CHALLENGING HIDDEN ASSUMPTIONS:
Colonial Norms as Determinants of Aboriginal Mental Health

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Mental health has been receiving increased attention of late as an area of concern for many Aboriginal[1] peoples in Canada. The First Nations Health Council in British Columbia (n.d.) and Inuit Tapiriit Kanatami (2011), for example, have both committed to creating mental wellness plans and are taking specific actions to improve the mental well-being of Aboriginal peoples. The Standing Senate Committee on Social Affairs, Science, and Technology (2006) conducted an in-depth examination of the mental health of Canadians, including a chapter on the specific circumstances of Aboriginal peoples in Canada. The First Nations Regional Health Survey (First Nations Information Governance Centre, 2011) also incorporates questions based on personal wellness, substance use, and child mental and social well-being.

The social determinants of health are becoming an established way of framing health inequities. Research has shown that people who live in poverty or under conditions of stress, who are unemployed or discriminated against, face greater health difficulties than those for whom the conditions of life are more comfortable and secure. For Aboriginal peoples, colonialism is considered a social determinant of health (see, e.g., Gracey & King, 2009).

Colonialism is a process with a long history, and mental health services and values in Canada have been informed by the colonial foundations of the nation. The present health of Aboriginal peoples is impacted by these colonial foundations, which have resulted in the displacement and marginalization of Aboriginal communities and individuals, and the perpetuation of discriminatory or stereotyped ideas about what it means to be Aboriginal.

This paper examines how mental health service research and discourse reflect such remnant colonial ideas and, as such, constitute a social determinant of mental health for Aboriginal peoples in Canada. The paper is organized as follows. First, the methods used to gather information are briefly described. A second section looks at what areas research tends to focus on with regard to mental health for Aboriginal peoples in Canada. Third, a brief historical look at mental health and its relationship with colonialism around the world is presented, followed by a discussion of some hidden assumptions that stem from colonialism and can be found in the present-day mental health literature. A fifth section looks at the

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[1] The term 'Aboriginal,' as stated in Canada's 1982 Constitution Act, encompasses First Nations, Métis, and Inuit peoples. These three categories, in turn, include a wide variety of cultural and language groups. Throughout this paper, the term Aboriginal is used to refer to these groups in Canada; the term Indigenous is used to refer to Indigenous populations in an international context.

concept of social determinants of health as a framework for understanding health inequities, and positions colonialism in this framework. Next, a section on cultural competence and cultural humility is meant to offer some possibilities for how mental health research in Canada might better incorporate Aboriginal views of the world. A concluding section describes what Aboriginal scholars are saying about mental health and colonialism, and how mental health services are changing in response.

Methods

This paper draws on a scan of the literature relevant to colonialism and various proposed social determinants of health and mental health in Aboriginal contexts. The literature was identified through a search of the databases JStor, CINAHL, Medline, PsycInfo, and the Bibliography of Native North Americans, using the terms 'mental health,' 'colonialism,' 'colonization,' and 'Aboriginal,' 'Native,' 'First Nations,' 'Indigenous,' 'Métis,' 'Inuit,' or 'Indian.'

Select journals including *Pimatisiwin, A Journal of Aboriginal and Indigenous Community Health*; *The International Indigenous Policy Journal*; and *Social Science & Medicine* were browsed for relevant articles. The reference lists of relevant published documents were also used to find additional sources. While most of the literature came from Canadian sources published within the past ten years, prominent scholarly work from other regions or that predated this time frame have also been included. It must be noted that this was not a systematic review, nor is it intended to be a comprehensive review of the literature.

One important gap that must be noted, given the results of this literature scan, is that there is a serious lack of research and writing in the area of Métis mental health. Although 'Métis' was used as a search term, no documents were found specifically relating to Métis mental health. This remains a gap that needs to be addressed.

Literature and Research Foci – What is Mental Health and How is it Measured?

