

**DON'T CALL ME CRAZY:  
RE-ENVISIONING MENTAL HEALTH SERVICES FOR ABORIGINAL PEOPLES  
IN PRINCE GEORGE**

by

**Sarah Elizabeth Nelson**

B.Sc., University of Toronto, 2006

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF  
MASTER OF ARTS  
IN  
FIRST NATIONS STUDIES

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

April 2012

© Sarah Elizabeth Nelson, 2012



Library and Archives  
Canada

Published Heritage  
Branch

395 Wellington Street  
Ottawa ON K1A 0N4  
Canada

Bibliothèque et  
Archives Canada

Direction du  
Patrimoine de l'édition

395, rue Wellington  
Ottawa ON K1A 0N4  
Canada

*Your file Votre référence*  
ISBN: 978-0-494-87549-0

*Our file Notre référence*  
ISBN: 978-0-494-87549-0

#### NOTICE:

The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

#### AVIS:

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protègent cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

---

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

# Canada

### **Abstract**

This study explored Aboriginal clients', Elders', and health care providers' perspectives on mental health to see how mental health services might better serve Aboriginal populations. The study used phenomenology and principles of Indigenous research, in partnership with the Central Interior Native Health Society, a primary health care clinic in Prince George. The Aboriginal Caucus, a cultural advisory board for the clinic, acted in an advisory capacity. Two talking circles and twelve semi-structured qualitative interviews provided the information the study draws on. Findings support the literature in saying that a broad approach to mental health, with attention to the whole person and the formation of healthy, supportive relationships, is most appropriate for Aboriginal peoples; also that decolonization will enhance the mental health of Aboriginal peoples and communities. The study also introduces the idea of mental health as energy, which may be a useful alternative way of framing mental health discourse.

### Table of contents

Abstract.....	2
Table of contents .....	3
List of tables.....	5
Acknowledgements and dedication .....	6
Chapter One.....	7
Background and overview .....	7
Purpose of the study and rationale .....	7
Research questions.....	9
Organization of the thesis.....	9
Chapter Two .....	11
Literature Review.....	11
Introduction .....	11
What is mental health? .....	11
Mental health services .....	19
Mental health and mental health services from Aboriginal perspectives .....	21
Summary.....	28
Chapter Three .....	29
Theory, methodology and methods .....	29
Theory.....	29
Methodology .....	32
Methods.....	35
My journey here .....	44
Summary.....	45
Chapter Four .....	46
Results.....	46
What is mental health? .....	46
What factors improve or detract from mental health? .....	53
Mental health services .....	65
Summary.....	85
Chapter Five.....	86
Discussion .....	86
Aboriginal health discourse .....	86
What is mental health? .....	87
Factors influencing mental health.....	96
Mental health services .....	101
Summary.....	105
Chapter Six.....	106
Conclusion.....	106
Limitations of the study .....	107
Suggestions for future research.....	108
Key messages.....	109
Concluding thoughts.....	111

Reference List .....	113
APPENDIX A – Interview questions for health care providers.....	121
APPENDIX B – Interview questions for clients.....	122
APPENDIX C – Talking circle questions .....	123
APPENDIX D – Talking circles invitation letter.....	125
APPENDIX E – Interview invitation letter .....	127
APPENDIX F – Information and consent letter (interviews).....	129
APPENDIX G – Information and consent letter (talking circles) .....	133

**List of tables**

<b>Table 1 <i>Participants</i> .....</b>	<b>22</b>
<b>Table 2 <i>Talking circles</i> .....</b>	<b>23</b>
<b>Table 3 <i>Interviews</i> .....</b>	<b>25</b>

### **Acknowledgements and dedication**

First of all, a big thank you to everyone who participated in this research and so generously shared so much knowledge with me. I hope I have done justice to your insight and expertise. Thank you doesn't seem like quite enough to say to the members of the Aboriginal Caucus – Leonard Ward, Jane Inyallie, Lynette Lafontaine, and Louise Creyke – your support has been invaluable, your advice has kept me on track and honest, and it has been the deepest pleasure to spend time together and work together.

I would like to express my deep gratitude for the help and support of my supervisor, Dr. Josée Lavoie, who has provided invaluable guidance, has inspired me at times when I most needed it, has opened up many opportunities for me, and has been generous in allowing me to pursue my own path and passions in the course of this research. Thank you. Thank you, also, to my committee members, Dr. Ross Hoffman and Dr. Tina Fraser, for their support and understanding, for their guidance, especially in matters of ethics and the practicalities of research, and (last but not least) for their seemingly unending tolerance of my requests for reference letters. Thank you to my employer, Dr. Margo Greenwood, for her support and flexibility at work, for the many learning opportunities, and for the philosophical, ethical, and practical guidance she has provided.

I would also like to thank my parents, Elaine and Peter Nelson, for supporting me through everything I have chosen to do, for proofreading papers at the last minute, and for teaching me to be hungry for both knowledge and justice. Also my brother, Dominic, for proofreading and listening to me practice presentations, for the many interesting conversations, for inspiring me to do a Master's because his was so cool, and for being the best of friends.

I would like to acknowledge the financial support of a Kloshe Tillicum Master's student health research fellowship, a Network for Aboriginal Mental Health Research summer internship, a research project award from the University of Northern British Columbia, and a travel award from the Canadian Institutes of Health Research.

*This thesis is dedicated to my soon-to-be-husband and partner in life, Brent. Many of the ideas contained herein grew directly from our conversations. Thank you for your unswerving support through all the ups and downs.*

## Chapter One

### Background and overview

#### Purpose of the study and rationale

Health care for Aboriginal<sup>1</sup> peoples in Canada deserves unique consideration because of the way enduring colonial practices and mentalities influence Aboriginal peoples' health and access to health care (Browne, 2007). Within the broader category of health care, this study is focused on mental health and mental illness. Mental health problems, such as substance abuse, depression, and "social suffering" (Tanner, 2009, p. 429) are said to be prevalent in Aboriginal communities in Canada, and suicide rates among Aboriginal youth are three to six times higher than rates for Canadians from other populations (Kirmayer, Tait, & Simpson, 2009; see also Chandler & Lalonde, 2009, for a break down of rates in British Columbia by community). It is not entirely clear what indicators such as substance abuse, suicide, depression, and social suffering tell us about the mental health of Aboriginal peoples in Canada. There is also a lack of coherent and clear descriptions and consistent terminology in the literature on mental health (Roberts & Grimes, 2011); this is true of the literature on mental health with reference to Aboriginal peoples and communities as well. Further, Bill Mussell writes that "there is no concept for 'mental health' in traditional Aboriginal languages" (Mussell, 2006). For these reasons, further investigation into the meaning of mental health from the points of view of Aboriginal peoples is needed.

---

<sup>1</sup> Throughout this study, I use the term "Aboriginal" to refer to all of the many First Nations, Inuit, and Métis peoples living in Canada. The term "Indigenous" is used when I wish to refer to first peoples in an international context. I use the term "Aboriginal peoples" to refer inclusively to First Nations, Inuit, and Métis nations and groups in Canada, whereas "Aboriginal people" refers to individuals who identify as Aboriginal.



In this study, mental health is treated as a concept which exists and can be measured separately from mental illness (Keyes, 2005). Mental health and mental illness are understood in different ways by Aboriginal peoples, and it is often impossible to separate mental health from its place within the interconnected aspects of emotional, physical, mental and spiritual health (McCormick, 2009). The purpose of this study is to investigate mental health and mental illness, and the services in place to provide treatment, from the perspectives of Aboriginal clients, Aboriginal Elders, and mental health care providers who work with a predominantly Aboriginal clientele, in an attempt to find out how different concepts of mental health and illness influence the ways different types of mental health care services are delivered for, and received by, Aboriginal clients.

Statistics showing that Aboriginal peoples tend to have worse health, including mental health, than other peoples in Canada abound (Waldram, Herring, & Young, 2006). One of the causes of this situation is Canada's history of colonization and the continuing colonial practices of the Canadian state. One way in which colonialism is perpetuated is through the concepts and assumptions underpinning the way mental health services are delivered, but unfortunately, these concepts and assumptions are rarely questioned. Therefore, an examination of different concepts that influence the ways mental health care is offered and the ways in which Aboriginal individuals access this care is highly relevant and much needed.

Many studies of mental health in Aboriginal communities use the concept of "culture" without thinking critically about it (Waldram, 2009; Waldram, 2004). A Eurocentric bias in the school system leads many researchers to approach Aboriginal peoples with

preconceptions of which, often, they are not consciously aware. It has been my goal, in undertaking this research, to remain vigilant about my own preconceptions so that I can continue to learn and to correct myself when biases come to light.

Some scholars also argue that studies need to be conducted at the community level in order to assess health problems in a meaningful way and to offer solutions that will work (Chandler & Lalonde, 2009). There is room for a great deal more research specific to mental health care in the Prince George area of British Columbia. This study will be a way to contribute to the body of local knowledge, specific to Prince George.

### **Research questions**

The following are the research questions that guided the development and undertaking of this research.

1. How do Aboriginal clients seeking mental health care conceptualize their own mental health and illness?
2. How do health care providers, including Aboriginal Elders, conceptualize mental health and illness?
3. Do these various perspectives have an impact on the lived experience of Aboriginal clients when they access treatment for a mental illness or mental health problems?

### **Organization of the thesis**

This thesis is organized into six chapters. Chapter One contains the background to the study, its purpose, rationale, and research questions. Chapter Two presents a review of the literature in the field of mental health and Aboriginal mental health. Chapter Three outlines the theory and methodology that provide the foundation for this study, and the

methods used to collect, analyse, and compile information. Chapter Three concludes with a brief discussion of my background as a way of situating me with relation to this research. Chapter Four presents the study results, and Chapter Five places the results in relation to the literature and discusses the implications of the findings. Chapter Six outlines some limitations of the study, and offers recommendations for future research, before presenting key messages and concluding thoughts.

Having presented the rationale, purpose, research questions, and organization of this thesis, I now turn to an examination of the relevant literature.

## **Chapter Two**

### **Literature Review**

#### **Introduction**

This chapter gives an overview of the literature related to Indigenous mental health, in order to give context and background to the study and to get a sense of where scholars stand theoretically on this topic, as well as to look at what work has been previously undertaken in the field. It begins with a section outlining different ways of describing mental health, followed by a brief overview of the mental health services that are available to the participants in this study. Next, a section on some Aboriginal critiques of mental health, and attempts to describe concepts of mental health from Aboriginal perspectives, is presented. The chapter ends with a short outline of some of the problems with the literature as it stands, followed by some concluding thoughts.

#### **What is mental health?**

It is becoming increasingly clear that the mind does not exist separately from the body; this is particularly true in most Indigenous concepts of mental health. So what does it mean to refer to “mental” health? In the context of this research, it is tempting to discard the term “mental health” in favour of a concept of overall wellness that does not perpetuate the artificial distinction between the mind and the body. However, mental health still has meaning in health care, and services are often divided or categorized according to whether they attend to a person’s mental or physical well-being. Therefore, in this section I take a broad look at how scholars define mental health.

A great deal of the literature proposes that Aboriginal worldviews have some fundamental differences from non-Aboriginal ones. However, most of the literature also stresses that we must not forget the wide variation that exists among Aboriginal peoples, making generalization difficult. This same variation also exists among non-Aboriginal peoples. Thus, it seems that people cannot reasonably be divided into only two groups for the purposes of any definition.

There exist a multitude of definitions of mental health from scholars and mental health care providers. Some of these definitions are identified as originating in Aboriginal worldviews, some as originating in psychology or psychiatry – and many are not given any label or association with a particular culture or discipline. In many cases, Aboriginal conceptions of mental health are interwoven with emotional, physical, and spiritual health – mental health cannot stand on its own. In many cases, non-Aboriginal definitions of mental health say the same thing. I propose that, in defining mental health, the distinction between Aboriginal and non-Aboriginal cannot be comfortably drawn, both because there are too many different Aboriginal peoples to place everyone in one group (and the same applies to non-Aboriginal peoples), and because both Aboriginal and non-Aboriginal definitions can be relevant in both non-Aboriginal and Aboriginal contexts.

In examining definitions of mental health, several broad patterns can be discerned. Mental health is defined in relation to what is normal; it is given cognitive origins and explanations; in some cases its causality and effects are traced to the physical body; some define it as a holistic, whole-person concept; and others base mental health in relationships

among human beings and the surrounding world. I will examine each of these patterns in turn.

One question which is raised straight away is, are mental health and mental illness the same thing? In Western<sup>2</sup> medicine, these two terms have often been interpreted as two ends of a single continuum. As Corey Keyes puts it, "there exists no standard by which to measure, diagnose, and study the presence of mental health; science, by default, portrays mental health as the absence of psychopathology" (2005, p. 539). However, in his study Keyes argues that in fact, mental health and mental illness "are correlated unipolar dimensions that, together, form a complete state of (mental) health" (2005, p. 539). The two can be measured separately, by different criteria – in other words, a person can have a mental illness but still have relatively good mental health.

The World Health Organization (WHO) takes a similar approach to defining mental health and mental illness:

Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO's definition of health: 'A state of complete physical, mental and social well-being, and not merely the absence of disease.' It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders. (World Health Organization, 2010)

Throughout this research I treat mental health and mental illness as separate, but related, concepts, both of which are important for this study.

---

<sup>2</sup> The term "Western" refers to what is today known as "Western civilization," a wide-ranging and nebulous set of traditions and beliefs developed mainly in Western Europe that are typically described in three main historical ages – the ancient, the medieval, and the modern. The foundation of Western values and world view are generally accepted as having developed during the years between the Renaissance (14<sup>th</sup>-17<sup>th</sup> centuries) and the Enlightenment (18<sup>th</sup> century) in Europe.

One pattern of defining mental illness contrasts it with what is "normal." Terms such as "disorder" (World Health Organization, 2010), "abnormal" (World Health Organization, 2010), and "behavioural oddity" (Kirmayer, Fletcher, & Watt, 2009) beg the question: what is normal? According to the Oxford English Dictionary (OED), "normal" refers to "the usual state or condition" (1991, p. 1942). A "norm" is "a standard, model, pattern, type" (1991, p. 1942). What is "usual" or "standard," however, depends on the situation. As such, what is normal can change – from one elementary school to another, from one family to another, between communities, nations, and of course, between cultures. The failure to acknowledge that different people have different standards has led to the normalization of one cultural, racial, or gendered ideal in much of North America. The standard by which everyone else is judged is often a healthy, Christian, Caucasian, heterosexual male (Dyer, 1997; Gould, 1981).

Defining mental illness in terms of what is normal, therefore, can be problematic. In Kirmayer, Fletcher and Watt's (2009) study of Inuit conceptions of mental health, the authors describe an earlier study by Vallee (1966), in which:

Finding no general indigenous concept of mental or psychiatric disorder, Vallee chose as his basic criterion of mental breakdown: 'incapacity of the person to perform some or all of his normal roles accompanied by behavioural oddity, as defined by the interviewees, and where the incapacity and oddity are attributable to the head rather than to some other body organ.' (Vallee, 1966, p. 57; cited in Kirmayer et al., 2009, p. 297)

Vallee's study attempted to define mental illnesses based on what was normal, but narrowed the definition of normality to a specific locale, a specific society, and a particular cultural context.

Claude Denis (1997) investigates the idea of normality and how the Canadian state has positioned Aboriginal societies in opposition to the norms of colonial society. Denis centres his argument around a Coast Salish initiation ceremony whose recipient did not consent to the initiation – which involved a four-day fast, among other physical deprivations – and subsequently took his initiators to court. The press as well as the Supreme Court took the side of the man who was initiated, ignoring all the factors that led to his being initiated without his consent (for example, his partner and his brother both asked that the initiation be performed; he had problems with alcohol which were affecting his relationships with those around him). According to Denis, the story of this initiation as told in the press:

Is a morality tale, then, which makes us moderns feel good about ourselves, about our respect for human rights, and which at the same time undermines our ability to respect aboriginal cultures. Most of all it allows us, when we hear the word 'Indian' or 'aboriginal,' to displace concerns, from our domination of them to *their* 'savagery.' (Denis, 1997, p. 57; emphasis in original)

This case illustrates one of the dangers of judging what is normal from a particular point of view, without taking alternative interpretations into consideration; namely, the risk of condemning or stereotyping practices that seem different, without understanding the whole story.

Denis also writes, "there are some circumstances in which modernity will allow denials and violations of the rights of men, such as with convicted criminals... and individuals who are deemed mentally incompetent to make their own decisions" (Denis, 1997, p. 54). Mental illnesses can be used as an excuse for confinement, and are often a method of enforcing cultural norms (Foucault, 1965). It is important to remember, though,



that different cultures have different cultural norms, as well as different ways of enforcing them.

A second category of definitions, perhaps most true to the term "mental" health, are those which define mental illnesses as having cognitive origins. In this case, mental illnesses are seen as dysfunctions of thought. Kirmayer, Fletcher, & Watt (2009) offer this type of definition based on the above-mentioned studies conducted with Inuit people of Nunavik, Québec. They write, "*Isumaaluttuq*... thinking too much.... covers a very broad range of problems and situations, ranging from ordinary worry and preoccupation to profound depression, withdrawal, and behaviour clinically consistent with psychosis" (Kirmayer et al., 2009, p. 300). Also, "*Isumaqqanngituq*, implied more severe problems... Glossed as 'he has no mind/brain,' 'crazy,' 'doesn't know what's going on around him'... suggests an inability to act normally because of incoherent thoughts" (Kirmayer et al., 2009, p. 301).

Another approach to mental illness which focuses on thought processes is cognitive therapy, more often now included under the umbrella of cognitive-behavioural therapy. This technique, used for a variety of illnesses, from anxiety to psychosis to chronic fatigue, involves consciously training one's mind to change habitual negative patterns of thought (Richards, 2010).

Disorders in the way we think are not the only answer, though. There are some definitions of mental illness which associate it with the physical body, generally in one of two ways. Either physical illnesses are seen to have their causes in the mind, or mental illnesses are considered as being caused by physical processes. An example of the latter is the definition of depression as a malfunction of the brain's neurotransmitters (National

Institute of Mental Health, 2009). An interesting example of the former is Dr. Gabor Maté's description of "*psychoneuroimmunology*," which refers to "the indissoluble unity of emotions and physiology in human development and throughout life in health and illness" (2004, p. 5). Maté brings together numerous examples to show that feelings such as stress or repressed emotion can cause physical illness, because the systems in our body are all inextricably linked. We cannot, therefore, separate mental illness from physical illness, because our mental or cognitive lives stem from, are affected by, and have effects on, our physiological bodies.

Gabor Maté's approach fits well with holistic definitions which place mental health as an inseparable piece of overall health, the other components of which are usually emotional, physical and spiritual health and well-being. Durie, Milroy, & Hunter write about the Māori concept of *Te Whare Tapa Wha*, which "invokes the image of a four-sided house, each wall representing one aspect of health. *Taha wairua* (spirituality)... *Taha hinengaro* (mind) concerns the way people think, feel, and behave... *Taha tinana* (physical health)... *taha whānau* (relationship)" (2009, p. 43). In North America, the holistic model of health is often represented by the medicine wheel, which contains the four aspects of emotional, physical, mental, and spiritual health (Royal Commission on Aboriginal Peoples, 1996). Caring for all aspects of ourselves will almost always result in better overall health.

Then there are definitions which emphasize relationships among human beings, and between humans and the world. Joseph Gone writes that "my own community (as but one concrete example) still tends to configure wellness (i.e., life lived 'in a good way') much differently than the 'mental health' of professional psychology, emphasizing respectful

relationships instead of egoistic individualism and the ritual circulation of sacred power instead of the liberating enlightenment of secular humanism" (Gone, 2009, p. 427).

According to Michael J. Kral and Lori Idlout, "the Bathurst Mandate"<sup>3</sup> (Nunavut 1999a) appears to have defined the Inuit perspective on mental health as *Inuuqatigiitiarniq*, 'the healthy interconnection of mind, body, spirit, [people], and the environment'" (2009, p. 318). Mental illnesses seem, more than anything, to disrupt a person's relationships with oneself, with other people, or with the world in general.

For the purposes of this study, mental health is only one part of overall health, albeit an important part. Mental health can be affected – positively or negatively – by physiological, emotional, or spiritual states. It involves healthy, positive ways of conceptualising the world and framing situations within it, which promote positive personal and relational growth. It is nurtured by mutually respectful, caring relationships with family and friends as well as a positive relationship and a sense of safety within the environment in which a person lives and works. It is promoted by feelings of purpose in life, and fulfilling ways of addressing questions of spirituality.

Mental illness, for the purposes of this research, is, rather than the departure from a norm, the distance from an ideal. I believe that we all have ideal ways of living, feeling, and thinking, and mental illnesses are some of the things that can prevent us from achieving

---

<sup>3</sup> "Born in 1999, the government of Nunavut was the result of more than twenty years of negotiations between Inuit officials and the government of Canada. One of the goals of the "Nunavut Project," first submitted for negotiations in February 1976, was to empower the Inuit of the Canadian Central and Eastern Arctic with the necessary political tools to better cope with their contemporary socio-economic challenges. These challenges were well described in a statement of priorities, known as the Bathurst Mandate, first put forward by the government of Nunavut a few months after its inception (October 1999). The Bathurst Mandate exposes the socio-economic goals and visions of the new government over a twenty year period (2000-2020)" (Légaré, 2009)

these ideals. The difference here is subtle, but the main difference is that fitting a norm is dependent on others' perceptions and interpretations, whereas living up to an ideal is a more personal goal. Mental illnesses often have a physiological component to them, which can be either a cause or an effect of the illness. Mental illnesses can also be habits of thought, ways of thinking that can negatively affect a person's self- or social image and quality of life, as well as one's relationships with other people, the environment, or one's conception of the spiritual. I find it important also to note that the effects of mental illness are not always negative. People with autism or Asperger's Syndrome<sup>4</sup>, for example, often have exceptional gifts (see, e.g., Tamm, 2006). Depression is popularly linked to creativity. Mental illnesses are experienced very differently by different people, but I believe that in many instances they allow people to see the world in unusual, creative, and sometimes enlightening ways.

### **Mental health services**

In order to get a sense of what mental health services are available to the participants in this study, I will here give a brief overview of health and mental health services for Aboriginal peoples in Canada and in Prince George. Health care services for Aboriginal peoples in British Columbia (B.C.), as in the rest of Canada, are provided by a variety of sources. The federal government, through the First Nations and Inuit Health Branch of Health Canada, is responsible for funding and health promotion on reserve (Lavoie & Forget, 2006). The province provides acute care and hospital services for First

---

<sup>4</sup> "Asperger syndrome... is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behaviour" (National Institute of Neurological Disorders and Stroke, 2010, n.p.).

Nations populations both on reserve and off reserve, as well as for Inuit and Métis peoples, as it does for all Canadians. Other health care services available to Aboriginal people include those offered by voluntary organizations in the non-profit sector. Some of these organizations have a specifically Aboriginal focus, others specialize in certain types of care for the general population. Non-profit sector services tend to be more varied than public sector health care services, are considered more responsive to the needs of their clients, and in Canada are most often funded by the provincial governments (Hanlon et al., 2007, pp. 344, 345).

