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A Discussion Paper

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Giti Caravan, and Terrie Fitzpatrick

Reducing Mental Health Disparities Project

Prairie Region Health Promotion Research Centre
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The Reducing Mental Health Disparities Project is a collaborative project between the Prairie Region Health Promotion Research Centre, the Indigenous People's Health Research Centre, University of Saskatchewan; The Indian and Métis Friendship Centre, International Women of Saskatoon, Global Gathering Place, and Open Door Society.

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Reducing Mental Health Disparities Project

Reducing mental health disparities through population health promotion: translating knowledge into practice – practice into knowledge

Through knowledge development and translation activities, this project aims to understand and address mental health disparities among vulnerable populations, specifically Indigenous and racialized immigrant women (women who are visible minorities and newcomers to Canada). Building upon projects currently underway at the Prairie Region Health Promotion Research Centre, this project mobilizes a trans-disciplinary and multifaceted research program that will create new knowledge in mental health promotion theory, policy and practice, particularly as this is informed through the lens of cultural-power dynamics.

Research Objectives

1. To map the continuum of approaches to mental well-being and culturally-embedded conceptualizations of mental health in mental health promotion processes relevant to the study groups
2. To develop culturally-relevant evaluation frameworks
3. To develop the theory of mental health promotion processes relevant to the study groups
4. To develop innovative and culturally-relevant knowledge translation approaches
5. To build interdisciplinary and long-term research capacity through integrating multi-disciplinary and trans-disciplinary approaches with university and community-based training opportunities

Hypothesis

Processes of economic, social, and cultural marginalization and vulnerability have some common implications for the ways in which the mental well-being and self-determination of Indigenized and racialized immigrant women are shaped. Understanding these dynamics and theorizing ethno-cultural similarities and differences in mental health promotion processes will contribute to reduced mental health disparities of these vulnerable populations through the development of more robust mental health promotion theory and better informed mental health promotion policy and practice.

Research Plan

The five-year study consists of three research modules:

1. Uncovering and understanding the conceptual frameworks that inform mental health policy and practice
2. Understanding mental health disparities; and
3. Addressing mental health disparities.

Module One (year one) consists of an in-depth literature review and analysis. Modules Two (years two and three) and Three (years four and five) are participatory in nature, drawing primarily on qualitative methods.

Executive Summary

This report reviews and analyzes eight key constructs found in mental health promotion-related literature. It analyzes each construct not only for its meanings in relation to mental well-being and articulation within mental health promotion practice but also for its theoretical perspectives—explicit or implicit—and, even more fundamentally, its underlying epistemological orientations. It relates to Objective One of the Reducing Mental Health Disparities research project "to uncover and map embedded knowledge systems (e.g. representative of Indigenous, immigrant, and Euro-western) and conceptualizations of mental health and mental health approaches in relevant peer-reviewed literature, policy and programs" and specifically addresses the question of "How are key cultural concepts and knowledge systems of Indigenous, racialized immigrant women and Euro-western populations currently situated within mental health promotion theory?" [1]

Our decision to embark upon this particular piece of research is informed by the growing body of knowledge which pinpoints mental health disparities between groups to be not only a function of individual capacities and environmental supports but to be more deeply rooted in cultural and epistemological disparities in terms of how these are represented within official knowledge and institutional policies and practices.

In keeping with much of the anecdotal evidence, the literature also tells us that our study populations—Aboriginal and racialized immigrant and refugee women—are very much at the margins in terms of health care provision and policy and programming more generally. Alongside this, the evidence increasingly suggests that mental well-being is closely related to power relations, whether in terms of psychological experiences of power and powerlessness, the distribution of environmental supports, or the ways in which institutionalized practices serve some groups more than others. Power/knowledge relations, in terms of just whose knowledge and world views are given legitimacy, are reflected within each of these domains.

Accordingly this report is a first step in terms of assessing these power/knowledge relations with respect to the published peer-reviewed mental health promotion-related literature, given this is near the top of the knowledge hierarchy and is reasonably influential in terms of mental health promotion-related policy and programming. As might be expected, our overall finding is that for the most part the ways in which the constructs are represented within the literature have their roots in western, Cartesian, and liberal humanist frameworks. It is increasingly the case, however, that these frameworks are being unmasked and challenged by various writers. Ever so gradually mental health promotion is moving from being considered a benign and neutral domain to one that is theoretically contested.

This report is a starting point in terms of providing a summary of the ways in which some of these theoretical tensions play out in the articulation and practice of these concepts. As such it is intended as a reference point and discussion paper for academic and community partners within the Reducing Mental Health Disparities project to begin to critically unpack the theoretical and epistemological frameworks underlying these concepts and, more importantly, articulate what these concepts might begin to look like within the culturally-based frameworks of the study populations.

With warm regards,

Lewis Williams, PhD
Principal Investigator, Reducing Mental Health Disparities project
Associate Professor, Department of Native Studies, University of Saskatchewan
Director, Prairie Region Health Promotion Research Centre

[1] Note this pertains to the larger question of 'How are key cultural concepts and knowledge systems of Indigenous, racialized immigrant women, and Euro-western populations currently situated within mental health promotion theory, policy frameworks and health system practices?' It is the second question within Module One of the original grant proposal.

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INTRODUCTION

Mental health and well-being is a major public health issue in Canada and internationally (Government of Canada 2004, World Health Organization 2001, 2004). Within the context of mental health, indigenous and racialized immigrant women living at the economic, social, and cultural margins of society are identified as groups who experience elevated rates of mental distress and illness relative to other populations (Adelson 2005, Canadian Council on Social Development 2004, Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees 1988). While these experiences are gendered, they are also influenced by social power inequities that are shaped by race and class relations (Culhane, Tait, Fiske, and Boscoe 2003, Spitzer 2005). Such social power inequities are reflected in the limited access that many Aboriginal and racialized immigrant women have to a number of health determinants such as adequate housing, income, food security, literacy levels, as well as health status itself. At an even more fundamental level, these social power inequities are reflected in public policy and service delivery biases and official definitions of health, as well as in the production and recognition of 'formal knowledge,' where 'formal knowledge' is often made up of dominant western/European perspectives at the expense of any indigenous, feminist and interdisciplinary perspectives. As a result, contemporary services, policies, and funding streams tend to privilege western epistemological and ontological perspectives.

In an effort to uncover and articulate the embedded Euro-western conceptualizations of mental health and well-being, this report will examine eight key mental health promotion-related concepts as defined within contemporary, peer-reviewed published literature. Through a review and analysis of these constructs, it will ask questions such as: 'Which and whose knowledge systems inform present mental health promotion?'; 'How has the history of white western medicine contributed to our current conceptualizations of mental health?'; and finally 'How are key cultural concepts and knowledge systems of indigenous and racialized immigrant women populations currently situated within mental health promotion theory?'

These questions arise from a larger research project entitled *Reducing Mental Health Disparities through Population Health Promotion: Translating Knowledge into Practice—Practice into Knowledge* in association with the Canadian Institutes of Health Research. Key aims of our broader research project are to work with our study populations—Aboriginal and racialized immigrant women—to ascertain and articulate how they conceptualize mental well-being (or what it means to live well), and accordingly to influence the development of mental health promotion-related policies and programs as relevant to these populations.

In order to fully understand the context of mental health promotion in Canada and globally, this report focuses its efforts on the body of knowledge related to and informing the field. Mental health promotion can be thought of as being derived from three conceptual strands: population health promotion, socio-cultural determinants of health, and mental health.[2]

Population health promotion conceptualizes mental health status as a function of individual capacities and the equitable distribution of environmental supports (Labonte 2003). It aims to address the health of whole populations, conceptualizing health as a state of well-being. A key strategy of population health promotion is empowerment practice—e.g. the process of working with individuals and communities to increase their control over factors that influence their overall health (WHO, 1986, 2004; Williams 2003a, 2003b). In recent years this strategy has gained increasing prominence as research has consistently demonstrated the links between relative inequalities in wealth and power, including psychological experiences of power and powerlessness, and health status (Evans et al 1994, Kawachi et al 1999, Wilkinson and Marmot 2003).

2 As articulated in the research proposal *Reducing Mental Health Disparities through Population Health Promotion: Translating Knowledge into Practice—Practice into Knowledge* to the Canadian Institutes of Health Research.

A socio-cultural health determinants framework sees the health status of different populations as being determined by a wide range of determinants including social, cultural, environmental, economic, and psychological factors (Health Canada 2001). In this way institutions beyond health care systems, such as governments, education systems, and corporations, are seen to influence population health status (Scott 2001 16).

Mental well-being is broadly defined as the ability of individuals and groups to live lives that are meaningful and valuable to them. It is, therefore, closely aligned with the concept of agency or self-determination. While it is recognized that some factors are universal to human emotional, mental , and spiritual health (WHO 2004), understandings of mental well-being and health-promoting behaviours are directly influenced and shaped by cultural attitudes and beliefs.

Drawing on these conceptual strands, mental health promotion has emerged as a field within its own right. Although it remains a contested field in many respects, our review of the literature shows that it is generally conceptualized as 'the process of enhancing the capacity of individuals and communities to take control over their lives and improve their health.' As an emerging discipline, mental health promotion is faced with a number of challenges, several of which we intend to address in the Reducing Mental Health Disparities research project.

For the purposes of this report, we intend to address the systematically unquestioned bias, within mental health promotion theory and practice, toward western conceptualizations of health and subjectivity. These biases can largely be found within bio-medically-oriented frameworks, policies, and funding streams and are also evident in the naming and articulation of various mental health promotion–related constructs. The Reducing Mental Health Disparities (RMHD) project aims to move mental health promotion theories, policies, and programs toward models that integrate mental health promotion with general health promotion strategies and with holistic approaches derived from indigenous and other non-western understandings and approaches (Anae, Moewaka Barnes, McCreanor, and Watson 2002, Tannahill 2000, McCreanor and Watson 2004).

The literature reviews and preliminary fieldwork that have been carried out[3] as part of the RMHD project indicate that while our study populations (Aboriginal and racialized immigrant women) have distinct differences, both communities hold some degree of indigenized or holistic perspectives of mental well-being. This refers to a world view which links the idea of well-being to our human connection to both the natural and the supernatural worlds (which includes the ancestors), viewing the physical, emotional, mental, and spiritual spheres as inextricably linked (Cajete 2000, Durie 2005, Madriaga-Vignudo et al 2006). For example, religious, spiritual, and supernatural dimensions are also embedded in elements of health in Asian and African cultures (Weerasinghe and Mitchell 2007) to which many members of Canada's racialized immigrant communities belong. Not all of the study participants hold indigenized views of well-being as described above; some subscribe to other ontologies of connectivity,[4] such as Buddhist or Taoist thought.

These ontological perspectives are at odds with the western scientific paradigm which is based on objective, rational, and dualistic forms of thought. This model views the natural world from a purely

3 Williams, White, Tait, Fornssler, and Earl (2007). *Daring to Dream: Honouring the Realities of Racialized Immigrant and Refugee Women in Canada. A Literature Review and Synthesis*. Prairie Region Health Promotion Research Centre and the Indigenous People's Health Research Centre, University of Saskatchewan. Tait, Williams, and Fornssler (2007). *Women, Health and Migration. A Literature Review and Synthesis Regarding the Experience and Mental Health Effects of Migration within Canada for Indigenous Women*. Prairie Region Health Promotion Research Centre in collaboration with the Indigenous People's Health Research Centre, University of Saskatchewan. Williams, White, Tait, Cezerilo, and Mease, (2008). *Land, Belonging & Nomadic Identities: Women, migration & well-being. A research symposium and community gathering for racialized immigrant women and people working with these communities*. Prairie Region Health Promotion Research Centre in collaboration with the Indigenous People's Health Research Centre, University of Saskatchewan.

4 An ontology of connectivity (Rose and Robins 2004) emphasizes the profound interconnectedness between all forms of life, entails mutual causality between organism and environment and views such relationships as re-cursive – events enter into, and become entangled with, and then re-enter the universe they describe.

materialistic standpoint, where human beings are separate from both nature and from one another (Cajete 2000). The prevalence of the western scientific paradigm within health-related literature is evident both in terms of published peer-reviewed literature and within the field of mental health promotion itself. It has exercised a gate-keeping function within scientific publications, determining what constitutes verifiable knowledge, at the expense of including other paradigms.

Predictably then, western paradigms also dominate mental health promotion-related policies and programming, often expressed through individualistic and objective conceptualizations of humanity that underlie mental health constructs. Accordingly, the mental health promotion-related concepts articulated in this report are largely representative of Euro-western perspectives and as such act as a reference point for the kinds of conceptualizations that are likely to predominate within most Canadian mental health promotion-related public policy and programming initiatives.

Mental Health Promotion: The Contemporary Context

As an emerging discipline, mental health promotion is besieged by conceptual and methodological confusion. It has grown from two disciplines—mental health and health promotion—both of which have their roots in western medicine. Until recent years, the cultural hegemony of western medicine has largely gone unquestioned, as indicated by the bio-medical epistemologies that inform the majority of mental health theories and practices. Defined as more linear, static, or success-oriented, western paradigms have historically focused more on an 'absence of disease' model, than on a 'promotion of health' model. However, the adoption of a health promotion approach has included particularly problematic ideologies such as individualism, objectivity, and Cartesian dualism, which continue to impede the development of more community-based, holistic mental health promotion practices.

Over the past 15 years, the *Ottawa Charter for Health Promotion* (World Health Organization 1986) has played an influential role in guiding the development of mental health promotion in Canada and globally. Several of the Charter's action strands—creating supportive environments, the development of healthy public policy, strengthening community action, and developing personal skills—continue to inform emergent mental health promotion practice. However, while both practically and conceptually significant, the Ottawa Charter is insufficient on its own, with respect to theory and Canada's urgent needs around decolonization.

In 2005, the World Health Organization met in Bangkok to create the revised *Bangkok Charter for Health Promotion in a Global World*. The document acknowledges further challenges within mental health promotion, including gender-, age-, and ability-based differences, as well as differences between indigenous and non-indigenous persons. In addition, the Bangkok Charter outlined the importance for widespread responsibility to mental health issues taking into account the diversity of a global world.

There is general consensus among leading experts in the field that mental health promotion has the following characteristics:

1. Builds on the potential of whole populations;
2. Sees health as the function of individual capacities, environmental supports, and equity in the distribution of environmental supports;
3. Has a holistic view of health; and
4. Has self-determination as its central tenet (Labonte 2003, Williams 2005).