Mental health research involving Aboriginal peoples has historically been undertaken from a Western[2] point of view – that is, because such systematized research efforts are largely the product of 'Western' ways of knowing, they involve certain assumptions about what constitutes mental health (or, as is more often the focus of such research, mental illness) and about the nature of knowledge itself. Aboriginal peoples have, historically, not initiated or been involved in a large proportion of the mental health research involving their communities (Waldram, 2004). In addition, much of this research has been based on assumptions on the part of the researchers rather than on empirical evidence (Waldram, 2004). This imbalance in the authorship of mental health research is currently changing as more Aboriginal scholars and organizations are carrying out their own research; however, because

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[2] The term 'Western' refers to what is today known as 'Western civilization,' a wide-ranging and nebulous set of traditions and beliefs developed mainly in Western Europe. The foundation of Western values and world view are generally accepted as having developed during the years between the Renaissance (14th-17th centuries) and the Enlightenment (18th century) in Europe (Perry et al., 2003). Western approaches to knowledge tend to be based in secular, liberal, and individualist ideologies (Gone, 2009; see Cannistraro & Reich, 1999 for more discussion).

of the previous imbalance, assessing and addressing the prevalence of mental health and mental illness in Aboriginal communities can still be difficult.

To date, research involving Aboriginal communities has predominantly focused on specific types of mental illnesses or mental health problems. For the purposes of this paper, 'mental illness' refers to any disorder described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychiatric Association [APA], 2000), but it also implies a certain degree of severity in the amount of impairment a person experiences. More severe mental health problems – those which tend to cause more suffering than other disorders from the DSM-IV-TR, and those which can be more difficult for a person to manage on their own – are what are referred to in this paper as mental illnesses. 'Mental health problems' refer to less severe problems that, on their own, tend to cause less impairment in day-to-day functioning but can still greatly affect a person's quality of life.

Mental health research and measurement to date in Aboriginal communities tend to focus on the prevalence of mental health problems such as rates of suicide,

injury and violence, and substance abuse or addiction. There is presently a gap in the literature related to rates of severe mental illness among Aboriginal populations. As de Leeuw, Greenwood and Cameron (2010) point out, "high rates of suicide (particularly in youth), alcoholism, violence, and feelings of demoralization appear to be the most commonly experienced mental illnesses in Indigenous communities" (p. 284). Similarly, Kirmayer, Tait, and Simpson (2009) find "elevated rates of mental health problems in some communities," citing that "age-standardized suicide rates of Aboriginal youth are 3 to 6 times that of the general population." They go on to say that "in 2001, survey rates of emotional distress reported were about 13% among First Nations individuals living off-reserve, compared to 8% in the general population" (pp. 6-7). Suicide, substance abuse, violence, and depression or anxiety (emotional distress or demoralization) are the indicators overwhelmingly used in the literature to estimate rates of mental health problems in Aboriginal populations.

Some suggest that the major problems in Aboriginal communities are not best understood as expressions of psychopathology or severe mental illnesses,

but are better conceptualized as being the result of relatively high levels of social, mental, and emotional distress that cause poor quality of life. A witness reporting to the Standing Senate Committee on Social Affairs, Science and Technology (hereafter cited as Standing Senate Committee) stated that:

> There is no reason to expect, and I see no evidence that mental illness is any greater within the native community than it is in the general population. The fact that we have more mental problems is true. That is what we are referring to and looking at. There is a highly significant difference between the two. (Devlin, cited in Standing Senate Committee, 2006, sec. 14.2.1)

It is important to remember that research in the area of Aboriginal mental health is too often built upon or influenced by assumptions rooted in stereotypical views of Aboriginal peoples. This makes determining the prevalence of mental health problems or illnesses among Aboriginal peoples a complex undertaking. The oppression of Aboriginal peoples within Canadian society has resulted in social inequities that are at the heart of many mental health issues. The resolution of such issues requires attention to the

effects of colonialism on both individual and community health, and the promotion of self-determination and community control within mental health care.

Mental Health in the Colonies – The Relationship Between Colonialism[3] and Mental Health

The term 'mental health' was introduced to Canada with colonialism, as a government with its origins in Europe imposed its ways of thinking on Aboriginal peoples (Mussell, 2006). Today in Canada, the language and worldview that predominate in mental health services research and discourse still have foundations in colonial thought – thought which involves inequitable assumptions about colonized peoples, inherently disadvantaging Aboriginal peoples who access mental health care.

