

CANADIAN ABORIGINAL CONTEXT: A POST-COLONIAL PERSPECTIVE

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Unlike the American Psychological Association ethics code, which remains silent on the matter, the Canadian Psychology Association's ethics principle IV (responsibility to society), sub-category 5, states that an ethical psychologist 'would':

participate in the process of critical self-evaluation of the discipline's place in society and in the development and implementation of structure and procedures which help the discipline to contribute beneficial social functioning and changes (Association, 1991, p. 25).

In the spirit of this principle a critique of the role of clinical psychology in the context of work with Canadian aboriginals.

The question that must be considered is: how can I serve Aboriginal people as a psychologist, without inadvertently contributing to their oppression (and my own)?

The critical analysis (i.e. post-structural/colonial-feminist approach) of psychology works with five basic assumptions:

- (1) psychological problems must be understood in their sociocultural context (i.e. their sources, emergence, symptomology, meaning and prognosis are socially constituted) (Kleinman, 1986);
- (2) individual and family clients are not all equal in the sociocultural context (Heenan, 1996);

- (3) both clients and clinicians are disempowered by mainstream power relations in the psy-complex which exists to maintain the sociocultural-economic status quo (Prilleltensky, 1994);
- (4) the psychological focus on individual autonomy and pathology maintains the (oppressive) hegemony and the field's status within it (Korin, 1994); and
- (5) only if psychologists choose to view social activism as intrinsic to our therapeutic, research and educational work is the alleviation of suffering (our *raison d'être*) possible (Korin, 1994; Prilleltensky, 1994).

According to this perspective, the dominant power structure within any social system perpetuates itself to maintain the social (read throughout as the sociocultural-economic-political-historical) status quo. This social milieu is created and maintained through control over definition:

- (a) 'normal' is defined by the psy-complex -- giving moral legitimacy and a notion of universality to hegemonic institutions' (Duran & Duran, 1995);
- (b) resistance and any problems related to the oppression inherent within the system are defined in a manner that is not threatening to the power structure (Prilleltensky, 1994).

Thus, with marginalised clients (such as Aboriginal people), we are guilty of false generosity—i.e. the exchange of apparent healing in exchange for further supplication to hegemonic demands (Burman, 1996; Freire, 1990). The result is the dehumanization of clients and clinicians, as each becomes an object of the hegemony (i.e. oppressor and victim).

Despite the diverse manner in which Aboriginal individuals integrate their unique experience, all Aboriginal people in Canada share the experience of colonization (e.g., Duran & Duran, 1995; Kirmayer, et al., 2000b). Offering a critical analysis of the hegemonic discourse, the post-colonial paradigm considers colonization to operate at an ideological level--a *cognitive imperialism* that impacts identity and socioculturally sanctioned knowledge, continuing long after the obvious signs of imperialism have faded (Battiste, 2000). Colonialism is considered to be an often un-verbalized value system that initiates conquest (via trade or arms) and justifies the appropriation of land and that defines the culturally different as inferior to one's own culture and, therefore, an appropriate site for social intervention. In order to legitimate and perpetuate the hegemonic status quo, the dominant coloniser imposes their value system upon those colonized by the production of knowledge about them and the subsequent interventions that are deemed necessary according to that knowledge (Freire, 1990; Harris, 2002; Said, 1993). Post-coloniality is not an historical event (i.e., the end of colonization), but the comprehension of the processes of colonization while they continue to be played out on populations targeted by the dominant culture (Waldram, 2004).

Post-colonial Psychology

According to the post-colonial perspective, the hegemonic role of psychology has been and continues to be accomplished two ways. First, the Universalist notion of a value-neutral approach to individualized psychology is argued to render invisible the sociocultural and historical differences between cultural groups, resulting in the depreciation and pathologizing of individuals and cultures that lie outside of the ideological frame of reference. Further the individualist focus denies the strengths of

the social context, particularly within a culture that emphasizes the collective (e.g., Dana, 1996; Duran & Duran, 1995; Lykes, 1996; Satzewich, 1998; Schwartz, 1992; Smith, 1998; White, 1992).

The second process criticized by the post-colonial psychological perspective is the isolation of mental health from its sociohistorical context through the *medicalization* of psychopathology, healing and resilience. Mental illness and mental health is considered to be a *psychologised* social judgement--one in which a behavioural response to a difficult sociocultural situation is individualised and pathologised. Universalist psychological treatment and research with oppressed peoples promotes the subjugation of oppressed groups by the dominant culture by reducing the distress associated with oppression, rather than the oppression itself. Empowerment is conceived as psychic (rather than political) liberation and the pursuit of *social change* is exchanged for *social adjustment*. Issues of history, privilege and marginalization are avoided as knowledge is understood to be personally derived--rather than socially constituted. Thus, dominant psychological methodologies are used to colonize political terrain and uphold the position of the dominant power structure (Atleo, 1997; Burman, 1996; Billington, 1996; Duran, 1996; Gutierrez & Lewis, 1999; Heenan, 1996; Ingleby, 1980; Kitzinger & Perkins, 1993; Kleinman, 1988; Prilleltensky, 1994; Wade, 2000). In the Aboriginal context, the individualized experience of a distressed Aboriginal person may be made sense of by means of the correlating of factors in the individual's life (e.g., familial treatment, addiction, etc.)--which necessarily lineignores socio-cultural constants of ongoing colonial oppression (Chrisjohn et al., 1997; Lykes, 1996). For example, post-colonial psychologists argue that the cause of the depression among the

oppressed is a normal response to the hegemonic demand that the colonized passively accept their victimization. The “language of deficiency and dysfunction reduces to personality and syndromes behaviours that have emerged as survival or resistance to oppressive conditions (Young, 2005, p. 7)” and a wide range of institutions and models have been developed to substantiate this designation. (e.g., Duran & Duran, 1995; Freire, 2005; Wade, 2000).

See Appendix 1: Colonial History of Canadian Aboriginal Peoples in Brief

The federal government has offered a variety of therapeutic responses to the “Aboriginal mental health crisis”. A so-called “Aboriginal Social Welfare Industry” has offered a method to continue control and exploit the Aboriginal population as effectively as the previous colonial waves (Chrisjohn, et al., 1997; Smye, 2003; Wade, 2000; Ward, 2001). According to Freire (2005):

Any attempt to ‘soften’ the power of the oppressor in deference of the weakness of the oppressed almost always manifests itself in the form of false generosity...

An unjust social order is the permanent font of this ‘generosity’ which is nourished by death, despair, and poverty (p. 44-5).

Stephenson (1995) introduced the related notion of *psycholonization*: “In the discourse of colonization, Aboriginal persons were violated and displaced because they were seen as deficient. In the discourse of psycholonization, Aboriginal persons are seen as deficient (damaged, disordered, dysfunctional, etc.) because they were violated and displaced (p. 201).”

