

UNDERSTANDING DEPRESSION IN ABORIGINAL COMMUNITIES AND FAMILIES

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INTRODUCTION



Depression is a common mental disorder that affects both males and females in every age group and is found across cultures. An investigation into the global burden of disease found depressive disorders to be the second leading cause of disability worldwide (Ferrari et al., 2013). Depression is characterized by a combination of emotional, cognitive, physical and behavioural symptoms (American Psychiatric Association [APA], 2013; Oltmanns, Emery, & Taylor, 2006). Depressed persons often experience sad mood, disturbed sleep, poor concentration, feelings of guilt or low self-worth, loss of interest in pleasurable activities, marked loss of libido, decrease in energy and, in worse cases, thoughts of suicide (APA, 2013; World Health Organization [WHO], 2008). These symptoms may become chronic or reoccur over the lifespan and can lead to substantial functional impairments resulting in an inability to participate in everyday activities and responsibilities (WHO, 2010). In addition to substantially reducing quality of life for sufferers and their families, severe cases of depression can lead to completed suicide. Due to the substantial burden of depression on individuals, families and communities, the prevention and treatment of depression has become an important public health issue.

The aim of this paper is to examine depression from a cross-cultural approach and acknowledge views of Aboriginal peoples across Canada in the context of mental health and wellness. *Culture* as a concept may refer

to symbolic systems of values, beliefs, and shared understandings that bring meaning to the world for a particular group of people (Birx, 2010). This paper will begin by providing a brief outline of symptoms of depression, followed by a discussion of depression across cultures and the known prevalence of depression among Aboriginal peoples in Canada. Selected risk factors for depression are also considered within the historical context of Aboriginal peoples in Canada. Finally, the paper will conclude by examining some health consequences related to depression as well as a discussion of Western and Aboriginal approaches to healing.

Relevant research concerning depression and Aboriginal peoples was identified through a systematic literature search. The databases PsycINFO, PubMed and PsycARTICLES were searched using combinations of the keywords Depression and Prevalence; Depression and Aboriginal; Depression and Risk; Depression and Gender; Depression and Treatment; Depression and Health; Culture and Depression; Depression and Attachment; Intergenerational and Depression; Aboriginal and Healing; Aboriginal and CBT; Spirituality and Resilience; Spirituality and Mental health; Spirituality and Depression. Preference was given to the most current research and for studies that included Aboriginal populations. The specific journals *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health* and *Transcultural Psychiatry* were also searched with the key terms. Articles and books that were suggested

by peer reviewers were also reviewed. All searches were limited to articles published in English.

Throughout this paper, the term 'Aboriginal peoples' refers to all of the original peoples of Canada and their descendants. The Canadian constitution recognizes three separate groups of Aboriginal peoples: First Nations, Inuit and Métis (Aboriginal Affairs and Northern Development Canada [AANDC], 2013). These groups represent distinct peoples with unique histories, language, culture, and spiritual practices and beliefs (AANDC, 2013). Within these three defined groups of Aboriginal peoples there is enormous diversity, with more than 60 different languages within 12 major language families (Statistics Canada, 2012). Aboriginal languages are important, as they are a part of distinct identities, histories, and cultures. Language also represents connections to the land, family, community, and traditional knowledge (Norris, 2007). The use of 'Aboriginal peoples' as a blanket term is highly misleading given the vast diversity that exists between groups (Kirmayer, Tait, & Simpson, 2009). However, early European colonization and the colonial policies of Canadian governments have resulted in common political, social, and economic challenges for Aboriginal peoples across Canada, which to a degree has created a collective identity across many diverse Aboriginal groups (Kirmayer, Tait, & Simpson, 2009).

UNDERSTANDING DEPRESSION



Diagnostic features of depression

Clinical guidelines for the diagnosis of depressive disorders may be found in *The Diagnostic and Statistical Manual of Mental Disorders 5th edition* (APA, 2013). There are several categories of depressive disorders, which are differentiated by duration, timing, and presumed causes. While it is beyond the scope of this paper to cover all symptoms and diagnostic guidelines for each type of depressive disorder, common features of depression are discussed. Among all depressive disorders is the presence of sad, empty or irritable mood accompanied by physical and cognitive changes (APA, 2013). Cognitive changes may include reduced concentration and attention, thoughts of low self-worth, and reduced self-confidence. Pessimistic anticipation of the future and ideas of guilt or of self-harm are also associated with depression (WHO, 2008). Physical changes accompanied with depression include, but are not limited to, loss of appetite, weight loss, low libido and disturbed sleep, including insomnia or excessive sleep (WHO, 2008). Unexplained aches and pains often accompany depression, and individuals may also experience a loss of energy, fatigue or lethargy (WHO, 2008). Diagnosis of mild, moderate or severe depression relies on a complicated clinical judgment that takes into account the type, number, and severity of symptoms present (WHO, 2008). While the experience of

sadness is normal, prolonged, persistent feelings of depression over time is not (Oltmanns et al., 2006).

Prevalence of depression among Aboriginal peoples in Canada

Studies have found that compared to the general population, depression rates for Aboriginal people are higher for both males and females residing either on or off reserve. For example, data collected for the *First Nations Regional Longitudinal Health Survey* (2002/03) indicated that 25.7% of First Nations men and 34.5% of First Nations women living on reserves reported they felt sad or depressed for two weeks or more in the past year (National Aboriginal Health Organization [NAHO], 2006). Aboriginal people living off reserve have also shown increased levels of depression compared to the general population (13.2% vs. 7.3%) (Tjepkema, 2002). An examination of race, ethnicity and depression in Canada found that Aboriginal groups reported higher levels of depression symptoms and more episodes of major depression compared to English (Caucasian) Canadians (Wu, Noh, Kasper, & Schimmele, 2003). However, not all studies indicate Aboriginal peoples in Canada have higher rates of depression compared to the general population. In a rural community in British Columbia, Aboriginal residents had similar rates of depression/anxiety disorders compared to non-Aboriginal residents in the

same area (Thommasen, Baggaley, Thommasen, & Zhang, 2005). However, the study was based on the diagnosis of one clinician and included only help-seeking individuals within the area. As a result, the findings may not be generalizable to the wider population. A study examining depression rates in Manitoba found that at the provincial scale, Métis had similar rates of depression (22.0%) compared to the general population (20.4%); however in some regions the Métis rate was higher (such as in urban Brandon where the rate of depression for Métis was 28.9% compared to 22.9% of the general population) (Martens et al., 2010). In Nunavut, 9% of a sample of 1710 Inuit indicated they felt so depressed nothing could cheer them up, a rate that is only slightly higher than the diagnosis of major depression in the general population (8%) across Canada (Galloway & Saudny, 2012). While a survey cannot diagnose depression, these results indicate substantial variability in depression rates among Aboriginal communities in Canada.