These tenets are evident in conceptualizations of mental health and mental health promotion which have emerged over the past decade or so. The World Health Organization, for example, articulates mental health as a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community (WHO in Labonte 2003). Meanwhile, various mental health promotion theorists have begun to incorporate issues such as power, citizenship, and structural inequities in their conceptualization of mental health promotion as a practice (Friedli 1999, Joubert and Raeburn 1998, Murray 2001, WHO 2004). For example, Friedli suggests that mental health promotion is essentially about promoting mental health at three levels: strengthening individuals or increasing personal resiliencies, strengthening communities, and reducing structural barriers to mental health (Friedli 1999), whilst Williams (2005) similarly refers to three levels of agency, each of which she claims are influenced by particular sets of cultural-power relations.[5] The Public Health

5 Former work by Williams (2001, 2007, in press) has developed the concept of power-culture. Power-culture refers to the dynamics produced between different forms of power and culture that are activated within various contexts. Different forms of power (individual, group and institutional) are brought into dynamic interaction with different cultural systems (such as ethnicity, gender, class, sexual identity), resulting in various forms of self-determination relations. Such power-

Agency of Canada's Mental Health Promotion unit articulates mental health promotion as incorporating the following elements:

> By working to increase self-esteem, coping skills, social support and well-being in all individuals and communities, mental health promotion empowers people and communities to interact with their environments in ways that enhance emotional and spiritual strength. It is an approach that fosters individual resilience and promotes socially supportive environments. Mental health promotion also works to challenge discrimination against those with mental health problems. Respect for culture, equity, social justice, interconnections and personal dignity is essential for promoting mental health for everyone. (2008)

Perhaps one of the biggest tensions within mental health promotion as a newly-emergent field is that it is not well developed theoretically—or rather it has failed to directly address its historical underpinnings within liberal humanism,[6] essentially an ideology of universalism and a practice of Eurocentrism. Western forms of democracy, economic, social service, and health care institutions have as their basis the human-liberalist concepts of the sovereign, rational individual who is able (without constraint) to exercise their free will. Epistemologically this world view aligns with western-style science and the Cartesian, dualistic conceptualizations of reality outlined earlier, wherein illness has traditionally been viewed as being located within the individual who is a discrete bio-physical entity. Human liberalism has neither included any critical analyses of power relations nor questioned the epistemological and ontological assumptions of how we come to know our reality, and by extension the majority of mental health and mental health promotion-related literature and practice has largely failed to directly address these fairly critical dimensions.

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culture or cultural power relations include the construction of discourse, knowledge, and subjectivities in terms of how they shape self determination.

6 The defining tenet of humanism is the belief in an essential human nature (based on European, male norms) and in the power of reason to bring about human progress. Liberal philosophy is characterized by a belief in the inalienable rights of the individual to realize him or herself to the full (Jordan and Weedon 1995, O'Brien and Pena 1998).

Indigenized Approaches to Health and Power/Knowledge

The concept of health is largely a cultural construct, often contingent upon the distinct world views of particular populations and communities. World views are constituted by deeply-held values and cultural beliefs influencing how we experience our world and how we attribute meaning to these experiences. They incorporate the organization of our perceptions and experiences with our understandings about the nature of reality, including how human beings interact with each other and the natural world. Particular world views are often closely associated with science, described in broad terms by native scholar Gregory Cajete as "any foundational way of coming to know and understand the nature of life and our relationships therein" (2000 2).

Broadly speaking, indigenous and western world views represent different notions of reality and ways of being in the world.[7] Indigenous approaches to health place an emphasis on wholeness, connectiveness, balance, harmony, and growth. For First Nations peoples, for example:

> The development of the individual is interwoven with the well-being of the community and of the nation. Moreover an individual's identity, status and place in the world are tied not only to the [extended] family, but also to one's ancestors and community. This leads to a view of mental health that is very different from western models that focus on individuation, independence and self-reliance. (Aboriginal Healing Foundation 2006 24)

The inclusion of indigenized perspectives of well-being, which we claim are held by both Canadian Aboriginal women and other racialized women who have migrated internationally to Canada requires a paradigm shift within mental health promotion. While theorists and practitioners throughout the world are increasingly focusing on structural determinants of health and well-being, they are doing so from a westernized basis of population health promotion as articulated earlier. Inclusion of indigenized perspectives of well-being requires the adoption of de-colonizing approaches to mental health promotion which must potentially include the expression and institutionalization of traditional epistemologies and conceptualizations of health alongside tackling the structural inequities produced as a result of colonizing practices. Indeed it may be that for those holding indigenized perspectives of well-being, the basis of mental health promotion is ontological and epistemological sovereignty.

For indigenous communities (mental) health promotion could be defined as:

> a process of enabling individuals and communities to realize evolving aspirations and consciously constructed identities and cultural systems through equitable access to capacities such as land, language, employment, economic resources and decision-making institutions. (Williams 2005)

Such an approach is potentially rooted in indigenized epistemologies and constructions of health and potentially demands a re-orientation of dominant approaches to mental health promotion, including what constitutes evidence. To date, as a discipline, mental health promotion has largely failed to engage communities holding indigenized perspectives of well-being (including both study populations of the Reducing Mental Health Disparities project) in either its theory or practice. A major reason for this is the hierarchical nature of knowledge production which is closely tied to status quo power relations and is particularly powerful in structuring professional and lay knowledge (Foucault1980, Frazer and Lacey 1993, Weedon 1987). "The power to name, the power to represent common sense, the power to create official versions and the power to represent the legitimate social world" are four major areas where power can be realised by some groups more than others (Jordan and Weedon 1995 13).

7 These should not be considered as mutually exclusive as both world views exhibit elements of the other.

The naming of western approaches to knowledge as science, and the subjugation of indigenous epistemologies within, is a pertinent example of these power/knowledge relations—historically and today. The close connections between knowledge and dominant cultural power relations are very evident within mental health promotion discourse and practice. Often what becomes recognized as best practice and ultimately funded is the result of hierarchical cultural-power relations wherein policy and programming people—the majority of whom are of Euro/western origin and/or have been educated and socialized within the western paradigm—uncritically mobilize dominant discourses in their decision-making and implementation activities (Williams and Mumtaz in press).

Theoretical Perspectives

Concepts of mental health are informed by various medical, anthropological, and psychological models but, even more importantly, these concepts are framed by the normalized epistemological structures that remain from a long history of western rationalism and modernism. These knowledge systems act as the 'invisible informants' to the fields of science, medicine, and psychology, prioritizing the individual, scientific inquiry, objectivism, as well as beliefs that support race-, class-, and gender-based discrimination. Akin to Foucault's discussion of "technologies of power," western medicine and science both police and are policed by systems of thought such as liberal humanism, enlightenment thought, and Cartesian dualism.

Although these theoretical systems are deeply embedded within our mental health theories and practices, they are not without criticism as contemporary theorists have turned to critical theory, poststructuralism, and social constructionism/postmodernism to guide their research. Even more importantly, the fields of feminist theory, critical race theories, and indigenous epistemology have brought the situated knowledges of marginalized individuals and communities to the table, arguing that models of health and well-being must pay particular attention to factors of race, gender, and sexuality, in addition to socio-economic factors, when developing policies and practices.

Although there are more and more perspectives being articulated from the margins, the bulk of mental health promotion and practice continues to be viewed through a western/European lens. As previously outlined, this paper intends to explore the theoretical perspectives which inform the field of mental health promotion, both in order to expose those western biases that go unnoticed and to reveal alternative perspectives that challenge these dominant models. Following a brief discussion of the more transparent models that organize mental health research, this section turns to a number of the deeper theoretical perspectives which underlie understandings of mental health and mental health promotion, including those views which have challenged dominant epistemologies.

Disciplinary Approaches

Mental health research has its roots not in the concept of mental health, but in the concept of mental illness, where health, whether mental or physical, was often referred to as the absence of illness or disease. A number of disciplinary fields have contributed to this negative view of mental health including the more orthodox fields (biomedicine, psychiatry, and clinical psychology) as well as areas of the social sciences, including anthropology and sociology. Among these fields there are competing views of both mental health and mental illness as well as multiple overlaps in definition, but a brief summary of some of the disciplinary positions, as outlined by Herron and Trent (2000), are as follows:

Orthodox Systems (Biomedicine, Psychiatry, Clinical Psychology)

Within these fields, mental illness is described as a "clinical problem which can be identified, categorized and treated" (Herron and Trent 2000 31). Relying on empirical models of medicine and science as objective and neutral, these views take the individual to be the primary subject of analysis. Furthermore, this subject has traditionally been examined[8] in the absence of her or his socio-cultural environment as one's situated knowledges and cultural experiences are believed to interfere with the medical process. Orthodox views, then, identify mental health as the "absence of identifiable, recordable pathology in the individual and, subsequently, in given populations" (Herron and Trent 2000 31), thus contributing to the view of health as absen*ce*, and illness as the dominant topic of inquiry.

[8] Whilst the disciplines of clinical psychiatry and clinical psychology are increasingly incorporating systems approaches within theory and practice, both disciplines by and large still take the individual to be the primary subject of analysis.

Anthropology

Anthropological perspectives of mental illness contrast with the more orthodox models, arguing that mental illness must be viewed in consort with cultural contexts. Resisting the orthodox belief in any universality of mental illness, and mental health for that matter, anthropologists argue that mental health promotion strategies "can only be developed once an understanding of an individual's and community's view is obtained" (Herron and Trent 2000 32). Through various research methods, anthropologists believe that contextualized observation and study can contribute to the development of diverse and culturally-specific understandings of mental health.

Sociology

Sociological views locate mental illness within social forces, including the relationships between institutions, systems of care, professionals, and individuals. Arguing that power dynamics frame all of our experiences, sociologists work to reveal the relationship between the labelling of mental illness and the interests of the biomedical professions. In effect, sociologists argue that "when attention is brought to the violation of social norms, a mental illness label is given to the individual" (Herron and Trent 2000 32), indicating the implicit use of health as a means of social control.

Epistemological Frameworks

As described above, a number of more embedded theoretical perspectives have informed many views on mental health, as well as mental illness, and continue to influence theories and practices of mental health promotion. These perspectives are generally interdisciplinary in nature, demonstrating wider-held ideological beliefs about such things as the human condition, social relationships, experiential knowledge, and the nature of reality. The perspective of liberal humanism is likely the most influential; however, contemporary theories have reworked and challenged more traditional epistemological viewpoints.

Cartesian Rationalism/Dualism

One of the most entrenched beliefs within Euro-western knowledge systems, particularly those informing medicine and science, is that of Cartesian rationalism. In contrast to pre-modern systems of belief which had roots in religion and mythology, Cartesianism searched for absolute truth and universal scientific knowledge. This meant that all spiritual, religious, and other non-scientific medical practices were put into question, and individuals turned to methods of scientific analysis in order to find meaning. Another legacy of Cartesianism is the separation between body and mind that has plagued medicine for centuries. Rather than ascribing to historical views that the mind and body were linked, modern philosophers such as Descartes and Kant argued that the mind was a fortress of reason, while the body was made up of a lesser substance. This meant that any discussions of illness focused only on the material/bodily realm, whereas the mind was considered to be a separate entity.

Liberal Humanism/Neo-Liberalism

Also described as 'enlightenment humanism,' liberal humanism is the offspring of Cartesian dualism, aligning with the belief in rationalism, objectivism, and the scientific method. Initially put forth by the philosophers of the 17th and 18th centuries, such as Rousseau, Locke, Hume, and Kant, liberal humanism argues that human experience is shaped by reason as are any and all social and institutional human organizations. Also arising in contrast to beliefs about the divine, the transcendent soul, and other spiritual conceptions of reality, liberal humanism argues for the autonomous, self-made man.[9] In its sharp separation between religion and the state, liberal humanism hinges upon the concepts of freedom and individuality such that the liberal subject is not bound by teleological frameworks or concepts of connectedness, either to other beings or to nature.

9 The use of 'man' is intentional as enlightenment thinkers did not consider women to be rational participants in society. Instead, women were relegated to the corporeal realm. Similarly, indigenous and non-western races were also not considered to possess the capacities for autonomous thought and so were deemed irrational and driven by their bodily impulses.

Consequences of liberal humanism for medicine and science include the belief in the abstract, rational individual separated from cultural, economic, gendered, or racialized contexts. Also, it argues that any problem can be addressed through scientific inquiry as conducted by an objective, impartial observer. As one of the most influential epistemological frameworks of modern thought, liberal humanism continues to structure contemporary knowledge systems and practices, taking the contemporary form of neo-liberalism, which remains focused on an economic, progress-oriented, and individualistic agenda.

Critical Theory

Arising out of socialist and Marxist thought, critical theory rejects the central tenets of liberalism, such as logical positivism and the concept of universal truth. Critical theorists also object to arguments that the individual is the starting point for analysis instead paying attention to the power dynamics and social forces that structure human experience. In relation to mental health, critical theory views psychiatry and its accounts of mental illness as "a means for the control and oppression of certain groups in society" (Herron and Trent 2000 32). Through its categorizations and markings of mental illness, psychiatry—and other orthodox approaches—acts as a system of control, classifying health according to a disciplinary model. Critical approaches to mental health look specifically at society as the cause of mental illness, determining that the concept of mental health would imply the absence of social systems which control certain groups within society (Herron and Trent 2000).

Postmodernism/Social Constructionism

Although there are diverse definitions of postmodernism within any field, it generally relates to a view that the concept of a knowable reality is problematic. Postmodern and social constructionist theories invert the belief that human beings have an essential or internal nature, which influences how we find meaning in the external world. They argue that human beings are instead constructed by the social systems which govern our experiences. The implications of these theories include the denial of any degree of truth within our social, political, and scientific epistemologies, as well as the denial of any degree of objectivity.

Within the field of mental health, social constructionist theories determine that since reality itself is socially constructed, then mental illness itself is also social constructed (Ingelby 1981). This does not mean that social constructionists deny the material effects of mental illness but rather that any understandings of mental illness must take into account the cultural, temporal, and spatial context. In terms of mental health promotion strategies, social constructionist and postmodern theories reject the search for truth about mental illness as well as the attempt to provide universal models. Instead, they call for multiple approaches to mental health promotion, each of which is located within a particular cultural context.

Poststructuralism

Similarly to postmodernism, poststructuralism denies the existence of an external true reality. However, poststructuralism is particularly concerned with the roles of language and sign systems in moulding subjective experience. Since language exists within historically-located and politically-motivated discourses, poststructuralists argue that our educational, political, social, and economic systems are not neutral and instead maintain disciplinary systems of power and control (Wheedon 1987).

