Encounters with the North: Psychiatric Consultation With Inuit Youth

Azaad Kassam MD, FRCPC[1,2,3]

Abstract

Introduction: The Inuit population of Canada experiences high rates of mental health problems. Youth are particularly affected, with rates of youth suicide among the highest in the world. Psychiatric consultation is one model that has been used to address this problem. Is this the most appropriate method to assist Inuit populations with these issues? **Methods:** This review addresses this question by examining literature focusing on psychiatric consultation in Canada's north, especially that which pertains to Inuit populations. **Results:** The traditional model of medical-psychiatric consultation has significant limitations including assumptions about its validity and usefulness, its segmented approach, and its individual focus. **Conclusion:** Openness to other forms of knowledge, cultural competence, and understanding the importance of social factors are crucial in order for psychiatric consultation to be effective.

Key words: Inuit, Aboriginal, youth, consultation-liaison, culture

Résumé

Introduction: La population Inuit du Canada connaît un taux élevé de problèmes de santé mentale. Les adolescents sont particulièrement touchés, leur taux de suicide étant l'un des plus élevés du monde. L'un des modèles utilisé pour étudier ce problème est la consultation psychiatrique. Est-ce la meilleure façon d'aider les Inuits à résoudre leurs problèmes? **Méthode:** Cette étude traite de cette question et analyse la littérature portant sur les consultations psychiatriques dans le nord canadien, notamment auprès des Inuits. **Résultats:** Le modèle traditionnel de consultation médical ou psychiatrique a de sérieuses limites, notamment en ce qui a trait à sa validité et à son utilité, à son approche compartimentée et à son objectif individuel. **Conclusion:** L'ouverture à d'autres formes de connaissances, la connaissance de la culture et la compréhension des facteurs sociaux sont essentiels à l'efficacité des consultations psychiatriques.

Mots-clés: Inuit, Aborigène, adolescents, consultation-liaison, culture

[1]Attending Psychiatrist, Northeast Mental Health Centre, North Bay, Ontario, Canada
[2]Assistant Professor, Northern Ontario School of Medicine, Laurentian and Lakehead Universities, Sudbury and Thunder Bay, Canada
[3]Clinical Preceptor, University of Ottawa
Corresponding email: akassam@nemhc.on.ca or azaad.kassam@mail.mcgill.ca
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Aboriginal mental health is an area of immense need in Canadian health care (Chaimowitz, 2000). Little epidemiological research has been done with Canadian aboriginal youth. However, the available data suggests that there are high rates of suicide, substance abuse and other mental health issues among aboriginal adolescents (Gotowiec et al., 1994, Kirmayer et al. 2000). There are significant differences in rates of mental health problems between communities. Inuit youth have been shown to suffer higher rates of problems than some other aboriginal groups. The incidence of completed suicide is 5 times higher than that of non-aboriginal youth in Canada. In Nunavik (Northern Quebec), the rate is up to 20-fold higher than that of non-aboriginal youth in Canada (Boothroyd et al., 2001). The causes and consequences of mental health burden in Inuit communities are complex and not well studied. However, most aboriginal mental health research strongly supports the important role of social and historical factors in the production of psychological distress. Kirmayer, in a recent review of Canadian Aboriginal mental health states that there is "clear and compelling evidence that the long history of cultural oppression and marginalization has contributed to the high levels of mental health problems found in many [aboriginal] communities" (Kirmayer et al., 2003b).

The question of how to best meet the mental health needs of Inuit communities remains unanswered. One approach that has been used is consultation with a psychiatrist or other mental health professional. Some Inuit patients are sent from northern Canada to tertiary care centres in the South for psychiatric assessment while others are seen by psychiatric consultants visiting Northern Inuit communities.

If we are to employ a consultation model to populations of the North we must ask if ourselves what is the most appropriate method to approach assessment within such populations? The existing literature reveals significant limitations to application of standard psychiatric methods to aboriginal youth.

Clinicians need to recognize that biomedicine and psychiatry are in themselves traditions that embody their own cultural values and practices (Kirmayer et al., 2003b). Modern psychiatry has arisen from, and is driven by, western ways of thinking about the world. Following the medical model, the approach tends to be specialized and segmented. That is, a consultant with a lot of knowledge about his or her own field assesses an individual (or family) and provides an expert opinion about the client. The evaluation is often driven by diagnosis – albeit multiaxial - and symptoms as *we* see them. Implicit in this approach, we often make the *assumption* that our diagnoses are valid across cultures, that it is useful to apply these understandings to the client, and that by doing so we are doing good and doing no harm. This view is not necessarily shared by all peoples and the research evidence does not support these assumptions" (Kirmayer et al., 2003b).

