the Division of Social & Transcultural Psychiatry, McGill University.

The aim of the meeting was to bring together experts on mental health research among indigenous peoples in Canada, the US and Australia to exchange perspectives, methods and models for research and service delivery. The meeting was supported by grants from the Conseil québécois de la recherche sociale.

Many people assisted with the organization of the conference and the subsequent preparation of these proceedings. We thank all of our colleagues and the staff of the CMHRU for their help and support.

It is our hope that this report will help those working in and with Aboriginal communities in Canada and elsewhere to conduct meaningful research and promote culturally responsive mental health services.

Laurence J. Kirmayer
Montreal, January 2001

1. INTRODUCTION

The Mental Health of Aboriginal Peoples: Transformations of Identity and Community¹

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Abstract: 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 most dramatic 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.

Résumé: Cet article examine un certain nombre de recherches récentes portant sur la santé mentale des Premières Nations, des Inuits et des Métis du Canada. Nous récapitulons les preuves militent en faveur des origines sociales des problèmes de santé mentale et illustrons les réponses actuelles d'individus et de communautés face à l'héritage de la colonisation. La discontinuité culturelle et l'oppression ont été associées à des taux élevés de dépression, d'alcoolisme, de suicide, et de violence dans de nombreuses communautés, avec l'impact le plus dramatique exercé sur la jeunesse. En dépit de ces défis, nombre de communautés s'en sont très bien tirées et de la recherche s'avère nécessaire afin de pouvoir identifier les facteurs qui favorisent le bien-être. La psychiatrie culturelle peut contribuer à repenser les services de soins en santé mentale et la promotion de la santé pour les populations et communautés autochtones.

Introduction

Around the world, Indigenous peoples have experienced rapid culture change, marginalization, and absorption into a global economy with 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 dramatic impact on youth. Despite these challenges, many communities have done well. This paper will explore issues in the mental health 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

¹ A version of this paper appeared in the *Canadian Journal of Psychiatry* 2000.

and collective problems caused by this history of systematic suppression and dislocation. We also consider some of the 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 implications of an emphasis on identity and community for mental health services and health promotion.

First Nations, Inuit and Métis constitute about 1 million people or 4% of the Canadian population. There are 11 major language groups, more than 58 dialects and some 596 bands residing on 2284 reserves, cities and rural communities (Frideres, 1998; Morrison & Wilson, 1988). The cultural and linguistic differences among many groups are greater than the differences that divide European nations. In addition 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 people together under generic terms like *Aboriginal* or *Indigenous* profoundly misleading; nevertheless, most groups 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, there are striking parallels in the mental health problems of Indigenous peoples around the world suggesting that, while biological, social, cultural and political factors vary, there are common processes at work (Hunter, 1993; Kunitz, 1994; Spencer, 2000).

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 (Ray, 1996; Waldram, Herring & Young 1995). However, a dramatically accelerated process of cultural change began in the 16th century, the result of European fishing expeditions, European exploration, and the European missionaries, fur traders and colonists who moved to the New World. As well, Mesoamerican and Caribbean Natives accompanied some European expeditions, which brought different Indigenous cultures into contact as well (Trigger & Swagerty, 1996).

The history of the European colonization of North America is a harrowing tale of decimation of the Indigenous population by infectious disease, warfare, and an active suppression of culture and identity (Stannard, 1992; Thornton, 1987). 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 century to about 8,000 by 1850 (Trigger & Swagerty, 1996). Economic, political, and religious institutions of the European settlers all contributed to the displacement and oppression of indigenous people.

Culture 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 also had profound effects on the health of Indigenous peoples. These effects continue to the present day with problems of obesity and diabetes endemic in many Aboriginal communities (Waldram et al., 1995; Young, 1988, 1994).

Colonization did not end with the creation of the new nation state. Over the last century, Canadian government policies, which include forced sedenterization, the creation of reserves, the relocation of Aboriginal peoples to remote regions, residential schools, and bureaucratic control, have continued to destroy indigenous cultures (Miller, 2000; Richardson, 1993).

Although the process of sedentarization began with the response of indigenous peoples themselves to the presence of fur traders and missionaries, it took new forms 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 (Dickason, 1997). In many cases, this resulted in the arbitrary social groupings of people who had no history of living together in such close quarters. Groups of people were thus forced to improvise new ways of life and 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 was a late chapter in this process of forced culture change that revealed the government's lack of awareness of cultural and ecological realities (Marcus, 1992; Royal Commission on Aboriginal Peoples, 1994; Tester & Kulchyski 1994).

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 (Titley, 1986). This ideology justified legislation to prohibit Aboriginal religious and cultural practices like the potlatch or the Sun Dance (Hoxie, 1996). Aboriginal peoples were viewed as unable or unready to participate in democratic government; they needed to be "civilized" in order 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 of children by non-Aboriginal families (Armitage, 1995).

From 1879 to 1973, the Canadian government mandated church-run boarding schools to provide education for Aboriginal children (Miller, 1996). 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 (Haig-Brown, 1988; Johnston, 1988; Knockwood, 1992; Lomawaima, 1993). 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 (Chrisjohn, Young & Maraun, 1997).

During the period of the residential school system, assimilation of Aboriginal peoples was the explicit motivation for the removal of Aboriginal children from their communities. Aboriginal parents were not necessarily seen as 'unacceptable' parents, but as incapable of 'educating' and passing on 'proper' European values to their children (Fournier & Crey, 1997; Johnston, 1983). Beginning in the 1960s, the government effectively handed over the responsibility for Aboriginal health, welfare, and educational services to the provinces, although remaining 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 (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 counseling 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 Aboriginal children that they took into care, resulting in Aboriginal children experiencing much longer periods of foster care than their non-Aboriginal counterparts (MacDonald, 1995). 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 (Fournier & Crey, 1997).

While some of these policies were well intentioned, 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 (Tittle, 1986). The cumulative effect of these policies has, in many cases, amounted to near cultural genocide (Chrisjohn et al., 1997). The collective trauma, loss and grief caused by these shortsighted and self-serving policies are reflected in the endemic mental health problems of many communities and populations across Canada. However, framing the problem purely in terms of mental health issues 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 of non-Aboriginal Canadians; despite efforts at income assistance and community

development, this gap had widened over the decades since 1980 (Frideres, 1998). The effects of poverty are seen in the poor living conditions on many reserves and remote settlements, leading to chronic respiratory diseases, recurrent otitis media with hearing loss, and tuberculosis, which in the past necessitated prolonged hospitalizations, further subverting the integrity of families and communities (Grygier, 1994). Of course, the very notion of poverty is a creation of the social order in which Aboriginal peoples are embedded and 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 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 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 through publicity aimed at influencing public opinion in the U.S. 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 likely have had a positive effect on the sense of efficacy and mental health of many Cree. Efforts at re-vitalization of communities and collective identities thus must be understood 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 the general Canadian population and they continue to have substantially shorter life expectancy (Frideres, 1998; Waldram et al., 1995). This is largely due to higher infant mortality and increased rates of death among young people by accident and suicide.

A range of epidemiological studies has documented high levels of mental health problems in many Canadian Aboriginal communities (Kirmayer, 1994a; Kirmayer et al. 1993; Royal Commission on Aboriginal Peoples, 1995; Waldram et al., 1995). The high rates of suicide, alcoholism, violence and the pervasive demoralization seen in Aboriginal communities can be readily understood as the direct consequences of this history of dislocations and disruption of traditional subsistence patterns and connection to the land (LaFromboise, 1988; Richardson, 1991; Shkilnyk, 1985; Waldram, 1997a; York, 1990).

Most estimates of the prevalence of psychiatric disorders are based on service utilization records. Since many 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 – two of these in Canadian populations (Roy, Choudhuri & Irvine 1970; Sampath, 1974). These studies indicate rates of psychiatric disorders varying from levels comparable to the general population to up to twice those of neighbouring non-Aboriginal communities.

In the U.S., Kinzie and colleagues conducted a 1988 follow-up study of a Northwest coast village originally studied by Shore and colleagues in 1969 (Kinzie et al., 1992; Shore et al., 1973). The Schedule for Affective Disorders and Schizophrenia Lifetime version (SADS-L, with a supplementary section on Post-traumatic Stress Disorder (PTSD), was used to generate DSM-III-R diagnoses. In all, 31.4% of subjects met criteria for a current DSM-III-R diagnosis. A marked sex difference was observed with nearly 46% of men affected and only 18.4% of women ($p < .002$). Most of those fully employed (88%) had no diagnosis of mental disorders; the presence of a diagnosis was not related to marital status, age or educational level. The most impressive finding in 1988, as in the 1969 study, 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 (Kunitz, Gabriel, Levy, Henderson, Lampert, McCloskey & Quintero, 1999).

Data pertaining to Aboriginal children's mental health is quite limited, but there is clear evidence of high rates of problems including suicide and substance abuse among adolescents in many communities (Beiser and Atneave, 1982; Gotowiec & Beiser 1994). The *Flower of Two Soils* re-interview study followed up 109 of 251 U.S. Northern Plains adolescents (age 11 to 18), who took part as children in the earlier study (Beiser et al., 1993; Sack et al., in press); diagnoses were ascertained with the DISC 2.1C, including a PTSD module. Fully 43% of the respondents received a diagnosis of at least one DSM-III-R disorder. The most frequent diagnoses were: disruptive behaviour disorders 22% (including conduct disorder 9.5%); substance use disorders 18.4% (including alcohol dependence, 9.2%); anxiety disorders 17.4%; affective disorders 9.3% (including Major Depression, 6.5%); and PTSD 5%. Rates of comorbidity were very high with almost half of those with behaviour or affective disorders meeting criteria for a substance use disorder. Almost 2/3 of respondents reported having experienced a traumatic event; 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., 1999). Conduct disorder before age 15 is a risk factor for adult alcohol abuse in this population (Kunitz, et al., 1999).

The First Nations and Inuit Regional Health Surveys conducted across Canada (but excluding Alberta, and the northern and James Bay regions of Quebec) in

1997, 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 their child had more emotional or behavioural problems than other children of the same age (MacMillan, 2000).

Epidemiological surveys undertaken by the Province of Québec among the Cree (Clarkson et al., 1992) and Inuit (Santé Québec, 1994), in 1991 and 1992 respectively, used brief measures of generalized emotional distress, and 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, 1994a). In Quebec, for example, the Inuit, Attikamekw and several other Nations have very high rates of suicide while the Cree have rates no higher than the rest of the province (Petawabano et al., 1994). 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 (Kirmayer, Boothroyd, & Hodgins 1998; Kirmayer, Malus, & Boothroyd, 1996). The risk factors identified are similar to those of other studies of Aboriginal youth, including: male gender, history of substance abuse (especially solvents or inhalants), history of a psychiatric problem, parental history of substance abuse or psychiatric problem, feelings of alienation from the community, history of physical abuse. Protective factors identified in this research include good school performance and regular attendance at church. It is striking that young males are not only much more likely to complete suicide but also attempt more often. This fits with the perception that there has been greater disruption of traditional roles for males 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 (Petawabano et al., 1994). 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 gender, early loss of parents or a relative, and a smaller social network (less than 5 close friends or relatives) (Kirmayer et al., 2000). 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 of 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 as they are required not only to work or study but also continue 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, which provide not only an important source of food but also a way of life with significant social and spiritual meaning which contribute to well-being (Tanner, 1993).

Studies in which the level of analysis is the individual may not identify factors that account for differences in the prevalence of suicide and other problems between communities. This requires systematic comparisons between 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 rates of suicide among Aboriginal peoples in British Columbia (Chandler & Lalonde, 1998). 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, education, and health, existence of local facilities for cultural activities, self-government, and involvement in land claims. The presence of each of these variables was associated with a lower level of suicide in communities compared to those where such local control was absent. An index created by summing these factors was strongly negatively correlated with suicide rate across the 196 bands in the study. This is clear evidence for a strong association between lack of local community control and high rates of suicide.

Although most attention has been given to the common mental disorders (depression, anxiety, post-traumatic stress disorder) which are endemic in Aboriginal communities, psychotic disorders present 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 (Freilich, Raybeck & Savishinsky, 1991). Our own studies of Inuit concepts of mental health and illness and attitudes toward deviant behavior suggest that cultural factors play a role (Kirmayer, Fletcher, & Boothroyd, 1997; Kirmayer et al., 1994). Inuit tend to label states rather than people allowing for the possibility that someone whose behaviour is bizarre today may be ordinary tomorrow (Nuttall 1998). There may be features of Inuit ethnopsychology that promote better adaptation and outcome of psychotic disorders (Kirmayer, 1994b). Longitudinal outcome studies are needed to examine this possibility.

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 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 (Chandler, 1994; Chandler & Ball, 1989; Chandler & Lalonde, 1995; Petrie & Brook, 1992; Phinney & Chavira, 1992), which, in turn, are strongly influenced by collective processes at the level of band, community or larger political entities.

All cultures are in constant evolution so that cultural and ethnic identity must be understood as inventions of contemporary people responding to their current situation (Roosens, 1989). 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 both from within and without. For Aboriginal peoples, two important arenas for this contestation and change involve the relationship of individual groups to pan-Indian political and ethnic identity movements, and the relationship of traditional healing practices to cosmopolitan medicine and religion, as well as their appropriation by “New Age” practitioners.

Notions of being Aboriginal involve crosscutting historical, cultural, linguistic, geographic and political dimensions (Krupat, 1996; Vizenor, 1999). To a large extent, they are situational, and emerge out of encounters with others who are viewed as sharing a generalized Aboriginal heritage or a political position (Trimble & Medicine, 1993).

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 socio-politically marginalized from nation-state populations. This discourse of aboriginality was used originally by colonial powers when confronting ‘the others’ whose territory they conquered (Archer, 1991; Beckett, 1988; Hollinsworth, 1992). 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 discusses how the construction of stereotypical images impacted on Native Americans self-image (Berkhofer, 1978). 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 (Lattas, 1993). 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 forging of identity (Krupat, 1996).

The creation of an explicit ethnic identity requires that certain beliefs, practices or characteristics are 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 so contributes directly to mental health. Studies of how cultural and historical knowledge is used to construct ethnic identity and the way in which such ethnicity is then used for psychological coping, social interaction and community organization can therefore contribute directly to Aboriginal mental health (Trimble & Medicine, 1993). For example, the development of a collective identity has posed particular problems for Métis who have suffered from ambiguity of status (Dickason, 1997; Peterson & Brown, 1993). In this situation, the writing and dissemination of a group's history takes on special urgency (Sioui, 1992). To be effective the expression of collective history and identity requires a public forum.

Contemporary environmental rhetoric and New Age spirituality both promote the notion that indigenous peoples practiced a generic form of spirituality characterized by a harmonious, non-exploitative approach to nature based on an underlying animistic ontology (Hultkrantz, 1992). 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 (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 who 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 (Fletcher & Kirmayer 1997). Pan-Indian 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.

Cross-cultural psychology makes a distinction between egoistic or individualist and sociocentric or communalist cultures (Triandis 1996). Many Aboriginal cultures appear sociocentric in that the self is defined relationally and the well-being of family, band, or community is of central importance; however, this co-exists with strong support for individual autonomy and independence. For peoples like the Inuit, who lived in small groups of one or two extended families, the notion of a sociocentric self is misleading, since there was no social group larger than the family to define the self. Traditional notions of Inuit family relations have been extended to the new situations of large settlements (Briggs, 1985; Dorais, 1997; Drummond, 1997).

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 (Drummond, 1997; Stairs, 1992). Damage to the land, appropriation of land, and spatial restrictions all then constitute direct assaults on the person (Sioui, 1992). Traditional hunting practices are not just a means of subsistence, they are sociomoral and spiritual practices aimed at maintaining the health of person and community (Tanner, 1993). For example, Inuit concepts of self include physical links with animals through the eating of “country food” (Borré, 1991). 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).

Notions of health, illness and healing play a central role in 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”, *miyupimaatisiun*, serves both to organize social life and create a sense of collective identity (Adelson, 1998, 2000a). Contemporary Cree communities have a variety of healing practices drawn from Christianity, Cree traditions, pan-Indianism and popular psychology that provide settings and symbols to articulate social suffering and narrate personal and collective transformations (Adelson, 2000b; Tanner, 2000). In some cases, there are conflicts between adherents of different traditions but all share a concern 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-Indian healing movements have enjoyed increasing popularity in Aboriginal-run treatment centres. Waldram discusses the emergence of a form of pan-Indian spirituality in his study of symbolic healing in prison settings (Waldram, 1997b). Participants in Aboriginal spirituality and healing come from diverse cultural, socio-economic and personal backgrounds. They must first learn the mythic underpinning to which the healing process is attached (Dow, 1986). This places the emphasis on the healer 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-Indian healing are evident in an ethnographic study conducted by Brass of an Aboriginal-run half-way house/treatment centre in Quebec for men in the correctional system (Brass, 1999). Clinical staff integrated a generic construction of Aboriginal identity, largely spiritual in nature, with standard methods of western psychotherapy. In so doing, they created hybrid forms of group and individual therapy, which were meaningful to a large proportion of

Aboriginal clients who differed from one another in cultural, linguistic and personal backgrounds. This syncretic approach provided local idioms of suffering and healing through which residents were able to 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 (Manson et al. 1996). 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 the persistent inequities, but these individual events are part of larger historical formations that have profound effects for both individuals and communities 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 (Kirmayer 1996a, 1996b). Social analysis is necessary to delineate these structural forms of violence and oppression and so to aid efforts to resist and change social structural problems.

Another set of dilemmas is faced by communities created by government fiat that now must respond to government programs aimed at promoting a 'Healthy Community'. In her ethnographic study in Nunavut, Allen has shown how terms like 'community', 'participation' and 'empowerment' are given different meanings by individuals within one community to create personal and collective continuity with the past and effectively position themselves in the emergent self-government (Allen, 1999). 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 many Aboriginal communities is the rapidity with which social and cultural change has occurred. This has introduced 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

careful 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 utilization (Royal Commission on Aboriginal Peoples, 1993). As well, there are distinctive features of Aboriginal communities 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 geographically distant from major cities. This results in fewer material resources for medical and social services, and multiple roles being played 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.

As a result of the size and scale of Aboriginal communities, there is little opportunity for the sort of anonymity that protects the practitioners' 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 'burn out'. As of yet, few Aboriginal people have had the opportunity to pursue professional training in mental health.

Language is a basic conveyor of culture and most people are connected to their emotions and intimate thoughts most readily in their first language or language of everyday life. Few health professionals working in Aboriginal communities have made the effort to learn local languages and little mental health information has been translated. Culture, though, is a much broader issue than language and includes notions of how people work (ethnopsychology), patterns of family and social interaction, and basic values that must be central to any mental health program. A new generation of people able to put together local knowledge about health and healing with the most useful aspects of psychiatry and psychology is emerging. Aboriginal heritage is no guarantee that a professional will be culturally sensitive, however, both because of the diversity of traditions which may differ from one's own and because of the implicit cultural values and assumptions of psychiatry itself. A cultural critique of psychiatry is necessary to open up the space where creative reformulations of theory and practice can take place.

For example, psychotherapy and other mental health interventions assume a particular cultural concept of the person with associated values of individualism and self-efficacy (Bellah et al., 1985; Gaines, 1992; Kirmayer, 1989). These approaches may not fit well either with traditional Aboriginal cultural values or contemporary realities of settlement life. There is a need to re-think the applicability of different modes of intervention from the perspective of local community values and aspirations. Family and social network approaches that emphasize the 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 (Drummond, 1997; Speck & Attneave, 1973; Trimble et al., 1984).

The epistemology of many Aboriginal peoples allows for the validity of mythological knowledge and for forms of empirical understanding that are often discounted in a technological world that defers to scientific authority (Krupat, 1996; Nabakov, 1996). The value of myth and story telling can be easily appreciated in terms of psychological processes of making meaning and coherence from often quixotic 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 spread 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 which never had such traditions) is part of a more global movement of re-generating Aboriginal identity and exploring the significance of an evolving tradition in the contemporary world (Bucko 1998; Washburn 1996). Of course, in some hands, Native spirituality becomes a product, open to commercialization: for example, neo-shamanism has become the subject of weekend workshops for middle class Americans (Atkinson 1992). The relationship 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 his 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.

While essential, government and professional responses to social pathologies that provide more health care or support traditional forms of healing 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 a 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 (Warry, 1998).

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 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 maintain cultural tradition must contend with the political, economic and cultural realities of consumer capitalism, technocratic control and globalisation.

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, 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 (Macauley et al., 1999).

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

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2. SOCIAL ORIGINS OF DISTRESS

“... the deep sleep of forgetfulness”: Reflecting on Disremembering

Ernest Hunter

Abstract: Since the 1980s the human rights of the indigenous populations of Australia and North America have come under intense scrutiny in the light of international charters and agreements which now constitute a significant political lever. These charters emerged in the aftermath of the Second World War through the Nuremberg trials and the formation of the United Nations. Among the perpetrators brought to trial at Nuremberg were medical professionals in the ‘Doctors’ Trial’. This paper will examine doctors as perpetrators, bystanders and victims of state-sanctioned traumatisations drawing on medical roles during the National Socialist era of Germany and the first half of this century in indigenous Australia. The resonances across these very different events and settings will be used to explore ways in which medical professionals continue to contribute to the traumatisations of indigenous peoples in Australia through denial, rationalisation and trivialisation.

Résumé: Depuis les années 1980, les droits humains des populations autochtones de l’Australie et de l’Amérique du Nord ont fait l’objet d’un examen minutieux sans précédent à la lumière des chartes et accords internationaux qui constituent aujourd’hui un levier politique important. Ces chartes sont apparues à la fin de la Deuxième Guerre Mondiale suite aux procès de Nuremberg et à la création des Nations Unies. Parmi les auteurs de crimes cités à procès au tribunal de Nuremberg on comptait des professionnels de la médecine dans les fameux procès dits des «docteurs ». Cet article examinera les docteurs envisagés soit comme auteurs de crimes, spectateurs ou victimes de perturbations traumatisantes cautionnées par l’État, et établira un parallèle entre les rôles médicaux joués à l’époque du parti National Socialiste en Allemagne et pendant la première moitié de ce siècle auprès des autochtones australiens. Les résonances conjuguées qu’éveillent ces événements et cadres très différents seront utilisées afin d’explorer les façons par lesquelles les professionnels de la médecine continuent de contribuer à infliger des traumatismes aux autochtones en Australie par le biais de la dénégation, la rationalisation et la banalisation.

Set your flags at half-mast,
 Memory.
 At half-mast
 Today and for ever.

— “Shibboleth”, Paul Pessach Antschel

Paul Antschel wrote many poems including *Todesfuge* (“Deathfuge”), the most famous poem of the Holocaust and, arguably, in modern German. He was a Jew and a survivor, returning in 1944 to find the vibrant Jewish community of Czernowitz, his childhood home, gone, its province, Bukovina, divided between the USSR and Romania. *Todesfuge* was written in 1944 or 1945. In 1947 he left for Bucharest where, before fleeing to Vienna, by anagram, Paul Antschel became Paul Celan. He eventually traveled to Paris, passing through Germany as he had on Kristallnacht 1938. In 1988, *Todesfuge* was recited in the Bundestag to commemorate the fiftieth anniversary of that night.

Celan is not the only survivor remembered by their birth name’s anagram. The Austrian Jew, Hans Maier fled to Belgium after the *Anschluss*, becoming Jean Améry when the Germans followed. He joined the resistance, was arrested, tortured and sent to Auschwitz. Améry and Celan have more in common: both died by suicide. Celan drowned in the Seine in 1970 and Améry took his life in 1978. Others also ‘survived’ the Holocaust only to succumb to another horror beyond the power of words to exorcise. For instance, Tadeus Borowski, author of *This Way to the Gas Ladies and Gentlemen* died by gas in Warsaw in 1951, and Primo Levi plunged to his death in Turin in 1978.

Similarities and differences: Améry and Celan, both anagrams and both authors who wrote in German, the language of their tormentors. But very different responses to Germans: Celan, feted in Germany. Améry, paraphrasing Celan’s “*Todesfuge*” in 1976 to emphasise resurgent German anti-Semitism as: “playing with the fire that dug a grave in the air for so many” (in Felstiner, 1995: 289). The year before he died he wrote:

The victims are dying out... The hangmen, too... But new generations, molded by origin and environment, are constantly rising in both camps, and between them the old unbridgeable chasm is opening again. Someday time will close it, that is certain. But it must not be done by hollow, thoughtless, utterly false conciliatoriness, which already now is accelerating the time process. On the contrary: since it is a moral chasm, let it for now remain wide open. (1986: xix)

While two of these authors, Jean Améry and Primo Levi, survived Auschwitz, their writings suggest very different attempts to incorporate that trauma. However, despite being in that terrible place at the same time, their experiences were, in fact, very different (Stille in Améry 1986). Levi, from a country that was fascist but not, relatively, anti-Semitic, was able to return to a Jewish community and family. He was not deported by Italians but by

Germans. Améry was captured, tortured and deported by fellow German-speakers, probably including many Austrians. He could not return. But regardless of their differences, both were fascinated by the paradox of the intellectual in Auschwitz—Levi writing on this theme in *Survival at Auschwitz*, and Améry in *At the Mind's Limits*.

Celan called for the surrender of memory. By contrast, Améry and Levi were dismayed that memory may fade, tarnish, or disappear, and were driven to question whether the intellectual was better able to find meaning in the inverted world of the camp, or in memories. As the ultimate fate of all three suggests, for them it did not.

Now brood no more
 On the years behind you
 The hope assigned you
 Shall the past replace,
 When a juster justice
 Grown wise and stronger
 Points the bone no longer
 At a darker race.

— “Song of Hope” Oodgeroo of the tribe *Noonuccal*

Oodgeroo Noonuccal was born in 1920, the same year as Paul Celan but a world away, growing up on Stradbroke Island. As with Celan, Oodgeroo underwent a name change, formerly being Kath Walker. Her writing was also a response to injustice – the experience of being an Aboriginal woman in a patriarchal European settler-colonial society. Unlike Celan, her name change was to reclaim identity, although her medium, like him, was the language of the oppressor. But is it reasonable to consider these experiences together? Well, even Levi and Améry, both of whom were at Auschwitz at the same time, present enormous difficulties to any with the temerity to generalise. To consider the Holocaust and the experiences of Australia’s indigenous populations in the same space seems reckless.

That is how I felt in 1991 after return from Yad Vashem in Jerusalem where I had been studying medical professionals as perpetrators during the Nazi era and where I had begun to consider the relationship between doctors and indigenous Australians. Thus, I completed a paper that was never submitted and instead, it became two, dealing with each issue separately (Hunter 1991; 1993). At the time I felt associating these issues was unfair and unlikely to gain a sympathetic hearing among my medical peers. That proved to be true, sensitivities close to the surface. In this paper I return to the original project,

but consider medical professionals as perpetrators, bystanders and victims of the trauma of the Holocaust and colonisation. I argue that this history is critical to understanding the social and political context of professional work with these traumatised populations, and that to not do so may lead to complicity in rationalising and trivialising the harms done.

I begin by considering genocide in Australia. Over the last decade this term has come into common use in the indigenous context, often with reference to the 1948 *Convention on the Prevention and Punishment of the Crime of Genocide*, in which subclause 2(e) includes: “Forcibly transferring children of the group to another group.”

Figure 1. United Nations Convention on the Prevention and Punishment of the Crime of Genocide (1948)

Article II

In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group, such as:

- a. Killing members of the group
 - b. Causing serious bodily or mental harm to members of the group
 - c. Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part
 - d. Imposing measures intended to prevent births within the group
 - e. Forcibly transferring children of the group to another group
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In *Bringing Them Home*, the Human Rights and Equal Opportunity Commission 1997 report on the removal of indigenous children, the Commissioners state:

The Australian practice of indigenous child removal involved both systematic racial discrimination and genocide as defined by international law. Yet it continued to be practiced as official policy long after being clearly prohibited by treaties to which Australia had voluntarily subscribed (1997: 266).

This position has been most forcefully put by Colin Tatz (1999) who emphasises that Article II does not stipulate degrees or absolute destruction, but “acts committed with *intent* to destroy” a group. As such, Australia may be guilty of four acts of genocide:

First, the essentially private genocide, the physical killing committed by settlers and rogue police officers in the nineteenth century...; second, the twentieth century official state policy and practice of forcibly transferring children from one group to another with the express intention that *they cease to be Aboriginal*; third, the twentieth century attempts to achieve the biological disappearance of those deemed “half-caste” ...; fourth, a *prima*

facie case that Australia's actions to protect Aborigines in fact caused them serious bodily or mental harm. (Tatz, 1999: 6)

Allegations of genocide are now so common (Havemann, 1999) that there is a danger, ironically, of trivialisation and denial. If accusations are to be taken seriously, then where are the trials? Can we talk of genocide in living memory and *not* prosecute? Is it too late? Too late to prosecute Konrad Kalejs for crimes committed in the Second World War? Is it because the accused is above accountability? Well, consider actions filed in The Hague against the United Nations, under whose auspices the Genocide Convention emerged, in relation to Rwanda and Srebrenica. Is it because the accused would insist that they were 'following orders' and had 'good intentions'? Well, remember Nuremberg, which dismissed such evasions in laying the foundations for crimes against humanity.

Prosecutions are unlikely. Regardless, there is much discussion including, in 1999, books by three prominent Australians which consider together the Holocaust and the history of indigenous Australians. Geoffrey Robertson (1999) addresses both within a wider context of the history of 'crimes against humanity' since Nuremberg. Inga Clendinnen, historian of Aztec and Mayan civilizations, was stimulated by the Demidenko/Darville affair to consider her, and our, 'forgetting' in *Reading the Holocaust* (1999a). She tackled a more proximate 'forgetting' – of Indigenous Australians – in the Boyer lectures, published as *True Stories* (1999b). Finally, Raymond Gaita (1999) who rhetorically asks why, if there are allegations of genocide there are no trials, considers both in *A Common Humanity*.

Genocide, ethnocide—crime against humanity? The Genocide Convention, which was signed in Paris in December 1948, the day after adoption of the Universal Declaration of Human Rights, emerged in response to the events of the Second World War. The definition reflected that context with many signatories concerned about trouble in their colonial back yards. Minority rights received no mention in either the Charter of the United Nations or the Universal Declaration and were not seriously considered for several decades. Furthermore, this is a legalistic swampland, as Robertson suggests:

The Australian policy of taking babies and small children from their Aboriginal mothers and fostering them with white families has been alleged to be genocidal, but this would depend on whether force (rather than persuasion) was used and whether the purpose of the policy ('assimilation') was to destroy the group 'as such', as distinct from altering its culture. (Robertson, 1999: 310)

Robertson is not dismissing the attribution or minimising the trauma but pointing, as a lawyer, to the legal complexities. He also emphasises that progress in the wider human rights arena, that is, progress rather than talk about human rights, is more about dedication than declaration. History demonstrates that progress is possible, but is incremental rather than instrumental. That is not to suggest that instruments and conventions should not or are not being used by indigenous peoples; they should and are (Barker,

1997). But it is by using rather than simply making them that their potential is realised. Finally, history teaches that human rights concern everyone and that relevant debate and decisions should not be left to intellectuals, professionals or academics. If these were the only voters in 1967, the Commonwealth Referendum regarding citizenship for Aboriginal Australians may not have been passed, as it was, with a 90% yes vote.

In what follows I will consider these groups with particular attention to medical professionals, in terms of their contribution to the traumatisation of Holocaust victims and Aboriginal Australians. I am not suggesting equivalence but exploring how the lessons of the former may support critical reflection in Australia. I will start by briefly examining medical professionals as perpetrators during the National Socialist era—briefly, because there is now an enormous literature, most emerging in the last decade, including works available in English by Paul Weindling (1989), Michael Burleigh (1994), Burleigh with Wolfgang Wippermann (1991), Gotz Aly, Pewter Chroust and Christian Pross (1994), Michael Kater (1989), Arthur Caplan (1992), George Annas and Michael Grodin (1992), Stefan Kuhl (1994), Henry Friedlander (1995) and, of course, Robert J. Lifton (1986). There are also works by Benno Muller-Hill (1988) on genetics, Robert Proctor (1999) on public health, and Geoffrey Cocks (1985) on psychotherapy.

The available information is far too extensive and well known to review. Suffice it to say that there is a lineage from the racist science of the nineteenth century, of Gobineau through the likes of Richard Wagner's English son-in-law Houston Stewart Chamberlain, to the medical profession within the Nazi biomedical state. Foundations for medical murder were laid well before the Nazis came to power and articulated in 1920 by Professor Karl Binding, a jurist from the University of Leipzig, and Alfred Hoeh, professor of psychiatry at the University of Freiberg in an influential book, *The Permission to Destroy Life Unworthy of Life*. Medical murder masquerading as euthanasia was implemented in Germany in 1939 through the T4 program, which was in direct lineage to the death camps in Poland, as Henry Friedlander notes:

In 1940 German concentration camps were growing in number and size, but they did not yet possess the facilities to kill large numbers of prisoners at one time ... The SS therefore [sought] to determine how to utilise the T4's killing capabilities. Early in 1941 Reich Leader SS Himmler conferred with [T4 program] chief Philip Bouhler concerning "whether and how the personnel and facilities of T4 can be utilised for the concentration camps." Soon thereafter, in the spring of 1941, a new killing operation commenced, aimed at prisoners in the German concentration camps. (p. 142)

Medicalised murder by gas was subsequently transferred, through the 14f13 program, to the more pressing job of extermination in the east, first at Chelmno where carbon monoxide, as in Germany, was used. Perhaps the best known extermination camp Kommandant, Franz Stangl, good catholic, diligent policeman and the subject of Gita Sereny's (1974) masterly *Into that darkness*, was recruited into the T4 euthanasia program in 1940. He

subsequently went to the 'Foundation for Institutional Care' at Hartheim, working and killing under medical direction. In 1942 he was sent east to set up Sobibor and was convicted in Dusseldorf, in December 1970, of co-responsibility in the murder of 900,000 people during his tenure as Kommandant of Treblinka.

Stangl was not a medical professional but his career exemplifies the connection between the murder of unwanted Germans under medical supervision and the Holocaust. Many doctors, such as Josef Mengele (Lagnado & Dekel, 1991) participated in perversely rationalised medical murder in the camps largely motivated by opportunism and self-advancement. Maneuvering for power, prestige, and favour on a personal and institutional level was rife throughout the Third Reich among academics who Alice Gallin (1986) refers to as *Midwives to Nazism*, and particularly among doctors, who were probably the first beneficiaries of the anti-Jewish laws of 1933.

Of those directly involved—Lifton (1986) estimates about 350—only a minority were ever prosecuted, and most careers continued, supported by professional denial and collusion. No senior doctors responded to a call from the German association of physicians to observe the Nuremberg medical trial (Maretzki, 1989). A young doctor and a medical student (Alexander Mitscherlich and Fred Mielke) subsequently produced a report, which was met by silence, unsurprising given their comments on complicity:

Only the secret consent of the practice of science and politics can explain why the names of high ranking scientists are constantly dropped during this trial, of men, who perhaps did not right off commit any crime but took advantage of the cruel fate of defenseless individuals (in Pross, 1992: 40).

I believe that the responsibility of doctors and the profession of medicine during the National Socialist era must be considered on the following levels:

- as providing and refining the ideological and intellectual foundations for race theory and medical killing;
- as influential supporters lending legitimacy to an immoral regime, both by silence and complicity;
- as planners and administrators within the bureaucracy of state-sanctioned killing;
- as designers and refiners of systems for expeditious killing;
- as executioners;
- as beneficiaries of the suffering and deaths of their victims (through payment for processing euthanasia evaluations of psychiatric patients, power within the state medical system, and advancement through 'research');
- and as survivors, who have frequently fared far better in the aftermath of the War and the Holocaust than other supporters of the regime.

The greatest responsibility lies at the level of ideas. The racist science of the Third Reich was not a consequence of political events – it was itself the ideological agenda. While not a Nazi creation or confined to Germany, racist science was central to the party's platform. It provided a biomedical vision of racial purity that galvanised support and gave direction to political events that focused hatred and violence. Race science and Nazi ideology existed in symbiosis, the institutions of one essential to the other. They nurtured each other and devoured their children. Can these events, now extensively documented, be overlooked. Well, as Benno Muller-Hill (1988: 3), Professor of Genetics at the University of Cologne, comments:

When I think today of how genetics was once put to use ... I see a wasteland of desolation and destruction. The blood of human beings, spilt millions of times over, is completely and resolutely forgotten. The recent history of these genetically orientated human sciences in action is as full of chaos and crime as a nightmare. Yet many geneticists, anthropologists, and psychiatrists have slipped from this dream into the deep sleep of forgetfulness.

Forgetfulness or 'disremembering'? In Australia, a "cult of disremembering" is how Bill Stanner (1979) described the "great Australian silence" – by which the surviving indigenous people of this land were 'disappeared' from the consciousness of most Australians until recent decades. Silence certainly about the abysmal state of indigenous health, something of which the medical profession should be ashamed. Indeed Brendon Nelson, then head of the Australian Medical Association, loudly proclaimed at the 1993 Aboriginal Mental Health Conference that he was ashamed to be a doctor for the profession's failings. I was in the audience and admit to feeling angry. The AMA had little investment in indigenous health and of the doctors in the audience, many of whom had worked in Aboriginal health for years, few, if any, would have been AMA members. I felt slighted and resentful – sensitivities close to the surface. But, regardless of motives, at issue was responsibility by omission – medical professionals as bystanders to indigenous trauma and ill-health. This has been commented on variously over the last decades, including by the *Royal Commission into Aboriginal Deaths in Custody* (1991) and in *Bringing Them Home* (HREOC 1997). But is there more to consider than responsibility by omission? I think so and will examine two issues: discriminatory treatment and the conflation of medical and political roles in controlling indigenous lives.

Gross inequities in health care, let alone health status, persist for indigenous Australians (Deeble, Mathers, Smith, Goss, Webb and Smith 1998). Indeed, as late as the 1960s there were segregated hospitals in certain parts of Australia (Hunter 1993). However, the discriminatory practice that I will focus on relates to sexually transmitted diseases (Hunter 1998). In Western Australia at the turn of the century there was widespread concern about leprosy and venereal diseases. The responsibility for these, it was declared, lay with Asians and Aborigines. In 1898 the Health Act was amended to provide police with special powers for the control of infectious diseases and from 1909 Aboriginal

lepers were confined on Bezout Island off Roebourne, beginning a history of discriminatory detention that continued to the closing of the Derby leprosarium in 1985.

Venereal diseases were thought to be widespread and blamed on Aboriginal immorality with legislation from 1905 prohibiting cohabitation of Europeans and Aborigines. In 1907 Perth doctors called for segregation and were supported by the Chief Protector of Aborigines who explained: "The menace to the white population, although probably the seeds of evil have been sown by them in the first instance, is becoming so great that ... some drastic steps should be taken to check the spread of the disease" (in Mulvaney, 1989: 185). In 1908 desolate Dorre and Bernier islands off Carnarvon, were selected as sites for lock hospitals which remained in operation for a decade despite a recommendation of the Australasian Medical Conference in 1911 that venereal diseases should be treated in general hospitals (Lewis, 1988). Indeed, although in 1914 the Commonwealth provided for free testing and treatment for syphilis, the scheme specifically excluded Aborigines, the Federal Director of Quarantine noting that they "are not included in the scheme" (in Lewis, 1998: 376).

Conditions on Dorre and Bernier were described by a visitor, Daisy Bates, who referred to them as the 'isles of the dead':

Now and again a dead body would be wrapped in a blanket and carried away to burial in the sands, and the unhappy living could not leave the accursed ground of its spirit. Some became demented, and rambled away and no one of an alien tribe would go to seek them. One day an old man started to "walk" back over thirty miles of raging waters to the mainland. These shores are infested with sharks, and he was never seen again. Another hid in the thick scrub, and died there, rather than be operated on. A third sat on the crest of a little rise all day long, pouring sand and water over his head, wailing and threatening, in his madness. (in Healy, 1978: 133)

With no training, police were empowered to examine, identify and detain Aborigines suspected to be infected. Dr. Herbert Basedow (1932: 181) recalled that: "A special expedition collected as many natives as possible between the Ashburton River and the Eastern Gold Fields". Visitor and author E.L. Grant Watson gave a more detailed description:

The method of collecting the patients was not either humane or scientific. A man unqualified except by ruthlessness and daring, helped by one or two kindred spirits, toured the countryside, raided the native camps and there, by brute force, 'examined' the natives. Any that were obviously diseased or were suspected of disease were seized upon. These, since their hands were so small as to slip through any pair of handcuffs, were chained together by their necks, and were marched through the bush, in the further search for syphilitics. (1946: 112)

'Patients' or prisoners, they were segregated by sex and set to work. Over a quarter of those who survived abduction and transportation died (see Table 1)

before the last twenty-four inmates were removed in 1919 to the “Depot for Diseased Natives” in Port Hedland (Mulvaney 1989) where their misery continued.