Although there is limited information available to provide a clear picture of the prevalence of depression in Aboriginal populations across Canada, high rates of suicide may, in some cases, be an indicator of high rates of depression. Research has indicated that suicide in Aboriginal populations is a complex issue influenced by many different personal, historical and contextual factors (Kirmayer, Brass, Holton, Paul, Simpson, & Tait, 2007). There is

great variability in suicide rates among Aboriginal communities across Canada, with some communities suffering extremely high rates while others reporting no suicides (Kirmayer, Tait, & Simpson, 2009). Nevertheless, as a whole, suicide rates are much higher for Aboriginal peoples in Canada when compared to the general population. For example, the Centre for Suicide Prevention (2013) reports that suicide rates for Aboriginal males age 15 to 24 are 126 per 100,000 compared to 24 per 100,000 for non-Aboriginal male youth. Suicide rates for Aboriginal females of the same age group are 35 per 100,000 compared to 5 per 100,000 for non-Aboriginal females (Centre for Suicide Prevention, 2013). Numbers of suicide attempts are also disproportionately high among Inuit in Nunavut; with 29% of Inuit having attempted suicide at least once in their lifetime (Galloway & Saudny, 2012).

Suicide is not thought to be the result of any single cause but may occur in some individuals as a result of complex relations between personal and social factors (Kirmayer et al., 2007). While the authors do not wish to present an oversimplified view that suicide in Aboriginal communities is solely the result of depression, depression has been shown to be associated with higher risk of suicide in Aboriginal peoples in North America as well as in other countries. In a review of 23 studies investigating Indigenous youth suicide in North America, New Zealand and Scandinavia, depression and having a friend who committed suicide were the two strongest factors predisposing an individual to suicidal ideation, attempts, and completions (Harder, Rash, Holyk, Jovel, & Harder, 2012). Given the substantially higher suicide rates for young Aboriginal people, the possibility of individuals struggling with depression is an important topic for research and investigation.





INDIVIDUAL INTERACTIONS FAMILIES LAND COMMUNITIES SOCIETY

Depression across cultures

Researchers who study depression across cultures face many challenges as the disorder has been defined by Western diagnostic and classification systems (Tsai & Chentsova-Dutton, 2009). The Western view of the individual as autonomous and self-contained has shaped the diagnosis of depression and locates the illness within the individual (APA, 2013). The Western viewpoint of mental health asserts that an individual should have positive emotions and feel good about one's self (Tsai & Chentsova-Dutton, 2009). This emphasis on the individual leads to the assumption that depressive symptoms are a product of internal processes (thoughts, perceptions and feelings) that are separate from the social world (Tsai & Chentsova-Dutton, 2009). This focus on the individual in psychology does not take into account that many of the challenges people face involve

interactions with families, communities and the wider social world (Kirmayer, Tait, & Simpson, 2009). The Western view of the individual does not reflect the views of cultures that consider the individual to be interdependent and connected to society (Tsai & Chentsova-Dutton, 2009). As a result, several researchers have expressed concern that the diagnosis of depression cannot, without question, be generalized to non-Western societies (Jenkins, Klienman, & Good, 1991).

From the perspective of many Aboriginal worldviews, Western conceptualizations of mental health are too simplistic and do not reflect holistic, traditional understandings (Vukic, Gregory, Martin-Misener, & Etowa, 2011). The Aboriginal view of mental health acknowledges the connection between the individual and the collective, and is reflective of the balance that is achieved between

physical, emotional, cognitive, and spiritual dimensions (Blackstock, 2008). As an integrated holistic approach, interventions focus on the individual's well-being within the context of relationships to other people as well as to the land (Blackstock, 2008). This holistic model for healing is often represented with the medicine wheel where each dimension reflects an equal portion of the whole; however, different Aboriginal communities may express the model differently according to their own teachings and cultures (Blackstock, 2008).

Culture and explanatory models of depression

In the field of psychology, the biopsychosocial model has been adopted as a method of explanation for mental illness whereby biological, psychological, and social processes interact in complex



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TRADITIONAL WORLDVIEWS HOLISTIC COLLECTIVE SPIRITUAL BALANCE

and unique ways that can result in increased vulnerability to mental illness (Koehn & Hardy, 2007). While this model is more comprehensive than the traditional Western biomedical model, it is still regarded as incomplete compared to a holistic view of health and wellness. In a classic article outlining an argument for the need for a new medical model, Engel (1977) explained:

Broadly defined, a model is nothing more than a belief system utilized to explain natural phenomena, to make sense out of what is puzzling or disturbing. The more socially disruptive or individually upsetting the phenomenon, the more pressing the need of humans to devise explanatory systems. (p. 196)

The predominant message in Engel's argument is that the development of models that are used to identify and explain illness are based on culturally

derived beliefs and worldviews. The comprehension that any theory of knowledge, including Western methods of empiricism, evolves out of a belief system allows for the understanding that one system of knowledge is not superior to another. Duran (2006) argues that the use of Western empiricism to validate Indigenous knowledge is a method of colonization as this process assumes Western knowledge is superior to Indigenous knowledge. Duran further explains that Indigenous knowledge should be accepted as valid simply because it is, and the attempt of colonial powers to maintain control over the validation of Indigenous knowledge is a process of colonization. He points out that spirituality is an essential part of mental health and even though the terms 'soul' and 'spirit' may make some researchers uncomfortable because they are not a part of Western psychology, the root word of psychology (psyche) is Greek in origin and translates into soul.