Clinicians working with Inuit populations have long recognized that consultation techniques used in the South are only "partially appropriate and valid" in northern Inuit communities (Atcheson et al., 1976). Misunderstanding between aboriginal clients and psychiatrists can result from lack of attention to and respect for culturally influenced differences in values, assumptions, models and methods (Kirmayer et al., 2003a). In an American Psychiatric Association study of Alaska Natives (Group for the Advancement of Psychiatry, 1995), problems encountered by Inuit and other aboriginal groups in Alaska often did not fit the range of standard psychiatric practice. Natives viewed many of their community's "psychiatric" problems as social and political rather than as individual issues. Community members often felt that the consulting professionals were too far removed from local concerns and psychiatric consultants found themselves dealing with issues beyond their areas of expertise. The authors concluded that an "off the shelf" approach that might work in their usual practice setting did not apply to the Alaskan Native situation.

Kirmayer and other authors encourage mental health professionals to rethink our approach and the assumptions that underlie them (Kirmayer et al., 2000, Group for the Advancement of Psychiatry, 1995). For example, as psychiatric consultants, we usually assume that diagnostic assessment of a patient in distress is a valuable endeavour. If an Inuit patient is given a diagnosis but there is no practical treatment available, as can be the case in remote regions of the North, the diagnostic label can lead to stigmatization, devaluation of social status and, possibly, exclusion from his/her community. This loss of social support can lead to worsening the course of illness (Kirmayer et al., 1997). Thus, psychiatric diagnosis should not be assumed to always be helpful. By applying standard psychiatric methods without attention to cultural and social factors, there remains the possibility of doing more harm than good.

Despite this cautionary view of psychiatric consultation in Inuit populations we must ask if there is a useful role for this type of service. Abbey et al. (1993), Hood et al. (1991) and other researches (Group for the Advancement of Psychiatry, 1995) have documented consultation work in Arctic regions and this literature suggests that a consultation model can be effective. As well, The Cultural Consultation Service at McGill presented evidence that a consultation-liaison model can be used effectively with culturally diverse populations (Kirmayer et al., 2003a).

So what are the ingredients of effective cross-cultural consultation? Attitude is primary. One must start with open-mindedness and humility. We must accept that a standard medical-psychiatric approach is not the only valid way to view a problem. It is rather egocentric to talk about what we "know" and what others "believe". For example, we may see a client whose family "believes" he is possessed by spirits but we diagnose (and therefore "know") that the client is psychotic. Why should our psychosis be superior to another's spirit possession? Why cannot both types of knowledge co-exist? In another example, a client who we "know" needs antidepressant medication and psychotherapy might "believe" he needs certain foods or natural products. The following vignette is illustrative:

> A psychiatric consultation was requested for a young Inuk man on the general medical ward of a children's hospital who was suffering from a ter-

minal illness. The patient felt that he would be best served by consuming "country food", such as caribou and raw fish. Our permission for his family to bring these traditional Inuit foods to the hospital ward facilitated mutual understanding and respect. For some time after, he was able to use a discussion of "country food" as a symbol of strength and healing. Therapeutic alliance was improved and supportive therapy allowed both the young man and his parents to mourn.

In this consultation, listening openly to the patient's culturally based needs and facilitating meaningful intervention proved to be helpful. De-centering from a perspective focused on psychopathology and listening openly to cultural knowledge allowed both psychiatric and traditional Inuit perspectives to enter the discourse. Both sets of knowledge could co-exist.

The Group for the Advancement of Psychiatry in Alaska (1995) found that they were able to learn much from the programs and methods used by the local communities and recognized the "two way nature of the process". Rather than assuming that the approach of psychiatry is the only way to view one's problems, perhaps an effort toward exchange of values and understandings would be more fruitful.