In the city of Prince George, mental health services are provided by the province through the regional Northern Health Authority (NHA), which operates the Community Response Unit (CRU) and the Community Acute Stabilization Team (CAST) to deal with adult mental health and psychiatric issues. In addition, the Provincial Health Services Authority (PHSA) operates specialized health care programs such as BC Mental Health and Addiction Services ([BCMHAS] PHSA, 2010).

For Status Indians within the NHA, the federal government contributes funding towards certain health care programs, and the First Nations and Inuit Health Branch of Health Canada “provides funding to First Nations and First Nations organizations for programs that address particular health needs,” including mental health (Kendall, 2007, p. 174). Status Indians can also access short-term crisis counselling through the Non-Insured Health Benefits program (Kendall, 2007, p. 175).

Prince George is also home to a variety of non-profit mental health organizations, including the Canadian Mental Health Association, the Native Healing Centre at the Prince

George Native Friendship Centre, The British Columbia Schizophrenia Society, and the Prince George Brain Injured Group, as well as primary care organizations which address mental health and addictions issues, such as the Central Interior Native Health Society.

### **Mental health and mental health services from Aboriginal perspectives**

I now move to a discussion of mental health from the point of view of scholars who work with Aboriginal peoples and who look at mental health with Aboriginal perspectives in mind. The first part of this discussion has to do with critiques of the concept of mental health, and the research done into mental health. I will conclude this section by briefly discussing the work of several scholars who have investigated the concept of health, or mental health, from different Aboriginal perspectives, and several who are conducting research into modifying mental health services to better serve Aboriginal populations.

There are a few points that need attention when we address the topic of mental health, especially when examining the topic from potentially divergent cultural perspectives. First, with diagnostic labels like "oppositional defiant disorder" and "conduct disorder," mental health seems to be the study of people who feel, think, or act differently than what is considered to be normal (American Psychiatric Association [APA], 2000). When applied to Aboriginal peoples in Canada, this definition sends up a warning flag, because colonialism tends to make its own processes and values normal, at the same time positioning colonized peoples outside of what is considered normal, in order to study and subsequently control them (Gould, 1981).

Further, when we define something as a mental illness and give it a diagnosis, it is attributed a certain amount of scientific objectivity that is often taken for granted. With

regard to Aboriginal mental health, concepts like culture and race are often defined according to simple, outdated, colonial-anthropological paradigms, and the ways in which these paradigms inform mental health research frequently remain unquestioned (Waldram, 2009; Duran & Duran, 1995). For example, Waldram writes that, "whereas the behaviour of non-Aboriginals is interpreted primarily in terms of class and socio-economics, as though they have no culture, the behaviour of Aboriginals is too frequently explained as though it is only a manifestation of culture or, worse still, of biology" (2009, p. 72).

The discourse of mental health for Aboriginal peoples in North America maintains a close relationship with discourses of colonialism (Duran, Firehammer, & Gonzalez, 2008; Duran & Duran, 1995). Joseph Gone makes an important point about the changing face of colonialism:

If the colonizing campaigns undertaken through church and school are no longer fashionable in America and Canada at the opening of the twenty-first century, a more recent constellation of progressive humanitarians – once again bound together in the name of helping indigenous North Americans to better adjust or adapt to challenging societal circumstances – continues to expand its influence in Native lives and communities through what might be loosely termed the 'psy-fields' (Ward, 2002) or the 'mental health' professions. (Gone, 2009, p. 420)

Gone is a formally trained psychologist and an Indigenous person. He is not rejecting the mental health professions, but reminding us that we need to be watchful, because colonialism can be perpetuated in many forms.

It is sometimes hard to tease out the effects of colonialism on Aboriginal people's mental health and separate the broad, structural experience of colonialism from the more immediate effects of socioeconomic disadvantage or discrimination in the workplace, for example. Whitbeck and colleagues make an interesting point with regard to this distinction.

They write, "are we dealing with actual historical issues or more proximate grief and trauma from the daily lives of often economically disadvantaged people who live with constant overt and institutionalized discrimination, severe health issues, and high mortality rates? The current conditions may be related to historical causes, however, the origins of the symptoms may be contemporary experiences" (Whitbeck, Adams, Hoyt, & Chen, 2004, p. 119; cited in Kirmayer, Brass, & Valaskakis, 2009, p. 454). The distinction between historical and contemporary causes is perhaps artificial; however, the point is that the causes of mental illnesses and mental health problems may be multi-layered and found in the past as well as the present in a complex chain of causation.

Several Canadian scholars have undertaken to describe equivalent, or at least complementary, concepts related to the terms "mental health" or "mental illness" that are found in various Aboriginal communities across the country. Kirmayer, Fletcher, and Watt, in a study mentioned above, asked people in Inuit communities in Nunavik to describe their concepts of mental health. They were told about two related concepts that had to do with disorders of the mind, or dysfunctions in thinking: *Isumaaluttuq* and *Isumaqqanngituq*, described above (Kirmayer et al., 2009). Kirmayer, Fletcher, and Watt built on ideas formed from a previous study conducted by Vallee in the mid-1960s, who asked Inuit people to describe their concepts of mental disorder (Vallee, 1966). Specifically, Vallee asked people about "happenings in which people were rendered incapable of performing in their everyday capacities and where there was no obvious physical cause for this inability, and where the individuals behaved in an unusual, although not necessarily unpatterned, manner" (Vallee, 1966, p. 57; cited by Kirmayer et al., 2009).



In another recent study among Inuit peoples of Nunavik, Kirmayer and Paul write that “Inuit concepts of health and well-being are informed by contemporary medical and psychological views as well as by specific knowledge rooted in Inuit cultural tradition” (Kirmayer & Paul, 2007, p. 2), and include central concepts of connections with the land and animals. Mental illnesses, or mental health problems, are seen as stemming from:

Four types of causes: (1) physical or organic effects of the environment or human behaviour; (2) psychological or emotional factors related to problems in child-rearing, interpersonal relations, and mental functioning; (3) spirit possession or other negative influences recognized by Christian religion; and (4) cultural change, marginalization and social disadvantage. (Kirmayer & Paul, 2007, p. 3)

Van Uchelen conducted a study in Vancouver, BC, of different Aboriginal peoples’ views of wellness and strengths with relation to mental health (1997). Beginning from the perspective that a strengths-based approach is most appropriate, and that Aboriginal people living in the city will have a wide variety of views of wellness, the author describes some common themes in participants’ descriptions of strengths and wellness, in particular a focus on holistic approaches to health and a sense of connection to others and to one’s own cultural identity (Van Uchelen, 1997).

It is worth noting, too, that several scholars have undertaken to describe Indigenous concepts of overall health; these concepts tend to include a mental health component. For example, Cargo et al. looked at the relationship between perceived notions of holistic health and balance, and the amount of inactivity among Kanien'kehá:ka (Mohawk) youth (Cargo, Peterson, Levesque, & Macauley, 2009). The authors found that a holistic view of health, represented by the medicine wheel and encompassing mental, spiritual, emotional, and physical health, made sense to many youth, and that the youth who subscribed to this

concept also tended to be more physically active. The holistic concept of health and the promotion of balance are suggested by the authors as culturally appropriate ways of addressing problems of inactivity among youth (Cargo et al., 2009). Naomi Adelson conducted an ethnographic study among the Cree of Whapmagoostui, examining their concepts of overall health, and found health to be inextricably linked to the environmental, social, historical and political contexts in which the Cree live (Adelson, 2000).

In addition to researching concepts of health and mental health, several scholars have focused their attention on the provision of mental health services for Aboriginal populations. Duran and Duran had an early impact in the field of psychology, pointing to the influence of colonialism on the mental health of Native American and Alaska Native Peoples in the United States, and the transmission of colonial hurts across generations of Native peoples, which they called the “soul wound” (1995, p. 24). Duran and Duran pointed to the cultural specificity of Western psychology and advocated new approaches to counselling that take into account the different situations and cultures of Native American and Alaska Native peoples (Duran & Duran, 1995); a task which Eduardo Duran has carried on in more recent publications (Duran et al., 2008; Duran, 2006).

Joseph Gone is another American scholar whose work is becoming more prominent in Canada. An Indigenous, Western-trained clinical psychologist, Gone has explored the boundaries between Indigenous and Western approaches to the treatment of mental health problems (Gone, 2009; Gone, 2008) and is currently developing ideas about how the different approaches can be compatible, for example through scientific evaluations of Indigenous healing practices (Gone, 2011).

Rod McCormick's work also focuses on culturally appropriate counselling techniques for Aboriginal peoples in Canada (McCormick, 2009; McCormick, 1996). McCormick's work strongly emphasizes the holistic nature of Aboriginal concepts of health and how these can be incorporated into counselling techniques using the medicine wheel (McCormick, 2009).

There are a few fairly common, and problematic, assumptions that can be found in much of the literature under discussion, that are worth mentioning briefly here. The first is the tendency to make generalized criticisms of Western science and medicine that have the effect of creating a polarized division between "Western" approaches to mental health and "Aboriginal" ones (Blackstock, 2008; Stewart, 2001; Van Uchelen, 1997). It is true that there remain vestiges of far-outdated concepts in Western science and medicine that still inform how mental health is conceptualized and services are offered; it remains for the most part compartmentalized and disease-treatment oriented, rather than holistic and wellness and prevention oriented, for example (Van Uchelen, 1997); however, Western concepts of mental health in Canada are, and continue to be, influenced by Aboriginal approaches and other forms of complementary medicine, with the result that there is an ever-growing number of mental health services which incorporate Aboriginal approaches and treatments (Anishnawbe Health Toronto, 2011; Central Interior Native Health Society, 2011; McLeod-Shabogesi, 2010) as well as a growing emphasis on prevention, holistic health, and the social determinants of health (Wilkinson & Marmot, 2003; Smith, 2002).

A second problematic assumption to be found in the literature is a tendency to generalize broadly about the effects of colonialism and residential school on Indigenous peoples' mental health, in particular in discussions about intergenerational or historic

trauma (Wesley-Esquimaux & Smolewski, 2004; Duran & Duran, 1995). Unfounded assertions about the pathology and mental illness of vast proportions of the populations of Indigenous peoples echo the colonial tendency to portray Indigenous peoples as pathological, sick, and mentally unsound (Waldram, 2004). For example, with reference to the experience of contact and colonization in the United States, Duran and Duran assert that:

Many of the Native American people who survived the onslaught were not only physically abused but also psychologically tormented.... If these traumas are not resolved in the lifetime of the person suffering such upheaval, it is unthinkable that the person will not fall into some type of dysfunctional behavior that will then become the learning environment for their children. (Duran & Duran, 1995, p. 31)

The point that the impact of colonization can carry on through generations is a salient one; the problem is with the assertion of inevitability that accompanies a description of psychological wounding and subsequent pathology. Saying that it is "unthinkable" that a person will not become dysfunctional is simply unfair. Illustrating how this assertion of inevitability can be harmful, a participant in a study by Lavallee and Poole said:

Somebody said something to me and I had to kinda set him straight. He said, "Your boys don't realize what they have. They don't know. You took them to China, you did this, and you did that." And I was like, "And, your point is what? Just because they are Native kids they have to suffer? Is that what you are trying to tell me? That just because we've had such a rough start, now my kids, because they are Indian, they have to have a hard life? Why? Tell me why!" (Lavallee & Poole, 2010, p. 278)

It is important not to understate the impacts of colonization and colonialism for Aboriginal peoples; however, it is equally important to recognize that things can change and improve, not to normalize illness or problems, and to focus on successes and strengths.

Overall, several themes become apparent from the preceding discussion of the literature on critiques of mental health, concepts of health, mental health and well-being,

and approaches to mental health treatment from Aboriginal perspectives. The first is the distinct and significant role that colonialism plays in the mental health of Indigenous peoples in Canada and around the world. Second, an emphasis on holistic care and the interconnectedness of life, paying attention to all aspects of a person's life and being, is considered of the utmost importance when approaching the mental health of Aboriginal peoples. Third, it is considered more appropriate to focus on strengths and wellness, rather than on weaknesses and disease, in the study and treatment of Aboriginal mental health. Assertions by many scholars that Aboriginal peoples have ways of thinking about mental health that differ from Western approaches, and that Aboriginal people often are reluctant to access Western mental health services, informed the initial development of the research questions and the subsequent design of this study.

### **Summary**

This chapter has summarized the major literature related to Aboriginal perspectives on mental health and mental illness and located this study in relation to this literature. The next chapter describes the theory, methodology, and methods used in this study, as well as looking at the researcher's background and life experiences in relation to the topic.

### **Chapter Three**

#### **Theory, methodology and methods**

Having examined the literature relevant to this study, this chapter turns to an examination of how the study was undertaken; namely, the theoretical and methodological foundations on which it rests and the specific methods used in gathering and analysing information. It concludes with a brief discussion of the researcher's background in order to situate me in relation to the study.

#### **Theory**

My theoretical stance draws on the dialogic theories of learning and the philosophies of liberation of Paulo Freire, who wrote that you can oppress someone else but you can't liberate someone else – you can also oppress yourself, but you don't in fact liberate yourself. Only "human beings in communion liberate each other" (Freire, 1970, p. 133). This is a stance which in some ways seems to contradict the teachings of Elders, who place a great deal of responsibility on the individual for both liberation and healing. As Ross Hoffman writes in his account of the teachings of Joe Cardinal, a Cree Elder and healer, "the responsibility and power to confirm one's own story, one's own truth, always rested with the individual. Therefore the power to bring about change, to heal, is also vested in the seeker" (Hoffman, 2010, p. 27). In fact, it is "perhaps dangerous, for an individual who facilitates the healing process in another to begin to believe that they are responsible for the healing that takes place" (Hoffman, 2010, p. 27).

The two stances are not in direct conflict, however. Freire writes about the danger of turning a rebellion against oppression into one leader's "private revolution" (1970, p. 46),

which is dangerous because it merely perpetuates the order of oppression, and works against authentic freedom. The revolutionary leader – like the healer – who takes undue credit is not offering genuine help.

Freire's assertion that an individual cannot liberate him- or herself stems from his belief in the "communion" of human beings (1970, p. 133). He is committed to the power of the collective: "when [the oppressed] discover within themselves the yearning to be free, they perceive that this yearning can be transformed into reality only when the same yearning is aroused in their comrades" (Freire, 1970, p. 47). The power of the collective, however, is not diminished in Joe Cardinal's teachings of personal responsibility. In fact, a person's position within a collective only adds to their personal responsibility. As Claude Denis puts it:

As I understand it, the relationship between individualism and collectivism in Coast Salish culture is dialectical; they feed on each other, in a state of tension as much as reinforcement. Now this is also the case in occidental culture, at least as individualism is constructed in philosophical and ethical systems. This dialectic of individual, family and community is, for instance, at the heart of Hellenistic individualism... It is also crucial in the genesis of modern individualism. (1997, p. 66)

Individualism, being the responsibility of an individual for one's own actions and decisions, is far more important when the individual is embedded in the context of family and community than it would be if a person could genuinely exist outside of this context.

Freire (1970) also poses the idea of praxis, or reflection combined with action, as being necessary in order to achieve liberation. I am optimistic that this concept has underpinned my thesis, and that I have acted and reflected in an ongoing cycle, sometimes alternatively and sometimes simultaneously, so that the two processes inform each other.

I work within David Newhouse's concept of "complex understanding," articulated as a

defining feature of Indigenous scholarship. “Complex understanding occurs when we begin to see a phenomenon from various perspectives as well as the relationships among those perspectives.... A phenomenon is not one thing or another but all things at one time” (Newhouse, 2002). It is important to remember that there is not one truth, but many, all of which exist simultaneously.

My work is also informed by Michel Foucault (1965), whose history of madness brings perspective to the idea of mental illness as a form of social control. Stephen Jay Gould (1981) brings to light the ways in which science – or scientists – can be manipulated by popular ideas, without ever being conscious of the manipulation. This seems to happen a great deal in mental health research, especially that dealing with “other” cultures. Linda Tuhiwai Smith’s (1999) position on the links between colonialism and research also informs my thesis, in addition to her methodological ideas.

Finally, my theoretical stance includes authors working in psychoneuroimmunology, a philosophical-medical discipline which examines how the mind, body, and emotions are interrelated. This includes Thomas Fuchs (2002), who writes about the inability of brain science to provide complete understandings of mental illness, because it looks exclusively at the brain, rather than at the person as a whole and the influence of that person’s surroundings. I also include the work of Walter Glannon (2002), who asks, if the workings of the mind can be shown to affect the physical body, then how can mind and body be separate entities? Finally, I take into consideration the ideas of Gabor Maté (2004), who draws on his own clinical experiences with patients to show how stress and an overbearing sense of duty can cause serious physical illnesses.



## Methodology

Max van Manen writes that in research, “the method one chooses ought to maintain a certain harmony with the deep interest that makes one an educator... in the first place” (Van Manen, 1990, p. 2). In other words, all researchers should be guided by what interests and inspires them, and should therefore choose methods which reflect the same.

My deep interest as a researcher lies in uncovering the power structures on which the Canadian nation is based, and tracing the roots of the colonial system in order to show how colonialism still affects all peoples in Canada to this day. The inequalities inherent in this system are blatant and irrational and yet continue to be supported in the mainstream imagination by stereotypes, myths, and misinformation. In order to undertake responsible research, I need a methodological framework that is flexible, that allows for ongoing re-evaluation of my own motives and beliefs, and that validates ways of understanding the world that depart from colonial thought. This study has, therefore, developed as a community-based phenomenological research study, informed by the ethics and other underlying principles of Indigenous research.

I chose phenomenology as my starting point, due to its focus on depth of understanding and the importance it attaches to the meanings people make.

Phenomenology is a methodology with a long history, and roots in German and French philosophy (Spiegelberg, 1994). The purpose of a phenomenological study is to examine participants’ experiences of a given phenomenon in depth, and to find commonalities among these various experiences in order to find out the essential characteristics – the essence – of that phenomenon. It requires the researcher to thoroughly examine – or

“bracket” – his or her own beliefs and experiences regarding the phenomenon under investigation. Similarly, when examining data from a phenomenological study, the researcher is required to engage in “suspension of belief” (Spiegelberg, 1994, p. 107) in whatever he or she may already know. This suspension of belief can help the researcher keep an open mind to new possibilities – and, in this case, avoid reproducing colonial ideas. The role of intuition in leading to the truth is an integral part of phenomenology. Husserl's phenomenology also strongly emphasizes the researcher's responsibility, not only for one's own actions but also for all of humankind (Spiegelberg, 1994).

Max van Manen (1990) describes what he calls hermeneutical phenomenology. The primary focus of this methodology is a dedication to thoughtfulness, or “a fullness of thinking” (Van Manen, 1990, p. 31). “To be full of thought means not that we have a whole lot on our mind, but rather that we recognize our lot of minding the Whole – that which renders fullness or wholeness to life” (Van Manen, 1990, p. 31). Van Manen also emphasizes the importance of writing in research, as a way of enabling reflection. This method is one which I already use to gain a deeper understanding of the world, and therefore suits me well.

The end product of the study is an examination of the commonalities and differences among all participants' ideas about mental health, articulated both through directly thinking about what mental health means, and through their own experiences with mental health in various facets of their own lives.

Phenomenology also fits well with what have been described as the principles of Indigenous research (Wilson, 2008; Smith, 1999). Indigenous research stems from the need

to develop more sensitive, accountable, and practical research methods so that research can be undertaken with, by, and for Indigenous peoples. Historically, much of the academic research that has been done regarding Indigenous peoples has been done by non-Indigenous academics, without the inclusion of the people they were studying in the research process (see Smith, 1999; Waldram, 2004, for a discussion of some of the problems with this type of research). Indigenous academics are now working to change that and to articulate new paradigms for conducting research with Indigenous peoples that will respect, and benefit, Indigenous peoples and communities. It is my hope that this research contributes to that project.

Shawn Wilson's work emphasizes what he calls "relationality," which is the perspective that "relationships do not merely shape reality, they *are* reality" (2008, p. 7). Based on relationality, he outlines what he sees as an Indigenous ontology (way of being), epistemology (way of knowing), axiology (ethics and accountability), and methodology (guiding principles of research methods). The emphasis on forming and honouring relationships with other human beings, as well as with all living things, is important in my work. When I see myself and my work as interconnected with the people, places, and philosophies I am working with, I remember that everything I do has an effect on others, and as a result hold myself more accountable for this effect.

Māori scholar Linda Tuhiwai Smith (1999) has written a quite comprehensive and accessible account of imperialism, colonization and colonialism. For her, the overarching purpose of Indigenous research is decolonization, because research has been guided by colonial purposes and assumptions for far too long. An examination of how colonial ideas

continue to be perpetuated in health care is at the heart of my own research. Linda Tuhiwai Smith provides a list of “twenty-five Indigenous projects” for research (1999, p. 142). These projects are thought-provoking guidelines for what the underlying purposes of Indigenous research are, or should be. The two that have particular relevance for this study are “celebrating survival” (Smith, 1999, p. 145) – in other words, placing emphasis on the positive aspects of health rather than focusing on everything that’s wrong – and “reframing” (Smith, 1999, p. 153), which means looking at a situation with a new perspective, and bringing to light any assumptions that may have guided prior interpretations.

A Western academic methodology that resonates well with the above-mentioned principles and guidelines of Indigenous research is community-based research (also called participatory action research [PAR] or community-based participatory research [CBPR], among other names). Community-based research has long been associated with social justice and is growing in popularity, particularly in the various fields of health research, where training in this type of research is often mandatory (Israel, Eng, Schulz, & Parker, 2005). It is a type of research generally associated with investigating, and taking action to reduce, health disparities – especially for populations considered marginalized or *discriminated against based on race or cultural identity, and “involve[s] a commitment to conducting research that shares power with and engages community partners in the research process and that benefits the communities involved”* (Israel et al., 2005, p. 5).

### **Methods**

Research that is grounded in the community, with community involvement, seems like a way of going about research that has a chance of not perpetuating colonial ideas –

which often happens without a researcher like myself even realizing it. As a complete stranger to northern BC, I didn't initially think that I would have the opportunity to do community-based research. It takes the formation of good, strong relationships to do this type of work, which takes time, and I started out knowing no one. Luckily my supervisor, Dr. Josée Lavoie, works with an organization called the Central Interior Native Health Society (CINHS), and as she got to know me, it is here that Dr. Lavoie saw my potential place.

The structure of the team at CINHS includes a consulting or advisory board called the Aboriginal Caucus, whose core group at the time the research was conducted included Jane Inyallie, Louise Creyke, Lynette Lafontaine, and Cree Elder Leonard Ward. They have agreed that I use their names in describing the research that we undertook together. We met through an initial presentation that Dr. Lavoie and I made to the CINHS team regarding collaborating on a research project. The Aboriginal Caucus expressed interest early on, and we met several times to agree on how to work together and what our research should focus on. This led to the development of two projects, to be carried out simultaneously: one, the research contained in this thesis; and two, an investigation into the role of Aboriginal Elders in health care. The second project culminated in a report that belongs to CINHS and can be used by the team to support future research or funding applications.

