J Pop Research
DOI 10.1007/s12546-016-9159-y

Colonisation, racism and indigenous health

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Abstract In settler-colonies such as Canada, Australia, New Zealand and the United States, the historical impacts of colonisation on the health, social, economic and cultural experiences of Indigenous peoples are well documented. However, despite being a commonly deployed trope, there has been scant attention paid to precisely how colonial processes contribute to contemporary disparities in health between indigenous and non-indigenous peoples in these nation-states. After considering pertinent issues in defining indigeneity, this paper focuses on operationalising colonisation as a driver of indigenous health, with reference to emerging concepts such as historical trauma. Conceptualisations of coloniality vis-à-vis health and their critiques are then examined alongside the role of racism as an intersecting and overlapping phenomenon. To conclude, approaches to understanding and explaining Indigenous disadvantage are considered alongside the potential of decolonisation, before exploring ramifications for the future of settler-indigenous relations.

Keywords Colonisation · Racism · Health · Indigenous · Settler · Australia

Introduction

Although its meaning has changed considerably over the twentieth century (e.g. Horvath 1972; Veracini 2013), colonisation nonetheless possesses largely agreed upon manifestations. It encompasses a range of practices, predominantly historical: war, displacement, forced labour, removal of children, relocation, ecological

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Published online: 18 February 2016

destruction, massacres, genocide, slavery, (un)intentional spread of deadly diseases, banning of indigenous languages, regulation of marriage, assimilation and eradication of social, cultural and spiritual practices (Evans-Campbell 2008; Glenn 2015).

Wolfe (1999: 163) argues that colonialism is an ongoing structure of domination, which Glenn (2015: 62) contends has “often swung (and still does) between the poles of elimination and coercive exploitation”. Racism has similarly been defined as oscillating between extermination and exploitation (Hage 2015). In fact, it is largely through societal systems of racism that colonial structures maintain material and symbolic (e.g. political) privilege. Forms of franchise colonialism primarily seek to extract value from subjugated populations through exploitation (e.g. in British India), with extermination a mere ‘side effect’ despite its vast magnitude in some instances; for example up to 10 million deaths in the Belgian Congo (Roes 2010). In contrast, settler colonialism is principally focused on extermination, with exploitation a convenient ‘value-add’ in the short- to medium-term (Veracini 2011a), although such annihilatory intent is covert enough to engender debate as to its genocidal nature (e.g. Moses 2005). While primarily providing unearned privilege, the ‘fact’ of colonisation can also generate anguish for settler-invaders who yearn for their own autochthony and/or absolution of colonial sins through a disavowal of indigenous prior occupation, denial of harm caused by settlement, or assimilation of the indigene (Bell 2014) into ‘settlerness’ (Veracini 2011b).

It is important to note that, although colonisation is most often associated with indigenous peoples, it is also closely related to historical and contemporary phenomena experienced by other populations. In addition to the extensive literature on franchise colonialism, the Atlantic slave trade has left large African-diaspora populations in the Americas who also suffer from land insecurity, cultural/language suppression and, in some cases, pressure to assimilate (e.g. Perry 2013). Clearly, what makes colonisation distinct for indigenous peoples is not the domination of a settler majority group, but, rather, a status as ‘first peoples’ or, at a minimum, peoples inhabiting a territory at the time of invasion, even if not the actual first according to Western archaeological science. This primacy of occupancy is what Povinelli (2011) calls the ‘priority of the prior’.

The fundamental impact of settler-colonialism on indigenous peoples is now well-recognised within public health discourses (King et al. 2009; Sherwood 2013; Czyzewski 2011). Although they represent only a fraction of the estimated 370 million indigenous people worldwide (United Nations 2009), the focus of such scholarly attention is often indigenous peoples in the so-called CANZUS nations—Canada, Australia, New Zealand and the United States (Ford 2012). Although receiving relatively less attention, settler colonialism is also recognised as a factor in indigenous ill-health and disadvantage in other regions of the world, notably South America (Maldonado-Bouchard et al. 2015). Despite its widespread recognition, it is only recently that investigation has begun into the specific pathways by which colonialism and colonisation impact on the health of indigenous peoples. Following a brief foray into the vexed question of who precisely is indigenous, this paper takes the developing scholarship on historical trauma as emblematic of the complexities inherent in conceptualising coloniality as a determinant of health. Intersections with

racism are canvassed, with decolonisation explored as a potential solution. The paper concludes by examining frames for explicating indigenous disadvantage and exploring implications for settler-indigenous relations into the future.