Michel Foucault's work on power/knowledge draws specifically on the concept of the discursive field as a way of understanding the relationships between language, social institutions, subjectivity, and power (Foucault 1980). The discursive field is made up of the many ways of giving meaning to the world, including the ways we organize social institutions and practices through systems such as the church, the family, the education system, and the media. In revealing the constructed nature of these

systems of meaning, Foucault argues that technologies of power, in the interest of the dominant class/culture, police the very construction of knowledge.[10]

Postructuralism then challenges the link between power and knowledge—i.e. who owns knowledge, who has access to it—and consequently the belief in a foundational epistemology at all (Foucault 1980, O'Brien and Penna 1998, Weedon 1987).

Theories from the Margins

Although postmodern, poststructuralist, and critical theories have been crucial in challenging the far reach of liberal humanism, they have also come under attack as a result of their own masculinist and western-European biases. Consequently, contemporary feminist theorists have important and useful things to say about the inherent gender-based inequities that exist within mental health strategies. And more importantly to the purposes of this report, the rising area of indigenous epistemologies is increasingly revealing the embedded racial biases that operate within the above-mentioned theoretical frameworks. Indigenous and feminist epistemologies arise not only as critiques but as developed theoretical frameworks through which to develop practical mental health promotion strategies.

Feminist Theory

The rise of feminist theory coincided with achievements within the women's movement, including the women's suffrage movement as well as demands for equal recognition for labour. At the heart of feminist theory is the argument that all aspects of society—be they economic, familial, educational, or political—are shaped according to an androcentric world view. The project of feminists has thus been to critique and subvert these inequities by revealing the gendered bias that structures epistemological and ontological projects. The disciplines of philosophy, medicine, and psychiatry have worked in tandem to demoralize traits perceived as feminine, such as emotionality, anxiety, and passivity. This discourse has located women within the secondary realm of the physical, whereas perceived masculine traits, such as reason, strength, and stoicism, are linked with the primary realm of the mental.

This lasting effect of Cartesian dualism has contributed to embedded structures of discrimination and the oppression of women in all areas of life. In her book *Women and Madness* (1972), Phyllis Chesler provides a revelatory account of the ways that psychiatry has historically linked the category 'woman' with the concepts of irrationality, mental illness, and madness as a means by which to keep women in a subjugated position. The tendency to relate women with mental instability still influences mental health practices gaining particular force because many theorists and practitioners still refuse to admit that science and medicine have any degree of gender bias.

Indigenous Epistemologies

Rising out of the intersections between research by indigenous scholars and community practitioners from Canada, Aotearoa, New Zealand, and Australia, indigenous epistemologies bring the cultural and social knowledge systems of those groups that have previously been marginalized, if not entirely absent, within a field of epistemology dominated by western perspectives. Gegeo and Watson-Gegeo (2001) state that an important feature of indigenous epistemologies is their situated or insider status. Where anthropological, sociological, and psychological studies have often been conducted from an external or outsider position—observer/scientist watching and/or documenting his or her

10 Previous work by Williams (2001, 2007, in press) has developed the concept of power-culture. Power-culture refers to the dynamics produced between different forms of power and culture that are activated within various contexts. Different forms of power (individual, group, and institutional) are brought into dynamic interaction with different cultural systems (such as ethnicity, gender, class, sexual identity), resulting in various forms of self-determination relations. Such power-culture or cultural power relations include the construction of discourse, knowledge, and subjectivities in terms of how they shape self-determination.

population of study—indigenous knowledges are those created and built from within indigenous societies and communities.

A key component of postmodern, poststructuralist, and feminist theories has been to investigate the very nature of western epistemology, including asking questions such as: 'What constitutes knowledge in a given context?'; 'Who has access to knowledge?'; 'How does one lay claim to knowledge?'; and 'What is the role of belief in created knowledge systems?'. Indigenous epistemologies take these questions further to reveal the inherent blindness to practices of colonization and racial discrimination that characterize many epistemological constructs.

With these criticisms in mind, indigenous epistemologies "[focus] on the process through which knowledge is constructed and validated by a cultural group, and the role of that process in shaping thinking and behavior" (Gegeo and Watson-Gegeo 2001 59). They claim not only that all knowledge systems are socially constructed but that these systems are specifically culturally constructed, revealing that western epistemology still operates from a largely unacknowledged position of privilege.

As mentioned earlier, indigenous epistemologies function as both a criticism of western epistemologies and as a culturally-situated, epistemologically-validated position from which to view the world and the nature of reality. As Williams claims, indigenous groups around the world are "renewing languages, recovering ancestral lands and actively maintaining and revitalizing traditional knowledge systems and cultural practices" (2008b 9). These practices contribute to the development of unique world views, including diverse and culturally-relevant means of responding to issues as wide ranging as mental health, housing, education, and citizenship. Whilst indigenous cultural knowledges are by no means homogenous, they share a number of similar ontological roots and principles, which Maori scholar Makere Stewart-Harawira has summarized as follows:

1. The profound interconnectedness of all existence which governs all relationships;
2. The principle that every individual element of the natural world has its own life force;
3. The principle of balance or reciprocity which requires that we acknowledge and honour the being of the other; and
4. The development of holistic understandings of knowledge that consider everything in relation to the whole (2005).

In sharp contrast to western views on health, well-being, and the construction of knowledge, indigenous knowledges refuse to separate the mind and body, as well as the person from his or her environment including ancestors and the supernatural realms. This extends beyond the anthropological or sociological views that illness must be understood in relation to the socio-cultural context and focuses instead on a quality-of-life model where well-being is the "balance and harmony of the body, mind, and emotions. . . . [and is] . . . inclusive of the health and well-being of the individual and family and the community" (Alberta Mental Health Board 2006 12).

Significantly, indigenous constructions of well-being, then, encompass the idea of being in harmony with "all our relations," wherein human beings are just one among many of the life forms or intelligences that comprise our natural world. Health is the result of being in balanced and reciprocal relations with other peoples and life forms that comprise the natural world. This is a profoundly different cosmological orientation from most of the other theoretical perspectives outlined here on which the majority of mental well-being perspectives are predicated.

Methodology

Literature was initially collected over a three-month period in 2006. A second search was conducted to gather literature from 2007 and 2008. The consulted literature spans from 1996-2008 except in the case of the construct of 'citizenship' as it was included in the second search period but not the first. Within the reviews, priority is given to literature from the last four years, as the majority of indigenous mental health initiatives and conceptualizations are quite recent. Also, within our search we found that although historical and theoretical discussions of the constructs dated back to 2000 and earlier, articles that documented their relationship to health and well-being, as well as their application to mental health promotion practice, were generally from 2003-2008.

Our search strategy included consulting those sources of information thought to bear the most influence on contemporary mental health promotion discourse, policy, and practice in Canadian contexts as identified by the research team. Sources consulted in order of priority were:

1. Databases of peer-reviewed published literature accessible through the University of Saskatchewan library;
2. The content pages of key mental health promotion-related journals;
3. Consultation with well-known experts in the field in order to identify key articles;
4. Grey literature, accessed through web sites of key mental health promotion organizations in Canada and internationally, as recommended by the research team, key professionals, and as cited in the peer-reviewed published literature; and
5. A general web search was conducted and relevant citations followed up on.

Databases utilized include: Medline (Ovid version), PubMed, PsychINFO, Eric, Illumina, Academic Search Complete and the University of Saskatchewan Library Catalogue. Keywords were chosen to reflect those usually used to describe the concept. In the case of 'mental health,' for example, well-being and happiness were also substituted. In mapping out the search, each main keyword was further specified by choosing suitable sub-categories. For example, the use of 'well-being' as a key search term revealed a number of other common sub-categories, such as 'health promotion,' 'mental health,' 'physical health,' or 'mental health.' A further search of relevant sub-categories was conducted—in the case of 'empowerment,' for example, further searches were conducted using the key search terms of power, control, autonomy, or competence.

In reviewing the contents pages of key mental health promotion journals, preference was given to those well known within academic mental health promotion research and publishing circles and secondarily to those pertaining to the disciplines of community psychology, nursing, sociology, psychiatry, and medicine. These journals included: the *International Journal of Mental Health Promotion*, *Canadian Journal of Community Mental Health*, *Prevention and Treatment*, *Canadian Journal of Psychiatry*, *Journal of Mental Health*, *Journal of Public Mental Health*, *American Journal of Community Psychology*, *Journal: American Psychological Association (APA)*, *Journal of Applied Social Psychology*, *Journal of Happiness Studies*, *Journal of the British Psychological Society*, and the *British Medical Journal*.

Throughout the literature search, a number of additional journals revealed themselves to be relevant to the topic, including: *Journal of Public Economics*, *Australasian Psychiatry*, *Journal of Cross-Cultural Psychology*, *Journal of Personality and Social Psychology*, *Journal of Personality*, *American Psychologist*, *Personality and Social Psychology Review*, *American Sociological Review*, *Quality of Life Research*, *Community Mental Health Journal*, *Journal of the Royal Society for the Promotion of Health*, *Social Indicators Research*, and *Social Science and Medicine*.

Use of the search term 'mental health' tended to yield material that was mental illness-oriented, reflecting the ways in which the field remains disease-oriented; both terms were often used synonymously.

The terms 'well-being,' 'subjective well-being' and 'happiness' were much more associated with positive definitions of mental health. In particular, 'well-being' was prominent within the mental health promotion, social psychology, and sociological literature. As a field, it increasingly comprises a number of disciplinary perspectives, including social and cultural studies, medical anthropology, sociology, cultural psychiatry, social and community psychology, and, very recently, Native or indigenous studies, which is emerging as a field within its own right.

The literature is increasingly drawing on the theoretical perspectives outside of the liberal humanist paradigm, although often indirectly. For example, concepts commonly used in the mental health promotion-related literature are often developed from a variety of disciplinary and theoretical perspectives and subsequently imported into mental health promotion with little discussion regarding their theoretical orientation. The implications for the field mean that slippage within and between concepts is common, making coherence in definitional terms challenging.

We argue that theoretical transparency within the literature is important for two reasons. First, because mental health and mental health promotion have their roots in bio-medical and liberal-humanist discourses, as practices they have often maintained status quo power relations and health disparities. And second, the field's rather ad hoc and eclectic, multidisciplinary development means that emergent counter-theoretical positions (to liberal humanism) tend to be implicit within conceptualization but not made explicit, therefore weakening their ability to directly challenge status quo framings of issues. In summary, the field will be much better able to serve the needs of populations at the economic, cultural, and social margins—including Aboriginal and international migrant women—if critical theoretical perspectives are brought to bear on the field in a direct manner.

Review of Key Mental Health Promotion Constructs

This section reviews key mental health promotion-related constructs found in the published literature. These constructs fall into two categories:

1. Those that relate to or are indicators of well-being, and
2. Those intended to improve states of well-being, otherwise known as practice concepts.

They were selected on the basis that they are each oriented towards positive mental health and are among those most commonly articulated in the published mental health promotion-related literature. Each construct is reviewed for its meanings and representations within the literature, both at the individual and systems level. Drawing from these definitions, we provide a theoretical analysis of the concepts as they are understood within mental health practice.

This section also explores the epistemological frameworks (as outlined previously) that inform each construct, identifying differences between Euro-western and indigenous conceptions if applicable. A brief discussion follows on the relevance of each key construct to mental well-being, and, finally, we outline the concept's application to mental health promotion strategies and practices.

Resiliency

Overview

Resiliency research began primarily with children and adolescents where researchers attempted to understand how children/youth adapted to adversity in theirs lives (Gillespie et al, 2007). Although the literature still predominantly focuses on children and youth (Beltman and McCallum 2006, Engel 2007), analysis has extended to adults, examining factors such as personal attributes, biology and/or genetics, environment and psychosocial factors, and asking questions about why some individuals cope differently than others.

There is no general agreement over the definition of the term, and it is used differently across the disciplines; however, Ungar and colleagues describe the history of resilience research as being comprised of four waves, including a focus on individual mediations, a focus on protective factors and processes, the role of one's environment in creating and sustaining resilience, and finally turning to a view of resilience as culturally sensitive both in nature and definition (2007).

A common conceptualization of individual resiliency is through the idea of "bouncing," or "springing," as Carver (1998) describes resiliency as the ability to bounce back from stressful experiences. Similarly, Joubert and Raeburn describe resiliency as the "vital sense of flexibility and bouncing back (i.e. the capacity to re-establish one's own balance)" (1998 16). Both Rutter (2006) and Gillespie (2007) indicate that a resilient nature is developed through an individual's lifetime exposure to adversity. In terms of specific traits, the resilient individual is believed to posses characteristics such as competence, coping skills, hardiness (Kobasa et al 1985), self-efficacy (Bandura 1977), and a sense of coherence (Antonovsky 1987), where these traits enable one to "modify one's responses effectively to changing situational demands" and to have the ability to "recover effectively from stressful circumstances" (Tugade and Fredrickson 2007 319).

As Ungar (2007) indicates, more recent approaches have evolved from the dissection of individual traits to the impact of both protective and environmental factors on the development and maintenance of resiliency. These views explore the impacts of environmental supports, or the lack thereof, in enabling resiliency in a community's members. According to Resnick, these protective factors could include:

> a strong sense of connectedness to parents, family, school, community institutions, adults outside the family, the development and enhancement of academic and social competence, and involvement in extracurricular activities that create multiple friendship networks. (2000 142)

The turn to protective, and somewhat environmental, views of resiliency exemplifies the second and third waves of resiliency research as described above and often involves an emphasis on the family, as both a resource for individuals and an essential starting point for the development of resiliency on a larger scale (Landau 2007, Walsh 2003). McCubbin and colleagues (1997) view family resiliency as composed of protective factors which help the family to deal with risk factors as well as capabilities for adjustment and recovery which promote the family's ability to adapt during times of crisis.

Landau (2007) extends the discussion of the family to the community, providing a definition of community resilience as a community's "inherent capacity, hope, and faith to withstand major trauma, overcome adversity, and to prevail, with increased resources, competence, and connectedness" (352). Kulig similarly defines community resilience as "the ability of a community to not only respond to adversity, but in so doing reach a higher level of functioning" (2000 374). Consequently, Kulig determines that community resiliency leads to improved health and well-being among community residents.

Following a study of youth aged 12-23, Ungar and colleagues (2007) articulate a fourth wave of resiliency research that moves beyond looking at the individual and his or her immediate environment to take the cultural context into account. Noting that definitions of resiliency and positive outcomes of mental health differ greatly between indigenous and non-indigenous peoples, they define resilience as "not only an individual's capacity to overcome adversity, but the capacity of the individual's environment to provide access to health-enhancing resources in *culturally relevant ways*" (Ungar et al 2007 288).