Table 1. Lock Hospitals (W.A.): Mortality 1909 – 1917 (from Jebb, 1984)

	Male	Female	Total
Admissions	209	426	635
Deaths	46 (22%)	116 (27%)	162 (26%)

There are historical links between northern Western Australia and north Queensland. The Queensland 1897 *Aborigines and Restriction of Sale of Opium Act*, the basis for discriminatory legislation that continued until the late 1970s, was taken as the model for the 1905 *Aborigines Act* in Western Australia. Involved with both was Dr. Walter Roth, who became Northern Protector of Aborigines in Queensland in 1898. There were similar concerns about venereal diseases in north Queensland where Asian men and Aboriginal women were held responsible. Roth initiated an isolation compound in Cooktown gaol in 1904, various sites subsequently used to detain ‘syphilitics’ with ‘chronic cases’ sent to Palm Island until nearby Fantome Island lock hospital opened in 1928. As in Western Australia, fear spread as the inmate population increased to 227 in 1933. In 1932 the head of the Australian Institute of Tropical Medicine, Dr. Raphael Cilento, described his vision for Fantome:

The whole abo population should be worked through Fantome & then regraded into new cases, incurable aged, incurable young & part cured & thence drafted when clean back into Palm from which they can be sent out into the mainland to be (1) assimilated if white enough; (2) employed under supervision & protection; or (3) kept on Palm as minor officials or peasant proprietors working personal strips around a collective farm. (in Yarwood, 1991: 63)

Conditions for the inmates were poor and mortality through the early 1930s was similar to Dorre and Bernier (see Table 2). The limited resources that were available were further compromised by corruption, rationalised by blaming the patients for their miserable state. Chief Protector J.W. Bleakley reported that the inmates: “are admitted to Fantome Island through their own fault” (in Kidd, 1997: 113).

During the Second World War concerns abated, detentions fell and ceased in 1945. But that did not end Fantome as a medical prison. In 1940 it began receiving lepers, and continued as a lazarette until the transfer of the last inmates to Palm Island in 1975 (Patrick, 1987). For both leprosy and sexually transmitted diseases policies were discriminatory and not consistent with best

practice (Saunders 1990). Largely due to the influence of the likes of Raphael Cilento in Queensland and Cecil Cook in the Northern Territory, isolationists prevailed.

Table 2. Lock Hospitals (Qld): Mortality 1930-1937 (from Lewis, 1998)

Year	Admissions	Deaths	Percentage
1930	45	12	27
1931	70	8	11
1932	128	28	22
1934	36	16	44
1935	69	30	43
1936	213	19	11
1937	193	28	15
Total	754	141	19

This leads to the second issue – the conflation of medical and political roles. Both of these influential doctors were vocal supporters of the White Australia Policy, held abiding suspicions of Asians and were influenced by then current eugenic theories in their consideration of the ‘Aboriginal problem’ (Yarwood, 1991; Austin, 1990; McGregor, 1997). Indeed, the first Aborigines Act in the Northern Territory fused political and health roles – the Chief Protector of Aborigines was also Chief Medical Officer. The first occupant, Herbert Basedow, soon after appointment called for a system of identifying all Aborigines by scarification, which could: “be done in an absolutely painless way and without disfigurement. The space occupied by the mark need not exceed one or two square inches and would be chosen in quite an inconspicuous position” (in McGregor, 1997: 69). His proposal was rejected by more sensible and humane bureaucrats and his tenure was short.

Cecil Cook, who held these positions from 1927 to 1938, was more influential and an advocate of eugenics, seeking clarification in 1933 as to whether he “could demand the compulsory sterilisation of those half-caste children who were classified as ‘congenital idiots’ or as ‘mentally defective’” (in McGregor, 1997: 161). His support for absorption was enduring. In 1937 he stated at the Conference of Commonwealth and State Aboriginal Authorities:

The policy of the Commonwealth is to do everything possible to convert the half-caste into a white citizen. The question arises whether the same policy should not be adopted in regard to the aborigines ... My view is that unless the black population is speedily absorbed into the white, the process will soon be reversed, and in 50 years, or a little later, the white population of the Northern Territory will be absorbed into the black (in McGregor, 1997: 177)

The political influence of doctors was such that the statement by historian Raymond Evans that “white colonists obtained vital support for their racial attitudes from the most respected thinkers of the nineteenth century, the natural and social scientists” (Evans, Saunders & Cronin, 1993: 16), I believe, may be paraphrased as “white bureaucrats obtained vital support for their racial attitudes from the most respected professionals of the first half of the twentieth century, medical practitioners.”

So far I have discussed doctors as perpetrators in Europe during the Nazi era, and as complicit bystanders in Australia through the same period. Drawing on the typology *perpetrators, victims and bystanders* (Hillberg, 1993), I will now consider doctors as victims, returning to Europe (Hunter, 1997). Raphael Cilento is a connection. In the closing days of the War Cilento was sent to Europe with the United Nations Relief and Rehabilitation Association, eventually becoming UNRRA Director of the British Zone of Germany. He was with the first civilian allied medical team to enter Belsen. Later he was the UN Director of Disaster Relief in Palestine leaving in 1948 after the assassination of his friend Count Folke Bernadotte (Fisher, 1994) which cemented his anti-Semitism.

Among the refugees moving across Europe at that time were Jewish doctors who documented their experiences of survival. These include the Polish pediatrician and resistance fighter Adina Blady Swager (1990), who survived the Warsaw ghetto, another Pole and ghetto doctor, Abraham Wajnryb (1979), for whom there is now an annual lecture in Sydney, and the Polish partisan Michael Temchin (1983). However, there were also Jewish physician survivors of Auschwitz who wrote at war's end, including the Hungarian gynaecologist, Gisella Perl who published *I was a Doctor in Auschwitz* in 1946, the Dutch physician Elie Cohen, whose 1952 Doctoral thesis became *Human Behaviour in the Concentration Camp* (1988), Myklos Nyiszli, a Hungarian forensic pathologist who released *Auschwitz: A doctor's eye-witness account* (1973) in 1946, and Victor Frankl, an Austrian psychiatrist, who published *From Death-camp to Existentialism* in 1946, known in English translation as *Man's Search for Meaning* (1984). Because their experiences were so similar and yet, as I will explain, so different, I will focus on the last three. In a way that recalls the typology of victim, perpetrator and bystander, it is their identity as medical practitioners that is central to these differences.

Elie Cohen sets out to present an ‘objective’, scientific account of his experiences, so much so that, recognising the “danger that lack of objectivity may prevent me from viewing the problems I have set to solve in their true proportions ... in furtherance, therefore, of objectivity – I have given priority to the accounts of others rather than my own” (1988: xxiii). Cohen clearly sees his medical identity as having contributed to his survival, but not without conflicts, such as about accessing extra resources and the roles of other doctors in the killing of prisoners – even the roles of German doctors. After presenting material from the Doctors’ Trial supporting charges of medical murder, he concludes: “For me to pass verdict on the attitude of German physicians during the Hitler rule would be going outside the scope of this study” (1988:

268). In a conflicted sense, Elie Cohen's medical identification is clear, but that of a bystander.

Miklos Nyiszli also identified as a doctor: "When I lived through these horrors, which were beyond all imagining, I was not a writer but a doctor. Today, in telling about them, I write not as a reporter but as a doctor" (1973: 19). Yet very different was his relationship to his medical identity. Nyiszli was laboratory assistant to Dr. Josef Mengele and his story is all the more horrible given his relationship to Mengele, whose "research" (Nyiszli's term) is discussed with a mixture of horror, awe and admiration: "Dr. Mengele was indefatigable in the exercise of his functions. He spent long hours in his laboratories, then hurried to the unloading platform where the daily arrival of four or five trainloads of Hungarian deportees kept him busy all day" (1973: 36). He talks also of the "vast possibilities for research" explaining that: "The abundance – unequalled anywhere in the world – of corpses, and the fact that one could dispose of them freely for purposes of research, opened even wider horizons" (1973: 51). While Mengele saved Nyiszli's life, reflecting on moments of closeness seems unfathomable, such as the following, immediately after Mengele had sent a trainload from Riga to the flames:

During our numerous contacts and talks together, Dr. Mengele had never granted me what I might call a private conversation. But now, seeing him so depressed, I screwed up my courage. "Captain," I said, "when is this destruction going to cease?" He looked at me and replied: ... "My Friend, it goes on and on ..." His words seemed to betray a note of silent resignation" (1973: 127).

Nyiszli's survival involved affirming his professional role and identifying with a medical perpetrator whose inhuman acts seem sealed off from his medical identity. Perhaps this was not entirely without conflict for Nyiszli, as suggested by a comment regarding his future: "I would begin practicing, yes... But I swore that as long as I lived I would never lift a scalpel again" (1973: 158).

Very different is Victor Frankl's account. While Cohen struggled to present facts in as unbiased a fashion as possible, Frankl insists that: "this book does not claim to be an account of facts and events but of personal experiences, experiences which millions of prisoners have suffered time and again" (1984: 21). Whereas Nyiszli clearly stated that he survived and wrote "as a doctor", Frankl states that: "this story is about my experiences as an ordinary prisoner, it is important that I mention, not without pride, that I was not employed as a psychiatrist in camp, or even as a doctor" (1984: 25).

That Frankl emphasises that he did *not* work as a doctor seems to reflect his desire not to be advantaged over others. Frankl was, of course, an exceptional man and in his account his medical identity does not feature. Instead, we read of his identification with fellow prisoners. What allowed Frankl to survive was surely not his profession. As his Viennese contemporary, Bruno Bettelheim, himself a survivor, but as a political prisoner who was released before the war began, commented: "Those who stood up well in the camps became better

men, those who acted badly soon became bad men; and this, or at least so it seemed, independent of their past life history and their former personality make-up" (1970: 25). That Frankl "stood up well" was critical for survival. That he did so by not being a doctor may have enabled his return to Vienna and his profession after the War. The strength that Frankl deployed in surviving and writing was despite rather than because of his medical identity—his identification was with the victim rather than the doctor.

While the paths of these three doctors differed, they all led to Auschwitz and all were victims. Yet they have evoked very different reactions. Bettelheim is scathingly critical of Nyiszli stating: "Those who tried to serve their executioners in what were once their civilian capacities... were merely continuing if not business, then life as usual". He continues that: "The same business-as-usual attitude that enabled Dr. Nyiszli to function as a doctor in the camp, that motivated him to volunteer his help to the SS, enabled millions of Jews to live in ghettos where they not only worked for the Nazis but selected fellow Jews for them to send to the gas chambers" (in Nyiszli, 1973: 9). This is an extraordinary accusation and takes us to what fellow Auschwitz survivor Jean Améry called "the mind's limits" in terms of ethical analysis. The camps made terrible demands of those who fought for survival, as much of doctors as of others. As victims all, there was no ethically privileged starting point. And neither did those who survived leave redeemed by suffering, as Améry (1986: 20) explains: "in Auschwitz we did not become better, more human, more humane, and more mature ethically. You do not observe dehumanized man committing his deeds and misdeeds without having all of your notions of inherent human dignity placed in doubt".

Was some higher morality or altruism expected of doctors because they were doctors? Nazi doctors render that untenable. Was more expected of prisoner doctors? If so, it is unfair and unreasonable. Unfair for presuming greater capacities for personal and family sacrifice; unreasonable in assuming ethical superiority by virtue either of being doctors or being prisoners. As we have seen, neither is justified and we should not be surprised by same range of survival responses among doctors as among other victims. There was probably very little if anything in the training of these doctors that related to issues of ethics and moral decision-making. There was nothing that could have prepared them for Auschwitz. Nazi doctors serve to warn us of the folly of assuming a correlation between academic attainment and professional standing on the one hand, and humane and ethical behaviour on the other. Their actions were a matter of choice and should be judged accordingly. By contrast, the actions of prisoner doctors alerts us to the danger of judging those trapped in dehumanising and coercive systems.

In *The Drowned and the Saved*, Primo Levi asserts that: "To confuse [the perpetrators] with their victims is a moral disease or an aesthetic affectation or a sinister sign of complicity; above all, it is a precious service rendered (intentionally or not) to the negators of truth". In this paper I have considered doctors as perpetrators of, bystanders to, and as victims of various systematic, state-sanctioned and professionally supported traumatisations. As the reactions

to the ways in which the three Auschwitz doctors survived suggests, even with knowledge of the enormity of trauma, it is easy to blame the victim. There are parallels in terms of providing the imprimatur of the medical profession to victimising Aborigines. Thus, a 1991 article in the *Sydney Morning Herald* (Spectrum, 16 February 1991) written by a doctor and based on a psychiatrist's work, titled "Black violence: why whites shouldn't feel guilty" commenced by quoting Dr. Jock McLaren: "Brutality is part of black culture, and it's time whites shed their guilt for Aboriginal violence". McLaren argues that because there was violence in Aboriginal societies before colonisation, and because most contemporary perpetrators and victims are Aboriginal, Europeans bear no responsibility. This neatly elides two centuries during which almost all the violence involved European perpetrators. It gives professional support to a form of denial; it is professional complicity in perpetuating trauma.

Thus two final issues: denial and responsibility. Richard Hovannisian, an Armenian genocide scholar, describes three faces of denial; straight *denial* ("it didn't happen"), *rationalisation* ("war is hell", "collateral damage"), and *trivialisation* ("there are lots of genocides", "what about the baby whales?"). This may be used to consider, for instance, the Stolen Generations. Denial is the 'disremembering' of the Great Australian Silence. *Why weren't we told?* Henry Reynolds (1999) rhetorically asks in the title of his recent book about a personal search and a national forgetting. For very self-serving reasons, he concludes. That would seem no longer possible, but consider Padraic McGuinness' comments on ABC Lateline (August 25, 1998) that memories of abuse reported by the Stolen Generation were examples of "false memory syndrome".

Rationalisation is the expedient: "it would have been worse if they had remained on the reserve". Thus, in Parliamentary debate on the Queensland Children's Services Act 1965 in support of removal it was stated that "No group of children is more neglected than those who are living with their coloured parents in the fringe-dwelling areas of many of our country towns" (in HREOC, 1997: 80). There are many examples. Trivialisation includes pointless comparisons to other 'genocides'. It may also occur inadvertently, even with best intentions. The commissions into Deaths in Custody and the Stolen Generations both resulted in significant reports, there for all to read and, perhaps, to say: "we've dealt with that". Sadly but predictably institutionalisation and racism have led to the internalisation of denial, rationalisation and trivialisation by many indigenous victims, compounding the collective trauma and, in turn, supporting mainstream denial.

Medical professionals have been involved at all levels. In terms of denial, the disruption of families was known to many doctors—who were better placed than most to observe the events and consequences. They supported discriminatory treatment and rationalised racist policy. They may contribute now to trivialisation by medicalising human rights violations. Following release of *Bringing Them Home* serious debate was politically stifled. The government's formal response was a marginal increase in funding for

indigenous social and emotional well-being, specifically grief and loss counselling. Clearly there is grief and a need for healing, but this has effectively consigned a human rights issue to a mental health arena, forcing indigenous people to voice their grievances through its idiom. Unquestioning health professionals support that process. At times it is more cynical. Grief and loss counsellors generally have non-recurrent positions and, often, little or no training. One year will probably make little difference. But it is a worker for a year and looks good on paper. Done that.

This leads me to the last issue. Reflecting on the Holocaust and indigenous Australia, Colin Tatz (1983) wrote fifteen years ago on ‘atonement’, pointing out that it involved acknowledgment, restitution and reparation. A decade ago Paul Keating acknowledged that “it was we who did the dispossessing. We took the traditional lands and smashed the traditional way of life. We brought the diseases. The alcohol. We committed the murders. We took the children from their mothers” (in Tatz, 1999, p.41). Restitution is restoration of that which can be returned and in Australia has involved engaging with Aborigines and Torres Strait Islanders around their just claims to land and resources. To date this has been contested at nearly every point by successive state and Federal governments. Reparation – compensation for that which cannot be given back – will ultimately be the most difficult and important national task. The Human Rights and Equal Opportunity Commission’s inquiry uses a similar framework, reparation involving:

- acknowledgment of the truth and an apology
- guarantees that these human rights won’t be breached again
- returning what has been lost as much as possible (known as restitution)
- rehabilitation
- compensation

Monetary compensation, the Commission contends, is due for breaches of human rights. While they also demanded improvements in the mental health services and for grief and loss to be addressed, in no way can this be understood as reparation, which would be a gross example of trivialisation. No amount of tears on the Parliamentary floor, or crosses on the Parliamentary lawn, changes that fact. Raymond Gaita (1999: 105) makes this point:

We must therefore not be sentimental about reconciliation. We should resist especially the kind of sentimentality expressed in ‘Sorry Day’, which, good hearted though it may be, really hides from us the terrible evil the Aborigines have suffered and our responsibilities to them.

Which is not to diminish the importance of symbols. However, we should not be blinded by them, by representations rather than responses. Each time I have visited Yad Vashem in Jerusalem I have been overwhelmed by the monuments that testify to the events of the Holocaust—particularly the children’s memorial. I was thus surprised to encounter Raul Hilberg’s

comment that: “the Yad Vashem memorials are 70% kitsch The children’s memorial with all those lights – what’s the difference between that and the walkway between Terminal B and Terminal C at United Airlines in Chicago” (in Markle 1995: 132). I would not characterise those memorials, as does Hilberg, as “holokitsch”, but there are some products that I *would* so describe, and somewhere between *Todesfuge* and “holo-kitsch” there is a point where trivialisation and denial begin. That point is about foregoing thought for feeling. It is the point where the emotional response is the end point rather than reflection. It is the difference between feeling sorry for Aborigines versus reflecting on why one should so feel. Gaita (1999: 93) talks about this in terms of “remorse” – that is, “pained acknowledgement” of our past—not just feeling but reflecting. Returning to the issue of medicalised responses, Gaita also comments, I believe insightfully, that responding must be to more than the consequential emotional pain:

Relief of the material and psychological misery of many of the Aborigines will not count as reparation, however, unless the spirit in which that relief is given is informed by a recognition of the wrongs they have suffered...

Acknowledgment of those wrongs as a source of torment distinct from and not reducible to their mental or psychological consequences is, I believe, what Aborigines desire when they ask for a national apology” (1999: 93).

Exploring responsibility, Gaita suggests, may lead to difficult places: “Unless trials become thinkable for us, I believe, we cannot claim fully to understand the moral dimensions of our past” (1999: 128). They are thinkable to some. Gary Foley noted in 1993:

There is an Aboriginal kid sitting on death row in Florida ... The man who signed the adoption papers to take that kid away from his mother that ultimately resulted in him being in a cell on death row in Florida, is still working in the Office of the Minister of Aboriginal Affairs in Victoria – to this day! Now folks, if it’s good enough for this Australian government to drag decrepit old pensioners – decrepit old Nazi pensioners – out of wardrobes in Adelaide and stick them before the court for war crimes – crimes committed fifty years ago half way around the world – then some of the people that have done some of the things to us need to have the same thing done to them. (Aboriginal Medical Service 1994)

Will we have trials? Probably not of individuals as perpetrators, thus weakening any cases. Should there be doctors in the dock? I don’t think so, but we should strive to answer why not. Mental health professionals should consider not only how to address the symptoms of trauma, but reflect on the profession’s past and the political implications of contemporary interventions. The suit brought by Joy Williams, an Aboriginal woman, against the State of New South Wales is instructive. While the human rights violations of family terrorism, of which she was a victim, are cast in mental health terms, because she was demonstrably mentally ill her cause was lost. So, if you were removed it is not a human rights violation, but can cause mental health problems. But, if

you have mental health problems it is not because you were removed, it was probably your genes. She was victimised by the state, the mental health system and the judicial system.

I have considered a number of issues relating to medical identity stemming from reflecting on the Holocaust and the experiences of indigenous Australians. I am not suggesting equivalences but calling attention to resonances, which, I believe, have relevance for those who seek to relieve the pain of trauma. That requires engaging with someone's pained memory and its meaning, in an asymmetrical power relationship that in certain respects may resonate with the experience or context of the original harm. That may be amplified in circumstances where, historically or directly, medical activities have contributed to traumatisation. I have presented examples of doctors as perpetrators and complicit bystanders causing harm to whole groups. I have also described how, even as victims of extreme trauma, doctors' professional identity can influence their experiences, including their acceptance of medical complicity in their own harm. I have also noted, in both contexts, that doctors can contribute to blaming the victims. They may do that because they are unaware, or unwilling to be aware. Perpetrators have their remedy – amnesia. Bystanders may surface only fitfully from the “deep sleep of forgetfulness”. Our patients, victims, must live with their memories, “today and forever”. Unlocking memory in the service of healing demands respect, and both professional and personal reflection.

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Health Implications of Political Violence, Ethnic Conflict and Contemporary Wars in Latin America

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Abstract: The health status of Amerindian nations is clearly a reflection of the powerful interplay of their colonial past, a history of violence and forced acculturation, and the relentless process of global change. In the context of structural adjustment, the emergence and consolidation of a free market economy, far from reducing inequalities, has widened the gap between the rich and poor. In addition, the threatening presence of multiple stressors, including socio-political and structural violence from various sources is rising, creating new health risks and inducing profound changes and transformations in the health status of indigenous populations. It is against this backdrop of poverty and powerlessness, violence and trauma, that the health status and, in particular, the mental health of Amerindians today must be understood.

Résumé: L'état de la situation actuelle de la santé des nations amérindiennes est clairement une conséquence de l'interaction extrêmement puissante exercée par leur passé colonial, une histoire marquée par la violence et l'acculturation imposée, et le processus implacable du changement se produisant à une échelle plus globale. Dans un contexte d'ajustement structurel, l'apparition et la consolidation d'une économie de marché reposant sur la libre entreprise, loin de réduire les inégalités, ont plutôt contribué à creuser le fossé entre riches et pauvres. De plus, la présence menaçante de multiples facteurs aggravants, incluant notamment la violence socio-politique et structurelle originant de diverses sources, lesquels sont en pleine recrudescence, créent ainsi de nouveaux risques pour la santé susceptibles d'induire des changements profonds et des transformations en regard à l'état de santé des populations autochtones visées. C'est sur cette toile de fond faite de pauvreté et d'impuissance, de violence et de traumatismes, qu'il convient aujourd'hui de tenter de saisir et comprendre la problématique de la situation de la santé et, notamment, la santé mentale des amérindiens.

Nationalism and the Escalation of Armed Conflicts

According to a recent analysis, on today's changing political world map there are more than 190 nation-states, the majority of which have been created since the Second World War. On the other hand, the number of "nations,"¹ mostly composed by ethnic groups and indigenous peoples pre-dating the creation of the modern state, has been estimated at more than 6 000,² with an even greater

¹ Once an ethnic group has become aware of being distinctive, it will most often seek a form of political expression and recognition of its uniqueness—such as claiming a territory and subsequently becoming a "nation." If sovereignty over a given territory is effectively gained, a nation-state will evolve, usually accompanied by some form of nationalistic ideology (Isajiw, 2000).

² For instance, there are more than 450 nations in Indonesia, 200 in Brazil, 450 in Nigeria and 130 in the former Soviet Union.

number of spoken languages. All such nations in the world when combined are estimated at around 600 million people (or 10-15 percent of the world's population) who claim rights to over 25-30 percent of the earth's land surface and natural resources (Clay, 1994).

This apparent discrepancy in the population/resources equation has become a lasting source of conflict among ethnic groups, indigenous nations and nation-states, since most often it is nation-states who control access to and exploit these resources for their own benefit and are ready to use force to advance or protect their interests. Stern conflict and political violence arise when access to critical resources is under dispute, especially at times of general economic decay.

Since the Second World War, many wars have been fought under the banner of "national liberation" (or "national unification" like in Vietnam or Korea) aimed at ending what is considered to be illegitimate rule over a more or less well-defined community or nation. Nationality is strongly anchored in the sense of uniqueness and distinctiveness of certain cultural values attached to a sense of place.

Under the growing influence of globalization and an imposition of a "global culture," we are more and more confronted with rising tensions between "nationalism" on the one hand, and "cosmopolitanism" on the other. The intersection of global processes with local or regional differences, bring into focus "the ways in which identity is shaped, constructed, imagined and reconstructed for various political ends" (Marden, 1997). Moreover, the relentless process of globalization, transnational economic trade, global communication patterns, and transnational social movements, has generated mixed responses around the idea of "identity," challenging the very notion of "nationalism" and the existence of the nation-state, projecting an image of a world without borders. At the same time, the fragmentation of blocks of countries, such as the former Soviet Union and Yugoslavia, and the rising number of states claiming secession or sovereignty, seem to reaffirm "nationalism" as a political force and a contemporary reality. While nationalism is perhaps the most common expression of an ethnic group's assertion of its claims for political recognition and legitimacy, it often leads to armed conflict aimed at resolving disagreement and dissent. Genocide and the atrocities of "ethnic cleansing"—most often fuelled by extreme nationalism and tinted with religious or political aims—is another way to put an end to ethnic conflict by imposing total supremacy of one group over another.

The official discourse of nationalism is widespread in form and content and often tends to dehumanise and stigmatise other peoples and ethnic groups as being biologically and culturally inferior, providing a justification for state intervention and forced assimilation or extermination. In Latin America, in the course of 500 years of colonization and the emergence of the new Republics, there are several examples of explicit or implicit official policies which, under the banner of nationalism, have proposed ethnic homogenization, either by promoting selective immigration policies (in order to "dilute" the genetic pool

of Amerindian ancestry) or by ethnic cleansing, in order to “even out” social and cultural differences and forge a “single” national identity.

In the second half of the twentieth century, the number of ethnic conflicts and wars have increased significantly, but their primary causes remain the same: differential access to critical resources and the fundamental quarrels about ideology and/or the nature of collective identity, including nationalism and the processes and problems of state-building.

The Political Economy of Internal Wars

The nature of armed conflict and wars have substantially changed over time and today wars have diverse causes and take on different forms than in the past. Most strategic analysts agree that in the second half of the 20th century, contemporary wars are less of a problem of relations *between* states, than a problem *within* states. According to Holsti (1996), the classical and persistent Clausewitzian conception of war “as the continuation of politics by other means” bears little relevance to the analysis of today’s contemporary wars. Other forms of war and domestic conflict within the states have replaced the classical great-power warfare, which was the predominant form of war in Europe for almost three centuries (1648-1945). The emergence of internal wars, the so-called low-intensity wars³ or “wars of the third kind” (Rice, 1988) –which are at once “a war of resistance and a campaign to politicize the masses whose loyalty and enthusiasm must sustain a post-war regime” (Holsti, 1996)—are the prevailing forms of armed conflict today. In the wars of the third kind, the target is the local population, mostly the poor, including those who have an added symbolic value (local leaders, priests, health workers, and teachers). Psychological warfare is a central feature in these wars: terror and atrocities, mass executions, disappearances, torture and rape are the norm and it can be devastatingly effective (Summerfield & Toser, 1991; Summerfield, 1995).

Ethnic conflict, political violence and wars that presently shape many parts of Africa, Eastern Europe, Asia and Latin America have deep-seated structural causes. The collapse of formal economies and the emergence of economic crisis in the marginal areas of the global economy lead to further impoverishment and food insecurity for vast sectors of the poor countries’ population, combined with growing ethnic tensions and conflict over a shrinking resource base (Duffield, 1995). The slow economic growth and modest achievements of many countries of Africa and Latin America in the 1970s were quickly reversed in the subsequent decades. In turning toward a more open and Western-oriented production regime, national economies attempted to increase production of raw materials and intensify traditional farming and mining activities. Intensification was a failed strategy, as the

³ Low-intensity warfare is a “total war at the grass roots level” (Walhelstein, 1985), where the local population and not the territory is the target for psychological warfare, terrorisation and other traumatic experiences.

external debt soared and export trade declined. More importantly, intensification accelerated environmental decline, asset depletion and the erosion of the subsistence base, resulting in further impoverishment, food insecurity, rural-urban migration and growing ethnic tension over remaining meagre resources, which in turn lead to the emergence of predatory practices, rivalry, ethnic conflict, political violence, and internal wars (Duffield, 1991, 1995).

Both sectarian governments and subversive movements have used common strategies that have led to ethnically structured internal wars or wars of the third kind. Violence and armed conflict have generated massive exodus, depopulating rural areas and “choking” cities by terror and predatory practices while imposing a local war economy (Pedersen, 1999). In countries as far apart as Mozambique, Sudan, Angola, Sierra Leone, Guatemala, Colombia, Peru, Afghanistan, East Timor and the Philippines, sectarian and authoritarian governments and subversive groups have emerged and pursued much the same tactics: disruption of agricultural production (i.e., landmines in Africa and *coca* plantations in Latin America), systematic destruction of service infrastructure (health services and schools, communications, roads and bridges), sabotage of water and electrical supply, poisoning of wells, killing of livestock and burning of harvests, disruption or elimination of local markets, confiscation of property and imposition of tributary peasant plantation systems. The killing and prosecution of local authorities and annihilation of its symbols often accompany the physical destruction of the economic infrastructure. New “taxation” or appropriation systems are imposed to the local populations. Impunity and claims for “immunity” of war-lords place the dominant groups above the law and make the system sanction-proof (Duffield, 1995; Pedersen, 1999).

The Rising Death Toll of Wars and Atrocities

A complete record of war and atrocities around the world is beyond the scope of this paper. However, it may be useful to outline some of the most recent war scenarios in order to reveal the truly catastrophic proportions of human suffering and desolation in different regions of the world.

It has been estimated that, since the Second World War, there have been more than 160 wars and more than 24 million related deaths world-wide, although certain estimates suggest that double this number of people have been killed. Civilian casualties have increased significantly and now make up approximately 90% of all war-related deaths in current times. In recent war scenarios, such as the former Yugoslavia and Somalia, about 9 out of every 10 people injured or killed were civilians. In 1996, *The State of the World's Children* estimates that within the last decade, two million children have died in war, while two to three times as many have been wounded or disabled, one million orphaned and 12 million made homeless (UNICEF, 1996). In all, a significant proportion of the displaced populations and more than 80% of armed conflicts

in the world involved, in one way or another, politically marginal “Fourth World” peoples (Nietschmann, 1987). By and large, indigenous populations have been most affected and subject to genocide in vast numbers.⁴

In other parts of the world, such as Central and South America, there are many recent examples of ethnic conflicts and internal wars resulting in high death tolls, particularly among indigenous peoples: the extra-judicial executions of Miskito Indians in Nicaragua; the massive killing of Mayas in Guatemala and Tzotzils in Chiapas, Mexico; members of the Shuar nation killed in action in the Ecuador-Peru border dispute; the murder of Yanomami Indians along the border between Venezuela and Brazil; indigenous leaders and their advisers (usually lawyers, priests or trade unionists) in Brazil; and the annihilation and disappearance of Quechua peasants in the Peruvian highlands undertaken by Shining Path guerrillas and military repression. In the case of Guatemala, large segments of the population have been displaced because of internal conflict and violence, the majority of them Maya Indians from the north- and south-western regions of the country. It is estimated that, in the last three decades, approximately 75,000 Guatemalan Indians have disappeared or been killed by political violence, and more than 300,000 are refugees abroad, half of whom are in Mexico⁵. In Colombia, the level of political violence, and massive assassinations conducted by subversive forces, the military and its paramilitary associates, has reached unprecedented levels and the number of refugees is well over a million.⁶

The lives of entire nations, ethnic groups and indigenous peoples are increasingly under threat as they attempt to defend their land and possessions from incursions by insurgent groups and the military, mining and timber companies, drug traffickers and drug enforcement operations, corrupted government officials and disruptive development projects (Pedersen, 1999b).

Dislocation: Internal Displacements and Refugees

If we look at figures of dislocation, while 20 million people have taken refuge across national borders (Toole & Waldman, 1993), another 150 million have been forced to flee their homes and become internally displaced. Most internal migrations and forced displacements are a result of war and ethnic conflict, fuelled by religious or ideological differences, disputes over land and property rights and state-guerrilla warfare, including low-intensity wars, all of which create extremely unstable and unfavorable conditions for survival.

⁴ It has been estimated that about 50 million Indigenous peoples were eliminated prior to the First World War (Clay, 1994).

⁵ According to the Guatemalan Supreme Court of Justice, over 200,000 children have lost one or both parents because of indiscriminate violence and widespread repression (Melville & Lykes, 1992). The long-term consequences of this deprivation on such a large cohort of orphans are still unknown.

⁶ Colombia has been the leading Western hemisphere recipient of U.S. arms and military training as violence increased through the 1990s, and that assistance is now increasing, under a “drug war” pretext dismissed by almost all serious observers (Chomsky, 1999).

The breakdown of the social fabric, family loss and disruption of daily life, lack of shelter and food shortage, the dismantling of basic services and destruction of local infrastructure, all contribute to intense suffering and disability. These have contributed to a new disease ecology especially in the low and middle-income countries (Pedersen, 1996) with the re-emergence of infectious diseases (e.g., cholera, tuberculosis, malaria, diphtheria), and new epidemics (e.g., HIV-AIDS, Ebola, Lassa fever), increasing malnutrition and poor health outcomes, and creating towering rates of mental illness and behaviour-related conditions (Desjarlais et al., 1995).

In the Latin American region, another effect of dislocation occurs when large sectors of working-age men and women are forced to flee and relocate to peri-urban areas of intermediate or main urban conglomerates, resulting in booming satellite cities and shantytowns. In these settings, poverty and high unemployment, inadequate shelter, incomplete families, alcohol and drug abuse, domestic and street violence are dominant features, which often turn into multiple sources of distress and adversity, likely to have physical and psychosocial consequences, closing a vicious circle which perpetuates violence and related disease conditions.

Many Questions, Few Answers

In the greater world scenario, the Western powers, lead by the US and the United Kingdom, apply the new label of “State of Concern” to seven countries: North Korea, Cuba, Iraq, Iran, Libya, Sudan and Syria. In the diplomatic language, this new specific category replaces the term “rogue states” which was applied to those states considered out-laws or “pariah states” because they have chosen to sponsor international terrorism and political violence as a means to impose their political and religious aims (Chomsky, 2000). This unilateral declaration, in lieu of protecting national interests, and far from promoting security, creates general unease and increases the sense of insecurity in the world today. Paradoxically, the end of the Cold War (1947-1989) marks a new state of world affairs which is not one of concord and peace, but of rolling and systematic confrontation in search of new enemies. Chomsky (2000) raises a sharp question: this time against who?

There is a growing body of evidence suggesting that the interrelationships between political violence, ethnic conflict and war with population health are more complex than initially thought. A few central questions still remain largely unanswered: Do our conceptions of nationalism as a political force adequately explain the current chaos or is this chaos symptomatic of a new geography of globalization with all its paradoxes? (Marden, 1997). Which role is played by the super-powers in sustaining ethnic conflict and wars? And similarly, what is the role of corrupt and sectarian governments and of subversive movements in contemporary wars? Are the classical understandings we have derived from European and Western armed conflicts and Cold War experiences relevant to the analysis of contemporary wars? Do

the various world regions and cultures have the same security problems as the powerful nation-states of the West?

Moreover, what is the long-term health impact of ethnic conflict, political violence and wars in a given population? What about the role of other psychosocial factors such as resilience, social cohesion, coping skills, density and quality of social support networks? How is political violence linked to poor health outcomes and trauma at the individual and at the community levels? Are post-traumatic stress disorder (PTSD) and trauma-related disorders a universal and unavoidable outcome of political violence? What is the role of other social factors, such as racism and extreme nationalism, alongside poverty and wars, in determining the health and disease equation? What is the social production of collective and individual suffering? I intend to address some of these questions in the following section.

The Health Implications of Political Violence, Ethnic Conflict and Wars

Emerging political struggles, armed conflict and wars have a very different impact on present populations than the “conventional” wars of the past. Contemporary wars often mean continuous violations of cease-fire and neutrality of health services and relief operations. At times, health services and health workers become “useful” or strategic targets of political significance. Medical personnel has been subject to death threats, mass executions, murder or arbitrary detention and torture by the military and repressive forces in the Philippines, Iraq, Croatia and Bosnia, the Occupied Territories, and Indian Kashmir (Physicians for Human Rights, 1993; Summerfield, 1995). In Mozambique, during the conflict between Renamo guerrillas and government forces, half of the primary health care network (over 1000 health centres) was looted and destroyed, and landmines were placed in the vicinity of hospital facilities. In Nicaragua and Peru, health posts in war zones were sacked and subsequently ruined to prevent one or other faction from getting medical supplies or services of any kind. Incursions by guerrillas and military personnel resulted in the exodus of health workers, with subsequent deactivation or destruction of services, surgical facilities, and maternity wards. In El Salvador, mutilated bodies of health workers were exposed with the letters EM (*Escuadrón de la Muerte*) carved in their flesh, as a brutal warning to hostile opponents (Summerfield, 1995).

The implications of contemporary wars to the collective health status and well-being of affected populations, at home or in exile, go beyond the loss of life and destruction of physical infrastructure; they also imply the devastation of the social and cultural fabric. The people’s history, their right to transcend, their life trajectories, identity and value systems, all vital for their survival, are under threat of fading away or disappearing. The instilled terror, social polarisation and forced militarisation of daily life (Martin-Baró, 1989) lead to significant changes in the lifestyle of civilian populations (e.g., powerlessness, erosion of social capital) which are difficult to measure and attribute

significance in terms of life expectancy or resulting morbidity and burden of illness. On the other hand, the collective responses in confronting extreme violence and death represent a range of critical mechanisms for restoration and survival that should not be underestimated.

The literature focusing on long term effects of war and atrocities has attempted to establish direct linkages between the original experience of trauma and persistence of certain symptoms in some individuals, at times for as long as 50 years, interpreted as anxiety, depression, alcohol and drug abuse and chronic PTSD. Summerfield (1996) reminds us to be more cautious in making false attributions and drawing erroneous conclusions while ignoring the presence of confounding variables in the chain of events leading to mental disorders, or simple emotional states accompanied by vivid and painful memories of the past. In phenomenological terms, these emotional states are not necessarily psycho-pathological but rather aspects of normal cognitive functioning and normal response to an adverse context (Summerfield, 1995).

Whether internally or cross-nationally, the majority of refugees are clearly women, children and the elderly. They are often subject to various forms of exploitation, rape and sexual abuse and are exposed to political violence and torture. The conditions found in sheltered zones, in larger cities or across the border in neighboring countries, are not necessarily better than the ones left behind. The lack of sanitation, food and water shortages, loss of family and social support networks, crowding and overall deprivation experienced in refugee camps impose additional health risks, increased mortality and morbidity, and inflict further suffering among survivors. Outbreaks of cholera, diarrhea, tuberculosis, acute respiratory infections and other viral diseases, such as measles, are common occurrence in most refugee camps. Pregnancy, sexually transmitted diseases and AIDS are also on the increase among refugee women and young adolescents who have experienced sexual abuse. According to UNICEF (1996), in Rwanda virtually every adolescent girl that survived the genocide of 1994 was subsequently raped. Rape and commercial sex is also widespread in refugee camps, often resulting in unsafe abortions, and the spread of sexually transmitted diseases, including AIDS. The displaced are usually deprived from the social, material and emotional support systems, which may make them more fragile and vulnerable to environmental adversities and social distress.

Working with refugees is a complex task. The epidemiological instruments and the clinical tools for diagnosis developed in Western medical settings are fairly limited when applied to people from a different culture (and language), who in addition have been exposed to traumatic experiences like the atrocities of war. As most research in refugees' health is carried out in northern European countries, the U.S and Canada, the tools used in the assessment are usually derived from professional categories (such as the DSM, and the International Classification of Diseases) that may have little relevance to the culturally constructed categories and local idioms of distress. The dominant scientific models used in the construction of health questionnaires and checklists generally applied to refugees not only define the problems people

should experience but also "...prescribe the ways of how people should adjust or acculturate after immigration, how they should express their distress, how disorders should be classified, and how distress should be remedied" (Eisenbruch, 1991). There seems to be two opposing approaches to the issue of displaced populations and refugees. One, represented by the universalistic "refugee studies" position (i.e., all refugees experience overwhelming trauma, with an emphasis on the clinical effects), and two, a more relativistic "anthropological" position by which the refugees' experience of displacement, violence and trauma are considered as "normal" reactions. Both extreme positions tend to ignore how other factors, such as gender, class, religion, ideology, and income, influence the refugee experience (Zarowsky, 1995).

Despite the growing number of armed conflicts and wars throughout the world, not enough attention is being paid to the local patterns of distress and the long-term health impact and psychosocial consequences of the various forms of political violence against individuals, communities or specific ethnic groups. The mental health effects of a changing social and economic context (i.e., globalization) and the impact of political violence and wars have not been sufficiently documented. The short or long-term impact assessment on these populations have been scarce, and studies focusing on experiences of socio-political violence, collective suffering, and presence of disease and trauma-related disorders are just beginning to emerge in the scientific literature.