Defining indigeneity in the late colonial settler condition[1]

In the CANZUS nations, indigenous claims to priority are rarely contested directly by the state but are, instead, managed indirectly through efforts to define indigeneity (e.g. Gardiner-Garden 2003). While who 'counts' as indigenous in the CANZUS societies varies considerably, definitions are administratively entrenched while highly contested socially (Bell 2014). Such is not the case in other parts of the world such as India (Karlsson 2003) and Africa (Balaton-Chrimes 2015) where there is no government, let alone civil society, consensus on indigeneity.

In fact, the question of whom is 'allowed' to be indigenous is a central concern of modern-day settler-colonialism which seeks to either relegate the indigene to primitivism or assimilate them completely into settler identities (Bell 2014: 83). In CANZUS societies, where virtually all indigenous people are descended from both colonised and colonising ancestors, this colonial goal is increasingly articulated through a desire to 'ration' indigeneity by 'shedding' those indigenes deemed 'too white,' and retaining only those with the appropriate 'sheen of exoticism'. Moreover, such boundary policing is increasingly undertaken by indigenous communities themselves who wish to avoid being 'swamped' by 'wannabes' (Bell 2014). Framing indigeneity as 'mixed race' (Fozdar and Perkins 2014) also highlights the 'practically indiscernible' line for light-skinned individuals with indigenous ancestry but tenuous cultural connections, between 'happy settler hybridity' (i.e. achieving the yearning for belonging noted above) and indigenous subjectivity; a veritable tightrope bracketed by 'privilege, intention and choice' (Bell 2014: 84).

An example of what can be associated with such intense scrutiny is evidence from Australia of a 20 % 'churn' in and out of indigeneity, with a smaller net increase, over a 5-year period (Biddle and Crawford 2015), with similar dynamics exhibited among indigenous Canadians (Caron-Malenfant et al. 2014). Such identify 'turn-over' results from various intersecting factors such as changes in survey terminology or sampling, varied willingness to identify due to socio-political events or life-course influences on self-identification (e.g. adulthood, marriage, parenthood, etc.). Whatever the cause, clearly this phenomenon impacts on the already complex dynamics of indigenous health disparity measurement (Pettersen and Brustad 2013), adding to the already difficult task of elucidating the ongoing contribution of colonisation to such inequalities.

Although detailed examination of indigeneity itself is beyond the scope of this paper, it has been introduced here as a cogent reminder of the ongoing challenges inherent in understanding colonisation, not only as a driver of ill-health, but also as

[1] This term is taken from Hage (2015).

a crucial backdrop to the very question of who constitutes the colonised in the contemporary era.

Historical trauma as indigenous ill health

Beyond mere assertions that colonisation underpins indigenous ill-health (i.e. in a plethora of opinion pieces and editorials), the more meagre empirical investigation of colonisation and health has, thus far, utilised only a handful of specific constructs, most notably trauma. Variously know as historical loss (Whitbeck et al. 2004), historical trauma (Prussing 2014) and historical consciousness (Bombay et al. 2014b), as well as collective, intergenerational or multigenerational trauma (Evans-Campbell 2008), this is the best known and most investigated construct to operationalise the impact of colonisation on indigenous peoples.

In relation to indigenous peoples, the concept of historical trauma was first explored in the 90s (Brave Heart 1993), with a focus on individual symptoms such as mourning, survivor guilt, rumination and intrusive cognition/emotion, vicarious impacts on children via parents 're-living' events, and indirectly through impaired parenting practices (Evans-Campbell 2008). Historical trauma has been found to impact on health above and beyond contemporary stressors such as family violence/marital problems or major life stressors (Walls and Whitbeck 2011). Evans-Campbell and Walters (2006) have also explored how historical trauma and present trauma (i.e. racism) may interact to cause further damage as well as the possibility that distinct types of historical trauma (e.g. disruption of social connections vs. physical harm) may impact on health in specific ways (Walters et al. 2011).

