The mental health of indigenous peoples

An international overview

Department of Mental Health

World Health Organization
Geneva
Nations for Mental Health

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- To strengthen mental health policies, legislation and plans through: increasing awareness of the burden associated with mental health problems and the commitment of governments to reduce this burden; helping to build the technical capacity of countries to create, review and develop mental health policies, legislation and plans; and developing and disseminating advocacy and policy resources.

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Foreword

Dr Cohen's overview of the Mental Health of Indigenous People inscribes itself in the World Health Organization's overall thrust to promote mental health, prevent major mental and neurological disorders and ensure the provision of appropriate care, particularly to the vulnerable and underserved. In putting this work into a broader context, it may be useful to recall one of WHO's constitutional principles, that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". WHO views health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

This review also comes to us at the midpoint of the International Decade of the World's Indigenous People. The Decade is under the auspices of the UN High Commissioner for Human rights and the Working Group on Indigenous Populations (WGIP) which reports to the UN General Assembly through ECOSOC, the Commission on Human Rights (CHR) and the sub-Commission on Prevention of Discrimination and Protection of Minorities. The WGIP is entrusted with the tasks of reviewing developments pertaining to the promotion and protection of human rights and fundamental freedoms of indigenous populations; and giving special attention to the evolution of standards concerning the rights of such populations. It has been responsible for drafting a Declaration on the rights of the world's Indigenous People, which is currently under discussion and is expected to be finalized in the course of the Decade.

The World Conference on Human Rights in Vienna in 1993 recognizes the inherent dignity and the unique contribution of indigenous people to the development and plurality of society and strongly reaffirms the commitment of the international community to their economic, social and cultural well-being and their enjoyment of the fruits of sustainable development. The establishment of a permanent forum for Indigenous People in the UN system, as proposed by the World Conference on Human Rights, would provide a much-needed mechanism for addressing the needs of indigenous people in a more concerted way. Principle 14 of the programme of Action of the International Conference on Population and Development, Cairo, 1994, states that, "in considering the population and development needs of indigenous people, States should recognize and support their identity, culture and interests, and enable them to participate fully in the economic, political and social life of the country, particularly where their health, education and well-being are affected. The programme of Action in this instance also incorporates the distinct perspectives of indigenous people. The Social Summit in Copenhagen in 1995 committed itself to recognize and respect the right of indigenous people to maintain and develop their identity, culture and interests, support their aspirations for social justice and provide an environment that enables them to participate in the social, economic and political life of their country; to promoting and attaining the highest standard of physical and mental health; to the
right of indigenous people to full access to health care; to the eradication of poverty and basic human needs and special circumstances of vulnerable and disadvantaged groups; to the unique concerns of indigenous people. International instruments, such as the Convention on the Rights of the Child, the Convention on Biological Diversity, but particularly ILO's Convention 169 on Indigenous and Tribal Peoples, add weight to the overall movement and WHO’s own policy of investing wisely in health as a key factor for human development is central to the present review.

In a sense, and Cohen confirms this, Mental Health is often separated out from overall health considerations in and by western society. On the whole, indigenous perceptions not only differ from western classifications of mental disease: as Cohen points out, some symptoms that warrant special attention in the West have positive connotations in indigenous society. They also go about managing such “disorders” in ways that are socially supportive in a process that broadens a perceived problem to an all-inclusive view of existence. Modern society tends to take existence apart and examine components under a microscope, then deal with each one separately. Each one also has a different owner with the promise that if he or she succeeds in making it more important, then there will be a reward. Indigenous ownership is communal. Indigenous society also tends to consider itself an integral part of a universal order in which it participates in both the spiritual and cosmic dimensions that hold sway over what happens to our total environment, as well as an intimate part of Mother Earth, contributing to and partaking of what she produces. Hence a major part of the story behind “victims of progress”.

This has a lot to do with “oneness”. It is a feeling that combines a sense of fulfilment, security and achievement with an appreciation of the warmth of the environment, the positive symbiosis of the elements, the satisfaction of creature comforts, a quiet conscience – in other words a coincidence. This coincidence is the natural element of indigenous people and there is an urgent need to restore it to its former integrity. The wisdom of maintaining it has been desecrated in the name of progress.

Cohen has identified this need for balance – it is a very delicate task, and one that needs to be addressed with humility.

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Chapter 1
Introduction

Relatively little research has examined directly the mental health status and treatment needs of the indigenous peoples of the world. This is both unsurprising and remarkable. Unsurprising, first, in that the needs and rights of indigenous peoples have been historically of little concern to those larger and more powerful nations that moved across the globe in search of wealth. Remarkable, however, in that during that same period of colonialism there has been no lack of knowledge of the brutalities to which the indigenous peoples of the world have been and continue to be subjected.

In 1552, Bartolomé de las Casas, a Spanish friar, published The devastation of the Indies, an account of the atrocities committed by the Spanish in their conquest of the New World. Of Hispaniola, he wrote:

[I]nto this land of meek outcasts there came some Spaniards who immediately behaved like ravening wild beasts, wolves, tigers, or lions that had been starved for many days. And Spaniards have behaved in no other way during the past forty years, down to the present time, for they are still acting like ravening beasts, killing, terrorizing, afflicting, torturing, and destroying the native peoples, doing all this with the strangest and most varied new methods of cruelty, never seen or heard of before, and to such a degree that this Island of Hispaniola, once so populous (having a population that I estimated to be more than three millions), has now a population of barely two hundred persons (Las Casas, 1992:29).

Las Casas estimated that some 15 million indigenous people were slaughtered in the Americas during the half century following Columbus's arrival in the New World. He then went on to describe, in some detail, the atrocities committed in Hispaniola, Puerto Rico, Jamaica, Cuba, Nicaragua, Mexico, Guatemala, Trinidad, Venezuela, Florida, Peru, and Colombia. The Devastation of the Indies caused great public outrage in Spain and Europe but did little to bring relief to the indigenous peoples of the New World.

Some three hundred years later, as the British Empire expanded across the globe, the British Government issued the 1837 Official report of the Select Committee on Aborigines, that documented the effects of colonialism on indigenous peoples. The report was an attempt to secure “the due observance of Justice and the protection of their Rights” (House of Commons Select Committee, 1837:63). Echoing the words of Las Casas, the report noted:

It is not too much to say, that the intercourse of Europeans in general, without any exception in favour of the subjects of Great Britain, has been...a source of many calamities to uncivilized nations. Too often, their territory has been usurped; their property seized; their numbers diminished; their character
debased...European vices and diseases have been introduced amongst them, and they have been familiarized with the use of our most potent instruments for the subtle or the violent destruction of human life, viz. brandy and gunpowder (House of Commons Select Committee, 1837:65).

Again, however, the message was ignored, and the destruction of indigenous peoples continued. Indeed, some eighty-five years later, in the third decade of the 20th century, W.H.R. Rivers, the British psychiatrist and anthropologist, had to argue against the prevailing notion that the depopulation of Melanesia had occurred as the result of harmful native customs and emphasize that it was the consequence of the introduction of infectious diseases such as tuberculosis, measles, and influenza, the harmful repercussions of the importation of alcohol, opium, and firearms, and the inappropriate modification of traditional housing and clothing (Rivers, 1922).

While the mass killings of indigenous peoples have been reduced in scale over the last five hundred years, they have never stopped (Amnesty International, 1992). Indigenous peoples in El Salvador and Guatemala have been the targets of political violence. Amnesty International has called for inquiries into killings of tribal peoples in the Chittagong Hill Tracts of Bangladesh, human rights violations against indigenous peoples in Myanmar, political killings of tribal members in the Cordillera region of the Philippines, and the torture, rape, and death of tribal peoples while in legal custody in India. Throughout the Summer and Fall 1997 issues of Cultural survival quarterly, one finds, despite the growing influence of the indigenous movement over the last twenty-five years, that indigenous peoples all over the world face the continuing loss of their lands and their ways of life in the face of encroaching development. For example, as noted in the Summer 1997 issue, the Ainu are struggling to preserve their culture in the midst of mainstream Japanese society, the Saami are seeking self-rule over lands that they have traditionally occupied in Sweden, Finland, Norway, and Russia, and the Himba and Herero peoples of Namibia are trying to stop the construction of a hydroelectric dam that will flood their winter grazing lands and ancestral burial grounds. The Fall 1997 issue notes the struggle of the Chorti people of Honduras to reclaim traditional lands and reports that the culture of the Mentawai peoples of Indonesia is being threatened by development plans that call for the establishment of a large palm oil plantation and the relocation to the area of 20000 non-indigenous families.

Given the traumas and dislocations that indigenous peoples have experienced, and to which they continue to be subjected, we can assume that they suffer from high rates of various neuropsychiatric and behavioural problems (Dohrenwend & Dohrenwend, 1974; Desjarlais et al., 1995; Link & Phelan, 1995; Fullilove, 1996). Yet relatively few data exist concerning the mental health status and treatment needs of the indigenous peoples of the world. What we do know points to great unmet needs. Throughout the Western Hemisphere, indigenous peoples suffer from high rates of alcoholism and
suicide. The same can be said of the peoples of Oceania and northern Russia, as well as the aboriginal groups of Taiwan, China. Furthermore, we can safely conjecture that dislocation, epidemics, depopulation, and subjugation have put indigenous peoples everywhere at high risk of depression and anxiety.