Most often, the literature on the psychological impact of political violence is based on studies of victims of terrorist attacks in countries such as France, Northern Ireland or the U.S. (see, for instance, Difede et al., 1997; Parson, 1995; Weisaeth, 1993; Abenhaim, Dab & Salmi, 1992; Shalev, 1992; Curran et al., 1990; Cairns & Wilson, 1989; Bell et al., 1988) or among fleeing migrants, refugees or torture victims from Southeast Asia or Central America emigrating to North America or Europe (see Mollica et al., 1987; Beiser, 1988; Beiser et al., 1989; Hauff & Vaglum, 1993; Ramsay, Gorst-Unsworth, Van Velsen & Turner, 1993; Gorst-Unsworth & Goldemberg, 1998; Rousseau et al., 1996, 1999).

In the late 1970s and 1980s, studies on the impact of political violence in Latin America were mostly limited to the victims of the *guerra sucia* (dirty war), families of the *desaparecidos* in Argentina, and the people who were tortured and/or murdered by the military dictatorship in Chile. In Central America (Guatemala and El Salvador) efforts to assess the impact from a social and epidemiological perspective have been uneven and short-lived.⁷

One of the most startling observations to be made after reviewing the literature on trauma-related disorders concerns the relative absence of studies of the most affected populations in their original locations or countries of origin. According to a recent literature review on the epidemiology of PTSD, of the 135 studies meeting the inclusion criteria, only eight (6%) were

⁷ See, for instance, the pioneer work on political violence in Central America carried out by Ignacio Martin-Baró (1989) and colleagues. Unfortunately, this valuable work was tragically interrupted with his death by "Death Squads" in November 1989, in El Salvador.

conducted in developing countries. For instance, in the Latin American region, only three studies of PTSD were completed with victims of natural disasters (one in Mexico and two in Colombia) and none among victims of terrorism, political violence, and wars (De Girolamo and McFarlane 1996).

Contextualized studies of trauma are rare, to the point that “trauma” has almost become synonymous with PTSD in both popular and scientific thought. Recent studies suggest that PTSD symptoms do not necessarily represent the continuation of the initial responses to trauma, and epidemiological studies indicate that the incidence of PTSD may be lower and more variable than previously thought (Breslau et al., 1998; O'Brien, 1998). Epidemiologic studies in the general population show that only a fraction⁸ of those exposed to traumatic events develop PTSD, the risk of PTSD varies according to the type of trauma experienced, and that past exposure to trauma predicts future exposure (Breslau, 1998). PTSD prevalence in the U.S. general population has been estimated between 1 and 9 percent, which may be explained by the differences in the sensitivity of instruments used to measure the presence of PTSD, but also may reflect the presence of other “hidden” factors involved (Shalev & Yehuda, 1998).

Furthermore, an ongoing discussion around the issues of trauma may have negative (e.g., psychopathological) effects but also may permit the development of new capacities or strengths and coping styles (Punamaki & Suleiman, 1990; Macksoud et al., 1996; Rousseau et al., 1998). As is discussed below, there is also a polarized set of conclusions as to which are the most appropriate and effective clinical interventions, if any, regarding trauma-related disorders and PTSD.

The challenge of this apparently contradictory set of findings indicates a need for closer examination of the following: First, the effects of political violence and wars not only in terms of the immediate stressful events and economic and political hardships which are their inevitable precursors, “but also to make the link between these and the broad social structures in which they originate” (Gibson, 1989); second, the differences and interactions between different types of traumatic events; third, the non-Western patterns of trauma-related conditions: local idioms of distress and wide range of responses to trauma – including adaptive and strategic responses—at the individual and at the collective level; and finally, the circumstances in which medical or psychological interventions help or hinder long-term recovery from traumatic experiences such as political violence and wars.

⁸ In fact, a meta-analysis of all trauma studies in North America indicates that only 20% of the persons who undergo a traumatic event do eventually develop PTSD (Yehuda & McFarlane, 1995).

War Trauma and PTSD

The health impact of political violence and wars should be examined not only along the lines of sheer number of casualties and trauma-related disorders among survivors, but also on the collective level. Indirect effects such as disintegration of family and social networks, disruption of the local economies, dislocation of food production systems and exodus of the work force have profound implications for the health and well-being of survivors.

Whatever structural, social and cultural factors lie upstream in the sequence of causes and health determinants, at some point – downstream – there are psychological and biological processes at work, linking the paths between the macro-contextual determinants (the political economy) with the micro-worlds of individual experience. What are, then, the bio-psycho-social pathways, if any, between ethnic conflict, political violence, wars and health outcomes? How does this web of causes, linkages and pathways determine the level of suffering, disease and death in a given population? By what mechanisms do social forces ranging from poverty to racism and political violence become embodied as individual experience (Farmer, 1996)?

Most of these questions have no definite answer yet. In fact, scientists have been concerned about these questions since the end of the 19th century, but have only recently begun to cross-examine and understand some of these complex interrelationships. Current trauma research is being undertaken not only by epidemiologists, clinicians, psychologists and neurophysiologists, but also by anthropologists, political scientists and historians. However, the vast majority of published studies focus on one possible main outcome of trauma: post-traumatic stress disorder (PTSD). The diagnostic category of PTSD was constructed in 1980 by the American Psychiatric Association in its third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The core set of disturbances and symptoms associated with PTSD are assumed to be universal human reactions to traumatic catastrophic events, in contrast with ordinary stressful experiences. The diagnostic construct of PTSD is characterised by three main aspects (van der Kolk, 2000): (a) the repeated reliving of memories of the traumatic experience (intense sensory and visual memories and intrusive recollections of the event, accompanied by extreme distress); (b) avoidance of reminders of the trauma, including emotional numbing, detachment and withdrawal, associated with an inability to experience joy and pleasure; and (c) a pattern of increased arousal (hypervigilance, irritability, sleep disturbances and an exaggerated startle response). In chronic forms of PTSD, the pattern of hyperarousal and avoidance may be the dominant clinical features.

In a recent “state-of-the-art” article, van der Kolk (2000) argues that the DSM-IV Field Trial showed that the majority of people seeking treatment for trauma-related problems have histories of multiple traumas. These findings have led to the delineation of a “new” syndrome. As part of this Field Trial, the PTSD task force “delineated a syndrome of psychological problems that have been shown to be frequently associated with histories of prolonged and

severe interpersonal abuse” (van der Kolk, 2000). The syndrome, composed by a complex of symptoms (alteration in regulation of affective impulses, problems in modulating anger, alterations in attention, self-perception and relationships with others, somatization, alterations in systems of meaning) associated with early interpersonal trauma – has been called “Complex PTSD” or “Disorders of Extreme Stress Not Otherwise Specified” (DESNOS). The DSM-IV Field Trial found a high construct validity for DESNOS as a diagnostic category: the earlier the onset of trauma and the longer the duration, the more likely people will “make up the DESNOS diagnosis” (van der Kolk, 2000).

Since the early 1980s, trauma has emerged as a key heuristic concept in much of mental health research, from developmental effects of early trauma to personality disorders to psychosis. However, some authors have begun to seriously challenge psychological or psychiatric models that posit the existence of biological, psychological, and social mechanisms which are based on assumptions of universality of PTSD (Young, 1995, 2000; Summerfield, 1996, 1999). Trauma exposure and PTSD have been associated with worse physical health, but the relative roles of trauma exposure, PTSD, and context are still contested (Gorst-Unsworth & Goldemberg, 1998; Friedman & Schnurr, 1995).

As proposed by Kirmayer (1996), trauma can be seen at once as a socio-political event, a psycho-physiological process, and a physical and emotional experience, usually followed by an explanation and a narrative theme. From this perspective, it can be argued that war trauma can not only be regarded as a political outcome but also be verified at multiple levels of experience: physiological changes (e.g., increased catecholamine and cortisol production), physical injuries and disabilities, anthropometric alterations (e.g., malnutrition and height), diverse psychosocial effects and a wide range of co-morbid entities and disease conditions associated with trauma (e.g., substance abuse, tuberculosis, AIDS). The experience of war trauma is observed in the various degrees of residual symptomatology reported in affected individuals’ narratives of suffering.

More recently, researchers have begun to explore how trauma is both a marker and product of social inequality and exclusion. Studies on narratives of distress have emphasized the taxonomies of stress, pain and suffering, but has not sufficiently contributed to our understanding of interrelations between poverty and trauma as health determinants, or to how culture models illness and healing traditions at the individual level (Waitzkin & Magaña, 1997). How is the social world connected to psycho-social-biological phenomena and the victims’ narratives of pain and suffering? What are the processes by which poverty and trauma connect to the soma (the body-mind) and to the expression of emotions? What are the mediating phenomena in the construction of emotions and somatic symptoms? What magnitude of the complaints reported by patients are due to social exclusion, social and economic inequalities, and severe trauma experiences? What paradigms are available to help patients, families, and communities manage and cope with

trauma-related conditions? What can a historical view tell us about the social construction of trauma, and medical responses to extreme events and its consequences? (Young, 1995, 2000).

On the clinical and biomedical front of trauma research, there is a need to understand better the relation between stress and traumatic stress. These two sets of literature have evolved separately and very rarely intersect. The biology of trauma suggests that there may not necessarily be a continuum of response (or symptoms) between stress and traumatic stress. The neurobiology of PTSD provides evidence that PTSD is biologically different from other traumatic (and non-traumatic) stress responses. A recent review of the neurobiology of PTSD (Vedantham et al., 2000) point at three important research findings: noradrenergic axis changes, neuroendocrine changes involving the hypothalamic-pituitary-adrenocortical (HPA) axis, and neuroanatomic changes involving the hippocampus.

In addition to noradrenergic changes, the exposure to acute stress brings out neuroendocrine changes modulated by the HPA axis: release of corticotropin-releasing hormone stimulates adrenocorticotrophic hormone, which in turn stimulates cortisol (a primary stress hormone) secretion. Cortisol activates a cascade of physiologic stress-related responses. In chronic (non-traumatic) stress HPA axis patterns seem to behave differently (as shown by lower urinary cortisol levels in veteran PTSD inpatients). In animals exposed to stressors of disrupted attachment, researchers have found damaged cells in the hippocampal region of the brain (also measured by hippocampal volume), similar to the damage induced by glucocorticoids directly implanted in the hippocampus. This preliminary evidence of changes in hippocampal volumes (as measured by magnetic resonance imaging in combat veterans and healthy controls) suggests that changes in size and function of the hippocampus may be an important feature of chronic PTSD (Vedantham et al., 2000).

From a clinical perspective, the diagnostic construct of PTSD, which has been primarily based on the experience of war veterans and victims of other types of trauma (rape, criminal assaults, torture, accidents and natural disasters) has advanced our understanding of the disease experience of individuals who have suffered single incident traumas (e.g., motor vehicle accident). However, these persons most often display a variety of complaints and psychological problems (e.g., somatization, depression, amnesia and dissociation) only some of which fall under the strict definition of PTSD. The PTSD model has important limitations in capturing the complex ways in which individuals, communities and larger groups experience massive trauma, socialize their grief and reconstitute a meaningful existence. It has been suggested that in non-Western populations, the sequelae of trauma are experienced as a cluster of signs and symptoms transcending the narrow boundaries of PTSD, manifested in local idioms of distress and diverse somatoform disorders (Young, 1993, 1995; Summerfield, 1995; Kirmayer, 1996).

From an epidemiological perspective, the magnitude and distribution of trauma-related disorders as a collective experience in local populations

exposed to political violence and contemporary wars is far from being understood. There are few and random findings, undeveloped frames for analysis and an overall lack of hypotheses on basic issues about how people experience and are affected by political violence, ethnic conflict, and wars. The preliminary results of a recent field study in the Peruvian highlands, which included a cross-sectional survey conducted among the general population of an area highly exposed to traumatic events – over a decade of extreme violence, terrorism and atrocities – show about 13 percent of the adult (14 years old and over) population interviewed as symptomatic for PTSD. Clearly, widows or single mothers and the elderly are the most affected, not only by the long-term effects of exposure to traumatic events, but also indirectly by the extreme poverty conditions, the disruption of social networks, lack of reciprocity and relative isolation from their peers, lack of food and overall deterioration of the local economy (Pedersen et al., 2000).

At the same time, we should emphasise that migrants and refugees exhibit various forms of resilience and survival strategies to cope with trauma and overcome adversity (Rousseau et al. 1998, 1999). Cultures of terror and resistance come in many forms, and research initiatives should help to “unlock the meaning” of violence and conflict, and explain both the negative (i.e., illness) and positive (i.e., resilience) health outcomes of trauma. As has been shown, cultural differences, social structures, and coping behaviours may significantly influence the incidence, course, severity and psychosocial outcomes of trauma, which is why there is an urgent need for studies in this area among different cultural groups, particularly in low-income countries of Asia, Africa and Latin America (De Girolamo & McFarlane, 1996).

Poverty, Social Suffering and the Humanitarian Responses to War Trauma

When trying to explain disease occurrence, distress and social suffering in relation with contemporary wars and atrocities, the issues of poverty and social inequalities cannot be ignored. In referring to the issue of infections and inequalities, Paul Farmer (1999) argues that scholars often make “immodest claims of causality” with regards to the distribution and course of diseases “which are biological in their expression but are largely socially determined.” Immodest because they are often wrong and misleading and divert attention from the preventable social origins of disease. He further argues that critical perspectives of disease occurrence should question “...how large scale social forces come to have their effect on unequally positioned individuals in increasingly interconnected populations” (Farmer, 1999).

In the last decade, political violence as a public health concern has been increasingly raised as an important issue (see Zwi & Ugalde, 1991). Public health has since its inception stressed the social and ecological determinants of health. Each new version of public health provides a specific model for linking the context (ecological, economic, political, social and cultural) in which communities, families and persons live, with the differential distribution of

health outcomes, both at the individual and collective levels. However, most community based studies (particularly epidemiological surveys) still produce probabilistic relationships between variables, such as exposure to violence and health outcomes, while generally bracketing many elements that are part of the macroscopic context and marginalizing the subjective experience and distress of individuals.

Critical social scientists believe that not being explicit about the social sources of inequality contributes to an inadequate reading of the context in which suffering and disease are produced. The neglect of the social origins of suffering often results in immodest claims of causality, medicalisation of social problems and ultimately leads to the maintenance of social inequalities. As a counter-position to the emphasis placed on “neutrality” and “objectivity” in the sciences, some health and social scientists insist on social injustice as the key factor in the production of distress, disease and suffering. While functionalist models still view society as being held together by common values and institutions, critical social sciences see social organisations in human groups as the historical results of socio-economic relations and as stemming from the power exerted by certain groups over others (Bibeau, 1999).

Critical theories consider that all social arrangements have political and economic bases and that health scientists have to analyse situations of suffering and pain resulting from such factors as class, gender, and race. In this approach, understanding conflictual situations serves as the main entry door for deconstructing the different processes at work in societies exposed to political violence, ethnic conflict and wars. More recently, such research has focussed less on formal class struggle and other divisions, and has emphasised instead the implications of Foucault’s insight that power in society relies not only on control, repression and submission of others, but also expresses itself—perhaps primarily—in its ability to define what is acceptable, appropriate and normal (Zarowsky & Pedersen, 1998).

Current crises, from Kosovo to Rwanda, highlight the prominent place of political violence, ethnic conflict and war in contemporary societies. The almost routine provision of “trauma counseling” in such circumstances reflects an impoverished understanding of the relationships among critically important determinants and the range of possible health outcomes (Summerfield, 1998). Indeed, the experience of trauma, war, and loss can play a critical role in mobilizing social cohesion and demonstrating resistance as well as resilience.

There is now a wide repertoire of therapies to deal with trauma-related disorders. They range from a) trauma counselling, psycho-dynamic and cathartic approaches, psychodrama, cognitive-behavioural techniques (e.g., exposure therapy, imaginal flooding, systematic desensitisation) (Scurfield, 1985), to b) techniques derived from Eastern traditions aimed to achieve transcendence and relieve distress (Kapur, 1997), to c) the use of psycho-pharmacological agents such as tricyclic anti-depressants, monoamine oxidase

inhibitors, serotonin reuptake inhibitors and mood stabilizers. While it is possible that PTSD (noncombat-related) patients may be responsive to medication, the complete remission of symptoms is an unattainable treatment goal (Marshall et al., 1998). Despite claims to the contrary, there seems to be insufficient evidence supporting the universal effectiveness of these therapies (psychosocial and pharmacological), including no treatment at all (Mollica, 1988). There seems to be no firm evidence that trauma counselling and debriefing effectively works and that clinical interventions delivered by humanitarian agencies provides something more valuable than what can be obtained from the personal social support networks (Raphael et al., 1995). No independent evaluation has been conducted of the outputs and outcomes of trauma programs in war zones, which are well intended but often driven by Western assumptions based in the bio-psycho-medical model (Summerfield, 1998).

Finally, most ongoing efforts and interventions carried out by official and private agencies for reducing harm and trauma-related disorders, improving living conditions and local economies in post-war situations, while promoting the re-settlement of displaced populations, have been limited to the “natural disaster model” of relief and humanitarian assistance. Most interventions have not been assessed in terms of health outcomes and overall impact on the life and well-being of local communities.

How, then, might clinical and epidemiological research and clinical practice arising out of psychiatric models speak to the social, political, cultural and economic dimensions of human experience? How might prevailing models of war trauma be influenced by the knowledge in the social sciences, especially with respect to different cultural and social systems? How might we link research exploring the ways in which individual experience over the life course becomes biologically embedded with the more social and political perspectives emphasized in this essay, and vice versa? What are the implications at various levels, from neuroendocrine structures to Third World refugees to economic or human rights or health policy, of the different approaches to trauma?

The above approaches have been criticised by other social scientists, particularly by some anthropologists, for paying insufficient attention to the lived experience of distress or suffering. In order to recapture this experiential dimension while avoiding the highly individualised perspectives of psychology and psychiatry (which were seen as contributing to maintaining structural inequalities by their silence on political, cultural and social issues and on power in general), the notion of *social suffering* was developed. The notion of social suffering evokes an assemblage of human problems that have their origins and consequences in the devastating injuries that the existing macroscopic social order of the world inflicts, in variable degrees according to local situations, on the experience of individuals and entire communities. Kleinman, Das and Lock (1997) have defined this notion as follows:

“Social suffering results from what political, economic, and institutional power does to people, and, reciprocally, from how these forms of power themselves influence responses to social problems. Included under the category of social suffering are conditions that are usually divided among separate fields: health, welfare, and legal, moral and religious issues. (...) For example, the trauma, pain, and disorders to which atrocity gives rise are health conditions, yet they are also political and cultural matters. Similarly, to say that poverty is the major risk factor for ill health and death is only another way of saying that health is a social indicator and indeed a social process.”

The notion of social suffering carries the idea that it is essential to address the following: both individual and social levels of analysis; experience of persons and politico-economic context; local problems and their relation to global issues; community grounded solutions and professional responses; health problems and social problems (Farmer, 1996). This perspective holds that the significance of the inter-linkages between these various domains is generally underestimated. It stresses the need for a clearer understanding of the ways in which macro-social dimensions interact with the micro-social (the community, the family and the person) in attempting to explain both the construction of suffering and its opposite, the production of health.

Finally, critical social sciences insist that knowledge production is never neutral, that there is no such thing as a “mere fact”, and that scholars and researchers themselves are inevitably linked to a particular social group and are working within a given social and cultural context. While critical theory and the social suffering perspective serve as an important and productive counterpoint to the neutrality of orthodox “normal” science and public health, these views must themselves be subjected to the same scrutiny that they bring to bear on medicine and science, including the criticism that they themselves silence dissent – in this case through claiming a morally rather than scientifically unassailable position. Why do scientists privilege certain explanatory models of war trauma, while ignoring others? Why do we base our humanitarian interventions in Third World countries in a set of Western unproven assumptions? (Summerfield, 1999; Zarowsky & Pedersen, 1998).

Summerfield (1998) stated that:

The effects of war cannot be separated off from those of other forces: throughout the Western world, structural poverty and injustice, falling commodity prices, unbridled environmental exploitation and landlessness are all linked to a withering away of traditional self-sufficient ways of life (...) imposed structural adjustment packages reflecting Western neoliberal economic orthodoxy mean slashed budgets for health, education and social welfare (but not arms) on which the poorest depend. This may undermine the social fabric no less effectively than the wars there have done.

Social epidemiology and critical theory converge in arguing that structural inequalities are the most important determinants of population health. Interpretative anthropology and cultural psychiatry converge in insisting on

the importance of lived experience. Knowledge production may never be neutral, but it is possible to aim at understanding and acting on the determinants of health, disease, and social suffering, while maintaining awareness of the particular stakes and interests of a given perspective and the particular social arrangements through which it is expressed.

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**The Legacy of the 'Stolen Generations':
Chronic Depression, Cultural Alienation, Incarceration
and Disruption of Individuals, Families and Communities**

Jane H. McKendrick

Abstract: The forced removal of Australian Aboriginal children from their families and communities is a particularly devastating and destructive aspect of the assimilationist policies employed throughout Australia from the time of British colonisation. The children were taken to non-Aboriginal institutions, foster homes and adoptive homes. Documentation shows that in many cases the only reason for committing a child to state care was 'for being Aboriginal'. Aboriginal child rearing practices, including having multiple extended family members, grandmothers, aunts and cousins caring for children at different times, were rejected. The release of *Bringing Them Home*, the Report of the National Inquiry into the Removal of Aboriginal and Torres Strait Islander Children from their Families, documented the experiences of the children. These included having their identity and family background hidden from them, being kept in institutions or sent from one foster home to another, and ongoing abuse (emotional, physical and sexual). Many Australians had been unaware of this part of their history. However, Aboriginal people and those who work with them in Aboriginal medical services, childcare services, and the justice system have long known of the devastating impact of 'taking the children away' on the children, the families and the communities. This paper describes research conducted through a partnership between an Aboriginal medical service and the Department of Psychiatry, University of Melbourne, and looks at the association between having been 'taken away' and mental health and well-being later in life. A three year follow-up study of the mental health of a random sample of Aboriginal adults attending a general practitioner at an Aboriginal medical service found that one third of the sample had been separated from their families as children under the assimilation policies. Those who had been separated differed markedly from other respondents on a range of study variables.

Résumé: Le retrait forcé d'enfants autochtones australiens de leurs familles et de leurs communautés constitue certes un aspect particulièrement dévastateur et destructeur des politiques d'assimilation pratiquées partout à travers l'Australie du temps de la colonisation britannique. Les enfants ont été emmenés dans des institutions non-autochtones, des foyers d'accueils et des familles d'adoption. La documentation démontre abondamment que dans de très nombreux cas, la seule raison alléguée pour confier un enfant à la charge de l'État était tout simplement « d'avoir été autochtone ». Les particularités ressortissant à l'éducation des enfants autochtones, incluant en outre le fait pour la famille étendue de comporter de multiples membres, tels grands-mères, tantes et cousins qui tous tour à tour s'occupent des enfants à différents moments, furent d'emblée écartées. La parution de *Ramenez-les à la Maison*, le rapport de l'enquête nationale sur le retrait des

autochtones et des enfants insulaires du détroit de Torres de leurs familles, ont amplement documenté les expériences respectives des enfants. Ces expériences incluent, entre autres choses, le fait qu'on leur ait dissimulé leur identité et leur origine familiale, qu'on les ait gardé en institution ou placé d'une famille d'accueil à une autre, et elles comportent aussi les abus actuels (d'ordre émotif, physique et sexuel). Beaucoup d'australien ont été maintenus dans l'ignorance au sujet de cette tranche de leur histoire. Cependant, les autochtones et ceux qui œuvrent auprès d'eux, que ce soit au sein des services médicaux destinés aux autochtones, des services d'aide à l'enfance, ou du système de justice savent très bien depuis fort longtemps quel a été l'impact dévastateur d'avoir « retiré un enfant de son milieu » sur les enfants, les familles et les communautés. Cet article décrit la recherche menée en partenariat par un service médical autochtone et le département de psychiatrie de l'Université de Melbourne, et se penche sur le rapport existant pour un individu entre le fait d'avoir été « retiré de son milieu » et sa santé mentale et son bien-être général manifestés plus tard dans le courant de sa vie. Une étude d'une durée de trois ans portant sur la santé mentale d'adultes autochtones choisis à partir d'un échantillon aléatoire, lesquels adultes autochtones étaient suivis par un praticien général d'un service médical autochtone ont permis de mettre en évidence qu'un tiers des individus de cet échantillon avaient été séparé de leurs familles alors qu'ils étaient encore enfants lorsque les politiques d'assimilation étaient en vigueur. Ceux qui ont été ainsi séparés différaient de façon significative des autres répondants en regard à une gamme de variables retenues dans le cadre de cette étude.

Background

The term 'Stolen Generations' refers to the Australian Aboriginal children taken away from their families and communities, usually by government or church agencies, and sent to children's homes, non-Aboriginal foster and adoptive homes and other institutions. Aboriginal children have been taken away from their parents and families, and sent to live with non-Aboriginal people since the earliest days of European colonisation. The tragic life story of one of the first victims of Victoria's assimilation policy set the scene for what followed.

Thomas Bungeleen (an anglicised version of his father's name, *Bunjil-ee-nee*) was "a lonely lad who spent his life among alien people" (Barwick and Barwick, 1984: 9). He was kidnapped from his tribe in 1847 by Police officers and taken to Melbourne with his father (a *ngurungaeta* of the Waiung clan, of the Brabralung group of the Kurnai of Gippsland), mother, brother and other family members. Thomas was two years old at the time and his brother, Harry, aged six months. His father died at the Narre Narre Warren Native police barracks. Thomas' mother died 3 years later, and in 1851, he and his brother were placed with a Melbourne schoolteacher and taught European habits. They were publicly baptised. Harry died in 1856, and Thomas, now aged 11, was said to have become increasingly uncontrollable. He was made a

messenger for the lands department, and visited Simon Wonga (*ngurrungaeta* (clan head) of the Wundjeri-balak clan of the Woiworung of the Kulin) on several occasions. However, Thomas was said to be "getting into bad company" after hours (Barwick & Barwick, 1984: 10), and in 1861 was bonded to service on a steamship. Thomas was bitterly unhappy and asked to be sent to live with Simon Wonga and his people. His request was refused and he continued to serve on the steamship until 1864, when he was sent to train as a draftsman. Thomas Bungeleen died in January 1865 of 'gastric fever', aged 18 years. He was buried with his brother in the Melbourne cemetery. Simon Wonga made a wood carving in memory of Thomas Bungeleen. The story told in the carving was summarised later by surviving Yarra people as:

...the men represented in the upper part ...are friends who have been appointed to investigate the death of Bungeleen; the figures of the birds and animals...indicate that he did not die for lack of food; and the strange.....forms below the hollow band are those of Moorroops, or spirits who have caused the death of the Koori by their wicked enchantments (Barwick & Barwick, 1984: 9). [It is thought the Moorroops referred to here are the *lohan* (white men).]

The taking of the children is a devastating and destructive aspect of the assimilation policies relentlessly pursued throughout Australia since colonisation. The United Nation's Genocide Convention, 1948 to which Australia was a signatory, states:

In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, such as ... (e) Forcibly transferring children of the group to another group".

Public documents detailing the removal of Aboriginal children from their families clearly demonstrate the removals were both forcible and intended to cause Aboriginal people to cease to exist as separate groups:

the pure-blood Aborigines were rapidly decreasing in numbers. Many people....accepted the idea that this group was becoming extinct and should be 'left alone to pass in peaceful ease'. ... the half caste were increasing in numbers... they were expected to merge into the white community. One obvious way of providing a solution to the 'Aboriginal problem' was to move the 'half castes' off the stations (and forbid them to associate with 'full bloods'). In a short period of time, the pure blood Aborigines would become extinct (Read, n.d.: 38)

It is the story of the attempt to 'breed out the Aboriginal race. It is the story of attempted genocide. Genocide does not simply mean the extermination of people by violence, but may include any means at all. At the height of the policy of separating Aboriginal people from their parents the Aborigines Welfare Board meant to do just that. The 1921 Report of the Board stated that 'the continuation of this policy of dissociating the children from camp life must eventually solve the Aboriginal problem'... when children were placed in a 'first class private home', the superior

standard of life would 'pave the way for the absorption of these people into the general population' (Rowley, 1973: 2).

Bringing Them Home, the Report of the Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their families (HREOC 1997) states:

By 1940 assimilation had become official policy in all Australian mainland States and territories (HREOC, 1997: 266)

The Australian practice of child removal involved both systematic racial discrimination and genocide as defined by international law. Yet it continued to be practised as official policy long after being clearly prohibited by treaties to which Australia had voluntarily subscribed (HREOC, 1997: 266).

The removal of Aboriginal children from their families was at its height during the 1950s, 1960s and 1970s. Under the law Aboriginal children could be taken from their families with no court order being necessary. Aboriginal people were not counted as citizens of Australia until 1967. Thus the parents of children who were taken away had no right to take court action. Generations of Aboriginal people have lived in fear of 'the welfare'. Stories abound of mothers sending their children to hide in the bush whenever a strange car was sighted. A few escaped but many were taken, never to see their parents or siblings again. Archie Roach was taken away from the Framlingham mission station in Western Victoria at the age of five years during the 1950's. He was reunited with his siblings as a teenager, but by then both his parents had died.

*This story's right, this story's true,
I would not tell lies to you,
Like the promises they did not keep and how they fenced us in like sheep.
Said to us 'come take our hand', sent us off to mission land
Taught us to write, to read, to pray
Then they took the children away,
Took the children away, the children away;
Snatched from their mothers breast, said it was for the best
Took them away.*

— "Took the Children Away," Archie Roach

It is horrifying to hear of the conditions faced by those taken away in many of the institutions and foster homes. The *Inquiry into the Separation of Aboriginal Children from their Families* had to break for several weeks to allow staff who had been taking depositions from members of the Stolen Generations to receive counselling. Hearing the stories was particularly devastating for the Aboriginal commissioners. Aboriginal friends, colleagues and patients who were 'taken' as children have told me about their terrible experiences in institutions or foster homes. They tell of emotional, physical and sexual abuse

which continued for years. Very few formed meaningful relationships with adults. Many were moved from home to home and then put out onto the streets when they reached 15 years of age and expected to fend for themselves:

When Robert was taken from his family by the police at the age of eight he did not speak any English. He was kept in institutions for the next nine years, and was released onto the streets with no where to go at the age of 16 or 17 years. When he was released from the homes he had no idea of what money was, or how to catch a bus He had no family or friends to turn to. For years after he just moved from town to town drinking and looking for his family. He spent a lot of time in lockups and jail (Case History No. 5; RUIHER archives)

May was taken from school by the police along with her three brothers and two sisters. She and her siblings saw each other for the last time at the police station. Thereafter May was sent to five different foster homes over a period of ten years. She was rescued from one (where she was locked in a shed with the dogs at night, remembers being hungry all the time and beaten if she cried) when a school friends mother noticed she was bruised all over her arms and legs (Case History No. 62; RUIHER archives)¹

Official records about the numbers of Aboriginal children removed from their families in Victoria are difficult to obtain. However, the records of the Victorian Department of Community Welfare Services for 1979 (well after the removal of Aboriginal children in New South Wales had stopped) indicated that:

- 21 percent of the Victorian Aboriginal population under the age of 20 were state wards.
- the rate of admission of Aboriginal children to state care was 26 times greater than that of non-Aboriginal children.
- 35 percent of state wards from East Gippsland were Aboriginal children
- in some areas of Victoria such as Lake Tyers Mission, every family had a child taken into state care during 1979 (Jackson, 1979).

These figures do not include the so called 'Informal Placements' which occurred outside the auspices of the department of social welfare – for example people who took Aboriginal children for holidays and failed to return them to their families.

Bringing Them Home found that up to one in three Aboriginal children were removed from their families from the 1940's to the 1970's (HREOC, 1997). The historian Peter Read (n.d.) has estimated that one in six or seven Aboriginal

¹ These case histories have been changed to prevent identification of those involved.

children have been taken from their families during this century; the figure for the general population being about 1/300. Almost half the Aboriginal people living in Adelaide in 1966 aged between 10 and 19 years had spent part of their lives in isolation from their kinfolk (Gale, 1969). In 1979, 30% of children in Brisbane childcare institutions were Aboriginal, and in the Northern Territory, 25% of Aboriginal children were under state care (Jackson, 1979).

There is considerable evidence that placements of Aboriginal children in non-Aboriginal adoptive or foster homes usually broke down. The Victorian Aboriginal Child Care Agency (ACCA) estimated 90 percent of placements of Koori children in foster or adoptive homes broke down, the child being returned to an institution. A survey by the South Australian ACCA for the period 1980-85 of the adoption of Aboriginal children by non-Aboriginal families (Gale, 1969) found that:

- 95 percent of ACCA adoption cases ended in breakdown
- 65 percent of breakdowns occurred when the children were teenagers. Adoptive parents were unable to cope with child's behaviour (drug and alcohol problems, contact with police, depression, self destructive behaviour, emotional stress, identity crisis).
- 35 percent of 'breakdowns' separated from their adoptive parents as adults, disillusioned and trying to cope with being Aboriginal.
- five percent of cases were not breakdowns. The adoptive parents sought to find the child's natural parents and family 'before it was too late'.

These figures are of great concern as the Aboriginal children, adolescents and young adults of today have grown up under this system, and are now endeavouring to bring up their own children. Many struggle just to survive, so severe is the emotional and physical damage they have sustained.

Aboriginal people who have been brought up outside their Aboriginal communities miss out on all the advantages of growing up in an Aboriginal family. In Aboriginal societies, the extended family/kinship system nurtures a strong sense of belonging to a particular family group and a community. The family is the most important unit in Aboriginal society; it is essential to health, where health is not only physical well-being, but also psychological, spiritual and cultural. Families retain a strong attachment to their 'country' (the area in which their ancestors held land prior to European settlement, the focus usually being the mission or station where their forbears lived). Aboriginal identity comes from the family and, by extension, association with a tribal group (community) and traditional land or 'country'. The support of family and community promotes self-esteem and pride in culture. Aboriginal children are used to having a wide range of caregivers apart from parents, including grandmothers, aunts, uncles, cousins and older siblings. Children may live with different family members for extended periods. Children who

do not have the benefit of close contact with their relatives are felt to be at a disadvantage.

Fifty percent of the deaths investigated by the *Royal Commission into Aboriginal Deaths in Custody* were of people who had been taken from their Aboriginal families as children (Royal Commission into Aboriginal Deaths in Custody 1991). Royal Commissioner Wooton in his *Report of the Inquiry into the Death Of Malcolm Charles Smith*, a New South Wales Aboriginal man, who had been taken from his family at the age of 11 years and sent to Kinchella boys' home, writes:

According to his sister Mary Anne, one of the things Malcolm did when in Dareton was to go round meeting family he had never seen before. 'He said I got a lot of catching up to do, you know, finding out who was my cousins, who was my uncles, and who was my aunties and you know relations here there and everywhere whatever (Wooton, 1990: 33).

Evidence from an anthropologist to the Inquiry into Malcolm Smith's death notes:

Kin relations are recognised as important in 'traditionally oriented Aboriginal' society: It is less well recognised that extended networks of kin continue to form the central organising structure in south eastern Aboriginal societies today. Severance of ongoing contact was a major loss in the children's social development. While the great strength of Aboriginal society remains the ability to locate the kin-place even of those people who were taken away decades before, the adults who missed their adolescent relationships because they were 'apprenticed' or otherwise removed sustain an intense sense of loss (Wooton, 1990: 33-34)

Despite changes in policy and the establishment of the Aboriginal Child Care Agencies (ACCA) throughout Australia during the 1970's (Jackson, 1979; Gale, 1969) to assist Aboriginal families, Aboriginal children are still growing up in non-Aboriginal environments. ACCA is under-resourced and the conditions associated with family breakdown, including poverty and social deprivation, are widespread in Victorian Aboriginal communities. Few Aboriginal families are in a position to foster or adopt. Those who do adopt or foster children from their extended family usually receive little material assistance. Aboriginal people as a group are over-represented in the criminal justice system. Rates of incarceration are up to twenty times that of the general population, with high rates of deaths in custody. Young Aboriginal people are similarly over-represented in the juvenile justice system (Gale et al., 1990). Mandatory sentencing introduced over recent years in some states and territories effectively discriminates against Aboriginal children and adolescent. In the year 2000 Aboriginal children are being separated from their families by the judicial system. Most of the children and young people are detained for minor offences. A 15 year old Aboriginal boy sent to a youth detention centre thousands of kilometer from his home for stealing a packet of coloured pens committed suicide earlier this year. Australia's mandatory sentencing laws have been condemned by the United Nations. It is remarkable

and a sad indictment that, until the publication of *Bringing Them Home*, many non-Aboriginal Australians had been unaware of this part of their history. Aboriginal people and their friends and those who work with them in Aboriginal medical services, childcare services, and legal services have long known of the devastating impact of 'taking the children away' on the children, the families and the communities. There is currently a Senate Inquiry into the findings of *Bringing Them Home*. The Federal Minister for Aboriginal Affairs (non-Aboriginal) has submitted, against the weight of evidence, that there is not and never has been any Stolen Generation in Australia (Commonwealth Department of Aboriginal Affairs, 2000).

A Psychosocial Study of an Urban Aboriginal General Practice Population

Ever since I began working with the Victorian Aboriginal Health Service in Melbourne, over twenty years ago, many of my patients and colleagues have told me about having been 'taken away' from their families as children and sent to institutions or to live with non-Aboriginal families. In 1990 we evaluated the Victorian Aboriginal Mental Health Network and found that over fifty percent of our in-patients and 45 percent of outpatients had been separated from their Aboriginal families in childhood and brought in to non-Aboriginal settings (McKendrick et al., 1990; McKendrick & Thorpe, 1994).

The research project described here was conducted through a partnership between the Victorian Aboriginal Health Service and the Department of Psychiatry, University of Melbourne. One part of the project looks at the association between having been 'taken away' and mental health and well-being later in life. The project objectives were to compare demographic, social and cultural characteristics and rates of chronic depression between Aboriginal adults from a random general practice sample who were members of the 'Stolen Generations' and those who were not. A survey of a random sample of Aboriginal adults attending a general practitioner at an urban Aboriginal medical service was conducted. Respondents were assessed over three years. Social history and mental health status was assessed using the 70 item Present State Examination and interviewed by a psychiatrist with experience in working with Aboriginal people.

This was a two-stage study. In Stage 1 a random sample of 116 Aboriginal adults attending a general practitioner at an urban Aboriginal Medical Service (AMS), were assessed at interview with respect to: (i) psychiatric status; (ii) social factors; (iii) cultural factors; and (iv) substance use.

Stage 2 interviews were conducted three years later using the same instruments. At Stage 1, 32 percent of the eligible patient population was interviewed, a response rate of 85 percent. At Stage 2, 81 percent of all eligible respondents were located and all agreed to be re-interviewed. Ninety percent of the original respondents had changed address between stages one and two.

A questionnaire was used to collect information about childhood experiences; demographics; current life circumstances; cultural factors; and substance use.

Psychiatric Assessment was conducted by a psychiatrist experienced in working with Aboriginal people. The Present State Examination-70 was used and a clinical assessment made (McKendrick 1993; McKendrick et al., in press). The presence of psychological distress, either continuous or intermittent, in the period since the initial study was assessed by inquiring about certain key psychiatric symptoms and contact with psychiatric or other health services for psychiatric treatment. To assess a past history of clinically significant psychological distress, respondents were asked about previous episodes of psychiatric disorder and previous history of treatment. The questionnaires were tested in a pilot study to assess that they were acceptable, they could be understood and that they were culturally appropriate. Dependent variables were analysed using the Chi square statistic comparing those who had an upbringing away from their Aboriginal families with those who did not. For each analysis the Yates correction was applied.

Sixty five percent of respondents were brought up by their Aboriginal extended family, 45 percent by one or both parents, and 20 percent by extended family members, usually grandparents or aunts. Thirty-five percent were brought up by non-Aboriginal people, six percent in non-Aboriginal adoptive or foster homes and 29 percent in institutions. All respondents brought up away from their Aboriginal families cited intervention by 'the Welfare' - which can mean police, hospital staff, social workers - as the reason for their upbringing away from their families. The separations usually occurred in early childhood (2 to 5 years of age), with almost one quarter stating they had been taken from their mothers as babies. Of those separated, 86 percent were brought up in institutions, multiple foster homes and family group homes. They were wards of the state and most had no contact with their Aboriginal family during this period. All respondents who had been taken from their families regained contact with their Aboriginal families between the ages of 15 and 25 years. All were in regular contact with Aboriginal people at the time of the study. None had maintained contact with their non-Aboriginal childhood carers. Respondents brought up by parents and those brought up by their extended Aboriginal families did not differ with respect to the variables examined during the study. Respondents raised in their Aboriginal families were compared with those brought up outside Aboriginal communities. Major findings include the following:

- Sixty two percent of respondents raised in Aboriginal environments were employed, while 38 percent were on a welfare benefit. In contrast, only 31 percent of those raised by non-Aboriginal people were employed, with 69 percent on a welfare benefit.
- Those raised in non-Aboriginal environments were significantly more geographically mobile.