By extension, *psychology* translates into "study of the soul" and psychotherapist translates into "soul healer" (pg. 19). While Western researchers have developed explanations for the increases in risk for mental illness in Aboriginal communities as a result of colonialism and historical trauma (see next section below), Duran (2006) has found many Indigenous peoples describe the effects of colonialism as ancestral hurt or spiritual injury. With the acceptance that there is more than one way to know the world, Western counsellors may begin to participate in, and contribute to, the process of healing for Indigenous peoples in a culturally appropriate way (Duran, 2006).

A large, rounded, reddish-brown rock formation dominates the right side of the frame, sloping downwards towards the left. The rock has a textured surface with some darker spots. In the background, a vast, flat, brownish landscape stretches to the horizon under a sky filled with scattered white and grey clouds. The lighting suggests a bright day, possibly late afternoon or early morning.

The colonization and forced assimilation of Aboriginal peoples in Canada are considered to be the root causes of the elevated levels of social and mental distress found in many Aboriginal communities today (Kirmayer, Tait, & Simpson, 2009).

ROOT CAUSES OF DEPRESSION AMONG ABORIGINAL PEOPLES



Colonization and forced assimilation: Increased risk and loss of protective factors for depression

The colonization and forced assimilation of Aboriginal people in Canada are considered to be the root causes of the elevated levels of social and mental distress found in many Aboriginal communities today (Kirmayer, Tait, & Simpson, 2009). The arrival of Europeans brought multiple levels of trauma for Aboriginal peoples, with the official condemnation of their religions and cultures, and the loss of rights to raise and educate their own children (Chandler & Lalonde, 1998). Aboriginal children became a main target in the strategy to eradicate Aboriginal cultures, and over the span of 100 years many Aboriginal children were separated from their parents and placed into residential schools where they were often subjected to multiple forms of abuse (Kirmayer, Tait, & Simpson, 2009). The trauma experienced by the removal of Aboriginal children from their families was not isolated to specific children but disrupted the cohesiveness of entire communities (Corrado & Cohen, 2003).

The residential school experience contributes to increased risk of depression in Aboriginal peoples in

Canada through multiple pathways, including through broken attachment relationships that resulted from children's separation from their parents, extended families and communities. In addition, many children were subjected to physical, psychological, sexual, and spiritual abuse (Corrado & Cohen, 2003). These experiences impacted a child's view of self and his/her ability to cope during periods of stress. Moreover, the negative impacts on Aboriginal children and their communities that occurred during the residential school era are not limited to the generations who attended the schools (Bombay, Matheson, & Anisman, 2009). A considerable amount of evidence exists to show traumatic events that have occurred on a collective level are often transmitted across generations and affect not only the children, but also the grandchildren of the original victims (Bombay et al., 2009).

Broken attachment relationships

The removal of children from their families over consecutive generations is a significant factor in the development of depression in many Aboriginal peoples in Canada. Studies have shown that separation from a parent during childhood is associated with increased risk for depression in adulthood (Amato, 1991). The link between depression

and broken parent-child attachment relationships may be found through two pathways: the development of the child's biological systems that are responsible for resilience to stress and the development of the child's view of the self in relation to others. During infancy, the attachment relationship functions to regulate the infant's stress levels by reducing negative emotion and stress through comforting contact with the parent (Schore, 2001a). This process is vital to the development of later resilience in the face of stress, as the early relationship with parents provides the building blocks for developing self-regulation of negative emotion and stress (Schore, 2001b). Children who do not have the opportunity to develop secure attachment relationships have difficulties regulating the intensity and duration of negative emotions (Schore, 2001b). Children who have difficulties managing negative emotions such as frustration and anxiety are more vulnerable to depression as they may become passive and helpless in the face of stress (Weinfield, Sroufe, Egeland, & Carlson, 2008). Additionally, these children may also experience feelings of alienation from others as difficulties managing negative emotions often places strain on social relationships (Weinfield et al., 2008).

The attachment relationship during early childhood also plays an important role in how children learn to view

themselves within relationships. For example, Cicchetti and Toth (1998) argue that parental accessibility and involvement within a healthy relationship is associated with the development of feelings of acceptance and value in the child. In contrast, parental unavailability or rejection leads to feelings and beliefs of unworthiness of care and love in the child. Consequently, disrupted attachment relationships and failure to develop a healthy relationship with parents or other close adults can result in increased vulnerability to future mental disorders due to deficits in coping with stress and difficulties in managing negative emotions (Schoe, 2001a).

During the residential school era, Aboriginal children often did not have access to their parents, extended family or members of their communities to help them cope with stress and develop healthy self-esteem in which the self is viewed as valuable and acceptable. In addition, accounts of an abusive environment in residential schools

indicate that the children did not have access to supportive adults within the schools who could provide a healthy attachment relationship and help them learn to view themselves as accepted and worthy of love and support. As a result, several generations of Aboriginal peoples were not given the opportunity to develop healthy views of the self and resilience to stress. The loss of these important protective factors has contributed to an increased vulnerability to develop depression over generations.

Physical, psychological, sexual and spiritual abuse

Residential school survivors have recounted devastating levels of physical, psychological, and sexual abuse suffered at the hands of residential school staff (Corrado & Cohen, 2003). Basic necessities for survival were often not supplied to the children and many suffered from malnutrition due to inadequate diet (Milloy, 1999). Unclean and unsafe living conditions resulted in epidemic proportions of disease whereby many (exact numbers were not kept) students died of tuberculosis (Milloy, 1999). Children suffered corporeal punishment, which was often unpredictable, as a method to enforce school rules, increasing their fear and anxiety (Corrado & Cohen, 2003). This psychological abuse, compounded by children's loneliness resulting from isolation from their families and communities and being exposed to ridicule and unkind treatment, placed these children at enormous risk to develop depression. Sexual abuse was also extremely common. While exact rates of abuse are not known (Corrado & Cohen, 2003), former students have reported a wide range of abuses from fondling to rape to sodomy (Haig-Brown, 1988). An analysis of various forms of child maltreatment and links to depression in mainstream society found adults with a history of sexual abuse were at the greatest risk for developing depression (Brown, Cohen, Johnson,

& Smailes, 1999). Additionally, risk of suicide attempts was eight times higher for youth with a history of sexual abuse (Brown et al., 1999).

