

DECOLONISING TRAUMA WORK:  
INDIGENOUS PRACTITIONERS SHARE STORIES AND STRATEGIES

by

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**Abstract**

This dissertation explores the areas of healing and wellness within Indigenous communities on Turtle Island. By drawing on a decolonising approach to Indigenous health research, this study engaged 10 Indigenous healthcare practitioners in a dialogue regarding Indigenous worldviews; notions of wellness and wholistic health; critiques of psychiatry and psychiatric diagnoses; and the cultural strategies that Indigenous healthcare practitioners utilise while helping their clients through trauma, depression, and experiences of “parallel and multiple realities.” Importantly, this study addresses a gap in literature and puts forth a necessary contribution in regards to Indigenous peoples and psychiatry. Indigenous healthcare practitioners reveal their thoughts and strategies in relation to psychiatric diagnoses, cultural treatment, and psychotropic medication. The stories and strategies gathered during the interview dialogues created a broader discussion that is situated among the existing literature. This research found that Indigenous knowledge and experience was deeply embedded in the practises of Indigenous healthcare practitioners. The strategies presented by these practitioners offer purposeful and practical methods that originate from Indigenous worldviews, yet can be utilised by any practitioner that is seeking therapeutic strategies to help traumatised individuals and communities. Moreover, this research will be a particularly relevant resource for health policy initiatives, agency programming, and education and training institutes. Bringing forth Indigenous strategies for helping and healing is a vitally important contribution to the field of trauma work.

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## Dedication

This work is dedicated to the two most influential women in my life:

*Waakenangok* aka Eva Linklater (1916-2007) - my grandma

and

Marion Dzwin Legge - my mother

And also to my son *Niiganibeness* aka Blaze Shilling for reminding me why we must always think of the future generations.

## Prologue

Everything about Indigenous research tells us that we have to *locate ourselves* in our research study. That is, first write our own stories and share our position in the world before we write about the world. This is a big task, because first we have to come to terms with *who we are* and *how we come to do the work that we do*. When I began my PhD journey, I was already pondering these questions. I had already been searching. I was searching for myself and for my place in the world. As the years passed, life continued to unfold and I discovered that this journey through my doctoral work was challenging me to unite with my Spirit in the deepest and most profound way. In the thesis writing stage, I realised that working with the stories was much like my healing journey—connecting the disconnected. And once I began to connect to myself, the thesis started to form and the stories came together.

Following Cree/Saulteaux scholar Margaret Kovach (2009), who noted the suggestion of Māori scholar Dr. Graham Smith, I decided to share my story at the beginning of this dissertation in a prologue, rather than as a chapter imbedded in the thesis, or as a section in the introduction. I felt that it was necessary to be upfront about my lived-experience and worldview. I have also had to be considerate, in that, this is not only *my* story, it is the story of my family—or families. I wanted to be sensitive to not bring about difficult emotions in family members because, for various reasons, people have different tolerance levels and I wanted to respect that. I also recognise that this is my version of circumstances and someone else may remember it differently. It has also been important that I not simplify or minimise my journey because I believe that it has been my life experience that has inspired and enabled me to embark on this journey to explore a very complex research topic.

My Anishinaabe name is Ozhaawashkobinesi (Blue Thunderbird) and I am from the Otter Clan. That is how I connect with Creation. I was born during the summer of 1969 at the Salvation Army's Grace Hospital in Toronto, Ontario. My mother was an Anishinaabe woman from Manitou Rapids-Rainy River First Nations in Northwestern Ontario; she journeyed to the Spirit World in 1985. My mother, uncle, aunts, grandmother, and grandfather attended St. Margaret's Catholic Residential School in Fort Frances (Ontario). After residential school, my mother was court-ordered to attend St. Mary's, a Catholic training school for girls in Toronto. A

few of my aunts (and a cousin) were also sent to this institution. After she had been there for a couple of years, my uncle (mother's brother) and his partner visited her at the school. They decided to tell the administrators that they would take responsibility for her and she could live with them in their west-end apartment and help look after their young daughter. This is where my mother met my father. My father's family came from England and Scotland and settled in Toronto in the 1900s. My grandmother (father's mother) was born in Glasgow, Scotland. My father has lived the majority of his life in Alberta working as a cowboy and rancher. Ironically, my great-grandfather's birth certificate (England) listed his father as being a "cowman." My claim to fame is that I am from many generations of cowboys and Indians!

I lived with both my parents for the first few months of my life. Family surrounded me, both my mother's and father's side. My Anishinaabe grandma and my aunt, from Northwestern Ontario, came to the city to support my mom during my birth. My paternal grandmother and great-grandparents were still living and very involved in the lives of their descendants. I was already in a matrix of cultures and communities. In November 1969, my mom and I boarded a train and headed to Northwestern Ontario. She wanted to bring me home. Within a few weeks the Children's Aid Society of the District of Rainy River apprehended me—while my mom cried and protested. At that moment, I became part of the *Sixties Scoop*<sup>1</sup> and was placed into foster care. Not surprisingly, the adoption records documented, "She was brought to the Children's Aid Society office voluntarily by her mother on December 1, 1969 as she was not able to care for her." On February 10th, 1970, at six months old, I began my journey back to southern Ontario with a couple that was seeking to adopt a baby. I became part of a family that lived in a small rural village with a mother, father, sister, and brother.

My adoptive grandparents, my mother's (herein referred to as 'mom') parents, immigrated to Canada from the Ukraine in the 1900s. They met in Canada, married, and raised a family with two daughters and seven grandchildren; including me being the youngest and the only adopted family member. Grams and Grampa always seemed to be so central in our lives; they had siblings that also immigrated to Canada, so there was a strong cultural and linguistic influence. They were all such characters. I remember after one family dinner we were wondering

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<sup>1</sup> According to Johnston (1983), this term was first suggested by a long-time employee of the Ministry of Human Resources in British Columbia who "admitted that provincial social workers would, quite literally, scoop children from reserves on the slightest pretext" (p. 23).

what Grampa, Uncle Nick, and Aunt Xenia were doing. They had vanished from the dinner table. We found them downstairs having a contest of *who could do the most push-ups*. They were all in their seventies. I think one of the most important teachings that I received from my Ukrainian elders, was that they taught me to *survive*. And no matter what happened in life, “we had to *plough ahead*.” I always found this an appropriate metaphor for this teaching, as ploughing is directly connected with the work of creating and maintaining a garden. They always had great gardens. Even still, my mom and my aunt are carrying on the Ukrainian legacy of survival by continuing to plant and nurture the earth around us.

My adoptive father was of English/Scottish ancestry. In 1975, he was hospitalised in the Whitby Psychiatric Hospital and became a recipient of electroshock treatments. I have no doubt that this procedure changed him in irreversible ways. He had a number of diagnoses; although the diagnosis that most accurately described his “symptoms” was likely manic-depression (now known as bi-polar disorder). After his discharge, he moved to Toronto and continued to struggle with his difficulties. He lived in rooming houses, hostels, and eventually ended up homeless on the street. In time, he was routed to a home with a level of care and supervision and that is where he lived out his life. In the years following his hospitalisation, our relationship with him was sporadic and minimal.

When our family separated I was devastated. Up to that point, he was my primary parent; and I suppose, I had just too many losses already. He was an engineer and worked out of an office in our house. Previously he held a pilot’s licence, flew with the Royal Canadian Air Force, and worked on the Avro Arrow. In many ways he catered to the very essence of my Spirit. When I wanted to go to the park he would take me. Even though we had to drive to the next town where they had schools with playgrounds. He would take me to two or three parks in one day. I would make meals out of sand and leaves and bring them to him to eat as he sat at the top of the play structures reading the newspaper or staring off into space. I used to watch him pace back and forth across the dining room thinking about very serious things. He gave me my first research job. When it looked like I needed something to do, he would ask me to check on the ski conditions. I gladly made my way to the telephone and dialled the number to hear the recorded message. I became very good at reporting back to him and he always responded like I had given him the most helpful information. When he noticed that I liked to sit high in the trees he nailed planks of wood between the branches so I could have a place to perch on. When I requested, he

opened the bathroom window so I could crawl out and sit on the roof of the house. He taught me to drive a car with my knees. I must admit that he didn't always exercise the best judgement—considering I was only four or five. One of my most favourite memories was being up at our grandparent's cottage and we were down by the lake getting our evening fire ready. He said, "Want to see something amazing?" Of course I said, "yeeaaahhhh." He proceeded to pour lighter fluid on the lake and then threw his cigarette in and POOF, the lake was on fire. Pretty amazing!

All of this came to an end one sad evening when my father's claims about the mafia threatening our lives finally landed him in the psychiatric hospital. I was insistent about visiting him and I remember clearly when my mom took me to the hospital. My brother and sister were older than me, so had a more mature understanding of the situation. They didn't come with us for the visit. I suppose it was too difficult for them to see him the way he was. But I was ecstatic about seeing him. He took me upstairs and showed me the dorm where he slept. It was a big sterile room with rows of beds. Under his bed he had a big bag of candy that his sister had sent for him. We sat eating and visiting. After we went downstairs, he began asking my mom for the "new phone number." But my mom wouldn't give it to him because he had been calling repeatedly. Despite the instructions I had received earlier, I whispered the new number in his ear. And then I disappeared back upstairs to where the candy was. I remember the rush of people (parents and white coats) practically flying up the wide stairwell and emerging at the entrance of the dorm room, only to see me smiling and sitting beside his bed with the bag of candy.

In the following years my mother, sister, brother and I did our best to *plough ahead*. I was certainly part of the family. However, deep inside of me I always knew that I came from somewhere else and my Spirit ached over my lost connection. I remember my brother and I watching *Snoopy Come Home*. I must have been around eight years old; my brother would have been 12. I watched as Snoopy made the difficult decision to return to live with his original owner, the grief expressed by both Snoopy and his Peanut friends caused me to burst into tears. I remember the look on my brother's face. I think he knew *then* that I was having some real difficulties.

My mom had been working as a real estate agent when she became a single parent. She had previously been a registered nurse; and after the separation, she re-entered the field, furthered her education and specialised in psychiatric nursing. She became certified as a group

psychotherapist through the Ontario Group Psychotherapy Association. She worked at the Clarke Institute of Psychiatry, Metropolitan Toronto Forensic Services, as well as the Inpatient Psychiatric Nursing Unit and the Crisis Intervention Team for the Grey Bruce Regional Health Centre. Because of her profession, I grew up with stories of the psych ward around the dinner table. These stories weren't expressed in a pathological context. At least I didn't interpret them that way. They were just experiences that people were having. They were more *stories* in the universe, and I liked stories.

By the time I was a teenager, and living in Toronto, I was starting to struggle with my identity. I was struggling because I don't think I had formed one. I was missing all the pieces that would help me know *who I am* and *where I came from*. I started to realise that I needed to reconnect with my birth family. I felt like an empty vessel without them. My adoptive family were always supportive and wanted me to have pride in my "Indian heritage." They always reminded me of where I came from. But none of us really knew what that meant. I remember my older sister showing me an Indigenous family in the laundromat and proudly telling me that they were like the family that I came from. My mom had always told me that when I was ready that she would take me back to where they got me from and I could see where my birth mother's family lived. As fate would have it, my reconnection was easier than I could have ever imagined and I returned home the summer I turned 19 years old. Over the past 21 years, I have become, more or less, relocated back into my Anishinaabe family and community. I have also rejoined my father's family. And I remain connected to my adoptive family.

Other than to say that identity formation was crucial to my development and understanding of my place in the world, I won't describe the details of my reconnection experience in this prologue as I wrote about my journey through adoption (Shilling, 2002) as part of a contribution to the *Book of Voices: Voices of Aboriginal adoptees and foster children*. I also wrote about my experience of healing from colonial trauma and coming to terms with my mixed-blood identity (Linklater, 2010).

In 1989, I started an undergraduate degree in Native Studies at Trent University. It was great to be connected with other students who were pursuing knowledge about our culture and history. It was the first time that I had heard about colonisation, residential schools, and *Indian Act* legislation. I struggled to process how much colonial policies had affected my family and



myself. I realised that my route through the child welfare system was a direct result of Canada's strategy to disable Indigenous families. I suppose one of my coping methods for mediating the distressing emotional responses was to become politically active and in the mid-nineties I moved to Ottawa. By this time, I realised that the government was completely negligent in keeping their terms of the treaty agreements. I became involved in the student movement and served as the National Aboriginal Students' Representative for the Canadian Federation of Students. We were at the forefront of the fight to eliminate the cap on post-secondary education funding for First Nation students. We organised an occupation of the Department of Indian and Northern Affairs and successfully shut down the Department for one day. They increased security after this event!

My son Blaze was born between first and second year university; and I feel that, in many ways, we have grown up together. It was important to me that I give him opportunities that I didn't have. I wanted him to be raised in a culturally connected environment and to have access to family and community. The Native Studies Department attracted many young families, so we had been part of a community network in Peterborough. After we had been in Ottawa for just over a year, I got an offer to move back to Northwestern Ontario for an employment opportunity. I quickly packed us up and we embarked on a journey that would teach me things that I was completely unprepared for.

It was during this time that I was with my family at a powwow. My uncle and aunt had been talking about my return to the family. That evening, my uncle offered *tobacco* to the men sitting at a traditional drum and asked them for a song. He was given the microphone and he spoke to the people in the Anishinaabe language. He spoke about how I had gone into the system and had come home. My uncle had a way of speaking that was really meaningful. They brought me into the powwow circle and we danced to the song that was being offered. I could feel that my mother's Spirit had joined us. After the song, my family stood with me as all the people came through and shook our hands. This was my sacred homecoming. It was a beautiful summer evening. The night sky was full of stars.

I knew in my heart that my experience of moving back to my ancestral homelands was going to be life changing. I revelled in the idea of being closer to my family and immersed in culture and community. I felt a part of me come alive that had been sleeping for many years. It wasn't long after this that my world started to take a confusing turn. My dreams became very

vivid and I was having spiritual experiences that I did not have the knowledge to understand. I remember calling my grandma and telling her what I was going through. She asked me, “Are you scared?” and I said, “No, I just want to be able to understand what is happening.” She shared with me that she also had these experiences when she was younger. As months passed, life became much more intense and my co-workers and I were advised to attend ceremonies because people were trying to cause us harm—through the use of *bad medicine*. This explained my dreams and some of the sensations that I was feeling throughout my body.

I grappled with whether or not I should include this part of my story in the prologue. I decided that I needed to because it is directly related to my understanding and experience of being *unwell* in an Anishinaabe context; and has become an important teaching in the evolution of my worldview. I am also aware that these types of experiences have been documented in the literature (Angel, 2002; Brant, 1990; Duran, 1990; Landes, 1968; Mandelbaum, 1979; Moodley, 2005; Taussig, 1987; Waldram, Herring & Young, 1995; Wolfart & Ahenakew, 2000). There is no doubt that I was experiencing severe imbalance and disharmony. During a heightened period of intense stress, I could see the world as I always knew it, but I could also see the Spirit World. It was like *parallel* vision. I felt frantic and terrorised. The spirits were interacting fully in my physical world by placing objects and sacred items in my space, manipulating my body, and interfering with electrical and mechanical devices. Importantly, I was not alone in this journey, so many of these occurrences were witnessed by others and are still affirmed many years later. Fortunately, my family and friends nurtured me and connected me to Elders and ceremonies that aided in the situation and I was spared the psychiatric system. I have thought of what might have happened had I been admitted to hospital and I’m sure that I would have been restrained and drugged. But instead, with family and community support, I stabilized and was able to access culturally-based healing opportunities.

The assessment process began with a *talking circle* that included myself, my grandma, my aunt and uncle, and my uncle’s mother, brother and sister. So essentially, I was surrounded by grammas, aunties and uncles. My younger cousin also sat in the circle and listened with curiosity. They asked me all kinds of questions, such as: who I had been around? who might I have offended? were there people who were jealous of me? had I broken any spiritual taboos? what had I been dreaming? what ceremonies had I been put through? who conducted the ceremonies? and so forth. After many hours of discussion, which concluded at six in the

morning, they decided that there were too many factors and that my gramma should take me to a Shake Tent ceremony to determine what was happening with me. They even decided together who should be approached to conduct the Shake Tent. I had been to a few Shake Tents before and knew that is what we did when we needed to seek advice directly from the Spirits. The following week, my gramma, aunt, and sister brought me to a Shake Tent and one of the things that was revealed was that I needed to proceed with cultural healing to deal with the spiritual afflictions that were impacting me.