- Respondents brought up outside their Aboriginal families were significantly less likely to experience a high affinity with their Aboriginal extended family and culture. They were less likely to know their traditional country, they had realised their Aboriginal identity later in childhood, and they spent little time with other Aboriginal people while growing up. It is interesting that there was no significant difference between those separated and those not separated and the nature of their memories of their lives with their Aboriginal families.
- Respondents brought up by non-Aboriginal people reported feelings of loneliness significantly more often than others, were less likely to have visits from extended family, and more often reported having no-one to rely on in times of crisis. They were significantly less likely than others to make positive statements about their relationships with extended family.
- Respondents brought up outside their Aboriginal families were significantly more likely to be users of psychoactive substances including alcohol and marijuana. All eleven respondents who stated that they used heroin had been separated from their Aboriginal families. Rates of feeling that life was not worth living and suicide attempts were significantly higher amongst those separated from their Aboriginal families. Over half of the respondents who had been separated stated they had attempted suicide compared with less than 30 percent of those brought up within their Aboriginal families. The application of standard psychiatric diagnostic screening revealed that nearly all of the respondents raised outside their Aboriginal families achieved criteria for chronic depression compared with 60 percent of others. The latter figure is also a considerably high rate of chronic depression than that found amongst non-Aboriginal general practice samples.

Discussion

Our study reveals a picture of remarkable disadvantage, social dislocation, and psychiatric morbidity in Aboriginal patients who were removed by the 'welfare' from their families as children. The findings are in line with evidence from a variety of sources reflecting upon the health and social conditions of Aboriginal people in modern day Australia. These include public statements given by prominent Aborigines (Rowley, 1973; Dodson, 1995; Dodson, 1990), clinical research findings, health service evaluation research (McKendrick, 1993; McKendrick et al., 1990; McKendrick & Thorpe 1994; Radford et al., n.d.) and influential public inquiries (HREOC 1997; NAHSWP, 1989; NAHS, 1994; Swan & Raphael, 1995).

There is an urgent need to examine the public health issues affecting Aboriginal communities who are battling to find solutions to the high rates of mental problems such as depression, post-traumatic stress disorders, suicide and substance misuse. Further, the special conditions and psychosocial status

of those who were removed from their families as children must be taken into consideration. Our findings suggest this group is a severely damaged and disadvantaged sector of the Aboriginal community.

What is the solution? Aboriginal people have the right to programs, which promote well-being and strengthen identity and self-esteem and to be able to access to equitable health and mental health care through mainstream and Indigenous-specific programs. However, the provision of programs will only help the situation if Aboriginal people achieve social justice and have their human rights as Indigenous peoples recognised. The principles of reconciliation, including acknowledgment of past wrong, restitution and reparation are essential aspects of the healing process, which must involve both Aboriginal and non-Aboriginal Australians.

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3. INDIVIDUAL & COLLECTIVE RESPONSES TO SUFFERING

An Overview of Suicide in Indigenous Australia

Ernest Hunter

Abstract: Suicide has increased dramatically in the Australian Aboriginal population since the 1970s. As this process has unfolded, understandings have changed and have progressed from considerations of the individual at risk to the community at risk. In this paper, work conducted since the 1980s in two regions of northern Australia—the Kimberley and Far North Queensland—are described to exemplify this transition.

Résumé: Le suicide a augmenté de façon dramatique au sein de la population autochtone australienne depuis les années 1970. Au fur et à mesure que ce phénomène a pris de l'ampleur, sa compréhension s'est peu à peu transformée et déplacée des considérations relatives aux individus à risque qu'elle était, à celles relatives à la communauté à risque. Dans cet article, le travail entrepris depuis les années 1980 dans deux régions précises du nord de l'Australie - soit le plateau du Kimberley et l'extrême Nord de l'État du Queensland - sera décrit dans le but d'illustrer cette transition.

*What is tormenting the youth of Palm?
A question that's been asked from Butler Bay to Farm.
Is it society or is it alcohol and dope, maybe no job?
That's when they think there's no hope.*

*Could it be so much pressure building up inside...
The young mind thinking perhaps there's nowhere to hide.
Maybe a drink will solve the pain, and a smoke to calm the brain.*

*One thing leads to another, arguing with family,
Your father and mother. Run and hide and let out the tears,
The pain is there but not the fears.*

*Is it some force that's taking them away,
Or pressure of society from living day to day?
No one knows what's in another's mind,
When a psychiatrist will try to seek and find.*

*Nothing works and nothing ever will,
Its over...its gone over the hill.
It's slowly tearing the mind apart,
From head to toe then finally the heart.*

Talking to someone but they just won't listen.
 Life is full of hits and misses.
 Finally it's back to the drink and smoke
 Where it all ends at the end of a rope.

— Winston Seaton, *Palm Island*

Introduction

This poem was written by Winston Seaton, a resident of Palm Island off the northern Coast of Queensland, Australia. In 1998, Palm was briefly a focus of attention following a story in Britain's *Sunday Times Magazine* (February 1, 1998), the cover of which showed the island in the background framed through a noose hanging from a tree with the accompanying headline, "Devil's Island." This lead article made sensational claims of violence and an 'epidemic' of suicide for which there existed no basis in statistics. Regardless, copies of this article have since circulated through communities of north Queensland reinforcing stereotypes and misunderstandings.

One decade earlier, North Queensland had also been a focus of national attention when a series of Aboriginal hangings in police custody sparked a frenzy of national media activity. Soon afterwards the *Royal Commission into Aboriginal Deaths in Custody* was empowered to investigate 99 Indigenous deaths, of which one third had been by suicide, between 1980 and 1988. Contrary to the image conveyed by the media, the interim report released at the end of 1988 revealed that Indigenous deaths in custody were not disproportionately high when compared to others in custody, but that Aboriginal and Torres Strait Islander rates of arrest and imprisonment were massively in excess of rates for non-Indigenous Australians (*Royal Commission into Aboriginal Deaths in Custody, 1988*). The focus of the Royal Commission subsequently shifted to examining the 'underlying causes' of this over-representation, issues of more importance but, apparently, less 'newsworthiness'. Media attention fell – and so did suicides in custody, both Indigenous and non-Indigenous. Both had increased as a result of increased coverage of deaths by suicide during the lead up and first year of the Commission. Rates returned to essentially the same levels as the years before the Royal Commission. The final, voluminous report of the Royal Commission ranged widely over Indigenous issues, and while many of the more than three hundred recommendations related to the criminal justice system, the majority addressed the wider context of Indigenous social disadvantage (*Royal Commission into Aboriginal Deaths in Custody, 1991*).

Much of the material gathered by the Royal Commission in Australia resonates loudly with that presented in the report on suicide compiled by the Canadian *Royal Commission on Aboriginal Peoples* (1995). Many of the same issues are raised or intimated in the poem by Winston Seaton – alcohol and drugs, family instability, hopelessness, failed services, and anxiety and fears of

things speakable and unspeakable. There are thus, parallels in the understandings of suicide resulting from research and commissions of inquiry, and that of members of the communities suffering the losses. However, there are also differences. On tours through Queensland and New South Wales to discuss youth suicide at community meetings, I have frequently encountered groups who are emphatic that *the* 'cause' of the suicides of their young people is clear, it is alcohol – or marijuana, or domestic violence, or child sex abuse, or unemployment and nothing to do, or ...

Perhaps the most that can be said of this is that these are issues for these communities and that, at some level, they probably all contribute to the condition of risk (Hawe et al. 1997). Sadly, for most Indigenous communities in Australia, there is more than a sufficiency of causes – Indigenous suicide is, in a very real sense, over-determined. However, while there is a lay understanding that suicide rates in Aboriginal and Torres Strait Islander populations are high, in part reflecting media reporting, reliable data for suicide mortality is poor. This reflects a range of factors including all the usual attribution issues that are associated with studies of self-harm, but compounded in Australia by problems of identification. Thus, in Queensland, it was only in 1996 that *aboriginality* was included on birth and death statistics, rates prior to that time being inferred from a variety of proxy measures. Finally, as understandings and responses are being developed, the picture of Indigenous suicide is changing. While that is the case also for the wider Australian society, those changes are amplified for Aboriginal and Torres Strait Islander Australians.

Background

In what remains of this paper, I will present an emerging, personal understanding as it developed for me, a non-Indigenous academic clinician/researcher, over the last fifteen years. Before proceeding it is important to locate this period historically as it follows several decades of dramatic social change across Indigenous Australia, the pace and nature of which was informed by various factors including location, current government policy and events on the local, national and international stages. However, across Australia, the 1970s stand as a watershed between two quite different eras in terms of Aboriginal and Torres Strait Islander affairs. The changes were from a 'regulated' world of containment and discrimination, to a world which offered, but by and large did not deliver, the apparent lustrous opportunities for full participation in Australian society.

Perhaps the most identifiable point in time by which to mark this transition is 1967, the year of the Commonwealth Referendum which, while commonly referred to in terms of granting citizenship rights, was responsible for two changes: including Indigenous Australians in the national census, and providing for the Commonwealth (rather than solely States) to legislate in Aboriginal affairs. However, while the Referendum was important, it is really

the decade of the 1970s that was the watershed; an interregnum – a period of turmoil and change between two distinctly different worlds.

The 1960s began with assimilation as national policy. Aboriginal Affairs was, however, almost exclusively the preserve of States in which the pace of political reform was even slower. It was a decade of significant Indigenous political activism: from the ‘freedom ride’ and protest of the east coast, to the landmark developments in the Northern Territory such the 1962 Yirrkala bark petition, the 1967 Gurintji walk-off at Wave Hill, and the 1968 Woodward Land Rights Commission which led, in the 1970s, to the Aboriginal Land Rights (Northern Territory) Act. The 1967 Referendum is located within this wider context of change rather than defining it. What it did initiate that transformed the landscape of Aboriginal affairs subsequently was to make the Commonwealth a key player by providing for it to legislate in an area which had previously been controlled by States. The Referendum had been passed during a Liberal-Country Party coalition government, but with the subsequent election of the Whitlam Labor government, enormous changes were set in train with substantial increases in funding, expansion of social security and the rapid withdrawal of State governments from positions of control over Indigenous missions and settlements which were, overnight, transformed into ‘communities’. There was little preparation or planning in this process of ‘deregulation’ (Hunter, 1999), with predictable uncertainty, confusion and tension. The politics of protest gained momentum with the Tent Embassy of 1972, and coalesced around Land Rights as a national Indigenous concern. While this appeared to be a world of new-found freedom from previous draconian controls, at times the transformation was illusory, as suggested by the following two quotations:

In this time of Aboriginal ‘self-determination’, advisers no longer issue orders to be obeyed by the Aboriginal clientele. Power has to be wielded more subtly and surreptitiously, by careful engineering and exploiting existing social trends, rifts, power-struggles and dynamics within a community, so as to bring about the desired results, rather than by blunt superimposition of will. (Kolig, 1987: 103)

These were heady days; and the distribution of government funds by an enthusiastic Australian government, motivated by a sincere wish to give a financial impetus to the much-publicised policy of ‘self-determination’, was often thrust upon groups which were unable to cope administratively with the sudden transition from poverty to comparative riches ... The losers in the long run were the Aboriginal communities themselves – not the swollen ranks of consultants and helpers that mushroomed in the night. (Long, 1979: 363)

The 1970s were thus a period of real change and of illusory change. Various forces resisted this process. For instance, the ‘Kiap factor’: large numbers of patrol officers and administrators returned from the newly independent Papua New Guinea to positions in Departments of Aboriginal Affairs and to gatekeeper roles in Aboriginal communities, often bringing with them a colonial mindset. This era was tumultuous not only on a national political

level, but at the community level where the unplanned withdrawal of controls was often compounded by the sudden unrestricted access to alcohol.

This turmoil was often foregrounded by non-Indigenous people rationalising the wisdom of previous paternalistic and discriminatory policies. However there was also another current through the decade as the foundations were being methodically laid for the more stable change processes of the following decades. Thus the beginnings and expansion of community-controlled organisations in the early 1970s (e.g., the Aboriginal Legal Service and the Aboriginal Medical Service, both of which originated in Sydney and went on to become national forces), the concerted and increasingly organised Land Rights movement, and, perhaps most importantly, the beginnings of a significant and sustained increase in Indigenous students progressing to tertiary education and professional development. If the interregnum of the 1970s can be characterised as a decade of ‘protest’, the 1980s were the decade of ‘professionalism’. Fundamentally, the 1970s represent a paradigm shift in Indigenous affairs from a colonial mindset before and during the 1960s in which Indigenous people were the objects of policy, to a world in the 1980s in which they had begun to participate in making policy. At a community level, however, improvements were significantly slower; Indigenous people were largely contained by that range of non-statutory forces that Brody (1966) referred to as “cultural exclusion”.

Before the Commission

As noted at the beginning of the previous section, in what remains I will describe changing understandings over the period from the mid-1980s to the end of the 1990s. Given what has already been stated in terms of problems with data, it should be no surprise that Indigenous suicide-specific mortality data was, until very recently, lacking. However, the consensus of anecdotal reports is clearly that suicide in tradition-oriented Indigenous populations and across Indigenous Australia until the 1980s was, at least, uncommon.

I became involved in this area in the mid-1980s when I was alerted to a series of Indigenous suicides that had occurred in Broome, a town on the coast of the Kimberley region in northern Western Australia which was, at the time, being transformed from a sleepy pearling centre to a bustling tourist destination. I set out to explore this issue across the Kimberley region as a whole, which contained some 18,000 Indigenous residents across a range of social settings. Most of what follows is published in various journals but is summarised in *Aboriginal Health and History: Power and Prejudice in Remote Australia* (Hunter, 1993). I began by examining all death records over a period of 30 years from 1957 to 1986, a period of major transformation for the region as a whole. Some fourteen suicides were located, almost all in the mid-1980s. However, what emerged from this exercise was a much more significant increase in deaths from other external causes (homicide, accidents and motor vehicle accidents, as well as suicide) that began at the beginning of the 1970s. The proportionate

mortality rate for such deaths (excluding deaths less than one year of age which fell significantly during this period) was steady at about 4% and 2% of Indigenous male and female deaths throughout the first fifteen years, but then increased progressively to reach almost 25% and 15% of deaths by the mid-1980s.

The midpoint of the 30-year period during which this increase occurred was also the year in which the sale of alcohol to Indigenous residents of the Kimberley was made legal. However, it was also a time of other dramatic social changes, with new 'freedoms' occurring in conjunction with dislocation from traditional lands for economic reasons, entry into the cash economy and unemployment, and so on. It was clear that suicide must be located within the wider frame of such deaths. It also emerged that the only of these external causes in which the proportion of female deaths was greater was homicide, suggesting the importance of impulsive, alcohol-associated male behaviour.

Several features emerged in looking at the fourteen suicides found by this method (and a further three in 1987, the year before the Royal Commission). All save two were female, almost all were of individuals from Broome and were of mixed descent, and most were in their thirties or forties. The latter is almost certainly a social proxy, demonstrating the salience of urban residence and social change. Only two of these fourteen had died in custody. Interviews and reviews of records further revealed that all had either a history of a recent interpersonal conflict, or a history of recurrent alcohol-associated psychotic symptoms, either recurrent delirium tremens or a picture consistent with alcoholic hallucinosis. A comparison with two male age matched control groups, one of individuals admitted to hospital around the time of the index case suicide, and the other of individuals who died around that time from other causes, confirmed both of the above. Furthermore, while those who died by suicide were not more likely to be drinkers than either of the control groups, they were more likely to have had a family history of heavy alcohol use. Coincidentally, this was also found in a study of non-traditional self-mutilation which also emerged at the same time as suicide in this population.

Subsequently these issues were followed up in a survey of a stratified random sample of 538 individuals across the Kimberley. Heavy drinking was found to be associated with a range of physical, psychological and social problems. Of salience to suicide, while ideation regarding self-mutilation and self-harm were both moderately related to alcohol consumption status, acting on those impulses was powerfully associated. Furthermore, in exploring the relationship among drinkers of frequency of consumption and quantity consumed per drinking occasion, it was the latter that emerged as the most important variable. These features were also found in relation to severe psychological reactions (panic, hallucinations, paranoid ideation) and rates of arrest and imprisonment. These findings suggested that alcohol was functioning not so much in a causal role, but in an enabling fashion, and that it was binge drinking that presented the most obvious risk.

After the Royal Commission

As noted earlier the *Royal Commission into Aboriginal Deaths in Custody* placed Indigenous suicide on the front page of newspapers across the country and, consequently, in the consciousness of Indigenous people. Whereas there had been only seventeen suicides identified in the Kimberley up to 1987, there were eight, all male, in the following two years. Furthermore, while only two of the initial seventeen were aged 20 or less, six of the eight in the following two years were of that age. The random sample study mentioned earlier allowed for comparison of these six young Aborigines with 23 similarly aged individuals selected at random and interviewed. Expressed suicidal thoughts and attempts were more common among those who had died. In addition and consistent with the earlier family history findings, whereas the proportions of drinkers was not greater, reports of parental heavy drinking were.

The findings of the Kimberley are consistent with findings elsewhere in that the suicide has become more common, and in the aftermath of the Royal Commission is becoming more common in remote settings (Parker 1999) and becoming more concentrated in younger age-groups. Combining the different sources of material from the above work in the Kimberley provides a more comprehensive picture. This data reveals that during a period of very rapid social change at the beginning of the 1970s at which time alcohol became freely available to Aboriginal residents of the Kimberley, there was a sudden and sustained increase in deaths from misadventure associated with alcohol use. Those impacted at that time were generally in their third and fourth decade. From the middle to the end of the next decade, the 1980s, there was, in addition to the above, a sudden increase in deaths by suicide which in due course were generally of men in the late teen years. This occurred at the same time that self-mutilation began to be recognised as an increasing problem, both occurring in the same age-group and both associated with family histories of heavy alcohol use.

The connection between these two developments is, of course, that the generation amongst whom suicide emerged in the late 1980s are the children of the generation that suffered the losses from alcohol-associated misadventure during the 1970s. The latter was the first group in the Kimberley to experience the impact of widespread alcohol use supervening on social change and continuing disadvantage. The suicide vulnerable generation is the first to have grown up in environments and families so affected. Thus, while the increase in deaths from external causes reflect the direct impact of alcohol and disinhibition in environments of social adversity, self-harm reflects the transmitted developmental consequences of the same.

The Contemporary Scene

In the next section I consider developments in the 1990s, shifting from the Kimberley in Western Australia, to far North Queensland on the other side of

the continent. To locate this with recent data, most recent estimates indicate a total Aboriginal and Torres Strait Islander population for Australia of 386,049, 2.1% of the national total. The State of Queensland is home to 104,817 people of Indigenous descent, being 27% of the national total and constituting 3% of the State's population (Australian Bureau of Statistics, 1998). The Queensland suicide rate for the period 1990 to 1995 is 14.5 per 100,000, with the Aboriginal and Torres Strait Islander rate being 23.6. The elevated rate is entirely accounted for by the increased Indigenous male suicides which are concentrated in the 15 to 24 (112.5 per 100,000) and 25 to 34 (72.5 per 100,000) year age periods. These are 3.6 and 2.2 times the rates of these male age-groups for the State as a whole (Baume et al. 1998), these age-groups comprising 84% of all Indigenous suicides. Because of the problems with identification of aboriginality in death records, these figures are almost certainly an underestimate.

The suicide rate for Australia as a whole has been remarkably constant over the last century being 20.6 and 5.5 per 100,000 respectively for males and females in 1897, and 21 and 5.5 per 100,000 in 1995. What has changed, and dramatically so, is the rate for young males (Figure 1) which has increased from around 10, to 25 per 100,000 since the 1960s. As Figure 2 demonstrates, the increase for males in Australia is largely accounted for by increasing rates of suicide by hanging, this being the most common method of suicide among Indigenous Australians (approximately two thirds of all completed suicides). The age specific suicide rates for Indigenous and non-Indigenous Australians for all States except Queensland (for reasons outlined earlier) is shown in Figure 3 for the period 1990 to 1992, demonstrating the concentration of loss among Indigenous Australians in the early adult years.

This is the first half of a longer period explored in some detail for Queensland by myself and colleagues in north Queensland (Hunter et al., 1999). Using data from the Australian Institute for Suicide Research and Prevention and fieldwork in a number of north Queensland communities, all coroner's reports in which the suicide was identified as being of an Indigenous person from 1990 to 1996 were reviewed. The number of deaths by year is demonstrated in Figure 4, revealing an increase of nearly four fold over this period. Of these deaths 88% were male and the mean age at death was 26 years, with 78% of male deaths resulting from hanging. The proportion of females among those who died was consistently small over the seven years, the increase being entirely attributable to increased deaths among males by hanging (Figure 5).

Closer inspection of the data revealed that north Queensland is responsible for a disproportionate number of these deaths (66%) and, furthermore, that three discrete communities were over-represented. Indeed, between 1990 and 1997, one third of all suicides of Indigenous Queenslanders occurred in these three communities that, together, constitute only about 5% of the State's Indigenous population (the disproportion would be further emphasised if one removed Torres Strait Islanders, whose suicide rates are lower, from the analysis).

Insert figures 1 – 6 here (2 per page).

However, the situation is yet more complicated as the contribution of these communities to total deaths is not even but occurred in waves that were separate in time (Figure 6). These findings indicate that 'risk' varies with both time and location, suggesting that rather than considering risk on an individual level (as has been the focus of national and Indigenous initiatives in Australia until recently), it will be more useful to consider risk at the level of the community. Furthermore, risk may be better considered in terms of lifestyle than in terms of vulnerability to suicide per se. Thus, information from one of these three communities was gathered in the late 1980s in the aftermath of the Royal Commission, involving identification of individuals identified as being at risk of suicide because of attempts and threats. An additional sample from the community was also interviewed. Ten years later, follow up revealed that mortality was, indeed, higher among the group considered at risk, but that death had occurred from a range of, generally alcohol-related, conditions. This suggests that in addition to considering risk at the community rather than individual level, it is appropriate also to consider it in terms of risk of harm broadly rather than of suicide specifically. In this sense it is lifestyles of risk that is salient.

These concepts are related. To state the obvious, a community may be at risk when a significant proportion of its young adult members is living lifestyles of risk. In turn this may reflect a range of factors, including the precedent of a suicide, external pressures, and internal tensions. This may be considered the "condition of risk" (Hawe et al., 1997). However there is also a further connection that recalls the synthesis of the data from the Kimberley. In communities in which there is a significant proportion of young adults living lifestyles of risk, that group is constituted of people who are parents of young children. In this sense, the situation is contributing to a continuing condition of risk through the impact on child development. Thus, returning to the clustering of Indigenous suicide among young adults demonstrated in figure 3 (which would be accentuated if data from Queensland and for the last four years were included, and if males only were demonstrated) there are two possible interpretations. First, the group among whom suicide is occurring (young adult males) are at risk because of characteristics of that group (high alcohol consumption, recklessness, etc.) and external factors impacting them as a group (unemployment, social change, cultural conflict). On the other hand this group may be at risk because of all that has preceded; that is, as a result of the developmental experiences of this group.

We believe that both interpretations are correct and that, critically, interventions must take account of the developmental issues. This has not been the case until very recently in Australia. Furthermore, the work undertaken in north Queensland also included the documentation of the experiences of one of the communities in responding to the emergence of suicide over the last decade. This community had sought answers from a variety of sources: initiating psychiatric services from the State Health Department, having experts provide suicide prevention courses, other experts conducting workshops on colonialism and its consequences, even having experts from Canada come to the community and sending community

members to get the answers in Canada. Through all of this, the suicides continued. Eventually, in 1995, certain events occurred which led the community to seek solutions from within the community and to redefine the problem as 'their' problem.

That process, painful and complex, demanded a range of activities which unfolded over the next few years. It included closing the local alcohol canteen, setting up a crisis response service and other initiatives. However, most importantly, it sought to locate its response within a wider frame of 'life promotion', and this within the broader context of spiritual and cultural healing. The community 'grew' these solutions and owned them. Suicides and self-harming behaviour fell and there were no suicides in the last three years of the decade. Sadly, in mid-2000 there were two further suicides, occurring at a time of particular tension from the community. Perhaps the strength of what had developed is demonstrated in the measured responses to these tragedies, building on what had been learned rather than rejecting it as 'failure'.

Reflections

In a sense this has been a personal journey and, consequently, there may be very different pictures constructed on the basis of others' journeys. Furthermore, I have addressed here only a few aspects of what is a multifaceted, complex and changing phenomenon. I have not attempted to develop here understandings based on the psychology of self, or the implications of the symbolism of suicide and hanging in particular in Aboriginal Australia. These are critical issues. I have also not sought to address intervention. Ultimately this will demand action on many levels, from national healing through reconciliation, to community development, and the development of innovative and effective forms of therapy. I believe that however these approaches are undertaken they must centrally be concerned with the environment in which the Indigenous leaders and community members of the future are nurtured and their potential grounded. While such approaches, alone, may not be sufficient response to the tragedy of Indigenous suicide, they are, in every sense, necessary. The last words from Western Australian: Aboriginal author, Jack Davis.

*Big brown eyes, little dark Australian boy
Playing with a broken toy.
This environment his alone,
This is where a seed is sown.
Can this child at the age of three
Rise above this poverty?*

— Jack Davis "Slum Dwelling" (1988)

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Aboriginal Identity and the Construction of Fetal Alcohol Syndrome

Caroline L. Tait

Abstract: Within Canada fetal alcohol syndrome (FAS) is understood mainly as a health and wellness concern of Aboriginal people. This is supported not only in the medical research literature but also by the historical experience of Aboriginal peoples. However, among Aboriginal groups concern is growing that fetal alcohol syndrome has become a blanket term to medicalize social problems such as poverty, lack of educational opportunities, and structural racism and violence against Aboriginal peoples. Some Aboriginal people have gone so far as to argue that the diagnosis of fetal alcohol syndrome is being used by non-Aboriginal people as a way to discredit them at a time when negotiations for Aboriginal self-government are taking place. This, they argue, is supported by powerful images of the drunken pregnant woman and the violent fetal alcohol affected youth, both of whom are believed to be typically Aboriginal and unwilling or unable to govern their actions in ways that are morally acceptable. Suggestions by medical and social service bodies that there are epidemic numbers of fetal alcohol affected youth in the Aboriginal population may thus serve to undermine claims by Aboriginal people that as a collective they are able to take on the responsibility of self-government.

Résumé: Au Canada le syndrome d'alcoolisme foetal (SAF) est davantage envisagé comme une préoccupation intéressant principalement la santé et le bien-être des autochtones. Cela trouve non seulement sa justification dans la littérature faisant état de la recherche médicale sur cette question mais s'appuie aussi sur l'expérience historique vécue des autochtones eux-mêmes. Cependant, parmi les groupes autochtones on craint de plus en plus que le syndrome d'alcoolisme foetal soit devenu une expression passe-partout générale servant à « médicaliser » les problèmes sociaux, tels que la pauvreté, le manque d'opportunités en matière d'éducation, le racisme structurel et la violence infligée aux personnes autochtones. Certains autochtones sont allés jusqu'à prétendre que le diagnostic de syndrome d'alcoolisme foetal est utilisé par les non-autochtones comme un moyen de les discréditer lorsque vient le temps d'entamer des négociations portant sur l'autonomie gouvernementale autochtone. Ce point de vue, prétendent-ils, trouve sa justification dans le recours à des images saisissantes de femmes enceintes ivres et de jeunes gens violents atteints du syndrome d'alcoolisme foetal, ces deux exemples étant présentés comme étant typiquement réservés aux personnes autochtones et visant à faire la démonstration que ceux-ci sont peu disposés ou tout simplement incapables d'assumer les conséquences de leurs actions et de se gouverner eux-mêmes d'une façon qui soit moralement acceptable. Les suggestions apportées par les différents corps médicaux et les services sociaux voulant que le nombre de jeunes souffrant du syndrome d'alcoolisme foetal parmi les populations autochtones atteint présentement des proportions épidémiques n'auraient ainsi pour autre but que de miner les revendications maintes fois exprimées par les peuples autochtones voulant qu'ils soient à même de s'assumer de façon responsable comme peuple et de se gouverner eux-mêmes.

This is a paper about the production of knowledge about fetal alcohol syndrome (FAS) and is written in response to a statement made to me by an Aboriginal woman in Winnipeg who stated: "Not all of our children are fetal alcohol syndrome." It is also a paper about timelines which are competing and complementary, such as the historical timeline of Aboriginal people in Canada, particularly the impact of colonization on communities, families and individuals. Future timelines involve self-government, and the future generations of Aboriginal children. It is also a paper about human reproductive timelines, namely the gestational period of the developing fetus, as well as a paper about the timeline of fetal alcohol syndrome and its introduction as a medical diagnosis thirty years ago. This paper examines individual timelines, namely the personal histories of alcoholic women, as well as professional timelines, including the creation of social work discourse and practices in Canada. Although there is a great deal that can be said about each of these, it is the intersection of the various timelines which is of interest here, and the ways in which fetal alcohol syndrome within the Canadian context has come to be known as an Aboriginal health and social problem.

During the early part of this century, the relationship between reproduction and alcohol had, for various reasons, become an uninteresting scientific question. However, this inattention suddenly became problematic in the 1970s as high rates of alcohol abuse among certain Native American communities suggested links to birth defects and developmental delays in children (Pauley, 1992; see also Jones & Smith, 1973). This led in 1973 to the formal description of *fetal alcohol syndrome* (FAS) as a medical diagnosis that is marked by pre- and/or postnatal growth deficiency; central nervous system dysfunction; and characteristic craniofacial malformations (Jones & Smith, 1973). A related diagnosis, *fetal alcohol effects* (FAE), sometimes referred to as *alcohol-related birth defects* (ARBD) (Stratton et al. 1996), *alcohol related neurodevelopmental disorder* (ARND) (Stratton et al., 1996), *possible fetal alcohol effects* (PFAE) (Clarren & Smith, 1978), or *prenatal exposure to alcohol* (PEA) (Mattson & Riley, 1997), was later introduced, which is marked by less severe abnormalities, and varying degrees of intellectual disability.

Since the first medical descriptions of FAS, studies have varied as to occurrence rates. In North America, FAS is believed to be the leading known cause of mental handicaps among children (Loock, 1998:166). In Canada, rates of FAS are usually estimated based on American and European findings, which are between 1 to 2 FAS babies born per thousand live births (Standing Committee on Health and Welfare, 1992:4). While Canada has no national data, the prevalence among Aboriginal peoples is believed to be much higher (Standing Committee on Health and Welfare, 1992; Ashley, 1994; Loney et al., 1994; McKenzie, 1996). This is partially due to population-based studies and studies that investigate specific communities, the large majority being First Nation (usually FAS publications involve case studies whereby a knowledge about FAS is extrapolated from a few individual case histories) (Armstrong, 1998). Studies undertaken in Aboriginal communities have found rates of FAS

to vary from 25 (Asante & Nelms-Matzke, 1985) to 190 (Robinson et al., 1987) per thousand live births which point to a serious health problem existing in some Aboriginal communities, a problem that has been labeled a 'crisis situation' among Aboriginal peoples in Canada (Standing Committee on Health and Welfare 1992: 4; Manitoba Tribal Council NADAP Coordinators and Treatment Directors Committee, 1997).

While these studies point toward staggering numbers of Aboriginal FAS children being born each year, some have cautioned against the methodological weaknesses of the studies (McKenzie, 1996) and the inconclusiveness of the results (MacMillan et al., 1996). Bray and Anderson state that the failure of researchers to control for higher fertility rates and the increased span of childbearing years among Aboriginal women accounts for much of the inflated rates currently published (1989). Hoyme argues that physicians and geneticists too easily blame birth defects on a mother's use of alcohol during pregnancy, and may miss genetic causes of the abnormalities (Hoyme quoted in Seachrist, 1995). Furthermore, others argue that because there is insufficient information about the prevalence of FAS in non-Aboriginal populations, it is impossible to conclude that there is a higher prevalence among Aboriginal peoples (MacMillan et al., 1996: 1576).

Over the past twenty-five years the diagnostic criteria for FAS has been well documented (for example, see Abel & Sokol, 1986; Mattson & Riley, 1997; Sokol et al., 1986; Streissguth & Kanter 1997; Streissguth, 1997). However, in practice the exact definition of each feature has remained vague with high variability from clinician to clinician as to whether a finding is normal or abnormal (Clarren 1998:141; for example, see Little et al. 1990). Young points out that in situations where diagnostic consistency is low this can be accounted for by 'meaning variance', whereby in the absence of standardized technologies or 'instruments', local knowledge untransformed by regulations and standards is a potential source of polythetic categorization (1995: 123). Young states that clinical ideology and science are interdependent practices; however, clinical ideology, unlike scientific discourse "is a local system of knowledge, embedded in a particular institutional hierarchy and production line" (1995: 199). Science on the other hand, "provides an ideology with a distinctive object," meaning that it naturalizes, in this case FAS, "giving it an existence that is independent of the clinical practices through which diagnosticians and therapists encounter it-and ideology, in turn, provides science with the institutional surfaces on which its invisible object is inscribed" (1995: 199). Therefore, while FAS is now understood as a taken for granted 'fact' existing in nature, researchers seek to develop more sophisticated diagnostic tools which will control meaning variance. Recently, diagnostic tools developed in the United States have produced higher rates of diagnostic consistency (Astley & Clarren, 1997; Clarren, 1998; see also Clarren & Astley, 1997; Astley & Clarren, 1995), however these tools require extensive collaboration on the part of different health care providers, as well as social service workers, to gather all the necessary data (Clarren, 1998: 142). A task which is not always easy, given government health cutbacks and professional time restraints.

While diagnostic tools are becoming more standardized and sophisticated, medical assessments for FAS are difficult to obtain in Canada, and in some cases virtually impossible. Assessments are more easily obtained in the Western provinces, and in large urban centers, especially in British Columbia, where the majority of the research and community programming has occurred, and harder to get in the provinces from Quebec eastward. Even though a significant number of physicians have become familiar with the diagnostic criteria for FAS, in the majority of clinical situations physicians remain reluctant to make a diagnosis (Loock, 1998:169). This is due to a number of factors such as physicians not having the training and experience to make a diagnosis; there is no simple, standardized test to detect FAS (the American test has only recently been used in Canada in certain geographical regions); the range of FAS characteristics are diverse, and many are not only distinctive of FAS, but other disorders such as attention deficit disorder; symptoms may vary widely in severity among FAS-affected individuals, and may change with age; in infancy, central nervous system impairments and facial abnormalities due to FAS may be difficult to identify; diagnosis needs to be made by an expert in birth disorders or a pediatrician with extensive experience in the field, however there are not enough expert diagnosticians or clinics in Canada that specialize in FAS diagnosis; diagnosis involves an interdisciplinary work-up which involves the coordination of many different medical professionals; and, some physicians are uncomfortable in working with birth parents with alcohol problems, and who are having difficulty dealing with their feelings about having a child affected by FAS (Loock, 1998: 169). Other contributing factors for few medical assessments include: the tendency of 'high risk' women to access pre-natal care on a limited basis making it difficult for doctors to be aware at birth that these babies were exposed to significant levels of alcohol in-utero (Tait, 2000); individuals with FAS may be receiving alternative diagnoses, such as attention deficit disorder or conduct disorder, which have similar symptomatology; and, caregivers may simply not understand their child's problems as medical in nature, and therefore never try to consult a physician for assessment.

Within Canada, rates of FAE have been estimated to be five to ten times the incidence of FAS, which translates into approximately one thousand infants affected by FAS/FAE born each year in British Columbia alone (Winquist, 1995). However, while the diagnostic criteria for FAS is becoming increasingly standardized, the criteria for FAE remains very controversial as individuals with FAE do not follow the exact configuration of the three characteristics that uniquely identify FAS (growth deficits, central nervous system [CNS] damage, and the distinctive pattern of facial anomalies) (Streissguth, 1997:28). Typically children with FAE are of normal size and have some but not all of the facial anomalies and CNS dysfunction associated with FAS (Streissguth, 1997: 27-28). Furthermore, because there is no specific criteria for FAE, FAE is not officially recognized as a diagnosis and has been criticized by some leading researchers in the field (Aase, Jones & Clarren, 1995). Despite this the term FAE has gained wide popularity among parents, community workers, teachers, and clinicians, probably for lack of a better term (Streissguth, 1997).

A diagnosis of FAS will depend on knowledge about whether or not the mother of the patient consumed significant levels of alcohol while pregnant. Accessing this information becomes problematic if, for instance, the biological mother cannot be located, as sometimes happens with children who have been adopted, or if the biological mother chooses not to report her alcohol consumption. However, in cases where the mother is receiving social assistance, less of a problem exists as her relationship with government institutions, such as social welfare, has meant that it is more likely that her behavior has been documented during her child bearing years (Swift 1991, 1995; Tait 2000). Past problems with alcohol addiction can be determined based on information contained within these client files. Furthermore, large numbers of Aboriginal women, while included in this group, also have their health and social histories documented in various other forms, due to the specific relationship Aboriginal women have with the Canadian government (O'Neil, 1993: 34; Kaufert & O'Neil, 1990), or for other reasons, such as Aboriginal women having significantly higher rates of incarceration (Barnett, 1997). These factors are likely to bias the knowledge compiled about FAS.

Michel Foucault argues that normalizing technologies effectively transform political problems into technical problems in that they remove the problem from the realm of political discourse, and re-situate it within the neutral language of science. This means that the problem is now a technical one for specialists to debate, an aspect of normalizing technologies which is essential (Foucault, 1979; see also Dreyfus & Rabinow, 1983). Karen Swift's analysis of mothers involved with the Canadian welfare system draws on Foucault's argument. Swift states that categories of 'child neglect' or 'child abuse' are seen by social workers to operate as part of a secondary level of socially and scientifically supported classification schemes, unrelated to race and culture under the rubric of 'equal treatment' of all individuals (1995: 127). Furthermore, the hope for children of a better future with an intact family follows from a hundred years of child welfare philosophy and belief in the foster care system. "The 'better future' also carries with it more modern implications of permanent placement in a home offering high standards of safety, health, and education-the element of a 'normal' life in Canada" (Swift 1995: 132). This idea is also predicated on the values of the dominant society, whereby material abundance is of supreme value, and racial and cultural heritage in the development of healthy individuals is negated (Swift, 1995: 132; Blanchard & Barsh, 1980).

Surveillance processes and technologies, such as client interviews and documentation in client files, greatly determine decisions made by social service providers about Aboriginal mothers and their children, including newborn babies. Swift states that documentation of cases over many years, and a history of multiple placement of the children, suggests attachment of children to mothers as risky and precarious. "This attachment cannot, does not compare with the implicit images 'held' in the idea of a better future" (Swift, 1995). Furthermore, in this process 'risk' is understood in relation to the child, and whether or not the mother is capable of adequately caring for this child on her own. The possible 'risks' to the mother when her child is removed from

her care—including increased surveillance of future pregnancies and the removal of these children as well from her custody—is of limited importance. Through these routinized procedures and technologies Aboriginal mothers, and families have been represented, documented, and managed in ways that help reproduce relations of subjugation of Aboriginal peoples (Swift 1995: 144). An example of this is case monitoring, common in neglect cases, through which Aboriginal women remain subject to considerable scrutiny and control by government social service institutions. Subsequently, for social workers, and even at times for the mothers themselves, the ideas, institutions, and rescue operations of the dominant society and their representatives appear as the only real safety for children whose mothers are ‘failing’ (Swift, 1995: 144, see also Tait, 2000).

Among FAS researchers, the majority believe FAS is ‘one hundred percent preventable’ (Dedam et al., 1993; Clarren, 1998; Loock, 1998). However, attempts to understand maternal drinking in the FAS-specific literature has for the most part had a narrower focus than the overall literature on alcohol and women (May, 1998: 13). FAS studies tend to identify a limited range of variables, focus on information which is mostly medical in nature, and collect data primarily in prenatal or obstetric clinical settings (May, 1998, for example, see Pierog et al., 1979; Sokol et al., 1980; Alpert et al., 1981; Hingson et al., 1982; Stephens, 1985; Abel & Sokol, 1986; Plant & Plant, 1988; Serdula et al., 1991). Furthermore, the scientific stance that FAS is one hundred percent preventable has become a moral touchstone to mobilize support for government and social action. Cultural representations authorized by a moral community and its institutions, especially one as powerful as biomedicine, elaborates certain modes of suffering while downplaying or ignoring others (Kleinman & Kleinman, 1997:2). With FAS, it is the quality of life of the affected child that is central in the discourse on suffering, and the majority of researchers believe that individuals who have FAS are sentenced to lifelong irreversible physical and psychological suffering (Dorris, 1989, 1997; Streissguth, 1997; Streissguth & Kanter, 1997). Limited attention, on the other hand, is given to the suffering of the pregnant woman and early on in FAS research a sense of urgency emerged to stop pregnant women from drinking alcohol. This reductionist view was then embodied in community prevention programs and government prevention campaigns, representing a typical Euro/American approach which assumes that health is a condition that should be sustained largely through individual effort, and that an individuals should be made responsible for behaviors believed to place them, or in this case their unborn, ‘at risk’ (Lock, 1998).

