

ABORIGINAL AND WESTERN CONCEPTIONS OF MENTAL HEALTH AND ILLNESS

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ABSTRACT

This paper forms the foundation for the promotion of mental health with rural Mi'kmaq youth through a community based participatory research project. Western understandings of mental health and illness are compared and contrasted with Aboriginal understandings. Mainstream mental health services that accommodate cultural differences do not speak to the totality of Aboriginal understandings of mental health or to self-determination and self-reliance of Aboriginal peoples. The paper comprises three sections. Differences in the major understandings of mental health and illness are examined in the first section and common understandings associated with these concepts are addressed in the second section. Within the third section an analysis of three exemplar models of Aboriginal mental health and illness services is conducted. These models illustrate similarities and differences, and provide evidence of the effectiveness of health promotion that is inclusive of difference. The paper concludes that research to address Mi'kmaq youth mental health must be conducted with an awareness of how Western and Traditional systems of health and healing operate: in isolation of each other; in parallel directions; and in collaboration with each other. Aboriginal youth can benefit from the knowledge and wisdom of both understandings of mental health and illness.

INTRODUCTION

This paper is the foundation for the promotion of mental health with rural Mi'kmaq youth through a community based participatory research project. Aboriginal¹ mental health and illness understandings are different from Western notions of mental health and illness. The focus of this paper is to increase awareness of how Western and Traditional systems of mental health and healing operate: in isolation of each other; in parallel directions; and in collaboration with each other. In a recent study, Vukic et al. (2009) found gaps in Aboriginal mental health services: a lack of culturally relevant services; concerns about Western labels for mental illness such as depression; and concerns about culturally appropriate questions to assess mental illness. Distinguishing between First Nations and Western understandings can be problematic and foster the process of othering.² However, an understanding of distinguishing features from these two standpoints is essential to effectively address the priority Aboriginal peoples give to mental health and illness. Othering may marginalize Aboriginal peoples or render Aboriginal knowledge as a commodity to exploit, appropriate, or potentially misinterpret. Distinctions between Aboriginal and Western worldviews of mental health also run the risk of generalizing Aboriginal culture without considering individual and tribal differences or appreciating the dynamic nature of cultural worldviews, values, beliefs, and understandings. Nevertheless, to ignore Aboriginal worldviews about mental health and illness is unethical and immoral as Aboriginal peoples fight the legacy of colonization to regain a sense of balance and harmony within their collective historical identity.

In this paper, major Western understandings of mental health and illness are compared and contrasted with Aboriginal understandings. Mental health promotion in rural First Nations communities may be constrained if non-Aboriginal health professionals assume a limited understanding of mental health within the confines of a Western biomedical system.

1. The term Aboriginal refers generally to the indigenous habitants of Canada, including First Nations, Inuit, and Métis. The Royal Commission of Aboriginal Peoples of Canada (RCAP) stresses that the term Aboriginal peoples refers to organic, political, and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called racial characteristics. The term First Nations replaces Indian and the term Inuit replaces the term Eskimo. Indian and Eskimo continue to be used for example; "The Indian Act." For the purpose of this paper we refer to Aboriginal when including First Nations, Inuit, and Métis, and refer more specifically to First Nations and/or Mi'kmaq depending on the context.

2. This term is used in the literature to explicate how the discourse of difference can promote racialization and an essentializing gaze on culture as static by categorizing a person as "other" with fixed belief, not taking into account differences in class, gender, age, context, or location. Collins (2006), Hooks (2006), Vukic and Keddy (2002) have written on the marginalization of othering.

Adapting services to be culturally relevant is advocated (Bernal and Sáez-Santiago, 2006; American Psychiatric Association, 2000), yet this approach alone does not speak to the totality of Aboriginal understandings of mental health or to self-determination and self-reliance of Aboriginal peoples.

The paper comprises three sections. Differences in the major understandings of mental health and illness are examined in the first section, and common understandings associated with these concepts are addressed in the second section. Within the third section, an analysis of three exemplar models of Aboriginal mental health and illness services is conducted. These models illustrate similarities and differences, and provide evidence of the effectiveness of health promotion that is inclusive of difference.