A paradigmatic example of psycholonization can be found in the proposed diagnosis of *Residential School Syndrome* (RSS), a designation commonly used by

psychological and psychiatric clinicians who specialize in work with the Aboriginal community (and now embraced by many in the Aboriginal community itself). Considered by Brassfield (2001) to be a particular form of Post Traumatic Stress Disorder, he argues that RSS requires: (1) attendance of an Indian Residential School (IRS) or a close relationship with an attendee, and the following symptoms: (2) the *intrusion* of terrifying memories, flashbacks, dreams or distressing physiological arousal triggered by a symbolic or actual contact with the IRS; (3) the *avoidance* of thoughts, feelings, activities or memories anything that reminds one of IRS and/or avoidance of cultural or social connection; (4) *self-control difficulties*, e.g., with sleeping, controlling anger, concentrating, and/or *hyper-vigilance* to danger (particularly among non-natives); and (5) *social symptoms*, including cultural loss, poor parenting, unemployment, substance use, etc. In fact, the diagnosis suggests that many of the problems currently experienced within Aboriginal communities (e.g., addiction, violence, unemployment, family problems, suicide, etc.) are a result of this *mental illness*.

This proposed diagnosis is challenged by the post colonial perspective, which argues that RSS places the responsibility for the symptoms on an individual's failure to adjust to their traumatic personal past. Focussing on the sociohistorical context of the proposed diagnosis, Chrisjohn, et al. (1997) suggest that RSS would be better defined as:

a personality disorder manifested in an individual's specific behavioural action of (1) obliterating another people's way of life by taking the children of the group away from their parents and having them raised in ignorance of, and/or in

contempt for, their heritage; while (2) helping himself/herself to the property of the target group. ... (p. 84).

From this sociohistorical and politically constituted perspective, it is not the Aboriginal individuals who are sick, but the colonizers who are pathological. Thus, the notion of RSS is, itself, viewed to be a colonial tool—a transference of the pathology of colonization that labels residential school survivors as pathological, rather than as individuals living with ongoing sociocultural oppression (Duran, 2006).

From the post-colonial point of view, the model of individual pathology and treatment promoted in government publications regarding service provision and best practices (e.g., Canada, 2005) allows for the continuation of oppression through the pathologization of individuals and the resulting false generosity (e.g., Freire 2005; Prilleltensky, 1994). According to an expression noted by Daes (2000): “you cannot be the doctor if you are also the disease (p. 4).”

Post-colonial View of Aboriginal Biopsocialpsychopathology

Ultimately, the impacts that have been identified by collectivistic post-colonial researchers are a compounding of social and personal problems (Brassfield, 2001; Dion Stout & Kipling, 2003; McCormick, 1997; Mussel et al., 2000; RCAP, 1995; Ross, 1992; Uchelen et al., 1997).

Biological impacts of colonization.

Aboriginal health statistics deviate negatively from the non-native. The prevalence of the five most common chronic ailments suffered by adults exceeds the non-native rates across all age and gender demographics. Specifically, compared with the non-native population: diabetes is more than 4 times more common (25% of those

above the age of 45 report being diagnosed with diabetes); heart disease is three times more common; cancer is nearly twice as common; hypertension is two and half times more common; and arthritis/rheumatism is more than one and a half times more common. While childhood health is similar in the Aboriginal and non-native communities, childhood death by injury is more than three and a half times higher among aboriginal families (with the highest risk to preschoolers) (Kue Young, O'Neil, Elias, Leader, Reading & MacDonald, 2001; White, Maxim, & Beavon, 2003).

Social impacts of colonization.

In the social sphere, the Aboriginal community is also negatively skewed in comparison to the mainstream in terms of family union, academic completion, employment and income. Among those between 15 to 64 years old, 51% of Aboriginal individuals are more than one and one half times more likely to live apart from their spouses and more than twice as likely to be lone parents. Academically, less than half of Aboriginal individuals graduate from secondary school and they are more than three times less likely to obtain some university degree. Aboriginal unemployment levels are nearly two and a half times the mainstream and nearly twice as likely to receive some kind of government transfer payment (e.g., welfare). However, the majority of Aboriginal people who are employed have jobs concentrated in low paying occupations. As a result, the average Aboriginal income is nearly ten thousand dollars less than the mainstream, with nearly half of Aboriginal workers earning less than \$10,000 per year. In terms of crime, Aboriginal people are almost three times as likely to be victims of violent crime and are more likely to come into contact with police than non-natives. They are four times more likely to be arrested and, depending on the province, between

twice and ten times more likely to be incarcerated (particularly for assault, sexual assault, and/or robbery) (Statistics Canada, 2001).

Psychological impacts of colonization.

Personal distress (e.g., hopelessness and helplessness, anger, depression and anxiety, loneliness, shame/guilt, apathy, identity confusion and self-hate, addiction, risky and self-destructive activities, suicidal ideation/attempts, etc.) is considered to be widespread (Brassfield, 2001; Chandler, 1998; Dion Stout & Kipling, 2003; McCormick, 1997; Mussel et al., 2000; RCAP, 1995; Ross, 1992; Uchelen et al., 1997). To explain this, Duran & Duran (1995) recommend the diagnosis: *Acute and/or Chronic Response to Colonialism*. In psychological terms, the negative impacts of colonization have been viewed within the notions of identity, self esteem and trauma. Self esteem (i.e., positive self evaluation) has been argued by individualists to outstrip all other indicators of life satisfaction, including social demographics and psychological variables (Crocker, 1999; Owens, Stryker, & Goodman, 2001; Rosenberg, 1979). Identity has been addressed as both a personal and social construct. According to Kirmayer, et al. (2000b):

It is likely that the mediating mechanism leading to high levels of emotional distress and problems like depression, anxiety, substance abuse, and suicide are closely related to issues individual identity and self esteem. These, in turn, are strongly influenced by collective processes at the level of band, community, or larger political entities (p. 611).

See Appendix 2: Colonization and Trauma

Aboriginal suicide statistics are thought to be very conservative (Mussel, Cardiff, & White, 2004; RCAP, 1995). This is due, in part, to a lack of a single construct of

suicide-related behaviour and the social influence on the derivation of statistics (Lester, 1989b). Specific to Aboriginal communities, four factors complicate matters and reduce the likelihood of accurate suicide statistical reporting. These are: (1) since many Aboriginal people are not officially registered as Status Indian, they are not consistently included in the data (Waldram, 2004); (2) it is estimated that up to 25% of fatal accidents on reserve are suicides, but are not so-labelled to spare the family from social stigma (RCAP, 1995); (3) medical complications from non-lethal suicide attempts, that later lead to death, are also often missed (Maris et. al, 2000); and (4) 60% of Aboriginal suicides were found to have been intoxicated at the time (versus 24% of non-natives)--many so severely intoxicated that their conscious choice to suicide can be called into question (Stephenson, 1995). However, despite these statistical limitations, the Aboriginal suicide rate has been identified to be three times higher than for non-natives for the last thirty years of coroner reports (e.g., 43.5 per 100,000 in 1984) and up to six times higher for Aboriginal people living on rural or isolated reserves (Mussel et al., 2004; RCAP, 1995).

Historically, after European colonization, a significant increase in the suicide rate among indigenous peoples around the world has been recorded and remarked upon (RCAP, 1995). This has been explained from the collectivistic perspective as an inverse relationship between level of assimilation and the elevation of the Aboriginal suicide rate (Cooper, Krarlberg, & Pelletier Adams, 1991). According to the Royal Commission on Aboriginal People's Report on Suicide (1995), Aboriginal suicide is:

the expression of a kind of collective anguish--part grief, part anger... the cumulative effect of 300 years of colonial history: lands occupied, resources

seized, beliefs and cultures ridiculed, children taken away, power concentrated in distant capitals, hopes for honourable co-existence dashed over and over... (p. 3).