Kelm (1998) defines colonialism as:

A process that includes geographic incursion, socio-cultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services and ultimately, the creation of ideological formulations around race and skin colour that position the colonizer at a higher evolution level than the colonized. (p. xviii)

Colonial conceptions of mental illness have always been closely interrelated with the goals of colonialism itself. Biomedical practices and ideologies were used as justification for colonization. As Ernst (1997) writes with reference to colonialism in India:

Measures such as health care came to assume an essential ideological position in the colony. They became a means to justify colonial domination and to convince the white ruling class in India, as much as the public back home, that the British had (unlike the supposedly despotic oriental rulers) not simply usurped power but assumed it legitimately in the name of human progress and on the basis of rational scientific knowledge. Because they claimed to better the lot and decrease the suffering of any people, Western medicine and its emergent offshoot, psychiatry, lent themselves especially well to purposes of ideological legitimation. (p. 169)

Medical and psychiatric practices in the colonies also generally reflected the ideologies of the metropole. An example of this can be found in the racial segregation of mental institutions in Cape Town, South Africa in the years preceding formal Apartheid. Deacon (1996) writes that patients at the General Infirmary on Robben Island "were divided from each other for a complex range of medical, social, and management reasons. But within groups already divided by disease type and gender, the main distinctions were made in class terms, effectively segregating 'better-class' patients (who were all white) from the rest," a practice clearly based on Victorian ideologies found in Britain at the time (Deacon, 1996, p. 296).

Through colonization, the language and worldview of mental health and other

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[3] In this paper, the use of the term 'colonization' signifies the geographic and economic processes of incursion, whereas 'colonialism' addresses the political, social, and ideological aspects which accompany colonization. While Aboriginal populations have their own conceptions of disordered minds or abnormal behaviours, the term 'mental health' itself remains a Western construct and it is arguable whether or not Indigenous concepts are actually parallel to the Western term (Mussell, 2006; for a discussion of specific Aboriginal concepts of mental health see Kirmayer, Fletcher, & Watt, 2009).

health care services were consciously transplanted from the colonizing country to the colonies. Ernst (1997) writes:

> The British in India had by the early nineteenth century developed a distaste for things Indian. They had come to view nearly any idea that originated in Europe as the ultimate yardstick against which to measure policies in the East. A process that was as widely applauded by contemporaries in England as the perceived 'discovery of the asylum' could therefore only invite imitation in the steadily expanding British Empire. (p. 154)

The history of colonialism must be taken into account in efforts to understand the healing processes of Aboriginal peoples in Canada, as elsewhere in the world. Duran and Duran (1995) describe the results of colonization and colonialism as a "soul wound" (p. 24). They explain, "the notion of soul wound is one which is at the core of much of the suffering that Indigenous peoples have undergone for several centuries. This notion needs to be understood in a historical context in order to be useful to the modern therapist providing therapeutic services and consultation to the Native American community" (Duran & Duran, 1995, p. 24).

Relationships Between Mental Health and Colonialism in Present-Day Aboriginal Health Literature

Colonial ideas permeate today's society in ways that can be difficult to see. Mental health care in Canada has historically been influenced by the goals and ideologies of colonialism, but it is not often acknowledged that these ideologies persist in the ways that mental health care is delivered today. In the Canadian context, Czyzewski (2011) writes about "the politics of erasure of the history of relations between Indigenous peoples and the colonial state," and notes that, among other things, "this erasure reflects a public consciousness that is ignorant of the goings-on in residential schools and the laws that were put in place to prohibit most forms of possible recourse for Indigenous families" (p. 2).

The process of colonization includes the creation of "ideological formulations" (Czyzewski, 2011), and then the erasure – or the re-creation (see Adams, 2000) – of the history of the colonial state. These processes are all the more important because, unlike the displacement of people

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and the dispossession of their lands, the ideological side of colonialism is shrouded in popular myths that are taken for granted in the public consciousness, making it much harder to identify.