Further, it is important to mention that a significant level of spiritual trauma was also inflicted upon children who attended residential schools. Residential schools were religious organizations whose teachings were focused not only on general education but also aimed to remove cultural identity, spiritual traditions, and language from Aboriginal people (Quinn, 2007). As one residential school student recalled, they were taught that all aspects of Aboriginal culture and tradition were evil and sinful and were forbidden to speak their language, dance, sing, or practice their ways (Haig-Brown, 1988). Other residential school students have recounted being taught to feel ashamed of themselves and their families (Haig-Brown, 1988). Moreover, the trauma of being subjected to sexual abuse while simultaneously being taught that anything sexual was dirty and sinful potentially increased considerably the trauma experienced by children.

Researchers are beginning to acknowledge the importance of spirituality in resilience against mental disorders. Hatala (2013) argues that spirituality is an important protective factor which not only increases resilience during times of stress and hardship, but also aids in healing. Similarly, in an account of his experiences in a holocaust camp, Frankl (1984) suggested that spiritual freedom allows life to be meaningful and purposeful, and is critical to one's ability to cope with stressful circumstances. Unfortunately spiritual teachings in residential schools may have been used to induce fear and guilt as a means to control, and may have been an additional source of trauma for some children. As a result, the potential for religion to function as a protective factor in the lives of residential school children may have been lost.

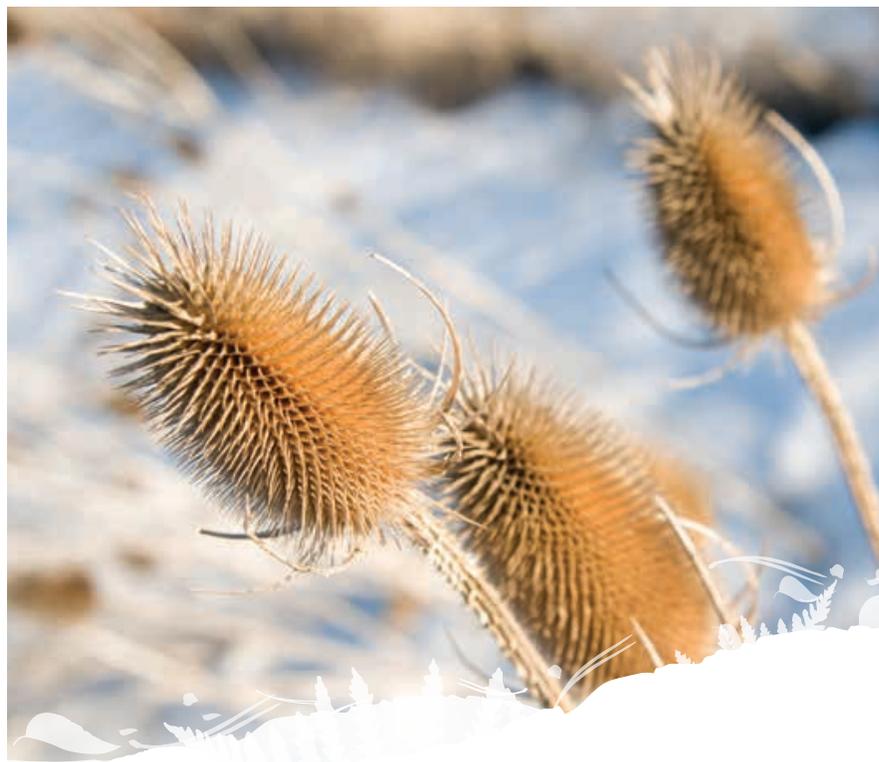


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Overall, the residential school system removed important protective factors required for children's well-being while simultaneously exposing them to multiple levels of risk for depression and other mental disorders. Removal from parents prevented children from developing resilience in the face of stress, and from developing and maintaining positive and healthy views of the self. Spiritual teachings in residential schools focused on introducing powerful feelings of guilt and shame in children and, as a result, potentially compounded the effects of psychological, physical, sexual abuse, and trauma. The removal of several important protective factors coupled with multiple forms of trauma placed enormous risk for the development of depression in past generations. Unfortunately, these effects are not limited to the individual. Evidence shows depression also has a profound impact on parenting and therefore places future generations at significant risk to develop depression.

Intergenerational transmission of depression

The consequences of residential school trauma are not limited to the mental health of past generations (Quinn, 2007). High rates of depression in Aboriginal communities place children and families at risk. Many studies from mainstream populations have linked maternal depression with higher rates of depression in children (e.g. Goodman & Tully, 2008), as well as increased rates of child behaviour problems (Brennan, Hammen, Andersen, Bor, Najman, & Williams, 2000). Some explanations regarding why children of depressed mothers are at an increased risk for a variety of problems focus on the social environment of the home. For example, children of depressed parents are exposed to, and learn from, the mother's or father's maladaptive or negative world views, behaviours, and emotions (Goodman & Gotlib,



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1999). Further, children of depressed parents are exposed to increased levels of stressful conditions in the family home such as increased levels of parental conflict, separation, and divorce (Goodman & Gotlib, 1999). Additionally, studies suggest children of depressed parents often do not develop healthy self-esteem and have difficulty cultivating healthy social relationships. For example, Hammen and Brennan (2001) found that depressed adolescents who were raised by depressed mothers have greater interpersonal dysfunction, higher levels of conflict in their relationships, and higher rates of stressful life events. These depressed adolescents were found to have dysfunctional cognitions (thoughts) about the social world and their role in it. They were also found to have fewer friends and reported they felt more insecure in their relationships.

Further, data collected from mainstream population studies have shown that children of depressed mothers

have elevated cortisol levels due to dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis (Guerry & Hastings, 2011). Specifically, in an analysis of several studies investigating HPA axis functioning in children of depressed mothers, Guerry and Hastings (2011) found elevated cortisol levels in children from six months of age to young adulthood. These findings indicate parental depression is associated with vulnerabilities in physiological regulation of stress in children of depressed mothers. Depressed adolescents show increased HPA axis activity in response to stress with slower recovery in comparison to non-depressed adolescents demonstrating deficits in regulation of the biological stress response (Lopez-Duran, Kovacs, & George, 2009). Ongoing dysregulation of stress may set the stage for the development of depression in children of depressed parents.