Suicide has been identified as the paradigmatic expression of the impact of colonization—the symbolic outcome of the hegemonic intent to annihilate a people.

Post-colonial View of Aboriginal Healing

Seen through the cultural and post-colonial lenses, the mainstream approach to mental health and healing ignores the importance of the client's culture on the one hand and sociohistorical context on the other (e.g., Prilleltensky, 1994). Duran (2006) argues that colonization:

can be described as a collective raping process of the psyche/soul of both land and the people. It is the inclusive life-world that becomes the victim of such an assault...at the physical, psychological, and spiritual level. Therefore, the healing must be addressed at all of these levels. Healing of the body, mind and spirit is further compounded by the fact that the trauma occurs at the personal, community, and collective levels (p.21).

As a result, it has been argued that healing must incorporate cultural processes/values that traditionally generated harmony between these levels—including the land (an essential part of Aboriginal identity) (e.g., Lykes, 1996; Tsosie, 2003). Since the Aboriginal community's current socio-historical context is considered to be pathogenic, a socioculturally-driven response to that oppressive context--i.e., active resistance to the pathogen--is identified to be the curative factor for both individuals and communities. Clinicians, researchers, and policy makers, on the one hand, and community members

committed to health and healing, on the other, are encouraged to conflate healing with de-colonization. In the mental health context, this is called “liberation psychology”, a stance which seeks to remove clinicians from their traditional role as ongoing “perpetrators of historical trauma (Duran, 2006, p. 34).” From this position, the role of a healer is to promote a culturally integrated holistic healing process, facilitate community/economic development, and/or to confront ongoing oppression (Dion Stout & Kipling, 2003; Prilleltensky, 1994). Thus, in the context of cultural oppression, “healing” is conflated with “resistance”.

For a Post-colonial culturally-rooted model of mental-health-related community development/healing/resilience/resistance (as presented to community leaders and caregivers), see Appendix 3: “The Community is the Medicine.”

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APPENDIX 1: A Post-colonial Canadian Aboriginal Sociocultural History

It is not possible to understand Aboriginal suicide and resilience—or any experience of an Aboriginal person—without considering the sociocultural history of their community (e.g., Canetto & Lester, 1998; Duran, 2006; Marker, 2003). The following historical survey will offer a critical narrative of Canada's social history as it pertains to Aboriginal peoples.

Pre-contact.

Aboriginal people began their history in what is now British Columbia (BC), Canada, between 30,000 to 70,000 years ago. In BC, the pre-contact population has been estimated 188,344, living in nearly two hundred First Nations on the coast and within interior regions and speaking eight major languages (each with a variety of dialects) (Brassfield, 2001; Mussel et al., 2004). Commonly, eighty percent of the year was spent in family groupings, rather than a broader community. Collectivistic social values emerged to support the survival of small and relatively stable groups living in close quarters. Family-oriented ethics (enhancing harmony within and between families), rather than individual or community-oriented ethics were generally emphasized. A hunter-gatherer lifestyle was formalized by inherited land use rights and social roles tended to support communal survival and were impacted by one's age, birth order, family membership, and capacity. Marriage was prohibited within one's clan, requiring a level of harmony between different communities and nations. While one's original clan membership was retained and passed onto one's children, war and inter-community raiding did occur (Ross, 1992).

Early contact.

The colony of British Columbia was formally established in 1858 after four hundred European settlers were invited to stay by a population of 63,000 Aboriginals. In 1867 Canada was declared a sovereign nation and BC joined the confederation four years later. Since the Aboriginal peoples were organized into pre-existing nations, they became the administrative responsibility of the federal rather than the provincial government. Nonetheless, authority over land and resources under Aboriginal title remained with the province (Harris, 2002). However, due to imported diseases and other consequences of colonisation, the post-contact Aboriginal population in British Columbia declined by between 90-95%--by 1890, Aboriginals were a minority in BC (Dion Stout & Kipling, 2003; Harris, 2002; Mussel et al., 2004). The resulting impact on the culture was a loss of traditional knowledge and leadership leading to an increased reliance on European trade and medicines, and openness to conversion by missionaries (Atleo, 1997; Wesley-Esquimaux & Smolewski, 2004).

The first three waves of colonization.

The *Indian Act* was passed in 1876. The federal government overtly stated that its intention was to solve the “Indian problem”--that is, to control and eventually assimilate Aboriginal peoples into the social and economic mainstream through the promotion of European land use methods, Christianity, and democratic-style government (Canada, 1895; Chrisjohn, et. al, 1997; Francis, 1992). The *Act* operated on three fronts--or waves.

The first, *legal wave* declared Aboriginal people to be “wards of the state” (i.e., equivalent to children) and the Department of Indian Affairs was created to manage the

lives of Aboriginal people, enforce legislation, and exert political control over the communities (Harris, 2002). Traditional practices, which served spiritual, social, personal and economic tasks essential to the cultural survival of Aboriginal communities (e.g., Potlatches), were criminalized and totem poles, ceremonial objects (such as masks), and regalia were destroyed or sold to collectors. Native political, cultural and spiritual leaders were jailed for facilitating heathen practices (Furness, 1995).

In a parallel *administrative wave*, the federal government created a reserve system in order to limit Aboriginal movement and their use of the land. Despite the *Royal Proclamation Act* (1763)--which established British control over Aboriginal territories in the country and required that the Dominion government provide “ample” reserves and compensation in exchange for colonial land use, the BC provincial government ultimately created very small reserves and did not offer compensation with the rationale with official intention of speeding the assimilation process. The first BC reserve was created on Salish territory in 1852 and many communities were forcibly re-located from traditional locales to reserves that had no resources for the survival of the community. By the time BC joined in Canada’s confederation, in 1871, 149 separate reserves were in place—on average nearly 99 percent smaller in size than those created by treaty in other parts of Canada. In 1920, the federal government prohibited Natives in BC from organizing to discuss the “Land Question” or raise money to pursue Aboriginal title--an offence punishable by fines or jail. Thirty years later, the British Columbia *Indian Lands Settlement Act* implemented the provincial government's recommendation that the reserve lands be reduced to less than 0.36% of the province's land base (Harris, 2002; Tennant, 1990). Today, there is only one ratified treaty in BC.