This report will attempt to offer: a working definition of “indigenous peoples”; an overview of the sociocultural and socioeconomic worlds in which indigenous peoples live; a survey of epidemiological information about mental health problems among indigenous peoples; and, finally, recommendations on ways to support efforts by the indigenous peoples of the world to address the mental health problems they are experiencing.
Chapter 2
Towards a definition of “indigenous”

On first examination, a definition of “indigenous” might seem to be a straightforward task, but, upon closer scrutiny, it is not a simple matter. In the Western Hemisphere it may be obvious which groups are indigenous: those peoples that were living in North and South America before European contact and colonization began in the late 15th century. A similar definition can be applied in reference to Oceania: the Aboriginal groups of Australia and New Zealand would meet any conceivable definition of indigenous peoples. But what of populations in Micronesia whose ancestral islands have not been extensively colonized and overwhelmed by European or Asian expansionism but who have experienced rapid sociocultural changes through contact with larger, more powerful outside forces? What of ethnic minorities who live within larger societies? Do the national minorities of China and the Scheduled Tribes of India constitute indigenous peoples in the same way as American Indians? Similar questions apply to Africa. The San Basarwa of southern Africa and the Pygmies of Central Africa can clearly be considered indigenous peoples. But what of the other tribal groups of sub-Saharan Africa?

To many, the term “indigenous peoples” conjures up Redfield’s “folk society”, which he characterized as “small, isolated, nonliterate, and homogeneous, with a strong sense of group solidarity” (Redfield, 1947:13). However, this is a rather simplistic and romanticized notion about a past that likely never existed and certainly does not match the present reality of heterogeneity among indigenous peoples in terms of social organization, cultural beliefs and practices, population sizes, and relative integration into national societies. Furthermore, for the purpose of establishing land and human rights, a more precise legal definition is required. Since the late 19th century, the international community has struggled to devise a definition that both protects the legal and human rights of indigenous peoples and satisfies the political and economic ambitions of the States in which they live (van de Fliert, 1994; UN Working Group on Indigenous Populations, 1996a) – an almost impossible task.

The most widely used definition comes from the International Labour Organization’s Convention No. 169 of 1989, which defined two broad categories of indigenous peoples:

- Those tribal peoples “whose social, cultural and economic conditions distinguish them from other sections of the national community and whose status is regulated wholly or partially by their own customs or traditions or by special laws or regulations”; and,

- “Peoples in independent countries who are regarded as indigenous on account of their descent from populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or coloniza-
tion or the establishment of present state boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural and political institutions" (van de Fliert, 1994:65). Convention No. 169 also includes self-identification "as a fundamental criterion for determining the groups to which the provisions of the Convention apply" (68).

A more pragmatic approach, one taken by the World Bank in an investigation of poverty among the indigenous peoples of Latin America, relied on three variables to define indigenous peoples: language, self-perception, and geographic concentration (Psacharopoulos & Patrinos, 1994). These variables were used in different combinations and were given different priorities depending on the country under investigation. For example, in Bolivia and Peru, language was the most important criterion; in Guatemala, self-identification or self-perception was primary; while in Mexico, language and geographic concentration were foremost (Psacharopoulos & Patrinos, 1994:xvii).

Lacking in these definitions is any sense of the relationship of indigenous peoples to the States in which they live. While it is true that indigenous peoples have unique land claims and retain much of their traditional cultures, their status is distinguished by something more. For Maybury-Lewis, a longtime advocate for the rights of indigenous peoples, a key feature of the term "indigenous" is the sense that it carries of marginality. In his view, indigenous peoples represent

groups that have been conquered by peoples racially, ethnically or culturally different from themselves. They have thus been subordinated by or incorporated in alien states which treat them as outsiders and, usually, as inferiors...The salient characteristic of indigenous peoples, then, is that they are marginal to or dominated by the states that claim jurisdiction over them (Maybury-Lewis, 1997:8).

What, then, is the most appropriate definition of indigenous peoples for the purposes of this report on mental health? Certainly, self-identification through cultural and historical distinctiveness must take priority. But beyond that basic principle, the task becomes difficult. For example, because of increasing migration by indigenous peoples to urban areas (Almeida-Filho, 1987; Somervell et al., 1995; Durie, 1995), the use of language and geographic concentration as criteria prove to be problematic. Are the Native Americans who live in the urban areas of the United States no longer indigenous? Furthermore, migration itself can create marginality as one finds among African and Middle Eastern immigrants to Europe or south-east Asians journeying to the United States in search of economic opportunities. These groups become marginal to the societies in which they are living, but it may be difficult to define them as indigenous.

An ironclad definition of the term "indigenous peoples" fails to convey an adequate sense of their diversity. It might be best, therefore, to follow the
example of the World Bank and use definitions that are flexible enough to encompass the diversity of populations in a wide range of geographic regions. Such definitions, with self-identification as the key element, are in keeping with the wishes of indigenous peoples who resist a sharply delineated definition in case it excludes peoples who do not exactly match the criteria (UN Working Group on Indigenous Populations, 1996b). This makes for variable and inclusive definitions that would allow, for example, both urban, English-speaking Maoris in New Zealand and rural concentrations of Quechua speakers in the Peruvian highlands to be considered indigenous peoples.
Chapter 3

The worlds of indigenous peoples

It is estimated, that there are 5000-6000 distinct groups of indigenous peoples living in over 70 countries (Burger, 1990; Cultural Survival, 1993). Their numbers total about 250 million persons, or about 4-5% of the world’s population (Burger, 1990; Maybury-Lewis, 1997). This population is far from homogeneous. While it may be true that indigenous peoples share a close attachment to their land, commonly lack statehood, are subject to economic and political marginalization, and are the objects of cultural and ethnic discrimination, they exhibit a wide diversity in lifestyles, cultures, social organization, histories, and political realities (van de Fliert, 1994). A thorough treatment of the historical, sociocultural, and socioeconomic worlds in which indigenous peoples live is, therefore, well beyond the scope of this report. Nevertheless, it is critical to this discussion to present a brief overview of several broad generalizations and historical trends in order to impart a sense of the contexts in which the mental health of indigenous peoples is shaped.

The most important factor in the history of indigenous peoples has been the European economic expansion and development that began a little more than five hundred years ago and continues to the present day. The initial phase of European colonialism during the 16th, 17th, and 18th centuries, which saw the discovery and exploitation of the New World, the beginning of the exportation of slaves from Africa to Europe and America, the establishment of colonies and trade routes in Asia, and the colonization of Oceania, was the first step towards bringing the entire world into a single economic system (Wolf, 1982). The effects were disastrous for indigenous peoples. First, the introduction of smallpox, diphtheria, influenza and measles resulted in what has been called the “great dying” in the Caribbean and Central and South America. Population decreases in the southern half of the New World reached ratios as high as 20-25 deaths for each survival (McNeill, 1976). This scenario of epidemics following European expansion was repeated in the Pacific Islands, Australia, Siberia, and southern Africa (McNeill, 1976; Cultural Survival, 1993:74). Second, the European expansion brought with it an economic system that sought lands and markets to exploit. This resulted in enormous pressures on indigenous peoples to protect their lands and ways of life in the face of usually overwhelming forces. In brief, indigenous peoples became “victims of progress” (Bodley, 1988) – meaning that when they stood in the way of plans by larger forces to exploit natural resources, they were slaughtered or dislocated. While the methods in use today are not quite as brutal as those in the past, indigenous peoples continue to be seen as standing in the way of development because they do not wish to relinquish their lands for exploitation (Bodley, 1988; Cultural Survival, 1988; Cultural Survival, 1988; Psacharopoulos & Patrinos, 1994; van de Fliert, 1994; Vinding & Wachle, 1996).
This document does not attempt a complete overview of how the worlds of indigenous peoples have changed in the last five hundred years; instead, it offers the following examples of the forces to which they have been subjected.

**Depopulation**

The Mehinaku Indians live in the Upper Xingu basin of the Amazon rain forest in Brazil (Gregor, 1977). When first contacted in 1877, about 3000 of them lived in the area. Less than one hundred years later, when Gregor did his fieldwork, their population had fallen to about 700, partly as a result of measles and influenza epidemics. The effects of this demographic change were far-reaching. The two original villages consolidated into one while also absorbing refugees from other groups that had disbanded or died off. Mehinaku culture changed in the process. With depopulation and its concomitant loss of collective memory, many rituals and games disappeared. Contact with the outside world — and its disastrous effects — have made the Mehinaku insecure about themselves and their future to such an extent that they have come to "fear the demise of their own culture" (Gregor, 1977:22).

