A First Nations perspective on mental health in the North

Psychiatry must incorporate the cultures and traditions of Aboriginal patients.

Michael K. McIsaac, BA

I have yet to attend a mental health conference where the theme was mental health. Rather, the themes inevitably describe what mental health isn't. I would not want my personal wellness to be stated in terms of "not schizophrenic," "not psychotic," "not depressed," and so on.

By contrast, I do not have an aversion to being described as happy, joyous, energetic, balanced, or grounded. Should an MRI or CT scan reveal that my neuroanatomy is abnormal or that there are holes in my brain tissue, I would have to learn to live with that. Physiological reference points are not the foundation of my sense of mental health. My sense of wellness is grounded in the medicine wheel philosophy. I strive to balance the four cardinal quadrants of the mental, physical, emotional, and spiritual realms.

I have read the *DSM-IV-IR* from cover to cover and I have found it wanting in wisdom. It retains very little flexibility for addressing individual or cultural differences.

Related problems are recognized in a study about barriers to mental health care: "The practice of psychiatric rehabilitation is a concept and method that developed in urban-based settings. It has become a widely used guiding principle in mental health practice… The results suggest that geographic and economic factors create serious barriers to application of the psychiatric rehabilitation method in a remote First Nations community."[1] (However, note that the author does *not* say that psychiatric rehabilitation is inappropriate in such a community.)

In another study about suicides in a remote northern community, the author concludes, "The provision of mental health assessments for patients in a remote community in Labrador, Canada, by videoconference was effective and saved money."[2] The study supports the role of psychiatry, but through a different medium. While there is a First Nations community that is conducting a video-counseling/telehealth pilot project, I feel it is inherently wrong to increase even further what has already become a cold, clinical approach to clients.

The problems with urban-based approaches to mental disorders are discussed in a *Washington Post* article. Dr Spero Manson, a psychiatrist who heads the American Indian and Alaska Native programs at the University of Colorado Health Sciences Center in Aurora, says, "I don't know of a single trial in the last 10 to 15 years that has been published regarding efficacy of a pharmacological agent in treating a serious mental disorder in American Indians."[3]

Carl Bell, a psychiatrist at the University of Illinois in Chicago, says, "This thing called psychiatry—it is a European-American invention, and it largely has no respect for non-white philosophies of mental health and how people function."[3]

And Dr Marcello Maviglia, a psychiatrist who has worked extensively with Native Americans in New Mexico, agrees, saying, "A lot of minority groups perceive psychiatric interventions as an ideological approach that discounts their own cultures. A lot of people wouldn't be able to verbalize this, but patients know when you are discounting them, their traditions."[3]

Queen's University and McMaster

Mr McIsaac has more than 20 years of experience providing therapeutic intervention for former attendees of residential schools and working with a native child and family services organization. He is currently an independent counselor exploring the role of mentorship as a commnity tool for helping mental health clients. His roots are in the Ojibway, Cree, Mohawk, and Algonquin tribes.

University have at various times provided psychiatric services to the James Bay region of Ontario. This area is populated mostly by Cree. For anybody concerned with native mental health, it might be interesting to delve into the various research studies of agoraphobia with this population. Would you venture into the streets if you were almost guaranteed to encounter someone (or many someones) who had abused you? Would you go for a daily stroll knowing that your ex-partner was drunk, armed, and angry, and lived only a house or two away?

The Royal Commission on Aboriginal Peoples asked Dr Laurence Kirmayer of the Culture and Mental Health Research Unit, Institute of Community and Family Psychiatry, at the Sir Mortimer B. Davis Jewish General Hospital in Montreal to submit a report on mental health among Canadian Aboriginal people.[4] I highly recommend this report. Dr Kirmayer obviously values the role of psychiatry *and* the role of culture in his work and braids these two streams of thought into an even stronger stream that still has natural flow.

Communities in the North often have plagues of alcoholism, abuse of all kinds, posttraumatic stress disorder as a result of the residential school legacy, little or no self-esteem or community esteem—and the list goes on and on. The only available counselor or social worker may have to meet with both the perpetrator and the victim of a crime. The next person who commits suicide may be closely related to the addictions counselor, and so the counselor will be out of commission for months dealing with his or her own grief. An individual in crisis may have to wait a week for the medical evacuation helicopter to arrive. Rather than going *to* something, you are always going *away* from your community. There is no way of dealing with your issues in a private and confidential manner—everybody in the community knows everybody else's business. And when you come home, you slowly revert to your designated place of dysfunction in your home and in your community.

Only a few short years ago, Bishop Desmond Tutu expressed his shock at the living conditions that existed in some northern communities—this from a man who hails from a country ravaged by despair.

To consider this from a more personal perspective, how would you react if you had 6 or 8 or 15 members of your family and community commit suicide in a 1-year period? How would you grieve? How would you achieve or maintain a state of mental health under those conditions? We will always have social and economic conditions that interfere with our ability to be healthy. We will always have natural disasters that test our coping skills. We will always have individuals around us who engage in negative, dysfunctional, and inappropriate behaviors. And we will always have people and communities who choose to listen to their own hearts and push their way through the emotional rubble to take ownership of their own wellness, including mental health.

Many northern and remote communities have a high percentage of Aboriginal residents. The fortunate ones have access to a healthy elder. There is a movement among elders to teach the younger generations about the importance of wellness and strength and balance. They desire to de-victimize themselves and their communities by visualizing and striving for health, not for its antithesis. Traditional wisdom is not a threat to psychiatry; it is merely a special ingredient that could be added to the recipe for mental health.

Would you venture into the streets if you were almost guaranteed to encounter someone (or many someones) who had abused you?

References

1. Schmidt G. Barriers to recovery in a First Nations community. Can J Commun Ment Health 2000;19:75-87.
2. Jong M. Managing suicides via teleconferencing in a remote northern community in Canada. Int J Circumpolar Health 2004;63:422-428.
3. Vedantarn S. Mind and culture: Psychiatry's missing diagnosis: Patients' diversity is often discounted. The Washington Post. 26 June 2005;A11.
4. Kirmayer LJ. Emerging trends in research on mental health among Canadian Aboriginal peoples: A report prepared for the Royal Commission on Aboriginal Peoples. Montreal: McGill University, 1994. http://upload.mcgill.ca/tcpsych/Report2.pdf (accessed 10 March 2000).