The Aboriginal Caucus has had an ongoing advisory role for me as I progressed through this research, as well as providing instrumental help in convening two talking circles and helping me to recruit clients for interviews. Without their assistance, this research would look very different indeed. We met every second week for about seven months until the data collection was completed, and the most significant work we did was organizing the

talking circles together. These were a genuine community effort, bringing together Elders from the area with health care providers from across Prince George. Throughout the time that I was writing, I met less frequently with the Aboriginal Caucus but still kept in contact, and they continued to offer advice, suggestions, and feedback as the research progressed. Leonard has also kept me supplied with sage and sweetgrass to help me as I write, and the group has verified my results through presentations and discussions, as well as through reading the document itself.

It took a willingness to compromise on both sides in order for the Aboriginal Caucus and I to work together. My thesis certainly changed over the course of many discussions, taking into account their needs and what they thought would provide the most benefit to clients. For their part, the Aboriginal Caucus as well as the rest of the staff at CINHS have taken a huge risk in supporting me, and their visions and goals regarding how I can help them have had to adapt to fit the person that I am. It has also been a significant time investment for them, in particular for the Aboriginal Caucus. Also, working together is slower, and we all had to wait a bit longer than expected to see results from this research. However, the benefits for me, in having research partners with extensive experience in health and mental health care with Aboriginal peoples, have far outweighed any drawbacks to this method. I hope, too, that the Aboriginal Caucus has benefited from the experience and will continue to benefit from this research. As I move on to the next phase of my career, we have agreed to continue to work and to learn together.

Participants for this study, described in Table 1, were recruited mainly through pre-existing contacts on the part of the Aboriginal Caucus members and myself. Elders and

health care providers were approached by phone or by email, by myself or an Aboriginal Caucus member. Interviews with three health care providers were arranged individually and each took place at the person's place of work. Clients were recruited through the placement of a poster in the waiting room at CINHS two weeks in advance of interview times. I set aside two afternoons (1-4pm) to conduct interviews with clients. On the first afternoon, I made an announcement in the waiting room explaining what I was doing and asking whether anyone would be interested in participating. At first people were reluctant, but one woman volunteered and by the time she and I had finished there was a line up of people interested in participating. With the organizational help of the Medical Office Assistants at CINHS, we filled that afternoon and scheduled enough people to fill the following afternoon as well. In total, nine clients were interviewed (see Table 1). Each interview participant was given a ten-dollar gift card to either Tim Horton's or the Pastry Chef. I actually had to turn some people away, due to time restraints and worries about data overload.

<b>Occupation</b>	<b>Elder</b>	<b>Provider</b>	<b>Client</b>
<b>How they were identified</b>	Elders were recognized as such by the consensus of the Aboriginal Caucus and/or other community members. All Elders identified as Aboriginal.	<b>"Providers" included:</b> <ul style="list-style-type: none"> <li>• Social worker</li> <li>• Counsellor</li> <li>• Addictions counsellor</li> <li>• Registered nurse</li> <li>• Educator</li> <li>• Peer support worker</li> </ul> Providers identified as Aboriginal (6) and non-Aboriginal (8).	<b>"Clients" consisted of</b> people who used the health care services at the Central Interior Native Health Society or were in the waiting room on the days that interviews were being conducted. All clients identified as Aboriginal.
<b>Number of participants</b>	<b>8</b>	<b>14</b>	<b>9</b>

Table 1

It should be noted that efforts were made to recruit health care providers who did not work in a specifically Aboriginal-focused environment. I distributed letters at CAST and CRU asking for participants, and spoke with one potential participant on the phone. In the end, however, no one was recruited using this strategy. It may be that providers who do not consciously incorporate Aboriginal world views into their work felt that they would not have anything to contribute to the study.

I will now move on to a discussion of the specific methods used in completing this thesis. The first step, in keeping with community-based research, was relationship and

<sup>5</sup> It should be noted that the divisions between "Elder," "provider," and "client," are somewhat arbitrary. For example, many providers and Elders are at other times clients of health and/or mental health services. The divisions between categories are not intended to be rigid.



partnership building, as described above. The second step, suggested by, and achieved with the help of, the Aboriginal Caucus, was the gathering of two talking circles. Initially conceived of as a way of framing the research, these talking circles proved to be rich sources of a variety of information. As shown in Table 2, eight local health care providers and Aboriginal Elders attended the first circle, and twelve participated in the second. Each circle's discussion lasted approximately four hours.

Details	Location	Duration	Number of Participants
First Talking Circle	Central Interior Native Health Society	4 hours	8
Second Talking Circle	Prince George Native Friendship Centre	4 hours	12

Table 2

According to protocol, lunch was provided at each talking circle as well as an honorarium (a \$10 gift card) for each participant and a gift of tobacco and broadcloth for each Elder. Cree Elder Leonard Ward opened with a smudge and a prayer and facilitated the circles. My role, once the circles were convened, was simply to ask the questions, and indeed, that is all that was required. Each group was asked the same three broad questions (see Appendix C), which were provided in written form to all participants, and in both cases once I had asked the first question the discussion carried on under its own momentum and had to be interrupted in order to stop after four hours had passed. The circles were held two weeks apart; the first took place at the CINHS and the second at the Prince George Native Friendship Centre due to the need to accommodate a wheelchair. The first circle's discussion

centred mainly on the question, “what is mental health?” The second group focused more on the questions “what is the role of an Aboriginal Elder?” and “what are some Aboriginal ceremonies and healing methods?” Both focus groups were digitally recorded, transcribed, and sent back to all participants for verification. Regarding transcripts, several people asked that I make them sound more coherent by taking out “ums” and “ahs” and (non-meaningful) repeated words, and so I made the decision to do this with all transcripts; as a result the quotations that can be found in this document have been cleaned up by me. In the majority of transcripts I simply removed the three above-mentioned sounds or pause words; if in any case I changed any wording I placed the changes in square brackets ([...]).

The third method that I used is the qualitative research interview or, more specifically, the “semi-structured life world interview,” described by Kvale and Brinkman as “an interview with the purpose of obtaining descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena” (2009, p. 3). The interview involves a set of pre-formulated questions as well as an overarching theme to be investigated, but is at the same time informal, conversational, and open-ended in order to give the research participant the time and freedom to elaborate on his or her experiences in his or her own way. Interviews were styled after Margaret Kovach’s “conversational method,” in which “the relational assumption of Indigenous methodologies seeks equal focus to that which connects the parts as much as the parts in and of themselves” (Kovach, 2010, p. 42).

I was struck both by the honesty of participants and by the depth of the stories that they were generous enough to tell me. I was quite non-directive in the interviews, allowing

people to speak for as long as they wanted to and asking follow-up questions or moving on to the next pre-set question only when they had finished speaking. Time and space were given, as much as possible, for people to tell me what they felt was important about their lives, in relation to their own, and others', mental health.

Table 3 <i>Interviews</i>			
Details	Number of Interviews	Average interview length	Location
Health care providers	3	1.5 hours	Each provider's place of employment
Clients	9	30 minutes	Central Interior Native Health Society private counselling room

Table 3

Throughout the course of the study I kept a journal of my thoughts, feelings, ideas and reactions to the research process and the things I was learning. Client interviews in particular had a profound impact on my learning process, and I found myself writing a great deal in response. I also kept track of communications with the Aboriginal Caucus and staff at CINHS as a way of tracing the development of the research, how it was changing and adapting, what I was responding to, and why decisions were made.

Interview and talking circle recordings were transcribed by myself, with some assistance from the Computer Assisted Telephone Interview Laboratory at the University of Northern B.C., as outlined in information letters and consent forms. Transcripts were verified after transcription, by listening to recordings and re-reading transcripts simultaneously to ensure the information was captured correctly. Transcripts were then

analysed using NVivo 8 software, using both thematic analysis (identification and labelling of thematic content) and content analysis (sorting results based on the number of occurrences of a certain theme) (Kellehear, 1993). Analysis was done in several phases. First, a general open creation of theme categories (Creswell, 2007) was used – this resulted in over 400 themes. Themes were then sorted, similar themes were grouped together, and overarching categories were created. Next, the themes and overarching categories were reviewed several times and refined as needed, while checking back to the original data to ensure the themes were giving an accurate picture of what participants had said. Finally, I pulled out all of the relevant quotes from each theme, within each category, and created a Word document consisting of quotes organized by theme. This document was re-ordered for logic and flow, and gradually each theme and category were edited down, summarized and paraphrased, so that what resulted was a summary of the compiled transcripts, containing only a few representative quotes. Analysing results this way was very time-consuming, but allowed for an organic emergence of themes designed to avoid, as much as possible, the imposition of my point of view onto the results. This was a highly inductive method of analysis, in which I undertook what Silverman calls a “narrative approach,” in which, “by abandoning the attempt to treat respondents’ accounts as potentially ‘true’ pictures of ‘reality,’ we open up for analysis the culturally rich methods through which interviewers and interviewees, in concert, generate plausible accounts of the world” (Silverman, 2000, p. 823). This is not to say that I take participants’ views as not representing reality; rather, their views are accepted as representing *their* realities, and further, their realities as they chose to reveal them to *me*.

Each participant is identified in the text as being a client, a provider, or an Elder, and within these categories, each person was arbitrarily assigned a letter (unrelated to their name); thus, information is attributed to, for example, Client A, Provider B, Elder C, and so on. Any identifying information such as place of birth or names of family members was omitted from the thesis.

### **My journey here**

At this point, in keeping with both Indigenous research principles (Smith, 1999) and phenomenology (Spiegelberg, 1994), in which the researcher needs to be situated with respect to the research, a brief introduction of my background and perspective is in order. I was born in Canada, on Algonquin territory in Eastern Ontario near a town called Perth. My family is from Scotland and Wales on my mother's side and has been in Canada for about four generations. My father's family is from Kansas – before that Sweden, Denmark, and Germany, going back about four generations as well. My interest in First Nations studies stems primarily from my interest in African studies, two fields which share many similarities. Unfortunately, these similarities mainly have to do with issues of race, oppression, injustice, and enduring structures of colonialism, all of which can have an impact on individual, family, or community health, including – perhaps especially – mental health.

I lived in Perth, with both my parents and my brother, in close proximity to my mother's mother, until I was nineteen years old, at which point I left to take a degree in Human Biology at the University of Toronto. I took a break from my studies in 2002, in order to travel to Ghana, West Africa, and came back to graduate in 2006. The next few years were spent in Ottawa, and in 2009 I decided to come to Prince George to undertake a Master's in

First Nations Studies – a program I had first heard about in Toronto after returning to school from Ghana.

It was a shock for me when, taking classes in African Studies as a minor within my undergraduate degree, I finally figured out that what had happened with regard to Aboriginal peoples in Canada was as much colonialism as any colonial projects that took place in Africa. It was at this point that my desire to investigate this topic further was sparked. I have approached this study from this perspective, believing strongly that colonialism in Canada has had a negative, and for people like me, unacknowledged, effect on all of us, and wishing that more people could be educated and aware of the aspects of the history of this country that are so often left untaught.

### **Summary**

This chapter has outlined in detail the theory, methodology, and methods used in this research. I now move to chapter four, in which the results that were compiled using these methods are presented.

## Chapter Four

### Results

This chapter outlines the results of the study. It is organised into three main sections, which emerged through data analysis. The first section deals with the question, what is mental health? The second section looks at factors that improve or detract from mental health, and the final section deals with mental health services. Within each section, results are organized according to the themes that resulted from the analysis. These themes are ordered according to how many participants referred to each theme, from highest number to lowest.

#### **What is mental health?**

This section looks at participants' responses related to what they think mental health, as a concept, means. It includes the following themes: addiction, labels, state of mind, normal, mental health as energy, holism, and Western theories of mental health.

**Addiction.** Participants, in particular clients and Elders, spoke in depth about addictions when asked about mental health (Client A, Client B, Client C, Client D, Client E, Client F, Client G, Client H, Client I, Provider A, Provider F, Elder B, Elder C, Elder D, Elder G). Addictions were described as interfering with clients' abilities to remain employed (Client A, Client B, Client D); as causing people to feel shame (Client A); as an oppressive force ruling their lives (Client D, Client E, Client G); as interfering with parents' being able to maintain custody of their children (Client E, Client G); and as being caused by trauma and abuse (Provider A, Elder F, Elder G). One client and two Elders related addictions directly to residential school (Client A, Elder D, Elder F). As one Elder said:

When I went to residential school, I seen abuse every day, you know, some of the kids getting hit, or being – you know, physically abused, mentally abused, verbally abused – to me that came, became a part of my daily life, it was normal. You know, I seen it every day for seven years, it happened every day. And to me, that became normal. You know, kids getting hit – it didn't mean nothing to me. Because I seen it every day. And now I work downtown, I see these people I went to school with, they come in to where I work, their children come in, and their grandchildren. We had three generations on the street at one time. And you know, that's all they know. Because of all the abuse they went through, they take it out, they use – they become addicted to alcohol, drugs, just to forget. I understand where they come from. And I sit and talk with them. And it's hard, some days, to see them. (Elder F)

Participants described addictions in terms of both their effects and their causes, of which residential school was a prominent cause. For many participants, addictions seem to be an integral part of mental health.

**Labels.** Labelling was another prominent theme that was raised when participants were asked about mental health (Client H, Client I, Provider A, Provider B, Provider E, Provider I, Elder A, Elder B, Elder E). People talked about labels as a fundamental part of both Western mental health services, and the concept of mental health itself. Mental health services were said to involve a process of labelling, and the term “mental health” was seen as a label, which one acquires simply by accessing mental health services. Mental health as a label comes with a negative stigma. As one client put it, “nobody really wants to admit even that they might have a mental health issue... for the longest time I had a hard time coming to grips with it” (Client I). Many people mentioned the use of the word “crazy” as a particular form of labelling (Client H, Elder A, Elder B, Elder E). Elders talked of being labelled as crazy for believing in spirits or performing their usual spiritual practices.

Mental health, from a First Nations perspective, was seen as a foreign concept. As one health care provider pointed out, “things I've learnt, working in First Nations



communities... for almost five years – those are Eurocentric terminologies. Mental health. Therapist” (Provider E). Elders corroborated the idea that mental health is a Eurocentric concept, saying that for many First Nations people, the concept of overall wellness makes more sense than what they see as the compartmentalized Western view of health (Elder A, Elder E).

Several people also said that there is a power imbalance implicit in the ways that mental illnesses are diagnosed – or labelled – in Western mental health care (Provider I, Elder B, Elder E). The person doing the labelling has power over the person being labelled.

As one Elder said:

We have to start – not to continue labelling ourselves the way we’ve been labelled... We have to get out of that, it’s like mental health, we have to start changing the terminology to holistic healing... If you’re healthy and strong and you go see a psychiatrist, he tells you you’re crazy, cause he’s got the power to tell you you’re crazy, then you’re crazy. You know, ‘cause he’s got that framed record that he’s a psychiatrist... You’re healthy, there’s nothing wrong with you – try and prove that in court. A psychiatrist with a big degree, telling you you’re crazy. (Elder E)

This Elder saw the process of labelling Aboriginal people by non-Aboriginal people as a way of taking power away from Aboriginal people, and refusing to label himself this way is a way of taking this power back again.

There were some who felt that being able to name an illness was helpful, at least in some ways – for example, as a way of becoming eligible for treatment (Client I, Provider A, Provider B). One provider spoke about the pros and cons of diagnosing people with a mental illness or a mental disorder. On one hand, she said:

There are pros and cons... If your quality of life is not what [you want it] to be, in order to get the treatment, you’ve got to have the label. And so for me, if you can get a label, and get a treatment that improves your quality of life, I don’t care if you

call it, I have XYZ, or I have the polka dot disease – if I feel better, I don't care what they call it. (Provider B)

On the other hand, however, she went on to say:

If you talk to mental health consumers, they're going to have a different world view. Because there's so much stigma that surrounds mental illness. Sometimes having that label, even if you're getting treatment and the physical symptoms are being treated, then you have to deal with the stigma. And individuals have said sometimes that's worse than the actual symptoms. So the negative kinds of prejudice and discrimination they experience can sometimes be worse than the symptoms. (Provider B)

From this perspective, it seems that the labels given to people with mental illnesses might be useful tools if it weren't for the stigma associated with them, and if having a label didn't mean that other people could take power and freedom away from the labelled individual. Overall, though, that the idea of labelling was a common thread in conceptualizing mental health suggests that mental health is seen as a way of defining a Western societal norm, and giving labels (with negative connotations) to people who don't fit that norm.

**State of mind.** Several participants described mental health in terms of mood, emotions, or state of mind (Client D, Client I, Provider A, Provider B, Elder A, Elder E). The moods people talked about were mainly sadness and anger, and losing control of these emotions was what caused them to stop being normal emotions and start being mental health problems. Two clients also described mental health as an attitude or a state of mind – specifically, keeping a positive attitude (Client E, Client I). As one client put it:

I just really try to stay positive. Like, I know what it feels like to... to get really depressed and oh my god, I never want to be there again! Yeah, like I, depression and mental are, you know, to get the chemical imbalance, those are two different, totally different things. Like to be depressed on an everyday, you know, or to get the actual chemical imbalance, is something I never, I never could have imagined anybody could feel so bad. (Client I)

Elders spoke of mental health as clarity and as being present (Elder A, Elder E). They described someone who is mentally healthy as someone who is able to think, feel, and understand, and as someone who is not stuck in the past or living in the future. One Elder talked about mental health as laughter. She said, “it’s the ability to also laugh at yourself. That’s mental health” (Elder A). Maintaining a clear and positive mental state was described by these participants as an important part of mental health.

**Normal.** Related to labelling, several clients and health care providers spoke about, and engaged critically with, the concept of being normal in relation to mental health (Client A, Client I, Client D, Provider A, Provider L). Labelling is a way of placing people outside of a given concept of what is normal. There were several different aspects of normality that people pointed out. One was the idea of feeling normal, whatever that means individually, as the goal of recovery from mental health problems. As one client put it, “I think that’s the most important thing is just feeling... normal, whatever that might be, but, you know, not being depressed” (Client I). Another aspect involved oppressive forces and a sense of being excluded from normality or feeling like one doesn’t belong – one client used his experiences in residential school as an example of this. As he said:

Even today I couldn’t define what normal means. Are you normal? I can’t say I, it’s like a bogus idea, what the word means. Cause I’ve never been normal. I really haven’t ever been normal. Just one big mess of life. (Client A)

Still another aspect of “normal,” brought up by two health care providers, related to the way that normal emotional reactions such as grief or anxiety, if they are too intense, can be labelled as mental health issues and made to seem abnormal. As one provider put it:

There’s lots of reactions that people have where I don’t do anything because it’s a normal reaction, so if they are in the midst of losing a loved one, and they’re wailing

and crying, and the nursing staff is saying, go in there and fix this, it's like, you go in, you do an assessment, you find out they're connecting to the experience, and it's like, okay. It's good. I mean, it's the nurse that needs the Atavan, not the family member, because that's a normal reaction to loss. What's abnormal is us being uncomfortable with an emotional outpouring. There's lots of situations where it's not about fixing, it's about supporting it and normalizing and saying it's okay. (Provider A)

Mental health was seen by these participants as doing and feeling things that are normal, whatever that may mean to an individual, and mental illness involved not feeling normal.

**Mental health as energy.** Health care providers and Elders also brought up the idea of mental health as energy (Provider A, Provider C, Elder E, Elder F, Elder G). One Elder described mental illnesses as negative energies which need to be brought out of the body. But mental health is a positive energy, as well. As one provider put it, "basically, what it is – it's energy work. You deal with the human energies, really, is what I do" (Provider C). These participants associated mental health with energy, but did not expand further on what they meant; although concepts related to energy, such as relationships and spirituality, were spoken of by many participants. This concept will be explored in more detail in the discussion section in chapter five.

**Holism.** Health care providers and Elders brought up the idea of mental health as holistic, both in practice and as a concept (Provider A, Provider B, Provider D, Elder E). Mental health as a holistic concept, rather than something that is, or can be, limited to the brain or the mind, was brought up many times by Elders and providers who I spoke with. One Elder put it this way:

**Mental health, from my teachings and from hearing from other Elders... what it really [is], is holistic healing. The mind is one of the most powerful gifts that was given, because the mind is the one that heals the body. (Elder E)**

**Providers and Elders also both spoke about the role of the body in mental health and mental illnesses; two Elders talked about the role of nutrition in mental health (Elder A, Elder B), and one provider mentioned yoga classes as a way of releasing trauma (Provider A). It was seen as important in mental health to deal with the whole person, rather than just focusing on the mind.**

**Western theories of mental health.** Two providers offered clear articulations of the theory that, for them, underlies mental health, mental illness, and mental health treatments. (Provider A, Provider B). One provider traced the history of theories of causation with respect to mental illness, noting that often there is a substantial burden of blame placed on the family of a person living with mental illness. She said:

**You have the psychoanalytical theory, [that] was sort of the original theory, where it was believed that the home environment, especially moms, were to blame for illness. And so there was a lot of blame there. And unfortunately, families, and moms still get that message, like you get them in tears in my office, right? Like you're a bad parent, if you did things differently then your son or daughter wouldn't have schizophrenia, like really, really mean. And the science doesn't support that, but lots of people still believe that. (Provider B)**

**Another provider spoke in depth about new theoretical approaches, which allow for a wider range of treatment options, some of which don't even require the person seeking treatment to talk. As he said, "newer approaches to therapy, you don't actually have to talk. You don't have to go through the story and, and a lot of times you just have to introduce people to the idea of hope and change" (Provider A). The approaches to mental health that**

these providers described focus on holistic health, on patient centred care, and involve a creative variety of techniques.

### **What factors improve or detract from mental health?**

This section explores the various factors which participants mentioned as impacting, positively or negatively, their mental health. It includes the following themes: residential school, identity, language, historical and colonial contexts, grief and loss, love, children, trauma, walking, housing, power or control, personal growth, safety, employment, breaking cycles, and fear.