**Violence**

The legacy of violence against indigenous peoples is appalling. One need look no further than the slaughter of the aboriginal peoples of the Western Hemisphere. But while the mass killings are generally no longer the rule for contact between states and indigenous peoples, they do occur. For example, during the 1994 war in Rwanda, as many as 30% of the Twa died or were killed in massacres, and another 30% were forced to flee the country (Vinding & Waehle, 1996). During the Guatemalan civil war, " Barely a day went by without reports of Maya being hacked to death, bombed, raped, shot, and, most commonly, burnt alive in their homes" (Wearde, 1994:22). The slaughter was so great that by 1983 the very survival of many of the smaller Mayan groups was in question. During a period of thirty years, an estimated 75000 Guatemalan Indians disappeared or were killed. More than 300000 have sought refuge in other countries (Pedersen, 1993), most of them going to Mexico, Belize, Honduras, or the United States (Wearde, 1994). The Guatemalan Supreme Court of Justice calculated that between 100000 and 200000 highland children lost one or both parents because of violence and repression. These experiences, along with dislocation from their homes and being subjected to state-sponsored terrorism, left many Mayan children traumatized and facing a bleak future (Melville & Lykes, 1992; Miller & Billings, 1994).

**Dislocation**

Whenever they have come into contact with more powerful nations, indigenous peoples have been pushed aside and forced to give up their traditional territories. For example, the Navajos and Hopis of the Southwest United
States were relocated so that mineral resources could be developed in northern Arizona; Australian Aborigines have been driven off their lands by cattle ranchers (Cultural Survival, 1988). In Thailand, many of the hill tribes were relocated because the Government believed that the tribes' traditional methods of slash and burn agriculture were destroying the forests (Cultural Survival, 1988). Hydroelectric projects in Brazil, China, India, Malaysia and the Philippines are displacing millions of people—many of them indigenous—from their traditional lands (Burger, 1990). Finally, dislocation comes about when, for sheer economic survival, indigenous peoples are forced to migrate to urban areas (Almeida-Filho, 1987). Whatever the reasons—war, development, or lack of economic opportunity—the psychological consequences of dislocation are serious and often result in high rates of distress (Desjarlais et al., 1995; Fullilove, 1996).

**Poverty**

Not surprisingly, indigenous peoples are among the poorest of the poor. A World Bank report concluded that poverty among Latin America's indigenous peoples is pervasive and severe: their living conditions are abysmal, they receive far less education, work more and earn less, and their over-all health is poorer than non-indigenous populations (Psacharopoulos & Patrinos, 1994). This is an oft-repeated story. The Scheduled Tribes of India lag economically far behind the rest of the country (Parmar, 1992). Unemployment rates among the Maori of New Zealand are three times as high as those of non-Maoris (Durie, 1995). The Lese and Efe of the Democratic Republic of the Congo are impoverished as a result of exploitation by government authorities (Grinker, 1994). And, finally, a survey of patients—90% of whom were Inuit—seen in a psychiatric service clinic on Baffin Island found that less than one-third had been employed in the previous year (Young et al., 1993).

**Challenges to and repression of culture**

Everywhere, the cultures of indigenous peoples have been repressed, challenged, or overwhelmed by larger populations and more powerful States. The following account of the indigenous peoples of the Russian Far North is provided as only one example of the processes by which indigenous peoples throughout the world have had their ways of life threatened or destroyed.

Europeans first made contact with the indigenous peoples of the Far North in the 1550s when fur traders came into the area. By the 18th century, the area had attracted Russian peasants, hunters, sailors and merchants who settled mainly along the large rivers and the coast. This incursion of Europeans into the territory, at least at first, did not result in a population crash among the indigenous peoples, but it did begin to change the traditional subsistence economies of reindeer breeding, fishing, gathering, and hunting. By concentrating on trapping, for example, the Northern Minorities were able to exchange furs for manufactured goods. Some groups developed large-scale reindeer breeding activities so that they
could sell meat to the Russian settlers (Vakhtin, 1992). In brief, the indigenous peoples were drawn away from the subsistence economies on which they had successfully depended since time immemorial towards a market economy over which they had little or no control.

At the time of the Bolshevik Revolution, many of the indigenous peoples of the Far North continued to depend on hunting, gathering, fishing and reindeer breeding (Schindler, 1992), even though their land and political rights had been continually eroded and their ways of life threatened throughout the 19th century (Vakhtin, 1992). With the triumph of the Revolution, however, the Soviet regime made a concerted effort to transform "primitive" indigenous cultures to 'modern' Soviet culture" (Schindler, 1992:57). These efforts included, most importantly, efforts at modernization and the breakdown of kinship relations. For the native minorities of the Chukchi Peninsula, this meant being buffeted by 50 years of social upheavals: regrouping and relocation of villages, sedentarization of the Chukchi reindeer herders, arrival of large numbers of immigrants from other areas who came to administer, exploit, or militarily "protect" the region, and the mixing of various cultural communities (Robert-Lamblin, 1993). Stalin's government carried out ethnical pogroms, and deported whole peoples from their homelands. Many indigenous peoples lost their rights to use their native languages, religions, and political and economic forms; some even lost their recognition by the Soviet Union as distinct groups. Mass relocations (which continued into the 1950s and 1960s), forced assimilation, and social malaise led to high rates of suicide, alcoholism and domestic abuse, as well as high unemployment (Vakhtin, 1992).

The future for the Northern Minorities is unclear. Whether they can regain the self-autonomy and relative well-being they enjoyed before their lands and ways of life were taken from them is open to question (Badger & Balikci, 1992; Bychkov et al., 1992; Sorin, 1992; Fondahl & Poelzer, 1997). If there is hope it lies in the fact that, along with many other indigenous peoples the Northern Minorities have begun to organize politically and reassert their rights, and have become active participants in the international movement of indigenous peoples.
Chapter 4
The Context of Mental Health

Sociocultural environments and mental health

The interrelationship between sociocultural environments and mental health must be held firmly in mind when discussing the mental health of indigenous peoples. However, a complete discussion of this topic is beyond the scope of this report. Readers are may begin a review of the relevant literature with the classic work, *My name is legion*, in which Leighton discusses how sociocultural environments may facilitate or block humans’ need for “essential striving elements” such as physical security, recognition, or a sense of belonging to a moral order (Leighton, 1959). Another landmark work is an article by the Dohrenwends which explores the social and cultural influences on psychopathology (Dohrenwend & Dohrenwend, 1974). Kleinman’s *Rethinking psychiatry* (Kleinman, 1988) offers an excellent overview of the topic. Finally, Fullilove’s consideration of the importance of “place” to psychological well-being is of especial relevance in view of the dislocations that indigenous peoples have experienced (Fullilove, 1996).

In brief, mental health must be considered as being deeply enmeshed with economic and political concerns such as poverty, hunger and malnutrition, social change, and violence and dislocation (Desjarlais et al., 1995). Furthermore, mental, social and behavioural health problems cannot be assessed in isolation from one another, because they “represent overlapping clusters of problems that...interact to intensify each other’s effects on behaviour and well-being” (Desjarlais et al., 1995:6). From this perspective, social pathologies (e.g., substance abuse and violence), health problems (e.g., heart disease and depression) and social conditions (e.g., poverty) are interrelated to such an extent that it is impossible to differentiate one problem clearly from another.

Before leaving this discussion of the context of mental health, it is critical to note that an essential feature of a people’s sociocultural environment is meaning. In concluding his remarks about the depopulation of Melanesia (see above), Rivers wrote:

The point I wish to emphasize is that through this unintelligent and undiscriminating action towards native institutions, the people were deprived of nearly all that gave interest to their lives. I...suggest that this loss of interest forms one of the reasons, if indeed it be not the most potent of all the reasons, to which the native decadence is due....The new diseases and poisons, the innovations in clothing, housing and feeding, are only the immediate causes of mortality. It is the loss of interest in life underlying these more obvious causes which gives them their potency for evil and allows them to work such ravages upon life and health (Rivers, 1922:89).
Goldschmidt's concept of the "human career" is particularly relevant here (Goldschmidt, 1990). Each culture provides pathways by which individuals may satisfy their needs for positive affect, prestige and meaning. Small-scale, hunting-gathering societies provide several such pathways: excellence in hunting or story-telling or as a healer. More complex societies offer a greater array of "careers". Whatever its size, complexity or environment, a central task of any culture is to provide its members with a sense of meaning and purpose in the world. What happens, then, when a people's way of life is destroyed through disease, genocide, loss of territory, and repression of language and culture, when pathways to meaning are no longer available? Leighton saw the result as psychopathology, Rivers as mortality. As an overview of the literature on mental health problems of indigenous peoples makes clear, it is both.

Problems of diagnosis and treatment

Epidemiological data on psychiatric disorders and behavioural problems among indigenous peoples are rare. Even when data do exist, methodological issues raise questions of their accuracy (Dohrenwend & Dohrenwend, 1974; Ebigbo, 1982; Manson et al., 1987; Kleinman, 1988; Guarnaccia et al., 1990; Good, 1993; Somervell et al., 1993; Durie, 1995). Indeed, all cross-cultural psychiatry faces problems of diagnostic validity (Kleinman, 1980; Kleinman, 1988; Guarnaccia et al., 1990; Good, 1993; Kirmayer et al., 1995; Manson, 1995; Mezzich, 1995; Lee, 1996; Good, 1997). As noted in a recent review of mental illness among American Indians and Alaska Natives:

The lack of well-validated assessment methods for research with Indians has hindered all substantive research on psychopathology. It should not be assumed that instruments of known reliability and validity in the majority culture will perform in the same way for these culturally distinct populations (Somervell et al., 1995:325).