Inter-related maternal risk factors identified in some FAS studies paint a more complex picture. Some of the risk factors are: engaging in binge drinking (Godel et al., 1992; Day et al., 1993); a long history of alcohol abuse (Sokol et al., 1980; May et al., 1983; Fillmore 1985, 1987); a history of major mental illness (Clarren, 1998); a partner who drinks heavily (Wilsnack & Beckman 1984; Wilsnack et al. 1991; Clarren, 1998); ‘heavy’ familial drinking (Abel, 1988); lower socio-economic status (Bingol et al., 1987; Sokol et al., 1986); a culture that tolerates ‘heavy’ drinking (May et al., 1983; Robinson et al., 1987);

sexual dysfunction associated with increased levels of drinking and 'heavy' drinking (Wilsnack, 1991; Wilsnack et al., 1991); never married, separated, or divorced (Wilsnack et al. 1991); and poly-substance misuse (Day et al., 1993; Serdula et al. 1991; Godel et al. 1992). Specific risk factors have been identified as occurring at higher rates among Aboriginal women, such as sexual, psychological, and physical abuse committed against Aboriginal women, either as adults or as children (Barnett 1997; Fournier & Crey, 1997); the long-term effects of institutionalization, such as residential schools (Fournier & Crey, 1997); the long-term effects of being in foster-care (Fournier & Crey, 1997, Tait, 2000); and, generational community and individual trauma resulting in the breakdown of the family, loss of traditional ways of life including spirituality, and loss of traditional land bases (Barnett 1997; Fournier & Crey, 1997). When looked at in this light, the moral claim that FAS is one hundred percent preventable becomes less obvious. However, despite this knowledge, a pregnant woman's consumption of alcohol remains the focus of public health prevention programs (Standing Committee on Health and Welfare, 1992; Loney et al., 1994) and is the moral touchstone which researchers and physicians reference when presenting FAS research arguments (for example, see: Continuing Education in the Health Sciences, 1998).

Contradictions arise between the moral stance that FAS is one hundred percent preventable and the realities involved when a pregnant woman wants to access addiction treatment. Barriers that prevent pregnant Aboriginal women from accessing addiction treatment range from addiction programs not accepting pregnant women because of their 'medical' condition, to factors such as not having the proper health coverage, status card, or band membership. As well, many addiction programs are residential programs which means that women have to find alternative childcare if they have children, a task which creates its own set of problems, especially if the woman has experienced previous problems with child welfare services because of her drinking (Tait, 2000). Furthermore, most facilities have long waiting lists, with no provisions for pregnant women to be given entrance priority².

Where the contradiction between FAS being one hundred percent preventable, and the realities mentioned above become even more obvious is in regard to a court case involving a 22-year-old pregnant First Nation woman in Winnipeg, known as 'G', who fought against court-ordered addiction treatment in 1996. This case, which ended in the Supreme Court of Canada one year later, was brought there by Winnipeg Child and Family Services who argued that mandatory addiction treatment in 'exceptional circumstances' is a necessary intervention to protect unborn children from the deviant behavior of their mothers. In this particular case, the social service agency, using information recorded in 'G's' client files, traced a long history of substance addiction, including events surrounding the permanent removal of three previous child

² Some provincial governments, such as Manitoba, have requested that all addiction treatment centers give entrance priority to pregnant women who want to access treatment. While this is a positive step, significant barriers still exist for pregnant women (for example, see Tait, 2000).

from 'G's custody at various times due to her addiction. Contrary to this 'abnormal' and 'deviant' behavior, the agency refers in their argument to the court to what is assumed to be 'normal' behavior exhibited by "the vast majority of women" whereby "pregnancy provides strong motivation to make lifestyle change in favor of the developing child" (Winnipeg Child and Family Services, 1997: 7). However, according to the agency this 'normal' behavior was never exhibited by 'G', and their only option was to seek a court intervention which would detain 'G' until the birth of her baby (Winnipeg Child and Family Services 1997). What was left out of their argument was that upon realizing she was pregnant, 'G' had independently sought addiction treatment but because there were no available beds, was placed on a waiting list (Women's Health Rights Coalition, 1997).

The debate concerning substance use during pregnancy is unique because of two interrelated factors: one, the woman's intention to give birth to the baby (i.e., the pregnancy is wanted, a belief that abortion is morally wrong), and, secondly (which is where the controversy lies), that the *behavior* of the woman will directly cause harm to the child to whom she intends to give birth. While few would dispute that alcohol consumption during pregnancy, especially in large quantities, is bad for the physical well-being of both the pregnant woman and her unborn, to decontextualize this behavior, and to individualize and psychologize such behavior simply as 'risk' taking is to prematurely assign moral blame, usually at the expense of considering other social and political ramifications (Lock, 1998: 12). For example, in the case of 'G', she had grown up basically moving from one institution to the next.

Overwhelmingly within the discourse surrounding FAS, focus has been on the future life of the unborn child who, as a creature of nature, exists outside of the moral order. The fetus by way of visualizing technologies has come to function as a modern "*sacrum*", as an object in which the transcendent appears (Duden, 1993). The fetus as *sacrum* "is the repository of heterogeneous people's stories, hopes, and imprecations" (Haraway, 1997: 175). In the case of FAS this image of the fetus exists in contrast to that of the pregnant woman, whose deviant behavior directly threatens this pure potential offered by nature.

Legal cases pursued by child welfare services in Canada of mandatory addiction treatment for pregnant women illustrate that being poor and Aboriginal are risk factors. Women most likely to be subjected to judicial intervention disproportionately fall into these categories (Royal Commission on New Reproductive Technologies, 1993: 953). These two factors are particularly true for poorer urban Aboriginal women such as 'G', who are more likely to be over-represented as clients of the child welfare system, and to have a longer history with governmental agencies and institutions. These women are also more likely to be isolated from social and political support networks in the urban milieu, such as band councils, to advocate on their behalf. Ironically it is this vulnerability which has limited the number of cases of court-imposed treatment which actually reach the courts as most women who are likely to encounter this situation are in no position to resist and

therefore comply with the wishes of physicians or social workers (Royal Commission on New Reproductive Technologies, 1993: 953).

At the level of the community, difficulty in obtaining assessments for FAS has created concern among front-line workers who are becoming aware of FAS as a public health problem in their communities. Among community workers (i.e., social workers, teachers, youth counselors, addiction workers, prison guards, judges), a discourse of FAS has emerged (for example, see Thio-Watts, 1998; Marcellus, 1998). This discourse is largely based on understandings of information published in scientific journals, (i.e., rates of FAS, diagnostic criteria, 'high-risk' populations), and information obtained at conferences or through public health campaigns (for example, see Van Bibber, 1997). Interestingly, it appears that non-medical community workers have been much quicker than medical professionals to embrace this diagnosis as an explanation for certain realities they see in the communities they serve (for example, see *Continuing Education in the Health Sciences*, 1998, Barnett, 1997). This is particularly true among Aboriginal community workers.

Among non-medical community services, such as pregnancy and community outreach programs, and women shelters, a sense of urgency to identify women at risk of having FAS babies, or to identify individuals who have FAS has emerged (for example, see: *Continuing Education in Health Sciences*, 1998). This is due to several factors, including the belief that FAS is preventable; that stopping pregnant women from consuming alcohol is necessary in prevention; that individuals who are not diagnosed are 'falling through the cracks' of the health and social service systems; and that community based organizations have the greatest opportunity of creating successful prevention programs (Tait, 2000). Furthermore, this moral discourse identifies a concrete problem around which organizations can lobby for scarce, but badly needed, government funding (for example, see *Continuing Education in the Health Sciences*, 1998).

Subsequently, a great deal of attention among community organizations is being paid to what scientific researchers have called *secondary disabilities* which "arise after birth and presumably could be ameliorated through better understanding and appropriate interventions" (Streissguth et al., 1997: 27). These include mental health problems, disrupted school experiences, trouble with the law, inappropriate sexual behavior, and drug/alcohol problems (Streissguth et al., 1997: 27). Interestingly, all of the secondary disabilities have been documented as occurring disproportionately among the general Aboriginal population of Canada (for example, see Royal Commission on Aboriginal Peoples, 1993, 1996; Waldram et al., 1995). As well, a type of informal labeling by community workers is occurring and the majority of individuals who are labeled FAS are of Aboriginal heritage. This points to a situation whereby in practice a medical diagnosis becomes 'known' and 'applied' to individuals first in non-medical settings by non-medical community workers who are more likely to see 'high risk' individuals (for example, see Barnett, 1997; Dorris, 1989).

The systems of surveillance that produce data about Aboriginal health are powerful social instruments for the construction of Aboriginal identity, problem identification, and resource allocation (O'Neil, 1993: 34). FAS research and prevention programs are one such example. To begin with, overwhelmingly FAS research, population assessments and prevention programs in Canada have been located in First Nation communities since alcohol abuse has been identified by many First Nation communities as one of the major health problems confronting them. This has meant that health issues related to substance abuse, such as addiction treatment, and prevention of FAS have been prioritized by the communities themselves (Brady, 1995; Assembly of Manitoba Chiefs, 1997). This appears, for example, to be the case in Saskatchewan where out of twenty FAS community development initiatives sponsored by the Saskatchewan Institute on Prevention of Handicaps in 1998, sixteen were located in reserve communities, and the other four urban and prison based initiatives were run by Aboriginal organizations or had a strong Aboriginal component.

While reserve communities with problems of alcohol abuse may be labeled 'high risk' sites for FAS, equally important is that they also offer the perfect research site for scientific investigation of FAS. First, reserve communities have a defined population based on band membership. Second, communities, especially the more isolated reserves, are marginally effected by in and out migration, and therefore longitudinal health and social histories are relatively easy to access through medical charts and records (Engeland et al., 1998, Hay et al., 1998); government health records and statistics (Moffatt et al., 1996); and school records (Moffatt et al., 1996). O'Neil argues that one of the reasons epidemiologists are attracted to working with data derived from Aboriginal communities is the comprehensiveness and relative completeness of the database (1993:34). He suggests that because of the highly centralized federal government surveillance systems of Medical Services Branch and Indian and Northern Affairs, little escapes the attention of institutions involved in service provision (O'Neil, 1993: 34). Third, pregnancy is closely monitored in northern Aboriginal communities and, with the exception of only a few communities, all Aboriginal women in the north are transported out of their communities to southern hospitals to give birth (for example, see Kaufert & O'Neil, 1990, 1993; O'Neil & Kaufert, 1995). Finally, because research and intervention strategies are usually supported by band councils, cooperation from women, and the community as a whole is higher, which makes accessing other information not given in formal records, such as measures of maternal alcohol exposure, much easier than it would be in a research situation where participants did not feel supported, or possibly coerced, by their community. Consequently, all of these factors contribute to FAS being identified as largely an Aboriginal health problem.

The contradiction, O'Neil points out, is that public health surveillance systems perform disciplinary and regulatory functions in society independent of their overt purpose of tracking health conditions (1993: 34). Therefore, they can construct knowledge about sectors of society that reinforce unequal power relationships; "in other words an image of sick, disorganized communities can

be used to justify paternalism and dependency” (O’Neil, 1993:34). Furthermore, external agencies and academics have the power to interpret data and construct an image of Aboriginal communities as desperate, disorganized, and depressed environments. “This image is created ostensibly to support lobbying efforts to secure a larger share of national resources for community development. However, this image is reflected through the Canadian media and general public and is to some extent internalized by Aboriginal communities, reinforcing dependency relationships” (O’Neil, 1993: 34).

Media coverage in Canada has played a significant role in raising public awareness about the effects of intoxicant abuse during pregnancy and has been central in FAS being understood in mainstream society as an Aboriginal health and social problem that is one hundred percent preventable. Although there had been media coverage of other court cases involving mandatory addiction treatment for pregnant women, extensive cross-Canada coverage of the ‘G’ case in 1996 and 1997 marked a turning point toward widespread public recognition of the long term health problems caused by substance use during pregnancy. Within this coverage, a certain public image re-emerged from previous cases of who exactly pregnant women are that abuse substances. Media images of ‘G’ reinforced what was already known through other cases: 1. these women are Aboriginal, and 2. the type of substances they use are not only illegal to consume (‘G’ was sniffing glue), but also overwhelmingly they hold no appeal for public spectators. However, during coverage of the ‘G’ case not a great deal of media attention was given to the problem of ‘inhalant addiction’ but instead to prevention and occurrence rates of FAS (for example, see Chisholm, 1996). In the end the image of ‘G’, carrying the future of Aboriginal people in her toxic womb, was firmly implanted in the collective imagination of Canadian society.

More recently, the media has begun discussing individuals who suffer from FAS. For example, in November 1998, *The Globe and Mail* published an article on murder rates in Manitoba involving Aboriginal people. This article, which painted a dismal picture of the lives of Aboriginal people in Manitoba, concluded by quoting a sociologist who “issued a warning” about the growing number of crimes in which the accused suffers from FAS (Roberts, 1998). The sociologist went on to “predict” that an “entire generation of FAS youths are about to enter the criminal justice system-youngsters with little or no ability to comprehend the difference between right and wrong” (Roberts, 1998). The article then quotes unidentified “experts” who claim that these individuals have little hope of rehabilitation. In conclusion, the article states that seventy percent of inmates in Manitoba’s prison system are Native, as are forty-five percent of federal prisoners in Manitoba, and according to “prison officials” at least half of these Native inmates suffer from FAS or FAE (Roberts, 1998).

Kleinman and Kleinman write that images of suffering are appropriated to appeal emotionally and morally both to global audiences and to local populations (1997:1). These images have become an important part of the

media which feature cultural representation of suffering as both spectacle and as the presentation of the real (Kleinman, Das & Lock, 1997: xii). Kleinman, Das and Lock argue that "what we represent and how we represent it prefigure what we will, or will not, do to intervene. What is not pictured is not real. Much of routinized misery is invisible; much that is made visible is not ordinary or routine" (1997: xiii). What moral sentiments media images of Aboriginal FAS youth, with little or no ability to comprehend the difference between right and wrong, bring to the public arena is complicated and controversial. However, recognition of the damage caused to Aboriginal peoples through colonialist processes of oppression and assimilation, an outcome of which has been the over-representation of Aboriginal men in federal and provincial prison, is silenced. In its place emerges a discourse of medicine and science where nature, in this case the effected brain, serves as a moral touchstone to account for a group who, lacking in the ability to comprehend consequence, are 'wild', 'uncultured', and inappropriately close to nature (Lock, 1997: 272-273). And more importantly, potentially disruptive and 'dangerous'.

At this point we have branched out from the esoteric realm of science to find that something 'known' as FAS exists in various contexts including the most public arena of all, the media. Here as well we find that FAS is largely viewed as an Aboriginal health and social problem by way of informants labeled as 'experts' who give moral credence to stories which reinforce cultural representations of the state in which Aboriginal people exist both as spectacle and as the presentation of the real.

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4. TRANSFORMATIONS OF IDENTITY & COMMUNITY

Healing the Aboriginal Offender: Identity Construction Through Therapeutic Practice

Gregory M. Brass

Abstract: As an ethnic term, “Aboriginal” can be understood to generally denote a definable segment of the Canadian population: peoples who are culturally, historically, and legally distinct from the general national population by virtue of their Indigenous origins. But in day to day social discourse, and in the specific case of bureaucratic and clinical practice addressed in this paper, the term has other more profound implications: here “Aboriginal” has connotative qualities that can homogenize diverse and often competing notions of localized (even urbanized) identities. This discussion will critique the clinical deployment of aboriginality as a discursive practice within a therapeutic setting for incarcerated men of Aboriginal ancestry: being Aboriginal is both a rhetorical means to therapeutic ends and a way of reconciling a bureaucratic policy which does not adequately acknowledge local Indigenous identities in the first place.

Résumé: Considéré en tant que terme ethnique, « autochtone » peut être généralement compris comme renvoyant à un segment bien défini de la population canadienne: des peuples qui sont culturellement, historiquement, et légalement distincts de la population nationale dans son ensemble en raison de leurs origines indigènes particulières. Mais dans le langage courant de tous les jours, et dans le cas plus spécifique de pratiques bureaucratiques et cliniques étudiées dans le cadre de cet article, le terme revêt d'autres implications plus profondes: ici « autochtone » possède des qualités connotatives qui peuvent homogénéiser diverses notions très souvent concurrentes d'identités localisées (même urbanisées). Cette discussion visera à critiquer le déploiement clinique du fait autochtone comme pratique discursive à l'intérieur d'un cadre thérapeutique pour des hommes incarcérés d'ascendance autochtone: être autochtone est à la fois un procédé rhétorique employé à des fins thérapeutiques et une façon de faire accepter une politique bureaucratique qui d'entrée de jeu ne reconnaît pas correctement les identités autochtones régionales pour ce qu'elles sont.

From June to August 1997, I did fieldwork research at Nechi House¹, a halfway house for incarcerated men of Aboriginal ancestry. At the time I conducted my research, the House was located in the City of Montreal and had been in operation for ten years. The House accepts Aboriginal men who have been paroled from federal and provincial institutions. It also accepts men awaiting sentence, who have a sentencing requirement to undergo psychotherapy or who have been referred by their community social services. In the fall of 1997 and spring of 1998, I conducted interviews with eight residents and with two members of the clinical staff of the House. Much of my work concentrated on the group psychotherapy program, referred to in this paper as *Nechi Community Circle*, which occurred three times a week, approximately for two to three hours each session.

My research represents an attempt to understand how such an institution as Nechi House must reconcile a set of competing factors in order to deliver a therapeutic program to a clientele that is as diverse and as in need of counselling as the incarcerated men who come to the House. I would like to stress, however, that I am in no way leveling harsh criticisms on the work of the counsellors, or trying to minimize the suffering of residents or trivialize their healing journey. As one of the counsellors whom I interviewed said, my work represents a critique of the House and its therapeutic service. What is important as well, and where I contend my strength as a researcher lies, is my attempt to effectively problematize specific areas where I felt some issues about personal and collective identity may be taken for granted.

Part of the issue for me was making sense of the relationship between the House's therapeutic ideology and the actual cultural diversity of the residents. During my fieldwork, at any given time there were, at least, five to seven different cultural groups represented at the House, ranging from Algonquin, to Cree, Inuit, Mi'kmaq, Mohawk and Naskapi. It was not uncommon for each resident to have come from a separate Native community. As well, residents spoke English, French, or their own Indigenous language. Interestingly, at least one quarter of the residents were Inuit from Nunavik (northern Quebec). As well, while most residents were from, or strongly affiliated with, their Native communities, others had been raised in urban centres, either because of adoption or their family's migration to the city.

My interest in the House centres on the link between what I view as an inclusive but vague bureaucratic and "ethnic" category – Aboriginal people – and Nechi House's conscious and strategic deployment of a set of generic beliefs, ideas, and themes about Aboriginal peoples within its therapeutic ideology and practices, what I refer to as *aboriginality* or a rhetoric of *pan-Indianism*. Specifically, I wanted to explore how these two concepts interplayed in this therapeutic setting and shaped the identity of residents.

¹ Nechi House is a pseudonym. The name of the house and residents discussed here have been changed to protect their privacy

In terms of my theoretical abstraction of aboriginality, of which pan-Indian spirituality forms a significant part, I feel it would be unproductive here to delve into an extensive elaboration (see Brass, 1999 for more discussion). Suffice it to say, aboriginality, as I have rendered the concept, is one that rests heavily on Michel Foucault's writings on discourse in language. That is, a discourse may be understood as a style of speech and "practices that systemically form the objects of which they speak" (Foucault, 1972: 49). Aboriginality is a socially constructed body of knowledge that serves as a 'dividing practice', one that has separated (and then marginalized) some members of the world's populations. Aboriginality, then, is a way of conceiving Indigenous peoples as cultural "others".

Over the centuries of contact, colonialism and then neo-colonialism, knowledge has served as a way for expansionist and industrial societies to subsume those human populations whose lands were conquered and who appear to be opposed to the cultural values, economic practices and political systems of European colonizers. Present-day North American society must contend with the devastating historical, political and social legacies of this period. Consequently, aboriginality remains the dominant form of knowledge of many developed "First World" nation-states in their relations with these "historically residual" Indigenous populations.

The image of the Indian has been well-documented, especially in comparative literature studies. For example in *The Whiteman's Indian*, Berkhofer (1979) demonstrates that the knowledge that developed around North American Indigenous populations came from a number of competing sources: diplomats, missionaries, military men, and men of science. The historical images Berkhofer presents of Native Americans demonstrates that the relationship between the colonizer and colonized was at times deeply ambivalent and contradictory. Yet, these images played a powerful role in shaping the identity of North American Indigenous peoples. In his epilogue he writes:

From this survey of the idea of the Indian over time, two dramatic historic trends emerge. What began as a reality for the Europeans ended as image and stereotype for Whites, and what began as an image alien to Native Americans became a reality for them. For Native Americans the power of the whites all too often forced them to be the Indians Whites said they were regardless of their original social and cultural diversity. (1979: 195)

The effect of these ideas was to homogenize the wide cultural and social diversity of Indigenous populations. This has been the case not just in North America, but, arguably, throughout those areas in the world where Indigenous populations were conquered and then subjected to economic marginalization, intense political control, and instances of severe state-sponsored cultural oppression, if not outright attempts at genocide (see Pedersen, *this volume*).

In terms of my research on the clinical programs of the House, I conceive the dialogic/therapeutic practices of the counsellors at the House as a line of

strategy and a vein of statements within the broader discourse of aboriginality. Among other things, this perspective appears to uphold the romanticist notion that Aboriginal peoples embody a natural and pure source of spiritual wisdom. In the words of the anthropologist Alice Kehoe:

Thousands of Americans and Europeans believe. . . that American Indians retain a primordial wisdom that could heal our troubled world. American Indians are supposed to be *Naturvolker* (natural peoples), in contrast to the civilized nations alienated from Nature. Personified as Mother Earth, Nature is the embodiment of life and thus hope of a future. (1990: 194)

Lovejoy and Boas called this “cultural primitivism... the discontent of the civilized with civilization.” That discontent gives rise to one of the strangest, most potent, and most persistent factors in western thought – the use of the term ‘nature’ to express the standard of human values, the identification of the good with that which is natural” (1990: 194)

My observations of the therapeutic dialogues and practices of counsellors, and of some residents’ interactions with the ideas, notions and themes contained in the clinical rhetoric, indicated to me an attempt to construct, or a tendency to assume that there existed, a generic cultural commonality among Indigenous populations. This commonality may be called ‘Native Spirituality,’ an inherent and shared pan-Indian religious tradition among significantly diverse Indigenous populations. Based on what both Berkhofer and Kehoe have written, as well as by my own attempts to formulate aboriginality, I would argue that such a notion represents an idiom of healing that is simultaneously quite new in its present form, function, and etiology and yet very old in so far as it evokes a romanticized portrait of Indigenous cultures as inherently more spiritual than other world cultures. The House, as a treatment centre for Native people, shares many therapeutic commonalities with other Native-run treatment centres, where pan-Indian spirituality, the Red Road, or Circle Healing seems to be most enthusiastically employed as a standard healing practice.

Based upon knowledge gained from discussions and interviews with residents and clinical staff, as well as my fieldwork observations, the House’s therapeutic ideology and practices represent a blended approach to psychotherapeutic interventions. All of the counsellors at the House are familiar with and trained in Western psychotherapeutic methods. The time frame of the therapy is about eighteen to twenty weeks. Much of the therapy revolves around “talking cure” forms of interventions: intensive group and individual counselling sessions, psycho-educational programs, meditation groups, and other conventional forms of western psychotherapy. These therapeutic group sessions are held at Nechi House throughout the week, often in the morning. The various programs and counselling sessions normally occupy a large portion of residents’ time during their stay at the House.

The therapeutic dialogues drew heavily on a generic pan-Indian religious and spiritual rhetoric. In turn this rhetoric seems to be strongly influenced by, and

borrowed from, cultural imagery from Great Plains, Eastern Woodlands and even Northwest Coast Native cultures. Some of the ceremonies and rituals include the use of smudging 'medicines', in particular cedar, sage and sweetgrass, and, on occasion, sweat lodge ceremonies and a variety of other rituals.

Pan-Indian ceremonies and rituals form an essential part of the counselling rhetoric and therapeutic practices. Based upon what I observed and learned through the actions and words of counsellors, most seemed to share a deep and sincere personal commitment to the spiritual teachings that they were themselves in the process of learning and which in turn they were passing on to residents. The most common venue for this transference of spiritual teachings was the Nechi Community Circle. As a powerful form of group psychotherapy, the Nechi Community Circle is orchestrated by two rhetorical devices that are central to the House's therapeutic ideology: "community" and "circle". According to the counselling staff, the House is conceived of as a therapeutic community. This therapeutic community surrounds a central "Sacred Fire" where "the Medicines" are kept and burned – a metaphorical hearth where the spiritual energy of the community resides and from which it emanates.

The Circle has both literal and metaphorical applications: thematically, it supports and widens the therapeutic concept of "community". The Circle is a metaphor for a set of concentric social experiences and relationships. Primarily, it refers to a pan-Indian conception of a 'holistic' self as a 'medicine wheel.' The medicine wheel, from my understanding, constructs the self as a balance of emotional, mental, physical, and spiritual components. The Circle or medicine wheel also refers to a set of intertwined social relationships: self, family, community, and (Indigenous) nation, as well as the natural, physical, mental and spiritual worlds. In short, the Circle implies a sense of moral integrity and personal strength.

The rhetoric of healing, the integration of the sufferer within a therapeutic community, and the transformation of one's problems from a source of despair and suffering to a source of revitalization and strength were strongly evident within the House. For many residents who desire to transform their negative experiences in life and the pain and sadness that goes with these experiences, the House's rhetoric of community and its language of healing do have positive effects while they are in the "care" of the House.

The House's therapeutic ideology and practices construct an image of Aboriginal identity that is woven into a rhetorical fabric of "community" and "healing". The identity being portrayed is for the most part a positive one that locates a resident's inherent *nativeness* in a framework of spiritual awakening and renewal.

However, pan-Indian rhetoric, in so far as it tries to construct or assume a generic Native identity, does tend to subsume the localized cultural identities of Indigenous populations and overlooks very specific senses of localized

identity. As well, it could be regarded as a source of identity more easily controlled, manipulated and promoted by the dominant non-Native society (for example, the mass media). Thus, I am suggesting that the negative consequences of pan-Indianism as a therapeutic practice is that it can seriously challenge or even thwart local expressions of cultural identity. Tad McIlwraith, a former graduate student at the University of British Columbia, conducted an anthropological study on formations of local senses of contemporary identity among the Sto:lo of the Fraser River Valley, near Vancouver. In his findings he suggests that some Sto:lo people, a Coast Salish population whose way of life revolved around the harvesting of salmon from the Fraser River, were actively resisting the presence of pan-Indian practices, such as the sweat lodge, smudging and powwow dancing, practices very similar, if not identical to those I have described. For some of his Sto:lo informants, such practices were regarded as culturally foreign and thus a potential source of confusion to local identity. In particular one of his Sto:lo informants offered this reflection of his exposure to pan-Indianism:

When I was going to high school I wasn't taught about my own history. I wasn't taught anything about place names, or villages, wasn't taught anything about *sxwey'xwey* masks, wasn't taught anything about winter dancing. But I was taught that there were Prairie Indians, and that to be Indian you lived in a tipi and had a long flowing headdress, and you're proud and you're noble, and you hunted buffalo, things like that. I wasn't taught about local Native culture. And of course watching TV, and watching movies, and everything that was to be Indian was exactly what we were taught in school. Pan-Indianism . . . you take that one culture and one people and apply it to everyone. (McIlwraith, 1995: 25)

In my interviews with residents regarding their responses to the pan-Indian rhetoric of the clinical dialogue and practices, I generally noted at least three categories: some residents seemed to outright reject it as it did not correspond to anything that was familiar to their communities' cultural practices; like the Sto:lo person above, it was too culturally foreign and came across as inauthentic. Yet, quite the opposite response was voiced among other residents. That is, there was open acceptance to it as an authentic and legitimate representation of a generic Native identity. An older Naskapi male typified this category: He had a fairly traditional upbringing in the bush, but through the early 1970s had been exposed to the counter culture movement while a university student in Montreal. Importantly, he was a sympathizer to the American Indian Movement, which in its early formation deployed generic and easily identifiable symbols of Indianness to attract Native constituents. Another example is a young man who had been adopted out of his home community and was raised by a non-Native family in Montreal. He too was sympathetic to militant Native political movements, and had taken part in the Oka Crisis of 1990, a violent confrontation between Mohawks and the Canadian state. Clearly, then, both residents had been previously exposed to a pan-Indianism that seemed to make them more responsive to it as a form of healing through which they could narrate their suffering. However, I felt the most interesting and tactical response came from Inuit residents, who as I reported earlier, represented about one quarter of the residents. The following

quote from one Inuit resident captures an attempt to delicately maneuver around the culturally foreign elements at the House.

Medicines, actually, for being an Inuk, I'm not really – how would you call it? Well, there's a lot of names for medicines. I really can't say what they're called. I would have to hear it again in order to call it. To me, that's how it is; I don't know very much about Indian things. But to tell myself to respect how it works around here. I have to get along with, with fairly strange things for an Inuk, strange things. . . . at first they were very strange cause in my life I never prayed to God. Like they call Him, Creator, and with this smoke [the medicines]. I never prayed like this before in my life before I came here. But I have to respect other cultures – how they pray and try to understand that. I mean try to see them just the same way as I would pray. I respect believers in what they believe like myself. I am a believer to something greater to myself. So I have to respect people when they pray to this Creator, they call him. And myself, I just call him God.

In the case of this Inuk resident, as with another other Inuit man I interviewed, Christianity, via the Anglican Church, played a profound role in their upbringing. The church was a significant socializing influence; in fact, the father of one was a minister and as an adolescent, the son had desired to be a minister as well. For both of these Inuit residents, the pan-Indian rhetoric was regarded as 'Indian and southern'. Their involvement with it, for the most part, seemed to be motivated by passive compliance, rather than any genuine interest.

To conclude, in its day to day relationship with the Canadian justice system, the House is forced to accept men whose backgrounds encompass considerable cultural, historic, geographic, legal, linguistic, political and socio-economic diversity. Secondly, there exists a pervasive and powerful notion among many European Canadians (and among many Aboriginal peoples as well) that all Aboriginal peoples share some sort of essential commonality, often in terms of their religious systems and spirituality. Given that these are the conditions upon which the House operates, it is not surprising that the counselling staff would develop and use a therapeutic ideology and set of practices which further homogenize the diverse cultural identities of its Aboriginal residents. Clearly, aboriginality as a discursive practice of the Canadian state has, to a large extent, already done this for them. Going back even further, these practices are historically rooted in the colonial encounters with the Indigenous "other". Thus, Nechi House is merely acting within a pre-established framework of knowledge that is inseparable from a contemporary bureaucratic state context.

Ultimately what the counsellors at Nechi House are attempting to do is to construct a surrogate Aboriginal community for their residents, most of whom are from, or strongly affiliated with a specific and rural Aboriginal community. The counsellors must operate with reference to a broad "ethnic" category, one that has been dictated by the state through the correctional systems, and which homogenizes the cultural and social diversity of a

segment of the incarcerated population. Thus, providing culturally relevant clinical programs that are specific to the actual backgrounds of residents is not really possible at this time. Consequently, the clinical staff of the House must on a constant and daily basis contend with a high level of cultural diversity among residents and is forced to provide a model of care that best addresses the therapeutic needs of the Aboriginal offenders as a whole.

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Towards a Recuperation of Souls and Bodies: Community Healing and the Complex Interplay of Faith and History¹

Naomi Adelson

Abstract: For many First Nations peoples, the present is a period of *recuperation*: a time of both ‘taking back’ and of regaining the health and strength of individuals and communities. Many First Nations people speak about this recuperative process in terms of healing and, for many, part and parcel of that process is a renewal of Indigenous spirituality. Both healing and spirituality are potent and multi-layered concepts, textured as much by what people are healing *from* as what they are healing *towards* since the recuperative process is always mediated by cultural, social and political factors. While mental health experts address individual expressions of and responses to social suffering (e.g., depression, substance abuse, suicidal ideation), I parallel those works with an examination of community responses and focus here on the complexity and heterogeneity of recuperation in light of a history of missionization. Drawing from ethnographic interviews with eastern Cree church elders, I discuss the active negotiation of faith as part of the recuperative process.

Résumé: Pour beaucoup de gens appartenant aux Premières Nations, le présent est une période de *restauration*: un temps d’arrêt pour faire à la fois le point et permettre aux individus et aux communautés de retrouver santé et vigueur. Beaucoup de gens issus des Premières Nations évoquent volontiers ce processus de restauration en termes de guérison et, pour plusieurs d’entre eux, des pans entiers de ce processus se réalise principalement à travers le renouvellement de la spiritualité autochtone. La guérison et la spiritualité sont des concepts puissants et multidimensionnels, organisés tout autant autour de ce dont les gens désirent objectivement guérir que par la guérison plus profonde à laquelle ils aspirent puisque le processus de restauration est toujours forcément médiatisé par des facteurs culturels, sociaux et politiques. Pendant que les experts en santé mentale s’intéressent aux différentes expressions individuelles et aux réponses apportées en regard aux souffrances sociales (par ex. la dépression, les abus de stupéfiants, les idées suicidaires), j’établis un parallèle entre ces travaux et les analyses des réponses émanant de la communauté elle-même et me concentre ici sur la complexité et l’hétérogénéité du processus de restauration à la lumière d’une histoire façonnée par le missionariat. À l’aide d’entrevues ethnographiques menées auprès d’ainées des églises des Cree de l’Est, je discute de la nécessité de composer activement avec la foi comme partie intégrante du processus de restauration.

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In this backward country, the missionary priest is the doctor of souls as well as bodies.
— Père Lacombe, 1874

I am sorry, more that I can say, that we tried to remake you in our image.
— Archbishop Michael Peers,
Primate, Anglican Church of Canada (1993)

There needs to be a healing in the land.
— Elijah Harper, 1995

*It is very important to treat everything with the greatest care and to think upon it
very carefully.*
— Whapmagoostui Elder, 1996

Introduction: Colonization and the Legacy of Social Suffering

In 1874, a French missionary writes about the medical practices of a northern Canadian Aboriginal population detailing the tremendous spiritual and herbal pharmacy actively used by the people whom he met. He ends his account with the following passage:

In this backward country, the missionary priest is the doctor of souls as well as bodies. These poor savages place their confidence in him and it is impossible to persuade them that the missionary cannot cure their sicknesses. This last procurement often alleviates their sadness by the confidence inspired and this is a means towards their conversion. Sometimes just a few words of encouragement is enough to [leur mettre l'esprit en repos] put them at ease and help them heal. Nonetheless the missionary is sometimes obliged to improvise the medicine. That is how Father Lacombe, by healing the son-in-law of a chief, who was diagnosed with an acute infection on his arm followed by the amputation of the hand, got the whole tribe to convert.

Since I first read this excerpt, it continues to disturb me and remains the impetus for my present exploration of the relationship between faith, bodies, souls, and healing. It is not simply the arrogance of the missionary's words that originally shook me, but the apparent ease with which he simultaneously ignores his own observations while, with single-minded determination, attempts to minister to peoples' bodies and souls. This missionary's actions were far from unusual. So many priests' journals from this era attest both to their seemingly willful blindness to the rich and vital belief system long in place throughout Indigenous Canada and to their own conviction of the fundamental links between medicine and personal salvation (Kelm 1998). Bringing what they believed to be a "healing civilization" (Comaroff 1993; Kelm 1998) to the north, the missionaries worked to systematically eradicate what they viewed as heathen beliefs and practices. While only one segment of

the colonial enterprise, the missionization process remains one of the most contentious domains of cultural loss and disenfranchisement. It is for this reason that, for many Indigenous peoples, organized religion is emblematic of the entire colonial enterprise. For others, however, and regardless of its origins, Christian doctrine is a vital element of a much older spiritual belief system.

Today, in this (so-called) post-colonial period, individuals and communities are grappling with the legacy of the colonization process. We are, for example, all too aware of the high numbers of mental health problems, including interpersonal violence, substance abuse, and related accidental deaths and suicides, in First Nations communities today (RCAP, 1995; Waldram, Herring & Young, 1995). At one level, many of these personal problems can be understood as individual expressions of social suffering; the embodied legacies, in other words, of colonization. Increasingly, communities are actively grappling with, and attempting to expunge, the physiological as well as social and cultural effects of social suffering. This is, in other words, a period of *recuperation* in two senses of that word: it is a time of “taking back,” of actively recovering land and cultural autonomy, and a time of “regaining health and strength” at the individual and community levels.

Many First Nations people speak about recuperation in terms of healing and, for many, part and parcel of that process is a (re-)awakening or renewal of Indigenous “spirituality” (cf. Harper, 1995). Both healing and spirituality are potent and multi-layered concepts, textured as much by what people are healing *from* as what they are healing *towards*. These concepts are made even more complex by the fact that there are often varying interpretations of what constitutes a proper course of recuperation. Indeed, some First Nations communities are divided by exactly this process, fraught as it is with all of the complex contemporary reality of diversity and difference around interpretations and valuations of spirituality, culture, tradition, and belief (Rowse, 1996).

The recuperative process is mediated by cultural, social and political factors that involve healing at a variety of levels including, of course, health care interventions. Mental health programmes, in particular, address the individual expressions of social suffering (e.g., depression, substance abuse, suicidal ideation) and many are looking for ways to incorporate appropriate, culturally-sensitive models of care for First Nations populations. There is an important and growing body of literature that addresses the ways in which spiritual therapeutics (such as sweat lodges, pipe ceremonies or other specific herbal or spiritual treatments) are being incorporated into the standard care of Aboriginal people in psychiatric as well as general medical practice (Waldram, Herring & Young, 1995; Waldram, 1998).

I, of course and without hesitation, support spiritual therapeutics and the mental health programmes that are culturally sensitive, integrative, and of substantive value to those who seek or initiate those services. Increasingly, however, there is a shift towards a model of health care for Indigenous people

that relies on a far too static notion of tradition and culture, removing them entirely from lived contexts (for example, see, Calabrese, 1997; McCormick, 1997; Tolman & Reedy, 1998). This sort of wholesale incorporation of “tradition” or “culture” often fails to acknowledge larger political and social contingencies or locally-based beliefs and practices (cf. Grim, 1996). Mental health care programmes must take into account the diversity of belief and practices that abound in First Nations communities. More specifically, we cannot presume that any one form of Indigenous spirituality, or healing for that matter, is commonly and equally shared by all members of any given community (Brady, 1995; Rowse, 1996; Waldram, Herring, & Young, 1995). Nor can we assume that there is any one programme of recuperation that would transcend these differences. To address these differences, however, should by no means hinder innovation in community health care work. Indeed, once we see culture as “open-ended [and] an arena of negotiation and contention” (Linnekin, 1992; Rowse, 1996; Adelson, 1997), we may also see ways in which community mental health programmes can be enhanced by this knowledge. In this paper, I examine contemporary configurations of faith as part of the larger recuperative process and, specifically, as an example of the kind of local-level diversity that must be accounted for in a comprehensive community healing strategy.

Linking Healing and Spirituality

Healing is never simply a personal, physical phenomenon. While it implies a process of recuperation and recovery from personal or social traumas, healing always, by definition, takes place in a particular historical and social context. It must be understood, after all, that there would be nothing to recuperate *from* if the travesties associated with loss of land, resources, culture or community were not at the heart of the personal traumas faced by so many First Nations peoples today. Political foot-dragging on Aboriginal rights, land and resource issues, inattention to the legacy of racist policies, ignorance of the personal and cultural losses incurred through those policies and through practices such as residential school programmes are the framework, context and reason for healing. The social and political actions now being taken by Indigenous people across Canada are attempts to actively address the decades of silence or inaction on these issues.

For example, the recent efforts of reconciliation at upper levels of government and community delineate the first steps in the recuperative process. At a national level, the 1993 apology by the Anglican Church of Canada for the tremendous wrongs that were practiced in the name of conversion (ACIP, 1996), Elijah Harper’s Sacred Assembly (Harper, 1995), the *Royal Commission on Aboriginal Peoples*, and the federally-funded Healing Initiative specifically allocated to redress the traumas inflicted through residential schools are all significant examples of the efforts to address some of the wrongs of the past. Inseparable from these larger political processes are the personal and community acts of recuperation, as individuals and groups actively attempt to

reconcile the embodied legacy of colonization (O'Neil, 1993). Healing thus connotes a dynamic process of recuperation from an inordinate realm of losses as well as the physical recuperation of bodies and minds.