The next week, I was taken to meet some Elders who my aunt thought would be able to help. I offered tobacco and shared with them what I had been experiencing. They told me to come back a few days later and we would have a Sweat Lodge. When I returned, I spent the afternoon with them visiting and preparing the Lodge. A few more people arrived that evening. Before we went into the Lodge we sat in the house and they started the ceremony by praying and smoking their pipes. The old man sat beside me as someone sang a healing song. I felt a wind breeze across me. Then the old man spit into the palm of his hand and we all watched and saw little black bugs moving around as he said, “Look at that, they are still alive!” I thought that was interesting until the woman across from me said, “Those came from you;” shocked I exclaimed “nooo...,” and she gave an affirming nod. The older woman then put a beaded emblem on her forehead to protect her own Spirit. She proceeded to put bear grease (medicine) on my arms and then brought out a rock and rubbed it up and down my arms. As she did this many little bugs came out of my pores. This was my first experience being *doctored* in the Anishinaabe way. And it was just the beginning. At this ceremony, I also received my Anishinaabe name *Ozhaawashkobinesi* (Blue Thunderbird). I was grateful that *Ozhaawashkobinesikwe* (Blue Thunderbird Woman) came into the ceremony and offered me her name and her protection. I continued with ceremonies over the next few months and was cleansed of other spiritual intrusions. I also felt like I was unravelling layers and layers of a protective wall that I had built around me over the years. I attended a few Sweat Lodges, a Peyote Ceremony, and was put out to Fast on an island for four days and four nights. All of these ceremonies helped me become grounded in myself and strengthen my Spirit. My dreams and spiritual sight seemed to remain strong—albeit less overwhelming.

In retrospect, I realise that if a psychiatrist or a practitioner within the medical model was assessing me, then I could have met the criteria of a few DSM (Diagnostic and Statistical Manual

of Mental Disorders) diagnoses. However, I honestly do not believe that such diagnoses would have been helpful in my situation, particularly because I was not seeking psychotropic medications for my difficulties. This was affirmed when months later (after I had moved back to southern Ontario), my medical doctor prescribed six Ativan (an antianxiety medication) when I showed up in her office immediately after returning to university and attending a class—which caused severe panic. The next day, prior to attending class, I took one of the pills. Within moments, I felt like a truck had run over me and I realised that the medication was not providing the type of relief that I needed. Fortunately, my doctor also recommended I begin journaling immediately and seek out counselling. On that note, I went to an Aboriginal counselling agency and was offered short-term crisis counselling. But more importantly, I was connected to cultural and community resources that could view my fragile state in the context of injury. It also gave me the opportunity to become a volunteer and lend my time and skills, which kept me connected with community, rather than isolated at home.

I started to come to terms with the reality that I had been severely wounded. And not just through my recent encounter of being under spiritual attack, but through a lifetime of injurious experiences. For the first time in my life I was actually *feeling* how much my heart had been broken. The crisis had been the catalyst that brought me to the centre of my being—to the core of my Spirit. And I began a healing journey that, over the years, would involve many practitioners and healing modalities; including continued spiritual and ceremonial support, culturally-based counselling and education, chiropractic care, acupuncture, massage therapy, cranial sacral therapy, and four years of psychotherapy. I also remain connected to my Doctor of Natural Health who provides advice on vitamins and natural supplements. And with my attention focussed on my own wellness, I engaged in a healthy lifestyle that involves yoga and regular physical exercise. In essence, I had designed my own wholistic healing plan. I also feel that it's important to share that at different times, and in different ways, I accessed the support of synthetic and natural forms of antidepressants. I fully acknowledge that regulating emotions is a necessity that sometimes requires use of psychotropic drugs or natural remedies. But once the disruptive emotions have been healed, there is no need for external regulators; and essentially, I believe that a healthy person has a good capacity to cope with and tolerate uncomfortable circumstances. My goal was to strengthen my own capacities.

It took a few years to fully stabilise, but this did not stop me from participating in the world. In fact I believe that connecting with community and returning to school was central in my healing. After I had some time to reflect on my experience of working in my home territory, I had the thought that maybe it would help our communities if we had an opportunity to learn about colonisation and talk about how colonial influences had changed the ways that we relate to each other. I decided to complete a Master of Education in adult education and community development, with a focus on transformative learning. This gave me an opportunity to study adult education and complete a research paper on *Critical Education for Decolonizing Indigenous Nations*. I had come to the realisation that education had a vitally important role to play in the healing of Indigenous peoples.

After I completed my Masters, I taught a course for the Native Studies Department at Trent University and held the position of Group Activities Counsellor at the healing agency where I had previously accessed services and been a volunteer. I then returned to graduate school to begin a PhD, yet kept myself closely connected to family and community work. I was also attending many training sessions available to Indigenous practitioners that explored topics relating to historical trauma, multigenerational trauma, mental health issues, addictions, grief recovery, and cultural ways of healing. As I pondered my PhD research topic, which changed a few times, I finally decided to write on *Decolonising trauma work*. I thought about my own experiences in healing and the experiences of others and I thought that it was important to engage in dialogue with Indigenous healthcare practitioners that provided a space for us to critique psychiatry and acknowledge the cultural philosophies and Indigenous strategies being utilised in the healing work among Indigenous communities.

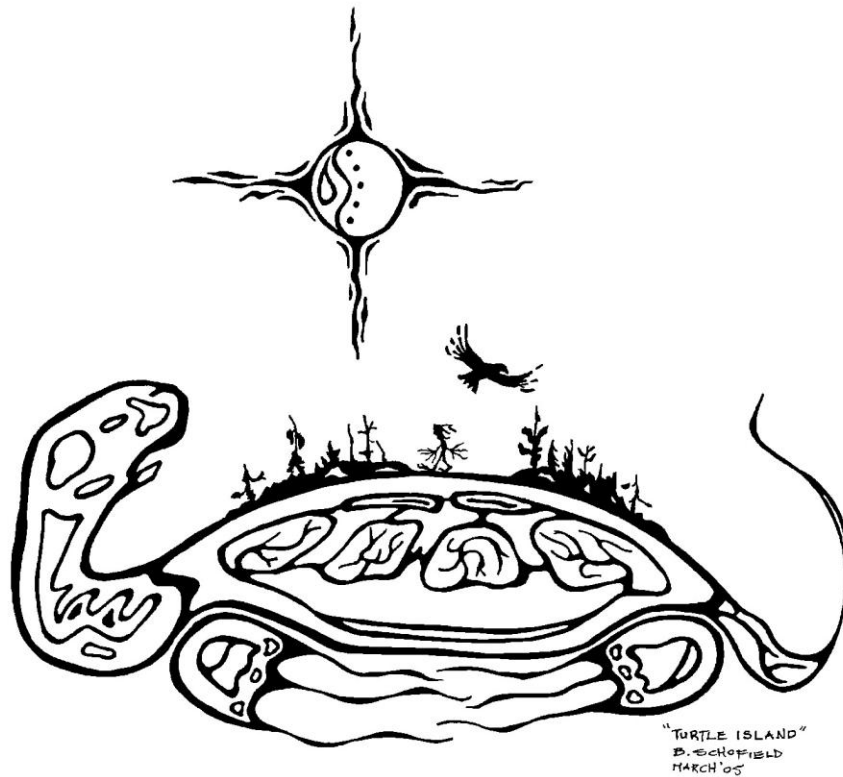
Locating myself in this research has been, perhaps, the most challenging aspect of my research process. In many ways I felt centrally located within my topic. I have experienced and witnessed the complexities of trauma, and have been continually reminded of how Canada's colonial policies have impacted on my family and myself. In some ways the research topic began triggering my own history and I felt overwhelmed with the *constant* trauma talk. My responsibility to myself as a researcher, and to the research topic, became to ground myself in wellness so that I could feel balanced during this process. And more so, it was important that I complete this inquiry from an Indigenous worldview. It also has become apparent that those who work in the field of trauma need to recognise the intense affects that this work has on the

practitioners themselves. This is a difficult task because for many of us, we are not only immersed in the trauma that exists in the community, but we are also immersed in the trauma that exists in our families. And for Indigenous families, this trauma seems to be continually unfolding in various ways.

For myself, it was essential that I came to terms with the reality that two generations of my family attended Residential Schools. I am relieved that the government of Canada has offered an apology and compensation to former students. Sadly, many students passed on prior to this acknowledgement, including some of my own family members. Tears streamed down my face as my 17-year-old son and I listened to the CBC broadcast of the apology in June 2008. I feel that the effects of the *colonial phenomena*, in general, will be felt for many generations. I suppose the most troubling family tragedies that we have had to live through in recent years were the suicides of one of my aunts who took an overdose of her antidepressant medication, and my 18-year-old cousin who hung herself from a pyramid-type hydro structure in Winnipeg. The multigenerational trauma experienced within our families can never be minimized; and nor can our abilities to survive and adjust to such circumstances. I am beginning to believe that, for the most part, Indigenous peoples are resilient and have the ability to remain hopeful and optimistic; although, unfortunately we have lost many people who have given up in a desperate attempt to end very painful circumstances. I hope the healing movement within Indigenous communities continues to increase culture-based strategies and wholistic opportunities for those seeking to heal their wounded Spirits and broken hearts.

In concluding the sharing of my story, I am thankful that my journey through life has placed me in a position to be able to bring together Indigenous healthcare practitioners to *share stories and strategies* of how they walk with our people and help them bring a greater sense of wellness to their lives.

## Chapter One: Introduction



*Figure 1. Turtle Island<sup>2</sup>*

This *study* creates a *story*. It is just one story among a universe of stories. This story is told from my perspective. Someone else would tell the story differently. This story takes place on Turtle Island<sup>3</sup>. I must admit my hesitation in putting this story *out there*, because as Thomas King (2003) acknowledges, “For once a story is told, it cannot be called back. Once told, it is loose in the world” (p. 10). Keeping this hesitation in mind, I offer this research study as my

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<sup>2</sup> Courtesy of Bentley Schofield. Drawing represents male/female existence, the elements (earth, air, fire, water), elongated hands and feet are roots and limbs that are still growing, and Turtle is watching how we grow from “what is there for us.”

<sup>3</sup> Turtle Island is an Indigenous concept that refers to the North American countries of Canada, United States and Mexico; some teachings include Central and South America. Oral history stories share that a Turtle came to the surface of the water and life began to grow upon her.

contribution to the important healing work that is being done in Indigenous communities. It is also written in honour of Indigenous healthcare practitioners; as these helpers and healers support, nurture, guide, and inspire wellness in our people. This chapter will introduce information relevant to the context and framework of this study, put forth Indigenous ways of knowing as legitimate knowledge production, and present Indigenous trauma theory that is relevant to this research study.

## **The Study**

Cultural approaches are essential for Indigenous peoples to move forward in healing from colonization. Over 500 years of contact between the original peoples of the Americas and settler nations has produced extensive displacement and disconnection. The colonial institutions that were manufactured by settlers caused a great deal of damage to the spirits of Indigenous peoples. We are now in a process of healing from the historical trauma (Brave Heart, 1998; Brave Heart, 1999; Brave Heart 2004; Brave Heart-Jordan, 1995; Wesley-Esquimaux & Smolewski, 2004) that has visited our lives. This research study sought to explore and gather the strategies that Indigenous healthcare practitioners and communities are using to support Indigenous peoples in the areas of healing and wellness.

### **Context.**

As a direct result of colonisation, the vast majority of Indigenous peoples have lived, or are living, in trauma; and in most cases, this trauma is multigenerational (Brave Heart 1998; Brave Heart-Jordan, 1995; Brave Heart Debruyn, 1998; Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998) and is relentlessly being reproduced and reinvented in various forms. High rates of Indigenous homelessness, experiences with the child welfare system, with the judicial system, and the number of suicides, acts of violence, accidental deaths, and high rates of substance abuses are results of Indigenous peoples living in trauma (Menzies, 2005). It is widely recognised that Indigenous peoples are often not well served by Western treatment styles (Benoit, Carroll, & Chaudhry, 2003; Gone, 2004; Hodge, Limb, & Cross, 2009; Mehl-Madrona, 2007b; McCabe, 2008; Stewart, 2007; Struthers & Lowe, 2003) and those seeking help are often confronted with more alienation and traumatising. Sones et al. (2010) point out that data regarding the mental health and wellness of Indigenous peoples is lacking “partly because of the challenges in the identification of indigenous clients, mistrust of mainstream mental health,



frequent absence of culturally competent care, and lack of access to indigenous healing options and care” (p. 55). Furthermore, culturally influenced Indigenous behaviour is often misinterpreted by Western oriented clinicians as evidence of psychopathology (Brant, 1990). There is a clear need to address the issues of culturally inadequate care that Indigenous peoples often encounter while seeking to address their trauma, and particularly, while accessing the mental health system. It is now recognised that when culturally appropriate care is provided, patients respond better to care (National Aboriginal Health Organization, 2008b).

For the most part, Indigenous trauma has been largely “diagnosed” through non-Indigenous theories. The fields of Western psychiatry and psychology have medicalised the experiences of Indigenous peoples by applying categories of mental illnesses, thus further pathologising their trauma through diagnoses such as posttraumatic stress disorder, psychiatric disorders, and particularly through Cultural Bound Syndromes (2000, DSM-IV-TR) which attempt to provide a cultural context in application of diagnoses. These fields have influenced the institutions in which the majority of healthcare professionals are trained and develop their practise.

Despite mainstream paradigms, there are Indigenous healthcare practitioners that utilise strategies that are rooted in cultural philosophies, worldviews, and trauma-informed approaches; however, these practitioners are often challenged by a vocabulary that may not represent their context in an accurate way. This is not to say that conventional psychotherapy has not helped Indigenous peoples, as Gone (2010) maintains “some Native individuals can and indeed have benefitted from conventional psychotherapy. Some have benefited from culturally modified psychotherapy” (p. 214). However, borrowing terms like *psychology* and *mental health* and bringing them into an Indigenous framework is often confusing and misleading. Indigenous concepts of wellness and Western psychology greatly differ in perspectives and ways of conceptualising the person, and therefore will additionally differ in determining a healing process. Wellness philosophies are wholistic approaches that consider equally the spiritual, emotional, mental, and physical aspects of the person; whereas Western psychology generally focuses on the mind and behaviour, and medicine treats the mind and body as separate entities (Letendre, 2002). Furthermore, the mind-body split has influenced much of psychiatric thinking (Voss, Douville, Little Soldier, & White Hat, 1999, p. 85). Consequently, both psychology’s and psychiatry’s approaches exclude a wholistic way of analysing and addressing the issues.

Indigenous healing philosophies are based on a wellness model, while the medical model is based on illness. Stewart (2007) notes that the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) defines mental health as “a state marked by the absence of illness” (p. 9). The term *mental health* has become a popularised concept in Indigenous communities, although Mussell, Nicholls and Adler (1993) caution:

It is important to understand that the meaning that [mental health] is given in First Nations cultures is different from the meaning it has in Western civilization. In Western civilization, mental health means being of sound mind. Mental health and mental illness are seen to be attributes of the mind and outcomes of certain mental activities. (p.19)

Stevens and St. Germaine (2003) define Aboriginal mental health as encompassing the “broad spectrum of challenges that Aboriginal people face in the life walk. We include the issues of addictions, violence, suicide, colonization in addition to the mental ‘illnesses,’ such as schizophrenia, depression, bipolar, post-traumatic stress and so on” (p. 160). Stewart (2007) writes that an Indigenous paradigm of mental health and healing is “focussed on restoring balance to the self through relationship with others and the environment” (p. 190).

Strong opposition to the pathologising of Indigenous peoples through psychiatry is beginning to emerge. Waldram (2004) criticises the writers of the DSM as naïve scholarship that entails primitivism, wayward psychiatric mythologizing and of constructing new disorders based on folklore. Chrisjohn and Sherry (2006) reject the notion of a DSM category *Residential School Syndrome* (Brasfield, 2001) and advocate against the pathological viewing of Indigenous peoples’ experiences. Duran (2006) argues the need for healing institutions to retain culturally competent staff and that the adherence to strictly Western models of treatment maintains the colonisation process. Hodge, Limb and Cross (2009) claim that the Western therapeutic project is inconsistent with many Indigenous cultures and often serves as a form of Western colonization. Chansonneuve (2005) noted that there were reports of Indigenous peoples feeling re-victimised by any institution, including hospital psychiatric wards, which replicate residential schools, and or/use restraining practises. Furthermore, Mehl-Madrona (2007b) has concluded that psychiatric treatment rarely worked.

Furthermore, there have been ongoing critiques of psychiatry in general (Burstow, 2003; Burstow, 2005; Honos-Webb & Leitner, 2001; Siebert, 2000; Vicary & Bishop, 2005), including those of the anti-psychiatry movement (Burns, 2006; Burstow & Weitz, 1988; Crossley, 1998; Dain, 1989; Duffin, 1999) that have brought forward important issues of human concern. This research will investigate how Indigenous healthcare practitioners are participating in these critiques, and as a result, utilising culturally appropriate healing strategies.

### **Framework of research.**

This research critiques the use of psychiatry amongst Indigenous peoples and argues that Indigenous philosophies and cultural practises provide the most appropriate and successful therapeutic techniques for individual and community healing. By utilising an Indigenous conceptual framework, an Indigenous research paradigm, and drawing on Indigenous worldviews and practises, this research will make an important contribution to the field of Indigenous knowledge, while also contributing to a body of literature that is needed to understand the practises of Indigenous trauma work.