Culture seems to have impacted the resiliency literature as a result of globalization but also because of an increasing understanding of the effects of ethnocentrism. This shift to addressing cultural diversity has meant that the inclusion of diverse world views within the very concept of resiliency has become more important; however, the epistemological underpinnings of resiliency theory still generally hinge upon a Euro-western framework.

Theoretical Perspectives

Throughout the literature, we can see a conceptual shift from theories of resiliency that focus on the individual and particular character traits to those that focus on the environmental and cultural contributions to the development of resiliency, including how it is defined. Within this shift, the former approach generally comes from medical or psychological research (Gillespie et al 2007, Tugade and Fredrickson 2006) whereas the latter is generally informed by more sociological or anthropological approaches (Ungar 2008, Engel 2007, Landau 2007).

In an attempt to provide a theoretically-derived model of resiliency, Gillespie and colleagues claim that the medical literature has focused on attributes of the term, particularly self-efficacy, coping ability, and hope (2007). Although the authors acknowledge that these attributes are less static traits than multi-dimensional processes, their examination is limited to a view of resiliency as an individual's capacity to "transcend adversity and transform it into an opportunity for growth" (2007 125). Exemplifying the aims of medical science and clinical psychology, this approach indicates a desire to define and therefore limit the concept of resiliency to a succinct and knowable category of analysis.

Viewing resiliency through the lens of critical theory, Gerrard and colleagues argue that "beyond the individual and family, socio-economic and political factors, such as war, racism, and poverty, can affect resiliency" (2004 60), indicating that it is important to examine the structural factors that influence an individual's or community's ability to develop resiliency. Similarly, Sun and Stewart (2007) argue that issues of gender and age have differential outcomes in resiliency research and should necessarily be taken into account when developing strategies to encourage resiliency.

The most extensive theoretical developments of resiliency are those conducted by Ungar (2001, 2004, see also Ungar et al 2007, 2008). Ungar (2004) examines constructions of resiliency within an

ecological framework compared to those that occur within a constructivist framework. Ecological[11] views of resiliency often focus on causal relationships between risk and protective factors and strive for objective measures of health. Ungar argues that this view comes up short in a number of ways but particularly because it both fails to address the diversity within the field of resiliency and fails to critique its own ethnocentric bias. In contrast, Ungar argues for a postmodern, constructivist framework of resiliency which hinges on plurality and diversity and embraces contextual and culturally-specific definitions of health. Through this constructionist approach, Ungar argues that researchers can examine the systems of power that structure health discourses in order that these systems can be destabilized (2004).

Although there is much less research pertaining to non-western definitions of resiliency, constructivist and culturally-situated perspectives generally take the concept to be more dynamic and indicative of process rather than static and individualistic (Grigorenko et al 2007). Also, non-western perspectives view the family, extended family, and community as a living system, constantly changing in response to the environment (Engel 2007). In a discussion of resiliency in relation to Native American children, Engel argues that the concept of resiliency must be incorporated into traditional Native American beliefs, including the teachings that "human beings are an interwoven part of the universe and that imbalance from stress can create disease, and even death, if harmony is not restored" (2007 46). Although sociological and anthropological literatures point toward a greater focus on cultural factors, there needs to be a greater recognition of the inherent differences in definitions of resilience, self-efficacy, and other related terms as they are understood culturally.

Relevance to Mental Health and Well-Being

The concept of resilience is often integrated into the very definition of mental health such that practitioners and researchers believe that mental health promotion involves the fostering of resilience through providing the necessary personal and environmental resources. Friedli (1999) views resilience as a useful construct for mental health because it moves away from a model of health that revolves around abstract states of wellness and is instead a human concept. In another definition of mental health promotion, the Health Education Authority defines mental well-being as the "emotional and spiritual resilience enabling a person to enjoy life and survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in one's own and others' dignity and worth" (1997 n.p.).

As mentioned previously, the bulk of resiliency research examines children and youth, a tendency which relates to the philosophy of the concept itself. As an indicator of mental health, the ability to express resilience in the face of adversity is considered to be a trait that is largely developed in childhood, thus research projects and mental health promotion initiatives believe it is useful to focus on these groups. Within the literature, resiliency is not measured so much in terms of particular health benefits, but rather in an individual's, family's, or community's ability to cope with stressors. Stewart and colleagues describe resilient children as recognized by some or all of the following characteristics:

> High self-esteem, internal locus of control, optimism and clear aspirations, achievement and goal-orientation, reflectiveness and problem-solving capacity, respect for the autonomy of themselves and others, health communication patterns, and the capacity to seek out mentoring adult relationships. (2004 26-27)

In effect, it is widely held that resilient children and adults experience less vulnerability to various health problems (Stewart et al 2004, Gerrard 2004).

[11] Note, the ecological view of resiliency that Ungar is discussing is from one particular theoretical perspective. For the most part, ecological approaches to various constructs, and as applied in practice, are generally likely to have their roots in social constructivist or indigenous epistemologies.

Another way that researchers have studied resilience is by identifying those things that characterize non-resilient persons such as low self esteem and self concept, and low levels of social support from one's environment, arguing that these things are risk factors for mental health development (Sun and Stewart 2007). As a result, resiliency is determined to be a desirable characteristic for both individuals and communities.

Application to Mental Health Promotion Practice

When it comes to applying the concept of resilience to mental health promotion, Friedli (1999) suggests that strategies should build resiliency and "resourcefulness" through encouraging the development of skills such as life and coping skills, communication skills, and relationship skills. In a study that moves beyond an individualistic perspective of resiliency to one that looks at the community as embedded in a particular social context, Gerrard and colleagues (2004) argue that strategies intended to promote both individual and community resiliency must take geographic location into account (i.e. rural communities experience very different stressors than urban populations). In addition, the authors identify the processes of developing skills, building intergenerational and extra-familial relationships, and enhancing support networks as meaningful strategies in promoting resiliency. Finally, the authors state that "the most successful ideas and strategies related to community resiliency should be generated from the . . . residents themselves" (2004 66) linking with other philosophies of mental health promotion dedicated to building capacity and autonomy in health promotion practices.

In one of only four studies found that focused on the resiliency of indigenous individuals and communities (see Fuller-Thomson 2005, Barry et al 2006, Engel 2007, and Ungar et al 2008), Engel outlines the importance of Native American perspectives and beliefs in informing strategies aimed at enhancing resilience. Similarly, Ungar and colleagues (2008) argue that "program outcomes are more likely to capture experiences associated with resilience when cultural and contextual differences are built into the design" (11). The authors provide the example of an education program that honours students' cultural contexts while at the same time addressing the social injustices they face on a daily basis, arguing that "programs that simultaneously promote culturally embedded and meaningful expressions of power and control, identity, relationships, and cohesion are likely to help young people navigate to health resources effectively" (2008 11).

Self-Determination (Including Self-Efficacy)

Overview

The concept of self-determination, as it relates to mental health research, is used in divergent ways throughout the disciplines. In our review of the literature, three perspectives in particular stand out:

1. Its use within psychology;
2. Its development within social work theory and practice; and
3. Its use within literature surrounding indigenous well-being and self-government.

In the field of psychology, the most prevalent discussion, psychologists Deci and Ryan (1985, 2000) have developed the concept of self-determination theory, stating that self-determination consists of human motivation and personality factors which enable an individual to endorse their actions within a particular social context. In their recent work, Deci and Ryan identify competence, relatedness, and autonomy as components of self-determination and as basic human needs, necessary for the facilitation of social growth and personal well-being (Ryan and Deci 2000). Psychological research surrounding self-determination theory primarily uses empirical methods in order to identify both what contributes to human motivation and how to foster greater degrees of autonomy and competence. This view of self-determination within mental health is echoed in research by Vansteenkiste and Sheldon (2006), where the researchers incorporate self-determination theory and the concept of motivational interviewing (see also Vansteenkiste and colleagues 2007) in an effort to increase individual feelings of self-efficacy. The concept of self-efficacy also has ties to self-

determination such that it refers to one's own sense of competence or causal agency (Bracke et al 2008).

Branching away from the clinical use of self-determination theory, the field of social work theory and practice has used the concept of self-determination in relation to client/practitioner relationships. Specifically, researchers identify self-determination to be an ethical responsibility in the provision of care (Reamer 2000, Ffloyd 2006). Defined as "the condition in which a person's behavior comes from his or her own wishes, desires and decisions" (Ffloyd 2006 para. 1), social workers are called to promote self-determined behaviours within their clients. Ffloyd (2006) indicates that the concept of self-determination has been heavily theorized in social work ethics (see Pearlman1975, Abramson 1996, Rothman et al 1996) and is set up in contrast to the paternalism/beneficence model of social work practice. However, Ffloyd states that empirical evidence of the benefits of self-determination in relation to mental health is largely absent from social work literature.

The concept of self-determination is used quite differently within indigenous knowledges, such that the term refers more to the necessity for mental health research and practices to be conducted and determined by indigenous individuals and communities. As a result of a history of western imperialism, many indigenous populations have been immersed in quests for self-government both politically and in relation to the provision of health services. As Williams defines it:

> Self-determination is the ability of individuals and communities to live lives that they have to value. It may be roughly equated to mental well-being. Self-determination occurs at individual and collective levels and includes the ability of people to authentically express themselves through consciously chosen identities. This includes chosen forms of cultural expression that are supported by access to health capacities, e.g. economic resources, social structures, and decision-making institutions. (2007 6)

Similarly, Smye and Mussell (2001) relate the concept of self-determination to self-government when discussing indigenous persons, arguing that communities that are self governing are empowered by greater commitments to community accountability and responsibility as well as being healthier and more involved in the overall well-being of the community and its members. A number of indigenous researchers have taken this approach, claiming that mental health research must be determined by indigenous perspectives and world views in order for culturally-based models of health, identity, and value to frame mental health promotion practices (Chino and DeBruyn 2006, Williams 2007, Smye and Mussell 2001).

Theoretical Perspectives

As the definitions of self-determination have taken different forms within the literature, so too have theoretical perspectives on the concept. Deci and Ryan's self-determination theory argues that it is human nature to strive for autonomy, competence, and relatedness (Ryan and Deci 2000). Furthermore, they argue that these psychological needs are universal and that they have a direct relationship with improved well-being (Deci and Ryan 2008). The specific definitions of each of these basic needs provide the theoretical basis for Deci and Ryan's self-determination theory, such that autonomy refers to "the freedom to choose one's own behaviors in accordance with one's inner needs, feelings and thoughts" (1980 1112). Competence refers to people's feelings of self-efficacy, and relatedness is the general feeling of connection and of being cared for within a particular environment.

Self-determination theory has been criticized within the research, particularly in regard to Deci and Ryan's argument that the concept of autonomy is a universal need. As Ryan and Deci paraphrase "some cultural relativists have maintained . . . that the need for autonomy is important only in cultures that value individualism and is essentially irrelevant in cultures that value collectivism" (2008 183). This criticism aligns with concerns regarding liberal humanism's value of the 'free and

autonomous individual,' and the view that the self-determined individual must be completely unconstrained by social convention. As Ffloyd points out:

> The roots of the concept reach back to the Enlightenment. As perennial as the ideas of self-determination, freedom and liberty are themselves, so is the competition and tension surrounding them in a society that equally values social welfare, general safety, protection and maintenance of the community. (2006 para. 1)

—thus indicating that the individualistic model has been met with resistance. Consequently, the theoretical discussion of self-determination within the field of social work is much more complex.

Rothman and colleagues (1996)[12] outline a debate that exists within the field of social work. On the one hand, social workers have a responsibility to be helpful and to protect persons from harm, while on the other hand, they are expected to provide supports which enable the autonomy and self-efficacy of those who access social services. Aware of the ties to liberal humanist doctrines, Rothman and colleagues (1996) are still wary of the conceptualization of self-determination; however, they and others argue that within the social service sector, it is necessary that persons be encouraged toward the exercise of self-determination at the expense of outdated and paternalistic methods.

Use of self-determination in reports on indigenous health and well-being take a different approach, understandably considering the history of paternalistic attitudes toward the health and well-being of indigenous persons. Within the literature relating to indigenous well-being, self-determination is often viewed as a goal, and it is enabled through means such as community-driven research programs and health programs, and other capacity-building methods rather than through individualistic studies. However, as Chino and DeBruyn state:

> for many tribal communities, the conceptualization and implementation of capacity building strategies are themselves disparate in that they are based on imported Western frameworks rather than on indigenous epistemologies and indigenous 'ways of knowing.' (2006 596)

Chino and DeBruyn further argue that if self-determination within indigenous communities is truly a goal, then models and theoretical perspectives for health programming and practice have to be grounded upon an indigenous knowledge base. This particular view of self-determination views the concept more as a means by which to attain better overall health and well-being through involvement in the creation and provision of care, whereas the previous, psychology-based analysis of the concept focuses on the specific character traits necessary for its development.

Relevance to Mental Health and Well-Being

In a critique of mental health legislation that was implemented in Britain, Plumb (1999) identifies the role that self-determination plays within mental health practice. Essentially, the legislation she is critical of imposes more authoritarian guidelines, described to be in the interest of the patient or client. However, Plumb argues that coercive or paternalistic frameworks within mental health are outdated and proven to problematically affect the feelings of autonomy, self worth, and self efficacy of those accessing services.

There is little research that outlines specific benefits of self-determination; however, there is general consensus that the construct is beneficial to mental health, both within the individual (Ryan and Deci 2000, Reimer 2000, Rothman et al 1996) and as a goal for communities (Chino and DeBruyn 2006, Williams 2007). In a review of the health benefits of self-determination for persons with intellectual disabilities, Shogren and colleagues (2006) indicate that although there is little evidence of a direct relationship between self-determination and specific mental health benefits, "people who self-direct their supports through consumer-directed service delivery models . . . report having a higher quality

[12] Note, this perspective is more representative of clinical models of social work rather than community development approaches.

of life than individuals who participate in traditional, agency-directed service delivery models" (106). Further, in a study of the health benefits of peer support, Bracke and colleagues (2008) found that an individual's provision of peer support services had a positive impact on self-esteem as well as feelings of competence and social usefulness. These characteristics are closely aligned with definitions of self-determination but more specifically with the related concept of self-efficacy.

In regard to the health benefits of self-determined health policy and programming at the community level, it is more efficient to look at the negative effects of experiencing a lack of autonomy or control over one's environment. As Cook and Jonikas indicate, persons with psychiatric disabilities in general experience low levels of self-determination in their lives and as a result have higher incidences of poverty, homelessness, and other related health problems (2002).