On the one hand, it should come as no surprise that spirituality is included in any programme of healing and recuperation. What does spirituality mean, though, and how is it currently defined and practiced? For many eastern James Bay Cree, for example, one's sense of spirituality has always been inseparable from one's sense of being. Fundamentally integral to Cree life is a spiritual awareness and belief that is rooted in a hunting and land-based culture that simultaneously permeates everyday social relations and practices (Tanner, 1978; Feit, 1986; Adelson, 2000a). This kind of spiritual belief is not necessarily incongruent with Christian doctrine and, for many, has long been enmeshed with Christian belief (Preston, 1981; Adelson, n.d.).

When we speak about Native spirituality today, however, many associate the term with particular beliefs and practices that transcend *but do not exclude* specific, local Indigenous beliefs. While not immediately connected to locally-held beliefs, this form of spirituality is also inseparable from being and living, and is based on the relationship between people living on earth and their spiritual ancestors. While we may associate Native Spirituality with particular practices, such as the sweat lodge, healing circles, or pipe ceremonies, these are only the more highly visible elements of a far more complex, integrated and holistic belief system.

Given that Native Spirituality encompasses all aspects of life, it also includes a complete range of healing practices. Spiritual elders are those who are recognized for their ability to communicate with or act as an intermediary for spirit ancestors. These gifts may include medical knowledge, as spirit ancestors guide an elder's actions in this world. As Samson succinctly explains, "[elders] do not claim expertise over the physiological workings of the body. Rather, their power lies in an understanding, often intuitive, of the ways in which the cosmos connects with individual people" (Samson, 1999: 77).

There has been a tremendous growth of Native Spirituality across Indigenous Canada, and that growth has occurred, significantly, in tandem with the recuperative process. In Whapmagoostui, for example, Mi'kmaq, eastern and western Cree elders (pipe carriers, spiritual advisors, healers) have regularly been invited into the community for the last seven years as guests of the community's cultural programme. These elders offer spiritual guidance, perform a variety of healing practices and ceremonies, lead sweat lodges, and train local members of the community to perform similar ceremonies. They have brought what is commonly referred to as "Native Spirituality" into Whapmagoostui – to the delight of some but to the horror of others.

For many, Native Spirituality is viewed as an essential part of the recuperative process and, for them, replaces the imposed, organized (Christian) religion that is directly associated with the annihilation of Indigenous spiritual belief

and practices. As well, healing and Native spirituality are often inseparable, either because one turns to Native spirituality in order to heal or because healing, by definition, implies an adherence to the beliefs and practices of spirituality. Healing thus often connotes a recuperation of Aboriginal awareness, which is increasingly becoming synonymous with Native Spirituality. For others, however, this form of spirituality is not only abhorrent, but anathema to their fundamental Christian beliefs. Indeed, fundamentalist (Pentecostal) Christianity is on the rise in some Cree communities, while others continue to adhere to the older, more established churches (Church of England, Catholicism) – regardless of their origins. Yet others are attempting new forms of syncretic religious practices, readily incorporating both Christian and Native spirituality. Thus, while there is clearly a growing adherence to Native spirituality in Cree communities, there is simultaneously a vast scope of Christian belief (including Pentecostalism, Catholicism, Anglicanism) and concomitant involvement in the church. In sum, and as I will demonstrate below, at the community level one finds a tremendous diversity of expressions of peoples' spiritual practices and beliefs and hence an equally diverse sense of an appropriate programme of recuperation.

Healing & Spirituality in Whapmagoostui

I began to take specific interest in the complexity of contemporary spirituality, faith and healing as I watched what seemed to be an entire community debating exactly this issue. Indeed, I began to explore this topic in earnest when I saw it becoming a growing and on-going concern in the community where I had already conducted previous research on health and issues of identity (Adelson, 2000a). In the very small northern Quebec Cree village of Whapmagoostui there was consensus around plans to re-invigorate Indigenous cultural values and practices. There was far less agreement however about what exactly constituted those values and practices (Adelson, 1997). Differences of opinion started to emerge around interpretations of faith.

Of course, kin and social ties, networks of power including political affiliations and economic concerns (which programmes get funded, which do not) all play a role in the alliances of thought on this subject. And, while some people remain indifferent and others quietly choose from the range of options available, there seems to be an almost palpable line dividing two particular camps of opinion in one very small community: those who are ardent (Anglican) church adherents and those who are actively and avidly turning to Native spirituality. It seemed as though the debate was growing more fractious with each passing year. Indeed, with rumors of a Biblical rationale to kill one of the guest spiritual elders a few years ago, the vocal and sometimes bitter debate had reached new heights.² It was soon after that rumor circulated

²The shaking tent ceremony, viewed as an abhorrent heathen practice by the missionaries, was the term used when translating diabolical acts into the Cree language Bible.

that I decided to discuss this subject directly with particular members of the community: the church elders. I specifically chose to speak with these elders because I wanted to hear their thoughts and concerns about the growing friction in the community around questions of faith. Having been born and raised on the land and as strong and long-time adherents to the church, these elders represent a unique and valuable voice on this subject. I was not disappointed. The elders all had strong opinions, yet for the most part, presented tempered and extremely thoughtful perspectives on this all too often fractious issue.

The political rhetoric which I employ as a social scientist is, of course, absent from the voices of the elders. They employ their own political nuance, however, allowing the listener (and reader) to contemplate the range of meanings behind their words. Regardless of where the elders situate themselves, it is clear that they, along with the rest of this small community, and like so many other communities across Canada, are actively contemplating the shifts and changes in what constitutes spirituality during this time of recuperation.

Let me now present a brief history and description of Whapmagoostui. I will follow that with the interview material and conclude with some brief comments on that data. Whapmagoostui First Nation, one of the nine communities that makes up the James Bay Cree (*Iiyiyu'ch*) First Nation, is located on a small spit of land on the Hudson Bay coast at the mouth of the Great Whale River. The permanent village that now exists at this site is but a few decades old and only a fraction of the land that is considered 'home' to these northern Cree. Nonetheless, the village is where people live most of the year, with more houses being built annually as the young population continues to grow. Also located in the village are the elementary and high schools, the local government (band) offices, the church, clinic, stores, and hockey arena. This is, in other words, the main residence for most of the Cree population, but not the only residence as the entire community spends at least a portion of the year on the land and engaged in either hunting practices or the preparation and cooking of the game.³

While the Whapmagoostui Cree have lived and traveled in the northeastern region of present day Québec for well over a thousand years, prospectors and fur traders arrived in the region less than three hundred years ago and missionaries about one hundred and fifty years after that. The Cree of present day northeastern Québec continue to maintain strong, spiritually-based links to the land and animals of this region (Adelson 2000a,b; Tanner, 1978). The missionaries, however, saw Aboriginal life as spiritually heathen and worked very hard to eradicate what they viewed as abhorrent beliefs (Long, 1985; Waldram, Herring and Young 1995). Despite the sometimes kind, but all too often heavy-handed and paternalistic, modes of conversion – and to the tremendous frustration of the missionaries – the Cree belief system and the

³ For a more extensive discussion of the village of Whapmagoostui, as well as the distinctions made between village and bush life, see Adelson (2000; see also Barger, 1981).

Cree way of life (*Iiyiyu'pmatisiun*) was never entirely usurped or eradicated (Long, 1985; Preston, 1981). The following quotes from my interviews with church elders point specifically to the ways in which Cree and Christian belief *to this day* are viewed as parts of an integrated whole:

As soon as it is daylight I look all around outside, at the mountains and the trees and these things remind me that God has given us this town and all that we see on the land that grows. God has made everything that we see on earth. It is these times when we remember this that we must give thanks to God for these gifts and the land. The land is like a living person. The food of the animals is growing on the land; everything is there to sustain them. In turn, the animals reproduce every year. That is what God had intended for the land to be like, everything that he had deemed for the *Iiyiyu* to survive on earth. When I look at the plan of God, which has been going for a long time, what he had given us *Iiyiyu* on the land, including the medicines from the land, He put everything on earth for us to *live*. Everything that is beneath the land [implying the spirit world] is also always available. A person can be helped by these things if they want to know about *Iiyiyu'pmatisiun* [the Cree way of life].

[Cree spirituality and Christianity] is the same thing. The *ntuhun* (wildlife) also has a *I'chaakw* (spirit). The spirit of the *ntuhun* was the thing that told the *Iiyiyu* where to go to find the *ntuhun* when he is searching for them. The spirit of the *Iiyiyu* was the one that interpreted what the spirit of the animal has told him. His understanding of it came from his own spiritual life. That is how it was. When I mention the *ntuhun I'chaakw* (animal spirit), this spirit could not communicate to the *Iiyiyu* directly but the spirit of the *Iiyiyu* was the interpreter of the animal spirit and told what this spirit had said. As it is told in the story, we are told that when someone conducts a *kusapichikin* [shaking tent ceremony] it was his *mistapaau* that told him things. This is what I meant. The *mistapaau*⁴ understood everything and all language. The Holy Spirit understands everything. All the languages come from this Spirit. It was like when the Holy Spirit came upon the Apostles when Jesus sent them the Holy Spirit. When the Holy Spirit came upon them, the Apostles were able to speak all kinds of languages.

You must have heard when they talked about the geese and that people are supposed to watch how many geese they kill. Some people think differently about this. I have heard some *Iiyiyu'ch* opinions about this on the radio. I am only talking about the nine Cree communities. These are the only *Iiyiyu* that I can understand when they speak. Some *Iiyiyu* think that the geese are not available because it may be God's will that the geese are not growing in numbers, but there may be a reason for this. Some *Iiyiyu* make sure that the feathers of the geese are not blowing all over the place and they gather them in one place. Some people pluck outside and then the feathers blow all over the place. Some *Iiyiyu* saw some geese where the "Whiteman" hunted where they only took the breasts and left

⁴ The shaking tent ceremony was conducted in the past for a variety of reasons. In particular, though, the ceremony was when game was scarce and had to be sought out by whatever means were available to the *Iiyiyuu'ch*. The *mistapaau* is a person's spirit intermediary who is called upon to search for the spirit of the animals (and ultimately lead the hunters to the game). The tent would shake upon the presence of one's *mistapaau*.

the rest to rot. When these things happen, we are continually being watched from heaven. If we do too many bad things we are shown in some way our wrongs. That is what the old man I heard talking said. Sometimes we are shown that we have not shown respect to a certain animal and that is why it does not grow in abundance. Some others think about it differently. We cannot all think the same.

These quotes attest to the ease of transition between animistic and Christian spiritual beliefs; both elements of a congruous whole in which the inherent power of animals and higher spirit beings permeate and enhance a particular form of Cree Christianity (Preston 1981; see Feit 1983, 1986 for a comprehensive discussion of spirit hierarchies and power). Those animistic beliefs, however, are far more relevant to those who spend, or have spent, a considerable part of their lives on the land. The spirituality that so richly imbues both hunting and the land with meaning is, for the most part, lost in the village context, and for some, even in the context of current hunting practices. All of the elders with whom I spoke agree that, of course, the way of life today is very different from what it was when they were younger men and women.⁵ Yet, despite a frustration with what constitutes the contemporary Cree way of life (see quotes in footnote 5), there has been a tremendous surge of interest recently in the community to maintain and revive Cree practices and traditions. These practices are being revived in specifically designated school programmes, culture camps and annual summer “Gatherings” (Adelson, 2000b). That revival, as one elder comments however, does not supercede Biblical teachings. Nor, for that matter, does an adherence to Christianity necessarily diminish Cree beliefs or practices.

Right now even the ministers are trying very hard to understand how they have wronged the *Iiyiyu* and they are now seeing the wrong that they have done to the *Iiyiyu*. They see that it was wrong of them to tell the *Iiyiyu* to completely abandon their ways. In the community, too, the *Iiyiyu'ch* are trying to get back and are searching for what the *Iiyiyu'ch* had and are trying it (again).

I am trying my best to help out where I can with maintaining and reviving the *Iiyiyu* way of life because I know I was meant to be an *Iiyiyu* and this is where we were put to live as *Iiyiyu*. I also tell what I have seen from the Bible because I have gotten much from the Bible as it is written why I should be respectful to creation and to all people that come my

⁵Some see the changes as having come with a terrible price, although not all are quick to lay the blame solely on the effects of the colonial enterprise or “Whiteman”: “Before the arrival of “Whiteman” the *Iiyiyu* was in total control of his life, he was in total control of his destiny. It is like the “whiteman” pushed this kind of living to the side, the *Iiyiyu* way of life in the past. That is the reason we do not have that kind of wisdom and skill the way the *Iiyiyu* lived and thought in the past before his way of life and thought was messed up.”

(2) “I do not trust when someone thinks that the “Whiteman” are not good and that they are the cause of the *Iiyiyu* losing some things from their culture. The one who says that is losing something from his culture.”

(3) “[People] have abandoned what they did in the past, even though there are some people saying, “forget about ‘Whiteman’s’ ways, let us practice our *Iiyiyu* ways.” It is not the *Iiyiyu* ways that are using, it is the “Whiteman” way they are following when they eat “Whiteman’s” foods. They eat eggs, juice, and toast for breakfast. At lunchtime they eat “Whiteman’s” foods and use spices for their foods. That is not what we do, we who are *Iiyiyu*.”

way. I know that whatever talents or gifts people have, they come from God and were given by God. I know that some people do not like some of the teachings of the *Iiyiyu pmatisiiuun* that are being taught these days. I do not see which part of the *Iiyiyupmatisiiuun* I should be unhappy about because I was put here as an *Iiyiyu*. These are my own thoughts about these things but I can not tell things that I think about. All I know is that I am trying to think of people equally and feel love for them for the love they feel for their own ways.

There are a lot of things under the earth [at a different dimension or level] that are there that can help us and will come to us if we seek to know the *Iiyiyu* wisdom. It is because we have abandoned the past *Iiyiyu* way of life, that it has left us, too. If we want to go back to the *Iiyiyu* wisdom, then it will come to us, that which can help us.

Thus, the elders agree, for the most part, that the revival of past Cree beliefs and practices is a positive development for the community. Some, however, reject specific past practices that were banned by the early missionaries and emphatically refuse to condone their return.

The way that I look at it and the way I believe it is that our salvation comes from the message that Jesus brought personally to earth with him. But before He came, some of the things that happened were not very good. It is those things that I am not very interested in knowing what happened in the past. These things will not lead to salvation, only the path that Jesus made is the only thing that will bring me salvation.

Turning to a discussion of the relatively recent incorporation of Native Spirituality opinions were even more divided as some absolutely rejected any introduced Native Spirituality (although it should be noted that this Spirituality is also associated with past Cree practices such as the shaking tent ceremony. The shaking tent ceremony, in particular, remains couched in controversy as it is the most closely associated with demonic activity⁶). In the next quote, the elder reflects not only on the importance of church in his life but offers a tempered, if firm, view on the recent changes in Whapmagoostui.

I personally think that the church is more important than anything that could possibly happen. But no one is forced to go to church. No one is told, "tell your relatives to go to church." It is up to each person to decide when they will go to church. It is known that the only thing that will be saved is the words and the message spoken in church. That is the only thing that will be saved and everything else will be destroyed on earth and in the sky. That is the reason why it is said that the church is very important, because of the message given there. I personally deem it very

⁶"The reason why Moses was able to do this was because he was doing what God wanted of him. As for the Pharaoh, he was leaning more towards the will of the evil one. The evil one also has great works to show people here on earth. You must have heard what happened here this past summer [referring to the shaking tent ceremony]. That was one thing that the *Iiyiyu* was stopped completely from knowing and practicing. This kind of knowledge comes from the evil one. The *mitauun* comes from the evil one. The reason why the *Iiyiyu* did not continue to practice the *mitauun* is because when the missionaries first came here and talked to them, they told the *Iiyiyu* to forget about this and to pray all the time instead. A lot of anger resulted from this kind of knowledge when the *Iiyiyu* still were practicing the *mituchisaan* [sweat lodge] and *kusapichikin* [shaking tent]. A lot of anger came from this."

important, the religion that the “whiteman” brought to me. As soon as the *Iiyiyu* were told about religion, they abandoned everything that they did: sweat lodges and conducting shaking tent ceremonies and dancing with the drum and singing with the drum. They abandoned all these things. I have a cassette recording of an old man who died six years ago, when he was singing with a drum. He said, before he started singing, “I am singing this way because this is the way the old men of the past used to sing. This is the only thing they would do before the religion [Christianity] was made known to them.” This was the only thing they did, only before the religion was made known to them, when they wanted to find something out. As for myself, when you want to find something out, you turn to the written words, that is exactly what I do [i.e. turn to the Bible to find things out]. More and more different things are happening around us. Even the *Iiyiyu* think that they will hold onto what they know [of the religion that they now practice]. There are many things from the south that are being introduced into our village [implying Native Spirituality]. Some people do not like it, but it is brought here because some people do like it. Some people do not agree that these things should be brought in. These new things are trying to break or push the religion that we have aside. As for myself, as long as there is the church, I will not think in other terms. I can only look after myself.

As this elders sees it, Native Spirituality is not only different from Cree spiritual belief but is an *introduced* or foreign and potentially incompatible form of religious belief. While others are somewhat less intransigent about the degree to which Native Spirituality can be incorporated into other local belief systems, there remains a sense among these elders that it is still coming from outside of the community itself and not necessarily an essential ingredient in the local efforts of cultural recuperation.

We were given different ways to worship. There are different religions in Canada. We use different religions. Even we who are called *Iiyiyu*, have different knowledge that we do not have, the *Iiyiyu* of the south. They have a different knowledge that we do not have. What they have and if we wanted to mix it with what we have, it will not work. What will happen is that one of these practices, if combined, will cripple the other. Each person was given their own mind and one kind of religion, therefore it is not right for another to bother the other about their religious practices and say, “here, have this.” It is not right to do this. I have heard the minister and the Bishop saying that no one should be bothered and just have the religion that they want to have. For example, if you were to say to me, “I will be with the Pentecostals, I will no longer be with you”, it would not be right of me if I were to bother you about your decision. I am just talking about you and me. Same thing goes for me if I were to tell you, “I will do this when I hold a church service.” You should not bother me, either. It is not right to bother each other. You would do what you want to do.

It has been three years that community members have had different views about what you are asking about. We all have different opinions about what you are asking about. Some people make a great effort to educate themselves about it. Some of them really want to have knowledge about

this and some do not even want to know about it. There is a reason why people do not even want to know about it. Soon after people are born, like myself, their parents take them to the church to get baptized. When they come into consciousness [i.e. get older] and understand things, their parents tell them about the time they and others made vows on their behalf. Some people make decisions to forget about this. Some people think that when the *waamstikuushiu* [Whiteman] first came to bring this religion, the one that we are using, he was not doing a good thing when he brought them the religion. But we do not know how he did this. I imagine that he was given the power to do this. He could not have been able to do this if he was not given the power to do so.

What is happening here in our town, it is not always the 'whiteman' that brings new things into our village. It is the *Iiyiyu'ch* themselves who bring these new things. If there are many *Iiyiyu* who will be swayed to follow a different path [from the present, existing religion] by what they are being told and what they see, things will be very different from what they were before. I personally believe that if we don't fight against what is being shown in our community, if the *Iiyiyu* do not fight it, many children will be lead astray and go the wrong way.

Conclusion: Recuperation, Faith and History

The last quote is, without doubt, tremendously difficult for some people in Whapmagoostui to reconcile. While some may agree with the elder who spoke these words, there are others for whom Native Spirituality is a vital element of who they are today and, most importantly, a vital element of their recuperation. The church elders whom I interviewed are, of course, a small segment of the community's population but their voices remain central to the debate that is currently taking place in this small community. This debate, I suggest – and as challenging as it is for some of the participants in it – is part and parcel of the recuperative process in the contemporary context. Particular beliefs and practices remain, for some elders, unacceptable to their cultural and spiritual ideals, regardless of their vitality and importance for other members of the community. Yet, this heady mix of perspectives and voices signals an assertion of cultural identity in all of its richness and diversity, emerging, as it has, out of a colonial and missionary past (cf. Voyle and Simmons, 1999; Warry, 1998).

I began with a quote from a 19th century missionary's journal as he detailed the way in which he ministered to – or, more realistically, missionized and colonized—Indigenous peoples' souls and bodies. The colonization of First Nations peoples did not begin with the church yet that institution's fervent involvement in the process remains one of the most potent symbols of penetration into and eradication of the cultural and spiritual core of Indigenous communities. The effects of the missionization process resonate loudly in the post-colonial context; indeed, the struggles to assert and maintain cultural and spiritual identity to a large extent define this period. Too often, however, when we discuss the post-colonial period we assume

clearly delineated divisions between those who colonized and those who were colonized. As indicated here, however, we cannot draw a simple line dividing the two. Regardless of its history of penetration, Christianity today is as important and fundamental an aspect of spirituality for some as Native Spirituality is for others.⁷ The recuperative process, in other words, is not occurring (nor should it occur) in any sort of neat or readily defined fashion. The process is as complex and varied as the individuals and histories that make up First Nations communities today and it is that complexity of faith in this particular moment in history that we must more fully understand in order to appreciate the extent and vitality of a community's process of recuperation.

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⁷ Increasingly as well, that debate is being tempered by the active involvement of a growing number of youth who see the more universal spirituality as a venue for an expression of their faith and sense of identity. This more abstracted form of spirituality, perhaps far removed from bush life, is more readily accessible to a generation more familiar with hockey arenas and the Internet than with full-time bush living.

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Negotiating Health: Meanings of Building a Health Community in Igloolik

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Abstract: At the intersection of institutional, local and personal perspectives, this paper explores what it means to build a 'Healthy Community' in a Canadian Arctic hamlet. Neither the dominant concepts of critical theory nor those of institutional health promotion can sufficiently account for the ways in which Healthy Community discourse and values are engaged locally. Instead, a qualitative understanding of social context and everyday practice informs an examination of the health promotion and wellness values of 'community,' 'participation' and 'empowerment' in the lives of Inuit participants. The results suggest some ways in which these key concepts are variously adopted, transformed or infused with particular meaning in the context of both personal and political identity and experience. By destabilizing the apparent consensus in institutional health promotion discourse and by recognizing that there is a multiplicity of meanings and practices surrounding the Healthy Community, the concept can continue to inspire innovation in health strategies.

Résumé: Au carrefour des perspectives institutionnelles, locales et personnelles, cet article explore ce que signifie construire une «Communauté en santé» dans un hameau de l'Arctique canadien. Ni les concepts dominants de la théorie critique ni ceux de la promotion de la santé sur une base institutionnelle ne peuvent adéquatement expliquer les façons par lesquelles s'articulent concrètement au niveau local le discours et les valeurs inhérentes aux Communautés en santé. Plutôt, une compréhension qualitative du contexte social et des pratiques ordinaires de tous les jours contribue à jeter un éclairage indispensable sur l'examen de la promotion de la santé et des valeurs associées au bien-être véhiculées par les termes de « communauté », de « participation » et de « responsabilisation » dans les vies des participants Inuits. Les résultats obtenus suggèrent quelques façons par lesquelles ces concepts clés sont diversement adoptés, se transforment ou en viennent à revêtir des significations particulières à la fois dans le contexte de l'identité et de l'expérience personnelle et politique. En déstabilisant le consensus apparent dans le discours institutionnel de la promotion de la santé et en reconnaissant qu'il y a une multiplicité de significations et de pratiques qui entourent la Communauté en Santé, le concept peut continuer à inspirer l'innovation dans les stratégies de la santé.

In recent years, the approaches to population health in general, and Aboriginal health in particular, have undergone considerable changes that now align them closely with strategies in health promotion and community development. Within this framework, notions of identity and community have become central to health discourse, though often in very different ways. The

institutional perspective of these notions, for instance, structures health promotion practice, but the local perspective can often challenge it. This is precisely the reason to consider them closely in the health care establishment.

The sector within the health establishment that is of interest to me here is known as the New Public Health. This is the practice of promoting health holistically through social and community development. It is based on the idea of building what is known as a *Healthy Community*. This strategy is among the most progressive trends in public health, moving the emphasis away from strictly biological or lifestyle factors that influence health status. It broadens the determinants of health and enlists diverse sectors of society and otherwise unconnected sectors of government to acknowledge their affect on health status and to put health on their policy agendas. It also encourages direct community participation in health sector planning and decision-making.

While some municipalities have become known for their high profile *Healthy Cities* and *Healthy Communities* projects, the term has also come to represent an unofficial social movement and organizational focus for governments' population health policy. This has created a new language, theory and expertise in the health care arena, at the heart of which are the principles of community, participation and empowerment. The government of the former Northwest Territories set the tone for this realignment of health policy in the north with its 1995 directions document:

In a healthy community, the community takes care of its own problems in ways that support wellness. The community controls or at the very least, is actively involved in, programs and services that serve community residents. When the community is not involved in the delivery of social programs, it cannot take on the responsibility for solving its problems (GNWT, 1995).

Over the course of the past few years, I have had the opportunity to witness this shift, working with both Inuit and non-Inuit community-based researchers on mental health promotion and community wellness research projects in Igloolik, Nunavut. These qualitative research projects ranged from preliminary work for suicide prevention strategies, to participatory evaluations of early childhood programs. Throughout these projects, an abiding interest has been on the use of certain expressions from the policy discourse in which they are embedded: "community wellness," "building a health community," "community empowerment."

All of our research seemed to fit seamlessly into this institutional and public discourse, which itself is assumed to reflect essential Aboriginal values of community and solidarity. However, considering interview and research data that continued to reveal some profound personal struggles, it is worthwhile to try to understand the consensus implied by these policy expressions, compared with the varied, complex and sometimes deeply painful accounts from people themselves. Indeed, little is known about the way in which health promotion directives operate at the level of families and individuals.

Through discussions and interviews, the Inuit researchers and project participants had a lot to teach about what works and what does not work in health and wellness promoting strategies. In particular, using local, personal and cultural realities to confront the principles of community, participation and empowerment, they helped to uncover a fundamental tension in the way we conceive of these concepts.

On one hand, the consensus surrounding these concepts may actually ignore important local diversity; it may assume that everyone has the will and the resources to participate in organized strategies for health and well-being. These assumptions can lead to frustration at the front-line when community participation is low and when incidents of “unhealthy” behaviour persist. They can also obscure the fact that ideas of community, participation and empowerment are built on culturally and socially bounded notions of responsibility, authority and social relations, which for some, may demand new ways of interacting socially.

On the other hand, this is not to say that the idea of a Healthy Community is not a productive and mobilizing force. Indeed, quite the opposite is true. In Igloolik, many people point to Healthy Community and community wellness strategies and programs as important practices that foster personal and cultural strength, awareness and resilience. This is echoed in Canada’s *Royal Commission on Aboriginal People* (RCAP) in which it is suggested that “many of the problems now confronting Aboriginal communities can be addressed more effectively in a health promotion framework rather than from a curative approach.” In RCAP, “illness” has been described as “loss, multiple losses, loss of ways of life, loss of language, loss of ceremonies and traditions. Loss of land base. Loss of meaningful control over day-to-day life.”

Given this tension, conventional critical social science is inadequate. It has been used to claim – among other things – that holistic health promoting strategies do the following: create a new public morality; reduce the responsibility of governments; oblige citizens to participate; force consensus; and expand the power of outside experts (Lupton, 1997, Peterson & Lupton, 1996). All of this is true in some cases, but such a critique also remains distant from local issues and local practices of health. It misses the instances in which consciously appealing to and perpetuating Healthy Community discourse is locally and politically important. Thus, a subtler and more flexible method of analysis is needed to attend to local words and practices that are both culturally rooted and influenced by political, economic and historical realities. This approach must account for people’s own role in shaping the Healthy Community discourse and often, shaping themselves accordingly (Lock & Kaufert, 1998).

Take first the notion of community. It is standard lexicon in the policy documents, consultants’ workbooks, community developers’ training manuals and resource kits provided by Health Canada. Sociologists Rachel Jewkes and Ann Murcott have suggested that the community itself is actually constructed through these documents: “mission statements, handbooks, even job

descriptions are technologies through which institutions define and operationalize their particular perspective on health and community development” (Jewkes & Murcotte, 1996; 1998). But who exactly is the community to which these documents refer? The planners, coordinators, front-line staff and members of the public who participate in a particular program become “the community.”

From the perspective of mental health promotion, the issue is even more layered. Community is defined not only by participation; but it is also invoked for its *sense of community* – a social integration that has long been considered a supportive and protective factor in health promotion in general, and mental health promotion in particular. Given that these are the premises on which public support for community-based programs rests, a shared holistic vision of community and participation must be constructed locally to ensure adequate delivery, evaluation and justification of initiatives structured around federally sponsored programs.

By contrast, individual experience of Healthy Community principles is shaped and determined by complex and interacting factors. Some of these include: socio-economic conditions, gender, family, religion, as well as larger forces such as colonialism and global economic forces (in the north, for instance, the European seal ban of the 1980s). Thus the transition from theoretical and political ideal to practical action and intervention involves some negotiation. For instance, Inuit columnist and social commentator Rachel Qitsualik reminds us that due to a history of colonisation, some Inuit might have very complex and ambivalent relationships with their communities:

The problem is that many hamlet dwellers do not consider their community to be home and understandably so... The communities seem like artificial constructs, as if Inuit were being made to play Qallunaaq. They know that their true home stretches across a quarter of the Canadian Arctic itself... Consequently, no one actually feels ownership over a hamlet. They have never planned it, never fought for it, and most certainly did not build it. A settlement of people only becomes a true community when sufficient numbers of people come to call it home and are willing to work for it (Qitsualik, 1998:31).

This comment is significant because it is at once a call to community action and at the same time a historical explanation for sometimes not being able to act collectively. It demonstrates that a sense of community cannot be taken for granted. Instead, there can be as many ways to construct community as there are voices and life histories within it. This is especially true given the speed of change in Igloolik. The perspective of Elders, adults, youth, women and men vary according to their own experiences. A few examples from interviews in Igloolik will help to demonstrate the actual diversity of what is commonly glossed simply as “the community” or a “sense of community.”

Many older people for instance often described a remembered community—that of the extended family, rooted in a time when social integration and community cooperation were necessary to the very survival of family camp

members. In contrast, the children of these Elders constitute a transitional generation that moved into the settlement as young adults. They echo Qitsualik with some ambivalent feelings about community:

There are too many people who came from different camps, before moving here. There were people living at outpost camps before the government told them to move here. Because we're from different places, there's too many things happening to the younger people, even the older people.

It is not surprising then, that both men and women of this generation often spoke of community not only in terms of family as many of their parents had done, but of changes within family structures shaped and constrained by multiple and complex demands that were imposed by community (that is, settlement) life.

For many teens, community as a source of support was often associated most closely with social networks of friends. As a female high school student expressed it: "To be well and healthy, hang out, definitely hang out with friends who agree with you and accept you for who you are."

These examples suggest the notion of community is interpreted and experienced in a variety of ways. However, there are at least two special circumstances with the power to transform meanings and transcend any diversity in these interpretations. The first case is a sense of community solidarity that is felt within the context of tragedy. One woman echoed many others when she suggested that mental health promotion strategies are able to reach a lot of people because suicide affects a lot of people: "people won't feel like they are the only one feeling this way." High school students agreed: "When there's problems in the community, that's when you realize that people care."

A second cross-cutting theme that reinforces a sense of community is the current historical moment. To many, the creation of Nunavut and in particular its implications for Igloolik as the headquarters for new government agencies, differentiates insiders from outsiders. A male high school student expressed it this way:

I heard that a lot of new people are going to come up here and look for jobs and we're going to have to make new friends with these people. And people from Igloolik are going to have to move out to look for jobs too. Lots of people coming in and moving out. So we're going to have less family to talk to I think. I might even have to leave for the career I want to achieve.

I have touched on some of the diverse circumstances in which are inscribed feelings of community. As many Inuit pointed out, a sense of community is most often expressed through people's actions. However, comparing their actions with conventional thinking in health promotion reveals yet another level of negotiation—this time surrounding the notion of participation.

Citizen participation has been called the cornerstone of a Healthy Community because it is intended to operationalize strategies for personal and collective empowerment and participatory democracy (Flynn, 1996; Raeburn & Rootman, 1998, Wilson, 1996). But as the following account from Igloolik demonstrates, simply trying to identify what is meant by participation can be difficult, especially when it is described (prescribed) from afar.

I met with the staff of an early childhood program as they were completing a self-evaluation questionnaire for their federal funders. The government needed to know how frequently parents participated in program planning, management and decision making, and whether it is difficult to get them involved. These questions sparked an animated discussion among staff members: 'What do they mean by involvement? How about the fact that a lot of parents like bringing their kids here now, and more parents are talking with each other?' The staff members were hoping that this type of involvement would count for the purposes of evaluation.

This example illustrates that the way in which participation is perceived by community members may take many paths. Some of these might be the high profile social development planning or committee work. However, the meaning of participation is often redirected and follows implicit interpersonal channels and everyday ways of 'being there for someone'. Indeed, this interpersonal support and profound sense of social responsibility structures many people's sense of participation. However, as became evident from interviews in Igloolik, acting on this goal can be quite difficult. Depending on their position within the community, people discussed a variety of barriers to institution-driven forms of community action.

For instance, Inuit social policy planners speculated that the impetus for community action was suppressed by a taught dependency on the colonial state and government over-service. From the perspective of women, while many are vocal at the forefront of political and social action, most have multiple responsibilities and sparse resources that limit their access to other activities. For their part, teens were motivated to organize around youth causes but issues of trust, self-esteem and the need for mentorship seemed to be considerable impediments.

Given the range of subtle barriers to organized community participation, there emerged a popular conception that the ideal candidate for community and social development work should be someone who is 'strong enough' to do it. To be strong enough often means to be able to maintain the necessary level of professionalism, distance and objectivity required in a southern style institutional setting, while remaining anchored within community and family affairs – a nearly impossible situation in northern and remote communities. Thus, for many in the helping field, being the strong one means that personal and emotional resources are over-burdened and compromised, which gives rise to the constant threat of burn-out.

To simply enumerate barriers would be to tell only half the story, however. The forms of participation that are valued, honoured and respected locally may not be as explicit as health promoters and policy makers would expect or hope, but front-line workers know that bringing children to the preschool and having coffee with other parents for instance, are real and significant ways of becoming involved in community affairs.

Perhaps even more significant from the perspective of many research participants, is the care taken to listen to a troubled friend or family member, to advise someone, or to share resources and traditional country food. These themes are consistent with what Elders and oral histories collected in Igloolik tell us about traditional social relations: *naalaktuq*, the learned balance between respect for another's autonomy and social obligation, which is structured by *ungayuq*, one's social identity and place within the family.

It would be inappropriate however, to consider these interpersonal channels of mental health support simply as the informal sector. Indeed, as one Inuit frontline worker pointed out, this sector can be considered 'informal' only the sense that it operates independently of institutional resources. Otherwise, it is a structured process of advice seeking and giving, which involves specific people within an individual's network of relations and friends. For instance, couples might consult the *Issumataq* (Respected Elder of the kin group) with relationship concerns. This is a reminder of the abiding importance of *ilagiit* (extended family) in defining and structuring modes of participation.

All of this is not to say that organized and collective social or political action is foreign to Igloolik. As sociologists and community developers have noted, the nature of community participation changes over time (Warry, 1998). Communities act politically and socially, but only under special circumstances (e.g., suicide clusters, trauma) when issues are cross-cutting and mobilizing. More frequently, the perception of involvement is shaped according to everyday strategies of health and helping.

The government's agenda for First Nation and Inuit wellness does recognize that there is a continuum of types of participation. Yet despite acknowledging the importance of family and social integration, the overall vision of conventional strategies privileges action toward self-improvement and collective empowerment, the logic being: the more people are themselves enabled, the more likely it is that they can contribute to social development.

While this logic has often proven powerful and effective, it also makes a conceptual leap between individual and society, as though people were unattached to intermediate structures such as families or social networks. Thus, within the institutional discourse, social and family networks remain unexamined, uncontextualized and incidental to the social development process, rather than becoming its focal point. This risks misunderstanding or by-passing the interpersonal relations that many Inuit themselves emphasize as important modalities of participation and strategies for wellness and a healthy community

Nevertheless, the bureaucratic discourse of the Healthy Community still links this particular vision of participation with the ability to be empowered. Considering that participation itself is mobilized in diverse and sometimes subtle ways, however, how can empowerment be fostered? Indeed, how does our theoretical understanding of it fit into the lives of individual Inuit?

As a third organizing principle in the discourse of building a Healthy Community (and the last one to be considered here) empowerment is perhaps the least well defined. A multidimensional concept, empowerment is thought to function at individual, community and political levels (Labonte 1990). It is linked to increased health status because the more people have control over the factors that affect their health, the healthier they will be.

Conventional thinking on empowerment assumes that it is embedded within a spectrum of actions by which individuals or groups can appropriate the power to determine and act on their own goals. This ranges from self-development to public consultation and planning, to transfer of health and social service to community control. Given the years of “colonial medicine” in the north (which is beyond the scope of this paper), empowerment at all levels represents a welcomed and long-awaited opportunity.

In practice however, local examples do not necessarily correspond exactly to theoretical ideals. In Igloolik for instance, it became apparent that the accounts most closely resembling the conventional sense of empowerment were not at all about the self-oriented appropriation of power or control. Instead, they described finding a confident place from which it is possible to take action. In short, both individual and collective examples of empowerment were closely aligned with the notion of *trust* across a range of people and in a variety of circumstances.

As a compelling theme, trust is mentioned but not adequately addressed in either health promotion or community development literature which takes it for granted that empowerment is the obvious result of participation. However, as Inuit emphasized, the ability to trust is both a prerequisite and a goal of the entire participation /empowerment process at all levels.

For example, at the political level, as the balance of power slowly shifts under the Nunavut administration, there is an expressed need to rebuild (or build) trust in a system, which since its inception, has privileged the assumptions and agenda of a southern bureaucracy. At a personal level, empowerment implies a sense of self-esteem and control over personal life that will lead to better health status. However, as so many young men in the suicide prevention project emphasized, the need to establish trust is perhaps most important here. They suggested that involvement in the self-help strategies, which are intended to foster personal empowerment, will not occur if potential participants cannot first establish the trust necessary to share their feelings.

These examples suggest that the tools for empowerment (individual and collective) are not necessarily found in its imperative to public action and the unidirectional appropriation of power for one's self or one's group. Rather, empowerment is relational and its strength is in the negotiation of trust. This considerably broadens the conventional notion of empowerment.

This discussion has demonstrated that the interpretations of community, participation and empowerment reflect some of the assumptions made in operationalizing them from an institutional perspective. For instance, when reinforced by formal bureaucratic structures which define community and set parameters for participation, an apparent consensus can actually alienate and indeed disempower the very people whom Healthy Community and health promotion movement is intended to reach: those who feel marginalized from the existing structures of power or social supports.

By contrast, we have also seen the ways in which the principles are variously adopted, appropriated, redirected or infused with new meaning in local discourse. Consequently, this discussion offers at least a hint of the underlying negotiations and complexity involved in what seem to be a common sense truth: building a Healthy Community. In so doing however, it does not discount the importance of this notion locally. Instead, it acknowledges that people involve themselves through the practices that they determine are possible and culturally, as well as interpersonally, important.

As Warry (1998) has noted for First Nations communities in southern Canada, there is a subtle difference between creating a supportive atmosphere for promoting wellness and a Healthy Community, and promoting approaches that "institutionalize" community healing resources and capacity (and in so doing, continue the colonization of community life). In Igloolik, like in all communities, there are important ideological divisions on issues and practices that are close to people's hearts – ways to heal, ways to contribute to society and ways to become empowered. These divisions should not be ignored.

The diversity of skills and differences in opinion, both within the community and between community and institutional bureaucracy is a source of creative tension; it is fuel for dialogue and innovation. Only by paying attention to diversity, constraints and apparent challenges, can Healthy Community values be translated into health promoting strategies that are truly responsive to the variety of local needs. Greater and more open dialogue, along with continued critical reflection, will only complement a move toward increased solidarity and community integration.

I will leave you with a few thoughts on some of the implications of this type of reflection and the actions that they may encourage. These could include:

Within governments: Encourage flexibility in the bureaucratic structures that supply resources and training and flexibility in program evaluation.

Within clinical and health promotion practice: Develop programs and intervention strategies that build on existing social and family networks. Such a model is already being tried in Igloodik's Early Intervention Project. This innovative resource for early childhood education combines the openness and community scope of a drop-in center, with more tightly focused programs that cater to the various requirements of children, youth and family support. The program can expand or narrow its scope according to the needs and wishes of individual families, emphasizing flexibility over institutional processes.