The framework of this research is based on an Indigenous conceptual framework that recognises the resiliency of Indigenous peoples and utilises a decolonising approach. In recent years, resiliency has become an important perspective in health policy literature (Dion Stout & Kipling, 2003). Inherent in this, is the significance of Indigenous knowledge and usage of storytelling as a methodology. It sets forth a framework that reinforces the interconnectedness of this inquiry. Recent decades have seen an emergence of decolonising movements among Indigenous peoples. Such movements challenge practises and influences that have altered Indigenous ways of thinking and living. As Wilson and Yellow Bird (2005) write, “Decolonization is the intelligent, calculated, and active resistance to the forces of colonialism that perpetuate the subjugation and/or exploitation of our minds, bodies, and lands, and it is the ultimate purpose of overturning the colonial structure and realizing Indigenous liberation” (p. 2). Hart (2002) notes that his research was an act of decolonization and resistance, as it “serves to inform those previously unaware, or barely aware, that we have our own worldviews, beliefs, values and practices” (p. 36). Decolonising approaches to Indigenous research is supported by Wilson (2008) as he suggests, “There should be no need for us to constantly justify, validate or

change our work in order to fit foreign research paradigms. We have our own standards and beliefs that we uphold” (p. 127).

A decolonisation approach that includes a reflective inquiry will support challenging our current thinking about trauma work. It will ensure that this research will contribute to discourse and documentation of two relevant areas of Indigenous trauma work. Firstly, it will indicate the relevance of Indigenous worldviews, knowledge, and cultural strategies that Indigenous healthcare practitioners are finding useful in their practises; secondly, it will engage in a dialogue about the use of psychiatry and psychiatric diagnoses amongst Indigenous peoples.

Furthermore, utilising a decolonising approach contributes to the developing field of Indigenous research methodology (Kaomea, 2001; Smith, 1999), which supports the presentation of findings in a framework that is rooted in Indigenous worldviews (Ermine, 1995; Fitznor, 1998, 2002; Little Bear, 2000). It is also important to note that as this research is conducted as part of the academy, a decolonising approach will support the need to reflect on the institutional influence that the academy has on trauma work, healthcare practises, and practitioner training. Couture (2000) writes:

Universities tend often to emphasize organization, efficiency, competitions, quantitative results, and a concern with *how* at the expense of *what* and *why*. These organizing principles manifest themselves through institutional mindsets, which in turn foster social institutions and social structures in which attitudes and values too often go unquestioned. (p. 163)

Moreover, this research brings forth Indigenous healthcare practitioners as theorists and experts of this field. Indigenous peoples who share in the experience of multigenerational effects of historical trauma (Brave Heart, 1998; Brave Heart, 1999; Brave Heart, 2004; Brave Heart-Jordan, 1995; Wesley-Esquimaux & Smolewski, 2004) must be at the forefront of the developing field of Indigenous trauma practise and theory and contribute to identifying solutions for overcoming its devastating consequences. The results of this research will not only benefit Indigenous communities, it will also benefit non-Indigenous practitioners and healing movements which are searching for new and creative ways to work with and through trauma.

### **Research questions.**

This research asks Indigenous healthcare practitioners to share: how they have formed their worldviews; their understandings of wellness and wholistic health; their critiques of psychiatry and psychiatric diagnoses; and their strategies for helping people through trauma, depression, and experiences of parallel and multiple realities. Essentially, the overarching question of this research study is: how are Indigenous healthcare practitioners supporting their people in the areas of healing and wellness?

### **The use of trauma terminology and psychiatric language.**

As this research critiques psychiatry, psychiatric language is subject to the same critique. References to trauma do not imply that trauma is validated by the diagnostic criteria as listed in the DSM-IV (2000) under Posttraumatic Stress Disorder (PTSD); although, PTSD is used in Chapter Six in efforts to generate a critique of psychiatric diagnoses. The title of this study *Decolonising trauma work* refers to the active therapeutic relational environment that exists among Indigenous healthcare practitioners and those that have sustained injury and continue to respond from a traumatised position. For the purposes of this research, trauma is a person's reaction or response to an injury. Trauma is defined in the Collins English Dictionary (2006) as (1): an emotional shock that may have long-lasting effects; (2): any bodily injury or wound" (p. 946). In separating the term trauma from the psychiatric diagnosis, Burstow (2003) declares, "Trauma is not a disorder but a reaction to a kind of wound. It is a reaction to profoundly injurious events and situations in the real world, and indeed a world in which people are routinely wounded" (p.1302). Traumatization implies that there is an *after effect* to the injury and that the responses continue to occur, despite the decrease of immediate threat. O'Neill (2005) writes, "In traumatic situations, all those integrated components of the embodied response—arousal, attention, perception and emotion—tend to persist in altered and exaggerated state long after the specific danger is over" (p. 75). The extent that a person has experienced trauma also influences how trauma is perceived and processed. Ross (2009) acknowledges, "What is clear is that painful events experienced in childhood *reduce* the capacity to respond well to further traumatic events even as adults" (p. 13). In the context of this research, it is recognised that colonisation has caused multiple injuries to Indigenous peoples, and therefore many Indigenous peoples experience trauma in a multitraumatic context; and thus, living in and with trauma, is a

common experience. Yet, not all people will be equally traumatised by the same circumstances; and therefore, some Indigenous people will experience a high degree of traumatic response, while others may experience little, if any at all.

The terms *intergenerational* and *multigenerational* trauma are defined as the cumulative emotional and psychological wounding over time that is transmitted from one generation to the next (Rakoff, Sigal, & Epstein, 1966). These terms are often used interchangeably. As pointed out by Dass-Brailsford (2007) the concept of intergenerational trauma was first introduced by Rakoff, Sigal, & Epstein as they described how “the effects of the Holocaust were transmitted to future generations” (p. 5). Multigenerational trauma is also represented in the literature (Danieli, 1998), including Indigenous trauma literature that recognises that trauma for Indigenous people is multigenerational and not limited to the life span (Brave Heart-Jordan, 1995). As many Indigenous peoples relate to these concepts, they have become popularised in Indigenous trauma theory, literature, and practise (Brave Heart-Jordan, 1995; Chansonneuve, 2005; Duran et al., 1998; Menzies, 2005).

With many generations of Indigenous peoples being traumatised, and without adequate address of the situations, family and community systems tend to recycle the trauma. Lane, Bopp, Bopp, and Norris (2002) consider that the various sources of trauma originating from outside Indigenous communities generated a wide range of dysfunctional and hurtful behaviours (such as physical and sexual abuse) which began to be recycled, generation after generation *inside* communities. They explain that this has meant “that as many as three to five generations removed from externally induced trauma, the great-great grandchildren of those who were originally traumatized by patterns of historical events and are now being traumatized by patterns that continue to be recycled in the families and communities of today” (p. 9). The concept of multigenerational trauma provides a useful way of discussing the multiple types of trauma that can be understood as current, ancestral, historical, individual, or collective experiences.

Intergenerational trauma has been identified as impacting generations of Indigenous peoples as the trauma is passed from one generation to the next. This transmission occurs behaviourally, observationally (Bombay, Matheson, Anisman, 2009; Brave Heart-Jordan, 1995; Chansonneuve, 2005; Menzies, 2005), and through memory (Auerhahn & Laub, 1998; Wesley-Esquimaux & Smolewski, 2004). The role of memory as it relates to the intergenerational

transmission of trauma is another area of literature that provides useful terminology. Wesley-Esquimaux and Smolewski (2004) cite Nathan Kellermann's work on *Transmission of Holocaust Trauma* (2000), who grounds his therapeutic work in recent genetic research suggesting that parental traumatisation may be passed on from one generation to another through genetic memory codes. His work puts forth that traumatic experiences may be "transmitted to the child through electro-chemical processes in the brain. The neural organization of various memory systems in the parent would lead to similar organization and constitution of the child" (p. 73). Traumatic memory contributes to the experiences in which Indigenous peoples are living. In theory, Indigenous knowledges and contemporary research indicate that intergenerational trauma and multigenerational trauma is passed on through parental/institutional patterning from one generation to the next, as well as being transmitted through the bloodlines. In Indigenous thought, blood memory is the occurrence of experience of those that have gone before us being embedded in our physical and psychological being (Younging, 2009, p. 327). Shilling [Linklater] (2003) notes that blood memory is "the collection of memories that we are born with" (p. 185). Pearsall's (1998) research studying heart transplant patients confirms that memory can be transferred with the organ, and thus, refers to this as cellular memory. Mehl-Madrona (2003) acknowledges that all of us possess cellular memory in our DNA.

The term *depressive disorder*, which is classified in the DSM-IV (2000) as a mental illness, is used in Chapter Six to contribute to the critique of psychiatric diagnoses. The term *depression* will be used in Chapter Seven to provide an opportunity for Indigenous healthcare practitioners to describe how they assist clients that have received a diagnosis of depressive disorder or have expressed feelings of "depression" in terms of sadness and low or lethargic moods that interfere with their productivity and general feelings of well-being. Depression is defined in the Collins English Dictionary (2006) as (1): a mental state in which a person has feelings of gloom and inadequacy; (2): an economic condition in which there is substantial underemployment, low output and investment; slump; (3): a mass of air below normal atmospheric pressure, which often causes rain; (4): a sunken place" (p. 227). Despite the usage of the terms depressive disorder and depression, this research will explore the ways that Indigenous healthcare practitioners are working with depression. It is important to note that Dr. Couture (Cree Elder and psychologist) agreed with the challenges of using psychiatric language and

validated the essential need to address the effectiveness of Western terminology in the therapeutic circles of Indigenous peoples (personal communication, January 16, 2006).

References to parallel and multiple realities are intended to replace the psychiatric classifications of *psychoses* and *psychotic episodes*. Some theorists frame realities using different terms; such as Ingerman (1991) a therapist and shamanistic practitioner uses the terms *ordinary reality* and *nonordinary reality* to convey the differences in realities that are involved in soul retrieval; and Burstow (2003, 2004) a psychotherapist, activist, and academic, uses the term *alternate reality*. However, terms such as *ordinary* and *alternate* imply that there remains an authentic and perhaps more acceptable reality that is understood in the legitimate sense. Using parallel and multiple realities recognises the value and legitimacy of these experiences, which often reveals important content that is vital to one's healing process. Implying that realities are merely *psychotic* experiences or that they exist in a realm that is *not* legitimate disregards Indigenous belief systems which value spiritual experiences and recognises the impact of ancestral trauma on an individual in current times (Duran & Duran, 1995). Parallel realities are two realities occurring simultaneously, such as the physical and spiritual world; whereas multiple realities include more than two realities occurring simultaneously, such as the physical and spiritual world, a past life and/or an ancestor's experience which may have been transmitted through blood memory.

### **Terms referring to Indigenous peoples.**

The term *Indigenous* will be used to refer, in general, to the original peoples of the world, and for the purposes of this research, will refer to the original peoples of Turtle Island. The term Indigenous reflects original peoples in a global context, who originate from their ancestral lands and are connected to their traditional and cultural heritage. Where appropriate, Indigenous peoples will be identified by the Nation that they originate from, such as Anishinaabe, Cree, Lakota and so forth.

In the United States of America, the term *American Indian* or *Native American* is commonly used; and therefore, will appear in this thesis in referenced texts and quotes. The term *Aboriginal* is a legal term in Canada referring to First Nations (Status and Non-Status Indians), Inuit, and Métis peoples, as defined in the *Canadian Constitution of Canada 1982*.



The term *First Nation* is distinctly a Canadian term. First Nation is not a legal term, but reflects a politically correct way of referring to Status Indians (as defined in the *Indian Act*) and Non-Status Indians of Canada. This term was first generated in the 1970s when French Canada and English Canada were debating their rights to Canada—as the *first* Nations here. Indigenous leaders spoke up in defence of their original rights and titles to the land and claimed the title, *First Nations*. Originally, this term was to conceptualize nationhood. However, with the adoption of this term to replace the *Indian*, it also replaced the term *Indian Reserve*, which is now, for the most part, referred to as a First Nation. Moreover, the term Indian remains a legal term within the Federal Statutes of Canada. Restoule (2000) points out that the *Indian Act* has been the source of many problems in the history of Aboriginal survival. “It has been the legal support for violence enacted against Aboriginal peoples in the form of regulations imposed on personal mobility, language use, and participation in cultural activities” (p. 106). Importantly, many people still refer to themselves as Indians; particularly if they are older, or have been raised in families where this term has been used.

A humorous note on terminology: A few years ago, my late Uncle Gordon and I were watching APTN (Aboriginal Peoples Television Network) and he asked me what “Indigenous” meant. I gave him the “textbook” definition and talked about how there are Indigenous peoples all over the world. Then I told him a joke that I had recently heard: “What is an Indigenous person? An Indian that went to university.” We both laughed.

### **Indigenous languages represented in study.**

During the interview dialogue process, the research participants often expressed themselves in their ancestral language. I felt that it was important to honour this articulation; and thus, this thesis contains several different languages, such as Algonquin, Anishinaabe, Cree, and Mohawk. Additionally, one of the participants used the Spanish language to communicate certain ideas and understandings. Translation is provided, in text immediately following the Indigenous language represented. Where participants used language other than the Nation that they identified with, I have indicated this beside the translation.

## **Indigenous Ways of Knowing**

This research is primarily concerned with bringing forth Indigenous ways of knowing as the leading source to formulate this knowledge contribution. In that, it was imperative that this study explores the notions of Indigenous worldviews and Indigenous knowledge.

### **Worldviews.**

Indigenous worldviews arise out of deep and profound connections with an Indigenous world. As Fitznor (2002) points out, “being Aboriginal itself does not mean that we necessarily work from Aboriginal self-determination and knowings” (p. 66). Accordingly, to acquire an Indigenous worldview, and exist from this location, one must maintain relations with their land, language, people, ancestors, animals, stories, knowledge, medicine, culture, and spiritual environment. It is only within the context of Indigenous communities that an Indigenous worldview can be maintained.

Ermine (1995) writes of the inner knowledge that Indigenous peoples seek which is necessary to arrive at insights into existence. This worldview is in contrast with the Western worldview, which is validated by the physical; whereas, Indigenous worldviews are validated by the metaphysical:

In their quest to find meaning in the outer space, Aboriginal people turned to the inner space. This inner space is that universe of being within each person that is synonymous with the soul, the spirit, the self, or the being....Aboriginal people found a wholeness that permeated inwardness and that also extended into outer space. Their fundamental insight was that all existence was connected and that the whole enmeshed the being in its inclusiveness. (p. 103)

Essentially, Indigenous worldviews evolve out of a direct wholistic relationship that encompasses one’s spirit and the universe. As Duran and Duran (2000) note “the Native American worldview is one in which the individual is a part of creation, living life as one system and not in separate units that are objectively related with each other” (p. 91). Solomon and Wane articulate, “In Indigenous Peoples’ worldview of societal and cosmological relationships, there is an acute understanding of respect for self, other people, and all of nature, especially the land and the water” (p. 54). K. Wilson (2003) suggests that a strong connection to the land, or Mother

Earth, contributes to the health of Indigenous peoples by providing individuals with food and medicines necessary to be well (p. 90). My Anishinaabe friend Brian Tuesday connects our worldviews with wellness and claims that, “The only way that we are going to become well in our communities is if we understand how we relate to Creation, ourselves, and to others (personal communication, June 30, 1996). Couture asserts, “There are only two things you have to remember about being Indian. One is that everything is alive, and the second is that we are all related” (Couture, 1991a; Couture, 1991b; Couture, 2005a).

The impacts of colonisation have altered much of the Indigenous worldview, including traditional education systems and overall community functioning. Residential schools (Chansonneuve, 2005; Fontaine, 2010; Miller, 1996; Milloy, 1999) in Canada and boarding schools in the United States (Beauchamp, 2004; Brave Heart & DeBruyn, 1998, Kawamoto, 2003; Struthers and Lowe, 2003) were profoundly effective, as they reached children at young ages and replaced their Indigenous world with an English speaking, Eurocentric-oriented, Christian-world. Little Bear (2000) uses the metaphor of *jagged worldviews colliding* to describe the challenges faced by Indigenous peoples:

colonisation left a heritage of jagged worldviews among Indigenous peoples. They no longer had an Aboriginal worldview, nor did they adopt a Eurocentric worldview. Their consciousness became a random puzzle, a jigsaw puzzle that each person has to attempt to understand. (p. 84)

Perhaps it is then possible to argue that the evolution of an Indigenous worldview has expanded to include the more recent experiences, particularly those that arose from the colonial experience. In as such, it may be necessary to decolonise our worldviews and essentially understand the fragmentation that has occurred. To deny the impact of colonisation on Indigenous worldviews would only contribute to the solidification of colonised perspectives.

For those seeking to ground themselves in an Indigenous worldview, it will be important to become immersed with cultural resources that adhere to traditional forms of learning and living. Such experiences will create opportunities to reconnect with Indigenous ways of being. Couture (2005a) acknowledges that, “Traditional learning modalities eventually bring one to

*think intuitively, to think with the heart, to think Circles, to understand and utilize dream, metaphor, and symbol*” (p. 13). In essence, being grounded in an Indigenous worldview, is to be connected to the Indigenous world—the past and the present.