Application to Mental Health Promotion Practice

Similarly to the construct of resiliency, self-determination is considered to be a primary principle of mental health promotion and is integral to the development of many mental health promotion initiatives (Labonte 2005, Williams 2005, Kermode et al 2007). As described above, self-determination in health programming, policy, and treatment plans has positive health outcomes, particularly in the case of indigenous communities. Health promotion strategies that contribute to feelings of self-efficacy and autonomy include participatory action research (Chino and DeBruyn 2006), peer-to-peer strategies (Bracke et al 2008), and self-directed treatment programs (Cook et al 2002).

Also, Cook and Jonikas (2002) argue that one subversive tactic for increasing self-determination is to provide extensive anti-discrimination training for health practitioners and staff in order to transform and challenge discriminatory views that people with mental health problems are incapable of autonomy in their own lives. One mental health promotion strategy in Ontario (the Ontario Peer Development Initiative) has used these principles to create a program that builds the capacity of persons with mental health problems (see Pape and Galipeault 2002 32). Particular initiatives include peer-support and self-help groups, the development and operation of small businesses by participants, skills development, and the provision of sensitization training to the community and staff. In an evaluation of the program, researchers found that participants felt better about themselves, had higher levels of participation in their communities, and had improved abilities to cope with their own mental illnesses (Pape and Galipeault 2002).

In a discussion regarding indigenous-determined health practices, Chino and DeBruyn state that:

> Capacity building for indigenous people needs to go beyond 'action planning' and 'engaging leadership,' concepts that are often the first steps in Western models. Before indigenous people can effectively engage in building healthier communities, the wounds caused by colonization, historical trauma, racism, and disparities in health, education, and living conditions need to be acknowledged, treated, and healed. (2006 598)

By taking a holistic and culturally-based approach to building capacity, and consequently community-determination, mental health promotion practices will be able to move out of the shadow of western conceptions of the autonomous individual, and toward a focus on direct experience, interconnectedness, and relationships in the strengthening of communities (Chino and DeBruyn 2006).

Spirituality

Overview

Like mental health itself, the concept of spirituality is difficult to define. Often the term is linked with concepts of religion or faith; however, there are important distinctions between religion and spirituality. Many view religion or religiosity as a more public, institutionalized system of beliefs, practices, rituals, and symbols (Richards and Bergin 1997). Often, religion acts as an organized means of developing a relationship to, and understanding of, a deity, a god, or another form of religious leader. Spirituality, on the other hand, often refers to the more private beliefs and values that guide us and is consequently viewed as an "inherent component of being human, and is subjective, intangible, and multidimensional" (Tanyi 2002 5000). Canda provides a general definition of spirituality as "a set of personal beliefs derived from the individual's perception of self and his or her relationship to both the natural world and some metaphysical realm" (1989 37).

From these definitions, the concept of spiritual wellness has developed within mental health practices, originating from medical wellness and health promotion literature (Westgate 1996). The concept is based on the holistic notion that the body, mind, and spirit are connected and that the health of any one of these areas has an affect on the health of the others. Historically, health education has focused primarily on physical wellness, and the counselling professions have focused on emotional, social, and occupational wellness (Chandler et al 1992). The inclusion of spiritual wellness within these categories encourages recognition of the interconnectedness of the mental, emotional, physical, and spiritual realms.

The concepts of both spirituality and spiritual wellness are most often understood at the level of the individual, where spirituality is believed to be a private, individualistic process of self discovery and determination of meaning. As Opatz claims:

> [Spirituality is] the willingness to seek meaning and purpose in human existence, to question everything, and to appreciate the intangibles which cannot be explained or understood readily. A spiritually well person seeks harmony between that which lies within the individual and the forces that come from outside the individual. (1986 61)

Similarly, Hawks refers to spirituality as a sort of personal journey which requires "a high level of faith, hope and commitment in relation to a well defined world view or belief system that provides a sense of meaning and purpose to exist in general, and that offers an ethical path to personal connectedness with self, others, and a higher power" (1994 6).

In addition to viewpoints which view spirituality as an individualized process, a number of researchers have looked at spirituality as it pertains to the community or how it operates at the systems level. Heintzman (1999) suggests that a broader view of spirituality pays attention to the relationships that develop between the individual, the community, and an external religious/spiritual figure (i.e. God). This relationship can take the form of selflessness and a desire to help others (Banks 1980) as well as the process of working together toward a greater good (Chandler et al 1992). Westgate (1996) suggests that the spiritually well person is one who engages with others through shared values, mutual support, and community outreach. This aligns with literature discussing the spiritual sense of transcendence—of being part of something larger than oneself—as an important component within the spiritual (and rational) community (Hill et al 2000).

Although there are attempts to understand spirituality within a cultural context, there is little to no literature that looks specifically at cultural differences that arise when applying spirituality to mental health. For example, and as the next section will demonstrate, although spirituality has been determined to be a large component of Aboriginal persons' health and well-being (Hunter 2006, Kirmayer et al 1994), researchers rarely explore the particular epistemological differences between spirituality as it is articulated within an indigenous world view and as it is articulated within a western world view.

Theoretical Perspectives

Dyson and colleagues (1996) suggest that the quest to find meaning in life is a focal point of mental health discourses that take spirituality into account, where an individual's relationship to others, to self, and to God contribute to the perceived meaning. They also suggest that spiritual well-being results in the development of one's inner resources, contributing to things such as individual resiliency, feelings of self-efficacy, and empowerment. Similarly, Anderson, Maton, and Ensor describe a religious world view as "a response to the human need for understanding the world, one's particular circumstances, and our inevitable mortality" (1991 11). In one theoretical framework for mental health practices which take spirituality into account, Anderson and colleagues identify three guiding principles, including: a promotion-oriented philosophy; a holistic view of life; and a strong sense of social responsibility.

Another framework for understanding spirituality in relation to mental health views the construct as a component of all areas of health. Where wellness is conceptualized by some as consisting of six major dimensions: intellectual, emotional, physical, social, occupational, and spiritual (Hettler 1979, 1991), Chandler and colleagues (1992) suggest that spirituality should be considered as more than just one of six dimensions of health and rather as an integral component of each. Thus, the concept of wellness consists of both one's personal health and one's spiritual health within the dimensions of intellectual, emotional, physical, social, and occupational health.

This philosophy of health believes that attending to both personal and spiritual health enables greater balance within the individual and will be more likely to have transformative effects. As Chandler and colleagues state, "spiritual health provides an avenue through which the individual can create the new and more complete self" (1992 171). Although the authors are intent upon forming a more holistic model of health and well-being, concepts of individual "betterment" and of creating the "new and more complete self" may have detrimental effects on individuals not able to successfully navigate their own mental health issues.

In relation to a more community-based perspective of spiritual well-being, a number of authors view spirituality and aspects of religion (e.g., liberation theology) as important factors in enhancing community capacity through the creation of ethical and empowering social and economic norms. This approach arises out of modernist principles such as humanism, structuralism, and the institution of religion itself in the effort to create a system or structure of spirituality which then structures the community.

Poststructuralists have long identified religion as a discursive institution of power which implements normalized expectations for moral behaviour. Similarly, critical theorists have implicated religious systems and organizations as means of control, which "legitimates the interests of the ruling gender, generation, race, nation, individual, collective, or class" (Seibert 2001 6). Interestingly, in its current renaissance within the field of mental health, spirituality is considered to be an alternative movement, conducted in contrast to the orthodox clinical practices, which rely on scientific fact rather than the intangible and multi-dimensional spirit.

The concept of holistic healing and the interconnectedness of individuals with their environment is not a new idea as it has long been a key component of indigenous epistemologies and world views. Although others have pointed to the need to differentiate between spirituality and religion, this is particularly important in reference to indigenous peoples as the institution of religion—particularly Christianity and the Catholic residential schools—has had detrimental effects on the spiritual, physical, and emotional well-being of their communities. Accordingly, the concept of spirituality, as understood from an indigenous perspective, is far from that of a "commodity that can be held, manipulated, or controlled" and instead it is an interconnected

process that "exists in all aspects of life and the universe" (Damianakis 2001 24). Essentially, the tendency to view mental health as something distinct from health in general is foreign to Aboriginal teachings, as Kirmayer and colleagues claim:

> The whole emphasis of contemporary psychiatry on describing discrete categories of illness runs against the tendency in many Aboriginal healing traditions to look for connections or inter-relationships to account both for the cause and cure of distress. (1994 56)

Although the inclusion of spirituality within mental health practices is itself a new event, brought forth largely by alternative and non-orthodox movements, the discourse is fuelled, in part, by a liberal humanist framework: the quest for self-betterment or for making sense of one's individual role in the world. As indigenous perspectives demonstrate, there is a need for departure from western perspectives of spirituality to those which are more culturally based and which take an interconnected approach to the spiritual wellness of the community, environment, and the individual.

Relationship to Mental Health and Well-Being

There is increasing scholarship surrounding the relationship of spirituality, or spiritual wellness, to mental health. As Reed declares, "spirituality is regarded as a basic characteristic of humanness, important in human health and well being" (1992 349). In a review of the relationship between spirituality and health, Thoreson writes that "empirical evidence based on over 300 studies has demonstrated in many but not all cases that a positive relationship exists between spiritual or religious factors and health" (1999 294). Some examples of these findings include greater life expectancy and overall health conditions among some religious groups (e.g. Mormons, Adventists), lower rates of depressive symptoms and suicide, lower rates of divorce and higher rates of marital satisfaction, and lower rates of alcohol and other drug abuse (Thoreson 1999 294). In addition, studies have indicated that individuals who ascribed to some form of religion or spirituality appeared to have more positive life assessments and a more hopeful, optimistic outlook in spite of immediate negative circumstances (Heintzman and Mannel 2002 71).

Although many researchers have identified a positive relationship between spirituality and health, others are wary of uncritical acceptance of this relationship, reminding us that religion, both as an institutional construct and in practice, has had negative effects on individuals and communities as a result of dogmatic, authoritarian, and discriminatory teachings (particularly toward women, non-heterosexuals, those of racial minorities, and those not privileged by the prevailing religious ideology) (Maton 2001, Seybold and Hill 2001). Also, spiritual awareness can potentially lead to negative consequences for mental health as a result of inner conflict and guilt over adhering to a religious or spiritually-directed life (Tanyi 2002, Carson 1989, Horsburgh 1997).

Application to Mental Health Promotion Practice

The inclusion of spirituality within mental health practices has received the most attention within nursing journals and articles (Chandler et al 1992, Culliford 2005). In an early study that takes spiritual wellness as its goal, Burdhardt and Nagai-Jacobson identify a number of ways for nurses to provide spiritual care for their clients: they may encourage clients to consider questions such as 'What do I feel good about?', 'What helps me—from within myself and from outside?', and 'What worries me most?'. Based on the clients' replies, the attending nurse can consider: 'What is sacred to this person?', 'What gives life meaning?', 'For what/whom will this person make sacrifices?', 'Does the person have a sense of belonging—to a primary group? —to the human family?' (Burdhardt and Nagai-Jacobson 1985 195). The authors then provide examples of how the nurse might approach the client based on their perception of the particular spiritual understandings/beliefs and, through understanding where they're at, the nurse can then guide them on their spiritual journey.

The process of guiding individuals through spiritual discovery is still prevalent within the literature (see Culliford 2005); however, in an ethnographic study of how First Nations people incorporate

spirituality and health issues, one participant notes that spirituality was a better fit when it was a component of all forms of health practices, not simply developed within one-on-one conversations between practitioner and client.

Culture

Overview

In recent years, the concepts of culture and cultural identity have received a great deal of attention in mental health promotion literature. Whereas historical research has almost ignored the role of identity, culture, race, and ethnicity on health, contemporary researchers are investigating the ways in which these factors act as determinants of health and can be incorporated into strategies of mental health promotion. Like many mental health promotion constructs, culture has a wide range of definitions and interpretations. Ekman and Emami (2007) describe it as "the inherited ways of life in which a person is socialized, including value systems, beliefs and norm systems that different groups deal with" (2007 417). Similarly, Dosamantes-Beaudry describes culture as the "one thing that gives humans our distinctive identity. . . . culture provides us with the rules of the ways we may express ourselves, behave, think, work . . . and organize ourselves economically and politically" (1997 129).

In a different view, Kent and Bhui (2003) describe culture as merely one component of a person's identity, subject to change over time as a result of contact with other cultures. This contact can have the effect of assimilation or acculturation, where acculturation is bi-directional and described as the "phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (Redfield et al 1936 as quoted in Kent & Bhui 2003 243). Assimilation, on the other hand, is unidirectional and results in the absorption of one culture into another.

The concepts of acculturation and assimilation are particularly important to discussions of indigenous and immigrant groups, as Kirmayer and colleagues (2003) argue that Aboriginal people in Canada have experienced extensive amounts of cultural oppression due to forced assimilation by Euro-Canadian institutions. Consequently, within the literature, the concept of culture has been most extensively discussed in relation to indigenous and immigrant groups as many have argued that assimilation and loss of culture have detrimental effects on the mental health of individuals and entire communities (Chandler and Lalonde 1998, Kirmayer et al 2000, 2003, Mossakowski, 2003).

Within indigenous and indigenous-focused literature, the concept of culture is used more as an ontological framework than as a characteristic of effective practices. Hunter and colleagues discuss the integral role of culture in health initiatives, stating that "there is a belief by Aboriginal clients and non-Aboriginal health professionals that an Aboriginal perspective and world view on the use of traditional healing are beneficial to the physical, spiritual, emotional, and mental aspects of health" (2006, p. 14). Not only that, but research has indicated that culture, including practices, norms, and world views, influences the distinct conceptualizations of health and well-being that different groups hold (Hunter et al 2006, Wilson 2003). As a result, culture is increasingly discussed as more than simply a demographic or individual characteristic and instead as a distinct social and environmental orientation (Murray 1998).

Theoretical Perspectives

Discussions of culture in relation to mental health rest upon theoretical understandings of social capital, social inclusion/exclusion, citizenship, and spirituality. As Snowden (2005) indicates, the social norms and perspectives of a community or particular cultural group have an effect on the health and well-being of its members.