As an example, it is worth examining how one neuropsychiatric disorder, depression, may be misdiagnosed among indigenous peoples. Two decades ago, Kleinman wrote:

The depressive syndrome represents a small fraction of the entire field of depressive phenomena. It is a cultural category constructed by psychiatrists in the West to yield a homogeneous group of patients (Kleinman, 1977:3).

A recent review of the literature on the interrelationships between culture and depression concluded that a better understanding of the phenomenology of depression must not only encompass symptoms but take into consideration "the social contexts and cultural forces that shape one's everyday world, that give meaning to interpersonal relationships and life events" (Manson, 1995:497). Furthermore, it is widely believed that the manifestation of depression in non-Western populations tends to take the form of somatic symptoms rather than psychological ones, the implication being that diagnostic categories
are, to a great extent, culturally constructed and their symptom profiles are not universal (Kleinman, 1988).

Although depression is the most frequently diagnosed problem among American Indians who present at mental health treatment facilities, it is easily misdiagnosed, and its relationships to other conditions, e.g., alcoholism, antisocial behaviour, physical illness, and grief, are not well understood (Manson et al., 1985:332). A better understanding of the character of depression among American Indians must precede accurate estimates about its prevalence and the testing of hypotheses about its etiology (Shore & Manson, 1981) and the development of effective guidelines for its treatment in these populations. Among the Hopi Indians in the American Southwest, for example, Manson and colleagues found that few (7%) of the subjects knew of any Hopi word or phrase that was the equivalent of the term “depression” (Manson et al., 1985:349). Moreover, 22% of the clinical sample with major depression reported dysphoric mood for one but not two weeks, indicating that duration of this symptom may vary significantly from one cultural setting to another. Fully one half of the clinical sample (compared to one quarter in a sample from the general population) was suffering from both chronic and major depression, a pattern that may explain why the clinical course of depression among American Indians is so pernicious and debilitating. And, finally, “the coexistence of alcoholism and depression among American Indian men...deserves closer examination”, in view of the fact this research found that “major depression was secondary to an alcoholic condition in every male subject” (Manson et al., 1985:359).

O’Nell (1989; 1993) has also examined the problems inherent in the investigation of psychiatric disorders, as well as the relationship between depression and problem drinking among American Indians and Alaska Natives. In brief, she cites the importance of native understandings of psychiatric illness in the attempt to arrive at better explanations of mental illness among these peoples:

[1] It has become increasingly evident that the field as a whole has labored under a constricted view which unquestionably assigns preeminence to Western psychiatric categories....We do not know, for example, the psychiatric significance of ‘flat affect’, ‘hallucinations involving spirits’, and ‘prolonged mourning’, all of which have been reported as more frequent among American Indians. Thus far these manifestations have been treated as symptoms of serious disturbance. Yet our current state of understanding cannot rule out the possibility that the converse of these manifestations, i.e., ‘emotional lability’, ‘inability to contact the spirit world’, or ‘truncated mourning’, may in fact indicate a greater degree of pathology for members of these populations than the original ‘signs’ (O’Nell, 1989:78).

In keeping with this perspective, O’Nell concludes from an investigation of drinking and depression at the Flathead Reservation in the United States that while these behaviours may be indicative of psychopathology, depression and drinking may also have positive connotations:
Depression...can be a positive expression of belonging...To be sad is to be aware of human interdependence and the gravity of historical, tribal, familial and personal loss. To be depressed, and that includes tearfulness and sleep and appetite disturbances, is to demonstrate maturity and connectedness to the Indian world. A carefree attitude is often thought of as indicative of immaturity (O'Neill, 1993:461).

Nor is drinking always pathological. It can be, at times, “a positive expression of sociality, a reaffirmation of bonds of kinship and friendship through the sharing of resources and time” (O'Neill, 1993:462). Nevertheless these conclusions should not be interpreted as maintaining that depression and drinking are not problems for many American Indians. One must be careful to avoid, through a stance of extreme cultural relativity, regarding obviously deleterious practices and conditions as vital aspects of a given culture. Rather, in order to address these issues effectively, it is critical for therapeutic interventions to be based on a rich understanding of the meanings of depression and drinking for American Indians and the contexts in which these behaviours occur.

"Culture-bound" syndromes

The so-called “culture-bound” syndromes, e.g., latah and amok in Malaysia, susto in Mexico, ataques de nervios in Puerto Rico, or Windigo psychosis among the Cree, Eskimo, and Ojibwa Indians of northern Canada, are often considered as nothing more than exotic conditions that mask underlying and universal disorders (Kleinman, 1988; see also WHO, 1997). That they are marginal to psychiatry is indicated by the fact that they have little prominence in the ICD-10 (WHO, 1993) and have been relegated to an appendix in the DSM-IV (Kleinman & Cohen, 1997). However, it would be more useful to consider these syndromes as “idioms of distress”: ways in which cultures designate how individuals can communicate psychiatric distress (Kleinman, 1988). Langness (1976) has gone so far as to say that the debate over culture-bound syndromes is fruitless. If the emphasis is shifted, he argues, “to the social responses to unconscious conflicts and to the cultural contexts in which behaviours appear, all such behaviours...can be seen as culture-bound” (1976:63); indeed, this is the argument that Kleinman makes about agoraphobia and anorexia nervosa in the West and among westernized elites in developing societies (Kleinman, 1988; Kleinman & Cohen, 1997).

A powerful argument in favour of considering culture-bound syndromes as idioms of distress can be found in the history of latah, a startle reaction syndrome often marked by coprolalia or compulsive mimicry, which is most often precipitated by “an unexpected noise, touch, or gesture experienced in the presence of persons whom the victim views as superior or desires to please” (Murphy, 1976:4). Latah has been found widely, but has been very rare except for among the peoples of Malaysia where it was first documented by Europeans in the mid-19th century. It only became a common condition around 1890 when reports from Malaya and Java described it as occurring in almost
epidemic proportions among all sections of the population – young and old, men and women, upper and lower classes – and being concentrated near European settlements. By the 1920s, *latah* had become far less common. Even more striking was the fact that it had become increasingly rare among the young, its distribution had moved away from European centres, and it had virtually disappeared among males while becoming concentrated among female servants. Over the next three decades, the epidemiology of *latah* continued to change. Its distribution moved further from centres of European influence to smaller towns and to populations that had never experienced it previously. It remained a syndrome primarily found among women, although in Java it affected older women while in Borneo it affected both young and old alike.

The causes of *latah* are not well understood. Nevertheless, its epidemiology indicates that social forces – European contact, shifting social roles of women, and economic factors – have played a critical role in the changes in its frequency and distribution. Clearly, then, it is important that the culture-bound syndromes are not simply relegated to footnotes and appendices but rather be seen as expressions of human response to distress. The reason for this discussion of culture-bound syndromes, together with the discussion of problems in diagnosis of depression among American Indians, is that when assessing the mental health of indigenous peoples, it is necessary to remember that the distinctness of their cultures and how they express distress and conceptualize well-being challenge many universalist notions in psychiatry.
Chapter 5

The mental health of indigenous peoples

A literature review on the mental health of indigenous peoples reveals that few data exist. For example, this review found virtually no information on the mental health of the Scheduled Tribes of India, the National Minorities of mainland China, or the indigenous peoples of Africa. The work of such organizations as Cultural Survival, the International Work Group for Indigenous Affairs, the UN Working Group on Indigenous Populations, the World Council of Indigenous Peoples and many local organizations documents the hardships and injustices that have been endured by indigenous peoples. However, little of this work refers directly to mental health. In many instances, it is possible only to speculate about the extent and nature of mental disorders among specific groups of indigenous peoples. Thus, the following information is at best impressionistic and preliminary, especially in view of the methodological problems already discussed.

Central and South America

There are some 13 million indigenous people in Mexico and Central America, 17.5 million in the highlands of South America, and 1 million living in the lowlands. According to the World Bank, they live under conditions of severe and pervasive poverty (Psacharopoulos & Patrinos, 1994). In addition, they have been subjected to political violence, wars, environmental degradation, and human rights violations (Amnesty International, 1992; Pedersen, 1993; Pedersen et al., 1996). Their physical health is poor. For example, life expectancy among the Maya of Guatemala – 47 and 48 years for men and women, respectively – is 17 years shorter than for the Ladino population of the country. Health conditions for the Maya, particularly in rural areas, are very poor; one survey in 1991 revealed that rural infant mortality rates were above 100/1000 and 76% of rural children suffered from malnutrition, 41% of them severely (Wcarne, 1994).