### **Knowledge.**

Indigenous knowledge arrived into the academic arena through a necessity for Indigenous peoples to express themselves from the very core of their existence. Absolon (2008) puts forth that “Indigenous research is now guided by a re-emergence and assertion of Indigenous knowledge” (p. 48). Western thought has opened a space, albeit limited, that is intrigued by the knowledge diversities available. Although pressures continue to impact on Indigenous peoples to conform, as Battiste and Henderson (2000) indicate, “Eurocentric thought demands universal definitions of Indigenous knowledge, even though Indigenous scholars have established no common usage of the term” (p. 36).

The power issues surrounding knowledge and knowledge validity remain unbalanced, with Indigenous peoples often striving to gain recognition in a colonised territory. As Little Bear (2000) highlights, “one of the problems with colonialism is that it tries to maintain a singular social order by means of force and law, suppressing the diversity of human worldviews” (p. 77). With this in mind, Indigenous knowledge production faces continued pressure to exist in a world that is only comfortable if the coloniser maintains the power over knowledge, including the power to verify legitimate knowledge. Duran and Duran (2000) claim, “A post-colonial paradigm would accept knowledge from differing cosmologies as valid in their own right, without having to adhere to a separate cultural body for legitimacy” (p. 87). I do not accept that we are in a postcolonial period, as the colonial relationship continues. However, the decolonising approach of this research is intended to challenge this relationship and put forth Indigenous knowledge as legitimate and practical.

Indigenous peoples have maintained knowledge systems and a complex way of life that has sustained their existence for thousands of years. Battiste and Henderson (2000) claim that “perhaps the closest one can get to describing unity in Indigenous knowledge is that knowledge is the expression of the vibrant relationships between the people, their ecosystems, and the other living beings and spirits that share their lands” (p. 42). Dei, Hall and Goldin Rosenberg (2000) write that Indigenous peoples “rely on oral traditions, on historical/ancestral knowledges, and on

their cultural resource bases to make sense of events around them in ways that are continuous and consistent with their traditional world views and cosmologies” (p. 19). Essentially, it is the understanding of relationships and cultural connections that Indigenous peoples utilise to interpret their place in the world, or as a sense of place (Cajete, 2002).

Consequently, hundreds of years of colonisation have placed Indigenous knowledges in a somewhat delicate position, even amongst Indigenous peoples. Brant Castellano (2000) acknowledges:

Aboriginal knowledge has been under assault for many years. In residential schools and other educational institutions, in the workplace, in social relations, and in political forums, aboriginal people have been bombarded with the message that what they know from their culture is of no value. (pp. 24-25)

The repercussions of cultural oppression have given rise to a kind of internal discomfort, perhaps even unspecified terror in many Indigenous peoples that lean towards revitalising their cultural practises. Only recently have Indigenous peoples in North America begun to revitalize traditional healing ceremonies openly without fear of repercussion and persecution (Martin-Hill, 2003; Crowe-Salazar, 2007). The outlaw of Indigenous ceremonies, particularly cultural healing ceremonies, has created extensive challenges in the health and well-being of Indigenous peoples in contemporary times. The United States government prohibited traditional spiritual practises between 1883-1940 (Voss, Douville, Little Soldier, & White Hat, 1999, p. 84). Gone (2010) points out that the full and free practise of Indigenous traditions was not affirmed in the United States until Congress passed the *American Indian Religious Freedom Act* in 1978 (p. 174). In Canada, an *Indian Act* amendment in 1884 prohibited the Potlatch for First Nations on the west coast. “This provision was expanded in 1895 to include Indian dances and ceremonies in which gift giving was practiced” (Deiter, 2008). Hodgson (2008) describes the banning of ceremonies as “taking away the ideas, values, and principles basic to community mental health. With the ceremonies went security, identity, ideology, rituals, belonging, reciprocity, and beliefs along with responsibility for actions, access to resources, time together, healing, and justice” (p. 364). Not only has ceremonial knowledge been displaced, but many generations have not had access to traditional ways of healing, grieving, and understanding balance and wellness.

Indigenous knowledge contains vast resources for healing. It is vital that traditional knowledge of medicines and ceremonies, and those that have maintained the cultural practises be encouraged to provide healing opportunities for Indigenous peoples. As Couture (2005b) reports “experience shows that an individual correctional/healing plan may exclusively and successfully be rooted in ceremonial activities” (p. 8). It is important to note that Indigenous knowledge contains different systems of understanding than that of a Eurocentric worldview, particularly in relation to time and intensity. Mehl-Madrona (1998) notes that helping people overcome the distractions of daily life seems to be a key to rapid healing, “Not only isolation for the client, but an intensive effort on the healer’s part, makes a substantial difference on how swift and profound the outcome will be”(p. 276). Duran and Duran (2000) suggest that, “In Native American healing, the factor that is of importance is intensity, not passage of time” (p. 92). My Cree friend Lloyd Martin concurs with these thoughts and expresses “that is the reason for all the effort, the drumming, the rattling...” (personal communication, August 10, 2008). Indigenous healing ceremonies often incite a powerful presence of spiritual activity that is generated to provoke healing in the person requiring assistance.

Many teachings are contained within Indigenous knowledge specific to the understanding of illness and disharmony. Mehl-Madrona (1998, 2007) discusses the concept that illnesses have spirits and that healing requires a dialogue with the illness. Others note the occurrences of spirit and object intrusions, which can be a result of bad medicine or breach of cultural protocol (Landes, 1968; Waldrum, Herring, & Young, 1995). Such intrusions require ceremony for extraction and restoration to good health. Smith (2004) articulates:

The Native belief system further stipulated specific concepts of illness and health. Illness affected all aspects of the human being; wellness represented harmony. Natural and unnatural illness, from the violation of the sacred or witchcraft, resulted in disharmony of the mind, body, and spirit. Each individual was responsible for their own wellness. (p. 118)

It was understood that an individual was a *whole* person; and that the spirit, mind, and body were not separate entities requiring separate treatment—as in the Western medical system. A person’s health was also seen in relation to their place within community. Furthermore, cultural

understandings of social functions and the importance of abiding by cultural protocols are also a significant aspect of individual and community wellness.

Challenges using the English language for documenting Indigenous knowledge raise many concerns and the limitations must be recognised and addressed. Battiste and Henderson (2000) problematise the language issues and advocate that “these methodologies [Eurocentric] derive from a noun-centered language system, and they are ineffective in verb-centered Indigenous language systems” (p.40). Mehl-Madrona (2007b) acknowledges that it is difficult for Indigenous Elders to articulate their knowledge in European noun-based languages; and that when they express themselves in their languages they are often translated by others “who do not fully understand their concepts, which can be quite sophisticated and are normally expressed in their own verb-based languages” (p. 185). Battiste and Henderson (2000) further argue that, “Indigenous languages are the means for communicating the full range of human experience and are critical to the survival of any Indigenous people. These languages provide direct and powerful ways of understanding Indigenous knowledge” (p.48). Various limitations exist for Indigenous peoples, such as myself, that are primarily English speakers and do not have a sufficient working base of an Indigenous language. This limitation makes it difficult to *fully* grasp the cultural concepts that flow from Indigenous knowledges.

In regards to teaching the knowledge of traditional medicines from generation to generation, oral communication is deemed to be the only acceptable mode of transmission, as Letendre (2002) comments, “oral transmission of knowledge reveals the dependence that traditional medicine has on Aboriginal culture for its very existence, which in turn serves to preserve the culture of Aboriginal society”(p. 80). The nature of traditional medicine exists in a context and environment that not only requires an appropriate relational and oral transmission process, but also would naturally require an authentic connection to the land in which the medicines originate from. This understanding reinforces that Indigenous knowledge remains directly connected to an Indigenous world.

Indigenous communities remain mindful of the influence of Western thought on Indigenous practises. In a consultation circle coordinated by the *National Aboriginal Health Organization*, concerns were expressed that the term *traditional medicine* was an English word and not an Indigenous concept. Furthermore, Elders and healers were uncomfortable with the

term and were frequently “reminding one another that it is not a Western ‘medical’ concept disconnected from culture, families and community” (Hill, p. 24, 2003). Such comments indicate difficulties that arise when utilising a language that contains meanings that do not necessarily represent Indigenous concepts and worldviews.

The concerns expressed regarding current usages of language are a vital response to hundreds of years of colonial influence. The consequence of not having access to Indigenous languages, and thus ways of thinking, has shifted the ways in which Indigenous peoples relate to each other. This points to a need to decolonise the use of language and find appropriate means of expression. Considerations are being made to address these complications. Couture (2005b) reminds us that culturally, individuals have an enduring expectation to be treated with respect; he explains that a *misbehaviour* is not so much that a person is “a *criminal* to be punished, but rather, is a person who is in need of teaching and healing, and, that the family and community are responsible for that” (p. 12). Moreover, Ross (2002) notes that:

Most Aboriginal healing programs intentionally refuse to use terms like ‘the offender’ or ‘the victim,’ preferring instead to speak of ‘people who have caused pain’ and ‘people who have been hurt,’ emphasizing that we are ‘more’ than what we have done or what has been done to us. (p. 19)

Indigenous scholars and academics should be mindful of how we articulate the concepts contained within Indigenous knowledge. Couture (2000) acknowledges that it is possible for a person to become in-tuned to the spiritual and psychocultural nature of traditional existence as well as to the demands of Western tradition; he puts forth, “Those who master these insights and skills can move forward to a better future—albeit—amidst a swirl of intertwining and often conflicting trends—in constant relationship and dialogue with the past” (p. 161). While using the English language, it will be important to remain cognisant of the implication that language can influence the ways in which Indigenous peoples relate to themselves and interpret the world around them.

Essentially, language is a communication tool that bridges peoples and generations. Ermine (1995) declares that, “Our Aboriginal languages and culture contain the accumulated



knowledge of our ancestors, and it is critical that we examine the inherent lexicons to develop understandings of the self in relation to existence” (p. 104). The importance of using the English language, as a working language, while making all efforts to capture the original meaning within the context of Indigenous knowledge is crucial to the survival of traditional Indigenous thought processes and the maintenance of Indigenous worldviews. Translating old knowledge into contemporary practises will provide tools for Indigenous communities to remain rooted in traditional knowledge systems.

### **Indigenous Trauma Theory**

In the recent decades Indigenous trauma theory began to emerge as Indigenous healthcare practitioners and frontline workers brought forth a way of understanding current circumstances of community life. These theories are rooted in Indigenous experience and worldviews, and contribute to the production of Indigenous knowledge. It is important to note that Indigenous trauma has changed since colonisation created a climate of systematic oppression, violence, and abuse. Pre-colonial trauma was predictable and consistently set in a cultural context; and its context revolved around death, tribal wars, starvation, separation, etc. In the contemporary field of trauma work, there are many forms of trauma relating to sexual abuse, rape, psychological assaults, ritual abuse, accidents, environmental disasters, wars, and Holocausts. However, Indigenous peoples across Turtle Island have been impacted by a unique form of trauma that is a direct result of European colonisation. The trauma resulting from mass deaths caused by foreign disease, the loss of lands and resources through relocation policies and treaty agreements, the imposition of state legislation and institutions including residential/boarding schools and the child welfare system, and the overwhelming assaults on Indigenous peoples’ lives and cultures were foreign and unpredictable. It was not in the cultural context familiar to Indigenous peoples, and thus a new form of trauma emerged, one that is uniquely characterized as historical and multigenerational (Brave Heart, 1998, 1999, 2004; Brave Heart-Jordan, 1995; Brave Heart & DeBruyn, 1998; Duran et al., 1998). This section explores some of the Indigenous trauma theory, namely ethnostress, soul wound, and historical trauma, which contextualises a way of understanding the impacts of trauma on Indigenous peoples.

### **Ethnostress.**

The concept of ethnostress (Antone, Miller [Hill] & Myers, 1986; Hill, 1992) arose as a need to address the “confusion and disruption that people were experiencing inside of their world” (Hill, 1992, p. 1). In the early 1980s, discussions were held among people of various cultures that shared a colonial history and were now experiencing severe stress within their communities. Robert Antone (Oneida), Diane Hill (Mohawk) and Brian Myers (Seneca) identified this stress specific to the disruption in Aboriginal identity and sought to understand the impact of this disruption on the individual and the community itself. Although this concept was not developed at a time when Indigenous peoples were actively generating literature regarding trauma and community healing, the connection that ethnostress made between political history and current social realities places it well within the field of Indigenous trauma theory. Essentially, ethnostress was introduced as a response to colonial trauma and it is consistent with the notion that Indigenous peoples have been injured, oppressed, and de-humanized by colonisation. “Their reactions surface as response patterns, feelings of powerlessness and hopelessness that work to disrupt the life of the individual, family, community, and nation....Ethnostress occurs when the cultural or joyful identity of a people are disrupted” (Antone, Miller [Hill] and Myers, 1986 p. 7). The recognition of a strong cultural identity that existed in pre-colonial times is crucial in understanding the effects of ethnostress, as the loss of traditional social organisation, spiritual practise, and governing systems shifted the foundation that underlies community.

Importantly, ethnostress brought forward a way for communities to view the internal struggles that were occurring. It was also a way to contextualise the high rates of suicide, family breakdown, alcoholism, and substance abuse. It provided a discussion point in which people could begin to explore the conditions that create ethnostress. This was a significant development as communities were only beginning to identify oppression, colonisation, and residential school history as leading causes for the chaos in Indigenous communities. Hill (1992) identifies the effects of ethnostress in Indigenous communities as: needs are frozen, loss of faith and belief, the hostage syndrome, the narrowing of culture, culture under glass, tribal isolation, internalized stereotypes, and the adopting of *survivalist* behaviours. This analysis not only contributed to the emerging field of Indigenous trauma theory, it also reflected the movement of decolonisation which became popularised in decades to follow.

### **Soul wound.**

Eduardo Duran, an Apache/Pueblo Native American psychologist, has contributed largely to Indigenous trauma theory and practise with his work acknowledging the *soul wound*. Duran derives his understandings and clinical frameworks from Indigenous worldviews and experience, and by reinterpreting some of the theoretical constructs developed by Jung. Gone (2010) refers to Duran's approach as *soul wound psychotherapy*. Duran also establishes that "Native patients have suffered a profound wounding of the soul that 'Western' therapy actually exacerbates" (Gone, 2010, p. 199). Duran (1990) maintains that the socio-historical factors of the US government policy, particularly of boarding schools, caused systemic destruction to the Indian family system by inflicting "a wound to the soul of Indian people that is felt in agonizing proportions..." (p. 28). Duran elaborates further:

The core of Indian awareness was the place where the soul wound occurred. This core being essence is the fabric of soul and it is from this essence that the mythology, dreams, and culture emerge. Once the core from which soul emerges is wounded then all emerging mythology and dreams of a people reflect the wound. The manifestations of such a wound are then embodied by the tremendous suffering that the people have undergone since the collective soul wound was inflicted half a millennium ago. (p. 29)

The extent of social chaos in Indigenous communities is testimony to the depth of the soul wound. In attempting to understand these issues, Duran (2006) spoke with Elders and asked about the problems in the community. The Elders did not speak about the "expected symptom-oriented problems," but instead articulated ideas of "spiritual injury, soul sickness, soul wounding, and ancestral hurt" (p. 15). This way of viewing community issues contextualises the difficulties as a response to injurious events, rather than characterising Indigenous communities in states of existential dysfunction. It is also relevant to note that the explanations of the soul wound are "centuries old" (Duran et al., 1998, p. 351) and have been maintained in the oral histories of Indigenous Elders.

Indigenous healing strategies that are designed to address the soul wound are decolonising processes as they confront the damage that has been caused by colonisation. It is important to establish a practise that assists clients on a journey to wellness, rather than keeping

them stagnant in a painful past and present. Duran (2006) emphasises that the treatment process must include proven Western methods and an understanding of the soul wound, “It would be naive to believe that simply making someone aware of the soul wounding process would provide a magical solution. Excellent clinical interventions must be part of the overall strategy” (p. 27). Devising healing methods that address the very core of injury are essential in wholistic healing; however, challenges exist because therapist education often excludes culturally competent strategies. Duran and Duran (1995) suggest that therapists will be more effective when working with families if they contextualise the historical issues and the impacts on the family. “Therapies involving communications, structural, and other systematic approaches can be seen as quite effective if the therapist has knowledge and also validates some of the historical issues that have had a profound intergenerational affect on the Native American family” (p. 158). Duran and Duran (1995) also emphasise that this validation must be done in the context of the actual therapy. They stress that it is important “that the family becomes empowered through the realization that some of the family craziness is due to outside forces—such as the long-term oppression of Native American culture within the social milieu of occupation that persists to this day” (pp. 158-159). When therapists understand the historical hardships that Indigenous communities have had to overcome, it helps them comprehend the context of healing and the need to address the soul wound.