From a psychological perspective, culture and self are believed to mutually-constitutive, where "human nature is seen as emerging from participation in cultural worlds, and of adapting oneself to the imperatives of cultural directives" (Heine 2001 as quoted in Wallace 2005 2). Within anthropology, understandings of culture have shifted from the view that they are closed,

homogenous systems to the view that cultures are multi-dimensional and constantly changing (Kirmayer et al 2003). Similarly to psychological views, anthropologists describe a linked relationship between the individual and culture, stating that:

> individual identity and self-esteem, which are central to health and well-being, may draw strength and depth from collective identity. Where the collective is devalued, the individual may suffer corresponding wounds to their esteem and to their social capital power and mobility. (Kirmayer et al 2003 21)

Research on culture as a determinant of mental health has often included indigenous, immigrant, and other racialized groups as study populations or test subjects; however, this does not necessarily mean that the research has been developed out of culturally-sensitive or indigenous-specific epistemologies. In fact, there is a growing body of research that challenges dominant views of culture within mental health research, arguing that they rely on western paradigms of health that are economically oriented, specialized, and abstracted from real-world experiences (Edwards et al 2004). The influence of Cartesian dualism has maintained both the mind/body division and the division between self and culture, where the self is thought to be separate from his or her community/environment (Dwairy 1997).

Although social constructionist theories have argued that the self is in fact constructed by surrounding socio-cultural systems, it appears that indigenously-developed and -determined models of mental health promotion extend these challenges further. For example, Edwards and colleagues (2004) call for models of health promotion that rely on the interconnectedness of mind, body, spirit, and environment. Cross (2003) argues that within western medicine the concept of culture has been framed as a problem in need of solving and, further, that western models "which [rely] heavily on linear thought and scientific process are likely to understand problems and solutions in terms of cause-and-effect relationships" (357). In contrast, Cross points to cultural frameworks that rely on teachings of balance, spirituality, interconnectedness, or more specifically on a culturally-informed theoretical model he describes as a relational world view. Through this approach, Cross argues that culture is viewed as a resource for health and well-being, rather than an emergent health crisis.

In sharp contrast to neo-liberal and Euro-western medical models that focus on the individual as an autonomous rational entity, indigenous epistemologies situate the body within its spatio-temporal location, such that the experience of cultural identity is inextricably linked to the land. In an exploration of the relationships between culture, land, and health, Wilson (2003) argues that one's identity is part of the interconnection with place and health, where "the land represents the interconnected physical, symbolic, spiritual and social aspects of First Nations cultures" (83). Through indigenous research, it is evident that western world views have provided limited examination of culture as an embedded and ontological property of community systems and environments.

Relevance to Mental Health and Well-Being

In Canada, the assimilation practices that occurred through residential schools have had devastating effects on indigenous communities. Also, the ongoing experience of discrimination based on cultural identity has had a continuing impact on mental health, resulting in higher incidences of depression, alcoholism, suicide, and violence among indigenous communities (Kirmayer et al 2000). Processes of acculturation can also have detrimental affects on mental health. Kent and Bhui (2003) describe the advent of "acculturation stress," effects of which include paranoid behaviour, anxiety, depression, and desocialization leading to marginalization.

Also, Ghaffarian (1998) found that immigrant women had more difficulty with processes of acculturation than men, indicating the need for a gender-based analysis of the topic. Negative acculturation can be described as "culture shock," or "a sudden unpleasant feeling that violates expectations of new culture and causes one to evaluate one's own culture negatively" (Bhurga 2004

252). Culture shock particularly affects immigrant and migrant groups and can result in feelings of deprivation, rejection, confusion in values and self identity, and anxiety (Bhurga 2004).

On a positive note, ethnic and cultural identification has been shown to benefit mental health by providing a sense of pride, cultural and social inclusion, and acting as a buffer against stress and anxiety (Mossakowski 2003). Suzuki-Crumly and Hyers (2004) state that there is a positive relationship between ethnic identity and self-esteem, so much so that those individuals who identify with a minority identity exhibit higher levels of psychological well-being than those who identify with a majority identity. More importantly, the literature increasingly indicates that mental health promotion strategies, which are not only culturally-sensitive but also informed by indigenous epistemologies, are more apt at responding to the particular mental health needs of those accessing services (Kirmayer et al 2000, Adelson 2000).

Application to Mental Health Promotion Practice

There is a great deal of literature that incorporates the construct of culture into mental health promotion practices; however, much more attention has been given to the shortcomings within the field—particularly regarding cultural context and diversity—calling for changes within health research, policy, and programming (Snowden 2005).

In an overview of culturally-based mental health care in Vancouver, Ganesan and Janzé found the following factors to influence positive outcomes among persons who accessed services: emphasis on community-based services (including multicultural representation within decision-making and administration teams); linguistic and culturally-appropriate information; acknowledgement of the experiences of immigration and migration as significant health determinants; and an emphasis on participatory research (2005 488).

Similarly, in an ethnographic study linking First Nations healing traditions to positive mental health outcomes, Hunter and colleagues (2006) outline a number of implications for practice and research including the development of programs that take balance, holism, and healing to be their foundation. The authors further indicate that:

> The concept of healing holistically is a fluid and dynamic process for an individual or community. Healing holistically . . . includes following a cultural path (losing and regaining culture), regaining balance (physically, spiritually, emotionally, and mentally), and sharing in the circle of life (respectful interactions with others). (Hunter et al 2006 21)

A central theme that emerges within the literature is the need for programs and strategies that are developed by, instead of for, specific indigenous and immigrant groups (Ganesan and Janzé 2005, Alberta Mental Health 2006, Edwards et al 2004). Similarly to suggestions made about mental health promotion in general, initiatives such as participatory action research and community-led programming empower communities and lead to greater levels of social capital and self-determination, and consequently have positive effects on overall health.

Social Capital

Overview

The concept of social capital has received a lot of attention in recent years. With links to the fields of sociology, economics, and psychology, among others, the concept of social capital attempts to explain the socio-economic success of certain communities in relation to non-economic factors, such as civic vitality and social cohesion—e.g. the presence of community networks or participation in community organizations. In general terms, the concept incorporates a variety of overlapping constructs, including "social trust/reciprocity, social cohesion, sense of community and social participation" (Boyd et al 2008 189).

Although researchers have been eager to establish a positive link between social capital and mental health outcomes, recent discussions have been more critical, claiming that the field of social capital research has been plagued by conceptual and methodological ambiguity. Falzer (2007) describes two dominant streams of thought that have characterized the field.

The first arises from the sociological perspectives of Bourdieu, Coleman, and Portes and adheres to an instrumental view, where social capital is "a means by which individuals gain access to economic and cultural resources" (Falzer 2007 35), or more specifically:

> Social capital is an attribute of an individual in a social context. One can acquire social capital through purposeful actions and can transform social capital into conventional economic gains. The ability to do so, however, depends on the nature of the social obligations, connections, and networks available to you. (Bourdieu as quoted in Sobel 2002 139)

Similarly, Coleman (1990) describes the instrumental value of social capital as a productive process that makes it possible for individuals to achieve ends that would otherwise be unattainable. Through participating in the relationships, levels of authority, and organizations of a community, individuals can make positive personal gains.

The second stream of thought looks at social capital, not as an instrument of the individual or community, but rather as a feature of the community that is rich in characteristics such as trust and engagement. Putnam, an initial proponent of this view, argues that social capital "consists of the features of social organization such as social networks, norms and social trust that facilitate coordination and cooperation for mutual benefit" (1995 67). Its function within society is to strengthen a community's social fabric, promoting the values of reciprocity, citizenship, and diversity (Falzer 2007). Isuma similarly defines social capital as a "series of relationships, networks, and norms that facilitate collective action" (as quoted in Van Kemenade 2002 6), highlighting the goal of community-building, or collective agency. Consequently, through building the social networks and cohesion of any given community, the health of that community's members benefits.

Although there are contrasting definitions of the concept of social capital within the research, there are many areas of overlap as researchers from both perspectives focus on the mechanisms of bonding and bridging as forms of social capital. Woolcock (2001) differentiates between these mechanisms, describing bonding as links or ties between family members, friends, or neighbours, whereas bridging refers to horizontal links made between more distant relations such as colleagues, acquaintances, and associates, but still within people of a similar demographic.

In addition, critical studies of social capital have highlighted the vertical stratifications of social capital, which result from issues such as poverty, powerlessness, and exclusion (Fox 1996, Heller 1996). In his discussion of the various forms of social capital, Putnam pre-eminently responded to Fox and Heller's inclusion, claiming that a focus on bonding social capital can be problematic as it creates narrow, individualistic processes of gain, whereas forms of bridging that take vertical as well as horizontal differences into account are better for "linkage to external assets and for information diffusion….Moreover, bridging social capital can generate broader identities and reciprocity" (2000 22-23).

Recent literature has turned to a more critical view of the concept of social capital, highlighting the need to ground the field more firmly in theories that work with diverse communities.

Theoretical Perspectives

Although the concept of social capital has a relatively well-defined theoretical history, finding its roots in sociological and economic theories, contemporary scholars are wary of its current use in health research. A collection of papers on the topic demonstrate that research does not necessarily show a causal link between social capital and positive mental health outcomes; however, the authors

argue that this is not necessarily because the link does not exist, but because the research is currently lacking methodological and theoretical sophistication (McKenzie and Harpham 2006).

As demonstrated above, the definitions of social capital are diverse, but the instrumental and more connective approaches still dominate the research. At base, the former of these definitions relies on a more neo-liberal, economic approach that "assumes that society is made up of the sum of persons acting individually to achieve non-collective goals" (Van Kemenade 2002 5). These individuals operate within structural norms which determine who has access to capital, who benefits, and how capital functions, exemplifying a more mechanistic view of the way that social capital operates within a society. In contrast, Putnam's view of social capital draws on the roles of human characteristics and inter-relational behaviours such as trust, feelings of connectivity, and cooperation. Rather than focusing on the economic benefit of a community rich in social capital, Putnam points toward its benefit for human well-being (2000).

As it is used within health research, social capital draws on the more quantitative, economic approach as well as the more qualitative, community-based approach without a great deal of differentiation between the methods. As McKenzie and Harpham (2006) demonstrate, this ambiguity has contributed to a shaky foundation within the field, and they argue that if health policy and programming are to benefit from the concept of social capital, there needs to be a thorough re-evaluation of the ways in which it is used and understood within the field.

Demonstrating the import of critical theory to the topic of social capital, Skocpol (2003) and Bookman (2004) have examined the roles of dominant ideologies and gender-based norms in limiting the attainment of social capital. Specifically, they argue that the ways that women participate in social organizations (i.e. through caring work or less-recognized forms of social labour) often fall outside the parameters of determined indicators within particular studies.

Although researchers are beginning to take factors such as ethnicity, gender, and age into account when determining the benefits of social capital (Mai et al 2008, Usher 2006, Berry and Rodgers 2003), there is no evidence within the literature that the construct has been theorized within any alternative knowledge systems such as feminist theory or indigenous epistemology.

Relationship to Mental Health and Well-Being

When applied to mental health, social capital research explores the construct as a social determinant of health, such that it is recognized that the nature of a community's social systems have a direct relationship to the community's health and well-being. This relationship evolved out of conundrums within the health field. As Wilkinson states "neither medical nor genetic science can provide answers as to why one country is healthier than another, or why most countries gain two or three years of life expectancy with each passing decade" (1996 2).

There have been many positive investigations into the relationship between social capital and mental health. Putnam demonstrated that child development was positively influenced by trust networks and norms of reciprocity within family, peer, and education environments (2000). Similarly, in a study involving rural Australians, Berry and Rodgers (2003) determined that higher levels of trust within a community resulted in less instances of psychological distress. Another study surveyed Australians aged 16 years and older to examine the benefits of social involvement and feelings of safety on mental health morbidity. Their findings indicated a positive relationship, but they called for more research into differences in socio-economic status for these groups (Phongsavan et al 2006).

Although there are a number of benefits to social capital within a given community, current trends in the literature point more to the gaps in this knowledge base than to the achievements. As Murphy summarizes, "social capital cannot be accepted uncritically as a universal remedy for psychological maladies. Rather than base analyses on aggregated characteristics of an area, it may be more useful to acknowledge that research on geographies of mental health needs to incorporate the contextual dimensions and nuances of the sociopolitical landscape" (2008 58-9).

Application to Mental Health Promotion Practice

Within the field of mental health promotion, researchers and policymakers must be cautious of uncritical acceptance of social capital theory. As Kay states, "Social capital is not always 'a Good Thing'" (2005 170). Referring back to Putnam's discussion of the differences between bonding and bridging, Kay states that "social capital that concentrates too much in binding the community into a cohesive unit can make a community more isolated and less tolerant of strangers and outsiders" (170). As a result, mental health programming which takes social capital into account must make sure to promote more vertically-oriented bridging links between groups in the formation of social cohesion.

Van Kemenade echoes this concern in claiming that "for those who follow the neoliberal doctrine . . . social capital could be used to justify privatizing, or even reducing public services" (2002 20). However, the literature demonstrates that those practices that encourage processes of community-building and social-responsibility have more potential to have positive effects on individuals and communities as a whole (Kay 2005, Van Kemenade 2002, Falzer 2007).

Power and Empowerment

Overview

Within mental health promotion research, increasing attention has been paid to the processes of power and powerlessness and how they affect individual health and well-being. Generally described as having access to adequate resources as well as control over one's destiny, power enables individuals, groups, and nations to procure resources, to create systems of meaning, and to make sovereign choices. Adversely, the experience of powerlessness denotes the absence of autonomy, access to resources, and ultimately the lack of experiencing oneself as an agent. Many studies have linked powerlessness with instances of poor health, including greater propensity for disease (Syme 1988, Wallerstein 1992) and elevated levels of depression (Zimmerman and Rappaport 1988, Seeman and Seeman 1983). In response to these links, mental health promotion has turned toward the processes of gaining power or empowerment as means of improving mental health.

Literature on mental health and empowerment appears to have been characterized by a burst of theoretical and conceptual inquiry during the late 80s to the mid 90s (Gibson 1991, Wallerstein 1992, Swift and Levin 1987) and then a plethora of studies (Bergsma 2004, Motahashi et al 2007, Vail and Xenakis 2007), reviews (Fitzsimons and Fuller 2002, Laverack 2001), and evaluations (WHO 2006, McCubbin and Dalgard 2002)) of its applicability to mental health promotion throughout the last decade.

The concept arose largely from self-help and social justice ideologies such as those developed within the women's movement. There is general consensus that the theoretical framework ties back, in part, to Friere's work (1970) which sought to empower oppressed groups to respond to their powerlessness and to work together for social change. Since Friere, the concept of empowerment has been used by diverse movements (feminism, gay rights, black power, rights of persons with HIV/AIDS) (see Gibson 1991) and, although the incorporation of empowerment practices has been varied within each, most of these early movements enlisted its aim of increasing the levels of control that people have over their own lives.