**Residential school.** A topic which a number of participants brought up was their experiences, or the experiences of people they knew, in Indian Residential Schools (also referred to simply as residential school) (Client A, Provider A, Provider C, Provider E, Provider F, Provider I, Elder A, Elder B, Elder D, Elder E, Elder F, Elder G). Participants spoke of residential school as having a significant impact on their own mental health or the mental health of their families, because of the treatment they experienced in the schools, because of the messages they were taught there, and also because of being separated from their families and communities. Some participants didn't even know what their family members had experienced in residential school, they could just see the result of these experiences as they became expressed in anger, addictions, difficulties in relationships, or in other ways (Provider I, Provider F). Some participants had attended residential school themselves and spoke about their experiences and what they were taught (Client A, Elder A, Elder E, Elder F). One client, who had spent eight years in residential school, said:

It was their objective to try – make us lose our Indian way of life. And the message we got in the residential school was that we, as Aboriginal people, are just low grade

people, we're just nothing but savages and hunters and people out of the bush and whatnot. And then they made us ashamed to be, to be Aboriginal or Indian at that time. They made us ashamed and then we learn how to hate ourselves. It was the first time I ever hated me, my family, my parents, I hated them for being born an Indian because that's the main message I was getting, I was growing up with it. I grew up with that and oh I hated and that's not a very good way to think in life. Today I think about it, I wasted a lot of time hating myself and hating other people because of that message that they gave us in residential school.... That was very hurting, very hurting to hear that kind of message. I sure hated my parents for sending me to the, to the residential school. Why did they do that? And I really don't respect the Catholic Church because of that. I still can see eye to eye with some of the Catholic members but I don't believe in that Church no more. Why would they make a deal with the government to treat us like so... They say god is love but they sure didn't show us no love. But anyway, I grew up with that, with that concept and for a long time I lived with it. I don't know if you want to call that mental illness or... It sure wasn't no comfort zone. (Client A)

One provider pointed out that because of residential schools and other forms of colonial oppression, a large proportion of the Aboriginal population of Canada is now dealing with some form of childhood trauma (Provider A). Overall, participants saw residential school experiences as a prominent contributing factor to mental illnesses for Aboriginal peoples.

**Identity.** Many participants talked about identity in relation to mental health (Client D, Client I, Provider A, Provider B, Provider C, Provider E, Provider F, Provider I, Elder A, Elder E, Elder G). Specifically, knowing and having a sense of pride in one's own Aboriginal identity was seen as fundamental to good mental health. One Elder explained:

At one time First Nations had a life that was very rich. We didn't have to [march to anyone else's drum]. We had all our own values, we got up, we knew that our family may need this, so we went and did it. And we came back, and we knew where we fit in society, what our rules were, and so on. And we knew that, we internally knew that. Respecting other people, and things like that – that we all take for granted today. I think we've forgotten who we are. And part of mental health is forgetting who you are. (Elder A)

Identity, as a collective and also as an individual, is ultimately important for mental health.

Participants also spoke about culture, heritage, and Indian status as facets of identity. Partly, it was about overcoming the shame that many people feel is associated with their identity. As one provider said:

I think that, as Aboriginal people, if we're strong in our belief in culture and we stand up there when we need to stand up there and don't – you don't have to be ashamed of what you do. Or you do it because you believe you are who you are.  
(Provider I)

Pride in Aboriginal identity is important because, as several participants pointed out, people have been put down and made to feel ashamed of being Aboriginal for generations. Regaining pride, then, is a way of regaining mental health. Elders expressed a great deal of concern for the younger generations and felt that it is of the utmost importance that the knowledge they and their ancestors hold be passed on. A sense of identity and strength, and the continuity of knowledge, are factors which the Elders feel will go a long way toward improving the mental health of many of their people.

**Language.** Identity was also closely linked with language in the context of mental health (Client A, Client F, Provider E, Provider H, Provider I, Elder D, Elder E, Elder G). Not being allowed to speak Aboriginal languages in residential school was seen as a damaging part of the project of assimilation (Client A). Not having a firm grasp on the language and the concepts that students are assumed to know when they enter university was a challenge for one provider, making her feel strange and out of place, and like she needed to catch up to everyone else (Provider I). Teaching Aboriginal languages to children, and changing the language used to describe mental health in order to describe it in a more holistic way, were spoken of as important by one Elder (Elder E). Another Elder also spoke about her difficulties with the terminology used in health care:



When you go to the hospital when you're sick, especially if you come from a remote area, northern, like where we came from, we had to fly in to Flin Flon, or Prince Albert, and if you didn't have an escort, you had to go alone and it's scary, it was really scary to go alone and you didn't know where you were going, away from your parents and nobody to talk for you, and people would ask you questions and you didn't know, like when you went to the doctors and you didn't know the terminology or you didn't know what, how to answer, or stuff like that. (Elder D)

Overall, participants related language to mental health in two ways. One was as a source of identity – in being allowed to speak their own languages, to have them be used on a daily basis, and to teach them to their children. And the other was related to the way language is used in health care services and other institutions. Health care terminology is difficult to understand unless you have grown up with it, resulting in many participants feeling alienated by their experiences with health care.

**Historical and colonial contexts.** Providers and Elders spoke a great deal about the historical and colonial context of their work in mental health with Aboriginal people (Provider A, Provider C, Provider E, Provider F, Provider G, Provider I, Elder A, Elder E). Residential schools form a part of this context, but providers and Elders also spoke of the context more broadly, in terms of oppression, discrimination, and negative energies. Colonization and the structures which continue to reinforce colonial ideas and ways of being in Canada contribute to an oppressive environment for many Aboriginal peoples which, participants insisted, must be taken into consideration when working in a mental health care setting. One participant pointed out that if it weren't for this historical and colonial context, we wouldn't be seeing the same mental health problems in Aboriginal communities. As she said:

You have to really understand what colonialism and oppression does to us... That's what [would have] happened to us [non-Aboriginal people], if we were oppressed,

the tables were turned, that's how it would look. You have to really understand that, to a deep level. So mental health is really about understanding that, and if you understand that, and work to take away the trauma, help process that, and have a safe place, to place it somewhere, you see already the increase of mental health. And help people find their voice, and get their power back. (Provider C)

Another provider said that an understanding of the broader contexts is essential for anyone working with First Nations people in a mental health context. Referring to the book, *Postcolonial Psychology* (Duran & Duran, 1995), he said, "If you're non-Aboriginal, and you don't think something bad happened to First Nations people, then don't work with them. 'Cause something did" (Provider E). Another provider linked oppression and discrimination in terms of whether or not she felt she could be herself without judgment:

I feel that I can be who I am within this organization, but once I walk out of here and go to the hospital, [it's] totally different. I go to the hospital and I will take somebody from on the street that's homeless and I'll hold their hand and walk into the hospital and I'm looked at in a different way... it just goes to show there's so much discrimination – this is still the White world, in Prince George. And it's sad, because you look around Prince George, and you look at the land that these structures are on, and it's just, Aboriginal people are not held in high regard. (Provider I)

For these participants, context is more than just a background to mental health – it is mental health. Causes, and solutions, to mental health problems in Aboriginal communities can be found within the oppressive historical and colonial contexts in which Aboriginal peoples in Canada live their lives, and the resolution of these oppressive situations.

**Grief and loss.** Many people spoke about grief and loss as impacting people's mental health (Client D, Client I, Provider A, Provider B, Provider C, Provider L, Elder E). It is interesting in light of the concept of "normal," to think about this theme – as discussed above, sometimes people have reactions to grief and loss which do not necessarily need any intervention besides understanding and time (Provider A).

However, sometimes grief and loss can be overwhelming – as one provider pointed out regarding suicide, suicide is a traumatic loss and therefore more support and healing may be needed (Provider A). Two clients pointed to grief and loss in their lives as the beginning of their struggles with addictions. One client remembered the ending of a sixteen-year-long relationship as the beginning of his problems with drug addiction:

It started out drinking, right? After the break up and then someone introduced me to it and that's where I went from there and something I should've caught on, and to tell you the truth I've never ever, anything that I've went up against, I've defeated, but this is one thing that I'm having a lot of hard time to defeat. (Client D)

Another provider pointed out that mental illnesses almost always involve a certain degree of loss. As she put it:

[For] families that have been affected by mental illness, there's lots of loss, and so grief is a huge part of our experience. And sometimes that's literal, many of us have lost family members to suicide. But it can be loss of lots of other things – loss of dreams, loss of family, loss of education, loss of jobs – lots of losses. (Provider B)

Loss and grief, for these participants, can have many dimensions but they are an important factor in mental health problems and mental illnesses.

**Love.** Loss and grief are closely linked to the role of love (in mental health) and the absence of love (in mental illnesses and addictions), something which was brought up by several participants (Client A, Client D, Provider C, Elder A, Elder B, Elder G). One client spoke of how he never learned to love himself during his time in residential school (Client A). Another client said that the absence of a loving family can make a hard life even harder:

[My uncle] said, that's all I can do is have faith in you, love you and show you that – and I do believe that because I do know that people, when they do reject, I'm not say give them money and stuff like that but when you do get rejected like, you don't hear that from your family, it takes you down even farther. When you don't hear, like, even my mom said, you know what son? Regardless of what you do, I love you. (Client D)

One Elder spoke about the need to care about people before you can help them. He said, simply, “You have to care for people, to help them. If you don’t care for people, then you can’t help them” (Elder G). Love was seen as an important part of having good mental health, and taking care of yourself and others.

**Children.** The presence of children in their lives was described as healing for many participants (Client D, Client E, Client F, Provider C, Elder E, Elder G). These participants also mentioned other family members, but these family members weren’t the ones who woke the participants up and made them take charge of their lives and their addictions or mental health problems. It was their children. Thinking of her children was what gave one client the strength to stay away from drugs. As she put it:

It’s kind of hard... living in the hood and – like all the addicts around, it is hard, but I do fight it cause I think about it, is like, in one hand I’ve got my kids and in the other hand I got my drugs. Which one. And I pick my kids. (Client E)

His son’s suicide attempt was what woke up one Elder to the need to heal (Elder G).

As he put it:

My brother tried to commit suicide. It didn’t mean nothing to me – and he’s my brother! Because I was dysfunctional myself. I was addicted, like my brother... And when my cousin tried to commit suicide, it didn’t bother me. But when my son tried to commit suicide, it touched me right there [at his heart]. How could my blood try to commit suicide? I talked to my son, half an hour in the basement, I talked him out, to coming down. Half an hour I plead to my son. Why are you doing that? Why are you hurting me? I did that. It [woke] me up, at that point. Life is precious. (Elder G)

Both of these individuals had other close family members in their lives as well, but it was their children who inspired them to make changes.

**Trauma.** Trauma, in different forms, was seen to be a significant component of all mental health issues, for many participants (Provider A, Provider B, Provider C, Provider E, Provider F, Elder G). Trauma, described as arising from loss or from being oppressed, was seen as a direct cause of mental illness or mental health problems. One provider said:

My focus is a trauma focus – whether you’re talking about addictions, or mental health, or anything else, if there’s an underlying significant trauma component, and you’re not addressing it, you’re missing the boat. (Provider A)

Another provider explicitly made the link between trauma and mental illness.

Although mental health can be helped or hindered by individual choices, she said:

Life can be very, very stressful. Even if we’re making very healthy choices, if we experience enough loss, or we have trauma, or, any number of things can sort of push us down and make us less mentally healthy. (Provider B)

Another provider spoke of the effects of trauma on mental health, specifically in the case of First Nations peoples in Canada:

For many, many years, because of our history of trauma, we’ve developed as First Nations people a belief system that we are inferior, that we’re uncivilized, and we lack in moral qualities. And those belief systems have been internalized. And it’s within us. When we’re coming from a belief system as disempowering as that, it leads to clinical depression, anxiety disorders, and self destructive tendencies, such as suicide, and reaching to addictions, to cope and survive. (Provider F)

These participants’ concepts of trauma, which seemed to include witnessing or being subject to inhumane treatment, violence, or suicide, and being shocked and emotionally hurt by the experience, were a fundamental part of mental illness. Trauma was something that providers always tried to take into account in their practices.

**Walking.** Something that several participants pointed out as helping to improve their mental health was to go for walks, and specifically, to go to places where they could find trees or water (Client F, Client G, Client H, Provider A, Elder A). As one client said:

There's things you can do like... take walks, say, into the paths and that. Or in, look at the trees and, just different things and be at peace with yourself, you know? Go sit maybe by the river or something, and just try to be at peace, and try to ease your mind. Cause your mind sometimes like, it's racing so fast, so if you go say, by the river or something – and just listening to the river, makes you calm. (Client G)

Having places to go to, like those this client described, where you can find trees and water and quiet peace, is very important in terms of maintaining mental health.

**Housing.** Linked to the idea of surroundings is the issue of housing (Client C, Client D, Client E, Client H, Provider B). Many clients mentioned that they lived on the street or that they had in the past. Getting her own place to live, where she could stay with her kids, was considered a big step and something of a victory by one client (Client E). Another client talked about why he chose to live on the street. He said:

I've never ever been on the street, ever, until I made it my choice. Like my parents and them, they all said no, you got a place here any time you want, blah, blah, blah and it's like you know what? Because of my lifestyle? I don't want to be around you guys because I don't feel normal around you guys when I'm high. (Client D)

Housing services were mentioned by one provider as something that people would like to have included in mental health services, but that there just aren't the resources for it at the moment (Provider B). Overall, housing was described as a social determinant of mental health or addiction, in that having stable housing helped people feel healthy, proud of themselves, and in control of their lives.

**Power or control.** Having, regaining, or keeping power or control over what happens to you was mentioned as an important factor in mental health by some participants (Client A, Provider A, Provider C, Elder E). Relationships in which there seems to be a power imbalance can be perceived as unhealthy or dangerous, as one provider articulated:

What I try to do is identify and normalize and, and have other professionals recognize, and be able to connect the dots if they're having a challenge working with a particular First Nations client, and say, you go and you find out the old records or you do an interview, and you find out that, you know, they've experienced a very substantial assault. Well you connect the dots for the professionals, saying, well the reason why they're telling us to F-off, is our approach to them, we're coming in with power, we're telling them what to do, as opposed to listening to them. (Provider A)

Another provider talked about the powerful place that First Nations people have in Canadian society. According to her, First Nations and other Aboriginal peoples in Canada have had a powerful influence on Canadian society as a whole, but this influence is not always recognized by non-Aboriginal people:

We're all in a different culture, you know, nothing is purely any more, First Nation, nothing's purely any more – and even for us, non-Aboriginal, it's not purely non-Aboriginal. We have, as we have lived in this country, taken on words, and meanings, you know, we don't even know it. We have the Chinook, we have – all that's part of us has, you know, been acculturated to the First Nations people. They have a powerful place... I think that if we look at the generations, of non-Aboriginal people that lived here for several generations, I'm sure we have First Nations, you know, blood in us, and knowledge exists all around, but we haven't dealt with it much, of how valuable it really is, we haven't given its proper meaning, and we haven't taken that in, and this is the gap that has to be closed. (Provider C)

One Elder talked about the great power that people who carry medicines – called dream speakers – had; a power which still exists and is working today. As he put it, “there [are] a lot of untold stories that are out there, about medicines that you can't even talk about, and that help our people this very day as we speak” (Elder E). It seems that these stories and medicines retain their power by being kept secret, especially in light of the many ceremonies that were banned by the government in the early twentieth century (Elder E) (Laliberte et al., 2000). The same Elder also spoke of the power that medical practitioners sometimes seem to hold over their clients. Overall, power and control are important aspects of mental health for these participants, and were discussed both as the

power that people have retained or regained for themselves, as well as power that has been taken away from them.

**Personal growth.** Five participants spoke about healing from mental health or addictions in terms of personal growth or change (Client A, Client E, Client F, Client H, Elder G). Many clients talked about personal changes, in particular in terms of recovery from addictions, and a resulting pride in themselves. As one woman put it, “I used to be on the streets... I’m straight now, big time. Like sometimes I feel proud, I give myself a tap on the shoulder. I cannot change, yes I can” (Client F).

One other client spoke of how proud she was that she “stepped up,” got clean, got off the streets, and got her kids back (Client E). One client also talked about how significant it was for her to have other people around who were proud of her (Client H). This made for a strong support system.

One Elder said that treatment for mental health issues is really about learning how to grow as a person. He said, “you talk about treatment. Treatment is just a place of growth. Get somebody to understand what personal growth is – [that] is treatment” (Elder G).

**Safety.** Being safe was also mentioned as impacting mental health. It was discussed with slightly different meanings by different participants (Client H, Provider C, Elder E). Many participants talked about the need to feel safe, in a patient-provider relationship, in an open discussion, or in life, in order to be mentally healthy. One client said that she was harassed so often by the police that she no longer felt safe, which was causing her anxiety. She said, “that’s where my anxiety comes from is because of the police because I’ve gotten



beat up so many times from them” (Client H). One provider talked about how she needed to create a safe space and safe relationships, in her practice, in order to help people to heal.

As she put it:

To try to help people live with either a so-called mental illness, or overcome it, you again have to do the very basics of, you know, creating a trusting relationship, being sure that they're safe, feel that they are safe, and that they can tell you that they're safe. (Provider C)

One Elder spoke about the safety of sharing information; when it was safe and when it was not safe to do so. He said:

The teachings are still alive, it's just a matter of, in circles like this we're able to share comfortably. In a very sacred way. I mean, we cannot talk about these things out there. In the street, or in the cafe – it has to be in a very – in the confines of a circle. Where the energy is. Something about a circle where you're open, you know that you can feel the energy, where it's – you're guided. (Elder E)

Safe spaces to live, to seek healing, and to share knowledge, were all important factors in mental health for these participants.

**Employment.** Three clients spoke about employment, meaning paid work, as a factor in mental health (Client A, Client D, Client H). Two clients said that their addictions were interfering with their ability to work, something they wished they could change. As one client put it, “I really want to go back to work one more time but at the same time I have a very, very serious problem with alcohol. That's what's holding me back, or holding me down” (Client A). Employment was a factor in feeling better about oneself, something that factors in to mental health.

**Breaking cycles.** Related to the effect of addictions on employment, one Elder spoke of regaining mental health in terms of breaking cycles (Elder G). He said:

When we have gatherings like this, the last few days of the conference, you lift people up, we do lift people up. But when they go back to their own community, they're back in the ditch. They're still back in the ditch when they get home, until they want to get out of it. You have to encourage them to get out of that cycle they're stuck in. That's what we have to do, and mental health should be able to do that. For different nations. (Elder G)

Mental health, for this Elder, involves breaking out of damaging routines.

**Fear.** One Elder talked about mental health as the absence of fear. She said that Aboriginal peoples in Canada used to be generous and open with whatever they had; they were taken advantage of, and as a result have become afraid to share. She said that fear leads to mental illness; it's an unhealthy, but common, way to live. As she said:

[A healthy person] doesn't have any fear. And would share with you. Where First Nations did that was with a lot of people when they first came here – they shared everything. Was no problem with sharing food, or whatever, with people. And then we became hoarders. As First Nations, we hoarded everything about ourselves, we hoarded the way we shared with other First Nations people, we hoarded ourselves, our wealth, which was given freely to our relatives and other people. And then that contributed to our illness and our mental health, or whatever you want to call it, our illness. That's the illness, that's there, is our inability to be sharing with people, and caring. (Elder A)

Fear of others, or of losing what we have, for this Elder, leads to mental illness.

### **Mental health services**

In this section I present the results related to various aspects of mental health services. The themes included in this section are: ceremony and spirituality, understanding, medication, culture, listening, readiness to accept and participate in treatment, medicines, trust, cure, working together, responsibility, taking time, access to information, follow-up, change, facilitating healing, life's work, stress on providers, resources, tools, basic needs, provider confidence, peer support, and paperwork.

**Ceremony and spirituality.** Ceremonies, and spiritual life and practice, were themes that were touched on by the greatest number of participants (Client A, Client F, Client H, Client I, Provider A, Provider B, Provider C, Provider D, Provider E, Provider K, Elder A, Elder B, Elder D, Elder E, Elder F, Elder G). One client said that she had attended healing circles at CINHS, and expressed a wish that they could be continued (Client H). She also said that she would like it if CINHS could put up a sweat for people who were clean (Client H). A provider talked about healing circles, as well; she liked the way that in a circle everyone is equal (Provider C). Elders spoke a great deal about healing ceremonies that they practice as well as those that their ancestors or others they know have practiced (Elder A, Elder B, Elder D, Elder E, Elder F, Elder G). With specific reference to mental health, one Elder described a healing ceremony that he performs:

I don't call myself a medicine man, but as a traditional – working with herbs, and medicines – if a person is ailing, the mental state of a person is what comes first. For a person [to] be able to think, and feel, and understand, and especially if a person's been traumatized – the smudging of the head, it gives clarity. Not the smudging we had, it's different. There's different forms of smudging, giving clarity to the mind where the mind gets clear – [if] it's fogged up right now in pain or, not be able to focus because of grief – with this medicine from different tribes. (Elder E)

Spirituality was also a very prominent theme. The spirits are understood to be all around us (Elder B), helping us but essentially unknowable (Elder E, Elder G). As one Elder put it, "I don't understand the spirits. I've been in the sweat lodge ceremony for about thirty years, and I really don't understand the spirits. But when they're there, it's very powerful. It's powerful" (Elder G). The acceptance of an unknowable, but undeniably powerful, force is an important element of healing, according to these participants.

For several participants, spirituality was related to a sense of connectedness and a sense of serenity (Client I, Provider C, Elder G). One client found a lot of solace in spiritual practice, but expressed a wish to be surrounded by more people with similar feelings. As she said:

One thing I'd like to do is try to surround myself with people with the same spiritual knowledge, I guess, that I'm kind of seeking, you know, because my kids just think I'm – lost my mind, you know! (laughs) You know, they just laugh at me and think I'm, yeah. So it's hard when you don't really have anybody to discuss things with. (Client I)

Spirituality also taught people ways of asking for help – help which would often come in the form of a dream (Provider D, Provider K, Elder B). One provider shared his experience of being healed by a Lakota medicine man in a dream, an experience which resulted in a cure (Provider D). An Elder spoke of asking her ancestors for guidance and receiving advice through dreams – she said that this is something anyone can do, if you need help (Elder B).

Spiritual practice, and spiritual help, also comes with a certain amount of responsibility. The idea is that you need to be sure that you yourself are healthy, before you can take care of others. As one Elder said:

I was given the honour to carry a pipe for the people and I have to make sure that I carry the pipe in a good way. You know, I don't – not to go partying or even, for myself I don't gamble, you don't see me in Bingo halls. But also the commitment I made is to help people. But first I had to help myself. (Elder E).

Spirituality was very closely associated with, and very important for, mental health, for the people involved in this study. Two Elders spoke about the concept of losing your spirit, and how healers can bring a person's spirit back, or take measures to protect it from being lost in the first place (Elder F, Elder G). As one of them said:

[The healer] told me, your spirit was taken away from you a long, long time ago. And as children we were taught, you know, you never scare anybody or, especially the medicine man because they can take your spirit. And she talked to me about how I had lost my spirit but she had brought it back. And still, I was doubting her. Until I stood up. My whole body was vibrating, like the floor was shaking. (Elder F)

Spirituality related to mental health in a different way, too, in that people who see and interact with spirits can be labelled as having a mental illness. As one Elder said:

Careful what comes out of your mouth, about anybody. Right? Because the spirits are all around us, listening. It doesn't matter if the person you're talking about went across the street. But the spirits are around you. And they will let that person know. And all these things come to mental health, you know a lot of our people believe this, right? And they, they're classed as schizophrenics. Because they're seeing spirits – and all this is part of mental health. I was afraid, until five years ago, to even speak about it. Because I was afraid somebody would look at me like I was crazy because I seen my grandmother, and talked to my grandmother, and my grandmother told me what medicines to make for somebody. Right? So I was really afraid of it. Afraid of what other people would think of me. (Elder B)

Spirituality is also an important component of identity, which is, as discussed above, essential for good mental health. As one Elder said, “some of our young people that try to commit suicide, they don't know their own spirit” (Elder G). One provider also said, “the best that I can do is commit myself to this process, and to do what I can, one by one, helping my people heal, and to become reconnected with the true spirit of who we are” (Provider F). For these participants, it was very important that spirituality and ceremony be included in mental health services.