The theoretical and practical applications of the soul wound are beginning to take root in therapeutic strategies that assist Indigenous people. Duran, Duran, Brave Heart, and Yellow Horse-Davis (1998) connect soul wound with historical trauma and note the success in using culturally-based strategies such as clinical settings, workshops, and group interventions. “Intervention strategies that have been useful in dealing with the soul wound have been effective in many ways. People have engaged the healing process and have made use of traditional forms of healing” (p. 352). Essentially, soul wound therapy draws on Indigenous knowledges and worldviews, offering therapists, healers, and healthcare practitioners a valuable way to assist clients to work through their traumatic content.

### **Historical trauma.**

The theoretical constructs of *historical trauma* and *historical trauma response* was first developed in 1988 by Lakota social worker Maria Yellow Horse Brave Heart (Brave Heart,

1998). In her doctoral dissertation, Brave Heart-Jordan (1995) put forth her understanding that the colonisation of Lakota people resulted in mass cumulative trauma and oppression. She has identified historical trauma, Lakota trauma response, and historical unresolved grief as repercussions of colonial history. Her research included an in-depth study of trauma response, survivor syndrome, and intergenerational trauma transmission. She drew from existing trauma and Jewish Holocaust literature recognising the relevance for Indigenous trauma theory and practise. As she was grounded in Lakota worldviews and experience, she was able to put forth her own understanding and advance constructs that were uniquely Indigenous. Nonetheless, the work of Erikson (1963), Krystal (1984), van der Kolk (1987), Fogelman (1988; 1991), Danieli (1989), and Wardi (1992) to name a few, must be acknowledged in contributing to the concepts of historical trauma and historical trauma response.

Brave Heart-Jordan (1995) used the terms *cumulative trauma* and *historic trauma* synonymously and put forth the definition as “collective and compounding emotional and psychic wounding over time, both over the life span and across generations” (p. 6). As her work evolved, so did the scope of her definition. Brave Heart (1998) defines historical trauma as “cumulative trauma—collective and compounding emotional and psychic wounding both over the life span and across generations” (p. 288). Brave Heart (1999) describes Lakota historical trauma as “cumulative and collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide” (p. 2). And Brave Heart (2004) defines historical trauma as “the cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from mass group trauma experiences” (p. 7). Brave Heart (2004) articulated *historical trauma response* as “the constellation of features in reaction to [historical] trauma” and offered criteria for assessment which includes: substance abuse as a vehicle for attempting to numb the pain associated with trauma, other types of self-destructive behaviour, suicidal thoughts and gestures, depression, anxiety, low self-esteem, anger, and difficulty expressing thoughts and emotions (p. 7). The development of historical trauma and historical trauma response contributed a framework to understand the multiple forms of trauma that are common in Indigenous communities. Most importantly, Brave Heart’s theories link contemporary realities to colonial history and make a clear connection between current health and lived experience.

Brave Heart's practical and theoretical constructs resulted in her proposal of a Lakota intervention model based on the premise that Lakota suffer from "chronic unresolved grief across generations" (Brave Heart-Jordan, 1995, p. 2). Her doctoral research study documented the healing outcomes and benefits of a four day culture-based psycho-educational program (Brave Heart, 1998; Brave Heart-Jordan, 1995). This program addressed historical trauma and historical unresolved grief by bringing Lakota human service providers and community leaders together to learn about grief and trauma responses connected to historical events, such as "the assassination of Sitting Bull, the Wounded Knee Massacre, and grief associated with the removal of Lakota children to boarding schools" (p. 3). The Lakota intervention model included four essential components: (1) the intent to stimulate traumatic memories about the generational past, including education about the history; (2) opportunities for group sharing, group identification, and modeling of affect tolerance and self-regulation; (3) incorporation of traditional Lakota culture, ritual, and memorialisation as components of therapeutic process; and (4) facilitation of communal support and connection (p. 125). In effect, this intervention model sought to initiate grief and trauma resolution through collective mourning. After stimulating traumatic memories and learning about historical events, participants were given the opportunity to release their pain through ceremony and cultural healing methods.

In her writing about historical unresolved grief, Brave Heart-Jordan (1995) conceptualises it through traditional practises and acknowledges that the extent of unresolved grief compounds multigenerational trauma. It is important to recognize that colonisation eroded Indigenous peoples' ways of resolving grief through the outlaw of ceremonies. Brave Heart discusses the impact of the 1875 prohibition of Indigenous religious practises [United States] and asserts, "Traditionally, the Lakota maintained cultural institutions which provided modes of coping and ceremonies to manage grief reactions" (pp. 2-3). As a result, generations of Indigenous peoples were not able to participate in culturally embedded practises of relieving grief, and thus, this grief became unresolved and multigenerational. Brave Heart and DeBruyn (1998) point out that "generations of American Indians face repeated losses of relatives and community members through alcohol-related accidents, homicide, and suicide....Many times death occurs frequently, leaving people numb from the last loss as they face the most recent one" (p. 64). It is important to understand the impact of living in a community where people are continually burying members of their families, extended families, and lifetime relations;

especially when many of the deaths are of young people, and often of young parents. Brave Heart and DeBruyn (1998) further explain, “These layers of present losses in addition to the major traumas of the past fuel the anguish, psychological numbing, and destructive coping mechanisms related to disenfranchised grief and historical trauma” (pp. 64-65). The extent of unresolved grief that resides in Indigenous communities is vast and diverse. Theories and intervention models, such as those proposed by Brave Heart, provide Indigenous people with methods and tools to address the historical trauma that has become part of the fabric of their community.

The construct of historical trauma has become a useful approach for Indigenous communities to understand the circumstances and impacts of cumulative trauma on their lives. It has also become a useful framework for healthcare practitioners who provide services to Indigenous peoples. Struthers and Lowe (2003) acknowledge that historical trauma has affected Indigenous peoples in numerous ways, including the psychological, social, economic, intellectual, political, physical, and spiritual realms. Brave Heart (2004) notes that “this theory describes massive cumulative trauma across generations rather than the more limiting diagnosis of post-traumatic stress disorder (PTSD), which is inadequate at capturing the influence and attributes of Native trauma” (p. 7). Importantly, the construction of historical trauma was generated to address the inadequacies of psychiatric diagnostic criteria. Furthermore, historical trauma and historical trauma response have been the stepping-stones of other theories intended to capture the impacts of colonisation and the transmission of intergenerational trauma. Wesley-Esquimaux and Smolewski (2004) propose a model of *historical trauma transmission* that recognises the “different social disorders with respective clusters of symptoms” (p. 65). Evans-Campbell (2008) notes the development of *colonial trauma response* proposed by Evans-Campbell and Walters which explores the “interaction of historical and current trauma” (p. 332). Developments such as these are great strides forward in the area of Indigenous trauma theory, as expanding the field generates discussion and provides Indigenous healthcare practitioners, academics, and theorists with models and frameworks to enhance educational curriculum and healthcare practises. Moreover, developing the field of Indigenous trauma theory will improve healing and health services and create a wider range of healing options for Indigenous peoples.

## Summary of Chapter One and Overview of Dissertation

*Chapter One* introduced the study and set forth the context, framework, and research questions. The use of language and terminology was also explained. It was important to include a section on Indigenous worldviews and knowledge, as this work is grounded in cultural contexts. Also relevant in the introductory chapter are the theories and practises that have been emerging in the literature specific to Indigenous trauma theory.

*Chapter Two* contains an exploration of Indigenous healing and an overview of the Indigenous healing movement. This chapter provides important contextual information that is necessary to understand the field of Indigenous trauma work. It also includes a section on Indigenous healthcare practitioners and discusses relevant areas such as education, training, and cultural competency.

*Chapter Three* explains the research procedures that were used to conduct this study. Central to the research process were the cultural ethics and protocols that are essential practises in Indigenous research. This Chapter also details the ways in which Indigenous healthcare practitioners were invited to participate in this research, the guiding questions that were utilised in the interviews, and the ways that the stories and strategies were analysed and brought together to write the bigger story.

*Chapter Four* introduces the 10 Indigenous healthcare practitioners that participated in this study. Participants share their worldviews and life experiences that have helped shape their practise. In *Chapter Five*, the research participants share their understanding of wellness and wholistic healing. Their views are situated amongst the voices of other Indigenous healthcare practitioners, theorists, and academics that have contributed their ideas and thoughts to the literature. *Chapter Six* initiates a dialogue with the research participants regarding psychiatry and Indigenous peoples. This chapter discusses critiques of diagnoses and psychiatric practises, cultural implications, and the use of medication. *Chapter Seven* brings forth the strategies that Indigenous healthcare practitioners are using in their practise to address trauma, depression, and experiences with parallel and multiple realities.

*Chapter Eight*, the final chapter, contains a discussion about *Decolonising Trauma Work*, the implications of this study, and concluding thoughts relating to the research journey.



## **Chapter Two:**

### **Trauma Work in Indigenous Communities**

It is abundantly clear that Indigenous nations cannot progress as long as this pattern of recycling trauma and dysfunction generation after generation is allowed to continue. Something is needed to interrupt the cycle and introduce new patterns of living that lead to sustainable human well-being and prosperity. (Lane, Bopp, Bopp, & Norris, 2002, p.10)

Over the years, Indigenous peoples have been devising meaningful and productive ways to address the extensive trauma that is impacting their communities. From learning about the influence of colonialism, and colonial institutions, to developing theories for understanding the current social realities, Indigenous peoples are seeking out strategies that will assist in helping their communities transform into healthier environments. For Indigenous peoples, communities can be urban, rural, or centred around an Indian Reserve. Communities are defined not only in terms of geographic locations but also the larger networks that link people together as members of First Nations, Inuit, or Métis communities that may be geographically dispersed yet strongly connected through a sense of belonging (Kirmayer, Sehdev, Whitley, Dandeneau, & Isaac, 2009, p. 65).

Counselling and therapeutic services, traditional healing ceremonies, and other culture-based strategies are being utilized by Indigenous healthcare practitioners and healing agencies in efforts to create safe spaces for Indigenous peoples to heal their spirits and develop healthy identities. “The policies of forced assimilation have had profound effects on Aboriginal peoples at every level of experience, from individual identity and mental health to the structure and integrity of families, communities, bands, and nations” (Kirmayer, Tait, & Simpson, 2009, p. 18). Still, many Indigenous peoples continue to access mainstream public healthcare services that are based on the Western medical model. Essentially, Indigenous peoples are moving forward in their healing and seeking out resources and opportunities that they believe will assist them on their journeys.

This chapter will discuss pertinent information relating to Indigenous healing, the healing movement, and the work of Indigenous healthcare practitioners. Essentially, this chapter will

assist the reader in understanding the context of trauma and trauma work in Indigenous communities.

### **Indigenous Healing**

Indigenous ways of healing have existed since time immemorial. Ceremonies, plants, and prayers, as well as various forms of doctoring, have long provided for the survival and wellness of Indigenous peoples. Strong identities, sustainable living, and healthy patterns of relating created resilient peoples that thrived in some of the most challenging lands and environments in the world. The healing movement, in contemporary terms, refers to more recent years as Indigenous peoples strive to recover from colonisation. This was a new aspect in Indigenous healing as colonial wounding had not been part of the lived experience. As such, healing practises required new strategies that could contend with the damages and multigenerational trauma that had arisen in the communities.

Access to healthy lifestyles, health services, and cultural healing varies for many Indigenous peoples on Turtle Island. Because of the divisiveness of colonisation, Turtle Island was divided into separate countries, each with their own colonial agendas and outcomes. This was further complicated by extermination practises that encouraged social organisation and/or implemented legal categories which essentially implied who could be identified as *Indigenous*. As a result, many communities of Indigenous peoples were redefined and relocated depending on the colonial forces impacting their existence. In Mexico, many Indigenous peoples became known as *Campesinos* (peasants); while Canada and the United States set forth a reservation system, and regulated how and where Indigenous peoples were to live their lives. Issues of Indigenous identity arose as the right to be a member of a *Band of Indians* (Canada) or maintain *Tribal Membership* (United States) prompted a splitting of the Indigenous populations. Much of the separation was due to assimilative policies such as *Indian Act* legislation (Canada) and relocation policies (United States). Also a factor were blood quantum issues, as Indigenous peoples began procreating with Europeans. Terms such as *half-breed* (Canada/United States), *mixed-blood* (Canada/United States), *Métis* (Canada), and *Mestizo* (Mexico), emerged and thus, populations formed communities with identities and cultures, often recognising both their Indigenous and European ancestry. In Canada, there were concerted efforts on behalf of the government to extinguish Métis claims to Indian Status, lands, and resources. In regards to health

services, Métis people are not able to access the national health insurance program for First Nations (Status Indians) and Inuit people, nor do they have access to many of the other Aboriginal health programs offered by the Canadian government (National Aboriginal Health Organization, 2008a). Although Restoule (2000) notes, “This does not mean that only ‘full-blooded’ Indians were entitled to be registered” (p. 107) as Indians; as the *Indian Act* is patriarchal in design and has a history of discriminating against Indigenous women and their children. This has resulted in a high population of Non-Status Indians (who do not identify as Métis) that are also excluded from the health insurance and programs available for Status Indians and Inuit peoples. This has created serious disparities in health service equity among Aboriginal peoples in Canada.

Also impacting issues related to Indigenous identity is the result of racism infiltrating the colonial regime, as many people with Indigenous ancestry denied an Indigenous identity and became absorbed into the dominant culture. For those that could “pass as white” did so because it secured their place in society and they were able to avoid overt racism and discrimination that was commonly directed toward Indigenous peoples. In recent years it is seen as more favourable to identify as an Indigenous person (Restoule, 2000). In fact, the Aboriginal population increased 45% from 1996 to 2006 in the Canadian Census. Statistics Canada (2008) notes that contributing to the increase in population statistics is high birthrate, more people identifying as Aboriginal, and more First Nations being enumerated. Nonetheless, issues of identity continue to be paramount for Indigenous peoples, and many find healing as they become rooted in their cultural community.

### **Lens of resiliency.**

Resiliency is the ability to withstand trauma and turmoil and be able to proceed with living and engaging in a productive life. Barnes and Josefowitz (2008) explain that resilience is “well-known to be enhanced by strong relationships with competent and caring adults in family and community, strong cognitive abilities, good self-regulation skills, positive view of self and motivation to be effective in school, work, or social environments” (p. 4). Dion Stout and Kipling (2003) remind us that “resiliency only operates in response to the presence of risk conditions and the possession of appropriate personal and social assets is not sufficient in and of itself to guarantee a positive outcome” (p. 6). Kirmayer, Sehdev, Whitley, Dandeneau, and Isaac

(2009) suggests that resilience “can occur at the level of the individual, family, community, nation, or global system as well as ecosystem” (p. 63).

This research uses a lens of resiliency because it is a concept that inspires hope in the face of harsh adversity (Tousignant & Sioui, 2009). While Indigenous people have experienced severe damage as a result of being subjected to intense colonial oppression and genocide (Brave Heart, 1999; Brave Heart & DeBruyn, 1998; Chrisjohn & Young, 1997; Derrick, 2005; Hodgson, 2008), the mere fact that Indigenous peoples exist today and many are experiencing vibrant and healthy culturally-connected lives is clear evidence that Indigenous peoples are extremely resilient. This study recognises that the resiliency of Indigenous peoples is often derived from cultural resources that generate strong contributions to community capacity building in relation to healing practises and health research.

Resiliency focuses on the strengths of Indigenous peoples and their cultures, providing a needed alternative to the focus on pathology, dysfunction and victimization (Goforth, 2007, p. 17). Scarpino (2007) found that Indigenous women articulated that resilience “is not the disregard of painful events, but the ability to process adversities through relationship with Creator, others and self” (p. 49). Indigenous peoples do not want to be defined by reference to others or as populations living in deficit modes. Rather than trying to understand Indigenous peoples by searching for explanations of failure, a focus on resilience enables the challenge to be reconfigured as a search for success based on the standards and the norms that make sense to Indigenous peoples (Durie, 2009, p. 3-4).

Using a lens of resiliency may very well encourage others to join the dialogue around trauma and healing. Ross (2008) explains that some Indigenous leaders seemed more willing to be open about the dire situation facing their communities once the dialogue shifted to “talking about *traumatized families* instead of *dysfunctional families*, and *traumatized communities* instead of *community breakdown* or *social chaos*” (p. 12). Putting the historical context into perspective and framing the discussion around the cause, rather than the resulting issues, encourages Indigenous people to understand their circumstances as a consequence of colonisation. They can then shift and begin to tackle *the problem*, rather than feeling stuck and shame in that *they are* the problem.

Indigenous peoples have protective factors that increase resiliency, including family networks, generational relationships, community support systems, cultural and spiritual resources, and a shared collective history that bonds people together and creates a sense of belonging. Humour is also recognised as a demonstration of resilience. Stevens and St. Germaine (2003) share that “the ability to laugh and learn from challenges is a reminder that good things can come out of negative situations (p. 162).