...depressed persons have more difficulty in self-care once they are already ill, and are less likely to adhere to treatment and lifestyle changes (Lichtman et al., 2008).

HEALTH IMPACTS OF DEPRESSION



Health, as defined by the World Health Organization's constitution, "is a state of complete physical, mental and social well being" (WHO, 2006, p. 1). Dr. Brock Chisholm, the first Director General of the World Health Organization, brought to attention the importance of the connection between mental and physical health in 1954, when he stated "without mental health there can be no true physical health" (Kolappa, Henderson, & Kishore, 2013, p. 3). Over the last few decades, substantial evidence has emerged that supports the strong relationship between mental and physical health, especially with respect to depression and anxiety. For example mainstream population studies have indicated depressed people are more than twice as likely to smoke cigarettes and have a lower self-reported quit rate compared to smokers without depression (Lasser, Boyd, Woolhandler, Himmelstein, McCormick, & Bor, 2000).

Overall we have learned from the mainstream studies that depression has a negative impact on physical health as it increases the risk of a variety of physical illnesses. Depression has been found to increase the risk of developing Type 2 diabetes (Cosgrove, Sargeant, &

Griffin, 2008), and is associated with increased morbidity and mortality rates in patients with coronary heart disease (Lichtman et al., 2008). In addition, depressed persons have more difficulty in self-care once they are already ill, and are less likely to adhere to treatment and lifestyle changes (Lichtman et al., 2008).

The connection between mental and physical illness is especially a concern for Aboriginal peoples given the substantially higher prevalence of chronic physical diseases among them compared to the general population (Reading, 2009). While there are variations across regions and sometimes within regions, the prevalence of diabetes over the last two decades has risen considerably in Aboriginal peoples (Public Health Agency of Canada [PHAC], 2011). For example, First Nations people living on reserve represented the highest proportion of the Canadian population reporting a diabetes diagnosis followed by First Nations living off reserve (PHAC, 2011). The Métis prevalence rate for diabetes was similar to First Nations living off reserve; however, the Inuit population rate of diabetes was comparable to the general population (PHAC, 2011). First Nations and Métis

children are also being diagnosed with Type 2 diabetes at an earlier age compared to the general population (PHAC, 2011). Additionally, Aboriginal people in Canada have higher rates of ischemic heart disease (IHD) compared to the general population and, importantly, the rates of IHD are not declining as it is in the general population (Reading, 2009).

Given the evidence regarding the inter-relationship between mental and physical health, there has been a call for developing a global strategy for the prevention and control of non-communicable disease to incorporate mental health interventions into primary care (Kolappa et al., 2013). The incorporation of mental health interventions, specifically for depression and anxiety, will ultimately reduce the global burden of non-communicable disease (Kolappa et al., 2013). Within Canada, incorporating culturally appropriate mental health interventions for Aboriginal peoples is important to reduce not only the burden of mental illness, but will also to aid in reducing the burden of chronic physical diseases as well.



...counselling and intervention services that incorporate culturally important aspects such as facilitating connectedness and spiritual healing into practice will meet with greater success.

PATHWAYS TO HEALING



There are many effective treatments for depression. While the Western approach has focused largely on antidepressants (Arroll et al., 2005), other treatment options are available including cognitive behaviour therapy (CBT) and psychosocial support. CBT has been shown to be more effective in comparison to antidepressant medication (Dobson, 1989). However, many Aboriginal people view Western approaches to treatment of mental illness with caution due to the oppressive history of colonization in which Aboriginal worldviews were undermined (Blackstock, 2008). While research indicates Aboriginal people across North America have higher rates of depression, suicide and substance abuse, they often do not seek help from services supplied by the dominant culture (McCormick, 1996). Further, when Aboriginal people do participate in western-based treatment, they are less likely to respond to it and have higher dropout rates compared to other ethnic minorities (McCormick, 1996). Consequently, researchers in the field of Aboriginal health argue it is crucial that any approach to healing or help with depression for Aboriginal people is culturally relevant and appropriate.

Programs developed for Aboriginal people should address healing on both a community and an individual level. Recently, there has been an increase in understanding that if healing practices are to be effective, they must be adapted to local cultural realities and reflect core values (Kirmayer, Fletcher, & Watt, 2009). While all cultures today are open and influenced by diverse sources of

information that allow individuals many different perspectives, there is general agreement that Aboriginal communities share certain guiding principles and beliefs grounded in holistic perspectives of mental wellness (van Gaalen, Wiebe, Langlois, & Costen, 2009).

In an exploration of factors identified as important for healing in a sample of 50 First Nations people across 40 communities in British Columbia, McCormick (1997) identified an overarching theme of interconnectedness as important for healing. Participants felt connecting with family, friends, community members, nature, and culture facilitated healing. In addition, many participants indicated they felt healing was facilitated through establishing a spiritual dimension of themselves through connection to the Creator. Participants in the study gave examples of participating in ceremony and prayer as helpful processes to facilitate healing (McCormick, 1997). The implications of these findings are that counselling and intervention services that incorporate culturally important aspects such as facilitating connectedness and spiritual healing into practice will meet with greater success.

In addition, some researchers argue that it is possible to integrate or blend traditional Aboriginal healing approaches with mainstream approaches for Aboriginal clients (Nabigon & Wenger-Nabigon, 2012). For example, CBT may be compatible with Aboriginal healing approaches as it utilizes strategies to bring about

emotional and behavioural change through changing one's thoughts (Nabigon & Wenger-Nabigon, 2012). A helper who is trained in CBT can incorporate traditional approaches to help him/her with assessment, therapy strategies, and treatment planning. These processes can be built around the structure of traditional teachings and incorporate traditional knowledge (Nabigon & Wenger-Nabigon, 2012). The combination of tools provided in CBT with traditional teachings that incorporate an understanding of a spiritual life enable the two approaches to bring about positive change in Aboriginal clients (Nabigon & Wenger-Nabigon, 2012).