A recent study found that a higher level of historical trauma among Native Hawaiian students was directly associated with reduced substance use but also indirectly associated with increased substance use mediated via higher levels of self-reported discrimination (Pokhrel and Herzog 2014). Bombay et al. (2014a) also found a correlation between historical trauma and higher self-reported racism. As suggested by Pokhrel and Herzog (2014), salience of historical trauma may

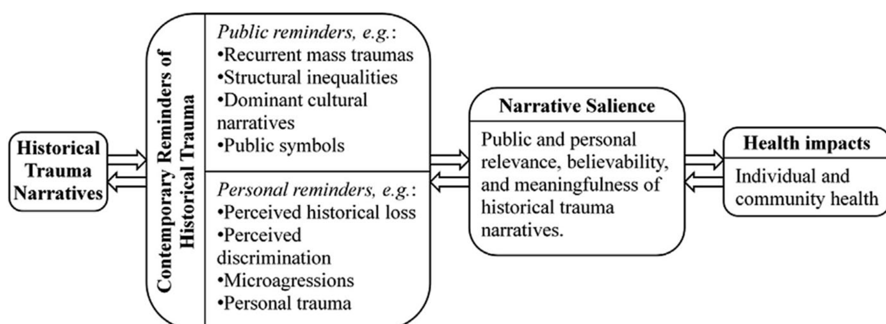

Fig. 1 Narrative model of historical trauma and health (Mohatt et al. 2014)

strengthen ethnic/cultural identity, which, in turn, has been associated with both greater self-reported racism and attenuation of its detrimental health impacts (Brondolo et al. 2009).

Conceptually, historical trauma is animated by the 4Cs: colonial injury along with the collective experience, cumulative effects and cross-generational impacts of such injuries (Kirmayer et al. 2014: 301). Much like the broader concept of stress (Paradies 2010), historical trauma serves “as both a description of trauma responses among oppressed peoples and a causal explanation for them” (Evans-Campbell 2008: 320). Two recent conceptual diagrams illustrate distinct ways of framing historical trauma as shown in Figs. 1 and 2 below (Mohatt et al. 2014; Kirmayer et al. 2014).

Figure 1 focuses on the health impacts of historical trauma discourses, with such narratives considered salient in the present through self-reinforcing ‘reminders’ which can be structural (e.g. racist media depictions) or individual (e.g. interpersonal racism) in form. Such a conceptualisation implicitly draws a clear demarcation between the ‘past’ and the ‘present’, with the former influencing the later only through ‘remembered stories’. In contrast, Fig. 2 is concerned exclusively with the causal pathways through which trauma has disempowered indigenous societies, fostered community dysfunction, disrupted child-rearing, compromised individual wellbeing and degraded physiological processes. This model portrays a