**Understanding.** A number of participants brought up the importance of understanding in mental health services (Client A, Client D, Client F, Client I, Provider B, Provider C, Provider F, Provider I, Provider K, Elder D, Elder E, Elder G). This refers to a deep and genuine understanding of a person's life situation and experiences, an ability to communicate effectively, and a relationship of reciprocity. Understanding in mental health

care is related to holistic healing, in that the whole person needs to be taken into account, not just pieces and parts of a person. As one Elder said:

Let's take a patient, okay, if a patient is there, and you put a bandaid on it, and that nurse that puts on that bandaid for you touches your hand, and gives you support, and comfort, and so on, along with a bandage, and recognizes that you're there in front of them, and saying hi, how are you, and I see you. And a lot of the health system, people don't have that I see you, [they] just slap on the bandage and away you go, you're better, go, away you go. And that piece of interaction, that could have given mental health, is not given. Instead it's guarded and held in so that you don't recognize that the person in front of you might have been there to give you a gift. And you've already pushed the gift away, and you're walking away. And in a lot of it, that mental health piece, if you want to call it mental health piece, is missed. You just missed an opportunity to really get to know yourself, through that person. (Elder A)

When a person seeks treatment for mental health, it is essential that the mental health care provider make an effort to get to know that person, what's going on in their lives, what has happened to them in the past, and what their family life is like, because all of these things have a strong impact on a person's mental health. One provider also made this point, speaking of the need to go beyond platitudes to a deep, real understanding of what a person has been through. She said:

For mental health, you know, they need to feel that they are seen as people. Whole, and worthwhile. We're not just – we feel. Not just the platitudes that we normally, you know, yeah, I hear you, emotional. You have to go deeper. (Provider C).

This relates to a point that one client made, that recovered addicts make the best drug counsellors. They are the only people who can truly understand what a person struggling with an addiction is going through. As he said:

Nobody can understand an addict better than another addict. I don't care how much school you got, if you were to put an addict with the same education as a regular person, that addict counsellor would blow that one away. Hands down. Because nobody really knows, even people that try to understand, how can you keep doing this? How can you blah, blah, blah. You had all this and that, I say, you know what?

You'll never understand, ever. I said you can read book after book, you'll get a good knowledge of it, I said but you won't ever, ever truly understand what I go through. (Client D)

This relates, also, to a point that will be explored below about being ready to accept treatment. Understanding means not taking it for granted that people's health is their first priority. Understanding means listening to what people say without placing a preconceived filter over it. It means allowing people to define their own problems and take part in finding a solution. All of these ideas were identified by participants as ways of improving mental health.

**Medication.** There were some interesting discussions around the topic of medication (Client B, Client D, Client F, Client G, Client H, Client I, Provider A, Provider B, Provider L, Elder A, Elder E). Clients, providers, and Elders talked about medication with a sort of resigned acceptance. They were not great proponents of having to take medication. One client said that health care doesn't deal with the problem, when it comes to addictions. She said all her doctor did was take her off street drugs and put her on legal drugs, but the addiction was still there (Client B). Another client felt that she needed medication, but the wait to see if a given medication would work was extremely hard. As she put it:

When you have anxiety, depression, schizophrenia, whatever it is, I mean, it's hard to feel that way for a single second of a day, you know, and then you got to wait six weeks to see if these pills might work for you! Like oh my god! That part of it, it's so bad. (Client I)

Elders teach that what is most important is to believe in the medicine that you are being given, and trust in the person who is healing you (Elder E). So if a person believes that pills will help them, then perhaps those pills are a good option. Overall, however, medication was generally negatively viewed by people in all three groups. It was accepted

that medication is sometimes necessary, but participants said that people sometimes seem to think that medication is all you need. The consensus seems to be that medication alone does not solve anyone's mental health problems.

**Culture.** Participants also talked about culture in mental health services; both how to incorporate Aboriginal cultures into mental health, and the culture of mental health services themselves (Client A, Client H, Provider A, Provider B, Provider C, Provider E, Provider G, Provider I, Elder E). It was noted that the culture of mental health services is still one that attempts to impose ways of healing on Aboriginal people, rather than being flexible enough to respect and promote Aboriginal ways of healing. One provider said, "still, it's the Western culture that tells [Aboriginal peoples] how to do medicine. And how to be. And we're still not too far from that. We're still struggling with that. Getting that traditional value piece the right honour" (Provider C).

Bringing elements of Aboriginal cultures into mental health services was perceived as very important. Another provider described how the Māori people of Aotearoa (New Zealand) achieved successes in mental health care:

The Māori people took care of mental health, and there was huge successes, with the clients that had mental health issues. Cause they brought back the cultural piece. They felt respect, or they felt they had a position. (Provider E)

It is not just bringing culture into mental health care; it is simultaneously giving Aboriginal cultures their rightful, meaningful, important place within Canadian society, including mental health care, that participants saw as important.

**Listening.** One theme that providers and Elders mentioned in common was the importance of listening to people (Client D, Client F, Provider A, Provider C, Elder E, Elder D,



Elder G). One Elder said that sometimes the medicine required is as simple as being there for someone and being someone they can talk to. One client noted that having more Elders available in the clinic for people to talk to would be of great benefit. He said:

Like you said, with the elders, it's going to be a good thing. Because it will give people, I mean, a lot of them don't have anybody to go to. And when you don't have somebody to vent to, that builds up and it knocks you down. I guess you could say, it's that kind of turmoil, right? If you have somebody to vent to, you're still getting that out of your system. And [an Elder is] someone that's going to, that actually is caring, right? (Client D)

One provider said that half of her job, in her role as a nurse, was just listening to people. Many of her clients had never had anyone just sit and really listen to them, before.

As she put it:

Mental health here means, really, telling your story. So what that means for me, and for them, is that I do set away time. I stop the clock... And that means that, say, especially in the beginning, when you get to know these people, if they needed four hours – four hours. If they need a lunch, go walk a bit, we walk a bit. So how do you do mental health? You meet them where they're at. And time stands still, that's what they want. And I've had a person here, in this week, and he had just one session like that, that I let him go, and whatever, and I was really attentively listening, and he came back, and I thought, oh, it's another counselling session, and he's telling me how he's doing, and I see how he's doing, and I said, what was the difference, how come you're doing so good? You know, it's not like, you're here for counselling, and he said, that was enough. For the first time, someone truly listened to my story. So truly listening, all by itself, is forty, fifty percent of the work. (Provider C)

As these participants pointed out, simply caring enough to really listen to someone can be important healing work.

**Readiness to accept and participate in treatment.** Many participants also mentioned that a person has to be ready to heal before any mental health treatment can be effective (Client D, Client I, Provider A, Provider B, Provider K, Elder A, Elder G). It needs to be the individual's choice to seek treatment for a mental health issue or an addiction;

otherwise, participants said, the treatment won't work. One provider summed up this idea by saying:

All you can do is put it out there, fan out the options and the choice, and say these are your choices. And people make their choices. They're going to stick to it, rather than telling them they've got to go do this, right? Nobody wants that. Well, they don't do it, anyway. It doesn't matter, we can tell people until the cows come home, if they don't want to do it they're not doing it. (Provider B)

One client demonstrated this idea with reference to a program he was required to go to through the justice system. He felt that the program was too invasive, taking place as it did in a group therapy setting rather than in individual counselling sessions. Because he didn't like the way the program was run, he did the bare minimum to meet the requirements of participation. Overall, he put it bluntly: "If you're made to do it? Well, it's not gonna happen" (Client D).

A theme related to being ready to accept and participate in treatment, which came up in client interviews, was the fact of wanting to be healthy. Clients talked about hating themselves, about not caring, about not having feelings, or about only caring whether or not they could get drugs (Client D, Client I). This is an interesting point with implications for health care – the circumstances of life which enable people to care about taking care of themselves might be the most important factors to address when trying to help people achieve, and maintain, health. One health care provider talked about mental health being about choices (Provider B). But if a person doesn't care about him- or herself, that person will not put much stake in getting enough sleep at night or eating properly.

These themes also relate to identity. Feeling a strong sense of identity, and being proud of who you are, are pivotal to the healing process. Without identity and pride, an

individual is much less likely to care about his or her own health or believe that treatment is necessary or worthwhile.

**Medicines.** Participants spoke about different Aboriginal medicines – perceived as something slightly different from medications – that can be used for healing (Client G, Provider A, Provider H, Elder B, Elder C, Elder D, Elder E). One client said that Elders can help with mental health through using the medicines. She said, “I really believe that, like, the Elders have the medicines, that they really help people. A lot, you know. They help people when they’re stressed out or they don’t know what to do with themselves” (Client G).

Medicines involve a close relationship with the spirits, which help in finding, harvesting, preparing and administering them (Elder B, Elder D, Elder E). One Elder mentioned that there are many medicines which are not shared or talked about (Elder E). The Elders knew that it is of great importance to keep their knowledge, and the knowledge of their ancestors, safe, and to pass it on to future generations (Elder E). It is also important to trust in the medicines that you are being given, if they are going to help you to heal.

**Trust.** Trust was a very important aspect of mental health services, according to a number of participants (Provider A, Provider B, Provider C, Elder A, Elder E). A trusting relationship was seen as essential for healing to take place within mental health care. As one provider put it:

*In some cases you do have to sell [treatment] a little bit, because people are so overwhelmed by their trauma, and what’s natural is for them to keep things contained, and to not talk about it and to not experience the symptoms, and so that’s what they’ve done out of survival, and so then to come to therapy and most people it takes a whole lot to get to therapy, for them to come and open up is a dramatic shift. And so lots of time spent on safety, trust, relationship, that kind of stuff. (Provider A)*

In addition to having a relationship of trust between the healer and the person seeking healing, sometimes healing requires trusting in what the healer does and the medicines a person is given. As mentioned above, if a person doesn't trust that the medicines will work, they won't work. If a person does, the healing can be powerful. As one Elder put it:

Mental health... It fits in a sort of – more like just trusting in the sacred process. Trusting in the healing process. It's part of healing when you trust... If you don't trust nothing, if you don't trust the medicine that you're being administered, you won't get well. If you don't trust the person that's trying to heal you, you won't get well. If there is negative energy in that transaction, the medicines or words, then the patient is not going to get well. It has to be in a – in a very sacred way. Just like ceremonial way. (Elder E)

Trust in the healing relationship, as well as in the medicines or methods being used to help a person to heal, were seen by these participants as an important part of any mental health treatment.

**Working together.** Another important concept, related to trust, that was raised by several providers was that Aboriginal and non-Aboriginal people need to work together in mental health care, and in health care in general (Provider A, Provider B, Provider C, Provider E). It should perhaps be noted that all the providers who raised this point were non-Aboriginal. One provider noted that the first step in working together is, "you need to get buy-in from the acute care model, in order to create change" (Provider A) – in this case, change within the health care system. Another provider talked about her struggle to get health care services to expand to include more aspects of health. Part of this struggle is, she said:

Constantly trying to get mental health and mental illness on the table as a primary health care piece – it's like, we can look at the toe and we can look at the elbow, but

somehow we've just left off the mental health piece, we can't seem to get past heart disease, and diabetes – which are important, I get that, but the irony is, that over fifty percent of people who have other physical illnesses, have depression. Again, we're only looking at the piece, and we're not considering the whole. And so for me, there seems to be something stopping that. And if you were to bring the Aboriginal piece, of course they're going to bring the whole piece. So for me, there's some resistance to that – or maybe, they're just doing it a little bit at a time, or – I have no idea. Anyway, I see huge opportunity for that. (Provider B)

Another provider said simply, “no one can do it alone anymore. We all need each other” (Provider C). We need to find more common ground and better understandings, because we are all interdependent.

**Cure.** One theme that clients and providers talked about in common was the idea of mental illnesses having cures, rather than just being stabilized and lived with (Client I, Provider A, Provider B, Provider D). One client expressed a desire for a cure, or at the very least better diagnostic tools for mental illnesses (Client I). When asked what her ideal mental health services would look like, she said, “a brain scan! Immediate fix! Which would be nice, I mean... that's probably way in the future, but you know, I imagine they will eventually come up with something that will... that will totally eliminate depression and stuff altogether” (Client I).

One provider talked about alternative therapies that actually get to the heart of a trauma and take it out, rather than creating a dependent patient-provider relationship on which the patient's stability depends. He said:

I'm a big fan of short-term intervention. I always tell people I have no interest in having you on my couch for the next two years. I want to identify the roadblocks that [are] stopping you from progressing, remove those roadblocks, and then kick you out of my office, I mean that's my goal as a therapist. It's not this Freudian psychotherapy where, you know, you're going to develop this dependent relationship. (Provider A)

He went on to say that cure is not a traditional focus of the mental health care system; that mental health care is more often about case management and dependency. As he put it:

When you look at the traditional mental health system, what you recognize is that people are happy enough just to case manage, and just keep people dependent on the system. And so, when you talk to people within the mental health system and you say, how many clients do you work with, and how long does it take for you not to see them again? That's a foreign concept, these are chronic people that they continue to see over and over and over again, and so the system gets clogged, and then they can't see the clients as often as they need to in order to keep them stabilized, and so really what we're talking about here is a system where we put out fires. (Provider A)

These participants said unequivocally that the possibility of cure exists in mental health treatment, and mentioned it as something which services should better take into account.

**Responsibility.** Many clients spoke as people who take sole responsibility for their own health (Client D, Client E, Client F, Client I). Clients were very aware that if they wanted to change their lives or improve their health they would have to do it themselves – they did not rely on anyone else for help. As one client put it, “everything you go through, you just take it a day at a time. One day at a time” (Client F). Another client spoke about taking opportunities when they arise. She said, “there's lots of help here. I just gotta ask and step up and do it. And grab it. Take it when, when it's available” (Client E).

The idea of a client being responsible for their own healing was something that providers also recognized, discussed in the section on facilitating healing, below.

**Taking time.** Allowing people time within mental health services was emphasized by three participants (Provider C, Elder A, Elder D). They said that often in health care people – both providers and clients – are rushed and do not take the time that is needed to heal.

Related to listening, discussed above, taking time allows a person to feel that they can tell their story at their own pace, and that the person listening truly cares about it (Provider C).

Rushing people can actually close them off to the possibilities of healing, especially where mental illnesses or mental health problems are concerned. As one Elder said:

When I was the first one home to my mom, she looks at me and she says, Ahhhhh, you know, and she'd say, what's wrong with you? Is there something wrong with you? Because they [Elders] could see, or feel it, through you, and they knew that there's something wrong with you. And you may not say anything to them, but you knew that they'd come back to it when you were ready. And a lot of times they did, but they never did it in front of anybody else. They always quietly brought you near, and would talk to you. I remember a lot of the love and the feelings that I had that were nourishing came that way. With my mom, talking and – just gently talking to me, you know, just asking questions. Sometimes you'd say, well, she'll start talking about where you were, and so on, and gently – pretty soon you were talking about things that, really, that you were guarding. But, I think in our rushed world, we don't have time to do that. We have a list, a book that says, okay, we need all these answers right away. And that puts people in a threatened – uneasy feeling. (Elder A)

Rushing people takes away from the feeling of safety and the feeling of being loved and cared for, both of which are essential for healing in the realm of mental health. Taking the time to listen to someone can be healing in itself.

**Access to information.** Although all the clients (when asked directly) said that their experiences with health care in Prince George had been good, one gap was clients' perceived lack of information (Client D, Client E, Client H). One client asked me to send her information about mental health, because she didn't have any. She said that she hadn't thought about mental health until she talked with me, but she also thought that it was something she should think about. She said she would like to:

Get more information on mental health, too because I gotta read about it and – because I probably need it, right? Cause I'm a recovering addict. I probably need that and I'd really appreciate it if I get more information on that. You got my address and that so –that would be good because like I said, I need it. I never thought about

it till right now, this, like my mind, I got to do it. And I want to grab the opportunity right now and get the information. (Client E)

She had just completed a treatment program for addiction, and was looking ahead to what was next. Her request seems to suggest at least two things. One, that she looked at mental health as a skill that could be acquired – rather than a state of being. And two, that she looked at the interview as an opportunity to learn more about something she didn't previously have any information about.

Two clients felt that there was lots of information on how to get into addictions treatment programs, but no information on what to do once you've completed the treatment (Client E, Client H). One woman, a recovered addict, said that she and her friends were often bored. She said:

I know people are trying to get off of [drugs] and what not but the thing is that there's nothing to do out here. [If] somebody out there would like take us to like places and stuff and it would be awesome. There's, like six of us that hang out all together, all the time and what not and sometimes more. And we always just walk around parks but it's just so boring cause you know, we don't do anything like using or anything like that no more and there's just nothing to do out here no more. They're just tearing down all these places and what are they doing rebuilding parking lots? And police stations? Where do the people come in? You know, if they want people to get off the streets and stop doing the crime stuff and whatnot, why don't they start doing stuff like that? Like think about that kinda stuff. (Client H)

These clients felt that they didn't have enough access to information about follow up services, once they were through treatment or out of a crisis zone.

**Follow up.** Having people in health care follow up with them was perceived as very positive by clients (Client A, Client D, Client E). One client suggested that it made him feel cared for. He said:

You do have counsellors out there that don't give two shits, it's their job. They listen and then – okay. But then you got some that are really, that you can tell, like you got



the nurse out there, she's one hundred percent. A lot of them are over there, but the new one seems like... She's right on the ball, that one. Like, she's always making sure you got this done, this done, this done. (Client D)

Having someone who would follow up with them made these clients more likely to follow treatment programs and access services to get help for mental health and other health problems.

**Change.** Two participants spoke about the relationship between change and mental health services, in drastically different ways (Client A, Provider A). One client said that he felt counsellors and mental health care providers couldn't understand him, because of all the drastic changes he had seen in society over the course of his lifetime. As he put it:

When you're in doubt, which – me, I'm in really big doubt. Any kind of drug and alcohol counsellors... Better if I stay far away from them. Cause when you walk a mile in your moccasins it's like, what they say, it just doesn't make sense to me. Just doesn't, cause I seen all that cultural change and everything that happened in front of me. (Client A).

One provider said that sometimes just getting people to see the possibility of change is enough to allow treatment to work. He said, "a lot of times you just have to introduce people to the idea of hope and change" (Provider A). For this provider, change was a good thing; for this client, it was something that created distance between him and mental health care providers.

**Facilitating healing.** It was interesting that several providers conceived of themselves as facilitators to healing, rather than as the agents who accomplish healing (Provider A, Provider C). They said that it is the person who is trying to get better who actually does all the work. One provider said:

I don't heal. They heal themselves. I facilitate healing. That's the whole – ultimately, all the kudos and credits go to the people that come here, and work through it. All of

it. But to be a facilitator, by, you know, saying, I'll be what you need [me] to be right now. (Provider C)

Another provider said the same thing, but also mentioned that sometimes he sees people heal themselves not through an intervention, but in spite of it. As he put it:

The reality is that sometimes people fix themselves in spite of the intervention. I mean, if you look at what we do sometimes on the third floor [the psychiatric ward of the hospital], it's aversion therapy, it's like, holy crap, I don't want to be stuck locked up in this unit, I'm going to pretend that I'm better, and you fake it, and then you make it. That's sometimes how people respond. (Provider A)

These providers were echoing the teachings of Elders in conceiving of healing as something that they can only facilitate, rather than making it happen for someone.

**Life's work.** Two providers mentioned that they saw the work that they do as a sort of calling (Provider B, Provider C). One provider called it "divine intervention" that she got the job she has, not being able to find any other way of explaining it (Provider B). Both women loved their jobs and couldn't imagine doing anything else.

**Stress on providers.** Providing mental health services can be stressful, however, as two participants pointed out (Client G, Provider A). As one client put it:

I look at the women sometimes and I know, I can tell, they're just kinda tired because there's so many people, a lot of people get mad because, oh, oh I thought I had an appointment today or you know, I thought you were gonna get me in you know, and stuff like that, they go through a lot too but they're doing the best they can right now with everything they do here. And I really appreciate what they've done for me. (Client G)

One provider saw other providers being under stress because they don't see change happening in their work. He said:

The reason why it's so difficult for workers and they get burnt out, is because they don't see change, right? I mean, they're rearranging the deck chairs on the Titanic, the Titanic is still sinking and we're doing this busy work, and you know, there isn't a whole lot of job satisfaction. (Provider A)

According to these participants, providing mental health services can be a very stressful job.

**Resources.** Two providers spoke of the need for more resources in order to have mental health services functioning the way they ideally should be (Provider A, Provider B). They talked about how the focus of mental health services is on acute rather than preventative care, which was something they felt needed to change. This ties in to a holistic view of mental health, as holistic care is not possible in an acute care setting; people need to have the time to get to know, and treat, a whole person. In order to have the time, however, these providers perceived that the system needed to have more resources. As one provider put it:

When we talk about the reality of actually being able to provide holistic care, our system doesn't have the resources to do it. We've barely got enough for psychiatrists and GPs [general practitioners] to write the prescriptions... The caseloads are just, they're totally unmanageable. You've got a couple of the case managers on the serious and persistent team, who have case loads of over a hundred. You can't – what kind of conversation can you have, when you've got a case load like that? (Provider B)

Resources were seen as a factor that limits the type of mental health services that can be offered.

**Tools.** One provider described his approach to practice in terms of using different tools (Provider A). He said that when he finds a tool that works, he'll incorporate it into his work, and if he ever finds himself without a useful tool, he will go looking for a new one. As he put it:

As a person who does intervention, the last thing and the worst thing to do as a responder is to go into a situation, look in your toolbox and not have the right tool. That puts you in a very helpless position, and then puts you at risk for having your own mental health problems, because again, you don't go into this profession because of the money, you go in because you want to help people, you want to

create change. And, so I mean, it's driven my whole practice, that kind of crisis – need a tool, get a tool, work with it. (Provider A)

For this provider, tools are an integral way of conceptualizing the work that he does for people, and having tools is a way of feeling that he can take care of a situation and meet a person's needs.

**Basic needs.** One provider pointed out that what she needed to do first, in her work, was provide for people's basic needs (Provider C). After people were fed and clothed and sheltered, then space is created for more in-depth mental health care. She said:

They don't care about HIV, or diabetes, if you're just struggling for the basics. And of course we must do the basics, we must find food, we must find a better home, we must do crisis intervention. It's a twenty-four-hour, around the clock thing. But if we do that, and walk beside them, until people can walk alone, and don't need us anymore – basically, that's when success is happening. (Provider C)

Success in mental health services, for this provider, lies in getting people past the point of looking after their basic survival needs so that they become independent, and then taking care of their mental health needs.