And finally, recognising that a lens of resiliency does not mean a disregard or minimisation of the conditions in which Indigenous peoples live within; more accurately, it should be viewed that as risk factors resulting from colonisation present challenges that deeply influence the protective factors, Indigenous resilience should be seen as a culturally-rooted, community-based, response that encompasses resistance and survival strategies as leading sources of strength. Importantly, Ross (2009) points out that it is essential to recognise that “despite sustained assaults on the physical, mental, emotional and spiritual health of so many aboriginal people, the majority are *not* in jail, nor are their lives swamped by addictions, violence and despair” (p. 16). That is to say that the majority of Indigenous peoples have a high degree of resiliency despite the historical circumstances. It is this resiliency that enables Indigenous peoples to persevere and continue in the journey forward, despite the often exhausting conditions and collective challenges.

### **Elements of the Indigenous healing movement.**

The Indigenous healing movement began to emerge through cultural, educational, social, and political advancement. At the end of World War II, the Canadian government introduced health and social service programs in First Nation communities (Indian Reserves); followed by additional services such as education, housing, and make-work projects (Mussell, 2005, p. 83). Changes to the *Indian Act* in 1951, such as the removal of the clauses which outlawed (1) the hiring of lawyers to pursue Indian land claims and (2) the practise of ceremonies and other cultural customs, initiated a shift in the cultural and political atmosphere. With the aid of government funding in the late 1960s and early 1970s, Indigenous communities established a number of political organizations. The organisations brought Indigenous people together in national, regional, and tribal/treaty political systems. However, because this political movement was essentially funded by the Canadian government, colonial control remained intact as the

government had the ability to reduce or eliminate funding if they felt that Indigenous communities threatened general societies' access to lands and resources.

As Indigenous people began meeting on common issues, an educational element was generated through a series of one-to-two day conferences and seminar-type workshops held between 1969-1975. These events focussed on a number of issues, such as the training of political and service field workers, local community development workers, court workers, media workers, and members of boards of various political and service groups (Couture, 1982, p. 18). Between 1971-1973 a number of workshops were held as part of an Elders' think tank program coordinated by the Alberta Indian Education Centre/Indian Association of Alberta. This program brought various Elders and young people (anyone under 50) together to discuss issues of the day; but more so, to reestablish relationships between Elders and the younger generations and to focus on cultural identity. "The *training* carried out here was very much of the *consciousness-raising* type. It literally stimulated, in most participants, a new awareness of who they were historically, and of who they could become in light of tribal tradition" (Couture, 1982, p. 15).

Cultural revival was paramount to the capacity building initiatives that were evolving in Indigenous communities. Colonial suppression of cultural knowledge, language, and ceremony, left many Indigenous peoples with little access to information, let alone environment, necessary to build a healthy cultural identity. In 1974, the Nechi Institute (now the Nechi Training, Research & Health Promotion Institute) was founded and began training community people to become alcohol and drug counsellors, as well as trainers for the program. The Nechi Institute proved to be the facilitation agency from which "the first group of highly-skilled" Indigenous trainers emerged (Couture, 1982, p. 16).

In 1981, as a result of Indigenous leaders in the Canadian healing movement bringing attention to the dire need to address the high rate of substance problems at the community level, the federal government established the National Native Alcohol and Drug Abuse Program (NNADAP). Nearly 40 years later the abstinence-based program is still providing treatment opportunities and education in First Nation communities across Canada. NNADAP leaders continue to promote the message to Aboriginal people that "alcohol and drugs must be kept out of their communities completely" (Wadden, 2008, p. 48).

In 1982, a historic council of over 100 Elders, cultural leaders and various professionals, representing over 40 Nations from North America, was held in Lethbridge, Alberta. This council was convened to discuss the root causes of alcohol and drug abuse in Indigenous communities, and inspired the work of the Four Worlds Development Project. This Project established philosophy, guiding principles, activities and strategies for human and community development. This vision was articulated in the *Sacred Tree* (1988), which utilized the Medicine Wheel as a framework for teachings (Linklater, 2010).

The decades to follow were full of cultural, educational, social, and political activity. This should be acknowledged as a significant demonstration of Indigenous resilience and a genuine capacity to address the needs facing their communities. Community-based healing initiatives have continued to develop as a result of people recognising its efficacy. “Crisis intervention teams, family-violence shelters, and treatment programs have grown out of government funding, while other approaches such as healing circles or AA [Alcoholics Anonymous] groups that incorporate traditional spiritual knowledge are sustained without government assistance” (Warry, 1998, p. 223). The initial healing movement focussed on addressing the pattern of alcoholism that was impacting communities. However, as more and more communities began to have some success with efforts to reduce widespread alcohol use, it gradually became clear that alcohol and drug abuse was only the beginning of addressing community problems. In reflecting on this period in time, Lane, Bopp, Bopp, and Norris (2002) point out that many issues “remained beneath the surface of community life” (p. 11). As communities moved forward in addressing local issues, it became evident that solutions must come from within the community. There was also a growing recognition that culturally-based programs would be most successful.

Initiatives such as that inspired by community members of Alkali Lake in British Columbia in 1972 were successful in transforming a community with a high rate of alcoholism to a community in which the majority of the population abstained from alcohol in less than a decade. In this community, members took strong leadership roles in implementing practises, such as taking control of Social Assistance funds and distributing food vouchers to problem drinkers, while forming peer support networks that assisted individuals to go to treatment (Tousignant & Sioui, 2009). In 1984, the community of Hollow Water in Manitoba began addressing the extent of sexual abuse by creating a community-based restorative justice program.

This program, known as the Community Holistic Circle Healing, brought both victim and (first time) offender through a process of circle healing with the goals of resolving the issues related to sexual abuse and restoring the relationships within the community (Aboriginal Corrections Policy Unit, 1997; Couture, 2001; Couture, Parker, Couture, & Laboucane, 2001). This program was unique as it was one of the first healing initiatives within Canadian First Nation communities which offered an alternative to the criminal justice system. Between 1999-2003, 200 adults (about half the adult population) from the Montagnais-Innu village of Nutashkuan in Labrador participated in nature camps located on their ancestral hunting territory. This program, which was strongly influenced by traditional Aboriginal spirituality, and resourced by both healers and professional psychologists, resulted in a “steep drop in the rate of consultations for domestic violence” (Tousignant & Sioui, 2009, p. 52). Community healing programs that engage the majority of community members seem to be most effective in creating a paradigm shift from survival towards healing and wellness.

There are several factors that influence the progress of Indigenous healing. As multiple traumas continue to unfold, communities exert great efforts to confront complex health issues, including high rates of violence, sexual abuse, substance abuse, addiction, suicide, unresolved grief, and poverty. The challenge of building resilience is demanding because the multitraumatic history has depleted personal resources and did not nurture a climate of trust, interdependency, and legitimisation of authority (Tousignant & Sioui, 2009). The destabilization of family networks and community support systems has added pressure for Indigenous peoples that are often faced with numerous constraints. This sometimes impacts on a family’s ability to provide support for members that are experiencing difficulties with health issues or are in chronic crisis. Mehl-Madrona (2009) points out that the overall sense of community “is hampered by deteriorating social structures, thereby forcing its members to look after their own individual needs and survival, which undermines traditional values and stories that put the needs and survival of the group above that of the individual” (p. 21). As a result, many Indigenous peoples experience extreme stress with few resources to assist them in a wide range of issues. Individuals, both helpers and those in need of help, often end up in isolated circumstances that creates barriers and obstacles to healing and wellness.

Colonisation resulted in a complex array of injuries sustained by Indigenous peoples. At the core of family and community issues are the impacts of the residential school system in



Canada (Chansonneuve, 2005; Fontaine, 2010; Miller, 1996; Milloy, 1999) and the boarding schools in the United States (Beauchamp, 2004; Brave Heart & DeBruyn, 1998; Kawamoto, 2001; Struthers and Lowe, 2003). In both Canada and the United States, the schools began operation around the mid-1800s and many became sites for extensive physical, sexual, and spiritual abuse. In many cases, children were forced to attend the schools. They were often removed from their families and communities by school staff, Indian Agents (Canada) and soldiers (United States). Indigenous families were torn apart, cultural transmission was seriously disrupted, and languages were threatened (Reimer, Bombay, Ellsworth, Fryer, & Logan, 2010). By 1930, 75 percent of Status Indian children between the ages of 7-15 years were enrolled in one of 80 such schools across Canada. In the 1940s, attendance was expanded to include Inuit children as well. Métis children also attended the schools, but at a much lesser rate as the federal government did not acknowledge responsibility for their education because of their lack of Indian Status (Dion Stout & Kipling, 2003, p. 29). Ross (2010) suggests that the experience of residential schools is very much connected to the current realities of Indigenous peoples, “While residential schools taught children to be ashamed of themselves, their families, and everything they knew, children growing up in today’s violent families are likely to be internalizing the same view of themselves” (p. 7). Furthermore, psychologists Rosemary Barnes and Nina Josefowitz (2008) acknowledge:

Individuals sexually abused as children are at an increased risk for major psychiatric difficulties including Posttraumatic Stress Disorder, Major Depression and Alcohol dependence, as well as deliberate self-injury, suicide, sexual promiscuity, academic difficulties, difficulties with self-esteem and perpetuating sexual acts against others. (p. 13)

In the years to follow, sexual abuse became prevalent in many Aboriginal communities (Heilbron & Guttman, 2000; Mussell, 2005), and it was acknowledged that residential schools were responsible for creating these conditions (Hylton, Bird, Eddy, Sinclair, & Stenerson, 2002). Despite the ongoing nature of the schools and the impact on Indigenous communities, until the 1980s a “veil of silence concealed thousands of stories of residential school survivors” (Archibald, 2006). Many individuals and communities were still very immersed in colonial

oppression and were functioning in survival mode. In the late 1980s Maggie Hodgson, a member of the Carrier Nation and prominent leader in the Aboriginal healing movement, was part of a national television show that discussed residential schools and community violence. She was concerned that there would be a backlash as the topics raised sensitive issues; however, there was no backlash. In 1990, the first National Residential School Conference was hosted by Charlene Belleau with 900 people attending (Hodgson, 2008, p. 367); and in 1994 the Assembly of First Nations published *Breaking the Silence: An interpretive study of residential school impact and healing as illustrated by the stories of First Nation individuals*.

Over the past two decades many Aboriginal people have come forward to share their stories and seek healing from the residential school experience. Extensive research and study has also been undertaken, which has been necessary to understand the impacts of residential schools on Indigenous peoples. Culture-based healing programs have emerged, as well as restorative justice programs that help restore the balance in Aboriginal communities. There have also been legal actions initiated in efforts to hold perpetrators accountable. Ross (2009) confirms that physical and sexual abuse by adult staff in some residential schools has been proven in a number of criminal prosecutions across Canada (p. 8). Despite the legal recourse available, the issues around residential school healing remain paramount. Mehl-Madrone (2009) cautions, “Although recent lawsuits have resulted in claims being paid by the perpetrators and the government of Canada to First Nations people, these monetary payments do little to change the long-term effects of residential schools” (p. 21). Much of the healing that is occurring is centred around family and community. “Many former students found support in Elders, Alcoholics Anonymous and healing circles. They have also opted to share memories and stories with other former students, pursue further education, relearn Aboriginal languages and follow spiritual paths to reinforce Aboriginal identity” (Dion Stout and Kipling, 2003).

It is also important to recognise that not everyone who attended residential schools feels that they had an adverse experience or that they have been impacted in an injurious manner. There could be several factors contributing to this perspective, including; (1) that each school had its own unique climate and perhaps the climate was not overtly abusive and violating; (2) former students may view that they were provided with quality education and skills training that benefited their long-term prospects; (3) there exists a potential for emotional suppression (Ross, 2009) or denial that the residential school experience affected their lives in a harmful way; and

(4) older children who were admitted to schools after they had been raised in their family households and experienced cultural life. “These students could better withstand the cultural assault, while others did not and absorbed the shame and negativity more intensely” (Ross, 2009, p. 10). Essentially, it is important to respect one’s interpretation of their journey and their experience within the world. The tendency to pathologise has not served Indigenous people well. As the healing movement continues to unfold, it will be important for communities to recognise the wide spectrum of understanding and experience that exists for those seeking balance and harmony within their lives.

A common dynamic that often overwhelms Indigenous communities is the prevalence of substance abuse and addictive behaviours (Brave Heart, 2004; Chansonneuve, 2007; Kawamoto, 2001; Menzies, 2004; Mussell, 2005; Spittal et al., 2007). In fact, the majority of participants in the *First Nations and Inuit Regional Health Survey* indicated that they saw no improvement in the reduction of alcohol and drug abuse despite all the efforts that have been exerted (Svenson & LaFontaine, 1999). Such addictions encompass more than substance abuse and include behavioural addictions such as gambling, eating, shopping, and sex. Maté (2009) defines addiction as “repeated behaviour, substance related or not, in which a person feels compelled to persist, regardless of its negative impact on his life or the lives of others. The distinguishing features are: compulsion, preoccupation, impaired control, persistence, relapse and craving” (p. 214). In getting to the root of addiction and its consequences, Maté explains that the question is never “why the addiction? but why the pain?” (p. 34). This is an important question for Indigenous peoples and communities that are immersed in the treatment and healing movement. Programs that address the colonial history and historical trauma will likely be most successful in helping those immersed in their addictions shift to a healthier lifestyle. McCormick (2009) suggests that for many Aboriginal people “consumption of alcohol has been their attempt to deal with the state of powerless and hopelessness that has arisen due to the devastation of traditional cultural values” (p. 348). Brave Heart (2004) asserts, “Alcohol remains the drug of choice, but inhalant and marijuana use are prevalent” (p. 10). The *Ontario Region First Nation Addiction Service Needs Assessment* found that alcohol is still the highest ranked substance abused in Ontario First Nation communities followed closely by cannabis, cocaine, and oxycondone (Williams, Williams, Williams, & Wakeford, 2009). It is evident that there is a high degree of self-medication occurring in Aboriginal communities. In many cases this is exacerbating social

problems rather than relieving them. Given the history that Indigenous peoples have experienced, it is important that a trauma-informed approach be used in working with people involved in substance abuse and behavioural addictions. This will provide an appropriate context to understand current circumstances and serve as a framework to address critical survival issues.

Many decades of alcohol-related destitution, family breakdown, violence, accidents, and despair have prompted leadership in some communities to implement zero tolerance policies and ban alcohol; although such policies often do not bring about the “dry communities” that leaders were trying to achieve (Wadden, 2008). Ross (2009) believes that “bylaws banning alcohol are futile” (p. 15). There is widespread debate within Aboriginal communities between the abstinence model and harm reduction strategies. It is important to note that “99% of alcohol and drug [treatment] programs in Aboriginal communities are abstinence based. This is reinforced by the medical model, which sees alcohol as a disease” (Paul Bourgeois, personal communication, November 9, 2005). Programs based on the abstinence model often end up limiting treatment opportunities as many programs will not accept people who are on a medically supervised methadone maintenance programs or using psychotropic medication such as antidepressants. A trauma-informed approach would view the use of harm reduction strategies as coping tools that help individuals manage traumatic responses while participating in treatment programs that are essential to their healing. Thatcher (2004) writes that a harm reduction perspective suggests “that the most vulnerable in society, such as homeless transients, sex-trade workers, chronic alcoholics, and drug addicts, should not be written off in public policy and programming service strategies because they do not meet the expectations of service providers” (p. 57). The challenge in Aboriginal communities will be to balance the realities of self-medicating survival strategies with the implementation of treatment and healing programs that are accessible, culturally relevant, and are based on a trauma-informed approach.

The difficulty with creating programs and services that are geared toward helping those struggling with addictions is that many people seeking treatment are in need of more comprehensive healing services. Maté (2009) maintains, “Not all addictions are rooted in abuse or trauma, but I do believe they can all be traced to a painful experience. A hurt is at the centre of *all* addictive behaviours” (p. 36). Many of the treatment programs in Aboriginal communities are based on the 12-step program (AA model), which is recognised for its “self-help” philosophy and is not intended to address deeper issues that are often at the root of addictions. Mussell

(2005) notes, “Staff at a treatment centre serving First Nations clients reported that 90 percent of the men coming for treatment disclosed they had been sexually abused. Such abuse most often occurred early in their lives when they were developmentally most vulnerable.” (p. 74). Research conducted by the Cedar Project monitored rates of HIV and hepatitis C in young Aboriginal people who use drugs in British Columbia. The study found that 48 % (69% of the women, 31% of the men) reported experiencing sexual abuse in their lifetime. Twenty-seven percent had never told anyone about the abuse before the study and 65% had never had counselling for the abuse. The study also revealed that 50% of the study participants reported that they had at least one parent that attended residential school (Christian & Spittal, 2008, p. 1133). Moreover, the youth identified that there was “inadequate access to drug and alcohol treatment, methadone maintenance and counselling services” (Spittal et al., 2007, p. 237). It is further identified by service providers and clients alike that there is a lack of programs and services for drug-addicted expectant mothers, youth, and family treatment (Williams, Williams, Williams, & Wakeford, 2009). Research is confirming the need for Aboriginal communities to expand services and develop programs that reflect the current realities and provide opportunities to address the traumatic content that often arises. Koptie (2009a) advocates, “The chronic lack of treatment, prevention programming, and harm reduction services in First Nation communities do not allow strong intervention in a cycle that has become intergenerational” (p. 78). The issues relating to substance abuse and addictive behaviours in Indigenous communities will require leadership, community involvement, and resources. As Koptie points out, the intergenerational cycle requires an intervention. Taking a wholistic approach that considers the multiplicity of circumstances will be most effective.