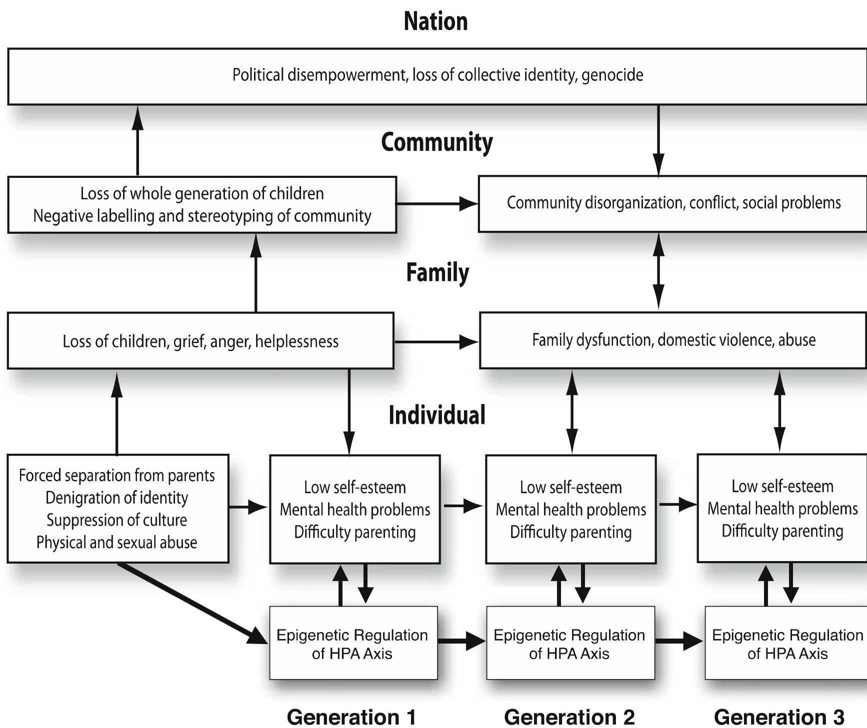

Fig. 2 Transgenerational transmission of historical trauma (Kirmayer et al. 2014)

clear sense of colonial continuity, without abatement, into the present. To some extent, these divergent paradigms resonate with the two broader schemas of indigenous disadvantage explored in the last section of this paper.

Another construct developed to capture the impacts of colonisation is 'colonial mentality', which centres on denigration of self and culture, and acceptance and tolerance of historical and contemporary oppression. Akin to a form of internalised racism, colonial mentality has been associated with self-esteem, anxiety and depression among both Filipino Americans and Ghanaian youth (David 2008, 2010; Utsey et al. 2015). Constructs such as colonial mentality and historical trauma may also impact on health as forms of hyper-vigilance or rumination (Mohatt et al. 2014) which, in relation to racism, have been correlated with emotional distress, depression, aggression, risky behaviours, hypertension and sleep disturbance (Borders and Hennebry 2015; Ashley Borders and Liang 2011; Hicken et al. 2013, 2014; LaVeist et al. 2014).

The notion that trauma can be transmitted across generations dovetails with surging interest in epigenetics (Brockie et al. 2013; Shannon 2013). However, this confluence has also been criticised as representing a "temptation to participate in fashionable forms of biological reductionism" (Kirmayer et al. 2014: 309). Others have questioned whether knowledge or consciousness of historical trauma events is necessary for a health impact to ensue (Walters et al. 2011). As with many other risk factors, ignorance of historical trauma does not preclude damage to health. By the same token, "the fact that individuals attribute their problems to past events does not prove a causal link," with such causality being "exceedingly difficult, perhaps even impossible" to establish in practice (Kirmayer et al. 2014: 307).

Such measurement concerns aside, historical trauma is a highly salient "cultural narrative" that can stifle "collective aspiration", "sustain resiliency" or a combination of both (Mohatt et al. 2014). Stifling can occur through a "moral economy [of] victimhood" as well as through "universalizing understanding of…colonialism" that relegate racism and oppression to the past rather than recognising its continuation in the present (Maxwell 2014: 407). On the other hand, historical trauma can combat self-blame among individuals as well as highlighting the recuperative potential of indigenous cultural maintenance and revival (Denham 2008; Kirmayer et al. 2014).

Certainly, given the established impact of disadvantage and racism, the utility of invoking colonisation as the cause of contemporary indigenous ill-health and disadvantage requires interrogation through questions such as: is trauma the best way to capture the ongoing impacts of continuing colonial legacies (Gone 2014)? What is the utility of (and the dangers inherent in) attempting to operationalise 'colonialism' as a contemporary public health construct? What analytical purchase does it add, if any, to the existing body of research on racism and indigenous health (e.g. Hansen 2015; Currie et al. 2013; McCubbin and Antonio 2012; Harris et al. 2013; Kelaher et al. 2014)?

Notably, colonisation and racism are concepts often paired in discourse, with an implicit assumption that colonisation temporally precedes and has 'caused' racism against indigenous peoples, while the salience of racism now outlives the more historically-inflected phenomenon of colonisation. Perhaps historical trauma can aid

us in "better understanding the health impacts of [racial] discrimination as a historically informed experience" (Prussing 2014: 452).