TENSIONS IN ABORIGINAL AND WESTERN UNDERSTANDINGS OF MENTAL HEALTH AND ILLNESS

Mental health and illness covers a broad landscape that encompasses personal growth and well being, everyday problems in living, common disorders such as anxiety and depression, and severe mental disorders such as schizophrenia or manic-depressive illness (Kirmayer et al., 2009). This wide range of conditions is currently understood and situated in a predominantly Eurocentric Western paradigm and often managed with mental health programs and interventions that may not recognize, or meet the health needs of Aboriginal peoples, particularly if such programs ignore cultural, historical, and social political contexts (Smye, 2004; Vukic et al., 2009).

The notion of two distinct and essentialized cultures; the Aboriginal and the non-Aboriginal, dominates the Aboriginal mental health literature. The problematic nature of conceptualizing Aboriginal mental health in this manner is explained by Waldrum (2009), a well known medical anthropologist working with First Nations. Some have attempted to understand the cultural reality of Aboriginal peoples in distress as caught between two worlds and experiencing acculturated stress. The Aboriginal/non-Aboriginal explanation and acculturated stress ideologies are awkward in addressing Aboriginal mental health practice and research. The Aboriginal/non-Aboriginal distinction uses cultural explanations as if there are discrete populations that can be accurately self-declared and known in the same way and to the same extent by each member; that there is a biological heritage associated with culture; that community, nationality, and identity are synonymous with culture; and culture is a uniform fixed entity (Waldrum, 2009). For example, Lemstra et al. (2008) isolated the variable culture from other covariates such as socio-

economic status to study depression in Aboriginal youth. Although culture did not prove to be a factor influencing depression, this study presents an essentialist notion of culture which Waldrum cautions against when conducting Aboriginal mental health research.

The acculturated stress ideology leaves little room for human agency, neglects other variables related to mental health and illness, and explains mental illness entirely as a manifestation of culture (Waldrum, 2009). "At present, the meaning of Aboriginality as a construct of both identity and culture, for an understanding of contemporary mental health issues remains unclear" (Waldrum, 2009, p. 75). However, the need to distinguish between Aboriginal and Western conceptualizations of mental health challenges established Western ideologies of mental health and illness, broadens the potential for decreasing a prescriptive Western approach to promoting mental health, and opens avenues for effective meaningful strategies that are derived from Aboriginal communities.

ABORIGINAL WAYS OF KNOWING AND UNDERSTANDING MENTAL HEALTH

There is great diversity among First Nations in Canada. This diversity influences worldviews, reinforcing the impossibility of one, uniform, fixed, collective Aboriginal identity. Similarly, how mental health and illness are understood by Aboriginal people is also not uniform. For example, many American Indians attribute depression to serotonin levels (Cohen, 2008), and yet there is no fixed explanation of the causes and cures for depression. The illness is multifaceted and there is limited written knowledge of traditional ways for addressing mental illness. The label depression itself becomes problematic since many different Aboriginal languages do not have a direct translation for the word. "In Indian language the terms of sadness are descriptive and fluid rather than diagnostic and rigid" (Cohen, 2008, p. 129). Furthermore, Aboriginal peoples' experiences of living with depression are largely unknown.

The Medicine Wheel³ is one model which has facilitated acknowledgement of the unique nature of Aboriginal ways of knowing and understanding mental health and is referred to by leaders in the field of Aboriginal mental health (McCormick, 2009; Mussell, 2004; Native Mental Health Association of Canada, 2007; Waldrum, 2008). Although the Medicine

3. Historically, the Medicine Wheel has been passed down orally from one generation to the next and is depicted as a circle with four quadrants balancing mental, physical, emotional, and spiritual well being of an individual as well as many understandings of the way of life. Today the Medicine Wheel and its teachings are widely available in many forms and can be readily accessed on the Internet.

Wheel has different symbols, and may be presented differently depending on the region, the overall principle that all knowledge is contained in the circle is constant. Everything in life is a part of the circle, which is different from understanding life as a continuum with a beginning and an end, or of excluding the natural world elements from the spiritual. The spiritual in this sense is not derivative of a God but to say someone or something has spirit or soul and that we are all related is significant. The circle represents the totality of existence, the interconnectedness of relations, and is symbolic of life. All things are interrelated (relatedness is a core value) and everything in the universe is part of a single whole.