**Provider confidence.** Another provider mentioned that it is important to have confidence in your tools and your abilities, as a mental health care provider, especially in a crisis situation (Provider A). As he explained:

You do have to be fairly confident, intervening in chaos, because if you're as out of control, or if you have any hesitation, or anything like that, people will read you like a book, and not want you to help. (Provider A)

This provider viewed at least some level of confidence as an essential characteristic of a mental health care provider.

**Peer support.** One provider emphasized the importance of peer support for mental illness and mental health problems (Provider B); partly because there is such demand on

the system that not everyone can get clinical help, and partly because of the sustainability of learning from one another and sharing experiences. She said:

From my perspective, the peer piece is important, because you will never have enough clinical services, there will never be enough resources, so for me, it's our right and our responsibility to build capacity in ourselves to support and educate each other. Because in the absence of clinical services, we've got each other. We've got our community. (Provider B)

Providing peer support was seen as a valuable complement to clinical services for mental health needs.

**Paperwork.** One Elder pointed out that having to fill out forms and do paperwork before receiving treatment can have a negative effect on people, especially when they are already suffering from a mental health problem (Elder A). Forms often ask you to describe what's wrong, and sometimes this is something that you need to talk to a supportive person about, rather than writing it on paper. The impersonal experience, she says, can be a trigger for people's mental health problems, and the gaps that are opened by this type of experience are often not addressed. As she put it:

When you come at somebody with, say, okay, fill this, have you done this, have you done that? I know in a lot of programs, you go through a lot of paperwork before you actually get help. And so when you're looking at mental health, you need help from the mental health, from all the papers that you just went over. Sometimes those open big gaps in you, [so] that you maybe close the door even tighter. And because it's threatening to have somebody come at you with a lot of paperwork, knowing that you don't know what that paperwork's going to be used for, sometimes, right? And so when you get into that space, you don't want to say anything. So it's threatening. (Elder A)

This Elder saw the impersonal experience of accessing mental health services as something that can be threatening and actually damaging to a person's mental health.

**Summary**

This chapter presented the results which were compiled and analyzed from talking circles and interviews. Results fit within three broad sections: first, discussions and thoughts that participants had surrounding the concept of mental health and what it means; second, several factors that were seen by participants as influencing their mental health; and third, thoughts and suggestions that participants offered regarding mental health services. The next chapter expands on these ideas by linking them to the literature on mental health and specifically Aboriginal approaches to mental health.

## **Chapter Five**

### **Discussion**

This section discusses the results, outlined in the previous chapter, in more detail, relating them to the literature on Aboriginal approaches to, and critiques of, mental health. It begins with a brief summary of the discourse on Aboriginal health and mental health and how the results of this study fit into the literature. The discussion which then follows is organized into the same three categories as were found in the results chapter: (1) what is mental health? (2) factors that improve or detract from mental health, and (3) mental health services.

#### **Aboriginal health discourse**

While diverse in its interests and directions, and a site of frequent and often vigorous debate, a foundational premise of Aboriginal health work is that health and illness are irreducibly interrelated with, and interconnected to, the social, cultural, economic, and political contexts in which Aboriginal people(s) live... This 'holistic' concept of health and health care is counter-posed to more narrow biomedical definitions that view health as contained within individual minds and bodies and evidenced by an absence of disease. (Culhane, 2009, p. 162)

The literature on Aboriginal approaches to mental health is embedded in the discourse of Aboriginal health. Aboriginal health is characterized by Culhane, above, as having a focus on the interconnections and relatedness of many aspects of life, health, and illness; and also as being positioned in opposition to biomedical approaches to health. This characterization holds true for much of the literature on Aboriginal mental health, as well (Gone, 2009; Blackstock, 2008; Calabrese, 2008; Duran & Duran, 1995).

There are some problems with this approach to Aboriginal mental health; mainly that it offers a slightly inaccurate picture of Western health and mental health services as

they attempt to reinvent themselves, becoming more patient-centred, more attentive to the whole person, more in tune with the social (and other) determinants of people's health, and more aware of the needs of Aboriginal peoples (First Nations Leadership Council, Government of Canada, & Government of British Columbia, 2007; Kirby, 2006; Fuchs, 2002; Glannon, 2002; Smith, 2002). However, this discourse also fulfills the purpose of raising awareness of the roots of many Aboriginal mental health problems in colonialism, including the experiences of residential schools and ethnocentric child welfare practice (Blackstock, 2009).

The results of this study support the argument for a broad approach to mental health, with attention to the interrelations of life, individual, and health, for Aboriginal peoples. These results also support the goal of decolonization as one that will improve the mental health of many Aboriginal peoples in Canada. The remainder of this chapter discusses the results of this study in detail, organized according to the general topics identified in the previous chapter, and positioning them in relation to the literature.

### **What is mental health?**

Several of the results relating to the concept of mental health provide support to themes found in the literature. For example, I initially approached this study believing mental health and addiction to be separate, but related issues. However, in much of the literature related specifically to Aboriginal mental health in Canada, substance abuse (assumed in this study to be synonymous with addiction) is one of the primary factors used to indicate the presence – and estimate the prevalence – of mental illness and mental health problems (Kirmayer et al., 2009; Waldram et al., 2006). Reflecting the association



between mental health and addiction in the literature, almost half of the participants in this study (15 of 32), when asked to speak about the concept of mental health, brought up addiction.

Several participants described addiction as impacting certain aspects of their lives, such as their ability to retain stable employment and the risk of having their children taken from their custody into the care of the state. In this way, addiction acts as a determinant of health, which in turn impacts on other determinants of health such as employment (Wilkinson & Marmot, 2003), creating new impacts on overall health (Loppie Reading & Wien, 2009).

Participants also described addiction as an oppressive force that caused them to do things they knew were bad for them or that they didn't necessarily like doing. This is consistent with literature on addiction, which says that one way of knowing that an individual is addicted to something is when they continue to take it/use it/do it even in the absence of feelings of pleasure (Maté, 2008).

Finally, participants linked addiction with trauma, abuse, and in particular, residential school. This is entirely consistent with the literature, including the growing body of work examining historic or intergenerational trauma – which traces trauma through generations of people who have suffered from the experience of colonization, including the trauma that many Aboriginal individuals and communities experienced as a result of residential schools (Wesley-Esquimaux & Smolewski, 2004; Duran & Duran, 1995). One way of coping with trauma is to turn to substance or alcohol abuse, a pattern which is frequently adopted by residential school survivors (Chansonneuve, 2007; Corrado & Cohen, 2003).

Whether or not addiction is a mental health problem, a cause of mental health problems, a result of mental health problems, or a completely separate issue remains arguable. What can be seen from the results of this study, and from the literature, is that addictions form a large part of what are seen as the mental health problems of Aboriginal peoples in Canada today (Kirmayer et al., 2009). As a mental health problem, addiction tells us less about genetic predispositions or individual biologies (see Waldram, 2004, for a discussion of these assumptions in the mental health literature) than it does about the life circumstances and the opportunities and control that people perceive themselves to have in, and over their lives (Loppie Reading & Wien, 2009; Wilkinson & Marmot, 2003). In this way, addiction is related to colonization and residential schools, as is discussed further below.

Another prominent theme that participants discussed was related to mental health as a system of labelling. This view of mental health shows up mainly in the literature of cross-cultural psychiatry and psychology, because it is in this field that the way mental illnesses are defined – or labelled – is most problematically shown to be culture-specific (e.g., Gone, 2009; Kirmayer et al., 2009). The message of cultural specificity was one that participants voiced strongly; they felt that the concept (or the label) of mental health belongs to a Western, colonial ideology or culture; a culture perceived to be separate from, and often antagonistic to (or at the very least ignorant of) Aboriginal cultures. Participants also expressed that the labels used in mental health care invoke a system in which power resides with those who give the labels and is taken away from those who receive them. Participants perceived this system as one that portrays Aboriginal peoples as generally

mentally ill, and by extension incapable of deciding or acting for themselves, thus excusing colonial intrusions into their lives. The portrayal of Aboriginal peoples as sick, dependent, or addicted, has quite a long history in mental health literature, as Waldram (2004) has shown.

The concept of labelling was also closely related to stigma and discrimination in the results of this study. Stigma and discrimination surround mental health in the literature, and have done so almost since the concept of mental health first came into existence (Foucault, 1965; Grandbois, 2005; Porter, 1987). This is one part of what makes mental health treatment so difficult; people with mental illnesses are treated with some trepidation by society at large, and are often portrayed as dangerous in the media (for example, in the shooting of congresswoman Gabrielle Giffords in 2011; see, e.g., National Public Radio [NPR], 2011). This stigma causes people to want to avoid being associated with the concept of mental health or with mental health services, as several participants stated.

It is important to note, however, that although Western mental health services have not always had a positive impact for Aboriginal people, there remain some similarities in approach between Aboriginal and Western approaches to mental health treatment (Korhonen, 2001). As several participants also pointed out, the Western system of mental health is recognizing its weaknesses and struggling to move toward a more holistic, client-centred model that would be more in line with many Aboriginal healing ways.

The concept of normality is another prominent theme, one which runs through all of the aspects of mental health discussed thus far. It is related to labelling, in that labelling (or diagnosing) mental illness focuses on identifying abnormality (American Psychiatric Association, 2000). Participants talked about recovering from mental illnesses in terms of

wanting to feel normal, and spoke of feeling stigmatized because they didn't feel normal. The concept of normality also relates to mood. Aligning with the literature (Kleinman, 2004), participants described how moods that are considered abnormal by health care providers can be labelled as mental illnesses, even when at times they may not seem abnormal to the person experiencing them, or the person's family. Normality can also be related to addiction, in perhaps a more complex way. Communities form around patterns of substance use, as participants told me and which is also reflected in the literature (Culhane, 2009), and in these communities, substance abuse is a normal part of life. Thus, addiction can be part of a strategy for feeling normal.

Another result from this study, which was not altogether surprising, was the association between mood and mental health. Mood disorders are by far the most common mental illnesses in Canada (Roberts & Grimes, 2011). Participants in this study described extremes of mood or uncontrollable moods as mental health problems, showing that mental health, for them, is equated with emotional health. The blurring of boundaries between different aspects of health (as, in this case, between emotional and mental health) fits with the medicine wheel model of health, in which overall health is perceived to be a congruence of emotional, physical, mental, and spiritual health (McCormick, 2009).

In keeping with much of the literature related to Indigenous approaches to mental health (McCormick, 2009; Durie, Milroy, & Hunter, 2009; Cargo et al., 2009; Stewart, 2001), many participants spoke of mental health as holistic health, in that it involves much more than the brain or the mind. One Elder said that the mind is very important because it can heal the body; however, the mind is still not necessarily seen as separate from the body.

The most common way of depicting this holistic approach to health, in the literature surrounding Aboriginal health and mental health, is using the medicine wheel, in which *emotional, physical, mental, and spiritual health are depicted as parts of a circular whole* (McCormick, 1996). While a useful way to get a sense of what is meant by holistic health, the use of the medicine wheel is not appropriate for all Aboriginal cultures; also, the medicine wheel (or sacred hoop, in another way of understanding it) has many deep layers of meaning, not all of which can be captured in the literature (Brant Castellano, 2000). There is perhaps a danger in oversimplifying what has long been a very sacred concept.

Only two participants, both non-Aboriginal health care providers, brought up specifically Western theories of mental health, but it is still worth mentioning here. They both talked at length about the training they had done as mental health professionals and how the theories they learned affected their current practice. In some cases it was in a negative way; psychoanalytic theories of the influence of family relationships on mental illness were perceived to cast blame on families, leading one provider to want to distance herself from these theories. Both providers articulated ways in which they have changed established theories to fit their personal philosophies of healing, such as by adding to the biopsychosocial model of health (Smith, 2002) to create a biopsychosociospiritual model, allowing attention to be focused on the spiritual life of a client. They also spoke about new approaches to mental health treatment, such as eye movement desensitization and reprocessing (EMDR) (Van der Kolk et al., 2007) that depart from the traditional division between mind and body and the focus on talk therapy in Western approaches to mental health (Calabrese, 2008). In general, these providers' responses are reflecting a shift in

medical and psychological literature from a narrow, cause-and-effect, compartmentalized view of health towards a broader and more holistic view (Smith, 2002), one which is more in line with many Aboriginal ways of approaching health. As the participants pointed out, practice may be a bit slow to catch up with the literature, but it does seem that attitudes are shifting, as is medical education (Smith, 2002).

Something unexpected and interesting that several participants brought up was the idea of mental health as energy – that helping people with their mental health involves working with people’s energies. Participants did not elaborate much on the idea, but they touched on many different areas which seem to be related to energy – such as relationships with nature and medicines, the importance of relationships and understanding within a health care setting, and spirituality and ceremonies. My familiarity with energy work comes from the realm of martial arts, where working with *chi* energy is said (and felt) to increase one’s life force (Kiew Kit, 1997). Energy is described in physics (Perkins, 2000) and chemistry (Crichton, 2008), in plant biology (King, 2011) as well as in human physiology (McArdle, Katch, & Katch, 1991), but it is not common in this literature to discuss, specifically, how to work with human energy. Colloquially, we often speak of how much energy we have, or of changes in perceived amounts of energy; in mental health terms, depression, for example, is described in terms of a loss of energy (American Psychiatric Association, 2000). Still, none of the literature reviewed on mental health or Aboriginal approaches to mental health mentioned energy in the way that participants spoke about it; a gap which, given all of the other types of literature on energy, is surprising.

In discussions with Elders and co-researchers, and in particular with Cree Elder Leonard Ward, I have come to understand energy as something which exists in all things, living or not. Elders stress that the medicines are used because they have powerful energies that can accomplish specific goals. Leonard teaches that the medicines can interact with human energies as well as with the energies that humans carry – such as negative energy that might be projected onto someone by someone else. Energies also exist in the relationships human beings have with one another. There are different types of energies in human relationships, one of which is the energy that carries knowledge and allows it to be shared and to grow. Other types of energies can be harmful; for everything that exists, there is positive as well as negative energy. Working with energy is a complex and delicate vocation, and I have no doubt that, consciously or not, it is something that anyone who works in mental health, or who deals with a mental health issue, has to learn to navigate.

The concept perhaps most closely related to energy in the literature reviewed on mental health is that of relationship. Healthy relationships, as will be discussed below, are considered important factors in good mental health. The concept of energy as Leonard explained it, as both what forms and what influences relationships, opens up a way of thinking about mental health that is both helpful in understanding mental health and intuitively makes sense. Energy in relationships is not restricted to human beings' relationships with one another – it also includes a person's relationships with the medicines, for example, making the concept more inclusive (and holistic). In terms of mental health and medications used to treat mental illnesses, the concept of energy makes sense. One participant pointed out that it often takes some time to find the medication that

is right for a particular individual. Framing the search for the right medication in terms of the energy and relationship between that individual and the medication could help to enhance a person's understanding of what they are going through. This is important, because, as Leonard has explained, if a person doesn't understand the treatment they are being given, it can lead to feelings of resistance or reluctance, which contribute to negative energy that can interfere with the healing process.

The other part of mental health discourse that I see as including the concept of energy is in discussions around the importance of spirituality to mental health. Energy and spirituality are very closely related concepts; as I see it, working with the spirits involves working with energy as well. The spirits can perhaps be thought of as facilitators of energy, as when their help is called upon to take negative energies away from a person; or perhaps the spirits are energy themselves. In the literature, spirituality is most often discussed in terms of specific ceremonies or practices; perhaps the concept of energy could be used as a way of broadening the discussion and facilitating an understanding of the effects of spiritual practice on people's mental health and wellness.

In discussions with the Aboriginal Caucus and Leonard Ward about energy, they all seem to have much more familiarity and a much more profound understanding of the concept than I do. I have the impression that it is a concept with a great deal of relevance and currency in their lives and in the milieu in which they work, and this is another reason that mental health might benefit from being framed by a discussion of energy. If mental health is conceptualized as energy, it may make more sense, have more positive connotations, and be more helpful to many Aboriginal peoples. My discussion of the



concept of energy has been guided by Cree teachings, but the concept may have relevance for other communities and nations as well.

The concept of mental health was discussed in many ways by participants, including as addiction, as a set of labels which enforces a set of norms, as mood or state of mind, and as energy. Next I will look at what participants had to say about the factors in life that influence their mental health.

### **Factors influencing mental health**

In this category, research results echo much of what is found in the literature. Residential school, identity, language, power and control, and an ongoing experience of colonialism were all said to be contributing factors to mental health and mental illness in Aboriginal populations. This is something that Aboriginal peoples have been saying for a long time, and something which scholars continue to write about (Czyzewski, 2011; Lavallee & Poole, 2010; Chandler & Lalonde, 2009; Gone, 2009; Kirmayer et al., 2009; Loppie Reading & Wien, 2009; McCormick, 2009; Waldram, 2009; Blackstock, 2008; Duran et al., 2008; Chansonneuve, 2007; Duran, 2006; Waldram, 2004; Wesley-Esquimaux & Smolewski, 2004; Corrado & Cohen, 2003; Durie, 2001; Stewart, 2001; Royal Commission on Aboriginal Peoples, 1996; Duran & Duran, 1995), thus placing this study squarely within the literature on colonialism as a factor in health and mental health for Indigenous peoples.

The problem with being thus situated is that there are some shortfalls in this body of literature as it currently exists. This is not intended to find fault with all of the literature in general, nor to overlook the significant contributions each author has made to advancing an understanding of Indigenous mental health and pairing it with an advocacy of Indigenous

rights. It is merely important to note certain assumptions that seem to be relatively common (I am certainly not above making them), to try to recognize their sources, and to see, account for, and reflect the world in all its complexity and changeability. A discussion of this literature has been undertaken in chapter two, but it is worth inserting a brief reminder here in an attempt to avoid making the same assumptions as I discuss the outcomes and recommendations of this study.

One problem involves a critique of Western science, medicine, and health care based on characteristics that people in these fields are currently working hard to change and overcome. As Western mental health care changes to become more patient-centred and holistic, critiques of the field need to adjust to take these changes into account. We need to make sure that we are not blindly criticising concepts of science that no longer have relevance to mental health practice today. If, as several participants noted, Aboriginal and non-Aboriginal peoples all need to work together to improve the situation and related health and mental health of many Aboriginal peoples in Canada, then it is worth at least acknowledging the positive steps toward a meeting of minds that are being taken.

This problem is related to that of making too rigid a distinction between “Aboriginal” and “non-Aboriginal” groups. Neither of these groups can be said to encompass anything like a coherent or homogeneous whole, and both overlap significantly. Insisting that a clear line can be drawn between these two groups runs the risk of perpetuating colonial assumptions about race and culture that hinder our abilities to gain a better understanding about mental health and, in fact, the world.

With these cautions in mind, however, the messages in the literature about the effects of colonialism on mental health for Aboriginal populations need to be heeded, and are strongly supported in this study. Addressing the effects of residential school experiences, for example, will go a long way towards improving the mental health of many Aboriginal peoples in Canada. Being free to know, to learn about, to teach about, and to be proud of, one's cultural identity and one's original language – a freedom which has been denied Aboriginal peoples in Canada – is essential for mental health (Lavallee & Poole, 2010). The historical and colonial contexts of mental health for Aboriginal peoples in Canada need to be acknowledged, and we need to continue to take steps to address them.

For example, many participants expressed a desire to learn more about their Aboriginal identity. Issues of identity are related to, and found throughout, the themes of residential school, language, power, and control, that were brought up by participants. What, then, does Aboriginal identity mean, and how does it relate to mental health? This is not a question which it is appropriate for me to definitively answer; however, with great respect, I offer some thoughts from the literature.

Aboriginal identity in Canada is unusual due to its legal aspect, which is regulated by the federal government through the Indian Act (Laliberte et al., 2000; Minister of Justice, 1985). It is often said of this legislation that its purpose is to gradually eliminate registered "Indians" (Minister of Justice, 1985), by assimilating them into the broader Canadian society and taking away legal status, thus releasing the federal government from financial obligations (Palmater, 2011). As Lavoie, Forget, and Browne write:

By 2029, a total of 29,186 individuals of First Nations ancestry (9,645 on reserve, and 19,541 off reserve) will not be entitled to Indian status. This is nearly 5 times the

numbers of individuals not entitled to registration in 2004. (Lavoie, Forget, & Browne, 2010, p. 92)

This has implications for health care, placing a larger burden of funding for health services on First Nations Health Organizations (Lavoie et al., 2010). In the current study, only one participant specifically mentioned status, saying that although his half-brother had status, he himself was not eligible, because he had a different (non-Aboriginal) father.

The experience of discrimination based on Aboriginal identity was mentioned by several participants and has been documented in health care (Browne, 2007).

Discrimination based on Aboriginal identity has been shown to relate to higher levels of distress and anxiety for Indigenous populations internationally (Hansen & Sorlie, 2012), as well as for Aboriginal peoples in Canada (Royal Commission on Aboriginal Peoples, 1996).

Many Aboriginal peoples, including some of the participants in this study, have been made to feel ashamed of their Aboriginal identity, often to the extent that they do not even know about it until fairly late in life (Iwama, 2003). Aboriginal identity is something that many participants expressed a wish to learn about, simply because they had never been taught about it, and the empowerment of learning about Aboriginal identity without accompanying discrimination or shame may be of benefit for mental health. This may also be one of the reasons many Aboriginal people turn to Aboriginal forms of spirituality – which are often closely related to Aboriginal identity – after recovering from addiction or other mental health problems (Duran & Duran, 1995).

Participants also spoke about several aspects of life that affect their mental health, which could be called social determinants of their mental health. Social determinants of health, according to the World Health Organization (WHO), are “the conditions in which

people are born, grow, live, work and age, including the health system” (World Health Organization, 2012), and are becoming more and more important as factors in the delivery of health care. As the WHO web site says, “why treat people without changing what makes them sick?” (World Health Organization, 2012). This is a core idea of this research, as the majority of information that participants gave me regarding mental health was not so much about mental health and mental illness themselves, but rather about the many factors surrounding people – in particular, Aboriginal peoples – that influence what comes to be called their mental health or mental illness. Colonialism, mentioned above, has been named as a social determinant of health (Czyzewski, 2011; Loppie Reading & Wien, 2009), and social determinants of health also include things like housing, employment, and relationships with or custody of children, all of which were mentioned by participants as having an impact on their mental health and well-being. Social inclusion (Wilkinson & Marmot, 2003) and social capital (Syme, 1996) are concepts that try to get at the ideas of marginalization or exclusion in broader society and the effects that this can have on health. In this study, participants talked of personal growth, grief and loss, love, fear, trauma, and safety, and the impacts that these aspects of their lives had on their mental health. Not feeling safe, for example, was linked to anxiety, and personal growth was seen as the ultimate goal of treatment. I see all of these concepts as falling under the umbrella of social inclusion or social capital.

There was one other interesting point about the factors influencing participants’ experiences of mental health and mental illness. One of the most common ways that participants said they make themselves feel healthier, was by going for a walk. The simple

act of getting outside, getting your body moving, and getting in contact with nature, came across as incredibly healing. Interacting with trees and water were mentioned in particular as making participants feel comforted and calmed. Thus, having places that are easy (and pleasant) to walk to, where one can find trees and water and relative quiet, can be considered important for mental health and may be something that cities should take into account.