It is clear that the indigenous peoples of Central and South America have experienced severe traumas in the past five hundred years and the mental health consequences of such a history could be expected to be far-reaching (Pedersen, 1993; Desjarlais et al., 1995). Evidence of this may be found in a study of Mayan children aged 8 to 16 years who witnessed and lived through acts of terrorism in Guatemala. While the long-term effects could not yet be anticipated, researchers found that children living in orphanages in Guatemala were experiencing high levels of fear, did not know where they would go after they left the orphanage at the age of 18, and were not earning a place for themselves in the Mayan rural community. Children in a refugee camp in Mexico were in the process of losing their Mayan ethnic self-identity. Without
land and without continuous knowledge of their traditional culture these children faced a bleak future that held out little hope for anything beyond bare subsistence (Melville & Lykes, 1992; Miller & Billings, 1994).

One area of psychiatric epidemiology for the indigenous peoples of Central and South America that has been examined carefully concerns the effects of migration on mental health. Loss of lands, poverty, and changing economies have meant large-scale migration to urban areas with the result that levels of psychosocial stress are higher and general health status is poorer among the migrants than among the general population (Pedersen, 1993). As we saw among the peoples of the Russian Far North, "the so-called development process places increasing numbers of the traditional population [of South America] into a market economy", and impels large scale migration to urban areas for economic opportunities (Almeida-Filho, 1987:9). However, given the realities of most South American societies, which are often highly stratified and exclusionary (Gaviria et al., 1986), migration, rather than offering expanded opportunities, is marked usually by displacement of indigenous peoples from any labour force, high rates of unemployment, and the exposure of individuals to risk of "extreme uncertainty and social stress, with temporary or permanent repercussions at a psychological level" (Almeida-Filho, 1987:9).vii

North America

There is more information about the mental health of the indigenous peoples of North America – American Indians, Alaska Natives, and Inuit of northern Canada – than for any of the other indigenous peoples of the world. In brief, rates of alcohol abuse or dependence, substance abuse, depressive disorders, and suicide are higher among American Indians and Alaska Natives than among the general population of North America (Somervell et al., 1995). However, in view of the lack of attention to intertribal variations, one should not assume that rates are high for all the indigenous peoples of North America (O'Neill, 1993). Given the great diversity in their histories, socioeconomic status and social organization, one would expect variation in the relative mental health status and needs of different groups. Therefore, instead of offering a general review of psychiatric epidemiology among the indigenous peoples of North America,viii the following paragraphs will summarize the experience of a programme that serves the mental health needs of the Inuit peoples of Baffin Island in the eastern Canadian Arctic as an example of the burden that mental health problems can pose to a community of indigenous peoples.ix

The Baffin Consultation Service of the Clarke Institute of Psychiatry in Toronto has provided psychiatric consultation services to the Baffin Island region since 1971 (Hood et al., 1993). About 10000 people live in this region, more than 8000 of whom are of Inuit origin. The service consists of a mental health team (usually a psychiatrist and a resident) that makes about eight visits per year to the region. During these visits of between five and ten days each, the consultants spend most of their time in the assessment of outpatients, while also devoting their
efforts to discussions with teachers and social workers, participation in community and interagency meetings, and educational activities.

During the period of 1986-1989, 581 new patients (of whom 89.5% were Inuit) were seen by the staff of the Baffin Consultation Service (Young et al., 1993). Women outnumbered men in a ratio of about 3:2. Depression (27.9%) and suicidal attempt or ideation (24.4%) were the primary reasons in more than half of the cases. Many patients were referred because of the consequences of psychosocial stressors, e.g., economic problems, conflicts with the law, grief, and separation. Alcohol and substance abuse were also significant problems. Although only about 10% of patients received a primary diagnosis of substance abuse, alcohol and drugs were implicated in at least a quarter of all cases.x

Reasons for referral differed for women and men (Abbey et al., 1993).xi More than twice as many women (37.8%) as men (16.4%) were referred for depression. In contrast, significantly fewer women (20.6%) than men (32.8%) were referred for suicidal attempts or ideation,xii and significantly fewer women (4.4%) than men (29.9%) had conflicts with the law.xiii Gender differentials were also found in the prevalence of alcohol problems: 24.1% of women reported alcohol problems, much lower than the rate reported by men (39.4%). However, alcohol use was a problem for women in that they reported far more alcohol problems in their families (36.1%) than did men (21.8%), and the concomitant problems of spousal assault and sexual abuse were also significant problems for women. Recognizing the social origin of the mental health problems among Inuit women, Abbey and colleagues reported:

While there will always be women with psychiatric disorders who will require care, there is an even more pressing need for programmes addressing the emotional sequelae of family violence, sexual abuse and alcoholism. Efforts to empower women to overcome these problems must be community-based, culturally sensitive, and cognizant of the complexity of the changing sociofamilial position of Inuit women (Abbey et al., 1993:34).

Australia

A 1995 report (Swan & Raphael, 1995) concluded that mental health was a major problem in most Aboriginal communities: depression, suicide and self-harm, trauma and grief, substance abuse, domestic violence, and child abuse rates were thought to be quite high generally, although available data are limited.xiv The report also found that effects of these problems were compounded by a shortage of services.

The Australian census of 1991 estimated that the Aboriginal and Torres Strait population (hereafter referred to simply as Aborigines) totaled 265458, about 1.6% of the Australian population. On all socioeconomic indicators, the Aboriginal population was clearly disadvantaged (see also McKendrick et al., 1992). Their unemployment rate (over 30%) was 2.6 times higher than in the
general population; their household income levels were lower; they were less well-educated; nearly one-third lived in overcrowded housing conditions; and Aborigines were tremendously over-represented in the criminal justice system (as measured by arrest and imprisonment statistics). Health status measurements were no better. Infant mortality rates among Aborigines were three times that of the general population, life expectancies were much shorter (17 and 15 years less for men and women, respectively), and Aboriginal age-specific mortality rates were between two and seven times higher. In addition, Aborigines suffered from significantly higher rates of such diseases as diabetes, respiratory disorders, hepatitis B, and sexually transmitted diseases.¹⁷

These conditions, in addition to a history of colonisation and loss of land, high levels of domestic violence, sexual and physical abuse, child abuse, and forced family separations, have made grief and trauma central experiences of Aboriginal life (McKendrick et al., 1992; Hunter, 1997).¹⁷ High levels of substance use, especially alcoholism (Cawte, 1991; McLaren, 1995), contribute to the milieu of grief and trauma. There is also a strong association between alcohol use and high rates of suicide among Aborigines (Clayer & Czechowicz, 1991).¹⁸ Although the association is not as obvious as it may appear at first glance. In an investigation of Aboriginal suicides and self-harm behaviour, Hunter (1991a; 1991b) notes that when drinking rights were extended to Aborigines in the Kimberley region, in 1971, the result was a sudden increase in Aboriginal deaths due to accidents (motor vehicle accidents in particular) and homicide. The resultant social disruption had its most potent effects on young adults who were already leading dislocated lives in town camps and under the stress of high rates of unemployment. About fifteen years later, these events were followed by a dramatic increase in suicide and self-destructive behaviours among young (mostly male) Aboriginal adults in towns. Hunter writes that these young people were “the first generation to reach adulthood in the aftermath of the transformations of the 1960s and 1970s. They [were] the first generation to have grown up in an environment of widespread drinking and its social consequences” (Hunter, 1991:663).

This would seem to indicate that alcohol use per se was not the immediate contributing factor to suicide and self-harm behaviour among Aboriginal young people; rather, the chaotic childhood environment that alcohol use helped to create was the fundamental cause. In fact, in an investigation of Aboriginal suicides while in police custody, Hunter found that alcohol use was not a significant factor, but that a history of heavy drinking in the family was predictive of suicides among incarcerated young Aboriginal men (Hunter, 1991).

These findings have far-reaching implications for mental health services, not only for Australian Aborigines but for all indigenous people whose social worlds have been disrupted by alcohol use. Such research indicates that it is essential to look beyond proximal factors and cross-sectional studies to social and historical issues in order to determine the fundamental causes of mental health disorders and to develop effective prevention and intervention strategies (Hunter, 1991; Link & Phelan, 1995). The implication for treatment can be
expressed in the form of a challenge: how does one provide culturally appro-
ropriate treatments to alleviate the suffering of individuals while, at the same
time, fostering efforts to address the problems that are posed by the social
worlds in which they live?