The Medicine Wheel has been used by some Aboriginal scholars and Aboriginal organizations to present the wholistic⁴ nature of mental health or what Western science would label mental illness or disorder. To say that mental illness is an imbalance of an individual is too simplistic, and does not capture wholistic understandings of traditionalists or Elders. Although the Medicine Wheel needs more development as a framework for understanding mental health and illness, it provides insight into Aboriginal understandings of this phenomenon.

Within the framework of the Medicine Wheel, mental illness cannot be reduced to the presence of a physical disorder, it is the interconnectedness of mind, emotion, spirit, and body (Mitchell, 2005). The expression, mental illness, perpetuates a mind-body dualism situated in Western ways of knowing and understanding mental illness. The interaction and balance of the mind, emotions, spirit, and body and its interconnectedness with all its relations is contrary to the individual mind/body dualism found in paradigms addressing mental illness as a biological entity. The Aboriginal wellness model involves the physical, emotional, mental, and spiritual aspects of a person in connection to extended family, community, and the land. This does not fit with an understanding of mental illness that focuses on the belief that the key to curing mental illness is to determine the underlying functions of the brain (Adelson, 2007).

According to McCormick, a well known Aboriginal psychologist (2009, p. 348): "Traditional cultural values provide Aboriginal people with teachings on how to attain and maintain connection with creation and many of the mental health problems experienced by Aboriginal people can be attributed to a disconnection from their culture." Aboriginal culture offers a rich

4. Mi'kmaq use the term wholistic, as opposed to holistic, as more in keeping with the traditions of entirety. It captures the missing link between individuals and the interconnectedness with the environment.

tradition of healing ceremonies. The Aboriginal Healing Foundation (AHF) (Waldrum, 2008) spearheaded research of five healing programs across Canada in urban and rural communities. Although definitive best practices could not be mapped out from research of this nature, the case studies provide significant understanding of the management and process of healing in Aboriginal communities in both urban and rural settings. Overall, the studies determined that an eclectic and flexible approach to healing is fundamental because not all clients are grounded in Traditional ways or Western ways; there is no one singular Aboriginal identity or one singular Aboriginal approach (Waldrum, 2008). One study conducted by Adelson and Lipinski (2008) focused on the Mi'kmaq Youth Initiative in New Brunswick. The initiative was structured as a youth centre and included aspects of Western healing and Aboriginal approaches to healing. Youth were involved with many activities that fostered their individual development and well being. When determining Aboriginal approaches to health and healing the authors found that those interviewed acknowledged unique Aboriginal approaches which were more community oriented, spiritually based, and included sweats, talking circles, smudging, and sun dance ceremonies.

Although not every Aboriginal person believes in ceremonies or the traditional values of Aboriginal culture,

the resurgence of interest in traditional practice ... is part of a more global movement to regenerate Aboriginal identity and explore the significance of an evolving tradition in the contemporary world. (Kirmayer et al., 2000, p. 614)

AHF (2005) defines culturally based approaches to healing as wholistic, including a central role for Elders and traditional people, use of the structure of the circle and outdoor physical setting, traditional teachings and medicines, storytelling and ceremony.

Standardized interventions by health professionals to address Aboriginal mental health may not take into account the Aboriginal concepts of wholeness or how we are all related. Standardized approaches, although they have their place, must be inclusive of Aboriginal understandings. There is no single approach that can effectively address the complexity of mental health and illness especially within diverse cultural contexts.

WESTERN PSYCHIATRIC CONCEPTUALIZATIONS

Mental illness, as an underlying function of the brain, is predominant in the literature on the treatment of mental disorders in childhood (Walkup et al., 2008). These authors suggest that advances in neuroscience associate child-

hood psychiatric disorders with abnormalities in neurotransmitters and/or structural or functional abnormalities of specific brain regions, and/or the circuitry that interconnects affected brain regions. Neurobiological explanations of childhood psychiatric disorders are often used to support the use of psychotropic medications for childhood psychiatric disorders (Walkup et al., 2008) and further perpetuate a mind-body relationship to understanding mental illness. Although advances in neuroscience increase knowledge of changes in brain function, it is difficult to determine if these changes are a result of brain dysfunction or if feelings and thoughts affect brain function. A neurobiological explanation of mental disorders does not include concepts of mind, body, emotion, and spirit or interconnectedness with family, land, and community.