### **Mental health services**

The most prominent theme that participants brought up related to mental health services has to do with ceremonies, spirituality, medicines, and “culture” being incorporated into mental health services. Spirituality and Aboriginal ceremonies are not traditionally aspects of Western mental health services, although many services are making changes to include certain Aboriginal ceremonies and spiritualities as part of their healing and treatment programs (e.g. Anishnawbe Health Toronto, 2011; Central Interior Native Health Society, 2011; McLeod-Shabogesi, 2010; see also First Nations Leadership Council et al., 2007; Kendall, 2007). In speaking about ceremonies and spiritual practices that they knew, participants seemed to be emphasizing the fact that Aboriginal peoples have their own ways of treating mental illnesses and promoting mental health, that still do not get enough credit in overall services, in spite of these changes. More inclusion of a wider variety of ceremonies and practices, and more acceptance of those practices within Western mental health care, would go a long way towards making Aboriginal people, and perhaps all people, feel more at home with mental health services.

It is important to be careful and clear in the way Aboriginal medicine is included within Western health care, however, to avoid misunderstandings or the inadvertent propagation of stereotypes. For example, the widespread use of the medicine wheel (Cargo et al., 2009; McCormick, 2009) as a way of describing general Aboriginal approaches to health can cause the medicine wheel to seem like a “pan-Indian ceremonial [practice]” (Tanner, 2009, p. 261). Pan-Aboriginality, however, is not necessarily an accurate way of framing ceremonies that a number of Aboriginal groups across the country have adopted. When ceremonies or practices are borrowed, it is usually acknowledged specifically where they are borrowed from. It is not the case that a certain ceremony is appropriate for all groups because they all somehow share the same essence of Aboriginality (what Chandler and Lalonde (2009, p. 243) call “the myth of the monolithic Indigene”); it is rather that different Aboriginal groups borrow practices from one another because it is found that they work in different contexts. Aboriginal peoples in Canada are composed of many nations and it is only the colonial government that has had cause to group all the diverse nations together under one umbrella category. Most Aboriginal individuals don’t see themselves this way (Palmater, 2011).

Another caution related to incorporating Aboriginal ceremonies into Western mental health services has to do with issues of authenticity. The prevalence of some types of ceremonies, practices, or representations can lead to others being seen as inauthentic, and thereby being excluded. It is important to remember that stereotyped images can become solidified in people’s imaginations, leading to problematic views of what makes a “real” Aboriginal person, for example (King, 2003; Brayboy, 2000). This is related to issues

about the distinction between Aboriginal and non-Aboriginal people, in that someone who identifies as Aboriginal but identifies too closely with practices that are seen as non-Aboriginal can be condemned as not being authentic (King, 2003).

The other themes brought up by participants in relation to mental health services have to do with the relationship of care; in Western mental health services this relationship generally exists between provider and client, although it is increasingly taking on a wider variety of forms as group therapy, healing circles, or spiritual mediation and treatment become more common. The importance of different aspects of a relationship between providers and clients, such as understanding, listening, trust, follow up, working together, and taking time, were strongly emphasized by a number of participants. Some providers mentioned that they felt themselves to be facilitators of healing, rather than having any particular powers to heal – this is a philosophy that has been taught by Elders in many places for many generations. The healer doesn't heal; rather, he or she acts as a mediator or facilitator and the client and the spirits do the healing together. The humility on the part of the healer and the empowerment of the client that are implicit in this approach are also seen in patient-centred medicine (e.g. Smith, 2002). These characteristics of the healing relationship can help to correct the power imbalances often seen in client-provider interactions in mental health services, as mentioned by participants in the section on labelling, above.

Access to information was also mentioned as a part of mental health services that could be improved. Clients said that there was plenty of information on how to get into addictions treatment, but nothing on what to do or what to expect once the treatment is



completed. The focus on starting treatment but not following up after treatment is over may have to do with the crisis-oriented nature of our health care system, something which providers alluded to and which is often mentioned in the literature related to Aboriginal critiques of Western mental health (Gone, 2009; Duran & Duran, 1995).

Another interesting point that came up with regard to mental health services is the idea that a person has to be ready to heal before treatment will work. This was mentioned with regard to addictions, as well – that treatment just doesn't work unless an individual is prepared to be dedicated to the process, with all its hardships. This point may relate to the social determinants of health, in that better life circumstances may make it easier to put the effort in to be well and to heal from mental health problems (Loppie Reading & Wien, 2009; Wilkinson & Marmot, 2003). This idea was described by one health care provider, who said that it is necessary to provide for people's basic needs to get them to the point that they can heal themselves. It is also an interesting point to make about mental health services, however, because having a mental health problem or a mental illness can actually make a person less inclined to take care of him- or herself.

Finally, the theme of pharmaceutical medications and their use in treating mental illness was a recurring one, and a salient theme for mental health services. It related to the idea of a cure, in that most participants saw medication as a method of alleviating symptoms rather than curing a person of mental illness. The literature on Aboriginal approaches to mental health does not generally touch on the issue of medication, unless the category is expanded to include illicit substances and alcohol (e.g. Kirmayer et al., 2009) and traditional medicines used by Elders (e.g. Marsden, 2005). Medication was frequently

associated with mental illness by participants, however, and was not viewed in the most favourable light, although some participants noted that at times, medication can be a necessary, and helpful, method of treatment. Perhaps the literature could stand to be more inclusive of a discussion of medication as an option for the treatment of mental health issues.

### **Summary**

This section has discussed the results of the study in more detail, linking them with what is found in the literature on similar topics. Much of what was found is a reinforcement of important messages already found in the literature, although some new ideas emerged, in particular the concept of mental health as energy. The next chapter forms a conclusion for this work, outlining the key messages, some limitations of the study, and suggestions for future research.

## **Chapter Six**

### **Conclusion**

The purpose of this phenomenological study was to explore the following questions: how do Aboriginal clients seeking mental health care conceptualize their own mental health and illness?; how do health care providers, including Aboriginal Elders, conceptualize mental health and illness?; and, do these various perspectives have an impact on the lived experience of Aboriginal clients when they access treatment for a mental illness or mental health problems? The research was guided by the principles of Indigenous research as well as those of phenomenology, and efforts were made to keep respect, reciprocity, relevance, and responsibility, as well as deep understanding, at the forefront throughout the entire research process. In partnership with the Aboriginal Caucus of the CINHS in Prince George, information was shared through two talking circles with Elders and health care providers from the community, as well as twelve individual interviews – three with health care providers and nine with Aboriginal clients accessing services at CINHS. Except in one case in which a client did not want the interview recorded, all interviews and talking circles were digitally recorded and transcribed into written form. Transcripts were then sorted into themes by the researcher, which were assigned to one of three umbrella categories: what is mental health?; factors influencing mental health; and mental health services.

Undertaking this research has involved a process of learning that will not end here. As Leonard has put it, I jumped into the unknown in order to learn about these questions, and my learning has extended beyond what is contained here, contributing to my own growth as a human being and resulting in constant changes and expansions in the way I

view the world. The Aboriginal Caucus and my supervisory committee have had tandem roles in keeping me on track and mindful of what I was doing and where I wanted the research to go. Every meeting with the Aboriginal Caucus has taught me something new and reminded me that there is still much to learn.

### **Limitations of the study**

Research findings from this study were strongly related to the literature and had quite a strong internal consistency. However, a few points must be noted that should be kept in mind when reflecting on the implications of these findings.

It seems that the location of the client interviews could have had an impact on the topics they were drawn to. Clients were recruited on a volunteer basis from the waiting room of CINHS – where they were waiting for health services – and taken into a room that is normally used for counselling, where they sat down with me – someone clearly affiliated with the clinic – and asked questions about their health. This is the sort of situation in which these clients would normally be accessing addictions counselling. The fact that they, without prompting, gave me detailed accounts of their addictions, their current situations, their struggles, and their plans and hopes for a clean future, supports the idea that clients were following a pattern they had come to expect in this location and situation.

However, clients also spoke clearly about the aspects of addictions that impact mental health. The sense of stigma and shame associated with having an addiction, as well as the sense of an addiction as an oppressive force that controls one's life, were brought up by several clients. Clients would spend thousands and thousands of dollars on addictions and expressed their frustration with this in terms of needing to get their lives back.

Frustration at the irrationality of what they had done, and a strong sense of what they were losing to their addictions, came through strongly in the client interviews. Therefore, it may have been a perceived association between addictions and mental health that led clients to talk to me about their addictions when I asked them about mental health.

Another potential limitation is that this study had an almost exclusive focus on Aboriginal perspectives of mental health, without giving mental health as practiced in a Western way (without specifically taking Aboriginal perspectives into account) a voice. Attempts to include physicians in the study were unsuccessful, which seemed mainly to be due to a lack of personal connections to these individuals on the part of the researcher, perhaps resulting in less willingness to sacrifice the time required to participate. Perhaps providers whose education or practice lacked an explicit focus on Aboriginal peoples' mental health also felt that, due to the focus on Aboriginal approaches to mental health in the study, they did not have sufficient expertise to participate.

The fact that a single researcher themed and analysed all of the data could also be considered a limitation, in that the information was interpreted from only a single point of view. The interpretations and analysis were verified by the Aboriginal Caucus and results were sent to all participants to verify.

### **Suggestions for future research**

Originally, it was thought that this study might elicit new descriptions or ways of thinking about mental health from different perspectives; however, all of the participants seemed to already have an idea in their minds of what mental health is, from a Western perspective, and so this is what they responded to. Undertaking a similar study but using

different terminology – avoiding the use of the specific term “mental health” – might elicit a discussion of other concepts similar to mental health, beyond the narrow perception of Western definitions (see also Vallee, 1966; Kirmayer et al., 2009).

### **Key messages**

In light of the first two research questions (how do Aboriginal clients seeking mental health care conceptualize their own mental health and illness?; and, how do health care providers, including Aboriginal Elders, conceptualize mental health and illness?) several key messages stand out. First of all, “mental health” is not a term that participants liked being associated with. It is seen as a way of labelling people, discriminating against them, and a way of upholding particular norms and values. Participants did not see themselves, as Aboriginal people, reflected in the concept of mental health. A way of thinking about mental health which perhaps makes more sense is by conceptualizing mental health and mental illness as energies, and helping people with mental health problems as a form of energy work.

Participants went beyond describing the concept of mental health, however, and spoke about the factors that can influence their own mental health, either in a positive or a negative way. Primarily, trauma originating through colonialism or residential school experiences is the cause of many mental health problems for Aboriginal peoples. Conversely, participants associated a strong sense of Aboriginal identity with good mental health. Also, the social determinants of health have a key importance for mental health and addiction; and specifically, related to energy, participants said that having peaceful and quiet places to walk, where there is access to trees and water, can be very healing.

With respect to the third research question (do these various perspectives have an impact on the lived experience of Aboriginal clients when they access treatment for a mental illness or mental health problems?), the simple answer is yes. However, participants also went into detail explaining how mental health services might better serve Aboriginal clients. One important consideration was that including Aboriginal cultural practices and Aboriginal forms of spirituality into mental health services is a good way of making mental health services more accessible to Aboriginal people; this is something that is being done in more and more health clinics across the country. Many participants also said that a positive and healthy relationship between provider and client, in which there is true understanding, genuine listening, and a lack of time pressure, improves mental health services vastly. Also, it was asserted that mental health and addiction services are most effective when it is the client's choice to reach out for help, and when the client is ready and willing to participate in their own treatment. Clients also said that mental health services could benefit from better follow-up (post-crisis) and better access to information about mental health for clients.

The most unexpected idea, with perhaps the greatest potential to inform future research, that was brought up by participants is the concept of mental health as energy. Thinking about mental health in this way could be a way of removing the negative connotations that participants found the term to have. Thinking of balancing a person's energies as a way of improving one's mental health makes intuitive sense, perhaps especially to Aboriginal peoples. The idea of giving and receiving energy in a relationship of care captures what many participants said about the importance of understanding and of

feeling that their health service providers really care. Keeping a balance of energy could be a way of framing the need for health care providers to care for one another and for themselves, to avoid becoming drained. The concept of energy also allows for the formation of relationships with non-human entities, including trees and water and other elements of nature, from which people can receive healing; and also with medications, so that the search for the right medication to help an individual can be framed as an ongoing series of interactions rather than a series of failures. Framing mental health in terms of energy could have a great deal of explanatory power, helping people who experience problems with their mental health to understand what is happening to them in a more positive way, rather than framing mental health problems as disease or malfunction. Every person will understand the concept of energy in their own way, and there are many opportunities for further research into this idea.

### **Concluding thoughts**

Leonard has pointed out to me that this is not the end. What is contained within these pages is a teaching for me, and I hope it can also help people who are looking for knowledge or to explore the ideas of mental health. But this knowledge does not end here, it continues to build and grow and change. Throughout this research, I have been continually surprised at the knowledge that has been shared with me and the fruitfulness of the twists and turns the research has taken. It is almost three years now, since my now-fiancé and I packed up the car and drove from Perth to Prince George, following our instincts that we would find what we needed here – without even fully knowing what that would turn out to be.



There will probably always be a part of me that questions my right, as a descendant of settlers, to be doing research with Aboriginal peoples and communities, and there may come a day when I will need to step aside. Up to this point, the support that I have had and the opportunities that have opened up for me reassure me that I am on the right path. There is certainly a place for greater understanding of Aboriginal cultures and thought among non-Aboriginal peoples in Canada, and I hope that this understanding is something I can contribute to. As I have said, echoing Leonard, this is not the end. This is a beginning.

**Reference List**

- Oxford English Dictionary* (1991). Oxford, UK: Oxford University Press.
- Adelson, N. (2000). *Being alive well: Health and the politics of Cree well-being*. Toronto, ON: University of Toronto Press.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR)*. Arlington, VA: American Psychiatric Publishing.
- Anishnawbe Health Toronto. (2011). Vision statement, goals and objectives. Retrieved October 9, 2011 from <http://www.aht.ca/>
- Blackstock, C. (2008). *Rooting mental health in an Aboriginal world view: Inspired by Many Hands One Dream* Ottawa: The Provincial Centre of Excellence for Child and Youth Mental Health.
- Blackstock, C. (2009). Why addressing the overrepresentation of First Nations children in care requires new theoretical approaches based on First Nations ontology. *Journal of Social Work Values and Ethics*, 6.
- Brant Castellano, M. (2000). Updating Aboriginal traditions of knowledge. In B.L.Hall, G. J. Sefa Dei, & D. G. Rosenberg (Eds.), *Indigenous knowledges in global contexts: multiple readings of our world* (pp. 21-53). Toronto, ON: University of Toronto Press.
- Brayboy, B. M. (2000). The Indian and the researcher: Tales from the field. *International Journal of Qualitative Studies in Education*, 13, 415-426.
- Browne, A. (2007). Clinical encounters between nurses and First Nations patients in a Western Canadian hospital. *Social Science and Medicine*, 64, 2165-2176.
- Calabrese, J. D. (2008). Clinical paradigm clashes: Ethnocentric and political barriers to Native American efforts at self-healing. *Ethos*, 36, 334-353.
- Cargo, M., Peterson, L., Levesque, L., & Macauley, A. C. (2009). Perceived wholistic health and physical activity in Kanien'kehá:ka youth. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 5.
- Central Interior Native Health Society. (2011). Central Interior Native Health Society. Retrieved September 11, 2011, from <http://cinhs.org/>
- Chandler, M. & Lalonde, C. (2009). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions:*

*The mental health of Aboriginal peoples in Canada* (pp. 221-248). Vancouver: UBC Press.

Chansonneuve, D. (2007). *Addictive behaviours among Aboriginal people in Canada* Ottawa, ON: Aboriginal Healing Foundation.

Corrado, R. R. & Cohen, I. M. (2003). *Mental health profiles for a sample of British Columbia's Aboriginal survivors of the Canadian residential school system* Ottawa, ON: Aboriginal Healing Foundation.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage Publications.

Crichton, R. R. (2008). *Biological inorganic chemistry: An introduction*. Amsterdam, NL: Elsevier.

Culhane, D. (2009). Narratives of hope and despair in Downtown Eastside Vancouver. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 160-177). Vancouver, BC: UBC Press.

Czyzewski, K. (2011). Colonialism as a broader social determinant of health. *International Indigenous Policy Journal*, 2.

Denis, C. (1997). *We are not you: First Nations and Canadian modernity*. Peterborough, ON: Broadview Press.

Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other Native peoples*. New York: Teachers College Press.

Duran, E., Firehammer, J., & Gonzalez, J. (2008). Liberation psychology as the path toward healing cultural soul wounds. *Journal of Counseling and Development*, 86, 288-295.

Duran, E. & Duran, B. (1995). *Native American Postcolonial Psychology*. Albany: State University of New York Press.

Durie, M. (2001). *Mauri Ora: The dynamics of Māori health*. South Melbourne: Oxford University Press.

Durie, M., Milroy, H., & Hunter, E. (2009). Mental health and the Indigenous peoples of Australia and New Zealand. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 36-55). Vancouver: UBC Press.

Dyer, R. (1997). *White: Essays on race and culture*. London, UK: Routledge.

First Nations Leadership Council, Government of Canada, & Government of British Columbia (2007). *Tripartite First Nations Health Plan* Victoria, BC: Government of British Columbia.

Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason*. New York: Random House.

Freire, P. (1970). *Pedagogy of the oppressed*. New York: Continuum International Publishing Group.

Fuchs, T. (2002). Mind, meaning, and the brain. *Philosophy, Psychiatry, & Psychology*, 9, 261-264.

Glannon, W. (2002). Depression as a mind-body problem. *Philosophy, Psychiatry, & Psychology*, 9, 243-254.

Gone, J. P. (2008). Introduction: Mental health discourse as Western cultural proselytization. *Ethos*, 36, 310-315.

Gone, J. P. (2009). Encountering professional psychology: Re-envisioning mental health services for Native North America. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 419-439). Vancouver: UBC Press.

Gone, J. P. (2011). In *Network for Aboriginal Mental Health Research Annual Conference and Summer School*.

Gould, S. J. (1981). *The mismeasure of man*. New York: W.W. Norton & Co.

Grandbois, D. (2005). Stigma of mental illness among American Indian and Alaska Native nations: Historical and contemporary perspectives. *Issues in Mental Health Nursing*, 26, 1001-1024.

Hanlon, N., Rosenberg, M., & Clasby, R. (2007). Offloading social care responsibilities: Recent experiences of local voluntary organisations in a remote urban centre in British Columbia, Canada. *Health and Social Care in the Community*, 15(4), 343-351.

Hansen, K. L. & Sorlie, T. (2012). Ethnic discrimination and psychological distress: A study of Sami and non-Sami populations in Norway. *Transcultural Psychiatry*, 49, 26-50.

Hoffman, R. (2010). Perspectives on health within the teachings of a gifted Cree Elder. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 8, 19-31.

Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (2005). Introduction to methods in community-based participatory research for health. In B.A.Israel, E. Eng, A. J. Schulz,

& E. A. Parker (Eds.), *Methods in community-based participatory research for health* (pp. 3-26). San Francisco, CA: Jossey-Bass.

Iwama, M. (2003). *Skin whispers down*. Saskatoon, SK: Thistle-down Press.

Kellehear, A. (1993). *The unobtrusive researcher: A guide to methods*. St. Leonards, NSW: Allen & Unwin.

Kendall, P. R. W. (2007). *Pathways to health and healing: 2nd report on the health and well-being of Aboriginal people in British Columbia [Provincial Health Officer's report 2007]* Victoria, BC: Office of the Provincial Health Officer.

Keyes, C. L. M. (2005). Mental illness and/or mental health? Investigating axioms of the Complete State model of health. *Journal of Consulting and Clinical Psychology, 73*, 539-548.

Kiew Kit, W. (1997). *Chi Kung for health and vitality: A practical approach to the art of energy*. Shaftesbury, UK: Element.

King, J. (2011). *Reaching for the sun: How plants work*. (2nd ed.) Cambridge, UK: Cambridge University Press.

King, T. (2003). *The truth about stories: A Native narrative*. Toronto, ON: House of Anansi Press.

Kirby, M. J. L. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada* Ottawa, ON: Senate of Canada.

Kirmayer, L. J., Brass, G. M., & Valaskakis, G. G. (2009). Conclusion: Healing/invention/tradition. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 440-472). Vancouver: UBC Press.

Kirmayer, L. J., Fletcher, C., & Watt, R. (2009). Locating the ecocentric self: Inuit concepts of mental health and illness. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 289-314). Vancouver: UBC Press.

Kirmayer, L. J. & Paul, K. W. (2007). *Qanuippitaa? How are we? Mental health, social support and community wellness* Québec, PQ: Nunavik Regional Board of Health and Social Services & Institut National de Santé Publique du Québec.

Kirmayer, L. J., Tait, C. L., & Simpson, C. (2009). The mental health of Aboriginal peoples in Canada: Transformations of identity and community. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 3-35). Vancouver, BC: UBC Press.

- Kleinman, A. (2004). Culture and depression. *The New England Journal of Medicine*, 351, 951-953.
- Korhonen, M. (2001). *Helping Inuit clients: Cultural relevance and effective counselling*. Ottawa, ON: National Aboriginal Health Organization.
- Kovach, M. (2010). Conversational method in Indigenous research. *First Nations Child & Family Review*, 5, 40-48.
- Kral, M. J. & Idlout, L. (2009). Community wellness and social action in the Canadian Arctic: Collective agency as subjective well-being. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 315-334). Vancouver: UBC Press.
- Kvale, S. & Brinkmann, S. (2009). *InterViews: Learning the craft of qualitative research interviewing*. Thousand Oaks, California: SAGE Publications, Inc.
- Laliberte, R. F., Settee, P., Waldram, J. B., Innes, R., Macdougall, B., McBain, L. et al. (2000). *Expressions in Canadian Native Studies*. Saskatoon: University Extension Press.
- Lavallee, L. F. & Poole, J. M. (2010). Beyond recovery: Colonization, health and healing for Indigenous people in Canada. *International Journal of Mental Health and Addiction*, 8, 271-281.
- Lavoie, J. G. & Forget, E. L. (2006). *A Financial Analysis of the Current and Prospective Health Care Expenditures for First Nations in Manitoba*. Manitoba: Intergovernmental Committee on First Nations Health.
- Lavoie, J. G., Forget, E. L., & Browne, A. (2010). Caught at the crossroad: First Nations, health care, and the legacy of the Indian Act. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 8, 83-100.
- Légaré, A. (2009). Nunavut, the unfulfilled dream: The arduous path towards socio-economic autonomy. *Northern Review*, 30.
- Loppie Reading, C. & Wien, F. (2009). *Health inequalities and social determinants of Aboriginal peoples' health*. Prince George, BC: National Collaborating Centre for Aboriginal Health.
- Marsden, D. M. (2005). *Indigenous wholistic theory for health: Enhancing traditional-based Indigenous health services in Vancouver*. Doctor of Philosophy University of British Columbia.
- Maté, G. (2004). *When the body says no: The cost of hidden stress*. Toronto: Vintage Canada.