Finally, in a third, *ideological wave*, the government established a legally enforced Indian Residential School (IRS) system run by several Christian denominations. Initially designed to assimilate the Native population into the mainstream, it later served to separate them from it (Furness, 1995). In British Columbia, nineteen residential schools were established at various times and locations between the years of 1861-1986 (Milloy, 1999). Adhering to the Department of Indian Affairs' tenet that Aboriginal children "must not be educated above the possibilities of their station," more time was spent in vocational preparation (i.e., unpaid labour) than in academic studies (Chrisjohn et al., 1997; Milloy, 1999). The children, starting as young as four were placed into classroom groups—regardless of their nationality or family membership—and segregated from their families during the school year. Conditions were generally very harsh in both physical and psychological terms. In addition to the structural violence (i.e., institutional oppression) inherent in the IRS undertaking (Sivaraksa, 1999), public humiliation and beatings were a normal response to any attempt at resistance, cultural expression, or attempts to escape (Dion Stout & Kipling, 2003), and arbitrary emotional, cultural, spiritual, physical, and sexual violations were commonplace (e.g., Chrisjohn et al., 1997; Claes & Clifton, 1998; Milloy, 1999). While some students had less negative experiences, in a 1996 study of ninety-six participants in the Nuu-chah-nulth Nation (one of three Aboriginal nations situated on Vancouver Island, BC), eighty-three percent of the group reported being abused and more than half stated that they still require healing from their IRS experience (Nuu-chah-nulth, 1996). Estimates suggest that, over the history of the residential school system, as many as 60% of the students died while in the schools (due to illness, beatings, attempts to

escape, or suicide) (Milloy, 1999). According to federal government estimates, there are 80,000 survivors of Indian Residential Schools remaining today.

The fourth Wave of colonization is *psycholonization* (as described in the body of the above paper).

APPENDIX 2: Colonization and Trauma

The second significant psychological problem commonly associated with the impact of colonial intervention has been that of trauma (e.g., RCAP, 1995). Described as a “disease of time”, in which a painful past intrudes upon the present (Herman, 1997), trauma has also been considered through both the individualistic and collectivistic lens.

Individualistic view of colonial trauma.

The notion of trauma within the individualist approach—the impact of a significant life-threatening-event on an individual—is well accepted (van der Kolk & Hart, 1995). The individualistic study of trauma has centred on the diagnosis of Post Traumatic Stress Disorder (PTSD) (Association, 1994); however, studies related to its prevalence of in Aboriginal communities have produced contradictory findings. On the one hand, research has found virtual epidemic of PTSD in Aboriginal communities. For example, in a review of 127 British Columbian mental health profiles of survivors of Indian Residential School, disorders were identified in all but two cases. Most common was PTSD (64.2%), followed by substance abuse disorder (26.3%) and major depression (21.1%), with half of those with PTSD having one or both of the other two as a concurrent disorder (Aboriginal Healing Foundation, 2003). However, it must be noted that the study was focussed on cases which had already been treated within a mental health clinic that required a diagnosis. A second study, a survey of nearly 250 adults in an undisclosed Nation in the southwest of the United States, 21.9% met the necessary criterion for PTSD after experiencing 5.7 traumatic events during their life (Robin,

Chester, Rasmussen, Jaranson & Goldman, 1997). This prevalence is far above that noted in the DSM-IV (1994) for the general population (i.e., 1-14%). However, on the other hand, Aboriginal participants in other studies identify a relatively low level of PTSD, despite identifying many traumatic events across the participants' lifespan. In one study with Aboriginal youth in the Northern Plains of the United States, while 61% of the respondents identified witnessing or experiencing a traumatic event (and 62% of those reported more than one such event), only 3% met the criterion for PTSD. Two explanations for the lack of apparent trauma were suggested by the authors. Firstly, the data lacked clinical validity, due to the measures being culturally inappropriate or the youth being insufficiently disclosing. Secondly, that constant distress in the community (poverty, violence, addiction, etc.) may make trauma easier to assimilate as *normal* (Jones, Dauphinais, Sack, and Sommervell, 1997).

Alternatively, the explanation may lie with the construct of the disorder itself. The diagnostic criteria of PTSD may not contain the impacts of cumulative ongoing trauma experienced through the life course of many members of Aboriginal communities (Robin, Chester & Goldman, 1996). Van der Kolk, Roth, Pelcovitz, Sunday and Spinazzola (2005) suggest the nomination of a new disorder to be called *Complex PTSD*, with symptoms to be identified within DSM-IV by the "catch-all" term of *Disorders of Extreme Stress Not Otherwise Specified*. Specifically, the symptoms would include: (1) *alteration in regulation of affect and impulses* (e.g., anger, self-destructiveness); (2) *alterations in attention or consciousness* (e.g., dissociation); (3) *somatisation*; (4) *alterations in self-perception* (e.g., guilt, perceived loss of efficacy or social support); (5) *Alterations in Perception of the Perpetrator*; (6) *alterations in relations with others* (e.g.,

loss of trust, victimizing or becoming a victim once more); and (7) *alterations in systems of meaning* (e.g., loss of hope or faith).

Collectivistic view of colonial trauma.

A collectivistic view of colonial trauma argues that the psychological construct of PTSD is limited by its emphasis on the individual--a stance that denies sociocultural trauma. According to Wesley-Esquimaux (2004):

the residue of unresolved historic, traumatic experiences and generational or unresolved grief, is not only being passed from generation to generation, it is continuously being acted out and recreated in contemporary Aboriginal culture. ... Over time, the experience of repeated traumatic stressors become normalized and incorporated into the cultural expression and expectations of successive generations, while trauma manifesting as culturally endemic will not be readily identifiable as a specific or *individual* disorder [italics theirs] (p. 3).

Further, the notion of PTSD does not consider the collective's loss in that the "destruction of cultural archetypes and metaphors annihilates or deeply limits the next generation's possibility of affirming aspects of their cultural life (Lykes, 1996, p. 167)." The collective view provides a context as well as an explanation for the suffering in their communities. According to Wesley-Esquimaux & Smolewski (2004):

Transmission of trauma always takes place in a social environment which is assumed to have a major impact on children. It is true that Aboriginal children of today did not witness the death, terror and suffering of their ancestors. However, it is also true that many of them witnessed rampant domestic abuse, alcoholism

and drug addiction of their parents who witnessed the lack of self esteem and unresolved grief of their parents (p. 76).

The loss of traditionally meaningful objects, rites, roles, rituals or locations has been variously described within the collectivistic paradigm as: a soul wound (Duran & Duran, 1995); anomic depression (Atleo, 1997); cultural post traumatic stress disorder; trans-, inter-, multi-, or cross-generational trauma; and historic trauma response (Wesley-Esquimaux & Smolewski, 2004).

A third model of aboriginal trauma (an aside)

Based on the study of the construction of memories and communal, narratives, a third view of Aboriginal trauma may be considered--a blend of cognitive constructionism and social constructivism (e.g., Gergen, 2000; Kelley, 1963; Mahoney, 1991). Namely, that suffering resulting from the impacts of colonization has been *re-conceptualized* as a *disorder*. That is, that individuals and communities have embraced a trauma-based model of history, a model that provides the collective continuity of a shared narrative (Chandler, 2001; Waldram, 2004). From an individualist perspective, Young (1996) points out that:

individuals re-discover and rework their memories of past events as a means of accounting for their present distress... Individuals 'choose' PTSD for this purpose, to reorganize their life-worlds, because it is a widely known and ready made construct, it is sanctioned by the highest medical authority, it is said to originate in external circumstances rather than personal flaws or weaknesses, and (in some situations) it earns compensation (p. 97-8).

Taking a collectivist stance, Antze & Lambek (1996) add that:

Memories are never simply records of the past, but are interpretive reconstructions that bear the imprint of local narrative conventions, cultural assumptions, discursive formations and practices, and social contexts of recall commemoration (p. vii).

The result is an individually and socially-driven medicalization of a normal response to colonial trauma (e.g., Duran and Duran, 1995).