Like India and South Africa, Canada formed a part of, and as a nation remains informed by, the ideologies of the British Empire. The literature on Aboriginal health and mental health that stems from biomedical traditions and epistemologies still maintains certain imperial or colonial assumptions. For example, the assumed supremacy of scientific knowledge and the implicit assumption that other knowledges or medical practices are ineffective can still be seen. What follows is a description of some of these assumptions that are evident in the literature.

Ideas about the past
One assumption that shows through in the mental health literature is that Aboriginal cultures are somehow frozen in time, or stuck in the past. This assumption almost certainly stems in great part from the pervasive use of the term 'traditional' to describe practices and knowledges that are specifically Aboriginal. For example, even a thoughtful group of writers such as Waldram, Herring and Young (2006)

contrast "Aboriginal healing" (in general), which "is primarily informed and guided by the traditions of the past," and in which "the accrual of new knowledge is relatively slow," (p. 249) with biomedicine, which "is positivist, [and] based on a philosophy of scepticism. Something must be proven to work before it is accepted, and the method by which such proof is obtained is scrutinized carefully" (p. 249). Although the contrast is presented in a fairly even-handed manner, the evidence on which the authors base their generalized characterization of 'Aboriginal healing' (or, in fact, biomedicine) is not made clear. The implication that Aboriginal healing relies exclusively on the past, however, overlooks considerations that the development of new knowledge in Aboriginal communities has been interrupted in a profound way by the past century of residential schooling. Further, in a society in which, as Blackstock (2011) argues, the generation of new knowledge is prioritized over the knowledge of Aboriginal ancestors, such an argument valorizes the cutting-edge, rapidly changing knowledge of biomedicine and implicitly devalues Aboriginal healing.

Waldram, Herring and Young (2006), in addressing the question, "does Aboriginal

healing 'work'?," defer to an argument that "the efficacy of Aboriginal healing must be seen within its proper social and cultural context" (p. 251). In other words, the answer is not a simple 'yes,' leading the reader to doubt the efficacy of Aboriginal healing, independent of its cultural context (see Taylor, 2003, for a discussion of 'real' versus 'cultural' knowledge).

Negative views of difference
Colonial conceptions of mental illness frequently involve the medicalization of difference, or the creation of diagnoses based on departure from a norm. It can be argued, in fact, that Western society has no basis for defining mental illnesses other than through this perceived departure from normality. This way of defining mental illness is not inherently problematic, but it can lead to problems when different groups of people have different norms or standards, or different ways of defining illness. Dick (1995) makes this point in his examination of the literature on *pibloktoq*, or 'Arctic hysteria,' a supposedly culture-bound disease which was thought to afflict, primarily, the Inuhuit of Greenland (or in fact, was seen to be inherent in the Inuhuit 'personality'). The Danish and American literature on *pibloktoq* was mainly based

on a handful of secondary accounts, and assumptions were made based on behaviour that appeared strange to the outside observers. Causes were found in the cold Arctic environment, the lack of light, the excess or lack of certain vitamins – or, often, hysteria was seen to be due to the childishness of a 'primitive' mind, comparable to incidences in Europe and America of 'female hysteria,' which were explained in similarly patronizing terms (Dick, 1995, pp. 3-4; for further discussion of *pibloktoq* see also Waldram, 2004). Thus it would seem that *pibloktoq* – still to be found in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) – is a purely Danish/American invention without relevance to the Inuhuit people themselves. There exists no benefit in giving a diagnosis if it means nothing to the person being diagnosed.

Making social problems into health problems

Tait's (2009) discussion of the public perception of Fetal Alcohol Syndrome (FAS) in Aboriginal communities provides an example of how the colonial situation of Aboriginal peoples can become obscured, and a discussion of the social situation replaced by a medical explanation of health and community problems. As she writes:

The construction of FAS as a public health issue unduly stigmatized and blamed impoverished Aboriginal women for elevated rates of mental and social distress unfolding in their communities while simultaneously ignoring historical, social, and environmental factors that could account for the same outcomes. (p. 197)

Making social problems into medical problems diverts both blame for sickness and responsibility for healing to those who are suffering. In the case of Canada's Aboriginal peoples, this amounts to placing the burden of responsibility for health and social problems on people who are simultaneously denied the resources with which to adequately tackle these problems.