Advances in pharmacology are also changing how problems experienced during childhood are regarded. Children's "troubles" are increasingly defined as disorders and access to services requires a diagnosis of a disorder (Harper and Cetin, 2009). The use of drugs to ameliorate the symptoms associated with mental disorders in Western science is specific to the mental illness diagnosis and is advocated by psychiatrists. Early detection and treatment in childhood can decrease the seriousness of the mental illness in later years. Kutcher et al. (2008) present a discussion of a host of essential pharmacological drugs for mental disorders in adolescents. The authors support a universal list to be established by the World Health Organization for disorders such as depression, sleep disorders, anxiety disorders, psychosis, obsessive compulsive disorders, and eating disorders. Kutcher et al. (2008) claim culturally appropriate assessments and interventions remain a primary focus for understanding mental illness as a physical disorder that can be assessed and treated pharmacologically. However, they do not explain how their culturally appropriate assessments and interventions blend with Aboriginal understandings, although their work is internationally known and has proven beneficial in the treatment of mental disorders as a biological entity.

The *Diagnostic and Statistical Manual of Mental Disorders DSM-IV* of the American Psychiatric Association is the psychiatric diagnostic system in use in Canada and the United States.

In DSM-IV each of the mental disorders are conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress, or disability or with significantly increased risk of suffering, death, pain, disability or an important loss of freedom. (American Psychiatric Association, 2000, p. xxxi)

DSM-IV recognizes cultural variations in clinical presentations, and culture bound syndromes and provides an outline to consider cultural differences in relationship to an individual's culture (p. 897). The culture-bound syndrome identified for Aboriginal peoples is labeled "ghost spirits" (p. 897). It is not clearly defined and excludes other descriptors of how some First Nations understand mental illness. Labels restrict understandings of mental health and illness which are more fluid and more descriptive.

Mental health service providers often struggle to conduct clinical assessments with culturally diverse clients using standard tests that do not take into consideration different understandings of mental health and illness (Mushquash and Bova, 2007). Empirical findings suggest that it is a challenge to assess Aboriginal clients in an unbiased manner because culture plays a significant role in the assessment process (Mushquash and Bova, 2007). If a mental health care provider is unfamiliar with cultural norms of emotional expression, mannerisms, and verbal style, he or she may misinterpret such expressions, which could affect the course of the treatment (Jackson et al., 2006; Whitbeck, 2006). There may be hesitation to use standardized tests. Zahradnik et al.'s (2009) research with a rural Mi'kmaq community highlighted the community's involvement and commitment to deal with Post Traumatic Stress Disorder (PTSD). The tangible benefits were that the community became more aware of PTSD and better informed about the ways to work with community members who may be suffering from PTSD. Although a standardized PTSD screening tool was available, the community preferred to use an informal atmosphere to assess clients with PTSD. The preference for an informal atmosphere was not explored; however, many hypotheses could be tested. For example, are the standardized tests for PTSD seen as less culturally relevant or is the assessment tool seen as intrusive to building a therapeutic relationship?

The need to adapt the assessment to be more culturally relevant, and for those who do the assessment to be more aware of the historical, cultural understandings and language when conducting a psychiatric/psychological assessment was emphasized by participants in Vukic et al's (2009) study on gaps and services for mental health. Although cultural sensitivity and awareness of difference while doing the assessments is one approach, there is no evidence to substantiate the effectiveness of this approach. Not only can the assessment tools lack cultural relevance, the process of assessment could be perceived as intrusive, or assuming a stereotypical stance of all Aboriginal peoples. If the cultural nuances of interpersonal communication

are also misread or dismissed, the assessment process may leave the client feeling vulnerable or discriminated against (Browne and Fiske, 2001). Kirby and Keon (2006) report a trend towards fast assessments and diagnoses. The report suggests standard screening programs, such as depression screening, may increase awareness of the problem of depression, but also support the idea of depression as a singular biological entity. This idea is highly promoted by the pharmaceutical industry but has no support in the literature.