- Maté, G. (2008). *In the realm of hungry ghosts: Close encounters with addiction*. Toronto, ON: Knopf Canada.
- McArdle, W. D., Katch, F. I., & Katch, V. L. (1991). *Exercise physiology: Energy, nutrition, and human performance*. (3rd ed.) Philadelphia, PN: Lea & Febiger.
- McCormick, R. (1996). Culturally appropriate means and ends of counselling as described by the First Nations people of British Columbia. *International Journal for the Advancement of Counselling*, 18, 163-172.
- McCormick, R. (2009). Aboriginal approaches to counselling. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 337-354). Vancouver: UBC Press.
- McLeod-Shabogesi, P. (2010, November). Mental wellness centre opens Sudbury office. *Anishnabek News*.
- Minister of Justice, G. o. C. (1985). The Indian Act.  
Ref Type: Statute
- Mussell, W. (2006). *Restoration of well-being for Canada's First Peoples* Ottawa, ON: Canadian Association of Occupational Therapists.
- National Institute of Mental Health. (2009). What causes depression? U.S.A., National Institute of Mental Health. Retrieved March 28, 2010, from <http://www.nimh.nih.gov/health/publications/depression/what-causes-depression.shtml>
- National Public Radio [NPR]. (1-10-2011). No bail for suspect, who gets unabomber's lawyer. Washington, DC, National Public Radio. Retrieved February 1, 2012, from <http://www.npr.org/2011/01/10/132780010/vitriol-cited-as-possible-factor-in-arizona-tragedy>
- Newhouse, D. (2002). *The promise of Indigenous scholarship. Aboriginal Policy Research Conference*, Trent University, Peterborough, ON.
- Palmater, P. D. (2011). *Beyond blood: Rethinking Indigenous identity*. Saskatoon, SK: Purich Publishing.
- Perkins, D. H. (2000). *Introduction to high energy physics*. Cambridge, UK: Cambridge University Press.
- Porter, R. (1987). *A social history of madness: The world through the eyes of the insane*. New York, NY: Weidenfeld & Nicolson.

- Richards, T. A. (2010). Cognitive-Behavioural therapy (CBT). The Anxiety Network International. Retrieved March 28, 2010, from <http://www.anxietynetwork.com/hcibt.html>
- Roberts, G. & Grimes, K. (2011). *Return on investment: Mental health promotion and mental illness prevention* London, ON: Canadian Policy Network, University of Western Ontario, & Canadian Institute for Health Information.
- Royal Commission on Aboriginal Peoples (1996). *The report of the Royal Commission on Aboriginal Peoples*.
- Silverman, D. (2000). Analyzing talk and text. In N.K.Denzin & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (2nd ed., pp. 821-834). Thousand Oaks, CA: Sage Publications.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and Indigenous people*. London, ON: Zed Books.
- Smith, R. C. (2002). The biopsychosocial revolution: Interviewing and provider-patient relationships becoming key issues for primary care. *Journal of General Internal Medicine*, 17, 309-310.
- Spiegelberg, H. (1994). *The phenomenological movement: A historical introduction*. Norwell, MA: Kluwer Academic Publishers.
- Stewart, S. (2001). *Indigenous mental health: Canadian Native counsellors' narratives*. PhD University of Victoria, Victoria, BC.
- Syme, L. (1996). To prevent disease: The need for a new approach. In D.Blane, E. Brunner, & R. Wilkinson (Eds.), *Health and social organization: Towards a healthy policy for the twenty-first century* (pp. 19-31). London, UK: Routledge.
- Tammet, D. (2006). *Born on a blue day*. London: Hodder.
- Tanner, A. (2009). The origins of Northern Aboriginal social pathologies and the Cree healing movement. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 249-271). Vancouver, BC: UBC Press.
- Vallee, F. G. (1966). Eskimo theories of mental illness in the Hudson Bay region. *Anthropologica*, 8, 53-83.
- Van der Kolk, B. A., Spinazzola, J., Blaustein, M. E., Hopper, J. W., Korn, D. L., & Simpson, W. B. (2007). A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), Fluoxetine, and pill placebo in the treatment of Posttraumatic



Stress Disorder: Treatment effects and long-term maintenance. *Journal of Clinical Psychiatry*, 68, 37-46.

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. London, ON: University of Western Ontario.

Van Uchelen, C. P. (1997). What makes us strong: Urban Aboriginal perspectives on wellness and strength. *Canadian Journal of Community Mental Health*, 16, 37-50.

Waldram, J. B. (2004). *Revenge of the Windigo: The construction of the mind and mental health of North American Aboriginal peoples*. Toronto: University of Toronto Press.

Waldram, J. B. (2009). Culture and Aboriginality in the study of mental health. In L.J.Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (Vancouver: UBC Press.

Waldram, J. B., Herring, D. A., & Young, T. K. (2006). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives*. Toronto, ON: University of Toronto Press.

Ward, S. C. (2002). *Modernizing the mind: Psychological knowledge and the remaking of society*. Westport, CT: Praeger Publishers.

Wesley-Esquimaux, C. C. & Smolewski, M. (2004). *Historic trauma and Aboriginal healing* Ottawa, ON: Aboriginal Healing Foundation.

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, 33, 119-130.

Wilkinson, R. & Marmot, M. (2003). *Social determinants of health: The solid facts* Copenhagen, DM: World Health Organization.

Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Black Point, N.S.: Fernwood Publishers.

World Health Organization. (2010). Mental Health. World Health Organization. Retrieved February 28, 2010, from [http://www.who.int/topics/mental\\_health/en/](http://www.who.int/topics/mental_health/en/)

World Health Organization. (2012). Social determinants of health. Geneva, CH, World Health Organization. Retrieved February 17, 2012, from [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)

**APPENDIX A – Interview questions for health care providers**

Interpretations of Mental Health and Illness: Implications for Services in Prince George  
MA Thesis – Sarah Nelson, University of Northern BC  
[snelson@unbc.ca](mailto:snelson@unbc.ca) – (250)981-6695

**Interview Questions**

1. Can you tell me a bit about yourself, your job, and your cultural heritage?
2. What was your training like? Was there anything in your training that had to do specifically with Aboriginal peoples or philosophies?
3. How would you describe the work you do with people? Do you work with Aboriginal people, and if so, is there anything you do differently?
4. What does the term “mental health” or the term “mental illness” mean to you? Do you have another term or another way of thinking about this type of health?
5. Could you talk a bit about the philosophies and guiding principles that guide your approach to health and well-being?
6. What have been your experiences working alongside an Aboriginal Elder (if any?)
7. What do you think of as the role of an Aboriginal Elder when it comes to health and well-being?
8. Do you refer, or have you ever referred clients to see an Aboriginal Elder? If so, what are usually your reasons for doing so?
9. Have you received any feedback from clients regarding their experiences with consulting an Aboriginal Elder?
10. Do you have any thoughts about how it works when we try to incorporate the work of Elders into different health care settings, alongside the medical model of health care?
11. Can you describe your ideal mental health services/methods/approaches?
12. Can you give me some examples of mental health services that are working well?
13. Is there anything else you would like to talk about?

**APPENDIX B – Interview questions for clients**

Interpretations of Mental Health and Illness: Implications for Services in Prince George  
MA Thesis – Sarah Nelson, University of Northern BC  
[snelson@unbc.ca](mailto:snelson@unbc.ca) – (250)981-6695

1. Can you tell me a bit about yourself?
2. Do you mind talking a little bit about what brings you to CINHS?
3. What does the term “mental health” mean to you? Do you have another term or another way of thinking about this type of health?
4. Can you talk a bit about how you think about your own mental health? Do you think about it differently than other people do?
5. What kinds of things make you feel healthy?
6. What made you choose to use the services here?
7. Have you ever consulted with an Aboriginal Elder?
8. If so, can you describe your experience(s)?
9. Can you describe your overall experiences with mental health services in Prince George?
10. What do you recommend in terms of how mental health services could be improved?
11. Can you give me some examples of mental health services that are working well?
12. Can you describe your ideal mental health services/methods/approaches?

**APPENDIX C – Talking circle questions**

Interpretations of mental health and implications for mental health services in Prince  
George  
Sarah Nelson  
Talking circle

*Purposes:*

1. To talk about different concepts of mental health and how these affect the way mental health services are offered.
2. To talk about how Elders practice healing, and how biomedical approaches and the healing ceremonies of Elders might work together.

*Questions:*

1. What is the role of an Elder when it comes to health and well-being?

## Follow-up questions:

- Does the role of an Elder usually involve looking after people's health and well-being?
- How does the role of an Elder fit (or not fit) with a medical model of health care?
- How does a medical model of health care fit (or not fit) with healing practices used by Elders?
- Is health care effective when Aboriginal healing and medical practices work together? How/why? (How/why not?)

2. What does the term mental health mean to you? Are there other terms or phrases we can use instead?

## Follow-up questions:

- Health care in Canada tends to be divided between mental health services and physical health services. Where do you think the idea that there is a division between mind and body comes from - why do people think this way?
- What is the significance of the medicine wheel? How can we use it in approaches to health care?

3. What are some Aboriginal healing ceremonies? Are they different than medical health care practices?

## Follow-up questions:

2. If these are different, how are they different?
  - How are Aboriginal healing practices helpful to people needing health care?
  - How do medical models of mental health help people who are looking for mental health care?

- **What do we mean by medical health care? Is this a useful concept? How can we conceptualize/define it?**
- **If every individual has different health care needs, how do we best go about meeting people's needs?**

**APPENDIX D – Talking circles invitation letter**

You are invited...

January, 2011

You are respectfully invited to participate in a focus group at the Central Interior Native Health Society (CINHS). The group will be in the form of a talking circle, guided by Leonard Ward, a respected Elder in the community. We will be talking about mental health and mental illness and what they mean to each of us, as well as the role of Aboriginal Elders in primary health care and how primary health care can best help Aboriginal clients. This circle, and the questions we wish to explore, have been organized with the help of Jane Inyallie, Lynette LaFontaine, Louise Creyke, Paula Wylie, and Karen Best, who together make up the Aboriginal Caucus of the CINHS.

There will be two focus groups – one on February 17, 2011 and one on March 3, 2011, from 12 until 4pm – so feel free to choose the date that is most convenient to you. Each group will have between 6 and 10 people, and will last for 3-4 hours. Lunch will be provided, and if you need to drive in from outside of the Prince George area we can cover the expense. We will also offer you a small gift as a thank you for being involved. If there is anyone you know, who has not been invited and who you think would like to participate, please pass on the invitation to them.

This focus group will be part of my Master's thesis at the University of Northern B.C., and also part of a study that I am doing for CINHS. For my thesis, I am trying to answer four questions:

- 1) How do Aboriginal people who use mental health services think about mental health and illness?
- 2) How can Aboriginal Elders help these Aboriginal clients?
- 3) How do health care providers think about mental health and mental illness? And,
- 4) How do different perspectives on mental health and illness affect the experience of Aboriginal clients when they use mental health services?

The project that I am doing for CINHS is a report on how Aboriginal Elders can make health care more accessible to clients. It is our hope that the learning we receive from this circle will help to improve health and healing for the benefit of future generations.

The focus group will be recorded, and afterwards I will send everyone a copy of the transcript, so that if I have written anything down wrong, or if you'd like to take anything out, you can make those changes and send them back to me. If you would like a copy of my thesis once it's finished, just let me know.

If you are interested in participating, please contact me at the phone number or email address below, or talk to Leonard or a member of the Aboriginal Caucus. Thank you!

Sincerely,

Sarah Nelson  
250-981-6695  
snelson@unbc.ca

**APPENDIX E – Interview invitation letter**

You are invited...

March 31, 2011

You are respectfully invited to participate in an interview for a study being undertaken at the Central Interior Native Health Society (CINHS). We would like to talk with you about mental health and mental illness and what these things mean to you, as well as the role of Aboriginal Elders in health care and your experiences or ideas about how Aboriginal Elders can work with other health care providers in a clinical setting. This study is being undertaken by myself (Sarah Nelson) along with Leonard Ward, Jane Inyallie, Lynette LaFontaine, Louise Creyke, and other members of the Aboriginal Caucus of CINHS.

These interviews will be part of my Master's thesis at the University of Northern B.C., and also part of a study that we are doing for CINHS. For my thesis, I am trying to answer four questions:

1. How do Aboriginal people who use mental health services think about mental health and illness?
2. How can Aboriginal Elders help these Aboriginal clients?
3. How do health care providers think about mental health and mental illness? And,
4. How do different perspectives on mental health and illness affect the experience of Aboriginal clients when they use mental health services?

The project that we are doing for CINHS is a report on how Aboriginal Elders can make health care more accessible to clients. It is our hope that the learning we receive from these interviews will help to improve health and healing for the benefit of future generations.

The interview will take about an hour, and with your permission I will make a digital recording of our talk. A member of the Aboriginal Caucus will be present during the interview. Those who participate in interviews will be offered a \$10 gift card as a small thank you for participating. Afterwards I will give you a copy of the transcript, so that if you'd like to change anything you can. If you would like a copy of my thesis when it's finished, just let me know.

If you are interested in participating or have any questions, please feel free to contact me at the phone number or email address below, or talk to Leonard or a member of the Aboriginal Caucus. Thank you!

Sincerely,

Sarah Nelson  
250-981-6695



snelson@unbc.ca

**APPENDIX F – Information and consent letter (interviews)**

Interpretations of Mental Health and Illness: Implications for Services in Prince George  
MA Thesis – Sarah Nelson, University of Northern BC  
[snelson@unbc.ca](mailto:snelson@unbc.ca) – (250)981-6695

- **Purpose and goals of the research**

The purpose of this project is to examine different ways in which we understand mental health and mental illness. I am exploring the experiences of Aboriginal clients seeking care, Aboriginal Elders providing care, and other health care professionals providing treatment for mental illness.

My research will address the following broad questions: How do Aboriginal people using mental health services conceptualize mental health and mental illness? How do health care providers and Aboriginal Elders conceptualize mental health and mental illness? How do the services of an Aboriginal Elder meet the needs of Aboriginal clients seeking mental health care? And how do the perspectives of clients and providers have an impact on the experience of Aboriginal clients when they access treatment for mental illness or mental health problems?

- **How information will be used**

The information that I gather will be used to write a thesis, towards the completion of my Master of Arts degree in First Nations Studies at the University of Northern British Columbia. Some of this information will also be used to write a paper for the Central Interior Native Health Society, which will be used to apply for funding for the organization. It is possible that some of my results will be used to write a paper that may be published in an academic journal, or to prepare a presentation to be given at an academic conference.

- **Risks and benefits**

Potential benefits from this study are the inclusion of diverse voices in discussion about mental health care and new perspectives on what mental health and illness mean. There is the possibility of improving mental health services, or at least making people think about alternative ways of offering mental health care. Potential risks to participants include the possibility that sensitive subjects may be brought up related to mental health, and discussing these subjects may result in experiencing negative emotions. If you feel uncomfortable at any point you are free to stop the interview.

- **Your role as a participant**

You have been asked to participate in this study because of your experience in mental health services. If you agree to participate, a one-on-one interview with the researcher will be scheduled at a time that works for you. This interview will address questions about how you and others think about mental health and illness. The interview will take approximately 1 hour and, with your permission, will be recorded. If you do not wish to be recorded, I will

take notes, or work from memory if you prefer. After the interview, you will be sent a copy of your interview transcript or my notes regarding the interview; feel free to make any corrections. If you make corrections, I will send you the revised version of your transcript for you to verify.

If you wish to have your own copy of the completed thesis, please let me know.

If you agree to participate, you may withdraw from the study at any time, without prior notice, without consequences, and without being asked to explain why. If you choose to withdraw, all of your information will be withdrawn as well, and immediately destroyed.

- **Anonymity and confidentiality**

If you agree to participate in this study, your responses will be kept anonymous. Your name will not be used, nor will any information or quotes that may allow others to identify you. Your name will only be used if you specifically request that it be included in the final reporting of results. If you choose to include your name, remember that your information may be used for purposes other than the thesis – such as a paper or a presentation.

Your responses in the interview will be kept confidential and read only by myself and possibly by a research assistant in transcription services at the University of Northern British Columbia. The research assistant will be recruited to help me transcribe the interviews, and will have signed a confidentiality agreement which states that the research assistant will not disclose your information to anyone other than their manager, and that all information will be kept either password-protected on their computer or in a locked cabinet. After the transcription has been completed, all information in their possession will be either handed back to their manager (who will pass it on to me), or destroyed.

While in my possession, the information from your interview will be stored on my personal computer and protected by a password. A backup copy on a USB key, and a paper copy, will be kept in a locked cabinet, either in my office at the University or at my home, or on my person. I will not copy the information to any other computer, or share the information with anyone other than the research assistant, as explained above.

I will keep your information until I have completed writing and defending my thesis, and have graduated from the University of Northern British Columbia. After graduation, I will erase all files from my computer and the USB key, and destroy all paper copies. This will happen, at the latest, by December of 2013.

- **Contact information**

Should you have any questions or concerns, or if you would like a copy of the research results at any time, please feel free to contact me:

Sarah Nelson  
(250)981-6695

[snelson@unbc.ca](mailto:snelson@unbc.ca)

To contact my thesis supervisor:

Josée Lavoie  
(250)960-5283  
[jlavoie0@unbc.ca](mailto:jlavoie0@unbc.ca)

If you have any complaints or concerns about this project or how the research is being conducted, please contact the Office of Research at the University of Northern British Columbia:

Office of Research  
(250)960-5650  
[reb@unbc.ca](mailto:reb@unbc.ca)

---

I will fulfill my obligations to those who participate in this study, as outlined in this letter:

---

Sarah Nelson

I have read and understand this letter and agree to participate in this study:

---

*Signature of participant*

I have received a \$10 gift card from Tim Horton's or The Pastry Chef as a thank you for participating in this study:

---

*Signature of participant*

Participant's mailing and/or email address:

---

---



**APPENDIX G – Information and consent letter (talking circles)**

Interpretations of mental health and implications for mental health services in Prince  
George

Sarah Nelson

University of Northern British Columbia

- **Purpose and goals of the research**

I am hoping to find out how Aboriginal patients, Aboriginal Elders, and health care professionals understand mental health and mental illness. Mental health services are often offered in a way that makes Aboriginal - and many other - patients uncomfortable. This is partly because mainstream health care takes a different perspective on mental health than many Aboriginal clients do. I am trying to find out what some of these different perspectives are, and how mainstream health care could change to include them. Aboriginal Elders and health care professionals will be included in the talking circle/focus group, and I will talk with clients in one-on-one interviews.

For my thesis, I am trying to answer four questions: 1) How do Aboriginal people who use mental health services think about mental health and illness? 2) How can Aboriginal Elders help these Aboriginal clients? 3) How do health care providers think about mental health and mental illness? And, 4) how do different perspectives on mental health and illness affect the experience of Aboriginal clients when they use mental health services?

- **How information will be used**

The information that I gather will be used to write a thesis, towards the completion of my Master of Arts degree in First Nations Studies at the University of Northern British Columbia. Some of this information will also be used to write a paper for the Central Interior Native Health Society (CINHS), which will be used to apply for funding for the organization. Also, my results will probably be used to write a paper for an academic journal, or to prepare a presentation to be given at an academic conference.

- **Risks and benefits**

Potential benefits from this study are the inclusion of Aboriginal voices in discussion about mental health care and new perspectives on what mental health and illness mean. There is the possibility of improving mental health services, or at least making people think about alternative ways of offering mental health care. Potential risks to participants include the possibility that sensitive subjects may be brought up related to mental health, and discussing these subjects may result in experiencing negative emotions. If you feel uncomfortable at any point you are free to leave the discussion, and if you feel that you need to follow up your interview with further conversation, please let me or another focus group facilitator know. There will be no consequences to you for seeking help.

- **Your role as a participant**

You have been asked to participate in this study because of your knowledge and experience related to Aboriginal communities and worldviews, and/or mental health services which serve Aboriginal people. If you agree to participate, you will be part of a focus group meeting (a talking circle) held in February or March, 2011. The purpose of this circle will be to discuss questions about mental health and illness, and about the roles Elders can or do play in health care. Each focus group will meet for approximately four hours and will be digitally recorded. After the meeting, you will be sent a transcript of the discussion; feel free to make any corrections.

If you are interested in participating in a one-on-one interview as well as participating in the talking circle, please feel free to contact me.

At the end of the study, a bound copy of the complete thesis will be available at Central Interior Native Health Society (CINHS) if you wish to read it, or you can ask me for your own copy.

If you agree to participate, you may withdraw from the study at any time, without prior notice, without consequences, and without being asked to explain why. If you choose to withdraw, all of your information will be withdrawn as well, and immediately destroyed.

- **Anonymity and confidentiality**

If you agree to participate in this study, your responses will be kept anonymous. Your name will not be used, nor will any information or quotes that may allow others to identify you. Your name will only be used if you specifically request that it be included in the final reporting of results. If you choose to include your name, remember that your information may be used for purposes other than the thesis – such as a paper or a presentation.

Your responses in the interview will be kept confidential and read only by myself and by a research assistant in transcription services at the University of Northern British Columbia. The research assistant will be recruited to help me transcribe the interviews, and will have signed a confidentiality agreement which states that the research assistant will not disclose your information to anyone other than their manager, and that all information will be kept either password-protected on their computer or in a locked cabinet. After the transcription has been completed, all information in their possession will be either handed back to their manager (who will pass it on to me), or destroyed.

While in my possession, the information from your interview will be stored on my personal computer and protected by a password. A backup copy on a USB key, and a paper copy, will be kept in a locked cabinet in my office at the University, at my home, or on my person. I will not copy the information to any other computer, or share the information with anyone other than the research assistant, as explained above.

I will keep your information until I have completed writing and defending my thesis, and have graduated from the University of Northern British Columbia. After graduation, I will

erase all transcript files from my computer and the USB key, and destroy all paper copies. This will happen, at the latest, by December of 2013.

- **Contact information**

Should you have any questions or concerns, or if you would like a copy of the research results at any time, please feel free to contact me:

Sarah Nelson  
(250)981-6695  
[snelson@unbc.ca](mailto:snelson@unbc.ca)

To contact my thesis supervisor:

Josée Lavoie  
(250)960-5283  
[jlavoie0@unbc.ca](mailto:jlavoie0@unbc.ca)

If you have any complaints, questions or concerns about this project or how the research is being conducted, please contact the Office of Research at the University of Northern British Columbia:

Office of Research  
(250)960-5650  
[reb@unbc.ca](mailto:reb@unbc.ca)

---

I will fulfill my obligations to those who participate in this study, as outlined in this letter:

---

Sarah Nelson

I have read and understand this letter and agree to participate in this study:

---

*Signature of participant*

I have received a \$10 gift card from Tim Horton's or The Pastry Chef as a thank you for participating in this study:

---

*Signature of participant*



Participant's mailing and/or email address:

---

---

---

---

---

---