The Diagnostic and Statistical Manual of Mental Disorders

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* [DSM], the fifth version of which is currently under development and scheduled to be released in May, 2013, contains several problematic assumptions about culture and mental health. The DSM is universally used by clinicians in Canada and having a DSM diagnosis can influence people's eligibility

for medications, or disability or worker's compensation benefits. If one attempts to define mental illness by looking in the DSM-IV-TR (the most recent published version of the manual), one quickly runs into a host of social, cultural, and gender issues. Several authors have pointed out that the DSM exists, and was developed, in a very specific cultural environment, and therefore may not be applicable to people who live in other contexts (see Phillips, 2010; Mezzich et al., 2008). However, the introduction to the DSM-IV-TR declares without qualification that "the involvement of many international experts ensured that DSM-IV had available the widest pool of information and would be applicable across cultures" (APA, 2000, p. xxiii). So, what did the Work Groups and Task Force charged with creating the DSM-IV-TR do to make their manual "applicable across cultures?"

The DSM-IV-TR attempts to account for cultural differences by including, in the text pertaining to each disorder, a section that describes cultural variations which may be seen in symptoms or the interpretation of symptoms. Specifically, as stated in the introduction, "this section describes the ways in which varied cultural backgrounds affect the content and form of the symptom presentation...,

preferred idioms for describing distress, and information on prevalence when it is available" (APA, 2000, p. xxxiv). Variations in interpretation of symptoms across cultures are also mentioned in the 'cultural formulation' section of the appendix, where it is stated that:

Aberrant behavior that might be sorted by a diagnostician using DSM-IV into several categories may be included in a single folk category, and presentations that might be considered by a diagnostician using DSM-IV as belonging to a single category may be sorted into several by an indigenous clinician. (APA, 2000, p. 898)

This attempt to be inclusive of different cultures still reflects a very specific cultural bias. For example, who is the 'diagnostician' referred to in this passage? There is no reference to the diagnostician's culture. On the other hand, it is implied that 'folk' categories are those used by the 'indigenous clinician,' who is defined by his or her culture, causing his or her expertise to be seen as applicable only within a specific cultural context. The Indigenous clinician is not allowed the universality that the diagnostician possesses.

Another appendix to the manual includes "a glossary of culture-bound syndromes" (APA, 2000, p. xxxiv). The inclusion of this information in an appendix at the back of the manual suggests that diagnoses that are limited to a specific culture are less worthy of consideration. It gives the impression that diagnoses in the body of the manual are significant, whereas those contained in the appendix are somehow less important. Also, there is a significant lack of detail in the descriptions of these 'syndromes,' each consisting of a short paragraph, compared to the pages of categorized description used in the body of the manual. As an example, this appendix includes the following description of *pibloktoq*, a culture-bound syndrome discussed above:

Pibloktoq: an abrupt dissociative episode accompanied by extreme excitement of up to 30 minutes' duration and frequently followed by convulsive seizures and coma lasting up to 12 hours. This is observed primarily in arctic and subarctic Eskimo communities, although regional variations in name exist. The individual may be withdrawn or mildly irritable for a period of hours or days before the attack and will typically report complete amnesia for the attack. During the attack, the individual may tear off his or her

clothing, break furniture, shout obscenities, eat feces, flee from protective shelters, or perform other irrational or dangerous acts. (APA, 2000, p. 901)

Waldram's (2004) and Dick's (1995) research into the literature surrounding *pibloktoq* discusses the significant lack of evidence that such a condition even exists – which leads one to wonder where the very specific numbers in this passage are drawn from, or what a 'typical' episode refers to. The evidence found by Waldram and Dick also points to *pibloktoq* being an invention of early European travelers, calling into question what 'culture bound' really means. In fact, any of the diagnoses throughout the body of the DSM-IV-TR could be considered specific to a certain culture, and the reasons for including a given disorder in the 'culture-bound' section instead of in the main part of the manual are not made clear.