With the advanced knowledge of neuroscience, technology, and pharmacology, psychiatry as a field of study and discipline offers much in understanding mental illness as a dysfunction in the brain. If psychiatry took into account Aboriginal ways of knowing or understandings of the wholistic nature of mental health and healing, it would broaden the assessment, diagnosis, and care of individuals with mental illness.

PSYCHOLOGICAL UNDERSTANDINGS

Psychology is the scientific study of the mind to understand mental functions and human behaviour. Psychologists are not necessarily trained in medicine although they may use the DSM-IV for diagnosis and some may prescribe medications. The emphasis for psychologists is on counseling, drawing on theories of abnormal behaviour, humanistic theory, behavioral theory, and therapies like cognitive behaviour therapy, and psychotherapy (Giordano 2007; Leftwich, 2007). Clinical psychologists are trained in assessing and treating mental disorders and applying empirically supported theories developed by Western science and specific techniques to treat disorders. Psychological counseling is practiced by nurses, social workers, and mental health workers who are working with individuals experiencing mental health problems. There is a plethora of psychological theories, approaches, and techniques for practitioners (Wheeler, 2008).

Counselors and other health professionals in Canada are aware of some culturally appropriate methods of assessment and counseling with Aboriginal youth and adults (Stewart, 2008). Gone (2009), a Native clinical psychologist, presents his concerns about culturally appropriate methods of assessment and counseling. He provides insight into different psychological approaches based on his background. He identifies the differences of Western and Aboriginal understandings as: individual egoistic enlightenment versus interpersonal relations or "life lived in a good way"; secular versus sacred therapeutic orientations; and the ascription of illness as endogenous rather than interpersonal. Gone (2009) identifies these distinc-

tions as paradoxes in Western understandings of the human mind, body, and spirit, and his tribal culture. He is not adverse to scientific inquiry to understand psychology, yet supports the need to have indigenous ways of knowing included in the scientific inquiry.

Other psychologists (Cohen, 2008; Jackson et al., 2006; McCormick, 2009) concur with Gone's concern of different worldviews and how this affects assessment and treatment. Jackson et al. (2006), based on a preliminary empirical study, support the concern that cognitive behavioural therapy may need to be adapted for Northern Plains Indians. Northern Plains Indians who are not acculturated may not find some of the underlying principles of cognitive therapy helpful. For example, a linear analysis of how thoughts cause feelings may be incongruent with attributing depressive symptoms to disharmony. McCormick (2009) asserts that the values of mainstream counseling such as individuation, self-actualization, independence, and self-expression may not be embraced by many Aboriginal clients. Stewart (2008) suggests that mental health services are under used by Aboriginal Peoples because of their different understandings. She claims: "research suggests that this is partly because most services are based on non-Indigenous conceptions of health and healing" (p. 49). More research is needed to substantiate the underutilization of mental health services within the Aboriginal population.

In summary, distinctions have been made in understanding mental health and illness from Aboriginal and Western worldviews. Specifically, Aboriginal understandings are generally focused on the framework of wholism; Western understandings are focused on mental health and illness of the individual, particularly in conjunction with thoughts and feelings or as a chemical, or neurotransmitter imbalance. The distinction is made not to promote one over the other but to acknowledge that Aboriginal mental health and illness cannot be addressed solely from Western understandings of mental health and illness. Western medicine has the power of the government, the law, and medical system behind it (McCormick, 2009); however, Aboriginal understandings of mental health and illness are needed as Aboriginal peoples prioritize approaches for promoting mental health and healing.

COMMONALITIES

Difference does not necessarily mean an absence of common ground between these two perspectives. Actually, there are similarities between Aboriginal and Western understandings of mental health and illness. These commonalities are the main focus of the following section of the paper.

DETERMINANTS OF HEALTH

There are many different ways in which social, environmental, psychological, and biological factors are thought to interact in the development of mental disorders (Kirby and Keon, 2006). The Kirby Report stressed the social determinants of health in understanding mental illness and in fostering recovery from it. The committee was repeatedly told that factors such as income, access to adequate housing and employment, and participation in a social network of family and friends, play a much greater role in promoting mental health and recovery from mental illness than is the case with physical illness. With respect to Aboriginal peoples most researchers support locating Aboriginal mental health and mental health care within these wider historical, social, political, and economic contexts (Adelson, 2005; Gone, 2009; Kirmayer et al., 2009; McCormick, 2009; Smye, 2004; Stewart, 2008; Waldrum et al., 2006; Wieman, 2009).