Within the literature, the concept of empowerment has been defined both as an outcome and as a process; the former refers to it as a quality or a property, and the latter refers to it as "a process by which people, organizations and communities gain mastery over their own lives" (Gibson 1991 355). In addition, researchers have differentiated between psychological or individual empowerment and

community empowerment. Psychological empowerment can be defined as an individual's realization of his or her own particular resources and potential (Klepp 2007), and community empowerment includes:

> a raised level of psychological empowerment amongst its members, a political action component in which members have actively participated, and the achievement of some redistribution of resources or decision making favourable to the community or the group in question. (Rissel as quoted in Klepp 2007 6-7)

The concept of empowerment has been central to mental health promotion research from the beginning, as mental health promotion intrinsically focuses on the positive aspects of health and human ability. Within community psychology, empowerment is and has been used as a preventive model (Rappaport 1987), while in mental health promotion literature it has been appropriately incorporated into models of health promotion, encouraging the development not only of individual capacity but articulating the need for programming and policy that enable the empowerment of both communities and their members. In a definition which looks at empowerment as both an outcome and a process of individuals and communities, the World Bank defines it as:

> the process of increasing capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes to build individual and collective assets, and to improve the efficiency and fairness of the organizational and institutional context which govern the use of these assets. (2005 n.p.)

Theoretical Perspectives

As previously mentioned, the concept of empowerment arose from both the social justice and self-help movements through such means as personal development, social action, and consciousness-raising. In *Pedagogy of the Oppressed* (1970), Friere discusses the intricate social, economic, and political power systems which ensure that those with power benefit while those without experience the detrimental effects of powerlessness. Emanating from critical theory, the concept of "pedagogy of the oppressed" then refers to the process of developing power from within, of empowering individuals and communities to bond together and speak out against inequities in an effort to upset the scales of resource distribution (including social, political, and economic resources) within any society.

Although the concept of empowerment is often problematically linked to an individual's quest for autonomy (Gibson 1991), in practice it is represented more by a philosophy of capacity building. As Fitzsimons and Fuller indicate, "the empowerment paradigm has served to challenge paternalistic practices in the mental health services, highlighting the fact that people can play a role in authoring their own destinies and participate fully in the life of the community without excessive reliance on professional supports" (2002 483). Fitzsimons and Fuller further demonstrate that mental health, as it is viewed within the medical system, has been informed by more orthodox ideologies from clinical psychology and psychoanalysis, both of which fail to recognize the extent to which they themselves, as dominant systems of knowledge, reinforce a hierarchical and disciplinary model of mental health. Empowerment strategies therefore mean:

> challenging control and social injustice, through political, social, and psychological processes that uncover the mechanisms of control, the institutional or structural barriers, the cultural norms and social biases, and therefore enable people to challenge internalized oppression and to develop new representations of reality. (WHO 2006 18)

An important factor within empowerment theory is that the very concept itself arises out of inequities within society (Friere 1970, Laverack and Wallerstein 2001), particularly the intersections

between individuals and the societal structures in which they participate (Zimmerman 1990). As Rappaport explains:

> to be committed to an empowerment agenda is to be committed to identify, facilitate, or create contexts in which therefore silent and isolated people, those who are 'outsiders' in various settings, organizations and committees, gain understanding, voice and influence over decisions that affect their lives. (as quoted in Fitzsimons and Fuller 2002 482)

This conceptualization of empowerment is indicative of social constructionist and poststructuralist theories of the impact of normative systems of knowledge on those who occupy marginal or non-dominant identities. However, although these useful theoretical frameworks are present within the literature, there seems to be a disjuncture between the research and the implementation of empowerment procedures. Although studies concentrate on populations that experience powerlessness, they fail to fully examine what makes up systems of power, including how they particularly affect marginalized groups such as indigenous persons and immigrants. As it is currently discussed within the literature, the philosophy of empowerment arises from those in power, demonstrating the need for conceptualizations that comes from those who actually experience powerlessness.

Relationship to Mental Health and Well-Being

Not only has it been documented that feelings of powerlessness, or the lack of power, result in negative health consequences (Bergsma 2004, Gibson 1991), but researchers have examined the reverse, determining that people who experience feelings of having control over their lives, whether through making important choices or having their needs and aspirations acknowledged within their environments, experience positive effects on their mental health (Adelson 2005, Williams 2005, Wilkinson 2004). As Nelson and colleagues articulate, "mental health is more than the absence of problems, it is also the presence of strengths" (2001 137).

In a study of 255 long-time users of self-help agencies, Segal and Silverman (2002) found that through providing programming that rested on principles of empowerment, clients had increased levels of self-reliance. Researchers also found that nursing home residents had better mental and physical health when they were given decision-making power within their environments (Rodin 1986). When applied at the community level, Wallerstein indicates that "participation in decision making and community actions can enhance psychological empowerment, with empowered individuals more likely to participate in community settings" (1992 200). Specific mental health benefits of empowerment at the community level include overall decrease in suicide rates (Motahashi 2007) and a reduction in rates of re-hospitalization after participation in self-help organizations (Trainor et al 1997).

Application to Mental Health Promotion Practice

The concept of empowerment is central to mental health promotion's focus on enhancing individual and community capacity regarding their own health and well-being. As a result, it is not uncommon for mental health promotion practices and programs to have empowerment listed as a key component of their policy or program guidelines. In a study of three mental health programs based upon mental health promotion principles, Nelson and colleagues (2001) found empowerment practices to be necessary for mental health programming to have positive outcomes. They outline these empowerment practices to be: the provision of access to resources such as employment, finances, and housing; the ability of individuals to control and monitor their own treatment services and plans; and the clients' meaningful participation in the service agency itself (Nelson et al 2001).

Motahashi and colleagues also argue that empowerment procedures are integral to mental health promotion following study of an initiative aimed at suicide prevention in rural Japanese communities. The initiative involved training people from within each community in suicide

prevention techniques so that workshops on suicide prevention were facilitated from within and not by 'experts' from outside the community (Motahashi et al 2007).

A work by Williams (2005), *The Mental Health Promotion Practitioner as an Agent of Self-Determination: Reflecting on practice*, applies critical postmodern theory towards illuminating the ways in which cultural identities and social statuses are mobilized (often unconsciously) by practitioners and mental health promotion-related organizations. She argues that an important part of the mental health promotion practitioner's role is the development of reflexivity in terms of becoming critically aware of the intersection between their own locations within social structures (i.e. through various identities, professional, and organizational roles) and those of the populations they are working with and, importantly, the use of these social power locations in ways which increase opportunities for empowerment within these populations.

Another particularly useful application of empowerment philosophies to mental health promotion is through the process of participatory action research. Participatory action research attempts to invert the hierarchical nature of the research process giving research participants the power to guide the research process. Furthermore, as part of mental health promotion, participatory action research is "designed to help community participants develop the knowledge they need to improve their quality of life and influence relevant policy, as well as build competent communities to effect social change" (Bergsma 2004 155-5).

Although the literature provides extensive discussions of empowerment practices and methods, most studies focus on mental health issues of the general population, such as learning disabilities (Deci and Chandler 1986), literacy issues (Bergsma 2004), or depression (Zimmerman and Rappaport 1988). With the exception of Williams' (2005) unpublished paper referenced above, of all the literature found for this review, not one looked at empowerment efforts that were culturally specific, indicating that although empowerment practices have positive outcomes within mental health promotion, these practices are not necessarily being devised from a non-western perspective and thus still possibly represent entrenched systems of power over indigenous groups and other ethnic minorities.

Social Exclusion, Social Inclusion

Overview

There is no shortage of literature regarding social inclusion and social exclusion and their effects on mental health. The concepts have been taken up by researchers, policy analysts, health practitioners, and governments in Europe, the United Kingdom, Australia, and Canada. As it is used within health literature, social exclusion refers to the experiences of being excluded from full participation within the social and political systems of a society. Walker and Walker describe the construct as:

> the dynamic process of being shut out, fully or partially, from any of the social, economic, political or cultural systems which determine the social integration of a person in society. Social exclusion may therefore be seen as the denial (or non-realization) of the civil, political and social rights of citizenship. (1997 8)

On the contrary, social inclusion refers to the advent of involvement, being accepted, or of belonging to the systems and processes of our families, communities, and societies (Guildford 2000). Some factors which contribute to social exclusion include stigma and discrimination, poverty, disability, marginalization, barriers to engaging in community activities/events, and isolation (Shookner 2002, Office of the Deputy Prime Minister 2004), or, more frankly, unemployment, poor skills, living in poor housing or unsafe environments, and ill health (Social Exclusion Unit 2003). Within the literature, particular groups are identified as experiencing greater incidences of social exclusion including ethnic minorities, sexual minorities, single parents (often female), adults with mental health problems, and low-income individuals.

Awareness of the concept of social exclusion developed in France almost 40 years ago when the country questioned why there were still people excluded from their innovative and comprehensive social welfare programs. As a result, European social inclusion models and policies have been part of government initiatives for years and have framed Canada's more recent conceptualizations of social exclusion as a prominent social determinant of health. Health Canada (see Guildford 2000) and others (Shookner 2002) has framed the issue as social and economic inclusion based on the close link between poverty and exclusion; however, as Walker and Walker explain, the terms must not become synonymous.

Poverty is more about "a lack of the material resources, especially income, necessary to participate in [society]" (Walker and Walker 1997 8). Although social exclusion can be the result of unemployment, socio-economic status, and shifting economic markets at local and global levels, it refers more to structural inequities that are perpetuated by these shifts such as systemic racism, barriers to women being able to enter the workforce, and the normative discrimination of persons with mental health problems (Murray 2001). Consequently, researchers have criticized the focus on those excluded and turned instead toward the systems that contribute to social exclusion. As Guildford writes, "exclusion describes the conditions many people face, but it also helps us to analyze and understand the *processes* by which social and economic exclusion occurs and is maintained" (2000 1).

Social exclusion has been a key concept for indigenous scholars and health practitioners in Latin America for a number of years, and they have recognized the distinct processes of racism, discrimination, and ethnocentrism that have systematically excluded indigenous persons from full participation in society.[13] More recently, scholars have incorporated social inclusion/exclusion into strategies and action plans directed at improving the social determinants of health for indigenous Australians (see Mowbray 2007, Hunter 2008).

However, Mowbray states that the concept of social inclusion, as it applies to indigenous communities, is embedded within other systemic health determinants and, therefore, requires a critical lens. He writes:

> The displacement of Indigenous people from their land through colonization is bound up with cultural disruption, social exclusion and tension, increased stress, diminished sense of identity and status, political and social subjugation, loss of control over lives and the loss of livelihoods. (35)

Thus, incorporation of the concepts of social exclusion/inclusion in indigenous–centred research and practice is characterized by a more multi-dimensional approach, cautioning against linear and ethnocentric views.

Theoretical Perspectives

In a review of the theoretical history of social exclusion, Labonte (2004) claims that earlier uses of the concept align more closely with social cohesion and social capital where "neo-liberal economic assumptions continued their global domination, cementing their gospel of liberalization, privatization, de-regulation and welfare minimalism" (116). Within this context, Labonte fears that the focus remains on a dangerous idealism or a drive for absolute social harmony that essentially halts diversity and movements for social reform.

In addition, the neo-liberal lens limits conceptualizations to an economic and individualistic focus, geared toward those who are excluded or unable to attain social capital, rather than on the systems and ideologies that perpetuate their exclusion. As Murray states "current interest in social exclusion does not pay appropriate attention to the structures and processes by which society creates social exclusion. Instead, the focus is on those deemed to be excluded, prioritizing the interests of the

13 Many of these documents are only available in their original Spanish. See Cajiao 2000 [Spanish], Kramer 2001 [Spanish], Elízaga 2004 [Spanish], and Cojtí Cuxil 2005.

'respectable majority' over those who are excluded" (2001 29). This criticism is influenced by poststructuralist theories that draw attention to the technologies of power as they manifest in social and political systems that maintain association for some while barring others.

In another critical examination of social inclusion/exclusion, Iwasaki and colleagues (2005) utilize a feminist lens to examine the ways that societal power dynamics influence and are influenced by public perceptions of various identity categories such as gender, race, sexuality, or ability level. The authors then illustrate how these perceptions work in tandem with socio-economic/cultural factors (such as poverty, inequality, and discrimination) to cause systemic exclusion and isolation.

Indigenous epistemologies build upon feminist and poststructuralist analyses of social exclusion/inclusion to point toward the structural factors that affect participation in society. However, indigenous scholars have expanded upon these positions to question the ontological basis of social inclusion theories as being dependent upon Euro-western value systems. In a report documenting the proceedings of the International Symposium on the Social Determinants of Indigenous Health, Mowbray writes:

> A quite separate and forcefully made point was that . . . the concept of social exclusion relates to exclusion from non-Indigenous society. This is taken as a problem. In contrast, Indigenous people 'are in fact marginalized from our capacity to practice our (own) knowledges, value our land and rivers, seas and resources.' This exclusion needs to be addressed. Indigenous people should have the right to be different and, if they wish, exempt themselves from the 'mainstream.' (31)

Australian scholars such as Mowbray and Hunter (2008) have offered a much-needed criticism of the foundations of social inclusion practices, asking questions such as: 'What exactly are indigenous and other disadvantaged Australians being socially included in?', 'What are they being excluded from?' and, more importantly, 'Does it matter?' (Hunter 2008 5). These critical perspectives, largely informed by indigenous epistemologies, examine whose interests are being represented in the development of policy and programming (the excluded or the excluders) and offer non-western conceptualizations of the constructs that may be more appropriate in a global context.

Relevance to Mental Health and Well-Being

Throughout the literature, social exclusion is recognized as a key social determinant of health (Murray 2001, Saloojee 2003, WHO 2003). Glover and colleagues found that children who experienced social exclusion (had no one to talk to, or to trust, and fewer meaningful friendships) had greater depressive symptoms than those who were more socially connected (1998). Structurally, individuals with mental health problems are one of the most excluded groups in any society—whether through discrimination, high unemployment levels, or barriers from accessing required services—and the literature widely holds that isolation can have debilitating effects on health and increase risks of suicide (London Department of Health 2001, Shookner 2004). Two significant determinants of social exclusion include economic factors, such as unemployment and poverty, and structural discriminations, such as racism, sexism, and homophobia. Mueser and colleagues (1997) conducted a long-term study of unemployed persons with serious mental health problems. In follow-up interviews they found that those who had found paid work had lower symptom levels, higher levels of self-esteem, and higher levels of functioning than those participants who remained unemployed.