Pacific Islands

New Zealand

As of 1986, there were an estimated 400,000 Maoris living in New Zealand,
out of a total population of 3.1 million. Since 1945, most of the Maori have
migrated to urban areas. Like their Aboriginal counterparts in Australia, the
Maoris fare poorly on all indicators of social well-being (Durie, 1995; Sachdev,
1989). They are poorer, less well-educated, and have unemployment rates that
are three times those of non-Maoris; they are imprisoned at a rate almost 14
times that of non-Maoris; Maori women aged 25-64 years have death rates
twice as high as non-Maoris; only 34% of Maori deaths occur above the age of
65 as compared to 71% for non-Maoris; and, life expectancy at birth is 7 years
shorter for Maori males and 8.5 years shorter for Maori females in comparison
to non-Maoris. At the same time, Maoris (and other poor New Zealanders)
experience serious inequities in access to and use of primary health care facili-
ties (Malcolm, 1996). It seems reasonable, therefore, to expect relatively high
rates of mental health problems among the Maoris. However, “it is difficult to
determine accurately the prevalence of mental illness among Maori people as
there has been no serious attempt to record the extent of psychiatric disorders
within a Maori community using either Western or Maori diagnostic criteria”
(Durie, 1995:336). Consequently, observations about their mental health
must be considered no more than impressionistic.\textsuperscript{19}

Since 1962, Durie reports that Maori rates of admission to psychiatric facilities
have increased substantially, especially among young people between the ages
of 20 and 29, Maoris accounted for 67% of court-ordered psychiatric admis-
sions. The leading cause of inpatient care from 1983 to 1987 was alcohol
dependence or abuse. While prevalence rates are not available, Durie reports
that since 1970 depression among Maori women has become the leading
mental health problem and is associated with obesity, poor health, and sub-
stance use. It is surprising, therefore, that overall suicide rates among Maoris
remain substantially lower than that of the general population of New Zealand
(Skegg & Cox, 1993; Lester, 1994; Durie, 1995; Skegg et al., 1995).\textsuperscript{21}

Papua New Guinea

A review of mental health research in Papua New Guinea concluded that in
view of the general absence of epidemiological data on mental health problems
there, it is difficult to draw any general conclusions (Robin, 1980-81).\textsuperscript{21} It is
clear, however, that like other indigenous peoples, those of Papua New Guine-
eas have suffered the effects of Western contact and development (Gordon,
1981). For example, alcohol use is a growing problem and is associated with violence, crime, and increased tribal warfare (Jilek, 1987).

**Micronesia and Western Samoa**

As in many other places in the world, the ill effects of development have been seen in Micronesia and Samoa in the forms of increases in rape, suicide, sexual promiscuity, crime, drug and alcohol abuse, and smoking. Changes in diet and lifestyle have resulted in high rates of obesity. High unemployment is common (Finau, 1993).

Since the 1970s, there has been a tremendous increase in the consumption of alcohol throughout the countries of the South Pacific (Jilek, 1987; Marshall, 1987). Western Samoa experienced a threefold increase in alcohol consumption in the 1980s; locally produced beer became the second largest industry in Fiji in 1982. Drinking among young males has been associated with rising crime rates in Micronesia and youth suicide throughout the region.

Of all these problems, the rates of male youth suicide are perhaps the most alarming. As reported by Rubinstein,

> The suicide phenomenon in Micronesia and Western Samoa is very nearly unique in cross-cultural comparison, owing to the extremely high incidence among adolescent men, the enormous disproportion of male suicides over female suicides, [and] the rapid onset of high suicide rates that occurred in the 1970s (1992:52; also 1987; 1995).

At present, suicide is the leading cause of death among young men aged 15-29 years in Micronesia and Western Samoa. The rates of male youth suicide peaked in the early 1980s (about 150/100000), fell off for a brief period, then began to rise sharply again. By 1990, the rates had reached new highs (about 160/100000). In Micronesia and Western Samoa, suicide rates are highest in periurban areas, somewhat lower in urban areas, and lowest of all in rural areas and outer-island communities (Rubinstein, 1992:69).

Rubinstein reviews a number of explanatory models for the phenomenon: loss of traditional family functions, structural change in the nuclear family, “blocked opportunity” or the lack of possibilities for upward mobility and culturally sanctioned goals, and changes in the processes of adolescent socialization, as well as alcohol use, population increases, and rapid cultural changes. As is the case among the Australian Aborigines, no single explanation can account for all youth suicides. A multifactorial model that considers a range of social, historical and cultural factors is the most useful in planning interventions to alleviate the crisis. How one might begin to construct that model is suggested by a striking congruence between Rubinstein’s examination of youth suicide in Micronesia and Samoa and Hunter’s work among Australian Aborigines. Where Hunter (1991) found that suicide had become a
problem for that first generation of children who grew up in an environment made chaotic by the effects of alcohol use, Rubinstein notes:

Children born after 1950 in Micronesia were...the first generation to enter the stage of adolescence at a time when significant erosion had occurred in the cultural activities and social structures that traditionally gave support to adolescent socialization, especially for young men. This first postwar genera-
tion reached sexual maturity and entered adolescence around the mid-1960s, at the same time that the youth suicide rates in Micronesia began to increase. During the next fifteen years, through the late 1970s, the suicide rates surged, as a swelling number of children born after the war moved in the stage of adolescence. (1992:67).

These findings point to the very specific need to focus suicide prevention programmes around efforts to rebuild supportive environments for children, youth and their families.

Hawai‘i

In the one hundred and fifty years following the arrival of Captain James Cook, in 1778, Native Hawaiians were subject to a loss of more than an estimated 90% of their population as a result of disease, social disintegration and spiritual alienation. The legacy of this disaster is still being felt; "the assault on the cultural integrity and the mental health of the Native Hawaiians has continued, unabated, with devastating consequences" (Takeuchi et al., 1987:153). At present, Native Hawaiians rank at or near the bottom for all major indicators of psychosocial distress,\textsuperscript{xxvii} including poverty, crime, illiteracy, health, suicide, and life expectancy (King, 1987; Takeuchi et al., 1987; Scheder, 1993; Kinney, 1996). For example, of all groups in Hawai‘i, Native Hawaiians have the highest rates of gout, asthma, bronchitis, emphysema, obesity, high blood pressure and teenage pregnancy, with the result that they have the shortest life expectancy and their mortality rates are the highest in the state (Kinney, 1996).

As is the case with other indigenous peoples, epidemiological research on the mental health of Native Hawaiians is limited;\textsuperscript{xxvIII} rates of suicide, however, have been examined closely. Although they do not have suicide rates as high as other peoples of the Pacific Islands, Native Hawaiians have the highest rates of suicide in the state. This was not always the case. Prior to 1968, Native Hawaiian males had the lowest crude suicide rate (10.5/100000), but by the period 1978-1982 it had risen to the second highest (25.5/100000). When the rates are standardized for age, Native Hawaiian males have had highest rates since 1958-1962. As of 1985, elderly Native Hawaiian males had the highest suicide rate (41.7/100000) of all groups, and young Native Hawaiian males (20-34 years) were among the highest.\textsuperscript{xxvIII}
Asia

Russian Far North

Officially, there are 26 groups that comprise the Northern Minorities of Russia (Vakhtin, 1992), although others put the count at over 30 (Fondahl & Poelzer, 1997). The USSR census of 1989 determined that the indigenous population totaled 183700, or 0.06% of the population of the ex-USSR. The size of the groups varies tremendously, from the Oroks who numbered less than 200 to the Nenets and Evenks who each totaled more than 30000 (Vakhtin, 1992:8). If one includes the Yakuts, the number of indigenous peoples in the Far North is increased by some 365000 (Lempert, 1992).

Under the Soviet regime, the Northern Minorities were subjected to forced collectivization of land and animals, an influx of overwhelming numbers of Russians, the suppression of native languages, forced relocation, and the destructive effects of compulsory boarding-school education (Schindler, 1992; Vakhtin, 1992; Robert-Lamblin, 1993). Furthermore, the environment of the region has become extremely polluted and degraded by reckless industrialization. In Yakutsk, for example, underground nuclear tests have left a legacy of high rates of cancer among both children and moose; the water of the Lena River is polluted by industrial waste and heavy metals (Lempert, 1992). In Chukotka, environmental pollution – black coal smoke, lack of rubbish collection, and lack of sewage and water purification facilities – poses serious hazards (Robert-Lamblin, 1993). Logging operations have resulted in drastic declines in wildlife and fish populations in the traditional territories of the Evenk (Bychkov et al., 1992).

Like indigenous peoples in other parts of the world, those of the Russian Far North suffer a wide range of health and behavioural problems: high infant mortality rates, low life expectancies, and high rates of homicides, suicides and substance abuse (Fondahl & Poelzer, 1997). Among the Eskimos and Chukchis of Chukotka, life expectancy in 1989 was estimated at 56 years, some 13 years shorter than that of the white population (Robert-Lamblin, 1993). Rates of active tuberculosis for the Siberian Eskimos are alarmingly high (Achirgina-Arsiak, 1992). Violent deaths (accidents, suicides and homicides) now account for a third of all deaths of the indigenous peoples of Chukotka; alcoholism is implicated in most accidents and homicides and about half of the suicides.