The DSM-IV-TR (and, in fact, many of the proposed changes to be included in the DSM-5; see APA, 2010) involve the medicalization of difference; in other words, those who are seen as deviating from certain specific norms are given labels of mental disorder. This is made clear in the contrast between "normality

and pathology," in which pathology – or the existence of disease – is seen to exist where normality is missing (APA, 2000, p. xxxi). One is then left to wonder what the criteria for normality are; presumably this is left to the discretion of the clinician. Given the preponderance of clinicians in North America who are of European descent (Gone, 2009), it seems likely that it is their perspectives on normality which predominate.

A further example of the medicalization of difference can be found in the diagnosis of "gender identity disorder" (APA, 2000, p. 849). The notion of gender itself is a social construct which many people see as restrictive and as bestowing unfair advantages on certain people over others (see, e.g., Torr & Bottoms, 2010; hooks, 1988). The diagnosis of a confused gender identity as a pathology then creates the impression of a silencing of protest; of restricting those who would challenge – or who are confused by – established roles. Further, while homosexuality is no longer classified as a mental disorder (Calabrese, 2008), one of the criteria for gender identity disorder is having an attraction to members of the same sex; something which, by implying pathology, seems to contradict the APA's recent statement in

support of legalizing same-sex marriage in the United States (Levine, 2011).

The DSM is widely used by mental health care providers in Canada; it is the only manual of its kind. The assumptions it contains are often questioned, but in the document itself, the primacy of one (colonial) cultural context prevails.

Social Determinants of Health

Social determinants of health are the circumstances and wider social forces that impact people's ability to be healthy (WHO, 2011). For Aboriginal peoples in Canada, colonialism limits available resources and opportunities, thereby making it more difficult to maintain health. More directly, colonialism has impacted Aboriginal peoples' mental health through the experience of residential schools, as well as government restrictions on ceremonies and movement in and out of reserves (see Laliberte et al., 2000). Colonialism is a determinant of health in itself, which at the same time can influence other health determinants.

The World Health Organization (2011) defines the social determinants of health as:

The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. (n.p.)

These circumstances and forces include: social gradients, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport (Wilkinson & Marmot, 1998). They also include "political empowerment – inclusion and voice" (WHO, 2008, p. 18). According to the WHO Commission on the Social Determinants of Health, "inclusion, agency, and control are each important for social development, health, and well-being" (Ibid.). Actions they recommend be taken include "strengthen[ing] political and legal systems to protect human rights, assur[ing] legal identity and support[ing] the needs and claims of marginalized groups, particularly Indigenous Peoples" (Ibid.).

Social determinants of health can have a cumulative effect. As Loppie Reading and Wien (2009) write, "not only do social determinants influence diverse dimensions of health, but they also create health issues that often lead to circumstances

and environments that, in turn, represent subsequent determinants of health" (p. 2). The example they provide is how living with low income can exaggerate the experience of illness or disability, which in turn influences a person's ability to work and thereby earn income.

Colonialism has an important impact on people's political empowerment, social inclusion, and voice, and is frequently listed as a determinant of Aboriginal peoples' health (see Czyzewski, 2011; Gracey & King, 2009; Loppie Reading & Wien, 2009). Loppie Reading and Wien (2009) identify three levels of social determinants of health: proximal factors, such as physical environment and employment, which have a direct impact on personal health; intermediate factors, including health care systems and community infrastructure, which are at the root of proximal determinants; and distal factors, which are overarching systemic, institutional, economic, or political factors that "construct both intermediate and proximal determinants" (p. 20). As they put it, "in the case of Aboriginal peoples... to a large extent, colonialism, racism, and social exclusion, as well as repression of self-determination, act as the distal determinants within which all other determinants are constructed" (Loppie Reading & Wien, 2009, p. 20).

The persistence of attitudes fostered by colonialism negatively impacts all peoples in colonial societies, including colonizers, by creating a divided society and by discrediting many valuable sources of knowledge and understanding; but it is beyond doubt that Aboriginal peoples bear the more severe impacts of colonialism on health. As a participant in Stewart's (2008) work points out:

> *The reality is that if you don't have some iota or some speck [of understanding] of yourself as a person on the planet that has value and connectedness to who you are [culturally], it is very hard to change behaviour, build on behaviour, change thinking, [or] build on different skills or abilities that will change your day-to-day experiences. (p. 15)*

In other words, when one's culture, behaviour, and norms are criticized and devalued, it becomes much harder for a person to be healthy.