Within research: Support and carry out research over a long term, and build relationships with communities that will include local voices in theoretical debates. Find ways to respect and represent local diversity without undermining the political master narrative such as self-government or devolution of health services.

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The Problem of “Culture” and the Counseling of Aboriginal Peoples¹

James B. Waldram

Abstract: This paper will critically examine how the concept of “culture” has been conceptualized and operationalized in cross-cultural counseling, with emphasis on counseling and psychotherapy with North American Aboriginal peoples. Particular attention will be paid to the problems inherent in the “handbook” approach, wherein short descriptions of cultures are provided to practitioners to serve as guides when treating specific patients. The paper will examine the historic roots of Aboriginal cultural portraits as well as contemporary perspectives.

Résumé: Cet article examinera d'un oeil critique comment le concept de «culture» a été conceptualisé et opérationnalisé dans le conseling transculturel, en plaçant l'emphie sur le conseling et la psychothérapie menés auprès des personnes autochtones d'Amérique du Nord. Une attention particulière sera accordée aux problèmes inhérents à l'approche du «manuel», une approche où de courtes descriptions des différentes cultures sont fournies aux praticiens afin de leur servir de guides lorsqu'ils traitent tel ou tel malade en particulier. L'article examinera les racines historiques de portraits culturels autochtones et abordera aussi des perspectives contemporaines.

Introduction

Throughout the decade of the 1990s, I was engaged in anthropological research in a variety of western Canadian prisons, both provincial correctional facilities and federal penitentiaries. The broad aim of my research was to understand the intersection of culture and forensic treatment, looking specifically at treatment issues pertaining to Canadian Aboriginal inmates. My intent today is not to revisit that research, which has been published elsewhere (Waldram, 1997), but rather to turn a critical eye toward the issue of culture in prison. Specifically, my work in the prisons, and especially my interactions with psychologists, psychiatrists, addictions' counselors, forensic nurses, and social workers, has lead me to ask two, interrelated questions: what do the mental health professions think they know about Aboriginal peoples, and on what basis do they think they know it? These are broad questions, and ones that can't be addressed in their entirety in this short paper. Here, I wish to focus on one very small part of the inquiry, the issue of counseling and psychotherapy with Aboriginal peoples. In particular, my aim today is to investigate how the notion of Aboriginal “culture” is reified in the day-to-day processes of the therapeutic encounter. I am less concerned with psychological pronouncements defining culture than I am with the type of

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knowledge delivered to the practitioner who is faced with the task of delivering mental health services to an Aboriginal client. Narrowing the task still further, in this paper I will look specifically at one dominant theme in the mental health training literature: the existence of different, culturally-based ethics, values and behaviours among Aboriginal peoples.

Before I begin, however, a note on the terminology. Since I am dealing here with phenomena on both sides of the border, different terminology will be required. I will use “Aboriginal peoples” when referring to the Indigenous peoples of North America, “American Indian” and “Canadian Aboriginal” when referring to the Indigenous peoples of those countries, but will try to retain the terms used by specific authors where appropriate, such as in the use of the term “Native American.”

Cultural Competence

Culture, cognitive anthropologists tell us, is good to think, and indeed anthropologists have been thinking about it for over one hundred years. The mental health professions, in contrast, have come to culture somewhat more recently (Cole 1996). Counselors and psychotherapists, insofar as they are compelled to think about culture at all, find themselves in situations in which it is expected they can, and will, move beyond simply a general understanding of “culture” as a human construct that imbues our existence with meaning. To consider culture, they must think about cultures. They must not only operationalize the concept, they must generate what might be thought of as an *applied* understanding: what does *culture* mean in the clinician’s or therapist’s office? It is the need to generate such a practical meaning that has led to two, somewhat parallel processes: the generation of the notion of “cultural competence” (a.k.a. multicultural competence), and the development of “handbooks” to guide the therapeutic encounter whenever a cultural “other” enters the scene. As I shall argue, these two processes are somewhat at odds.

The notion of cultural competence currently in vogue within counseling psychology is grounded in the 1982 work of Derald Wing Sue and his colleagues (Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vasquez-Nuttall, 1982; Sue, Arrendondo & McDavis, 1992),² scholars who issued a call to the mental health professions to adopt specific criteria for assessing the extent to which counselors and psychotherapists could successfully operate across cultural boundaries. The cultural competence movement is a reaction to “cultural encapsulation,” in Paul Pedersen’s words, the imposition of “a dominant-culture perspective on counseling without being sensitive to cultural diversity...” (Pedersen, 1994: 262; see also Pedersen, 1976, 1997; Wrenn, 1962). Psychology as a field has been described as one that is burdened by cultural encapsulation, in which cultural context is seen as

²For other discussions of the concept of cultural competence in social service delivery, see, for example, Cross, Bazron, Dennis, and Isaacs (1989), Olandi (1992), and Ronnau (1994).

irrelevant (Pedersen, 1994). Newly emerging notions of “multicultural counseling” (e.g., Pedersen, 1994; Ponterotto, Casa, Suzuki and Alexander 1995) and “culture-centered counseling” (Pedersen, 1997) have challenged this idea. This is surely a welcome development.

Cultural competence involves three basic components: being aware of one’s own culturally-based assumptions, biases, values and worldview; actively attempting to understand the worldview of culturally different clients; and developing culturally appropriate and sensitive treatment strategies (Sue & Sue, 1990; Sue, Arredondo & McDavis, 1992; Pedersen, 1994: 263; Este, 1999).³ Sue writes that what is required is a general understanding about “how race, culture, ethnicity, and so forth, may affect personality formation, vocational choices, manifestation of psychological disorders, help-seeking behavior, and the appropriateness or inappropriateness of counseling approaches” (Sue, Arredondo & McDavis, 1992: 485). But also required is a more specific cultural understanding; according to Sue, counselors must be “aware of the life experiences, cultural heritages, and historical backgrounds of the culturally different clients” (p.267). Furthermore, it is suggested that the “normative characteristics of cultural groups” be identified to enable counselors to understand culturally different clients and to utilize appropriate treatment techniques (Ridley, Mendoza & Kanitz 1994; Ridley, Espelage & Rubinstein, 1997). Pedersen (1997) has acknowledged that these represent two somewhat different approaches. The first, the “culture-general model,” emphasizes the development of knowledge and skills for work in complex multicultural settings without the focus on specific cultures. It presumes that self-awareness of one’s own cultural identity is an important first step in developing the ability to recognize, respect, and work with culturally different clients; the emphasis is less on specific cultural differences between counselor and client and more on comprehending the effects of cultural barriers (Pope-Davis & Dings, 1995). A logical weakness might be perceived to be the lack of specific cultural knowledge.

The “culture-specific model,” in contrast, emphasizes the acquisition of knowledge about specific groups. According to Pedersen (1997:272), “Its strength is that it provides a deeper and more comprehensive understanding of one potentially salient client identity feature. Its weakness is that it presumes that each client has only one primary cultural identity across situations and over a period of time.” Psychologists have developed instruments to assess the cultural competence of counselors (Pope-Davis & Dings, 1995). However, as Janet Helms and Tina Richardson (1997: 71) argue, “few psychologists have attempted operationally to define and assess culture in a manner that moves beyond mere racial or ethnic group classifications,” and therefore the challenge to become culturally competent often excludes information on “what psychologists are expected to do or to know.”

³The concept of “culture assimilators” parallels that of cultural competence. Culture assimilators are “critical incident” or real life scenarios, which are often used as tools in cross-cultural training, especially in the context of international business relations. Both culture-general and culture-specific approaches are often involved. See Flanagan (1954), Brislin, Cushner, Cherrie and Yong (1986), and Bhawuk (2000, in press), for a discussion of this approach.

According to Sue and his colleagues (Sue, Bernier, Durran, Feinberg, Pedersen, Smith & Vasquez-Nuttall, 1982:50), “The greater the depth of knowledge of a cultural group and the more knowledge he/she has of *many* groups, the more likely the counselor can be an effective helper” (italics original). But how is either the general or the specific cultural knowledge to be pursued? In terms of the culture-specific model, it is suggested that the counselor be familiar with the literature on cross-cultural counseling for specific groups (a somewhat problematic strategy, as I shall discuss momentarily). But it is also suggested that this knowledge come from active involvement with the client’s culture outside of the clinical setting (Pedersen 1994:268). Anthropologist James Green (1999) advises that therapists utilize key individuals as cultural guides and engage in participant-observation, two well-established anthropological techniques. But most anthropologists would caution about the enormous amount of time this takes, especially if one is unfamiliar to and with the culture in question. This strategy might work if the counselor is based in or near a singular Aboriginal community, for instance. However, given that counselors are likely to treat individuals from many different cultures, how reasonable is it to expect that they will truly engage in this type of knowledge gathering? The logical answer to this question opens the door to the “handbook” approach, collections of short cultural profiles, despite the protests of individuals such as Green (1999) that cultural competence does not simply involve the production of cultural trait lists. While Green argues forcefully that “there are simply no shortcuts,” that “no one-day workshops or list of intervention tips and guidelines will give anyone the skills for working well with others. . .,” the caution may fall on deaf ears in a counseling world full of quick fixes to the problem of culture. Certainly the bulk of the counseling literature with respect to Aboriginal peoples has followed the culture-specific, handbook model, but with a twist: while there is a tendency to emphasize the heterogeneity of Aboriginal cultures as a homage to the culture-specific model, there is also a tendency to conclude that there are significant cultural similarities. In effect, treating all Aboriginal peoples on the basis of these cultural similarities allows for the easy implementation of culture-specific approaches. If you know one, you know them all.

Handbooking Ethics, Values and Behaviors

A major theme in the Aboriginal counseling literature is the need to understand and appreciate the ethics, values and clinical behaviors of Aboriginal clients as central to the process of providing psychotherapy and counseling. As I have noted, there is a clear tension evident in the counseling literature: while, on the one hand it is often stressed that Aboriginal peoples are an immensely culturally diverse population, on the other hand it is all too frequently argued that there are core or universal Aboriginal ethics, values and behaviors. Let’s turn to this idea first.

Edwin H. Richardson, a psychologist of “Abnaki/Ute extraction” published some influential work on Indian values in the late 1970s and early 1980s.

While his work appears to be based on Sioux peoples, this fact is somewhat disguised in favour of a strong assertion regarding the commonality of basic values in all Aboriginal groups. Without citing a single source or indicating how he determined them, Richardson (1977:6-9) presented a list of 37 Indian values, each compared to a corresponding “White” value. Table 1 presents several of these comparisons. Richardson explained the counseling implications of these ethics, values and behaviors. For instance, how the office is configured was considered important; Richardson (1981:235) advised that “Since the Native American is humble and unpretentious, we suggest you have a small, homey, and lived in office,” with pictures of Indians on the walls. When greeting a Native American, a soft handshake is important because “it is typical of humble people to shake hands in such a manner” (1981: 236). In a reference to non-verbal behaviors, he emphasized the need to listen to and observe carefully Native American clients. “Native Americans will give you clues with their bodies, eyes, and tone of voice; but do not expect them to be as ostentatious, flamboyant, and dramatic as white clients. Rather, the clues they give are on a subliminal basis that many people miss” (1981: 233). A non-directive technique was advised, especially for non-Native American counselors, even though “The Indian expects direction” (1981:239). But, Richardson cautioned, while being sensitive to “this groups values and achievements,” “American Indians can almost feel a phony person. It is almost as if they had antennae that pick up signals, or as if the insincere person gave off a chemical that betrayed her or his insincerity, or maybe it is something like infrared or electrical vibrations” (1981: 248).

Table 1. Selected Comparison of Indian and White Values (Richardson, 1977)

<i>Whites</i>	<i>Indians</i>
Success is paramount, generally involving security, wealth, attainment	Happiness is paramount
Ownership	Sharing
“Think of number one” syndrome	Tribe and Family First
Competitive and believers in “if you don’t toot your own horn who will?”	Humble – causing them to be passive-aggressive
Flouting and Openness - “What you see is what you get”	Discrete – e.g. dating is restrictive
Look to the future – “tie your wagon to a star and keep climbing”	Look backwards to traditional
Work, earn money, save; make routine and habits a part of your life	Work for a purpose – once you have enough then quit
Don’t be a “boat rocker”	Be as free as the wind
Empiricism	Intuitiveness
Scientific	Mystical
Be sophisticated, eat your foods well prepared	Live natural, eat things raw – “remember your brother the fox”

Obviously I am not presenting the entire list here. However, two key points should be made about it. As Table 1 shows, in comparing values, directly comparable contrasts do not always appear. Similarities in values are also not mentioned; that Richardson may believe there are no similarities is evident in his comment: “No two races could so grossly differ in value systems than the Indian and the white” (1977: 6). Perhaps more interestingly, the sum of the Indian values presents a primitivistic portrait of a people who are egalitarian, free from interpersonal constraints, mystical and intuitive, and who are “natural” people, preferring their food raw. Clearly, they are also a people living in the past, and quite possibly entirely in Richardson’s imagination.

One should not conclude that Richardson’s work represents a by-gone era, however. Dozens of articles published up to and including 1999 have presented similar lists of ethics, values and behaviors. James Green, for instance, produced the list in Table 2 in 1999.

Table 2. “Selected Cultural Contrasts” (Green, 1999)

<i>Native American</i>	<i>White American</i>
Cooperation and sharing are highly valued; individualism, assertiveness and impulse are discouraged	Early displays of individualism and life-long care for the needs of the self are considered normal and even healthy
Noninterference and respect for the rights and choices of others are highly valued. Confrontation is rarely appropriate.	Assertive (but not aggressive) speech and behavior styles are favored. Leadership and individual achievement are honored
Pacing the activities according to the needs and expectations of others is more important than observing clock time and abstract schedules	Punctuality, promptness, and adherence to abstract time schedules are critical to success
Elders have important ceremonial and sometimes political roles; their views count	Elders usually live apart and are not expected to exercise political, ceremonial, or financial control over others

Table 3 is a partial listing of the most commonly declared universal American Indian ethics, values, and behaviors that are considered by the commentators to be relevant for counseling. There is persistence through time of this core set, from the early 1960s to 1999.

Table 3. Commonly Declared Universal American Indian Ethics, Values and Behaviors

- lack of eye contact
 - soft handshake
 - reticence/shyness
 - emotional restraint
 - passivity/submissiveness
 - a being activity orientation
 - humility
 - non-competitiveness
 - cooperation
 - giving/sharing/generosity
 - harmony (with others)/ avoid disagreement -
 - kindness
 - harmony with nature
 - present time orientation
 - lacking in time consciousness
 - respect for age/elders
 - individuality/autonomy/personal freedom
 - non-interference
 - holistic worldview
 - extended family orientation
-

An examination of the inter-connections between articles on ethics, values and behaviors reveals the relatively weak base upon which the universality argument is situated. Much of the work is simply an uncritical replication of ethics, values and behaviors presented by other authors. Several authors relied primarily on their own circumscribed clinical experiences with specific Aboriginal groups with no indication of empirical research, and then extended their limited observations to all Aboriginal peoples. A review of several dozen of the most commonly cited works reveals that only a handful have been based on empirical studies undertaken by the author. Of these, psychologist Joseph Trimble's published work is probably cited the most. This work was based on two studies (Trimble, 1981). The first involved the use of a sentence completion instrument in 1971, administered to 84 Indians and 137 non-Indians in southeastern Oklahoma. A second study, undertaken in 1973, involved the use of a small group of American Indians to generate a list of common values, which were then tested with 791 American Indians from five different regions of the country. The values identified and then tested in this process were: kindness, honesty, self-control, social skills, social responsibility, reciprocity (altruism), and independence. Statistical analyses concluded that there was close agreement between the five Indian groups on the desirability of the seven values.

Can we comfortably conclude from Trimble's experiment that these seven elements are important, universal American Indian values? Trimble (1981:214) himself noted, importantly, that "the seven value subscales are broad enough to be generalized to many subcultures." This clearly suggests that there is little

we can say with confidence, for if the values do not differentiate American Indians from others, of what utility are they? Some of the groups in the sample are known to have cultures very different from each other (e.g., the Pueblos and the Northern Plains). This may provide some support for the idea of common American Indian values despite the cultural heterogeneity. But another possible explanation is evident: given the possibility of the more-or-less uniform effects of culture change pressures on all American Indians, it is certainly possible that Trimble is really identifying broader American values absorbed by these American Indians, or perhaps a merging of American and American Indian values, or even the influence of an emerging pan-Indianism. Perhaps the underlying problem relates to the construct validity of his instruments which results in the homogenization of data. Indeed, the values listed are so general as to force agreement with Trimble's caution in this regard. Are not kindness, honesty, and altruism, for instance, also "American" values?

Miles Zintz (1969) is another scholar whose work on ethics, values and behaviors is often cited as foundational, yet a close examination underscores the vulnerability of the knowledge claims about American Indian values and counseling. Zintz, in a volume about cross-cultural education in the American southwest, presented a discussion of the cultures and values of the Navajo and the Pueblos. While it is evident that some of his observations were derived from his own personal experiences as an educator and education researcher, the exact source for his value lists cannot be determined. He is one of the few psychologists heavily influenced by the anthropological literature, and extensively utilized the works of Elsie Clews Parsons, Edward Dozier, Ruth Benedict, Ruth Bunzel, Fred Eggan and Margaret Mead, as well as the materials generated by the Indian Education Research Project. But in his listing of Pueblo values, there are no citations whatever and no indication to which, if any, specific Pueblo he is referring. Zintz's work was subsequently cited in the discussion of values by several scholars. In his oft-cited 1981 paper, Trimble uncritically reproduced Zintz's comparative list of Pueblo and Anglo values, noting that they compared favourably with other lists. In his 1983 treatment, John Dillard (1983) did not cite Trimble's work at all, but did present the work of Zintz. Dillard made it clear that Zintz's work pertained to the Pueblo peoples but, similar to Trimble, accepted Zintz's observations uncritically and used them to support the notion of a set of universal American Indian values. When we come to James Green's (1999) recent handbook, however, we see that at least one of Zintz's Pueblo/Anglo value contrasts, that Anglos prefer to win always whereas Pueblo peoples prefer to "win once, but let others win also" (Green, 1999: 244; adapted from Zintz, 1969: 210), is now a generic "American Indian" value! In the course of 35 years, this value has gone from an undocumented feature of an unidentified Pueblo to a generalized value common to all American Indians.

The stereotype ethics, values and behaviors generated are classic, essentialist tropes. "Like others living in close harmony with nature," writes psychiatrist Clare Brant (1990: 536), "the Native person has an intuitive, personal and flexible concept of time." *The American Indian* is one who lives in harmony

with nature, unrestricted by the bonds of western notions of time, free to move carefree with the seasons. They have a primal, holistic worldview, embodied in the wisdom of the elders. They are natural people, who relate to each other in natural ways. They listen before they speak; they do not threaten or act aggressively. They share. They maintain harmony with each other. They are a humble people. They are a *cultural* people.

Of course, this process of essentializing implicates the broader American society as well. This is best seen when contrasting lists of values are presented. Richardson (1981) wants us to believe that American Indians are intuitive and mystical, whereas non-Indians are scientific and empirical, conveniently ignoring the powerful role of religion in American life as well as the empiricism of American Indian knowledge systems. M.K. Ho (1987), like many others, suggests that non-Indians value control over nature, rather than harmony with it (as in the case of American Indians) without mentioning the influence of the environmental movement and American Indian involvement in resource industries.

Most American Indian values are presented as essentialized non-Indian oppositions: where Indians value generosity and sharing, non-Indians value greed and accumulation; where Indians are present-time oriented, non-Indians are future-time oriented; where Indians show emotional restraint, non-Indians are assertive. The tone of the literature is clearly one which disparages non-Indian values; the American Indian is an individual who values all that the non-Indian American has lost and, by inference wants to (or should want to) recover. Value conflicts should be resolved through counseling primarily in favor of American Indian values. The primal nature of these values is clearly suggested. John Red Horse (1980: 463), along with many others, even goes so far as to suggest that, despite enormous cultural changes brought on by colonization, American Indian values have remained largely intact. Freddy Paniagua (1994: 75) insists that “many of the American Indians’ rules, roles, values, and beliefs were developed during the precontact period.” Carolyn Attneave (1987: 137) believes that “the unconscious persistence of tribal values, customs, and ways of relating are still very strong” even where conscious recall is problematic. Similarly, Clare Brant (1990: 534) argues that certain ethics, values and rules of behavior “persist in disguised form as carryovers from the Aboriginal culture and which strongly influence Native thinking and action even today.” These ethics, values and behavioural rules are embedded within the very essence of the Aboriginal. A belief in the psychic unity of North American Aboriginal people is implicit.

Part and parcel of this is the belief that there are authentic American Indians and Canadian Aboriginals and that there is an authentic American Indian and Canadian Aboriginal culture. It is located on the reserves, according to many commentators, and off-reserve Indians can be expected to suffer from value conflicts perhaps moreso than on-reserve Indians. Marilyn Anderson and Robert Ellis (1995: 185), for instance, suggest that “The reservation... is the physical embodiment of the tribe and for an individual to leave the reservation that individual must, in a sense, reject the tribe and the values it

represents.” They must adopt the values of the non-reservation world if they are to be successful, and this often leads to trauma. The issue of authenticity is often tied to biology: Joan Weibel-Orlando (1987:275), for instance, contrasts the “full-blood, Navajo-speaking” individual who lives on the reservation with the “urban-born, ‘street-hip,’ half-Navajo college student.”

What makes this situation even more interesting is the fact that many scholars of Aboriginal heritage have contributed to the perpetuation of these tropes. From the early work of Alonzo Spang (Northern Cheyenne) (1965), Edwin Richardson (“Abnaki/Ute Indian extraction”) (1977, 1981), E. Daniel Edwards (Yurok) (Edwards & Edwards, 1980), and John Red Horse (California Cherokee) (1980) on through that of Clare Brant (Mohawk) (1990), J.T. Garrett and Michael Walkingstick Garrett (Cherokee) (1994), and Eduardo Duran (Pueblo/Apache) (Duran & Duran, 1995), it is apparent that being of Aboriginal heritage does not, in and of itself, eliminate the possibility of regressing to stereotype. These authors, like so many of their non-Aboriginal counterparts, have based their generalizations on both their circumscribed clinical experiences as well as the reading of the same, flawed literature. Perhaps their authority to speak to the ethics, values and behaviors of Aboriginal peoples comes from their own heritages, their own grounded cultural experiences. But socialization into the mental health professions is also likely a factor.

The involvement of Aboriginal scholars in this process may be a form of “double othering,” as described by Gerald Vizenor (1994). In the concept of “double others,” Vizenor argues for a comprehension of how Aboriginal peoples create their own constructs, their own tropes, based not on an intimate understanding of tribal tradition, but rather based on other constructs or tropes, very often generated by non-Aboriginals. The pan-Indian movement has involved the promotion of the idea of basic core values common to all Aboriginal North American societies in an effort to fill what is seen as a void in values resulting from colonial oppression and deculturation. Many Aboriginal scholars, writing about Aboriginal values, appear to be reproducing these values, authenticated by their own claims to Aboriginal cultural affinity and/or tribal membership.

Arguments that there are core, essential Aboriginal values that should be considered in counseling represent a perversion of the culture-specific model. The counseling literature is rife with generalizations regarding Aboriginal ethics, values and behaviors, their role as sources of distress, and their implication for counseling and psychotherapy even while the cultural heterogeneity of Aboriginal peoples is stressed. Much of this literature exists as guides to practitioners in the form of handbooks, cultural cheat-sheets if you will, which allow therapists to fool themselves that they have achieved “cultural competence”.

What, then, is the conceptualization of “culture” which is common to this process? Paul Pederson’s (1994, 1997) work perhaps represents one of the most progressive approaches to culture in counseling. Pederson argues for a broad

definition of culture, stating that it is a multi-faceted and complex concept and that individual culture members manifest their culture in fluid, imperfect ways. Cultural identity is not fixed, but rather shifts and is often context specific. "Values and worldviews are not themselves the culture," he writes, "but have been constructed as ways to find meaning in each cultural context" (1997: 23). So far, so good. However, much of the mental health research essentially establishes culture as an important *variable* in counseling and research, presumably one of many variables. Despite Pedersen's warning, self-declared ethnic status often becomes the proxy for culture in these types of studies. As psychologist Michael Cole (1996: 32) has argued, such an approach becomes particularly problematic because so much of the research that incorporates culture as simply a variable is, more precisely, "cross-cultural," which is to say it concentrates on cultural differences. It is readily apparent that much of the discussion on Aboriginal values falls into this trap, essentializing and stereotyping groups, even to the point of defining their impervious boundaries, in order to facilitate the examination of difference. And ethics, values and behaviours are particularly amenable to superficial operationalization in cross-cultural research, and therefore the exaggeration and stereotyping of difference. Simply put, culture, when operationalized in terms of values, is easy to investigate; by extension, this version of culture, especially for the cultural others, is easy for counsellors to learn. In fact the concept of culture as widely accepted throughout the decades of the 1960s, 1970s and 1980s viewed shared values as an essential ingredient, and resulted in the generation of values lists as part of an exercise to become more culturally sensitive (Kleinman, 1996: 16). But as this paper demonstrates, the attempt to become culturally sensitive, especially within the clinical setting and within the context of the therapeutic relationship, has lead inevitably down the dead-end road of quick-fix cultural handbooks which delineate stereotypical values and behaviours and serve only to cement the culturally different client in a fully constructed cultural quicksand.

A notion of cultural competence which is focussed on values ignores the fact that values are ideals and not necessarily grounded behaviours, and that therefore the expression of values in research can represent the constructed product of a myriad of influences. The emergence and influence of pan-Indian values, for instance, has lead to an Indian version of political correctness, in which the expression of idealized Indian values, even when accompanied by contradictory behaviours, becomes an important marker of Indianness and, by extension, an important marker of cultural distinction from the settler society. Research among Aboriginal prison inmates involved in culture-based treatment programming clearly demonstrates the powerful grip that such essentialized values can have in shaping the very public display of Indianness, even among those who were adopted at infancy by non-Aboriginal families and have had virtually no experience in an Aboriginal culture (Waldram, 1997).

It seems to me that we continue to swing from one broad extreme to another. During my work in prisons, I witnessed many therapeutic encounters in which the Aboriginal patient was clearly exhibiting behaviours that were

culturally-based and as a result misinterpreted by the clinician. But I also witnessed well-intentioned therapists, armed with a one-day workshop full of teachings on Aboriginal spirituality, treating Aboriginal patients as if they were, indeed, all traditionally spiritual and, essentially, all alike in cultural orientation. And I saw Aboriginal cultural resource people offering these quick-fix cultural workshops to eager mental health professionals without any mention of the extent to which their “teachings” were appropriate characterizations of contemporary Aboriginal reality. Further, I witnessed Aboriginal inmates both struggling to learn about a non-existent singular Aboriginal culture and struggling to learn how they could manipulate to their advantage the limited understanding of Aboriginal culture held by the staff. It seems as though a little cultural knowledge is, indeed, a dangerous thing. It is essential that we move away from the belief that cultural competence is readily achievable, that handbooks and workshops can deliver the cultural goods. This is not to suggest that we throw up hands, however, declaring culture to be transient, contested, subjective, and inherently unknowable. The greatest promise may well lie in the lessons of the “cultural-general” model, in the ability to discern culture without essentializing and stereotyping it.

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5. MODELS FOR COLLABORATIVE RESEARCH & MENTAL HEALTH SERVICES

Working in Partnership: Innovative Collaborative Research between Aboriginal Communities and an Academic Unit

Jane H. McKendrick

Abstract: There is still little documentation of the mental health problems faced by Australian Aboriginal people. Racial discrimination, dispossession and marginalisation all still have a heavy impact on the lives of Australian Aboriginal people. Loss of language without compensating fluency in the language of the wider group, exclusion from the educational system, exclusion from participation in the institutions of society all place members of the colonised group at risk of developing psychiatric morbidity. Work with victims of chronic trauma and loss indicates that where there is little or no opportunity for the victims to remove themselves from the traumatic situation or to 'work through' their grief, the risk of developing psychiatric morbidity is high. Aboriginal people continue to be subjected to trauma and most cannot escape its impact because of the parallel processes of acculturation and marginalisation. Similarly they continue to experience multiple losses, many having lost traditional mourning rituals with little to replace them. Psychiatric morbidity amongst Aboriginal groups remains largely untreated because mental health services like other institutions of the wider community are largely inaccessible to Aboriginal people, and in any case do not adequately meet their needs. This paper describes unique mental health research conducted in partnership with two Aboriginal communities in the south east of Australia. The major objective of our research was to document the nature and patterns of mental health problems experienced by members of the communities concerned. The methods were designed to achieve the objectives in a way that accurately reflected the situation of Aboriginal people in the communities in which they live, using their language, their ways of talking about health and illness and their views of life and experience of distress. At the same time we were careful to ensure that the research methods were scientifically sound and the measures of psychiatric morbidity, and social and cultural factors were reliable and valid.

Résumé: Il y a encore très peu de documentation à propos des problèmes de santé mentale auxquels font face les personnes autochtones australiennes. La discrimination raciale, la dépossession et la marginalisation ont toutes encore un impact considérable sur la vie des personnes autochtones australiennes. La perte de la langue maternelle sans l'apport compensateur de la maîtrise de la langue du groupe formant la majorité, l'exclusion du système d'éducation, l'exclusion de la participation dans les institutions de la société contribuent toutes à leur

façon à rendre les membres du groupe colonisé plus à risque de développer de la morbidité psychiatrique. Le travail effectué auprès de victimes de traumatismes chroniques et de pertes indique que là où il y a peu ou pas d'occasions pour les victimes d'échapper aux situations traumatisantes ou de « composer » avec leur colère, le risque de développer de la morbidité psychiatrique est élevé. Les personnes autochtones continuent d'être soumises à des traumatismes et la plupart ne peuvent éviter leur impact néfaste en raison des processus concomitants d'acculturation et de marginalisation. De la même manière, elles continuent d'éprouver de multiples pertes, beaucoup d'entre elles ayant perdu les rituels de deuils traditionnels d'autrefois avec peu ou pas d'option alternative. La morbidité psychiatrique parmi les groupes autochtones demeure en grande partie non traitée parce que les services de santé mentale tout comme les autres institutions rattachées à la communauté pris dans son ensemble restent dans la plupart des cas inaccessibles aux personnes autochtones, et de toute façon ils ne répondent pas adéquatement à leurs besoins. Cet article décrit les résultats uniques de la recherche sur de la santé mentale menée en partenariat avec deux communautés autochtones dans le sud-est de l'Australie. L'objectif principal poursuivi par notre recherche était de documenter la nature et les modèles de problèmes de santé mentale éprouvés par les membres des communautés intéressées. Les méthodes ont été conçues afin d'atteindre les objectifs de façon à refléter correctement la situation des personnes autochtones dans les communautés où elles vivent, en employant leurs langues, leurs façons propres de parler de la santé et de la maladie et leurs conceptions de l'existence et leurs expériences personnelles de la détresse. Par la même occasion, nous avons fait preuve de prudence en nous assurant que les méthodes de recherche soient scientifiquement rigoureuses et que les mesures de morbidité psychiatrique, les facteurs sociaux et culturels soient fiables et valides.

'I would call it grief and great loss, that's what it is great loss'

—Elder, (McKendrick, 2000)

Background

Aboriginal people have lived in Australia for over 40,000 years and probably more than 60,000 years. Over this time they have developed rich and sophisticated cultures in which everyday life, spirituality, and the practice of medicine and of law have always been interwoven.

Aboriginal people evolved a series of successful, varied economies. These broadly based economic systems allowed them to survive in a wide range of environments where European agriculture proved to be an abysmal failure... by 10000 years ago Aborigines had mastered the sophisticated aerodynamic principles of boomerangs... Society was organised so there

was ample leisure time... The achievements of early Australians are constantly underestimated by those who judge a society solely by its material possessions (Flood, 1983).

The arrival of British colonists had a devastating impact on the lives of Aboriginal people throughout Australia. In southeastern Australia, colonisation was so rapid and so destructive that:

Anthropological and historical analysis of Victorian clans is extraordinarily difficult because of the rapidity of European usurpation... By 1861 fewer than 2,000 of the original owners had survived what eyewitness accounts called 'wanton slaughter' starvation and the effect of European-introduced diseases (Barwick, 1984).

The parents were massacred and it happened down around those areas...yeah they just slaughtered them left right and centre down there. They say they used to push 'em back into the water, there's a lot (of bodies) down there you know (McKendrick, 2000).

Dispossession, destruction of traditional lifestyles, rapid cultural change, disruption of families and communities, discrimination, cultural exclusion, poverty, lack of educational opportunity, and poor health have been the legacies of colonisation (McKendrick, 1993; Dodson, 1990; Dodson, 1995). The Indigenous people of Australia are the most socio-economically disadvantaged group in the country and their health status is well below that of the general community with an average life expectancy twenty years less than other Australians. Relatively recent policies aimed at assimilation, such as the forced removal of Aboriginal children from their families have disrupted the fabric of Aboriginal family and community life. Aboriginal people are incarcerated up to twenty times more than the general Australian community, high school retention rates are many times lower and unemployment rates many times higher than for the general population. Chronic psychological distress has been shown to be associated with both longstanding environmental difficulties and intermittent acute stressors, such as physical illness in self and significant others, frequent bereavement, poverty and lack of educational opportunity (Kessler et al., 1985; Mann et al., 1981). The impact of colonisation and subsequent events have resulted in many Aboriginal people living in circumstances that promote the development of depression and mitigate against the resolution of such depression. It has been shown that a strong sense of cultural identity can be protective against the development of psychiatric morbidity. It is likely that Aboriginal people who have strong family connections, know about their Aboriginal heritage, including their tribal group and traditional lands, and who continue to live an Aboriginal life style (the nature of which varies between Indigenous groups) are similarly protected. Despite the near fatal impact of European contact on Aboriginal societies, the richness and durability of Aboriginal cultures has and can continue to enable Aboriginal communities to overcome the problems which continue to be imposed upon them.

Working Partnerships Between Aboriginal and Non-Aboriginal People: The Key To The Future

Innovative solutions and a preparedness to support Aboriginal peoples in their endeavours to develop cultural, social and health programs are required in order to bring about significant improvement in the well-being of Australian Aboriginal communities. Aboriginal peoples have great resilience. They know how they want to develop their own health and well-being programs. However, lack of educational opportunity means there are very few Aboriginal people with formal training in the health professions. In many areas traditional ways of healing have been all but lost. The marginalisation of Aboriginal peoples means that few are in a position to influence policy and planning or have access to academic institutions. Non-Aboriginal health professionals have technical expertise and are in a position to influence health policy and planning. However, they do not have the right nor the knowledge or understanding of Aboriginal cultures to determine the needs of Aboriginal communities or to make decisions about the ways health services for Aboriginal people should be developed. Gary Foley, who was a key figure in the establishment of Aboriginal medical and legal services in the 1970's, describes the partnerships which are needed between Aboriginal and non-Aboriginal people as:

Aboriginal people determining the specific problems in the community and setting out to do something about that problem themselves with whatever white expertise they could get to help them (Foley, 1976).

RUIMHER: The Resource Unit for Indigenous Mental Health Education and Research

RUIMHER is a unique program in Australia. It has grown out of the working style developed at the Victorian Aboriginal Health Service, an Aboriginal community controlled medical service (McKendrick, 1993), from the 1970's through the 1990's. The Unit, which is situated in the Department of Psychiatry of the University of Melbourne, has close links with Aboriginal communities and organisations. It aims to make the resources of the University more accessible to Aboriginal people and provide a model for the formation of working partnerships between Aboriginal communities, mainstream mental health services and academic institutions. RUIMHER aims to contribute to the well-being of Aboriginal people by:

1. placing the mental health of Aboriginal peoples in historical, social and cultural context
2. assisting Aboriginal peoples in development of mental health programs for their communities
3. facilitating equal access to mainstream mental health services for Aboriginal people

The RUMHER team consists of Aboriginal and non-Aboriginal mental health professionals who have expertise in Aboriginal health and mental health and academic and clinical psychiatry. Team members have a close ongoing involvement in Aboriginal community activities. We have known each other and worked together for over two decades. Some aspects of the work of RUMHER are articulated by team members who describe their work as follows:

Ongoing consultation with the Indigenous groups we work with is a major responsibility of RUMHER, so that we can check the validity of the work and promote meaningful dialogue.

The work is conducted in a way, which does not objectify Indigenous people, and counters racism and marginalisation. We aim to increase the power of Indigenous people to take action to improve the health status of their communities.

RUMHER monitors mainstream representations of Indigenous people and endeavours to make issues to do with Indigenous mental health more visible in ways that will contribute to better outcomes.

We do not assume that we have consulted properly unless we have made contact with a broad cross section of the communities we work with.

The Rumbalara Mental Health Project

The Rumbalara Mental Health Project (the Project) illustrates the ways in which RUMHER works with Aboriginal communities to assist them to develop their own solutions to health problems.

The Project addresses the related problems of high rates of psychological distress and under-utilisation of mental health services within a rural Victorian Aboriginal community. The impetus for The Project came from the concerns of local Aboriginal people. There had been five suicides of young men in the 18 months leading up to the study and community members were very worried about the future of their people. A group of people representing the local community came to me and asked me to work with them to develop and carry out a mental health research project which would lead to the development of appropriate mental health programs for local Aboriginal communities. Baseline information about the nature of mental health problems among Aboriginal people in the region is required if effective, efficient mental health programs are to be developed. Until now there have been no studies of the mental health of Aboriginal communities living in rural southeastern Australia. Clinical evidence indicates that there are high rates of mental health problems in Aboriginal general practice populations (McKendrick, 1993; McKendrick et al., 1990; McKendrick et al., 1992; McKendrick & Thorpe, 1994; 1995), however there is little information available about the patterns of such problems in community settings.

The ultimate objective of this research project was to collect information, which would inform the development of models of mental health programs to meet the needs of local Aboriginal communities.

The research method is innovative and designed to draw on the knowledge and expertise of local Aboriginal people. The training program which ran throughout the project was a two way process. I was privileged to learn about the lives and the cultures of the local people, to hear their stories and the ways they had withstood the devastating impact of colonisation. The local researchers learnt about their culture and history from the elders who passed on stories from the 'old people'. They also learnt about western health and research systems, the focus being on mental health. The local Aboriginal elders, researchers, teachers, and advisers all played key roles in the conduct of the research.

Background, Objectives and Methods

In 1992 the Aboriginal community served by the Rumbalara Aboriginal Cooperative was reeling as a result of a series of suicides amongst young men. The suicides were only the tip of the iceberg, dramatic signposts to alienation and distress barely contained. Rates of attempted suicide and risk taking behaviour were also high amongst the young. The suicides had a heavy impact in an area, where deaths due to physical illness in young and middle adult life were already common. The young men who died had seemed little different to the other young men of the area. If young people continued to take their own lives at this rate what would be the future of the local communities which have survived 170 years of trauma and loss? The Aboriginal Health Workers and General Practitioner from the Rumbalara Aboriginal Medical Service had noticed many of their consultations were for stress-related disorders. The Aboriginal health worker in charge of the local Aboriginal community antenatal and postnatal services had also reported high rates of post natal depression among young mothers. These apparently high rates of psychological distress were in the setting of extreme socio-economic deprivation, poor physical health and overt racism.

Aboriginal people do not utilize the local psychiatric services. They do not feel comfortable using the services, do not trust them, and do not believe they receive good treatment. The Aboriginal health workers, and doctor at Rumbalara have always done their best to help those who in distress. However their resources are very limited and they have not had appropriate support or training available to them. The story of the Aboriginal communities in this area is unfortunately repeated in Aboriginal communities throughout Australia. Circumstances beyond their control have forced Aboriginal people to move from the small towns, missions and settlements to the larger regional towns and cities over the past two generations. This in turn has resulted in extended family and kinship groups being disrupted, leaving young people, in particular, vulnerable to racism and marginalisation. Unemployment and

poverty are part of life. Young people drop out of school as soon as they can, disillusioned and scarred by the system. Unresolved grief, depression and post-traumatic disorders are common and pose a major public health problem. Much of this psychological distress and psychiatric morbidity remains untreated. Efforts by Aboriginal communities and others to establish appropriate programs are hampered by a paucity of good quality data about the patterns of mental health problems. Unfortunately this statement written over twenty years ago still holds true today:

The Aboriginal people are thus in the unenviable position of being the most disadvantaged group in Australia, with social and health statistics being almost non-existent (McKendrick & Christie, 1978).

In mid-1992, the Board of Directors of the Rumbalara Aboriginal Cooperative considered the suicides and their impact and decided a mental health program designed to meet the specific needs of the local Aboriginal community was needed. A meeting was held at the Victorian Aboriginal Health Service (VAHS) between a delegation from Rumbalara, the Administration of the VAHS and a non-Aboriginal psychiatrist from the Department of Psychiatry, University of Melbourne. A project plan was developed and funded by the National Health and Medical Research Council. The plan was based on two decades of collaborative projects undertaken by the VAHS and the University of Melbourne—'The Melbourne Model' (McKendrick, 1993; -13). These research projects had combined the cultural and social with clinical experience and understandings to build up a picture of not only the mental health problems, but also the strengths of communities which can contribute to solutions and healing.