Locating mental health contextually enables researchers and practitioners to view mental health and illness beyond an individual biomedical problem. The emphasis should incorporate the effects of colonization, oppression, and attempts of assimilation on the well being of Aboriginal peoples today. The atrocities of residential schools, the paternalistic approach of the Federal Government of Canada and its policies regarding Aboriginal peoples, and mainstream society continue to leave their mark. The notion of historical trauma as it relates to mental health and illness is not clearly understood in the literature. Historical trauma and its negative effects are conveyed as post traumatic stress syndrome for some (Mitchell, 2005). Kirmayer et al. (2009, p. 460) maintain:

the cumulative effects of internal colonialism on cultural identity and continuing tensions between the values of Aboriginal Peoples and mainstream society complicate the efforts of Aboriginal youth to forge their identities and find their ways in the world.

In any discussions of the determinants, historical, cultural, social, and political factors warrant consideration.

MENTAL HEALTH PROMOTION

Mental health promotion focuses on improving the social, physical, and economic environments that determine the mental health of individuals and populations. Incorporating the principles of mental health promotion in the community and addressing the determinants of health in a commu-

ity is not unique to any one understanding of mental health and illness and could, in fact, be a common ground for Aboriginal and non-Aboriginal health care providers and researchers. As Mussell, Director of the Native Mental Health Associate of Canada (2008, p. 6) states: “

In recent years, holistic models for health and wellness have begun to emerge in mainstream thinking, such as the population health and determinants of health model. These are more congruent with Indigenous conceptions and we welcome these changes.

The emphasis extends beyond the clinical and individual treatment focus of current mental health service delivery to address the influence of broader social and environmental factors on mental health. Barry and Jenkins (2007, p. 15) describe mental health promotion in the community with the following principles:

- involves the populations as a whole in the context of their everyday life, rather than focusing on people at risk from specific mental disorders;
- focuses on protective factors for enhancing well-being and quality of life;
- addresses the social, physical, and socioeconomic environments that determine the mental health of populations;
- adopts complementary approaches and integrated strategies operating from the individual to socioenvironmental levels;
- involves intersectoral action extending beyond the health sector;
- is based on public participation, engagement, and empowerment.

If the above principles were addressed in mental health promotion, the effects of historical trauma could be taken into account and strategies to address the issues would be forthcoming by the community. Stakeholders and community members may emphasize the structural factors influencing mental health such as good living, environment, housing, employment, transportation and education, or community factors such as social support, or individual factors that promote healthy ways to deal with stressful events in everyday life. Ensuring active participation and engagement of Aboriginal community members would elicit what is meaningful for the community to promote the mental health in the community given the historical legacy of residential schools and colonization. Imposition of health promotion strategies grounded in Western perspectives may only perpetuate a Western approach in the community and negate the significance of the community's

understandings of social, cultural, and historical determinants of mental health. Collaboration with community members is critical. Including the principles outlined by Barry and Jenkins (2007) would privilege and promote Aboriginal understandings. Clearly all participants must be meaningfully engaged not only in the social determinants of mental health but also the cultural and historical context relevant to the community.

The second principle for health promotion identified above by Barry and Jenkins (2007) is to focus on protective factors for enhancing well-being and quality of life. This principle emphasizes the enhancement of potential rather than the reduction of disorders. This approach is in keeping with scholars in the field of Aboriginal mental health who focus on the notion of resilience as opposed to identifying deficits. The National Network for Aboriginal Mental Health Research promotes the understanding of resilience in relation to mental health. Tait (2009, p. 214) claims:

alarmist arguments that characterize Aboriginal communities as dysfunctional and pathologic ignore the historical resilience and resistance of Aboriginal peoples in the face of adversity brought on by European colonization.