Kafele (2004) outlines the ways that discrimination, and social exclusion intersect to limit Aboriginal persons from accessing services and getting care that is culturally appropriate. Iwasaki and colleagues (2005) examine the experiences of social exclusion by Aboriginal persons, gays and lesbians, and persons with disabilities. In line with the general perspectives, the authors determined that social exclusion, particularly of marginalized groups has a detrimental effect on stress levels and coping abilities. Following the study, the authors argue that culturally-appropriate approaches to

health polices and practices are necessary for practices aimed at reducing the negative effects of social determinants of health.

Application to Mental Health Promotion Practice

The concept of social inclusion is a central part of mental health promotion literature, exemplifying its focus on positive outcomes rather than illness-oriented or 'absence of health' models. As Saloojee states, this method "reflects a proactive, human development approach to social well-being that calls for more than the removal of barriers or risks. It requires investments and action to bring about the conditions for inclusions" (Saloojee 2003 viii).

One mental health promotion strategy that embodies this philosophy is Health Canada's *Inclusion Lens* workbook (Shookner 2002). The workbook consists of a series of questionnaires designed to guide practitioners, policymakers, and programmers through the development of initiatives aimed at social exclusion/inclusion while paying attention to the diverse dimensions of the construct, including: cultural, economic, functional, participatory, physical, political, relational, and structural. Specific questions include: 'How will the policy or program increase or decrease discrimination on the basis of gender, race, age, culture, or ethnicity?', 'How will the policy or program add or remove barriers to common spaces, safe environments, and social interaction?', 'And how will the policy or program increase or decrease opportunities for participation in decision making?' (Shookner 2002 10-11).

Mental health promotion strategies that arise from indigenous epistemologies focus on societal responsibilities to provide social protection rather than on individual problems and 'risk' behaviours. As Galabuzi and Labonte (2002) state, "our concerns should be not with the groups or conditions that are excluded, but with the socio-economic rules and political powers that create excluded groups and conditions, and the social groups that benefit by this" (4). With this in mind, Galabuzi and Labonte recommend the following: increasing access to culturally-sensitive and language-appropriate mental health services for immigrants and racialized groups, implementing legal restrictions on racism, providing cultural sensitivity training to health workers, and empowering racialized groups to participate in developing policies and programs (2002).

Citizenship

Overview

There is a wide range of discussion around the construct of citizenship within the literature, and often this discussion takes on a multifaceted approach, including conceptualizations of citizenship at the individual, community, societal, and global levels. Evans and Harris (2004) demonstrate that the concept itself has roots in bureaucratic-professionalism, where citizens were viewed to be consumers of services. Shifting views within the political spheres, however, began to position the citizen as the "counterbalance to professional power and self-interest" (Evans and Harris 2004 70) with the capability to participate in decision-making processes about their own lives and the fate of the nation. In a general definition of citizenship, Chan and Chui (2007) state that:

> Citizenship defines rights and obligations of membership vis-à-vis the community and other citizens. It entails individual rights and access, which are significant for equality, participation and social cohesion. A citizen is one who is able to share rights and responsibilities, and to identify with a community with everyone else. (198)

Within mental health literature, citizenship is often examined as a basic right. A declaration from the International Forum for the Defense of the Health of People, held in Porto Alegre (2002) states, "health is an essential human right, a primary right of citizenship and a public good" (602). Through linking citizen rights and human rights, researchers and practitioners argue that citizens have basic human rights to services, resources, and other measures necessary for their participation within social and political systems (Barnes et al 2004, O'Ferrall 2007, Prior 2007). In addition, Evans and Harris (2004) argue that "citizenship is not just about having rights; it also entails being involved in

framing those rights" (87), referring to the importance for citizens of participating in the construction of those systems which govern their lives.

Another trend in discussions of citizenship has been through notions of identity, where citizenship is believed to be closely aligned with concepts of connectedness, social inclusion, and social efficacy. It is argued that individuals and communities experience greater mental health outcomes when their self identity involves some or all of these aspects (Ware et al 2007). This branch of citizenship research includes factors such as gender, race, ability, and immigrant status as components of one's identity, and consequently as having an effect on one's feelings of social inclusion and citizenship.

Within mental health promotion literature, the classical idea of national citizenship is changing, moving away from the focus on "who a citizen *is*" to "what citizens *do*" (Barnes et al 2004), including how citizenship functions at the community and societal level as opposed to simply the individual. As the next section will demonstrate, a growing trend within mental health promotion research is to view citizenship as an activity or a practice rather than as a mental state (Barnes et al 2004), thereby encouraging the rights and responsibilities of citizens to participate in the development of mental health programs and strategies.

Theoretical Perspectives

Unlike previous constructs discussed in this review, theoretical discussions of citizenship are prevalent within the literature (see Turner 2001, Evans and Harris 2004, and Barnes et al 2004). This is largely due to its conceptual roots within historical liberal, humanist, political, and legal discourse as well as current neo-liberal conceptualizations of the subject in relation to the nation-state. Its significance for mental health promotion research is a more recent event; however, there is also a growing body of work dedicated to the theoretical implications of citizenship for mental health promotion practice (see O'Ferrall 2007, Agnew 2002, Redden 2002, and Tedford Gold 2007). Absent from the literature is empirical research on the application of concepts of citizenship to mental health promotion; however, often studies regarding the related concepts of social inclusion and social exclusion demonstrate its role in mental health promotion strategies.

Although discussions of citizenship have diverged from more traditional definitions of the term, they still derive from a predominantly western paradigm in which the citizen is a necessarily healthy and productive contributor to the function of society. The following statement echoes this history:

> For citizens, mental health is a resource which enables them to realise their intellectual and emotional potential and to find and fulfil their roles in social, school and working life. For societies, good mental health of citizens contributes to prosperity, solidarity and social justice. In contrast, mental ill health imposes manifold exits, losses and burdens on citizens and societal systems. (European Commission 2005 2)

Prior (2007) provides a similar framing, stating that citizenship is the basic human right to civil, political, social, and economic opportunities, the access of which enables higher functioning of both the individual and society as a whole. Of course, these goals are not inherently bad; rather, they point to a systemic focus on function, prosperity, and success, all of which purport western values of economic and social prosperity, as well as the uncritical acceptance of development and progress as positive goals.

In other areas of research, citizenship has been reconfigured to be an activity or a practice (O'Ferrall 2007, Barnes et al 2004). Barnes and colleagues state that "the word 'practice' should help us to understand the dynamic social construction of citizenship which changes historically as a consequence of political struggles" (2004 189). With reference to postmodern and poststructuralist critiques of citizenship, Barnes and colleagues argue that the concept is better viewed as having multiple and complex incarnations, where it is the outcome of feelings of connectedness and notions of belonging rather than one's experience as an appendage of the nation (2004). Mezzina and

colleagues (2006) argue that citizenship has a positive impact on mental health, such that "participation and inclusion in the wider community . . . implies the awareness of being a citizen, and sometimes more affirmative actions at the political level (for civil, legal, and social rights) (58-9). Although the authors continue to discuss citizenship in relation to political or legal systems, the focus is less on individual responsibility to uphold the nation and instead on the mental health benefits of social inclusion and participation in one's social and political environment.

In one of very few articles that address indigenous communities, Tedford Gold (2007) argues that the concept of citizenship is undergoing even more change at the hands of indigenous epistemologists and researchers. She writes: "Indigenous self-determination struggles not only challenge assumptions about citizenship, they call for a rethinking of engagement or participation and what they mean for both individuals and communities" (2007 349-50). Furthermore, she writes that strategies and efforts to overcome colonization are:

> collective struggles for a new space or spaces and suggest that treating citizenship simply as membership or as an individual identity is inadequate. They demand [therefore] recognition of both individual and collective subjectivities that emerge through their efforts to shape and govern their own communities within a nation. (2007 350)

Indigenous discussions of citizenship and how it relates to mental health promotion provide a means of examining the construct outside of nationalistic frameworks and instead as an active process of self-determination, highly specific to cultural contexts.

Relevance to Mental Health and Well-Being

Based on the close ties between citizenship and human rights, this construct is particularly useful when mobilized to reduce barriers for persons with mental health issues (Ware et al 2007). As So and So say, everyone is entitled to health. In terms of specific health benefits, it is easier to refer to the negative effects that the lack of citizenship has on individuals and communities. Similar to the effects of social exclusion, the absence of civil and political rights often has a detrimental effect on individuals (Mezzina et al 2006). Not only that, but individuals with mental health problems are often already excluded from many levels of society, a factor which serves to aggravate feelings of worthlessness, depression, and despair (Mezzina et al 2006). The perceived stigma that results from social exclusion also contributes to the concealment of mental health problems and thus the delay of early detection and treatment (Chan and Chui 2007).

Where researchers have explored the concept of citizenship in relation to indigenous or immigrant groups, they have determined that adoption of the 'citizen' framework means different things to different cultural groups (Brettell and Sargent 2007, Turner 2001). In addition, researchers have argued that the citizen/non-citizen dualism has had extremely negative effects on the morale, health, and well-being of those groups not accepted as citizens.

Application to Mental Health Promotion Practice

As the construct of citizenship relates closely to concepts of social inclusion/social exclusion, studies which apply these principles to mental health promotion offer similar strategies (see *Social Exclusion, Social Inclusion*). Specific use of the notion of citizenship is rare within applied research and practice, and instead the term is often part of policy recommendations or strategy reports (see Keleher and Armstrong 2005, Pape and Galipeault 2002) where it is included as a necessary component of mental health promotion practices. In a recent discussion of the intersections of citizenship, health, and identity discourses resulting from the formation of the Canadian territory of Nunavut, Tedford Gold (2007) argues that it is imperative that dominant ideologies of citizenship be examined and challenged as these conceptualizations themselves often replicate the effects of colonialism through impeding self-government and marginalizing indigenous and immigrant groups. As a result she argues that, if it is to be enlisted as a useful construct for health practices, it must by understood as a diverse and changing hybrid of subjects situated in specific cultural and geographic contexts (Tedford Gold 2007).

Conclusion

Throughout our research, it became clear that the official knowledge that predominates in mental health promotion has its roots in western epistemologies, including Cartesian dualism, liberal humanism, and contemporary ideologies of neo-liberalism. These knowledge systems largely translate into policies and practices that focus on the individual and fail to take sufficient stock of one's environment in assessing health. As a result, the field of mental health promotion still lacks a lens that fully takes culture, gender, sexuality, race, and socio-economic status into account in the development and provision of services.

In fairly recent years, mental health promotion has begun to be informed by criticisms of liberal humanism and related paradigms, particularly through critical theory, poststructuralist, social constructionist, and feminist theories. These critical perspectives have played a key role in examining the structural inequity within societal systems of value, knowledge, and meaning, particularly how these translate into mental health practices. Critical and feminist theories have provided the lens through which to examine the biases that largely go unnoticed within health practice such as ethnocentrism, hetero-normativity, as well as the embedded effects of racism. Poststructuralism has identified the relationships between power and service provision, such that researchers can examine health as housed not within the individual but as an effect of the political, social, and cultural norms of western world views.

However, although these developments within mental health promotion theory have been useful, they are still relatively rare within popular mental health promotion-related journals. More fundamentally, they arise out of and in response to the Cartesian/liberal humanist paradigm, one result of which has been a continued focus on the problem rather than a transition to a more holistic view of health that focuses instead on formulating useful and practical mental health strategies. Consequently, whilst theoretical critique within the field is beginning to become more prevalent, there remains a significant gap in the knowledge base concerning what to do in terms of the applications of these theories within practice.

A less visible, but no less important trend within mental health promotion research is that of indigenous-developed and -focused conceptualizations of health and well-being. In a discussion of the differences between western theoretical approaches to health and Maori models of health, Anae and colleagues argue that the "risk-oriented" methods and practices that have characterized western medicine rely on a "pathogenic model of health, which in turn stems from dichotomous categorization of people into healthy and unhealthy classes" (2002 8). Through Maori and Samoan theories of health, Anae and colleagues argue that health initiatives must be both critical of western paradigms and must look at people's experiences of well-being as holistic and relational. The authors further argue that these models of health are not only relevant to the health of indigenous communities but have potential significance for health promotion in all communities. Potentially, Canadian Aboriginal and other indigenous ontologies could form the basis for the evolving cosmological re-orientation so desperately needed and absent from the psychological, social, and spiritual consciousness of modern societies (Cajete 2000).

The profundity of bringing an indigenized onto-epistemological orientation to the key mental health promotion constructs reviewed in this paper becomes evident even in beginning to consider its application. For example, if we begin to apply the indigenous onto-epistemological principles outlined by Stewart-Harawira (2005) earlier, the concept of self-determination takes on an entirely different paradigmatic orientation.

Within this ontological perspective of deep interconnectivity the concept of 'self' itself dissolves; the idea of achieving (mental) well-being through the exercise by the individual or community (as discrete and sovereign entities) of self-determination over various health determinants starts to

become questionable.[14] An indigenous onto-epistemological orientation implies that we cannot self-determine our lives because our lives and well-being are intimately connected to and influenced reciprocally by a complex web of interrelations, including both human and non-human life forms and material and immaterial intelligences. These views decentre the self and human community in terms of well-being, arguing for a profound cosmological re-orientation wherein human well-being is only achieved in concert with the well-being of community in its widest sense.

By and far, Euro-western and liberal humanist paradigms continue to dominate mental health promotion. Whilst, we are aware through other research (Williams and Mumtaz 2008) that there are some excellent Aboriginal-based approaches to mental health promotion—most often with youth—currently being implemented within Canada, these are underfunded, unpublished, and under-theorized in terms of their underlying conceptualizations of well-being. Nor are they directly applicable to Aboriginal women. The situation for racialized immigrant women in Canada is similarly marginal in terms of the profile and application of culturally-based, onto-epistemological perspectives and constructs and their application within practice.

It is, therefore, our hope that this paper will serve as one reference point amongst others for critique and analysis by investigators and collaborating community partners within the Reducing Mental Health Disparities project, and we look forward to engaging our participating communities—Aboriginal and racialized immigrant and refugee women in culturally-based articulations and applications of mental health promotion constructs and frameworks more relevant to these populations.

[14] This is not to argue that underlying health determinants (including the exercise of power) and their equitable distribution is unimportant in terms of shaping mental well-being – of course they are – but rather that according to indigenous ontological and epistemological orientations the situation is much more complex.

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