While some Aboriginal peoples in Canada may face challenges finding appropriate care for depression, it is crucial they seek help as depression is treatable and restoration of well-being is possible. Many mainstream therapists are now receiving culturally appropriate training in order to fulfill the needs of Aboriginal peoples (Canadian Collaborative Mental Health Initiative, 2006). In addition, the development of programs that blend traditional Aboriginal healing models with mainstream approaches show promise in addressing the needs of Aboriginal peoples. Successful treatments for depression will not only improve the lives of sufferers and their families, but will also protect the mental health and well-being of future generations.



CONCLUDING REMARKS

Depression is a common mental disorder that occurs in males and females of all ages and has a substantial impact on disability worldwide. Currently, the prevalence of depression among Aboriginal peoples in Canada is unclear as some studies indicate depression rates are higher while other studies show similar or lower rates of depression among Aboriginal peoples in comparison to the general population. Some researchers have formed the hypothesis that high levels of distress in many Aboriginal communities are the direct result of the lasting effects of colonization and forced assimilation. Broken attachment relationships and the experience of psychological, sexual and spiritual trauma have placed past generations at risk to develop depression. As a result, children of depressed parents are also at an increased risk to develop depression through exposure to the depressed parent's maladaptive negative worldviews, behaviours, and emotions and increased stress levels in the family home.

There are many effective treatments for depression. While antidepressant medications have been shown to be effective in the general population, other options are available that have been shown to be effective in

Aboriginal communities. For example, some counsellors have found promising results for CBT with Aboriginal clients. The incorporation of traditional healing strategies into the CBT model allow for a culturally appropriate treatment for Aboriginal peoples who wish to pursue a traditional approach to healing. While some Aboriginal people may encounter difficulties when seeking culturally appropriate therapy, it is vital that they do not give up and continue to seek help as healing is possible and will lead to substantial improvements to the physical and emotional health of the individual.

While depression has been found across all cultures, Western explanatory models of depression have important limitations when applied to cultures that hold holistic understandings of health. Many researchers believe explanatory models designed to address risk factors associated with depression in Aboriginal populations should adopt a holistic perspective that integrates spiritual, physical, cognitive, and emotional dimensions. Further research is necessary to fully incorporate holistic understandings of health when conducting healing as well as developing explanatory models of risk for depression among Aboriginal people in Canada.



RESOURCES

It is important to remember that depression is an illness that affects all members of the global community; therefore education about this disorder and support for those suffering from it is essential for the improvement of the health and well-being of individuals and communities. Health professionals are beginning to understand the necessity of providing culturally appropriate treatment strategies for Aboriginal peoples. The following resources may provide assistance in finding appropriate sources for help.

National Network For Aboriginal Mental Health Research

This website has a database for mental health promotion, prevention and intervention models and programs for Aboriginal peoples. The database allows users to search for specific types of health services with additional options to narrow the focus such as age, location, ethnicity, type of treatment sought and other relevant issues.

<http://www.namhr.ca/>

Mood Disorders Society of Canada

While this website is not designed specifically for Aboriginal peoples, information on depression and other mood disorders, such as bipolar disorders, may be found here. Contact information for finding mental health services is also provided.

<http://www.mooddisorderscanada.ca>

EYAA-Keen Healing Centre Inc.

EYAA-Keen Healing Centre Inc. provides an indigenous, multidisciplinary, treatment program for Aboriginal adults. Individuals have access to an Aboriginal behavioural health specialist, elder or traditional healer to help them deal with trauma or major loss. Individual support, group work and therapeutic training are provided with a view to facilitating both personal and community healing.

<http://eyaa-keen.org/about/>

Za-geh-do-win

Aboriginal Mental Health Services/ Support Directory

This document provides a directory for First Nations mental health services within Ontario.

<http://www.za-geh-do-win.com/PDF/The%20Key.pdf>

My Right Care.ca from the Winnipeg Regional Health Authority

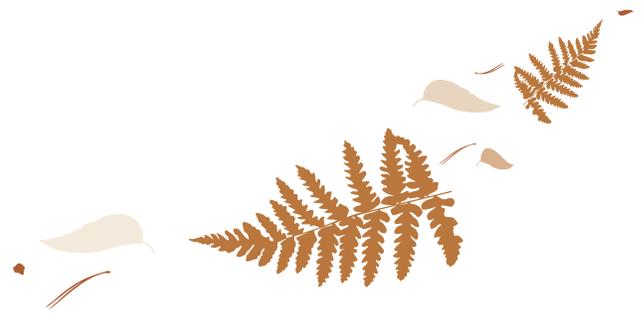
This website is a directory for people in the Winnipeg Region who are looking for healthcare services. The site includes access to mental health services including a crisis response centre and a mobile mental health unit. This website also has a section for Aboriginal Health in which users can find access to Spiritual and Cultural care as well as other relevant information for Aboriginal peoples seeking care in the Winnipeg area.

<http://www.wrha.mb.ca/aboriginalhealth/services/index.php>

Indigenous Cultural Competency Training Program

This website provides information on the Indigenous Cultural Competency training Program that is delivered by the Provincial Health Services Authority of British Columbia. A section for resources is provided where users can find resources for culturally specific services for mental health and addictions. The culturally specific resources are organized into Aboriginal, First Nations, Métis and Inuit groups.