High rates of suicide and suicide attempts are another tragic reality for Indigenous communities (Evans, 2004; Kirmayer et al., 2007; Masecar, 2007), particularly among youth (McCormick, 2009; Wesley-Esquimaux, 2004). The impact of suicide on families and communities often increases the extent of unresolved grief that already exists among peoples who have experienced significant loss. Ross (2009) comments that one community in his region has had “118 suicides in 18 years, and each death adds new trauma to be buried along with the rest” (p. 14). Neizen (2009) writes about cluster suicides and notes that “the very nature of the phenomenon suggests the influence of collective ideas, even the possible influence of collective self-image or identity” (p. 185). He further suggests that the cultural context of youth suicide, in

some communities, may be connected to identity attachments around suffering and self-negation. Although there are numerous factors contributing to suicide, “Sexual abuse is considered a major cause of suicide and substance abuse in Aboriginal communities” (Wadden, 2008, p. 86).

Research conducted by Chandler and Lalonde in British Columbia, as cited in Wadden (2008), sought to understand what made communities with low suicide rates different from troubled communities. This study found the healthiest communities maintain their cultural traditions, have the highest portion of people that speak their traditional languages, and are self-governing (p. 221). Sadly, far too many families and communities have to contend with the occurrences of suicide and suicide attempts. The stress that this creates for communities only reinforces the need to find ways to support both individuals and families in times of extreme duress. It is also an indication of the need to create environments that allow for the healthy expression of emotional turmoil.

Complicating the process of emotional expression, in the context of Indigenous healing, are the cultural values and social ethics that underlie relationships within communities. Brant (1990) acknowledges that conflict suppression, including the suppression of anger, is a cultural behavioural ethic among Indigenous peoples. Heilbron and Guttman (2000) elaborate on this notion and explains that one of the healing group participants expressed her concern with the traditional belief referred to as the ethic of non-interference (Brant, 1990) that discourages one from challenging another because such *interference* is viewed as culturally disrespectful. The group participant felt that the ethic was conflictual “because it prevented abuse from being addressed in the community” (p. 9). Not only has cultural ethics posed challenges to the healing process, but the legal oppression carried out by government has further ingrained a pattern of not challenging authority—even when it is abusive.

In many cases, the above-mentioned factors have discouraged people from coming forward to disclose issues of abuse, and it is only in recent years that disclosure is becoming more frequent and public. According to a 2003 Annual Report of the Aboriginal Healing Foundation, “Thousands of former students have come forward to reveal that physical, emotional, and sexual abuse were rampant in the school system and that little was done to stop it, to punish the abusers, or to improve conditions” (p. 16). The fact that there were no repercussions for perpetrators of institutional abuse within this system produced serious

consequences for children as they learned to de-value their safety and personal boundaries and more so, they became accustomed to living within abusive environments. Perhaps more damaging was that there was no acknowledgement within the system that this treatment was unacceptable and that abusers were permitted to carry out violations while receiving salaries and administrative support. Such experiences resulted in emotional suppression and disconnection (Ross, 2009) of many former students. Brant (1990) problematises this ethic of suppression and comments, “Still more problematic is the fact that the suppression and repression of hostility give rise to a number of psychosocial disturbances currently experienced among Natives” (p. 535). Such disturbances are evident in the cycle of intergenerational and multigenerational trauma that is prevalent within Indigenous communities today.

Over the years, many issues have been surfacing in regards to Indigenous healing. What has become clear is that healing needs to occur on many levels, particularly between women and men. Complicating this further is that a gender analysis of Aboriginal cultures is difficult to find (Mussell, 2005). Blaney (2003) notes the difference that the colonial process has had on Aboriginal women than on Aboriginal men, “Present-day systemic and institutionalized patriarchy ensures that the privileged male status in mainstream Canadian society is mirrored in Aboriginal communities. Men have considerable power in the political, economic and social spheres, and this enables violence against women and children” (p. 162). The *Indian Act of 1876* was instrumental in legislating the oppression of Indigenous women by granting only men the right to be recognised as chiefs and councillors; women were not permitted to hold political office, speak, or vote at Band meetings. Consequently, women’s place in community leadership and authority diminished significantly. It is evident that Indigenous women became less influential as European influence grew (Fernández, 2003). Women regained the right to participate in public and political affairs with revisions to the *Indian Act* in the 1950s (Anderson, 2000). More than half a century of legalised oppression had a drastic impact on the dynamics of Indigenous communities. Additionally, the divergence from traditional values and gender teachings has caused strong confusion about the “place of maleness” in Indigenous communities (Mussell, 2005, p. 70).

The continued effects of colonisation and colonial abuses created climates that were often characterised by violence and disruption. Healing programs with Indigenous women should emphasise the importance of clarifying power and control issues that Indigenous women may

experience in their relationships with men (Heilbron & Guttman, 2000). Although, it should be noted that in many areas in Indigenous communities, including families, workplaces, organisational structures, and political arenas, women hold *and* maintain positions of power. It is also of relevance that the Aboriginal women's movement in Canada is not feminist in nature and does not strive for the complete equity of men and women in all areas (Ouellette, 2002, p. 31). Nonetheless, the opportunities to address these issues of power inequity and violence will aid in the restoration of relationships and the traditional values that Indigenous cultures contain.

Another result of colonization, and more specifically, the long-term impacts of violence and oppression, has resulted in lateral violence. Societies of people who have been oppressed, generation after generation, learn how to adapt to the lifestyle and become their own oppressors (Mussell, 2005, p. 39). Jane Middleton-Moz (1999) defines lateral violence as “the shaming, humiliating, damaging, belittling and sometimes violent behaviour directed toward a member of a group by other members of the same group” (p. 116). She further explains, “When a powerful oppressor has directed oppression against a group for a period of time, members of the oppressed group feel powerless to fight back and they eventually turn their anger against each other” (p. 116). Hodgson (2008) comments that, “The current day acts of lateral violence that relate to work we do with the field are not separate and apart from our history, they are manifestation of our history” (p. 376). Duran (2006) writes that, “Manifestation of the soul wound is found in many facets of life, such as domestic violence, suicide, family dysfunction, community dysfunction and violence, institutional violence and dysfunction, tribal/political infighting and violence, spiritual abuse and violence, and epistemic violence” (pp. 22-23). The challenges that lateral violence presents must never be minimised as it produces an environment that contributes to behaviour that results in furthering collective trauma already so prevalent in Indigenous families and communities.

The challenge for Indigenous peoples to move beyond the traumatic history and engage in a healthier state of being will require healing practises that reflect Indigenous experience, worldviews, and knowledges. It may also require a paradigm shift from the healing circles that have often served as beginning points for those confronting their trauma. Mehl-Madrona (2005) asserts that:



support groups for particular illnesses sometimes encourage stories that keep people sick and support them in seeing themselves as ill. People who absorb these stories can come to define themselves as forever ill. A healing story needs to challenge their membership in the community of sufferers. (p. 133)

Abadian (2006) cautions that trauma narratives become a barrier to healing, and more so, further the traumatic wounding, “even when something horrible happens to us only once, we do not just experience it that one time. We recreate the experience through our stories, and in those stories we live it again” (p. 5). There is also recognition that simply remembering the trauma often seems to make people worse rather than better (Servan-Schreiber, 2003, p. 75). Nonetheless, in order to resolve the trauma, it is necessary to confront it and come to peace with the troubling effects. Indigenous cultures and philosophies have much to offer the healing movement as they are evolving through time and reflecting the needs of their communities. For the most part, practises based solely in Western medical knowledge have not provided effective treatment for healing from the trauma that is a result of colonisation. Indigenous healthcare practitioners and helpers in the healing movement are drawing on ceremonies, traditional knowledge, and cultural practises to assist in the healing of their communities. They are the ones who are determining the healing therapies that will be most effective and relevant for their people.

The challenges that pertain to funding Indigenous healing programs and services are common issues that effect availability of community-based healing initiatives. Amidst growing tensions between Indigenous peoples and the Canadian public, in August 1991, the government of Canada launched a Royal Commission on Aboriginal Peoples. This commission travelled across the country listening to the experiences of thousands of people who were able to attend the public hearings. The information gathered at the hearings, along with the Commissioners thoughts and recommendations, was compiled and released in 1996 in a five-volume report. One of the recommendations in *Volume 3: Gathering Strength* suggested that healing centres deliver community-based services. The report acknowledged that the implementation of a community health centre reduced hospitalisation in a nearby town, “We believe that a strong emphasis on community-based care would reduce the need for institutional-based care” (p. 240). As a result of the Commission’s work, in 1998 the Canadian government issued a Statement of Reconciliation contained within a document *Gathering Strength: Canada’s Aboriginal Action*

*Plan*, committed 350 million for a healing fund, and established the Aboriginal Healing Foundation. The Foundation was given an 11-year mandate and funded 1,345 community-based healing projects across the country. Through these programs, former students and their descendants were able to address the legacy of physical and sexual abuse that occurred in residential schools in Canada. In 2010, the government of Canada announced that it would not continue funding for the Foundation, despite the success of many of the programs. This caused immediate crisis in the healing movement as many counsellors and therapists had to terminate their therapeutic relationships with those that were accessing services. Many community agencies and organisations were forced to close their doors due to lack of funding. There were extensive lobby campaigns initiated in efforts to encourage the Government to reverse its decision to end funding to programs and services which were addressing generations of trauma – trauma that was essentially caused by Government policy. Unfortunately, the Government of Canada did not change its position.

Shifts in the healing movement occurred in the past decade as Canada began to take responsibility for its role in the residential school system. Former students launched a class action lawsuit against the federal government and churches that resulted in the largest settlement agreement in Canadian history. The Indian Residential Schools Settlement Agreement was finalised in 2007, at which point former students were eligible to apply for a Common Experience Payment (CEP); and, if applicable, they could also apply for the Independent Assessment Process (IAP) if they experienced serious abuses while attending residential school (Assembly of First Nations, 2007). In 2008, the government of Canada issued a formal apology which was delivered in the House of Commons and broadcast live across Canada. Over the past two decades, the churches who were involved in administering the schools have also apologised. As of June 2010, more than 100,000 applications for the CEP had been received, 95,000 had been processed, and 76,000 had been approved for payment (Indian and Northern Affairs Canada, 2010). Between September 2007 and August 2010, the IAP had received 17,336 claims, including claims previously filed under the former Alternative Dispute Resolution process (Indian Residential Schools Adjudication Secretariat Statistics, 2010). The Agreement also provided funding for mental health and emotional support services for former students and their families; as well as called for a Truth and Reconciliation Commission with a five-year mandate to hold a number of national and local events across Canada. These events were to provide

opportunity for all those affected by the residential school system, including former students, their families, school staff, church administrators, and government officials, to share their stories and aid in the healing of themselves, and the relationship between Aboriginal peoples and Canada. The first national event was held in Winnipeg, Manitoba in June, 2010.

As communities continue to move forward with healing initiatives, and more Indigenous people engage in healing activities, the opportunities for resolving the historical and multigenerational trauma that has resulted from colonisation has become apparent. It is hoped that the Truth and Reconciliation Commission will shed more light on the darkness inherent in Canada's past. Ideally, it will provide the platform for both Indigenous peoples and Canadian society to better understand the journey toward peaceful living and healthy relationships. Hodgson (2008) comments that, "Reconciliation is a Western concept that describes a process of bringing one's spirit to a place of peace" (p. 363). The testimony at the events will offer insight into healing and survival, and will likely be great learning opportunities for those that are able to listen. Koptie (2009a) expresses that we have to honour the journey of self-discovery undertaken by former residential school students longing for peace from their incomprehensible suffering, "Their suffering in silence comes from not hearing resilience stories from adults in the healing ceremonies of their communities" (p. 74). Without doubt, it is time for the resilience of Indigenous peoples to be recognised and celebrated. For the most part, there have been incredible gains in the health and wellness of Indigenous communities in the past few decades. However, there is much more work to do, as many still struggle and suffer with the overwhelming circumstances of their lives. Nonetheless, much hope lies ahead in the area of Indigenous healing.

### **Indigenous Healthcare Practitioners**

On the frontlines of Indigenous trauma work are healthcare practitioners, including counsellors, crisis workers, therapists, psychologists, psychiatrists, medical doctors, nurses, healers, helpers, and Elders. These people are in places of work that include the spiritual, emotional, intellectual, physical, cultural, political, social, and economic dynamics of the community. They are part of, work with, and for, the Indigenous community; and thus, these frontline workers are often at the point of where trauma intersects. They are frequently subjected to stressful working conditions, under-resourced, under-funded, overworked, and experience

burnout; yet, they continue to draw on their personal and professional resources in efforts to aid their communities in much needed ways. Stevens and St. Germaine (2003) discuss the importance of personal survival strategies that include achieving a personal balance and developing strong personal and professional supports, “We all have the ability to cope and survive in the helping field—a field that traditionally has a high turn-over and burnout rate” (p. 169). Despite the strenuous conditions that these workers routinely face, they are providing essential frontline services that have, for the most part, been developed and implemented within Indigenous contexts.

Also of relevance for Indigenous healthcare practitioners is the impact of vicarious trauma (Pearlman & Saakvitne, 1995, Richardson, 2001; Jenkins & Rae, 2002; Sabin-Farrell & Turpin, 2003) that is often experienced by frontline workers as a result of continually hearing the traumatic content of their clients. Recognising the signs is imperative for the health and balance of all those working in the field of trauma. Chansonneuve (2005) argues that it is important to understand the impacts of vicarious trauma on workplace problems as they are often “attributed to *personality differences* or *difficult people* instead of impacts of the work. This only compounds the level of stress for people already in difficulty. Much sick leave and workplace conflict is directly linked to unrecognized, untreated vicarious trauma” (p. 91). Fortunately there is a growing insight and understanding on the impacts of vicarious trauma and the effects for those working in a multitraumatic environment.

Indigenous healthcare workers have a wide range of experience, education, and training which assists them in their work. Culturally specific programming is an important component in education as Indigenous practitioners often differ in their practise from mainstream practitioners. Mehl-Madrona (2007b) points out that “Indigenous healers work within a different mode of thought than conventional medical practitioners. They are more intuitive than logical” (p. 65). In recent decades, the healing movement has seen an emergence of workshops and training programs specifically for Indigenous healthcare practitioners working in Indigenous communities. There is also a greater focus on the clinical and cultural components of training Indigenous healthcare practitioners. The following sections discuss education, training, and the need for cultural competency.

### **Education and training.**

The importance of education and training in Indigenous communities has been established as a priority necessary for community capacity building. Warry (1998) puts forth that, “Human-resources support and training are critical to the development of Aboriginal communities” (p. 227). The training of Indigenous healthcare practitioners is becoming a twofold process as there is a need to become both culturally and clinically competent (Durie, 2009). As such, universities, colleges, and Indigenous post-secondary institutes have a unique role to play in curriculum development and program planning as it relates to the education and training of Indigenous healthcare practitioners.

Many Indigenous peoples find contemporary educational experiences an important part of their healing journey. For some, it is their first experience learning about the effects of colonisation. It is also a place where students are able to access cultural education as there are numerous programs that are designed for Indigenous students. Such programming also creates a community among students who become connected to an environment where everyone is in recovery—recovery from colonisation. Couture (1982) suggests that this type of education is political in nature. “I understand *politicization* to mean an encompassing process by and through an individual and/or group becomes aware of all the dimensions of his/her/their existence, including oppressing conditions, social forces, economic circumstances, cultural repression—with particular attention to the political forces” (p. 13). It is essential that Indigenous healthcare practitioners are able to participate in educational programming that teaches them the effects of colonial history in relation to current health issues, as well as providing an opportunity to integrate culture and ceremony in their practises.

Indigenous healthcare practitioners participate in a wide range of formal and informal learning processes, as not all learning takes place in the classroom. Although, formally trained as a licensed practical nurse and physician’s assistant, Shangreaux (2001) acknowledges the importance of learning on the frontlines, “When you work everyday with Indian patients, attend various types of functions and activities...and listen to the views of different Indian community groups every week, you learn a great deal that you cannot get out of books” (p. 96). In discussing the purpose of Indigenous education, Couture (1985) indicates that Native education is not to provide an inferior education, “but to provide a different education, the objective of which will

be to develop knowledge, skills, and values rooted in a centuries-old tradition in order that a student can contribute to the betterment of his community and his people.” (p. 12-13). Svenson and LaFontaine (1999) recommend that First Nations and Inuit involved in education and training must give more emphasis to worldview differences and to their implications for all aspects of our lives with particular attention to health and healing, “Since medical practitioners, government officials, and academics exert so much influence over program design and development, funding, other views are seldom considered” (p. 205). Essentially, the importance of culturally relevant curriculum has never been more important, as Stewart (2008) states “mental health workers such as counsellors should be educated in terms of cultural notions of Indigenous mental health if they wish to meet Native clients’ needs” (p. 13). It has become clear that building sufficient capacity of healthcare practitioners in Indigenous communities requires culturally appropriate education programs that are accessible and meet the unique needs of Indigenous learners.