APPENDIX 3: The Community is the Medicine

Colonization and Suicide

If there is a single source of Aboriginal suicide, it is colonization. according to the *Royal Commission on Aboriginal Suicide in Canada (1995)*:

Suicide is... the expression of a kind of collective anguish—part grief, part anger... the cumulative effect of 300 years of colonial history: lands occupied, resources seized, beliefs and cultures ridiculed, children taken away, power concentrated in distant capitals, hopes for honourable co-existence dashed over and over. ... The damage must be acknowledged before it can be healed (RCAP, 1995, p.2).

According to oral tradition, suicide was discouraged and was rare before contact with Europeans. The only exception was self-sacrifice to aid (or unburden) the community.

Suicide Is About Stopping Pain and Hopelessness

Suicide is about stopping pain and hopelessness, it is not about dying. In almost every case, a person considering suicide would choose to live if they could find a different way out of their pain. This is why 80% of suicidal people send out a *signal of suicide* to those near to them--they don't want to die and are desperate to find another way out of the pain. This fact is the key to suicide prevention: *If you can reduce a person's pain, you can reduce their suicide risk.*

Aboriginal Mental Health

Harmony and balance are considered central to Aboriginal notions of mental health. According to Favel-King (1993):

Throughout the history of the First Nations people, the definition of health evolved around the whole being of the person—the physical, emotional, mental,

and spiritual aspects of a person being in balance and harmony with each other as well as with the environment and other beings. This has clashed with the Western medical model, which, until very recently has perpetuated the concept of health being the absence of disease (Favel-King, 1993: 125).

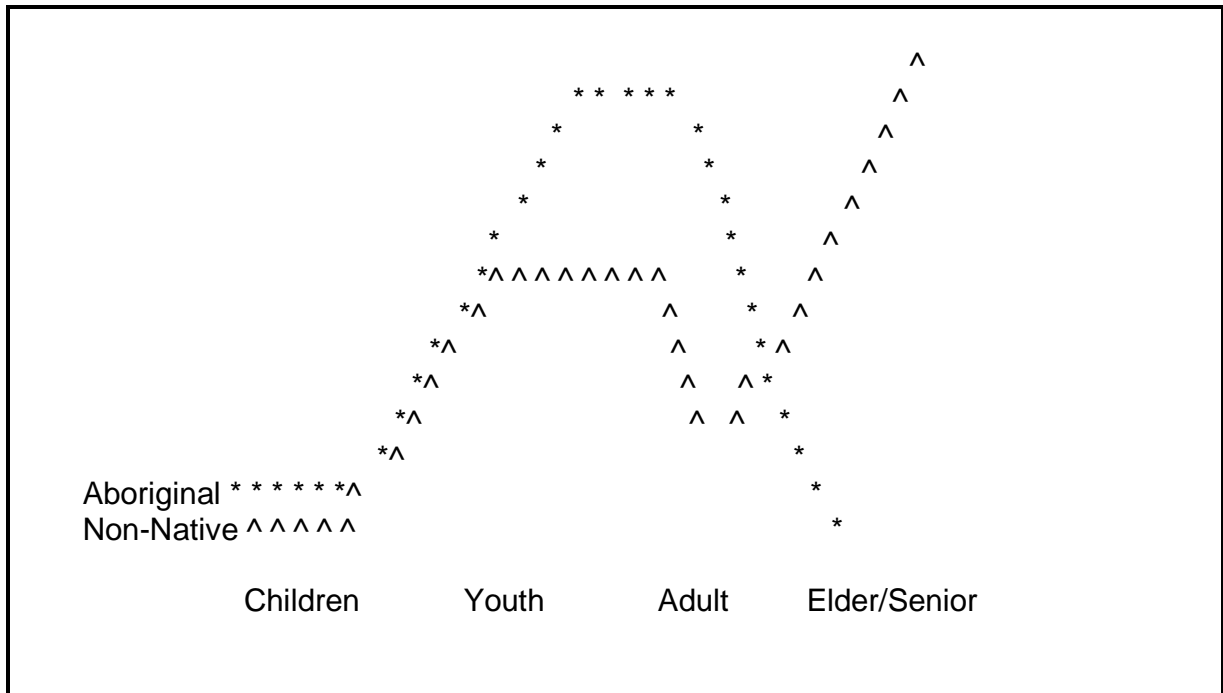
The element of interconnection renders the individual and collective context (familial, social, environmental) are indivisible and, likewise, conflates mental health with every other aspect of being in the world.

Suicide Resilience and Traditional Values

Resilience is the ability to lead a well-lived life (i.e., one that is meaningful and positive) and to value oneself (to have self esteem) despite difficult circumstances. Resilience does not merely describe survival (although for many this is a significant accomplishment in itself), but recovery or development. In relation to their families and communities, resilient individuals find a positive sense of: (1) *connection* (they feel cared for by those important to them); (2) *empowerment* (they feel capable to respond well to their life's demands); (3) *identity* through maintaining a positive social role; and (4) *vision* (hope for the future and a sense of how they are to live in the world).

Suicide Statistics Point to Suicide Resilience

The traumatic impact of historical and cultural losses on Aboriginal people has led to a significantly increased suicide rate in some communities. Youth living on reserve are most at risk. However, in non-native communities, the suicide rate increases continually after the age of fifty. But this is not the case with Aboriginal Elders.



In communities where Elders receive: (1) *care* for their well being, (2) *respect* for their wisdom/experience, (3) a *meaningful community role*, and (4) have the opportunity to serve as *cultural and/or spiritual* guides, the Elder suicide rate is very low.

Compare this experience with that of Aboriginal youth on reserve, who often feel that: (1) no one understands them (that the community doesn't really "care" about them), (2) they are not *respected* (and have no "voice" in the community), (3) they have no *meaningful family/community role* (except to stay out of the community's way or to be viewed as delinquents), and (4) they feel disconnected from traditional *culture* and *Spirituality*. In fact, Aboriginal youth living on a reserve are six times more likely to die by suicide than their non-native peers. However, those living within cities have a suicide rate equal to non-native youth. Significantly, gay/lesbian/bi-sexual/transgendered youth of all ethno- cultural backgrounds have the same statistically