<http://www.culturalcompetency.ca/home>



REFERENCES



- Aboriginal Affairs and Northern Development Canada [AANDC]. (2013). *Aboriginal peoples and communities*. Ottawa, ON: Author. Retrieved June 18, 2014 from <https://www.aadnc-aandc.gc.ca/eng/1100100013785/1304467449155>
- American Psychiatric Association [APA]. (2013). *Diagnostic and statistical manual of mental disorders* (5th Ed.). Washington DC: American Psychiatric Publishing.
- Arroll, B., Macgillivray, S., Ogston, S., Reid, I., Sullivan, F., Williams, B., & Crombie, I. (2005). Efficacy and tolerability of tricyclic antidepressants and SSRIs compared with placebo for treatment of depression in primary care: A meta-analysis. *Annals of Family Medicine*, 3(5): 449-56.
- Amato, P.R. (1991). Parental absence during childhood and depression in later life. *The Sociological Quarterly*, 32(4): 543-56.
- Birx, J. (2010). *21st century anthropology: A reference handbook*. Thousand Oaks, CA: Sage Publications.
- Blackstock, C. (2008). *Rooting mental health in an Aboriginal world view*. Ottawa, ON: Prepared for the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. Retrieved June 3, 2014 from http://www.excellenceforchildandadolescent.ca/sites/default/files/position_aboriginal_world_view.pdf
- Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health*, 5(3): 6-47.
- Brennan, P.A., Hammen, C., Andersen, M.J., Bor, W., Najman, J.M., & Williams, G.M. (2000). Chronicity, severity, and timing of maternal depressive symptoms: Relationships with child outcomes at 5. *Developmental Psychology*, 36(6): 799-66. DOI:10.1037//0012-1649.36.6.759
- Brown, J., Cohen, P., Johnson, J.G., & Smailes, E.M. (1999). Childhood abuse and neglect: Specificity of effects on adolescent and young adult depression and suicidality. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(12): 1490-6.
- Canadian Collaborative Mental Health Initiative. (2006). *Pathways to healing: A mental health guide for First Nations people*. Mississauga, ON: Canadian Collaborative Mental Health Initiative. Retrieved June 3, 2014 from http://camimh.ca/wp-content/uploads/2012/04/MIAW_EN_PathwaystoHealing.pdf
- Centre for Suicide Prevention. (2013). *Suicide prevention resource toolkit*. Calgary, AB: Author. Retrieved June 3, 2014 from <https://suicideinfo.ca/LinkClick.aspx?fileticket=MVlyGo2V4YY%3D&tabid=563>
- Chandler, M.J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry*, 35(2): 191-219.
- Cicchetti, D., & Toth, S.L. (1998). The development of depression in children and adolescents. *American Psychologist*, 53(2): 221-41.
- 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.
- Cosgrove, M.P., Sargeant, L.A., & Griffin, S.J. (2008). Does depression increase the risk of developing type 2 diabetes? *Occupational Medicine*, 58(1): 7-14. DOI:10.1093/occmed/kqm105
- Dobson, K.S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, 57(3): 414-19.
- Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other Native peoples*. New York and London: Teachers College, Columbia University
- Engel, G.L. (1977). The need for a new medical model: The challenge for biomedicine. *Science*, 96: 129-136.
- Ferrari, A.J., Charlson, F.J., Norman, R.E., Patten, S.B., Freedman, G., Murray, C.J.L., Vos, T. et al. (2013). Burden of depressive disorders by country, sex, age, and year: Findings from the Global Burden of Disease Study 2010. *The Lancet*, 382(9904): 1575-86.
- Frankl, V.E. (1984). *Man's search for meaning*. New York, NY: Pocket Books.
- Galloway, T., & Saudny, H. (2012). *Inuit health survey 2007-2008: Nunavut community and personal wellness*. Montreal, QC: Centre for Indigenous Peoples' Nutrition and Environment, McGill University. Retrieved January 26, 2015 from http://www.tunngavik.com/files/2012/09/IHS_NUNAVUT-FV-V11_FINAL_AUG-15_2012.pdf
- Goodman, S.H., & Gotlib, I.H. (1999). Risk for psychopathology in the children of depressed mothers: A developmental model for understanding mechanisms of transmission. *Psychological Review*, 106(3): 458-90.
- Goodman, S.H., & Tully, E. (2008). Children of depressed mothers: Implications for the etiology, treatment, and prevention of depression in children and adolescents. In J.R.Z. Abela & B.L. Hankin (Eds.), *The handbook of depression in children and adolescents* (pp. 415-50). New York: Guilford Press.
- Guerry, J.D., & Hastings, P.D. (2011). In search of HPA axis dysregulation in child and adolescent depression. *Clinical Child and Family Psychology Review*, 14(2): 135-60.
- Haig-Brown, C. (1988). *Resistance and renewal: Surviving the Indian Residential School*. Vancouver, BC: Tillacum Library.
- Hammen, C., & Brennan, P.A. (2001). Depressed adolescents of depressed and non-depressed mothers: Tests of an interpersonal impairment hypothesis. *Journal of Consulting and Clinical Psychology*, 60(2): 284-94.