As described by Gone (2014: 398), an underlying assumption of most historical trauma literature is that "the impacts of colonization are likely to reverberate through subsequent generations more or less indefinitely until active healing…occurs". Is such an assumption plausible? In terms of disease aetiology, can we study the number of generations for whom historical trauma impacts upon health? Although colonisation may be the 'root cause' of indigenous ill health, its aftermath may not be directly measurable in an epidemiological sense. Although glossing over the many nuances in the emerging literature on historical trauma and related constructs, this brief sketch has portrayed the deep epistemological challenges in tracing the impact of colonisation over centuries. Key elements of these tensions will be returned to in the conclusion. Beforehand, however, the next section examines the imperative at stake in understanding colonisation; improving our facility to address indigenous health disparities, with decolonisation considered key to this objective.

Decolonisation as the panacea for indigenous health disparities

While in one sense it is problematic to depoliticise and individualise decolonisation as "therapy for psychic wounds" rather than being about the search for "meaningful livelihoods within [fraught] material realities" (Kirmayer et al. 2014: 311), grappling with historical trauma as a avenue to decolonisation also represents a much-needed attempt to "engage with issues of affect and the intimate…alongside conventional concerns with governance, land" (Maxwell 2014: 427) and socio-economic disadvantage. Although there is some evidence to the contrary (Zimmerman et al. 1998), the view that 'cultural factors' are beneficial to indigenous health is a key plank of decolonisation discourses (Anderson and Kowal 2012; Dockery 2010; Chandler and Lalonde 1998). For example, Fig. 3 shows suicide rates by the presence of cultural factors from a seminal paper by Chandler and Lalonde (1998). Cultural factors were operationalised as pursuit of land claims,

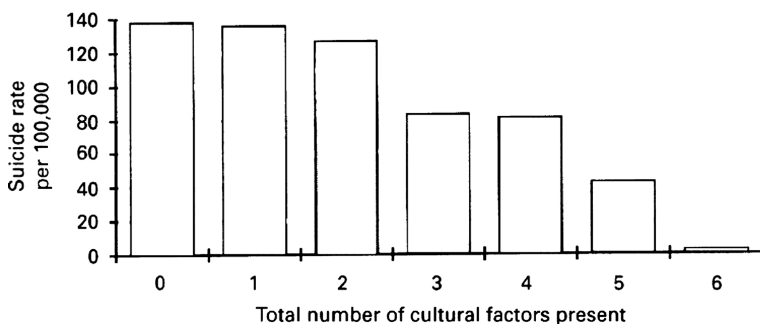

Fig. 3 Youth suicide rates by cultural factors in the community (Chandler and Lalonde 1998)

economic and political self-government, control over education, police, fire and health services and the existence of cultural facilities (Chandler and Lalonde 1998).

Figure 4 is a diagrammatic representation from Nunavut, Canada of the prevailing view that indigenous control reduced dramatically following colonisation but has increased in recent decades through developments such as the Inuit Broadcasting Corporation (IBC), Inuit Circumpolar Council (ICC), Inuit Tapirisat of Canada (ITC), Nunavut Land Claims Agreement (NLCA) and Regional Inuit Associations (RIA).

These figures graphically display decolonisation as endurance/recovery and its link to improved indigenous health/control. During parts of the 1970s and 80s, settler colonialism was associated with the 'project of improvement' (Kowal 2015), via its role in enhancing living standards and fostering economic development (Veracini 2013), with a focus on many of the same factors cited in the figures above but considered as outcomes of colonisation, rather than consequences of decolonisation. However, in the twenty-first century, the contention that settler colonialism is health-promoting is generally not well received, with its role firmly entrenched as the antithesis of enhanced control and improved health, even though the foundation for such claims is much more discursive than empirical in nature.