Data on which to base comparisons of rates of mental disorders in the indigenous and non-indigenous populations of the Russian Far North are not available. However, the levels of violence, the legacy of oppression, and their poor health status may be presumed to indicate that the indigenous peoples of the Russian Far North also experience high levels of psychiatric distress.
Taiwan (Republic of China)

Shortly after the Second World War a community study of mental disorders among aboriginal groups in Taiwan, found no significant differences between these peoples and the resident Chinese population. Rates of alcoholism, while higher among the aboriginal groups, remained comparatively low (Rin & Lin, 1962). Almost 40 years later, an epidemiological survey of the aboriginal groups found, in contrast, relatively high rates of mortality due to accidents, suicide, and certain physical conditions (chronic liver disease, tuberculosis, and other respiratory illnesses) (Cheng & Hsu, 1992). These findings suggest that there had been a “huge increase in alcoholism” among the aboriginal peoples of Taiwan in the decades following the Second World War. Since high rates of alcoholism are associated with a wide range of mental and social problems, it seems safe to presume that, at the same time, the burden of neuropsychiatric disorders has increased significantly among these aboriginal groups.
Chapter 6
Conclusions

Despite data limitations, it seems safe to conclude that the stressors to which the indigenous peoples of the world have been and continue to be exposed – epidemics, racism, violence, loss of territories and dislocation, high rates of morbidity and mortality – result in relatively high rates of mental disorders and behavioural problems. These include mental retardation, epilepsy, depression and anxiety, suicide and substance abuse (Pedersen, 1993; Desjarlais et al., 1995; Swan & Raphael, 1995). However, in view of the diversity of indigenous groups and the general lack of sound psychiatric epidemiology, we cannot say with any degree of certainty that the mental health status and the treatment needs of one group can be extrapolated to another.

The development of effective programmes of treatment and preventative services depends, first, on reliable and valid epidemiological knowledge, and, second, a thorough understanding of how the local worlds and beliefs of indigenous peoples shape their mental health (Pedersen, 1993). Understanding local worlds and beliefs will help to prevent the establishment of programmes that offer services and forms of treatments that are not culturally appropriate. For example, Manson and colleagues report that group and family therapies, as well as traditional therapies, are being used increasingly in mental health services for American Indians and Alaska Natives because these therapeutic techniques have greater salience for these peoples than individual therapy (Manson et al., 1987; Manson, 1996) see also (Schumacher & Guthrie, 1984; Desjarlais et al., 1995; Ewalt & Mokuau, 1995). Furthermore, the failure to place the mental health of indigenous peoples within larger contexts, raises the risk of medicalizing social problems. Hunter (1991:668) argues that Australian Aborigines deserve access to alcohol treatment and psychiatric facilities, but that “such programmes are unlikely, of themselves, to have any substantial impact beyond the veneer of appearing to be taking action”. Put another way, we must avoid a narrow perspective that leads to psychopharmacological and psychotherapeutic interventions aimed at individual and family-level factors while ignoring the socioeconomic and historical forces (e.g., poor health, poverty, genocide, and disenfranchisement) that ultimately put people at “risk of being at risk” (Link & Phelan, 1995).

It is also critical for indigenous peoples’ beliefs and attitudes about mental health to be integrated into the development of any programme. Swan and Raphael (1995:13) note the need for the development of services that are informed by a culturally valid understanding of Australian Aborigines’ concept of health as “encompassing mental health and physical, cultural, and spiritual health”. To establish a successful mental health programme for the Tarahumara Indians of northern Mexico requires an understanding that their concept of mental illness refers more directly to antisocial behaviour than to other symptoms of mental disorders (Irigoyen-Rascon, 1989). Even organic
disorders are shaped by cultural considerations. For example, the Tamang of Nepal recognize mental retardation primarily by the presence of speech problems rather than by symptoms of cognitive deficits (Peters, 1980).

A telling example of the importance of understanding cultural concepts and attitudes towards mental disorders comes from the work of Kirmayer and colleagues among the Inuit of northern Canada. Contrary to general expectations, they determined that “among the Inuit, greater familiarity with the problem and expectations for recovery are more important determinants of attitudes towards a person with deviant behaviour than are specific labels or causal attributions” (Kirmayer et al., 1997:85). Such knowledge can be used in efforts to integrate psychiatric patients into Inuit society through public education efforts to familiarize people with problematic behaviours and to stress the effectiveness of treatment regimens.

Effective mental health programmes for the indigenous peoples of the world must insure self-determination of policies and programmes (Swan & Raphael, 1995). This is more than a matter of administration. Communities must be able to define the critical mental health problems they face as well as to designate appropriate solutions. Indigenous peoples often consider mental health issues as synonymous with political and economic issues. For them, community mental health questions – such as provision of treatment for depression or alcoholism – are inseparable from issues of environmental degradation, loss of land, and political disenfranchisement. Social and economic forces influence the distribution and frequency of mental retardation and epilepsy (Desjarlais et al., 1995), and the same forces determine whether severely mentally ill persons have access to care and medication.

**Establishment of a knowledge base**

The creation of a knowledge base is an essential step in the effort to meet the mental health services and treatment needs of the indigenous peoples of the world. This knowledge base would consist of several parts. First, we need to know the distribution and frequency of mental disorders among indigenous peoples. Without an understanding of treatment needs, it becomes difficult to develop effective service programmes. Second, we need to understand community beliefs and attitudes towards mental illness and the ways in which indigenous peoples categorize mental disorders if mental health programmes are to be accepted and utilized by target populations. Third, because diagnostic criteria established for North American and European populations may not be appropriate for other populations, it may be necessary to recalibrate algorithms of symptoms to arrive at valid diagnoses among diverse peoples. Fourthly, appropriate treatment regimens must be established for specific indigenous peoples, not only for the techniques used in psychotherapy, but also for medications. Although the efficacy of psychopharmacology has been demonstrated among many populations, there are significant cross-ethnic and cross-national differences in responses to virtually all psychotropic medications, so
that optimal dosing practices and side-effect profiles vary significantly among different populations (Lin et al., 1995). Guidelines must be established for a given group before embarking on medication regimens that could prove harmful. Finally, even though the vast majority of indigenous peoples are without access to Western biomedical care, all human groups have developed systems whereby they attempt to respond to disease and restore health to individuals who are ill (Foster, 1983). While a thorough discussion of traditional medicine and its application to mental disorders is beyond the scope of this report, the knowledge base about the mental health of indigenous peoples must include information about traditional medical practices and their relative effectiveness (Eisenberg & Kleinman, 1980; Bannerman et al., 1983; Li & Phillips, 1990).

**Areas of greatest need**

From this review of the literature, it appears that substance abuse, depression and suicide represent the areas of greatest need with regard to the mental health of indigenous peoples. These problems cannot be separated from the social, cultural and historic contexts in which they occur. A strictly biomedical approach to depression, for example, is insufficient when the individuals seeking treatment are constantly facing conditions of life that engender distress. This is not to imply that treatment for depression through the use of psychopharmacology or psychotherapy, or both is not potentially efficacious. But it does mean that any mental health programme for indigenous peoples must offer a community psychiatry perspective broad enough to address both the needs of individuals and the local worlds in which they live. To achieve that policy-makers, mental health planners and clinicians must

be knowledgeable about those populations that are target groups for any proposed intervention...and be conversant with local history and issues...[A]ny interventions must be informed by a recognition that the conditions to be prevented largely reflect historical and cultural factors. [W]e must also be guided by an awareness of the contemporary dynamic relationship between [indigenous peoples] and the wider society” (Hunter, 1998:576).

To take that reasoning one step further, it should recognizing that, to have a lasting effect, efforts to rebuild supportive environments for children, youth, and their families must be an integral component of any mental health programme for indigenous peoples.

**A final note**

From the work of Bartolomé de las Casas through the 1837 report of the British House of Commons Select Committee, Rivers’ observations on the depopulation of Melanesia, and the continuing work of Cultural Survival and
the International Work Group for Indigenous Affairs, there is now documentation of five hundred years of the atrocities inflicted on the indigenous peoples of the world. This report has attempted to impart a sense of the social, cultural, economic and historical worlds in which indigenous peoples live, and how local worlds may shape a peoples’ mental health. Indeed, it would appear impossible, especially in the case of indigenous peoples, to disconnect the quality of social and physical environments from issues of well-being. To return to a question posed earlier in this report: how does one provide culturally appropriate treatments to alleviate the suffering of individuals while, at the same time, foster efforts to address the problems that are posed by the social worlds in which individuals live?

In addition, it is crucial to avoid concentrating exclusively on the negative aspects of the worlds and histories of indigenous peoples. While it is true that indigenous peoples can be described as “victims of progress” (Bodley, 1988), it is also true that the mere fact of their survival and continuing struggle for their rights is indicative of what must be regarded as a powerful ability to adapt and survive. Too often the label of “victim” carries with it negative connotations. The following observation about Native Hawaiians is suggestive of all indigenous peoples:

Hawaiians have not exhibited ineptitude in the face of change but have been caught in that tragic bind that occurs when a people confront change[,] try to control its quality and pace, and find they cannot do so (King, 1987).

Mental health professionals must place their practice within the wider frameworks of social justice and better living environments. Therefore, instead of considering only individual pathologies, community mental health programmes would do well to integrate the collective strengths and identities of indigenous peoples into treatment and care modalities (Hunter, 1995:577).