Cultural Competence and Cultural Humility

Cultural competence has been developed as a method of training health care practitioners in cross-cultural awareness in various settings. It is conceived of in various ways – including a spectrum encompassing different levels of understanding – and has been given different names. Overall, however, the goal of cultural competence training is to teach people – generally health care providers – about the history, beliefs, and practices of groups of people they have had little previous contact with, so that the provider can give care in a manner that will make the patient or client feel safe, respected, and understood.

Cultural competence training programs achieve their stated goal with varying rates of success. These programs run the risk of attributing static and uniform cultural values to groups (such as Aboriginal peoples in Canada) who are far from homogeneous. The best programs are those which introduce the learner to the history of colonization in Canada, and its effects on the social positions and health of Aboriginal peoples in a respectful and

honest way, avoiding blanket statements about the way people 'are' (for a good example, see University of Victoria, n.d.).

A concept that is potentially more useful than cultural competence, in terms of confronting persistent colonial ideas in mental health care, is that of cultural humility. Cultural humility is defined as: "a lifelong commitment to self-evaluation and self-critique in order to redress power imbalances and to develop and maintain mutually respectful dynamic partnerships based on mutual trust" (Minkler & Wallerstein, 2008, p. 100). The central requirement of cultural humility is "that the caregiver engage in a process of self-reflection in which one's own culture and assumptions are recognized" (Walker et al., 2010, p. 60).

Taylor (2003) addresses some of the difficulties with self-reflection that she sees in the medical community. Biomedicine, she argues, is seen by those who practice it as a "culture of no culture" (Ibid., p. 556); thus, cultural competence is seen as the acquisition of knowledge about other people rather than about oneself. The perceived absence of culture in biomedicine is explained in the way that "medical knowledge is understood

not to be merely 'cultural' knowledge but *real* knowledge" (Ibid., p. 556, emphasis in original). As we have seen above, the creation and use of the DSM in mental health care also seems to incorporate such a way of seeing the world, in which the clinician is thought to be culture-free and his or her knowledge universally applicable.

To imagine that some people are without culture and others are defined by their culture is a problem similar to what Dyer (1997) describes with reference to race. He states that "as long as race is something only applied to non-white peoples, as long as white people are not racially seen and named, they/we function as a human norm. Other people are raced, we are just people" (Dyer, 1997, p. 1). Gone (2009) makes reference to this tendency when he notes that "modern Western notions about mind, body, and person... are perhaps most appropriately designated '*ethnotheories*' of mind and behaviour" (p. 427, emphasis added), a term which is usually reserved for the raced or cultured 'other.' It is important for non-Aboriginal mental health care providers and researchers to be aware of this type of problem and work towards honest self-reflection and understanding.

Aboriginal Perspectives About Mental Health and Colonialism in the Literature

Aboriginal peoples have been vocal about the impact of colonialism on mental health, and on health in general. For example, the Health Council of Canada (2011) undertook a dialogue with front-line workers and community members about maternal and child health in Aboriginal communities and were somewhat surprised by the topics participants focused on. They commented that:

> We heard less than we had expected on some topics (there was very little discussion of well-documented health care issues among Aboriginal women and children, such as diabetes, low birth weights, or breastfeeding challenges) and more on broader issues affecting Aboriginal communities as a whole. In particular, we heard about the impact of the traumatic experience of colonization – the imposition of Western values and way of life – and residential schools. (p. 6)

Stewart (2008), in her interviews with Aboriginal counselors and support workers at an Indigenous social service agency, also found that experiences of colonization

and colonialism figured prominently in Aboriginal counselors' experiences of mental health. Healing at a community level from the effects of colonialism was considered essential in order for individual healing to take place.