Given evidence that they enjoy a health and mortality profile concomitant with neighbouring non-indigenous populations (Hansen 2015), the Sami people in Scandinavia serve as an instructive case in which this abstract tension is actualised. Assuming such equality is real (rather than say, due to difficulties in enumerating this population), we can ask if such health equity constitutes a 'failure' of colonisation to maintain the subjugation of the indigene or success in assimilating them to the health 'norm'? Does such equity represent empowerment for the Sami

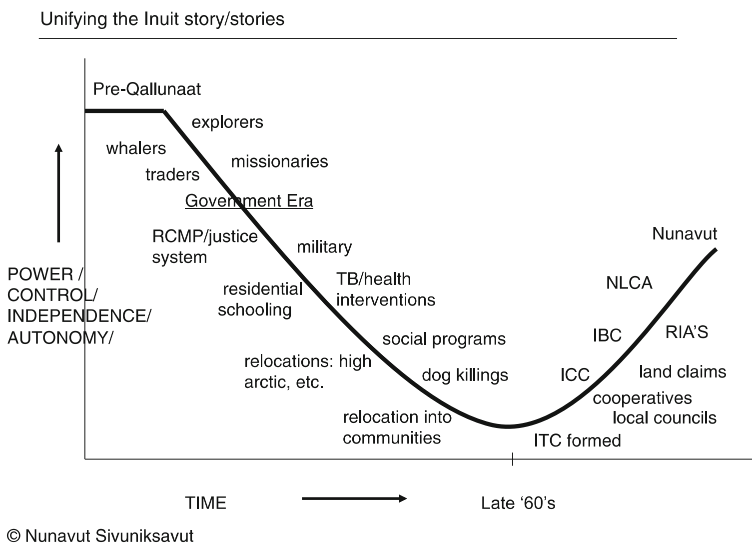

Fig. 4 Variations in indigenous control over time (Crawford 2014)

or has it come at the cost of ‘lost’ culture, control or power? The answers to such questions depend on how we understand the nature of indigenous disadvantage.

Framing indigenous disadvantage

As argued by Rowse (2015), debates about the ‘plight of indigenous peoples’ gravitate towards two diametrically opposed models. The first model appeals to a ‘community of fate’ rooted in an unbroken line of indigenous colonial disenfranchisement that requires “a massive and continuing project of social control” (Rowse 2015: 15) orchestrated by the settler-state and non-indigenous populace at large. The second model rests upon a ‘vicious circle’ of “social pathologies…in which many Indigenous people find themselves” (Rowse 2015: 14–15). The first linear model of ‘snow-balling’ disempowerment fails to account for ebbs and flows in the ‘fates’ of indigenous people over space and time, and is particularly ill-suited to explaining pockets of ‘indigenous flourishing’ within settler-colonial states (Rowse 2015: 20). Conversely, the second model gives little credence to colonisation as an ongoing system of oppression, thus fuelling a focus on individual responsibility and victim-blaming (Neale 2013). In other words, the second model fails to explain how the ‘vicious circle’ was first instantiated or how it is sustained over time. Rather, the circle is considered to be entirely self-perpetuating within indigenous communities, and very much in need of rupture through non-indigenous intervention.

Maldonado-Bouchard et al. (2015) contend that settler colonialism represents itself as a linear narrative of inevitable progress, essentially the same in nature as the line of unremitting colonisation portrayed in Rowse’s first model but with an entirely reversed (and, hence, positive) valence. Maldonado-Bouchard et al. (2015) also equate franchise (or, in their terms, classic) colonialism with a circle of invasion, exploitation and then return ‘home’, reminiscent of Rowse’s (2015) ‘vicious circle’. As illustrated in Fig. 5, model 1 requires settlers’ lines and

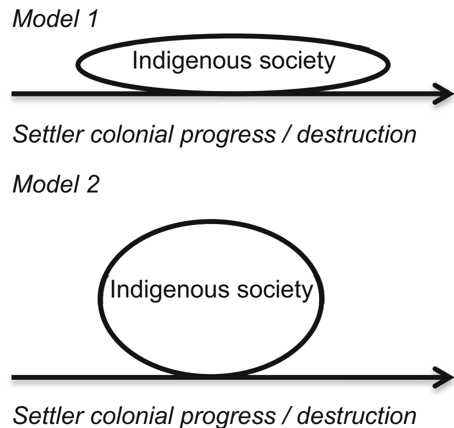

Fig. 5 Conceptualising indigenous-settler relations

Indigenes' circles to co-exist in the same one-dimensional, but highly contested, space. Conversely, model 2 locates indigenous society (akin to a franchise colony) as only tangentially intersecting with settler society.