Understanding resilience in youth mental health is congruent with a strength based approach to working with youth as opposed to a deficit approach and is in keeping with Aboriginal ways. Resilience highlights how youth can and do promote their well being despite adversity. A Lakota spiritual Elder, expressed how the concept of resilience is inherent in his tribal culture:

The closest translation of 'resilience' is a sacred word that means 'resistance' ... resisting bad thoughts, bad behaviors. We accept what life gives us, good and bad, as gifts from the Creator. We try to get through hard times, stressful times, with a good heart. The gift [of adversity] is the lesson we learn from overcoming it. (James Clairmont in LaFramboise et al., 2006, p. 194).

Although evidence to substantiate the effectiveness of mental health promotion within Aboriginal communities is limited, advancing mental health promotion with the principles described holds promise for fostering mental health and improving mental illness in ways that are relevant to the community's understanding of mental health and illness. Active participation with a community in the spirit of health promotion would create strategies consistent with the community's needs, strengths, and understandings of what would promote Aboriginal youth mental health in their community. Programs to promote mental health that are oriented towards empowerment restore mental health and a strong sense of cultural identity

by giving youth an active role in designing and implementing programs that meet their needs (Kirmayer et al., 2009).

Mental health promotion needs to be incorporated into the wider health development agenda in order that the broader determinants of poor mental health such as poverty, social exclusion, exploitation and discrimination can be successfully addressed. (Barry and Jenkins, 2007, p. 27)

In conclusion, the determinants of health, including the historical and social context of Aboriginal peoples, are essential for promoting First Nations youth mental health and illness. Including the principles of mental health promotion, as described by Barry and Jenkins (2007), provide an avenue for change. This is in keeping with some of the common understandings of mental health and illness from Aboriginal and Western understandings.

EXEMPLAR MODELS ADDRESSING ABORIGINAL MENTAL HEALTH AND ILLNESS

Most health initiatives, research, and services are designed to deal exclusively with specific aspects of illness experienced by individuals. The mind and body dualism of the Western medical model continues to be maintained within the mainstream health care system. Mental illness care is currently situated within hospitals, offices of psychiatrists and psychologists, and community clinics. Institutions for mental illness, for the most part, have been disbanded. The traditions, values, and health belief systems of some Aboriginal peoples are poorly understood by many mental health care providers. Western approaches to counseling are not always conducive to addressing mental health and illness with Aboriginal peoples. Although cultural sensitivity has been supported in the literature, the effectiveness of accommodating for cultural differences is not clear. All of the above concerns present some of the dilemmas associated with addressing Aboriginal mental health in general, in both urban and rural practice, and with rural Aboriginal youth mental health more specifically. Nonetheless, there are exemplars of practice that demonstrate how two worldviews can come together. Although the models are not comprehensive, their unique features illustrate how, in some ways, it is possible to overcome the differences described above.

Six Nations reserve in Ontario provides a unique mental health service that has been in existence since 1997. This is one of the largest First Nations communities in Canada, with a distinct delineation between more “Westernized’ individuals and those with a more traditional viewpoint”

(Wieman, 2009, p. 410). The service is a community based mental health and psychiatric clinic. While offering conventional medical treatment for psychiatric disorders, clinicians also offer more culturally sensitive and appropriate care to community members. There are four full-time mental health nurses, three part-time psychiatrists, a mental health/addictions counselor, two case managers, a crisis counselor, an outreach social worker, and an administrative assistant on staff who are familiar with and involved with the community. Emphasis of care is on all ages and stages of life.

The clinic promotes a “shared care” model and makes every effort to establish a mutually respectful collaborative working relationship with traditional healers in the community. Collaboration with agencies to promote culturally relevant programs and services within the community is another main goal of the staff. Cote (2007) explains how community members present with a host of psychosocial stressors that need to be included in a management plan before their mental health can improve. “They deal with poor education, employment, finances, housing as well as historical factors such as colonization, residential schools and racism” (p. 36). The year before the clinic opened 17 individuals accounted for 54 separate admissions. After one year of service there were 3 individuals hospitalized for a total of 5 admissions (Wieman 2009). Based on this outcome alone, it appears that this model of care provides the community with a balanced mental health care service that reduces hospital readmissions. This model could serve as a framework for other communities and it can be modified based on population size and available resources. The ability of staff to address mental health and illness, in the context of the community, and employing interdisciplinary strategies is the strength of this model of wholistic care when confronting Aboriginal mental health.