Many Aboriginal scholars write that health care, including mental health, incorporates a specific framework and specific ideas about how to make sense of the world which do not always fit with Aboriginal patients', or providers', own ideas. As one participant in Stewart's (2008) study explained:

> *I would like to see more [Native] cultural practices of mental health and healing be more accepted and incorporated into the mainstream, and not have the mainstream model of health so pushed and in your face in the helping fields. (p. 16)*

Having Western ideas "pushed and in your face" is an ongoing feature of colonialism, and one which interferes with Aboriginal community healing and mental health.

Two themes can be found in much of the literature pertaining to Aboriginal mental health: first, that colonization and colonialism have had a great impact on Aboriginal peoples' mental health; and second, that the services in place to address

mental health issues in Canada are based in colonial ideas and therefore may not adequately address mental health problems for Aboriginal peoples.

Historical or intergenerational trauma

One major area in which current research is being undertaken with respect to the links between colonialism and mental health has to do with what is called historic or intergenerational trauma (see, e.g., Wesley-Esquimaux & Smolewski, 2004). Historic trauma is described as a process by which the harmful effects of traumatic experiences are passed from those who have had the experiences (for example, residential school survivors) to their family members, in particular their children – regardless of whether the latter have directly experienced the same trauma. The concept is similar to Duran and Duran's (1995, p. 24) "soul wound", which describes a phenomenon in which an entire population is affected for generations by the experience of systematic violence, oppression, and widespread grief.

It is widely agreed that, because of experiences of colonialism and resulting historical trauma, addressing many mental health problems for Aboriginal peoples requires addressing the broader social, economic, and historical contexts in which

people and communities are situated (Mitchell & Maracle, 2005). In response, changes are being made in several areas across Canada to the ways in which mental health services are provided to Aboriginal peoples and communities.

What is being done in terms of service changes

Several health centres across Canada are changing the way they provide mental health services for Aboriginal peoples, in order to try to take these contexts into account. In some cases, services are described using Aboriginal languages and developed using concepts specific to an Aboriginal language and/or nation as a framework. For example, at the Noojmowin Teg Health Access Centre in Ontario, instead of referring to 'clients' or 'patients,' people who seek traditional healing are referred to as 'relatives,' highlighting the equal partnership between the healer and the person seeking healing that is an integral concept of Manitoulin area Anishinabe healing practice (Maar & Shawande, 2010, pp. 21-22).

The availability of traditional healers at mental health centres is another way in which mental health care services are changing to meet the needs of Aboriginal peoples. Although there are some challenges in integrating biomedical

healing practices with Aboriginal healing practices (Maar & Shawande, 2010), generally, having access to a traditional healer in a health centre setting is met with a positive response and is viewed as a good way of approaching mental health care for Aboriginal peoples (Anishnawbe Health Toronto, 2010, 2005; Skye, 2006).

Organizing and conceptualizing the delivery of mental health services in different ways and creating spaces in which Aboriginal and biomedical healing can work together allows the care offered to reflect a framework that diverges from a strictly biomedical one and, in the best cases, avoids perpetuating colonial assumptions about Aboriginal mental health and about mental health care in general.

Concluding Thoughts

The ways in which mental health services are offered – and researched – in Canada have a foundation in one particular view of the world; that of the colonial powers who imposed this nation-state on Aboriginal lands. Because of popular myths which assert that this view of the world is universal, it is not generally acknowledged that this view is in fact culture-specific. As a result, it is often difficult for others to fully understand why so many Aboriginal peoples have an unpleasant experience or are discouraged when attempting to access mental health services.

The colonial ideas that are found in mental health services research and discourses in Canada today can be traced back to the very beginnings of colonialism around the world. The assumptions underlying these ideas need to be made explicit so that they can be tested and challenged. Hidden assumptions based on colonialism carry risk for Aboriginal peoples who access mental health services in Canada today – such ideas need to be understood as a social determinant of Aboriginal peoples' mental health, and need to be addressed.

Aboriginal peoples have not been silent or still on this issue. Researchers, clinicians, and policy makers should reflect on what is perceived as 'real' knowledge, and why such knowledge is perceived to be culture-free. All theories are 'ethnotheories'; all human beings have culture. In fact, we all belong to several cultures simultaneously. Humility, respect, a willingness to question the status quo, and an openness to learning have the potential to create better well-being for us all.

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