- Harder, H.G., Rash, J., Holyk, T., Jovel, E., & Harder, K. (2012). Indigenous youth suicide: A systematic review of the literature. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 10(1): 125-42.
- Hatala, A.R. (2013). Towards a biopsychosocial-spiritual approach in health psychology: Exploring theoretical orientations and future directions. *Journal of Spirituality in Mental Health*, 15(4): 256-76.
- Jenkins, J.H., Kleinman, A., & Good, B.J. (1991). Cross-cultural studies of depression. In J. Becker & A. Kleinman (Eds.), *Psychosocial aspects of depression*. (pp. 67-99). Hillsdale, UK: Lawrence Erlbaum Associates.
- Kirmayer, L.J., Brass, G.M., Holton, T., Paul, K., Simpson, C., & Tait, C. (2007). *Suicide among Aboriginal People in Canada*. Ottawa, ON: The Aboriginal Healing Foundation. Retrieved January 26, 2015 from <http://www.ahf.ca/downloads/suicide.pdf>
- 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, BC: UBC Press.
- 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. 1-26). Vancouver, BC: UBC Press.
- Koehn, C., & Hardy, C. (2007). Depression and problem substance use in women. In N. Poole & L. Greaves (Eds.), *Highs and lows: Canadian perspectives on women and substance use* (pp. 129-41). Toronto, ON: Centre for Addiction and Mental Health.
- Kolappa, K., Henderson, D.C., & Kishore, S.P. (2013). No physical health without mental health: Lessons unlearned? *Bulletin of the World Health Organization*, 91:3-3A. DOI: 10.2471/BLT.12.115063
- Lasser, K., Boyd, J.W., Woolhandler, S., Himmelstein, D.U., McCormick, D., & Bor, D.H. (2000). Smoking and mental illness: A population-based prevalence study. *The Journal of the American Medical Association*, 284(20): 2606-10.
- Lichtman, J.H., Bigger, T., Blumenthal, J.A., Frasure-Smith, N., Kaufmann, P.G., Lespérance, F., Mark, D., et al. (2008). Depression and coronary heart disease. *Circulation*, 118: 1768-75. Doi:10.1161/CIRCULATIONAHA.108190769
- Lopez-Duran, N.L., Kovacs, M., & George, C.J. (2009). Hypothalamic-pituitary-adrenal axis dysregulation in depressed children and adolescents: A meta analysis. *Psychoneuroendocrinology*, 34: 1272-83.
- Martens, P., Bartlett, J., Burland, E., Prior, H., Burchill, C., Huq, S., Romphf, L. et al. (2010). *Profile of Métis health status and health care utilization in Manitoba: A population-based study*. Winnipeg, MB: Manitoba Centre for Health Policy, University of Manitoba. Retrieved January 9, 2015 from [http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP-Metis_Health_Status_Full_Report_\(WEB\)_update_aug11_2011\).pdf](http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP-Metis_Health_Status_Full_Report_(WEB)_update_aug11_2011).pdf)
- McCormick, R.M. (1996). Culturally appropriate means and ends of counseling as described by the First Nations people of British Columbia. *International Journal for the Advancement of Counseling*, 18: 163-72.
- McCormick, R.M. (1997). Healing through interdependence: The role of connecting in First Nations healing practices. *Canadian Journal of Counselling*, 31(3): 172-84.
- Milloy, J.S. (1999). *A national crime: The Canadian government and the residential school system, 1879 to 1986*. Winnipeg, MB: University of Manitoba Press.
- Nabigon, H., & Wenger-Nabigon, A. (2012). "Wise practices": Integrating traditional teachings with mainstream approaches. *Native Social Work Journal*, 8: 43-55.
- National Aboriginal Health Organization [NAHO]. (2006). *First Nations Regional Longitudinal Health Survey (RHS), 2002/03. Report on selected indicators by gender*. Ottawa, ON: NAHO.
- Norris, M.J. (2007). Aboriginal languages in Canada: Emerging trends and perspectives on second language acquisition. *Canadian Social Trends*, 1: 19-27. Retrieved June 3, 2013 from <http://www.statcan.gc.ca/pub/11-008-x/2007001/pdf/9628-eng.pdf>
- Oltmanns, E.F., Emery, R.E., & Taylor, S. (2006). *Abnormal Psychology* (2nd ed.). Toronto, ON: Pearson Education.
- Public Health Agency of Canada [PHAC]. (2011). Diabetes among First Nations, Inuit and Métis populations. In *Diabetes in Canada: Facts and figures from a public health perspective* (Chapter 6). Ottawa, ON: Author. Retrieved January 5, 2015 from <http://www.phac-aspc.gc.ca/cd-mc/publications/diabetes-diabete/facts-figures-faits-chiffres-2011/chap6-eng.php>
- Quinn, A. (2007). Reflections on intergenerational trauma: Healing as a critical intervention. *First Peoples Child & Family Review*, 3(4): 72-82.
- Reading, J. (2009). *The crisis of chronic disease among Aboriginal Peoples: A challenge for public health, population health and social policy*. Victoria, BC: Centre for Aboriginal Health Research.
- Schore, A.N. (2001a). Effects of a secure attachment relationship on right brain development, affect regulation and infant mental health. *Infant Mental Health Journal*, 22(1-2): 7-66.
- Schore, A.N. (2001b). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant mental Health*, 22(1-2): 201-69.
- Statistics Canada. (2012). *Aboriginal languages in Canada: Language, 2011 census of population*. Ottawa, ON: Statistics Canada, Catalogue no. 98-314-X2011003. Retrieved June 3, 2014 from http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-314-x/98-314-x2011003_3-eng.pdf
- Thommasen, H.V., Baggaley, E., Thommasen, C., & Zhang, W. (2005). Prevalence of depression and prescriptions for antidepressants, Bella Coola Valley, 2001. *Canadian Journal of Psychiatry*, 50(6): 346-52.
- Tjepkema, M. (2002). The health of the off-reserve Aboriginal population. *Health Reports Supplement*, 13: 1-17.
- Tsai, J.L., & Chentsova-Dutton, Y. (2009). Understanding depression across cultures. In I. H. Gotlib & C.L. Hammen (Eds.), *Handbook of depression* (pp. 467-91). New York: The Guilford Press.

- van Gaalen, R., Wiebe, P.K., Langlois, K., & Costen, E. (2009). Reflections of mental wellness in First Nations and Inuit communities. In Canadian Institute for health Information [CIHI], *Mentally healthy communities: Aboriginal perspectives* (pp. 9-16). Ottawa, ON: CIHI.
- Vukic, A., Gregory, D., Martin-Misner, R., & Etowa, J. (2011). Aboriginal and Western conceptions of mental health and illness. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 9(1): 65-86.
- Weinfeld, N.S., Sroufe, L.A., Egeland, B., & Carlson, E. (2008). Individual differences in infant-caregiver attachment. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications*, 2nd ed. (pp. 78-101). New York, NY: The Guilford Press.
- World Health Organization [WHO]. (2006). *Constitution of the World Health Organization*. Geneva: Author. Retrieved June 3, 2014 from http://www.who.int/governance/eb/who_constitution_en.pdf
- World Health Organization [WHO]. (2008). *The international classification of mental and behavioural disorders [ICD] (10 Rev. ed)*. New York, NY: Author. Retrieved January 9, 2015 from <http://www.who.int/classifications/icd/en/bluebook.pdf>
- World Health Organization [WHO]. (2010). Depression. Geneva: Author. Retrieved January 26, 2015 from <http://www.who.int/mediacentre/factsheets/fs369/en/>
- Wu, Z., Noh, S., Kaspar, V., & Schimmele, C.M. (2003). Race, ethnicity, and depression in Canadian Society. *Journal of Health and Social Behavior*, 44: 426-41.