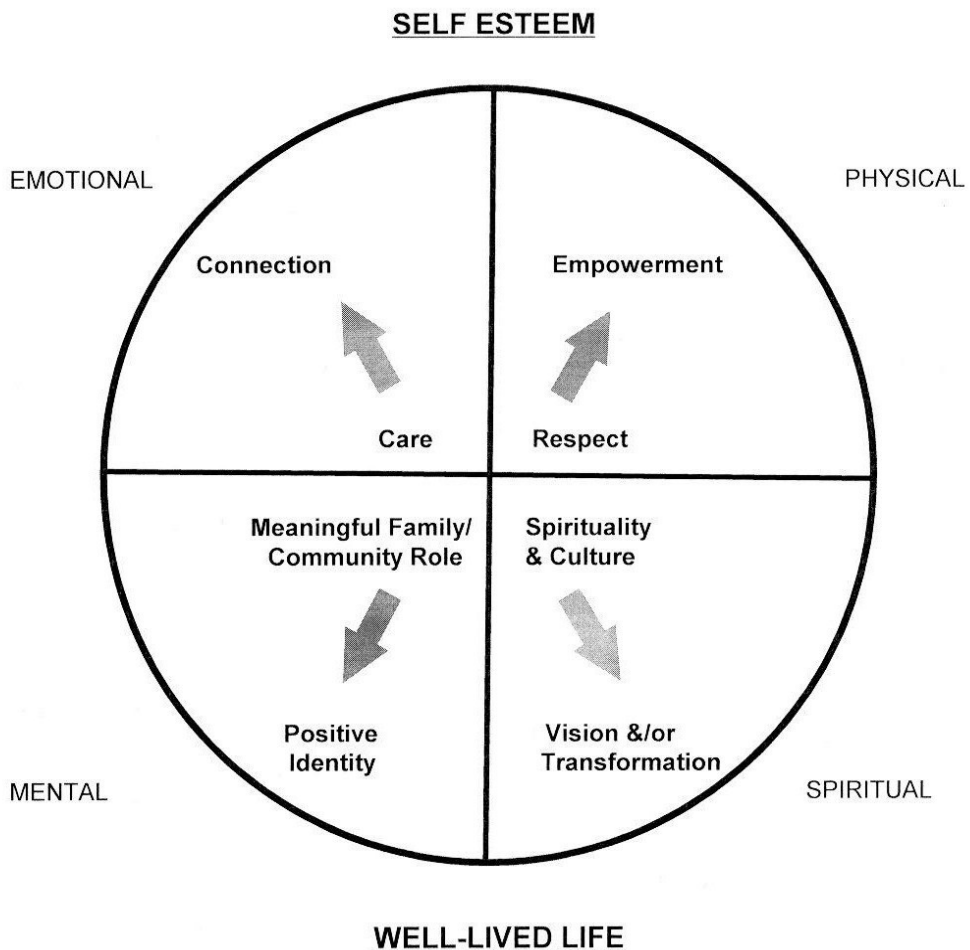
elevated suicide risk. Both groups share: a sense of isolation, a shortage of healthy role models, prejudice from others (and often themselves), and a lack of resources. It makes sense that both of their suicide rates are so high compared with Elders. And changing this in the community is true suicide prevention.

Traditional Values: The Path to Suicide Resilience

Not surprisingly, it is within Traditional values that the “cure” for the social and historical “disease” that is suicide can be found. Among these four, in particular, provide the key to suicide prevention: (1) *care* (for the whole community and the larger world); (2) *respect* (for people and the natural and spiritual world); (3) each person has a *meaningful family/community role* (depending on gender, age, family of origin, and talent); and (4) the importance of *spirituality* and *culture*. These four traditional values can be understood to emerge from one of the four directions and to provide for the four roots of resilience: (1) *Connection* (rooted in the emotional quadrant of the medicine wheel): when one *cares* about a person they are provided with a sense of *connection*; (2) *Empowerment* (rooted in the physical quadrant of the medicine wheel): when one *respects* a person’s capacity--to experience the world in a manner that is valid for them and to make choices that are right for them (within realistic developmental limits)—they are provided an opportunity to gain a sense of *empowerment*; (3) *Identity* (rooted in the mental quadrant of the medicine wheel): when a *meaningful family/community role* is provided, the individual, family, or community, has the chance to view themselves as contributors and thus, develop a *positive identity*; *Vision* (rooted in the spiritual quadrant of the medicine wheel): *spirituality* and *culture* offer the foundation of one’s *vision* (i.e., how one lives one’s life). These four roots grow into a tree with two branches: *self*

esteem and a *well-lived life*. *Self esteem*, the valuing of oneself, is rooted in the sense of being *connected* and *empowered*. It comes from the experience of being *cared* for and *respected*. A *well-lived life* is the result of a positive *identity*--coming from a meaningful community/family role--and positive vision--coming from a person's culture and/or spirituality.

THE TWO BRANCHES OF SUICIDE RESILIENCE



A Well-Lived Life: The Antidote to Colonization

A *well-lived life* is one in which a person finds reasons to live (i.e., a meaningful life) through activities which benefit others. One's *identity* (which emerges from a meaningful *family and community role*) and *vision* (which comes from *culture* and *spirituality*--however defined) are the root of a well lived life. A well-lived life is the ground upon which resilient families and communities grow. It is the antidote to colonization.

Respected Elders and the well-lived life.

The well-lived life is best understood by thinking of the qualities identified in a respected Elder. According to focus groups, these qualities include: contributed to community, teaching and healing; spiritual and wise, practices ceremony; lives their values with integrity; lives sustainably in nature; overcame adversity with kindness; puts others first, listens from the heart; strong, patient and creative; unconditionally loving, forgiving, non-judgmental and refuses to gossip.

Indian residential schools and the well-lived life.

One of the key tasks of residential school was to destroy the students' identity as Aboriginal people. To accomplish this cultural genocide, students were told that their culture was evil and backward and they were severely punished if they did not appear to assimilate to the cultural role they were offered, that is "second class" citizen in a Christian country. The students were not able to develop a healthy identity--personal, social, or cultural--due to the constant destructive "brain-washing" to which they were subjected. Without *self esteem* and a positive social identity or cultural vision it was believed that the children could be "civilized"--that is, re-created in the colonizer's image. Instead,

self esteem and the opportunity to learn how to lead a *well-lived life* was stolen from the attendees.

*A Meaningful Family/Community Role:
Offers the Opportunity for a Positive Identity*

There are two sources of our identity: *personal* identity (i.e., how we describe ourselves based on our own life experience) and *social* identity (i.e., how we describe ourselves based on the roles we play with others). This social source of identity includes the larger social world, so unfortunately, many Aboriginal people have come to view themselves according to the characteristics defined by the dominant culture—that is, in this latest wave of colonization--as sick and dysfunctional. This increases one's suicide risk. Thus, it is important that an individual not only try to view themselves positively, but that they take on positive and meaningful roles in their family and community. For identity to serve as a protection from suicide, it must depend on the individual and their family, community and culture.

A suicidal person has life events that support their identity as “a suicidal person”. The goal is to change an identity of “victim” or “failure” to that of “healthy” and “valuable”. A positive *identity* is additional protection from suicide and new life experiences can help a person in suicidal crisis to change their *vision*. While we cannot change the past personal experiences of a person, a caregiver can (with the help of their family community) offer them new life experiences that can lead to changes in their personal and social identity. Likewise, we cannot change all of the social roles a person in crisis plays, but we can assist them to change some of the negative ones and replace them with more positive ones. For example, to change their role as “delinquent” and

replace it with “volunteer for Elders” or assist them to better perform their positive roles—for example, to be a better parent/child.

*Culture and Spirituality Provide a Person
With Vision and the Opportunity for Transformation*

Culture is a foundation of one’s experience of being in the world. And for many communities, Spirituality is the basis of culture. It is through culture and spirit that many find the strength and vision to live a well-lived life. The goal of colonization was to annihilate Aboriginal people in Canada, if not physically, then culturally and spiritually. Even though spirituality has been shown to reduce suicide risk, the current “therapeutic” wave of colonization uses a secular and individualistic view of mental health that strips a person of their culture and ignores the power of spirituality. (However, there are certainly counsellors and other human service workers who encourage cultural healing and spiritual connectedness.)