The linear and circular figures articulate the tension between sameness versus difference as they apply to both to the colonial project and aspirations of social justice (Kowal 2015). The continuum anchored at one end by conformity and the other by divergence pertains separately to both health/social equity and cultural distinctiveness. Some forms of social justice mandate equity in substantive outcomes whilst stipulating that indigenous peoples remain culturally distinct. Within the confines of the settler-state this equates to the view that the 'destruction' wrought by colonial 'social control' (i.e. the line in Fig. 5 interpreted as settler colonial destruction) needs to be 'rolled back' through decoloniality as a simulacrum of restoration to pre-colonial idyllic times where it is purported that indigenous peoples enjoyed much higher standards of living. The contrasting linear model (i.e. the line in Fig. 5 labelled as settler colonial progress) asserts that colonialism can be beneficial via indigenous assimilation into both settler health/social and cultural norms, with the corollary that pre-colonial times were not particularly halcyon in nature and indigenous peoples will benefit from inclusion into 'mainstream' society. In Australia, this view is epitomised by a recent trend whereby public commentators (Indigenous and non-Indigenous alike) seek to 'flatten' this 'vicious circle' into the 'line of progress' (as per model 1 in Fig. 5) promised by settler coloniality, a one-dimensionality achieved at the price of indigenous alterity (Neale).

Turning to the circular model, we can see that it represents a form of settler colonisation with elements evocative of franchise colonialism, in that the impulse to exterminate indigenes inherent to settler-invaders is tempered by an urge to retain their cultural capital such that it can be forged into a mantle of settler-autochthonised legitimacy. In such a framework, cultural difference can be exploited for the symbolic and material gain of settler-invaders. A certain indigenous versus non-indigenous separation is retained whilst keeping indigenous society tethered, like a balloon, to the march of settler pro2013gress and, hence, open to the continued circulation of colonial/settler agents and structures. An alternate interpretation of the circular model is, of course, that such a separation of indigenous and settler social realms is necessary to avoid assimilation and preserve cultural particularity and that indigenous thriving is possible without the continuing suffering inflicted by the settler-invader seeking to mould indigenous peoples in their own image through their 'project of improvement' (Kowal 2015).

An Australian Aboriginal academic recently questioned whether racism (which he equated with "British invaders" and hence colonialism) "is the main source of oxygen that maintains the fire of Indigenous suffering and disadvantage" (Dillon 2015). Such a query leads us to ponder if we should be: (1) searching for "epidemiological echoes of [a] colonial past" (Jamrozik 2006: 4) through constructs such as historical trauma; (2) focusing on racism as the inherited successor of colonisation and hence the need for anti- or even alter-racism (Paradies 2016) as a countervailing force; and/or (3) devising efficacious strategies that address socio-economic disadvantage as the staple 'diet' fuelling the persistent flame of

indigenous disparity? Can either decolonisation or ‘deep colonisation’[2] preserve cultural distinctiveness beyond health and social disadvantage, leaving a ‘virtuous circle’ of indigeneity that intersects with, but isn’t ruptured by, the colonial arrow of settlerhood progress? Or must ‘culture’ be compacted out of existence in the merging of lines on a graph via the assimilative process of ‘closing the gap’? Is decolonisation simply another aspect of the ‘project of improvement’ administered in collusion with the settler-invader state or, rather, an authentic rejection of the liberal desire for commensurability in statistical outcomes? Perhaps there is even something beyond lines and circles that can constitute a kind of ‘supra-counter-colonialism [which] counters colonialism from a space outside and beyond it’ (Hage 2015: 158)? Although likely unanswerable in any definitive sense, these questions will, explicitly or implicitly, fashion indigenous futures well into the twenty-first century.

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[2] A term denoting colonialism hidden within purportedly progressive post-colonial discourses (Rose 1996).

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