The Project has been a joint undertaking of the Rumbalara Cooperative RUIIMHER. Its major objectives were to obtain:

- accurate population data
- good quality information about the patterns of health and illness in the community to be served by the program
- information on the views about and attitudes to health and illness within the community
- information on the ways community people view and use health programs
- information on the sorts of health programs community people want and will use.

The role of RUIIMHER in the Project has been to:

- provide expertise in mental health and mental health research and training
- help bring together two systems of knowledge and expertise – the Indigenous and the Western
- present the outcomes in a way that it can be used effectively in the

Western system of government, health policy and funding and health service provision operating in Australia, and provide the local Aboriginal communities with effective programs to promote well-being and help combat mental health problems and distress

The project was designed to be more than just a research study; it had also to incorporate positive, practical outcomes for the local community. Thus we aimed to develop skills in health research and mental health within the local community, and produce information which would enable the development of mental health and well-being programs. During the project, local Aboriginal people were trained in health research and mental health and developed skills, which were essential to the research project. The Melbourne Model was modified for the Rumbalara Project to suit local conditions and meet the requirements of the Aboriginal community. Initially this was achieved by local Aboriginal people from a range of family and age-groups with expertise and experience in health, meeting regularly on an informal basis with the core research team and acting as advisors. As the project progressed, more and more Aboriginal community people became involved as advisors, teachers, researchers, interviewers and participants in workshops, seminars and focus groups.

This project provides a detailed description of the mental health and needs of an Aboriginal community, both in the words of members of that community and in the form of survey findings. The mental health and service needs of the local community would be documented and used to develop a model for mental health service provision for the community. The project and the involvement of local Aboriginal people in all its aspects would serve to increase the awareness of mental health issues and establish a dialogue within the community.

Project Findings and Outcomes

Training Program

In line with the requirement that valid information was to be collected, local Aboriginal people had to be involved in all aspects of the Project. So, five local Aboriginal people were trained to be community mental health research workers. (There were no local Aboriginal people trained in mental health research prior to the commencement of the Project.) The training program was intensive for nine months and then continued through out the project. The teachers were local elders, the RUMHER team and local mainstream mental health professionals. The training program objectives were to train local Aboriginal people in:

- the cultural aspects of mental health and psychological distress in their own community
- community mental health research techniques

- the principles of epidemiological, anthropological, sociological and mental health research
- the administration of questionnaires and standardised psychiatric interview schedules
- report writing
- the principles of community psychiatry and public health with respect to improving both the mental and overall health of the Aboriginal community.

Further, an objective was to Enable the trained Aboriginal Community Mental Health Researchers to work with local Aboriginal Health Workers to:

- develop culturally appropriate mental health educational, preventative and treatment programs
- develop a screening strategy for early detection and intervention for individuals at risk of psychological stress
- conduct ongoing community evaluation of the efficacy of health programs

Five of the original team completed the intensive training program and gained a good understanding of the principles of research and completed their own mini research project. Three of the original team members conducted the main part of the census and were joined by a fourth team member just prior to completing the population count. These four team members contributed to the Focus Group discussions and became skilled at facilitating such groups. Three team members were involved in the community survey – one as the local team coordinator and the other two as interviewers. All three made an outstanding contribution to the project and were actively involved in the modification of the methodology to suit the local community.

The National Competency Standards for Aboriginal and Torres Strait Islander Health Workers had not been developed when this research began but were released in 1996. Three of the researchers who left the project before the community survey reached Level A of competency for Aboriginal health workers (Research Stream). The two researchers who acted as interviewers in the community survey attained Level B competency for Aboriginal Health Workers (Research Stream). The two researchers who acted as interviewers in the community survey attained Level C competency for Aboriginal Health Workers (Research Stream).

The Census

The project census was conducted because local Aboriginal people, supported by the Koori Health Unit, Human Services, Victoria, believed the 1991 census to be a gross underestimate of the populations of their communities. During discussions with local community people it became clear that a survey of a

random sample of the local Aboriginal community would need to be undertaken during the project. We needed accurate population figures to be able to conduct such a survey. A Best Estimate of the adult Aboriginal population of the region was obtained by: (i) interviews with local Aboriginal people; (ii) conducting Census Workshops; and (iii) consultation with the Aboriginal Medical Service Coordinator about the numbers of local Aboriginal people known to the medical service.

The three sets of data were cross-checked by the research team. Duplications were eliminated and children under the age of 15 years excluded. The final list consisted of the name, sex, age and area of residence. A 25 percent computer generated random sample of the Best Estimate Project Count population was then used in the community survey. The Best Estimate figures were compared with the 1991 and 1996 census figures from the Australian Bureau of Statistics for the study area. The official census figures were found to underestimate the population of the region by 35 percent. In some local towns underestimates were as high as 68 percent. These findings have serious implications for funding of Aboriginal health programs, and the collection of accurate health statistics.

The Ways Local People Talk About Mental Health

'Are there any other words we can use besides mental?'

'That's all I can think of is grief...strong loss or great loss you know.'
— Elders (McKendrick 2000)

The objectives of this part of the project were to document the ways Aboriginal people of the region talk about mental health problems, popular local concepts about the causes of a mental health problems and the solutions to them. Information was collected through interviews with individuals, and group discussions. All interviews and group discussions were taped. Interviews were conducted with elders, men and women, young people, people with experience of mental health problems and mental health services (personally or in their extended families), health workers, and interested community members. Specific groups were held with Elders (women and men), Elders (women only), young people, extended family groups, Aboriginal health and community workers, Aboriginal mental health workers and local mainstream mental health workers.

All participants traced their history through the mission stations along the Murray River and in southwestern New South Wales. The participants identified their main tribal affiliations as Yorta Yorta, Wiradjuri, Wemba Wemba. All were living in the area served by the Rumbalara Aboriginal cooperative. The time period covered during the discussions reaches back to mid-1800s, around the time of first colonisation, to the present day. There were common themes, which ran through all the interviews and group

discussions. The discussion groups and interviews consist of collections of stories. Stories were used to make a point, clarify family connections and relationships both within the group and more generally to recall the past, to demonstrate the impact of government policy and often for the pleasure of telling. Humorous stories and laughter were used to relieve the inevitable tension brought about by the subject matter. The stories and discussions ran across the main issues – health, mental health and illness – and back and forth in time. Health, mental health and illness were not discussed as entities in themselves nor as categories of disorder or as symptoms, but in terms of the impact on the individual and the family group, the associated and causal factors, and possibilities for healing or recovery. The main themes brought up in discussions were:

- Spiritual and Cultural Beliefs;
- Differences between blacks and whites
- Extended Family
- Knowing That Your Family Was Massacred
- Language
- Life on the Missions
- The Stolen Children
- Moving from the Missions
- Breakdown of Extended Family
- Loss of Culture
- Grief and Loss
- Identity
- Racism
- Socio-economic Problems
- Poor Physical Health
- Remedies and Healing
- Services and Service Utilisation
- Mainstream Mental Health Service
- Aboriginal Medical Service.

The participants all stated clearly that their concepts and beliefs about health and illness were very different to those of *'the white man'*. In speaking about health and illness they preferred not to differentiate mental health from physical health. Although they used terms like depression, anxiety, worry and schizophrenia, they did not see them as different entities, but used them to describe the whole area of distress. They clearly stated that the mental health problems faced by their people were related to history, racism, trauma and the losses, and socio-economic deprivation. They spoke of the grief of past generations not having been resolved and being passed onto the young. Participants from all age groups held strong beliefs about the association between spiritual world and health and illness. Spiritual factors were cited as the causes of both physical and mental illnesses and death. In the same way spiritual factors could have a healing effect. In terms of the solutions to these problems, all participants emphasised the need for social change and government action to address issues of poverty, lack of educational

opportunity and unemployment. The view that access to mainstream services was necessary, but would never be sufficient, was very strongly held. All participants believed that the solution was to bring people back to the way of life where extended family and kinship groups cared for and shared with each other, to get back to the bush, to be close to the forest and the river and the spiritual world.

The Community Survey

A community survey of a 25 percent random sample of the adult Aboriginal population of the region was conducted. The main objectives of the survey were to determine the rates and nature of psychological distress amongst the survey sample; to describe demographic and social characteristics of adult members of the community; to describe certain cultural characteristics of the adult members of the community; to describe patterns of alcohol and other substance use amongst adult members of the community; and to describe associations between distress in this community and other factors. The method used in the survey was based on that developed in a longitudinal survey of an urban general practice population and modified for use in this region through consultation with local Aboriginal people. Information about socio-demographic factors, cultural factors and substance use was collected by questionnaires specifically developed for use in this Project. The Prime MD was used to detect psychological distress. The interviews were conducted by 25 specially trained local Aboriginal interviewers who were supported and supervised by myself, local elders and the senior local researcher.

The findings of the community survey reveal a severely economically deprived community, which has been dispersed from the missions to cities and towns over the past two generations. Loss and grief are major issues with a high proportion of people interviewed reporting several deaths amongst close relatives in the five years preceding the survey. Almost half of those interviewed were depressed. Despite high rates of psychological distress, few people had ever used mental health services or sought any help for their distress. Rates of alcohol abuse were high, especially amongst young men. Certain socio-economic and cultural factors were found to be associated with higher rates of psychological distress. The findings of this community survey support the views of local community members, as expressed in focus group discussions about mental health, well-being, distress and the associated historical, social and cultural factors. The view that mainstream mental health services did not meet the needs of the Aboriginal people was re-inforced by the under utilisation of such services by respondents to the survey. Some stated they had been helped by the counsellors working at Rumbalara, but too few to have a real impact on a public health problem of such magnitude.

Summary & Conclusion

The Project shows that partnerships between Aboriginal and non-Aboriginal people can work with goodwill and a preparedness to work through difficult issues. Such partnerships are important in the development of programs designed to improve the well-being of Aboriginal communities.

After five years more than 400 local Aboriginal people have been directly involved in the successful completion of the Project and many more have been informed about issues to do with mental health and well-being. The project has important implications for the future development of health and well-being programs, locally and throughout Australia.

This information will be able to be used for many years to come by the local Aboriginal community and its representatives to develop programs for health and well-being and attract resources from government and other agencies. The research and the models developed during the project will also be useful for other Aboriginal communities throughout Australia who can make modifications to suit their own requirements.

Aboriginal people are wary of research because they rarely see any benefits. Mental health research and service development and delivery have run in parallel during the life of this project. As a direct result of the work carried out by the Rumbalara mental health project Rumbalara and the Victorian Aboriginal Community Controlled Organisation have received funding to establish mental health programs, run workshops and further develop mental health policy. The results of the project have been presented to community meetings at Rumbalara and will be disseminated more widely through workshop presentations, written publications and a video in which those who took part in the project will describe the process and the outcomes. The research team from RUMHER, Department of Psychiatry, University of Melbourne will be involved in all these activities and will remain available to Rumbalara and the local community to assist in using the project to further mental health and well-being of local people.

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Comments on Hollow Water Community Healing

Joseph E. Couture

Abstract. The Hollow Water Community Healing program in Manitoba has received significant interest from Canadian and international health and social service professionals. Unique to this program is the integration of treatment of first time sexual abuse offender, with that of their victim(s), their respective families, and the entire community. The following discussion lists selected key or defining characteristics of the success of this program.

Resume. The Hollow Water Community Healing program in Manitoba has received significant interest from Canadian and international health and social service professionals. Unique to this program is the integration of treatment of first time sexual abuse offender, with that of their victim(s), their respective families, and the entire community. The following discussion lists selected key or defining characteristics of the success of this program.

Introduction

The Hollow Water Community Healing program is a prototype of the contemporary blending of traditional and modern approaches to health and 'healing'. It is a blend that is determined and driven by the Anishnawbe Seven Sacred Teachings and healing customs. The Hollow Water Community Healing program for dealing with the problem of first time sexual abuse offenders has a reputation of having had tremendous success, and has received significant interest from Canadian and international health and social service professionals. Unique to this program is the integration of treatment of the offender with that of their victim(s), their respective families, and the entire community. The following discussion lists selected key or defining characteristics of the success of this program.

Demography and History

The name "Hollow Water" denotes the people of four First Nations communities located approximately 150 miles northeast of Winnipeg, Manitoba. Roughly 1100 people inhabit the four communities of Manigotagan, Ahbaming, Seymourville, and Hollow Water Reserve. The headquarters of the Hollow Water program is housed on the reserve of Hollow Water.

In 1972 several women from the Hollow Water Reserve began in secret to share with one another their experiences of sexual abuse. Their initial meetings were the foundation for the later formation in 1986 of the Wanipigow Resource Team. The mandate of the Team was to address community-wide substance and sexual abuse issues. As part of this team, a special sub-committee, The Community Holistic Circle Healing (CHCH) was created to focus on sexual abuse problems within the region where the four communities are located. The structure of the Wanipigow Resource Team and the CHCH remains in place today. Staff of the CHCH is comprised of six women and one man. All of the female staff members have in the past, been victims of sexual abuse and are considered to be recovering victims. The lone male staff member, who has a history of committing sexual abuse, is also considered to be "in recovery" as a male sexual offender.

From a Western standpoint, the Hollow Water Community Healing project constitutes a breakthrough in terms of its effectiveness of treatment for clients (both offender and victim), its ability to combine effectively professional training and personal development of staff, and to blend diverse healing strategies. From a Native traditional perspective, it is a convincing demonstration of how ancient wisdom and skills enable healing and survival. Hollow Water's practical focus on integrating treatment of the offender with that of the victim is the essence of its unprecedented success. Recidivism has occurred in only two cases out of 95 offenders treated.

Conditions of the Program

The CHCH healing process involves a set of requirements that all members of the recovery team must agree to. These include:

1. First time offenders, when entering a plea, plead guilty. Upon this, sentencing is delayed for two years during which time a healing strategy is pursued. After the two years, sentencing is given, usually a three-year period, during which time the person stays in the community. During this time periodic circle healing of both victim and victimizer, along with their respective families is facilitated and supported, eventually leading to the Special Gathering where restitution, and reintegration into the community is made.
2. Staff, within their employment mandate, are deliberately positioned so that they can participate in on-going activities that focus them on self-recovery and growth. This counterbalances the daily challenges they face that can lead to stress and eventual 'burn-out', such as being on twenty-four hour a day call throughout the year.
3. Provincial and federal agencies (police, courts, probation, parole, child and family services) are required to adjust their role to fit within the philosophical framework of the CHCH healing process.

Why is the Hollow Water Project Seen as Revolutionary?

The success of the Hollow Water approach is seen as revolutionary by a number of health and social service professional observers, inside and outside of Canada. For example, Canadian psychologist and internationally recognized authority on sex offender treatment, Dr. W. Marshall, describes the significant success of the program as follows:

“The real advantage of the Hollow Water program is that it is holistic in the sense of integrating treatment of the offender and the victim, their families, and the whole community...most non-Aboriginal people are hostile to the reintegration of sexual offenders...non-Aboriginal people can learn from Aboriginal approaches rather than our traditional strategy of attempting to foist our ways on other people...” (Marshall, 1997)

He goes on to state:

“If we have learned anything from the errors of our past it ought to be that Aboriginal peoples should have control over their own destiny and over their own problems. Indeed we should have the good sense to learn from Aboriginal ways. Certainly their way of dealing with offenders of all types could teach us as much as we are likely to teach them.” (1997:71)

The Hollow Water Community Healing program is revolutionary for several reasons:

1. The program successfully maintains a deeply rooted sense of individual in connection with the complex dynamic that makes up the self-family-community triad.
2. The program successfully facilitates and assures that both victim and victimizer proceed at their own pace in learning accountability to self, and self with family and community. It also successfully assists victimizers to take responsibility for their aberrant actions and to make restitution a way to give back to the community. The program successfully facilitates victim and victimizer in learning to deal with shame, and in learning to forgive self and others.
3. Within the program victimizer and victim are not labeled or blamed, but are treated as equals whose *spirits* remain essentially whole, but who have temporarily become unbalanced.

Conclusion: Important Implications

The Hollow Water Community Healing program is derived from a strong commitment to what staff members call “walking the talk.” “Walking the talk” involves a holistic approach in which clients, staff, and community work toward reintegration of offenders back into the community in ways that respect the experiences and needs of victims, their families, and the

community. This approach is grounded in age-old Anishnawbe teachings and healing customs. The implications of the success of the Hollow Water approach points toward a re-examination of training for professionals in therapy/counseling fields, particularly those who work with Aboriginal offenders. It also suggests a re-examination of all areas of the Canadian Justice System that is responsible for reintegration of sexual abuse offenders into the larger society.

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An Overview of Six Nations Mental Health Services

Cornelia Wieman

Abstract: Six Nations Mental Health Services is a community mental health clinic which opened for service in June 1997 on the Six Nations of the Grand River Territory reserve in southwestern Ontario. It is the first mental health clinic of its kind in Canada, being staffed by four mental health nurses, one mental health outreach worker, one counsellor and two psychiatrists – all, with the exception of the child psychiatrist, being of Aboriginal ancestry. Services offered include psychiatric consultation and assessment, case management, crisis response and education for patients, their families and the community regarding many aspects of mental health and disorders. Any band member with concerns regarding their mental health may access our services. This paper describes the efforts that were made to establish the clinic on the reserve and the cumulative clinic utilization data to date. For example, in the first seven months of service, thirty-eight individuals were seen for psychiatric consultation. Symptoms of mood disorders (55%) and disruptive behaviors (26%) were the most frequent presenting problems. The discussion will focus on the service delivery issues that have become apparent during the time the clinic has been in operation and on the measures taken to overcome some of the barriers that continue to impede Aboriginal individuals from accessing psychiatric services. This paper will also describe the issues involved in establishing collaborative working relationships between the trained mental health professionals and traditional healers in this rural community. Continuing attempts to optimize the services offered at the Six Nations clinic will hopefully be associated with the improved mental health status of the Six Nations community.

Résumé: Les Services de Soins en Santé Mentale des Six Nations est une clinique communautaire en santé mentale qui a débuté ses opérations en juin 1997 sur le territoire de la réserve de la Grande Rivière des Six Nations dans le sud-ouest de l'Ontario. C'est la première clinique en santé mentale en son genre au Canada, une clinique dont le personnel se compose de quatre infirmières spécialisées en santé mentale, un travailleur social effectuant un travail d'information et de sensibilisation en santé mentale directement sur le terrain, un conseiller et deux psychiatres – tous, à l'exception du psychiatre pour enfants, étant d'origine autochtone. Les services offerts incluent la consultation psychiatrique et l'évaluation, la gestion de dossier, l'intervention de crise et l'éducation des patients, de leurs familles et de la communauté en ce qui regardent de nombreux aspects touchant la santé mentale et les désordres psychiatriques. Tout membre de la bande préoccupé par sa santé mentale peut recourir à nos services. Cet article décrit les efforts qui ont été déployés afin de mettre en place la clinique sur la réserve et l'utilisation des données cumulatives de la clinique à ce jour. À titre d'exemple, au cours de ses sept premiers mois en service, trente-huit individus ont été vus pour consultation psychiatrique. Les symptômes associés aux désordres de l'humeur (55%) et aux comportements perturbateurs (26%) étaient parmi les plus fréquents présentant des problèmes. La discussion portera principalement sur les questions

entourant la prestation des services qui sont devenues manifestes depuis que la clinique est en opération ainsi que sur les diverses mesures qui ont été adoptées afin de surmonter quelques-uns des obstacles qui continuent de limiter l'accès aux autochtones à des services psychiatriques. Cet article cherchera aussi à décrire les principaux enjeux impliqués dans l'établissement d'une relation de collaboration efficace entre les professionnels spécialisés en santé mentale et les guérisseurs traditionnels au sein de cette communauté rurale. Il est à souhaiter que les différentes tentatives visant à optimiser les services offerts à la clinique des Six Nations se traduiront par une amélioration de l'état de la santé mentale des membres de la communauté des Six Nations.

Introduction

An often neglected aspect of Canada's relationship with its First Nations peoples is the wide-ranging and intergenerational impact of the residential school system and the 'Sixties Scoop' (Fournier & Crey, 1997, pp. 83-91). There were approximately 100 residential schools operated across Canada between 1863 – 1983 (Assembly of First Nations, 1998). The Assembly of First Nations (1994) *Breaking the Silence* report on residential schools and the *Royal Commission on Aboriginal Peoples Report on suicide* (RCAP, 1995) brought the abusive experiences of Aboriginal students attending these schools to public attention. In terms of the aftermath of the residential schools, in addition to the damage caused to the individual survivors who endured emotional, physical and sexual abuse, we must consider the long-term, cumulative intergenerational effects on First Nations communities. Many losses which encompass a wide range of psychological suffering were experienced by those who attended residential schools including dislocation from one's community, loss of pride and self-respect, loss of identity, language, spirituality, culture and ability to parent. The roots of this damage and these losses are reflected in the abysmal statistics which reflect levels of family violence, suicide, alcohol and other substance abuse in Aboriginal communities today (Assembly of First Nations, 1998).

Another pivotal event in Aboriginal history which has had repercussions throughout the generations is the 'Sixties Scoop', a term coined by Patrick Johnson (1993), a researcher for the Canadian Council on Social Development. This term refers to the accelerated removal of Aboriginal children from their homes and families, peaking in the 1960's but continuing into the present, and involves the generations following the residential school experience. In the 1950's, amendments to the Indian Act shifted responsibilities for Aboriginal health, welfare and education services to the provinces, who were guaranteed payment through funding for each Aboriginal child that was apprehended by child protection agencies. Following this amendment, the number of First Nations children who were taken into care and made legal wards ballooned. In 1959, only 1% of all children in care were Aboriginal; by the end of the 1960's, 30-40% of all legal wards were Aboriginal, even though they comprised

only 4% of the national population. These children were usually placed in non-Aboriginal homes and adoptive families were encouraged to treat even a status Indian child as their own, freely erasing his or her birth name and tribe of origin, and thereby extinguishing their identity and cultural birthright (Fournier & Crey, 1997). There have been significant consequences from adopting out Aboriginal children, similar in many ways to the residential school experiences but perhaps even more destructive in terms of the loss of Aboriginal identity. In this way, the 'Sixties Scoop' has further contributed to the social and health problems experienced by First Nations peoples.

In 1998, the federal government, partly in response to the RCAP report, delivered a public 'Statement of Reconciliation'. The key statement on residential schools reads:

The government of Canada acknowledges the role it played in the development and administration of these schools. Particularly to those individuals who experienced the tragedy of sexual and physical abuse at residential schools, and who have carried this burden believing that in some way they must be responsible, we wish to emphasize that what you experienced was not your fault and should never have happened. To those of you who suffered this tragedy in residential schools, we are deeply sorry.¹

Since then, there has been the establishment of the \$350 million Aboriginal Healing Fund which is designed to support communities in redressing the effects of the residential school system and to work towards community healing. It is Aboriginal-controlled via a Board of Directors headed by George Erasmus, former National Chief of the Assembly of First Nations, and has a 5-year mandate. The monies are to be spent on community initiatives and do not represent a compensation fund for individual survivors. Concurrently, there have been many Aboriginal community initiatives designed to address the many social and health, including mental health, needs of First Nations peoples in contemporary times. Six Nations Mental Health Services is but one example of a community-based mental health care initiative which is developing on an ongoing basis in one rural Aboriginal community.

Six Nations Mental Health Services

Six Nations Mental Health Services is a community mental health clinic which delivers a variety of psychiatric out-patient and mental health services to a rural Aboriginal community. Six Nations of the Grand River Territory is a First Nations reserve located in southwestern Ontario, approximately halfway between Hamilton and Brantford. The Six Nations consist of the Mohawk, Oneida, Onondaga, Seneca, Cayuga and Tuscarora Nations, each of which

¹ Speech Notes from an address by The Honourable Jane Stewart, then Minister of Indian Affairs and Northern Development on the occasion of the unveiling of 'Gathering Strength' – Canada's Aboriginal Action Plan, Ottawa: January 7, 1998.

have their own language, cultural and spiritual ways, although there has been considerable intermarriage between the various member nations. The band membership of Six Nations totals approximately 20,000 individuals, making it the largest First Nations community in Canada. Approximately 50% of band members live on-reserve while the other 50% live typically in surrounding rural towns such as Hagersville and Caledonia, and quite a few live in larger urban settings such as in Hamilton or Brantford (Six Nations Band Council, 1999).

The population distribution by age frequency for on-reserve individuals shows a distinct skew towards the younger age groups. For example, approximately 27% of on-reserve band members are less than 15 years, 17% are between 15-24 years and 36% are between 25-45 years. Only approximately 20% of on-reserve band members are 46 years or older. The reasons for this difference in population distribution by age of Six Nations when compared to the standard age distribution for the total Canadian population are somewhat unclear. There are higher rates of chronic diseases such as diabetes and renal failure in the Aboriginal population and higher rates of suicide for Aboriginal individuals compared to non-Aboriginal individuals in Canada. The average life expectancy for an Aboriginal individual, either male or female, is still approximately 10 years less than for the average Canadian (MacMillan et al., 1996). The 1991 census showed that Aboriginal peoples were the fastest-growing segment of the Canadian population and predicted an exponential pattern of growth into the 21st century, which may partially account for the greater number of youth and younger individuals in the Aboriginal population (Statistics Canada, 1991).

There are a number of health-related and social service agencies within the Six Nations community. There is a family medicine clinic, *Gane Yohs*, which is staffed by a family physician, several nurses and community health representatives (CHRs). Family physicians who have their primary practices elsewhere (in Hamilton, Brantford or the surrounding area) staff the clinic in 1/2-day blocks. There is family physician coverage in the community for 4 out of 5 working days. There is also a child and family counselling agency, *O Gwadeni:deo Satennikon:raren Onkwa:wen*, staffed by social workers who provide support and ongoing individual, couple and family counselling for a wide variety of social problems. There is a women's shelter, *Ganohkwa' Sra*, and a birthing center, *Tsi-Non:We Ionakeratstha - Onagrahsta*, where women can choose to have prenatal and postnatal care, as well as deliver their children with the assistance of traditional midwives. There is an out-patient substance abuse treatment program, *New Directions*, and community members also have access to a residential substance abuse treatment program, *Native Horizons*, aligned with a traditional healing approach.

Six Nations Mental Health Services is a free-standing community mental health clinic physically located in close proximity to these services in *Ohsweken*, the central village on the reserve. It opened for clinical services in June 1997. The clinic staff currently consists of a program coordinator, four mental health nurses, a mental health/addictions outreach worker and 2

psychiatrists (part-time). The program coordinator manages the administrative and day-to-day operations of the clinic. The outreach worker is shared half-time with the community substance abuse treatment program and works mainly in the schools in the community implementing mental health curriculum with youth between the grades kindergarten to grade eight. The outreach worker also plans and coordinated educational and awareness events in the community for the various health and social service providers, as well as the general community. The mental health nurses are all registered nurses with extensive previous experience in psychiatry and mental health. The nurses participate in the psychiatric consultation and follow-up processes as well as providing intensive case management for individuals with serious mental illnesses. The clinic has access to the services of a counsellor, who can provide ongoing individual psychotherapy for up to 10 clients at a time. There is one child psychiatrist who mainly provides psychiatric consultations only and who works with the service one day biweekly. The other psychiatrist sees adults and geriatric clients, providing psychiatric consultations and short- and long-term follow-up care two days per week. All of the staff, with the exception of the child psychiatrist, are of Aboriginal ancestry, with approximately half being from the Six Nations community and the others from various First Nations communities in Ontario and Manitoba.

The primary mandate of Six Nations Mental Health Services is to serve Six Nations band members, living both on- and off-reserve. However, individuals from other Aboriginal communities have been seen and treated; for example, individuals from the nearby Muncie community close to London, Ontario. Our clients span all age groups from children to the elderly; the youngest client seen was 4 years old while the oldest client 94 years old. Clients present with a wide-range of symptoms that can be diagnosed according to the DSM-IV diagnostic classification on Axes I to IV. Our clients suffer from a variety of mental illnesses and psychosocial problems, which range from mild to severe. A 1994 Needs Assessment conducted in the community showed that mental health services were urgently required, third only behind diabetes and cardiovascular care programs.

The Six Nations community has previously been under-serviced in terms of mental health services. Community members have been somewhat reluctant to receive mental health care in the larger cities of Hamilton and Brantford, partly due to the lack of cultural sensitivity of service providers. In order to improve accessibility, we take referrals to our service from a wide variety of agencies. Self-referrals consisted of 56% of all referrals to our service in the first 12 months the clinic operated. Family physicians (17% of referrals), nurses, social workers and clinical staff of other agencies (29% of referrals) account for the majority of the remainder of referrals. We occasionally receive referrals from an individual's family members, police and other emergency staff and hospitals in the surrounding areas of Hamilton, Brantford and Hagersville. Individuals who are referred to our clinic for psychiatric services must be under the care of a primary care physician who is aware of the referral.

Services offered by our clinic include mental health crisis response services, psychiatric consultation, assessment and short- and long-term follow-up as well as case management for the seriously mentally ill. Such individuals would include those who have illnesses such as schizophrenia and severe bipolar affective disorders. We also try to deliver education, support and awareness programs for clients and their families as well as to general community members.

Our regular clinic hours consist of service delivered between Monday and Friday from 8:30 am – 4:30 pm. Psychiatric services are offered on Tuesdays and Thursdays. Our crisis response service is in place from when the clinic closes on Fridays at 4:30pm and runs continuously until the clinic reopens on Mondays at 8:30am. Individuals in perceived distress or crisis may call our clinic during this time. The mental health nurses rotate their time slots each weekend with a partner. If called, they may speak with the individual over the phone, see them in their home or meet at a mutually-arranged place (e.g., coffee shop). The psychiatrist provides back-up to the nurses each weekend and is available 24 hrs/day by phone or pager. Decisions are made as to whether the individual requires transportation to the nearest hospital emergency department or whether they have settled after their visit with the nurse and can be seen in follow-up when the clinic re-opens on Monday. In our first year of operation, a total of 126 individuals were seen by the psychiatrist in the clinic. Approximately 40% of these individuals made their initial contact to the clinic through the crisis response service.

In the first year of service, 55% of those individuals referred for psychiatric consultation and assessment were female while 45% were male. 84% of these individuals were seen directly while the remainder were either indirect consults or did not show to the clinic. 73% of individuals were being actively followed by clinic staff after the first 15 months the clinic was open. The most common presenting problems were depression, suicidal ideation and anxiety. The most common diagnoses following psychiatric assessment were mood disorders (including depression and manic-depression), personality disorders, disruptive behavior disorders and anxiety disorders. While substance abuse was a comorbid condition for some individuals, the majority of those who have substance abuse difficulties as their primary disorder are seen by the various substance abuse treatment programs available in the community and surrounding area.

Clients who may be suitable for ongoing case management are discussed at the intake level by the nurses and psychiatrist and are then distributed equally among the three mental health nurses with the psychiatrist providing clinical back-up. These clients may be either seen directly or consulted on indirectly by the psychiatrist. In the first year of service, the average client intake for case management per month was 10.3 clients. Approximately 65% of the total individuals seen by our clinic are followed under our case management model; 40% of the total individuals remained in active case management status 18 months after the clinic opened.

In addition to clinical services with clients, we also provide a wide range of education, support and awareness services for clients, their families and community members. Approximately 13% of our clients initially presented or were referred requesting information regarding mental health, mental illness or various treatments. We have been compiling a large database of patient literature and pamphlets that we share with our clients as requested. There is a growing lending library of books and videos that are available to our clients and their families. The major criticism of these available materials is the lack of information directed specifically towards Aboriginal individuals and their communities. The mental health nurses will also assist clients and their families in accessing other available mental health/illness resources. For example, nurses will accompany clients to their first depression support group meeting or groups for parents whose children have committed suicide. This support allows clients and their families to feel more comfortable in accessing these services, which they have been reluctant to attend in the past.

Within the community, our clinic also holds biannual workshops focused on various themes to coincide with the national mental health and mental illness awareness weeks. For example, themes of depression, suicide, grief, loss and trauma are common within the community. A workshop open to the general community was held in March 1998 to address these issues and increase community awareness. Clinical staff also submit regular columns dealing with a variety of mental health issues to the 2 community newspapers; articles have included a review of the signs and symptoms of depression and information on how community members can access help if they feel they are depressed. We also participate in a phone-in show on the community radio station every 2-3 months. Clinic staff also regularly participate in various community events sponsored by the other health and social service agencies in the community in order to improve their visibility and hopefully ease access into the mental health care system. Finally, clinic staff function as facilitators in critical/traumatic incident debriefings in the community. For example, since the clinic opened for service in 1997, there have been several traumatic events including a shooting, several sudden deaths and several suicides. We provide support and debriefing for other clinical and emergency support staff including police, emergency response staff and social workers.

There are many service delivery issues at both the level of the individual and at the community level. First, there is a tendency for community members to mistrust 'outsiders' who provide health care in the community and there is uncertainty regarding their motivations for wanting to work in the community. Too often there have been stories of health care providers who lack cultural sensitivity toward their Aboriginal patients. As Aboriginal individuals, we try to provide culturally sensitive care and achieve a greater sense of trust with our clients because we have an 'insider' understanding of relevant issues within the community. Staff who are not originally from the Six Nations community have made an extra effort to meet the community, participate in various community activities and familiarize ourselves with its members and resources. We have also been respectful of an individual's wishes to pursue traditional healing approaches for their difficulties. Initially,

there was some concern from the community regarding confidentiality. For example, our clinic is located in the centre of the community and individuals stated they did not want to be seen by others entering our building. However, one of our goals has been to destigmatize mental illness and improve access to mental health services and we consciously made the decision to be placed in a central, accessible location. Initially, a lack of consumer awareness regarding mental health, mental illness, various treatments and available services was noted. Over the long term, we hope to improve this within the community by continuing our educational and increased awareness initiatives. There is also the possibility of our being able to expand our current services in the future; for example, extending our crisis response service hours and offering various groups for people with similar difficulties.

At the community level, there are a number of service delivery issues. Six Nations is a community with a very complex socio-political context. There is a distinct delineation between more 'westernized' individuals and those with a more traditional viewpoint. It is important for any health care provider to have an understanding of this complex context in order to deliver sensitive and effective care. Prior to the clinic opening, there was a lack of psychiatric and mental health services which resulted in the 'revolving door syndrome'. Previously, individuals with mental illnesses became acutely ill, were admitted to hospital psychiatric units in surrounding cities and subsequently discharged without any follow-up services being available in the community. They would then quickly deteriorate and often be readmitted to hospital. In the year prior to the clinic opening, 17 individuals accounted for 54 separate admissions to hospital. During the first year of our service, there were only 3 individuals who accounted for 5 admissions to hospital. There is also a complicated administrative structure within the community and much effort had to be put into our service planning, development and coordination in order that we not overlap services with existing agencies. We have also exerted efforts towards improving our interfacing with existing agencies and services by promoting a 'shared care' model with other clinical agencies and being available for case conferencing around complex cases.

There were also difficulties establishing collaborative working relationships with traditional healers in the community. There is ongoing consideration given to balancing the 'medical model' with traditional, holistic approaches. Also, due to the discrediting of traditional healing in decades past, many traditional healers in the community work 'underground' and are difficult to access. We have worked towards establishing respectful, collaborative relationships with traditional healers for the benefit of our clients. As a group of care providers, we have sought additional traditional teachings in order to increase our familiarity with traditional ceremonies and healing practices.

Finally, there is a lack of Aboriginal health professionals in Canada and specifically in the Six Nations community. Clinic staff work in a variety of ways to try and improve access for Aboriginal students into the health professions and related programmes. For example, we have provided both information for school projects and student placements for young individuals

in the community who show interest in a possible career in the health professions. We also make an effort to be visible at various career fairs which are held several times a year in the community. In an informal way, our clinic staff function as role models to the youth in the community and we have discussed establishing a more formal mentorship program for young students in the community who are interested in a health-related career.

In summary, Six Nations Mental Health Services is a community-based mental health and psychiatric out-patient clinic which has provided clinical, support and educational services to a rural Aboriginal community since June 1997. While we provide mainly 'medical model' treatment approaches to psychiatric disorders, we have strived to make significant modifications in order to provide more culturally sensitive and appropriate care to community members. We have tried to establish a mutually respectful collaborative working relationship with traditional healers in the community. In this way, we believe we are offering the community a "best of both worlds" approach to the prevention and management of mental disorders with the overall goal of providing culturally relevant services for the betterment of mental health at the individual, family and community levels.

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McGill Summer Program in Social & Cultural Psychiatry
ADVANCED STUDY INSTITUTE
The Mental Health of Indigenous Peoples
May 29-May 31, 2000

Monday, May 29 – Social Origins of Distress

- 9:00-9:30 *Opening Address – Paul Tekarontakeh Delaronde*
- 9:30-10:00 *Colonization, Marginalization & Technocratic Control – Laurence J. Kirmayer*
- 10:00-10:45 *“...the deep sleep of forgetfulness”: Reflecting on Disremembering – Ernest Hunter*
- 10:45-11:00 *Break*
- 11:00-11:30 *Violence and Suffering Among the Indigenous Populations of the Peruvian Andes – Duncan Pedersen*
- 11:30-12:15 *The Legacy of the ‘Stolen Generations’ – Jane McKendrick*
- 12:15-1:00 *Discussion – T. Kue Young, Gail Valaskakis*

Tuesday, May 30 – Individual and Collective Responses to Suffering

- 9:00-9:45 *Suicide among Australian Aboriginals – Ernest Hunter*
- 9:45-10:15 *Aboriginal Identity & the Construction of Fetal Alcohol Syndrome – Caroline Tait*
- 10:15-10:30 *Break*
- 10:30-11:15 *Lakota Psychology in Colonial Context – Theresa O’Neill*
- 11:15-12:00 *Discussion – Louis-Jacques Dorais, Kristin Norget*
- Transformations of Identity & Community**
- 1:30-2:00 *Healing the “Aboriginal” Offender: Identity Construction Through Therapeutic Practice – Gregory Brass*
- 2:00-2:45 *The Problem of Culture in the Counselling of Aboriginal People – James Waldram*
- 2:45-3:00 *Break*
- 3:00-3:30 *Towards a Recuperation of Souls & Bodies: Community Healing & the Interplay of Faith & History – Naomi Adelson*
- 3:30-4:00 *Negotiating Health: Meanings of “Building a Healthy Community” in Igloolik – Kristiann Allen*
- 4:00-5:00 *Discussion – Louis-Jacques Dorais, Kristin Norget*

Wednesday, May 31 – Models for Collaborative Research & Mental Health Services

- 9:00-9:45 *A First Nations Mental Health Clinic – Cornelia Wieman*
- 9:45-10:15 *The Hollow Water Study – Joseph Couture*
- 10:15-10:30 *Break*
- 10:30-11:15 *Working in Partnership: Innovative Collaborative Research Between Aboriginal Communities and an Academic Unit – Jane McKendrick*
- 11:15-12:00 *Discussion: John O’Neil, Gail Valaskakis*
- 12:00-12:30 *Closing –Paul Tekarontakeh Delaronde*

McGill Summer Program in Social & Cultural Psychiatry

The Division of Social & Transcultural Psychiatry in the Department of Psychiatry of McGill University organizes an annual summer program in social and cultural psychiatry as well as an Advanced Study Institute on current issues in cultural psychiatry. The program is directed to scholars, researchers and clinicians and advanced students working in the field of culture and mental health.

For more information, contact:

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ABORIGINAL MENTAL HEALTH RESEARCH TEAM

The Aboriginal Mental Health Research Team is dedicated to collaborative research with Aboriginal communities and organizations. The Team has been funded as a partnership between academics and community organizations by the *Conseil québécois de la recherche sociale (CQRS)* since 1995. The Team has been actively engaged in the study of emerging models of intervention for mental health and social problems in Aboriginal communities in Québec. The team provides a 'critical mass' for developing research as well as a multidisciplinary setting in which to train researchers and clinicians from Aboriginal communities.

Co-investigators on the team include: Drs. Laurence J. Kirmayer, Kathryn Gill, Naomi Adelson, and Adrian Tanner. The team coordinator is Caroline Tait.

Individuals from the following organizations are collaborating with the Team:

- Nunavik Regional Board of Health and Social Services
- Cree Board of Health and Social Services
- Native Friendship Center of Montreal
- Native Women's Shelter of Montreal
- Quebec Native Women, Inc.
- Culture & Mental Health Research Unit of the Jewish General Hospital, Department of Psychiatry
- Addictions Research Unit of the Montreal General Hospital
- McGill Departments of Psychiatry, Anthropology, Social Work, Social Studies of Medicine
- Departments of Anthropology of York, Memorial and St. Mary's University.

For more information, contact:

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