Spirituality does not require a religious affiliation, but an interest in ego-transcendence and transformation. In cultural terms, spirituality is the vision of life and our role within it that holds a community together. Spirituality provides a source of *connection* in relation to one’s culture and the Creator, God, the Universe, Nature, and/or the Ancestors. An opportunity for *empowerment*, by the practice of cultural or spiritual activities offers clarity regarding one’s *role* in the cultural community and the world as a whole, which contributes to a meaningful social role. The result is a *well-lived life*. As well, spirituality provides opportunities for transformation—to leave the past behind and be “new” again. A caregiver’s role, then, is to assist the person in crisis to develop their spiritual

and/or cultural *connection, empowerment, and identity* (in whatever manner is meaningful for the person).

Youth Related Activities That Will Promote a Well-lived Life.

Activities and relationships with youth that foster a well-lived life identified by group members have included: *service to the community* (e.g., volunteer work, sharing hunting/fishing/gathering “catch” with Elders and community members, youth work to make things happen for youth, etc.); *accountability and sobriety* (e.g., setting goals (e.g., travel or building a long house) and working to make them happen, sober activities, holding one another responsible, taking charge of their teen centre, restorative justice (i.e., community resolution mediation)...); *community support* (e.g., ceremony to honour those who are contributing, those who are healing, etc.); *positive peer culture* (e.g., youth run AA meetings, “Young Warriors Against Violence” group); *political involvement* (e.g., educate youth re: politics/history, have community youth ambassadors, youth advisory council); *inter-generational relations* (e.g., youth teach toddlers traditional stories, Elders and youth socialize together (each group teaching their dances, etc.); *allow for blended culture* (i.e., stop criticising youth for not being “traditional” enough); *family/community support* (e.g., connect isolated youth to their relatives, parents maintain relationship/responsibility through young adulthood, community leadership must be on side with youth-related initiatives, honour youth accomplishments in formal and informal manners); and *culture and nature* (e.g., integrate cultural activities into daily routine, culture camp, learn dances and songs, participate in ceremony, bush retreats, hunting, fishing, and gathering with knowledgeable adults).

The Community is the Medicine

Since crisis impacts the whole community, the whole community can respond to a crisis in one of its individuals, families, or the community at large. The capacity was there before contact and it's there now, because it is rooted in the Traditional values of *care, respect, a meaningful social role and spirituality*. However, to recognize and benefit from the wisdom and strength of the community, it is necessary to step outside the limited view of the community and its resources that have been the foundation of the fourth wave of colonization.

The Six Parts of a Community

In order to explore the range of resources available to a person in crisis, it is valuable to consider the whole *community* in which they live. Surrounding a person, a community can be considered to be made up of six inter-dependent parts: their *self, family, individual youth and adults, community services/agencies/institutions, those outside the community, and nature*. The six inter-connected parts with examples of their use as a source of *connection, empowerment, identity* and vision—as resources for a person in crisis are noted below: (1) *Self*: resources to be found within oneself; (2) *Family (or Clan)*: as identified by the family members. Note: no matter what their suicide risk, a suicidal person's immediate family (parents and/or partner) is often an essential resource. Their love, knowledge of that person, and ability to offer *support* and supervision makes them an excellent resource. They should be involved in the assistance of a person in crisis, unless their relationship to them is an abusive one; (3) *Individuals*: specific people (i.e., generally known by name or title). This includes *youth* (i.e., anyone who would be identified as a “youth” by the community) and *adults* (e.g., friends, professional and non-professional

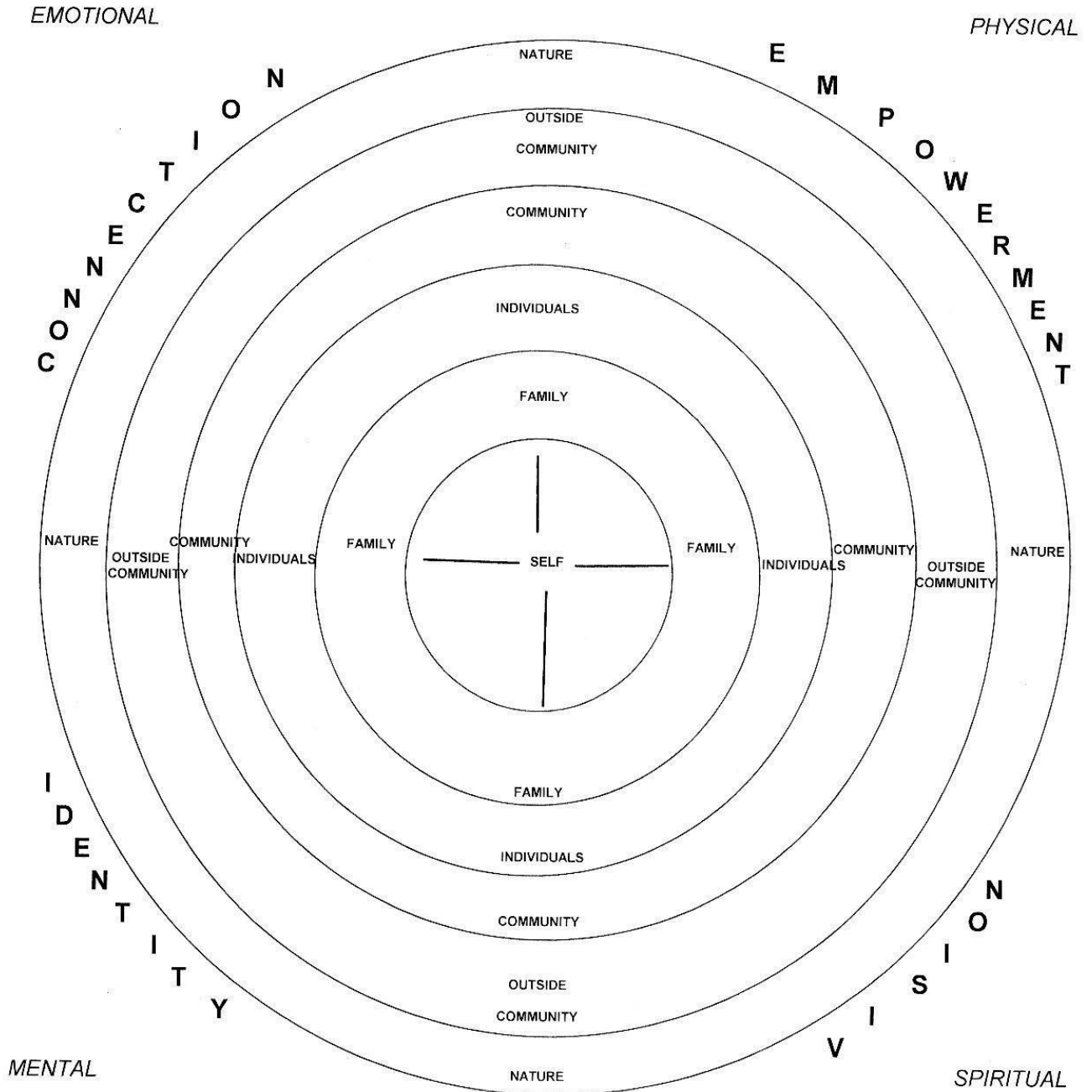
caregivers, etc.); (4) *The Community*: taken at large (e.g., agencies, services, community centres and schools, support groups, sports teams, etc.); *Outside Community*: forces or individuals outside the community which can have a positive impact (e.g., neighbouring communities, regional services, political leaders, heroes or youth idols, the media, etc.); *Nature*: the non-manmade environment in which a person lives can be profoundly important for their well-being. The following chart offers examples of resources:

| | CONNECTION | EMPOWER- MENT | IDENTITY | VISION |
|---------------------------|---|--|--|--|
| SELF | belief in one's self, hope, creativity, self-care, empathy, etc. | self-discipline, previous resilience, courage, responsibility, strength, etc. | sense of self as sober, helpful, caring, generous, etc. | prayer, faith, meditation, etc. |
| FAMILY and/or CLAN | the experience of love and support from family members, participate in family counselling, etc. | participate in family events/activities, get to know extended family members, write letter to removed children, do family-related chores, etc. | learn family history, take on a positive family role, view of family and its role by the rest of community, etc. | learn traditional family/clan stories, take on role in the family, learn and perform traditional songs/dances/ceremonies, etc. |
| INDIVIDUAL Youth | peer-helpers, friend's children, friends, etc. | volunteer time with younger children; participation in team sports/activities/clubs | role model, sober friend, helper, mentor, teacher, etc. | learn/perform traditional songs/dances/ceremonies, etc. |
| INDIVIDUAL Adults | adult friends, counsellor, teacher, social worker, doctor, sponsor, coach, mentor, etc. | volunteer help for elders, learn a skill, develop a resume, etc. | friend, client, colleague, patient, etc. | assistance from a spiritual guide/Elder |

| | | | | |
|--------------------------|---|--|--|---|
| COMMUNITY | social/human services, support/self-help groups, community programs, school-based support, school, community centre programs, healing workshops, teen centres, etc. | get a haircut, seek return to schooling, volunteer, attend support groups and workshops, apply for work, etc. | connect to cultural and spiritual identity; volunteer (e.g., clean corner store, chop wood for elders, arrange community event), invite “house family” involvement, etc. | congregation, spiritually designated buildings, community ceremonies, spiritual role in the community, etc. |
| OUTSIDE COMMUNITY | treatment centre, outpatient programs, crisis line, internet chat rooms, national organizations, music, long-distance friends/family, etc. | go for treatment, write to media, political/social activism, mental health assessment, detox programs, inter-community activity (e.g., sports exchanges), etc. | National identity, Aboriginal identity (world-wide relationships), etc. | inter-tribal ceremonies (“pow wows”) and/or social development initiatives, etc. |
| NATURE | sitting under tree or next to river, etc. | fishing, hiking, hunting, etc. | recognizing that one is an essential part of the universe | cleansing ceremonies, Spirit quest, sacred places, sweat lodges, walking around home territory, etc. |

In other words, the community (as divided into six parts) is able to offer an individual, family, or community as a whole, opportunities for: (1) connection; (2) empowerment; (3) a positive identity; and (4) vision and transformation. The **“COMMUNITY RESOURCES MAP”** worksheet below is a useful method to explore these options.

COMMUNITY RESOURCE MAP



Beyond Suicide: Community-Based Suicide Prevention

Communities were healthy long before colonization and they are healthy now. If they were not, they would not survive. The distress experienced within each community is a natural response to the oppression of colonization—however, suicide does not have to be in the community.

Suicide intervention can occur through confronting and reducing family and community problems, reducing the pain experienced by community members as a whole. Specifically, two target activities have been identified that promote the community resiliency and reduce suicide risk resulting from colonization. These are: (1) direct crisis services with a focus upon “high risk” behaviour, self harm, and suicide, itself); and (2) community development that revitalizing cultural and spiritual traditions--strengthening families and supporting children and youth—promoting of community change.

In communities in which cultural identity is being revived (or was secretly maintained), many examples of resilience can be found. Communities that are (1) *empowered* (in terms of self-government and treaty-making), (2) *connected* as a community and in the care of children and Elders, (3) providing a positive *identity* for its members through the encouragement of meaningful social roles, and (4) where a traditional cultural *vision* and practice has survived or has been re-developed have a lower suicide rate than non-native communities. Beyond the many individual transformations--from victim/abuser to contributing member of the community—and examples of family healing, communities are overcoming colonization through: political advocacy, self-government, and/or the pursuit of land claims and treaty rights; control over emergency services, mental health and family support programs, and schools; active participation in cultural practices,

the presence of cultural centres; language classes, recording Elders' stories, proper care of Elders; day cares, youth programs, etc.

Visioning the Future

Imagining the community without suicide—is to imagine a community in which its members feel connected, empowered, and in possession of a positive social identity and spiritual life. Imagine the social networks and programs responsible for this transformation. One useful way of organizing the vision is to use the *Community Resource Map* (above). The map ensures that the four traditional foundations of health and healing are supported by the process. This vision, if held by members from all parts of the community (i.e., community stakeholders), is the basis of transformation! So, with this in mind, a community meeting—organized by a *community prevention team* can be an excellent step. The Team may turn out to be the same as the *community postvention team*, since postvention is, actually, prevention—and vice versa.

Beyond Colonization:

Healing reaffirms cultural values as they can be expressed in the contemporary world. Balancing the four aspects of humanity—mental, emotional, physical, and spiritual—through the interconnection of nature, community, family, and the individual, it integrates the individual in their community (establishing harmony and improving relationships). Rather than treating specific diseases within an individual, healing impacts individuals, families, and the community simultaneously. For this reason, effective intervention must have the restoration of community balance as its primary aim—suicide prevention must have the community as its target.

A Community Response Team

Communities face significant challenges as they strive to prevent and respond to youth and adult suicide. They need the support and resources that might come from access to wellness/healing and community education training workshops that could promote wellness and address the issues underlying suicide (e.g., FASD, grief and loss, trauma, anger management, community development initiatives, etc.).

Community front-line staff and natural caregivers are often required to respond to community crises without the necessary clinical training. They are being asked to do the work without the skills or confidence to meet their community's needs. Unfortunately, most of our communities do not have access to the funding necessary to send natural caregivers and staff to training in critical incident response and suicide inter-/post-/prevention. Further, the responsibility they are required to take on can be too much and the resulting likelihood of turnover or burn-out often means that the community is left without any consistent support-system in place. Finally, the isolation of these workers from the natural caregivers and political leadership has sometimes led to communication challenges and conflict within their communities.

A promising model of crisis response being embraced by some First Nations is an integration of professional and non-professional services in a *Community Response Team*. *Community Response Teams* are made up of human services workers, first responders, community leaders, and natural caregivers for these purposes: respond to individuals in crisis (i.e., struggling with emotional distress); respond to critical incidents within the community (e.g., the aftermath of a house fire, serious accident, or suicidal crisis); lobby for and/or

facilitate community initiatives (e.g., a “girls group” or “men’s circle”, etc.); support a neighboring critical incident response team (if requested); invite the assistance of a neighboring Team (if required); and identify and facilitate educational initiatives (e.g., workshops on grief, crisis, suicide, etc.). *Community Response Teams* develop the community’s capacity to respond to their own critical incidents in an integrated fashion. This model is true community-based mobilization—empowering each community to respond to its own issues.