With respect to Aboriginal youth, certain models of research also provide insight into promoting Aboriginal mental health and incorporating cultural knowledge. Riecken et al. (2006) present the Traditional Pathways to Health Project (TPTH) established in Victoria BC. This project is a Participatory Action Research project that; “moves toward an in-depth, multifaceted understanding of the urgent and pressing health issues of contemporary Aboriginal youth” (p. 29). Students plan and create a videotape with their message, and present it to their community with the support of educators and University of Victoria researchers to ensure ethical guidelines of social science research are maintained. The outcomes to date clearly highlight the bridging of indigenous science and medical science. Students speak

knowledgeably of respect, interconnectivity, culture, listening to Elders, and other indigenous ways of knowing, which are all aspects of fostering mental health. “The students spend a great deal of time learning about traditional Aboriginal knowledge through their Elders and those recognized in the community as respected sources of knowledge” (Riecken et al., p. 39). These authors maintain that the role of understanding and embracing culture through the transmission of generational knowledge has an important effect on the needs of Aboriginal youth and adds depth and insight into effective avenues for change.

The concern for cultural identity in promoting mental health with Aboriginal youth is a phenomenon that is not necessarily addressed in the literature on promoting Western youth mental health. In the Western world the emphasis is on youth developing a sense of self-identity rather than cultural identity (Dixon and Stein, 2006; Kaplan and Love-Osborne, n.d.; McCreary, 2008; Youngblade et al., 2007). The distinction is relevant as health professionals and communities advance the promotion of Aboriginal youth mental health. Current models such as the one described above and the Jacano and Jacano (2007) model establish the significance of cultural identity. Jacano and Jacano (2007) worked with a group of Mi'kmaq Elders and an interdisciplinary group of academics to blend traditional Mi'kmaq knowledge and Western science knowledge to promote cultural continuity.⁵ This involved using puppets made from natural forest materials constructed by youth with Elders to promote culture, language, and history. Based on this work, these authors proposed that increasing support for the history, language, culture, ritual, and stewardship of First Nations land can only enhance pride, and help dispel the notion of separateness or inferiority among young Aboriginal youth. The significance of cultural identity with youth is further reinforced in McCormick and Arvay's study described in McCormick (2009). Youth, in the study, spoke of the significance of cultural identity as one of the important categories that facilitated healing and recovery from being suicidal. The notion of cultural identity is prominent in Aboriginal youth mental health.

The three exemplars described above acknowledge Western and Aboriginal understandings of mental health and illness and help to clarify the distinctions and similarities. The Six Nations model demonstrates a collaborative approach of Western and Aboriginal understandings by seeking

5. Cultural continuity is a term used by Chandler and Lalonde (2008) who were able to show youth suicide rates vary when viewed in light of efforts by communities to preserve and promote Native culture and to regain control over key aspects of their communal lives.

and maintaining mutually respectful relationships with traditional healers and involving agencies in the community to address mental health and illness of all ages in the context of community. The subsequent two exemplars focused specifically on Aboriginal youth mental health and reinforce the importance of Elders and Aboriginal ways of knowing.

CONCLUSION

In this paper major understandings of mental health and illness from Western and Aboriginal perspectives were compared and contrasted. The biomedical understandings of the mind and the body stand in sharp contrast to Aboriginal understandings that value the balance of physical, emotional, mental, and spiritual well being of an individual and his or her interconnectivity to family, community, and the land. Aboriginal psychologists identified specific aspects related to values, beliefs, worldviews, and context that are significant for promoting Aboriginal mental health. Overall, the focus associated with addressing Aboriginal youth mental health requires both Aboriginal and Western understandings.

The literature shows some common ground between these understandings in the determinants of health and the principles of mental health promotion but the historical and social context of Aboriginal communities must be considered. Cultural identity and resilience have been presented in the research and literature specific to Aboriginal youth mental health. The three exemplars presented in this paper demonstrate how Aboriginal and Western understandings can be included in a mental health service, and the importance of Elders in the process. Research to address First Nations youth mental health must be done with recognition of Aboriginal and Western understandings. First Nations youth would benefit from the knowledge and wisdom of both understandings of mental health and illness, and these need to be included in shaping the future.

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