Perhaps the greatest challenge is that the mental health status of indigenous peoples requires social scientists and mental health clinicians alike to seek strategies by which to address the suffering of individuals and the suffering of communities. Too often, medical anthropologists and sociologists accuse psychiatrists of transforming social problems into medical conditions. Yet social scientists who place illness entirely in the social realm deny the personal experience of suffering (Kleinman & Kleinman, 1991). In the end, a way must be found to balance these two perspectives, to facilitate the transformation of those social worlds that engender distress while, at the same time, attending to those individuals who are in need of care.
Endnotes

i As stated by Moana Jackson, a Maori representative:

\[\text{Ay} \text{efforts to define who or what are Indigenous Peoples are seen as further attempts to dispossess and take away our inherent right to be. Indeed to assume a right to define Indigenous Peoples is to further deny our right to self determination, since there can be no more fundamental expression of that right than the ability to determine who one is through self-identification (IWGIA, 1996:251).}\]

ii Because of difficulties in definition and census-taking, population estimates vary from 220 million (IWGIA, 1996) to 500 million (van de Wijlert, 1994).

iii Exile in Mexico was almost as traumatic as the massacres and repression that had provoked it. In addition to the trauma of dislocation, the Guatemalan Army conducted raids between 1982 and 1988 over the border into Chiapas (Weazle, 1994).

iv For a review of cultural influences on anxiety disorders, see Kirmayer, Young, & Hayton (1995).

v "American Indians" is a rather simplified term used to describe the many and varied peoples whose presence in the New World predated the arrival of Europeans in what is now the United States of America. Grouping sedentary agriculturalists and nomadic hunter-gatherers together with peoples whose economies were marine-based is not only invalid but promotes insensitivity to what may be important intertribal variations of all kinds.

vi This does not mean that literature about these peoples do not exists, just that we were not able to locate articles or books about their mental health, specifically. For example, the poor health of the San Basawas of Southern Africa is well-documented (e.g., O'Keefe & Lavender 1989). There is also research on such topics as genetic structure (e.g., Ramara, Naidu & Murty 1996) and changing demographics (e.g., Hemam & Reddy 1998) among the Scheduled Tribes of India. In neither case, however, could we find research on mental health. Literature was also excluded from this report when it was not in English (e.g., Xiang 1987). It is hoped that these omissions and gaps in the report will both stimulate others to provide the missing information through the use of literature that is not cited here or by encouraging research into the mental health of these populations.

vii Research in Peru cautions that while the experience of migration alone may have harmful effects on mental health, it is important to consider how that migratory experience is shaped by the particular sociocultural conditions under which it occurs. It appears that exclusion from economic opportunities while lacking support from kin and social networks and being forced to live in squalid conditions are the most significant factors in engendering distress among Indigenous peoples who migrate (Gavieria et al., 1986).

viii The following references – which by no means constitute an exhaustive list – are provided for those who wish to examine the literature on the mental health of American Indians and Alaska Natives more closely: general epidemiology (Beiser, 1981; Manson & Shore, 1981; Manson et al., 1981; O'Neill, 1989; Kintzie et al., 1992; Boehnhlein et al., 1993; Kirmayer et al., 1994; Somervell et al., 1995), depression (Shore & Manson, 1981; Manson et al., 1985; Paulikas et al., 1992; O'Neill, 1993; Somervell et al., 1993), alcoholism (Jilek, 1987; Leung et al., 1993), suicide (Gregory, 1994; Kirmayer, 1994; Kirmayer et al., 1994; Lester, 1994; Malus et al., 1994; Kirmayer et al., 1996; Echols-Hawk, 1997; Stedland, 1997; Kirmayer et al., 1998; MMWR, 1998), health (Thouez et al., 1990), and research questions (Ryan & Spence, 1978; Norton & Manson, 1996).

ix For a long-term perspective on mental health problems in one American Indian community, the interested reader can refer to the work of Kintzie et al. (1992), Boehnhlein et al. (1993), and Leung et al. (1993).
A similar profile of mental health problems was found in a mental health service on the Tohono O’odham Indian Reservation in the south-western United States (Kahn et al., 1988).

The broader gender patterns for referral follow those found in a psychiatric survey of adults in the United States (Kessler et al., 1994). For example, rates of depression were higher among women, while rates of substance use problems were higher among men.

The Baffin Island region has a suicide rate – 34.1 per 100,000; this more than twice the national average (Abbey et al., 1993).

This relatively high rate of contact with the legal system mirrors the situation of the Maoris (Durie, 1995) and the Australian Aborigines (Hunter, 1991). Interestingly, a study of ethnic differences in pathways to treatment reported that the legal system was the primary route by which American Indians living in Vancouver, British Columbia, found their way into the mental health system (Lin et al., 1978).

Although not necessarily representative, a survey of psychiatric morbidity among an Aboriginal clinic population in the city of Fitzroy, Victoria, substantiates these impressions for Australian Aborigines in general (McKendrick et al., 1992).

See endnote 24.

In their report, Swan and Raphael (1995) note that these data refer primarily to conditions among the Aborigines and not the Torres Strait Islanders. In fact, the health status of the Islanders appears to be even worse. For example, among Torres Strait Islanders women die at an earlier age than men, there are high rates of infant and maternal mortality, diabetes is widespread, and alcohol abuse is common. Virtually nothing is known about the mental health status of this population.

See Reid (1979) for a discussion of traditional mourning practices among the Yolngu.

See also Robinson (1990) and Reser (1990) for a discussion of other factors that may contribute to suicide among Australian Aborigines.

A series of articles by Sachdev (1989; 1990a; 1990b) thoroughly reviewed what was known – based on institutional data – about Maori mental health.

Increasing hospital admissions for psychiatric disorders among the Maori have also been documented for the period 1925-1935 (Beaghehoie, 1939).

Rates among young people have increased dramatically in recent years, however.

A number of studies have documented the occurrence of hysterical psychoses, spirit possession, and culture-bound syndromes in Papua New Guinea (Newman, 1964; Langness, 1965; Langness, 1976; Burton-Bradley, 1985; Schieffelin, 1996).

The detrimental effects of Western domination can also be seen in the history of psychiatry in Papua New Guinea. Goddard (1992; 1994) maintains that the few mental health services which have existed since the end of the Second World War (established by the Australian colonial administrations) have been more concerned with issues of social control than treatment or rehabilitation.

While epidemiological data on mental disorders are lacking, health status data are indicative. For example, a report on the Hagahai, a group of seminomadic hunter-horticulturalists of highland New Guinea, reveals that around the time of the Second World War this group suffered from devastating epidemics of infectious diseases. Their health status remained extremely poor throughout the next 40 years. In 1985-1986, the Hagahai crude death rate exceeded the crude birth rate, and the infant mortality rate was 444 per 1000 (Jenkins, 1988). It is difficult to imagine that living under these conditions would not have mental health consequences.

The changes in diet and the increased prevalence of obesity have brought about alarmingly high rates of diabetes. In the island State of Nauru, almost two-thirds of adults aged 55 to 64 years have been diagnosed with non-insulin dependent diabetes, with the result that the people of Nauru have one of the shortest life expectancies in the world. For the same reasons, other
indigenous peoples, e.g., American Indians, Native Hawaiians and Australian Aborigines, also suffer from high rates of diabetes (L. Eisenberg, personal communication, 1998).

The impact of development on the prevalence of severe mental illness in Micronesia is more difficult to determine (Hezel, 1987).

In contrast, there is evidence that females commit suicide at higher rates than males in the Solomon Islands (Pridmore, 1997).

By comparison, suicide rates (1991-1993) for American Indians and Alaskan Natives aged 15-24 and 25-34 years were 31.7 and 26.6 per 100,000 respectively, while rates for the same age groups of the general population of the United States were 13.0 and 14.5 respectively (MMWR, 1998).

The interested reader might look at Binglebole’s (1937) work on culture and psychosis in Hawaii, which offers a historical perspective. However, caution is needed since his conclusions are derived from hospital-based data.

Some work on culturally appropriate approaches to examining the mental and social health needs of Native Hawaiians has been done, for a resource in this area see Pukui, Haertig, & Lee (1972-1979).

Interestingly, a survey of Native Hawaiian high school students found no gender differences in the risk for attempting suicide in the previous six months (Yuen et al., 1996).

This life expectancy estimate for the indigenous people of Chukotka may be somewhat optimistic. Robert-Lamblin (1993), together with others (Schindler, 1992:61), reports anecdotal estimates of between 41 and 49 years.
References


Lester D (1994) Suicide rates in Native Americans by state and size of population. Perceptual and motor skills, 78:954.


Resources produced or distributed by Nations for Mental Health

Documents

Gender differences in the epidemiology of affective disorders and schizophrenia
WHO/MSA/NAM/97.1

WHO/MSA/NAM/97.2

Nations for Mental Health: An overview of a strategy to improve the mental health of underserved populations
WHO/MSA/NAM/97.3. Rev.1

Nations for Mental Health: A focus on women*
WHO/MSA/NAM/97.4

Nations for Mental Health: Supporting governments and policy makers*
WHO/MSA/NAM/97.5

Nations for Mental Health: Schizophrenia and public health*
WHO/MSA/NAM/97.6

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