Consultation must be culturally informed. Ignorance about the importance of cultural and spirituality has undermined efforts of health professionals to provide quality mental health care to aboriginal peoples (Chaimowitz, 2000). To be useful, consultations need to take into account culturally relevant understandings of distress (Boothroyed et al. 2001, Chaimowitz, 2000, Kirmayer et al., 2000, Kirmayer 2003b, Kirmayer et al. 1997, Manson, 2000). However, culturally informed consultation does not mean cultural expertise. A detailed knowledge of all aspects of Inuit culture is not necessary to be a valuable psychiatric consultant. An open attitude and basic awareness of some relevant cultural issues can serve the clinician well. Approaches that connect Inuit youth to their ancestral heritage have proven useful in addressing mental health issues (Group for the Advancement of Psychiatry, 1995). In contrast to most Westerners, Inuit may define themselves in relation to their land, that is, "ecocentrically" (Kirmayer et al., 2000). Traditional Inuit hunting practices have important spiritual meaning and are an integral part of male development. Maintaining a connection with the animal realm by eating "country food" can also be an important part of self-identity (Kirmayer et al., 2000).

One tool that can be useful to assess clients from another culture is the Cultural Formulation, outlined in the DSM IV (American Psychiatric Association, 1994). Manson has reviewed the five basic elements of the cultural formulation and applied them to aboriginal patients in the United States (Manson, 1996). These include cultural identity, cultural explanations of the illness, cultural factors related to psychosocial environment and levels of functioning, cultural elements of the clinician-patient relationship, and an overall cultural assessment. The value of the Cultural Formulation in the assessment and treatment of aboriginal adults and children has been clearly demonstrated (Manson, 2000).

Language and cultural barriers often prevent accurate psychiatric assessment, diagnosis and treatment (Kirmayer et al., 2003a). However, many health professionals resist the use of interpreters and culture brokers in clinical evaluation. This may be due to inconvenience or other factors but is sometimes rationalized as cost-saving or maintaining of confidentiality. On the contrary, the use of interpreters and culture brokers may require some extra effort initially, but can be high-yield and efficient (Kaufert et al. 1991, Kaufert et al., 1998). The use of interpreters has its merits and pitfalls and warrants a lengthier discussion than can be addressed here. Suffice it to say that it should be considered an important intervention that can alter outcome.

The recognition and inclusion of social and systemic factors is a crucial ingredient to providing effective consultation services to Inuit communities. Aboriginal mental health literature consistently and repeatedly emphasizes that it is essential to recognize the embeddedness of clinical problems in a social and cultural context (Abbey et al., 1993, Group for the Advancement of Psychiatry, 1995, Kirmayer et al., 2000, Kirmayer et al., 2003b, Manson,

2000). Some even consider the *community* to be the "primary locus of injury" when working with aboriginal populations (Kirmayer et al., 2003b). There is evidence that strengthening ethnocultural identity, community integration and political empowerment can contribute to improving mental health outcomes in aboriginal peoples (Kirmayer et al., 2003b). For example, a study examining all aboriginal communities within the province of British Columbia demonstrated that the number of suicides was inversely proportional to the amount of local control (which the authors referred to as "cultural continuity") the community had over its institutions (Chandler et al., 1998). Although the design of this study precludes determination of causality, it highlights the impact that social determinants can have on mental health. Successful psychiatric consultation in the American Psychiatric Association study (Group for the Advancement of Psychiatry, 1995) emphasized examination of social causes of distress and consideration of community-based issues such as local control and self-determination. This research strongly suggests that factors beyond psychiatric intervention are important in addressing mental health of aboriginal youth. In fact, Kirmayer (2003b) asserts that mental health issues faced by aboriginals "demand social and political solutions".

Poorly coordinated services are another problem that sacrifices the quality of mental health care in aboriginal communities (Chaimowitz, 2000). Services are most likely to be effective if initiated and based in the patient's community (Boothroyd et al., 2001). Thus, in addition to clinical assessment, an important role of psychiatric consultants is to liaise with local health and social agencies, schools and other organizations (Abbey et al., 1993, Hood et al., 1991). Child and adolescent psychiatric consultants working with Inuit youth in Alaska concluded that their interventions necessitated working with schools, clinics, churches, village leaders and tribal councils (Group for the Advancement of Psychiatry, 1995). As well, shared educational activities between mental health workers from the North and psychiatric consultants from the South presents an opportunity to contribute to longer term development of mental health services for Inuit communities.

Conclusions

Psychiatric consultation with Inuit youth presents a complex challenge. Clinicians must recognize that the traditional medical-psychiatric model of consultation has significant limitations with this population. Effective psychiatric consultation requires an attitude of humility and respect for other forms of knowledge; a willingness to engage in culturally informed consultation and recognition of the crucial importance of social factors to Inuit communities. With this expanded model in mind, psychiatric consultation can be one important facet of addressing the mental health needs of Inuit youth.

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