For decades, Indigenous peoples have been accessing mainstream post-secondary education, which is primarily Western in orientation. Consequently, Western paradigms dominate counselling education (Stewart, 2007). This creates problems for Indigenous practitioners as culturally appropriate education is not available in their area of study. It was also noted that there was insufficient development and integration of cultural training in most professional programs (Crowe-Salazar, 2007). As a result, Indigenous learners often undertake extensive training through relations with Elders, healers, cultural teachers, mentors, and in community-based programs that provide access to ceremonies and traditional teachings. Much of this education is not recognised or supported by mainstream institutes; however, recent initiatives involving Indigenous faculty and Indigenous educational institutes have begun to address these deficits. Baskin (2002) claims that spirituality is largely absent from the field of social work, “As a social work student, I had no ‘education’ regarding spirituality in my programs. As an educator, I am finding it infinitely challenging but increasingly rewarding to invite spirituality into the classroom.” Mehl-Madrona (2009) notes that mainstream education teaches students to be clinically detached and rarely discusses spirituality; he explains that mainstream education is often concerned with “teaching students how to be expert professionals who apply solutions to fix or treat problems, expecting their patients to comply to expert advice” (p. 27). The different, and often conflicting, paradigms that relate to healthcare and healthcare

education often place Indigenous learners in a complex position where cultural perspectives and mainstream ideologies complicate issues relating to practise. Duran and Duran (1995) point out, “The simple reason for the failure of most therapies performed on Native American populations is that most of the therapies are Western-based and irrelevant for Native Americans” (p. 87). The challenge then becomes to utilise therapeutic strategies that are rooted in Indigenous knowledge and experience, and thus, are relevant for Indigenous peoples.

As most healthcare professions are regulated by government legislation, registration in appropriate college or professional association is often a mandatory requirement of a healthcare practitioner. Mehl-Madrona (2009) argues that Indigenous worldviews are as valid as those of contemporary social and medical science, although he recognises the relevance of regulated health professions, “students must learn what is generally accepted by mainstream practitioners and licensing boards and must be competent in the standard practises of their field” (p. 27). Duran (2006) acknowledges that “the therapist must have a high level of training within the Western paradigm, as well as an excellent cultural understanding...” (p. 6). This supports the movement of Indigenous communities toward ensuring that healthcare practitioners are both clinically and culturally competent (Durie, 2009); however, it also raises issues relating to specialised traditional healers who may desire to practise outside of regulatory bodies. In fact, supporting this notion is section 35 of the *Regulated Health Professions Act* of Ontario which specifically exempts Aboriginal healers (and Aboriginal midwives) that provide traditional healing services (or traditional midwifery services) to Aboriginal persons or members of an Aboriginal community, except where a practitioner is a member of a College, and then the practitioner would be subject to the jurisdiction of that College. Nonetheless, the issues surrounding clinical competency, including definitions, regulations, and accreditation will be the focus of attention as Indigenous communities discuss and develop standards regarding the delivery of healthcare services.

### **Cultural competency and cultural safety.**

The concept of cultural competency arose from the need for mainstream practitioners from dominant culture to develop an appropriate way to work with peoples from other cultures. According to Sue (1998), cultural competence is the belief that people should not only appreciate and recognise other cultural groups but also be able to effectively work with them (p. 440).

According to the Wharerātā: Indigenous Mental Health website, cultural competence is defined to be inclusive of the “knowledge, self-awareness and demonstrable skill of practitioners.” This group points out that cultural competence reflects the “demonstration of skill to build therapeutic relationships that make intentional space for the client's culture.” The goal of cultural competency is to provide services that enable the recipient of the services to feel culturally safe (Ramsden, 2002; Koptie, 2009b). Sones et al. (2010) asserts that cultural safety is “an intentional construct that acknowledges the experience of the patient as the evaluator of the degree of safety provided by the practitioner” (p. 57). While recognising that culturally competent methods can facilitate counsellor effectiveness, client retention, and progress under controlled circumstances, Trimble (2010) warns that for non-Indigenous practitioners incorporating traditional spiritual and healing methods such as the “sweat lodge and talking circles” must be done so with a strong degree of caution (p. 248). The issues involved in cultural appropriation and exploitation of Indigenous healing ceremonies have been coming to light in recent years as non-Indigenous practitioners explore and learn about Indigenous ways of healing. Trimble notes that the counselling relationship is built on trust and respect, and with that, non-Indigenous practitioners must be careful in how they use Indigenous healing ceremonies in counselling as it “will undoubtedly undermine a counselor’s effort to gain acceptance from the Indian community and the client” (p. 249).

Other questions arise regarding cultural competency, such as that put forth by Gone (2010) who asks, “How much ‘culture’ is required for the culturally competent practice of psychotherapy with the culturally different?” (p. 210). Also part of this discussion should be the complexities and diversities of Indigenous cultures, and thus, how do we define cultural competency in working with different cultures with similar histories? In her presentation to the Ethics in Mental Health Conference, Baskin (2007) suggested that cultural competence was not a viable concept for working with Indigenous peoples because the question became: “whose culture?” These considerations are supported by social work research conducted by Weaver (1999) that found a clear need to “understand and appreciate diversity among and within Native American populations” (p. 223) as Indigenous healthcare practitioners often work with clients and patients from various Indigenous cultural and geographical backgrounds. It is also important to recognise that not all Indigenous healthcare practitioners have been educated in cultural perspectives or are grounded in Indigenous worldviews. In his experience with recruitment and



training of Indigenous students, Duran (2006) puts forth, “Many of the students do not identify with any aspect of Native culture and are basically Western in their cultural orientation and clinical practice. Therefore, just having a Native provider does not ensure cultural competency” (p. 37). And hence, it should not be assumed that all Indigenous healthcare practitioners are culturally competent. Despite the questions surrounding the practicality and definitions of cultural competency, these discussions are bringing forth a sense of accountability in the delivery of healthcare services that are client focused. It also brings us past the standards of cultural sensitivity and cultural awareness training that has been emerging in the healthcare field.

As Indigenous healthcare practitioners are taking the lead to ensure that programs and services are meeting the needs of Indigenous peoples, there is a greater sense of promoting paradigms that reflect the values and content relevant to the healing needs in their communities. Dion Stout and Harp (2007) advocate for safe, satisfactory, and sustainable healing programs for residential school survivors and their families. They recommend the integration of “cultural competency into programs by providing training to front-line workers on issues like historic trauma, traditional knowledge, and resilience so they can influence program development” (p. 68). Promoting the need for culturally appropriate and multifaceted approaches, Struthers and Lowe (2003) have developed conceptual models for nurses, Indigenous and non-Indigenous, working with Native American people suffering from historical trauma. These models emerged from focus groups of Native American nurses that identified seven dimensions to guide Native American nursing practise, education, research, and administration: caring, traditions, respect, connection, holism, trust, and spirituality (p. 265). Furthermore, in discussing the issues involved in ethical decision making and informed consent of patients that have limited fluency in English and French or that speak only an Indigenous language, Ellerby, McKenzie, McKay, Gariépy, and Kaufert (2000) suggest that “ethical communication should involve the use of trained Aboriginal health interpreters who have competence in both biomedical terminology and Aboriginal concepts of health and healing” (p. 847). As the practise of utilising culturally competent approaches evolves and the literature documenting these developments increases, there will be an established repertoire of field-based experience to guide practitioners in their practises.

While Indigenous healthcare practitioners, theorists, and writers have put forth culturally relevant and appropriate models and theories, the challenge will be for these contributions to be included in the curriculum of training programs and academic institutions. Sue (1998) contends

that treatment outcomes are more successful when a client and therapist are ethnically matched and therefore, the recruitment and training of therapists to serve their populations should be encouraged (p. 443). The training of Indigenous healthcare practitioners to serve their own communities is perhaps one of the most pressing issues facing the Indigenous healing movement today. Although, there have been thousands of Indigenous frontline workers that have been serving the needs of their communities over the past decades, the training of specialised healthcare professionals that meet the registration requirements of regulated healthcare professions is becoming increasingly important. There is also a need to shift the delivery of healthcare services from non-Indigenous medical model practitioners to Indigenous healthcare practitioners that are culturally and clinically competent.

### **Summary of Chapter Two**

Chapter Two discussed the area of trauma and healing in Indigenous communities, and in particular, who has access to Indigenous healing services. It was important that this chapter be framed in the context of resiliency, as far too often Indigenous peoples' lives are evaluated in deficit terms. Such analysis contributes to the tendency of society to pathologise Indigenous peoples despite the residual effects inherent in the colonial experience. This chapter focussed on the healing movement, which brought forth relevant issues relating to trauma and community-based efforts that have been initiated to assist in healing. Also discussed were the issues relating to Indigenous healthcare practitioners' education and training and the connection to cultural and clinical competency. The next Chapter will describe the research procedure and methodology utilised for this study.

## Chapter Three: Research Methodology

Wind swirls around aimless but precise  
shifting and sifting  
shaping and soothing  
Wind pushes her way and his way through the trees as if  
wawatay (northern lights) were plummeting through the  
universe  
shifting and sifting  
shaping and soothing<sup>4</sup>

This research is *Indigenous research*. It is not research that is grounded in Western research paradigms. I do not use terms such as *qualitative research*, *phenomenology*, or *narrative inquiry*. Although some people may look at my work and say that *that* is what it *is*. That is not my concern. I am not in a position where I feel the need to identify with the paradigms and frameworks that have been generated by peoples outside of Indigenous thought processes. I purposefully draw on Indigenous research methodologies which are based on cultural ethics and protocols as that is how I wanted to complete this research project. Similar to Kovach (2009), I put “Western research methodologies aside” and “returned to the teachings” (p. 40) as a way to formulate my research methodology.

### Utilising an Indigenous Research Paradigm

This research will be grounded in Indigenous research methodology by following cultural ethics and protocols as they pertain to Indigenous research, by using storytelling as a way to inform this research, and by drawing on a decolonising approach. Many Indigenous researchers

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<sup>4</sup> This piece was written in October 2004 during Dr. Ardra L. Cole’s class on “Perspectives in Qualitative Research: Part 1.” Students were asked to write a piece that reflected the research process.

have written on why Western Eurocentric research methodologies and research terminology are not only inconsistent, but in contrast with methods that need to be employed while conducting research in Indigenous communities (Absolon & Willet, 2004; Battiste, 2000; Fitznor, 2002; Graveline 2000; Kovach, 2009; Miheshuah, 1998; Smith, 1999). In discussing Indigenous research methodology, Wilson (2001) and colleagues discuss how Indigenous research needs to reflect Indigenous contexts and worldviews, “they must come from an Indigenous paradigm rather than an Indigenous perspective” (p. 176). In recent years there has been a significant increase in literature specific to Indigenous research methodologies. This has created a body of knowledge and experience that can be drawn on by Indigenous scholars and researchers, as well as non-Indigenous people conducting research in Indigenous communities.

It is important to recognise that there is no set paradigm for Indigenous research. Absolon (2008) points out that, “Prescriptions or formulas for Indigenous methodologies do not exist” (p. 94). However, there are certainly guiding principles and perspectives which contribute to culturally appropriate ways of conducting research with Indigenous peoples. Kovach (2009) describes key qualities of an Indigenous research framework centred on Plains Cree knowledge. She puts forth that these qualities include: [w]holistic epistemology, story, purpose, the experiential, tribal ethics, tribal ways of gaining knowledge, and an overall consideration of the colonial relationship (p. 44). It is also important to acknowledge that conducting research in Indigenous communities is not a new development. Cardinal (2001) declares that Indigenous research methods and methodologies are as old as our ceremonies and our Nations, “They are with us and have always been with us. Our Indigenous cultures are rich ways of gathering, discovering, and uncovering knowledge. They are as near as our dreams and as close as our relationships” (p. 182). In essence, Indigenous research methodologies need to consider the type of research being conducted, the community being researched, and the researcher carrying out the study. As such, Indigenous research paradigms will be reflective of the unique characteristics of each research project.

As this research is conducted to meet doctoral degree requirements, approval was sought from the University of Toronto’s Ethics Review Office. Indigenous research methodologies were adhered to and reflected in the Ethics Review Protocol Submission. My Submission considered the recommendations in Section 6 – Research Involving Aboriginal Peoples of the *Tri-council Policy Statement: Ethical Conduct for Research Involving Humans* (1998, with amendments

2000, 2002, 2005) prepared by Canadian Institutes of Health Research (CIHR), Natural Sciences and Engineering Research Council (NSERC) of Canada, Social Sciences and Humanities Research Council (SSHRC) of Canada. I also reviewed the CIHR Guidelines for Health Research Involving Aboriginal People (herein after referred to as CIHR Guidelines) which were developed to “assist researchers and institutions in carrying out ethical and culturally competent research involving Aboriginal people” (Canadian Institutes of Health Research, 2007).

### **Guidance from Elders.**

Cultural guidance and grounding is imperative within an Indigenous research paradigm and should be maintained throughout the research process. Early in my doctoral studies I took a master’s level course at Seven Generations Education Institute, which is an Aboriginal Institute on Coochiching First Nation in northwestern Ontario. The course was called *Anishnaabe Psychology: Ways of being and behaviour* and was facilitated by two Anishinaabe Elders (Jim Dumont and Annie Wilson), and an Indigenous academic (Dave Anderson). This course was imperative for my thought process and helped to ground my research in an Anishinaabe worldview. I also took the opportunity to spend time with my Elders in the area as they have provided continued support for my spiritual journey. I had been struggling with my research topic and process. I felt that I needed space outside of the fast-paced world to seek calmness and clarity. For four days I Fasted in a lodge that they prepared for me. This required the absence of food and water. As each day passed, I began to appreciate that Fasting was much more about the evolution of my *Spirit* and much less about my physical wants and needs. I thrived in the place where clutter seems to disappear. In the following years, my research topic progressed into a new area. Whenever I doubted my direction I would offer tobacco and prayers for guidance. I trusted the changes that unfolded, particularly in terms of research area and thesis committee. I knew that cultural guidance, grounding, and ceremonies had to be a central part of my research journey.

Indigenous researchers often involve Elders as significant participants in their research process as mentors, advisors, committee members, or research participants. They are an important part of Indigenous cultures and great value is placed on their involvement. The *Aboriginal Healing Foundation* describes an Elder as:

Someone who is considered exceptionally wise in the ways of their culture and the teachings of the Great Spirit. They are recognized for their wisdom, their stability, their humour and their ability to know what is appropriate in a particular situation. The community looks to them for guidance and sound judgement. They are caring and are known to share the fruits of their labours and experience with others in the community. (Chansonneuve, 2005, p. 70)

Elders have the ability of providing researchers with necessary guidance, cultural training, and grounding that supports the researcher in spiritual and cultural development. Many have also been involved in the academic environment and are able to play key roles in research related activities. Couture (1985) puts forth that Elders “are the guardians, purveyors, and teachers of oral traditions and history of the people: they are the doctors and healers, the expert survivors” (p. 8). Hart (2002) describes Elders as “individuals who understand themselves in relation to the universe around them and who have been able to centre themselves on a consistent basis” (p. 58). Ellerby notes, “Elders are highly qualified individuals, usually with decades of experience often both within and outside of institutional settings. An Elder has earned tremendous respect and appreciation in the communities that he or she has served” (p. 28). Because of their lived experience and demonstrated capacities, Elders are widely recognised by their communities as key resource people for involvement in community issues.

Indigenous researchers have many opportunities to draw on relationships with Elders as these people are members of our families and communities. In my experience, they play different roles in the aspects of our research. Some of these individuals may already be involved in our lives or we may seek out specific Elders based on their expertise. Smith (1999) writes about the protocols of respect and reciprocity that exist in the relationship between Elders and younger people conducting research. She asserts that the “relatively simple task” of gaining informed consent can take anything from a moment to years, and that some Indigenous students have had to travel back and forth during the course of the year “to gain trust of an individual elder, and have been surprised that without realizing it they gained all the things they were seeking with much more insight, and that in the process they gained a grandparent or a friend” (p. 136). The time spent with Elders provides valuable insight into cultural ethics and protocols that are relevant in Indigenous research. From personal conduct to cultural practises, relationships with Elders provide essential learning opportunities. Couture (1991b) states, “One learns about Elders

by learning from them over a long period of time, by becoming comfortable with a learning by doing model” (p. 208). Through this experience with Elders, Indigenous researchers are developing a stronger set of cultural values that increases the depth and understanding of Indigenous worldviews and knowledge. Working with Elders enables us to develop our sense of Indigenous knowing which will ensure that we are able to incorporate this information into research practises.

My doctoral process involved Dr. Joe Couture, Cree Elder, psychologist, cultural advisor, academic, educator, and 2007 recipient of a National Aboriginal Achievement Award. After a few telephone conversations, I travelled to Wetaskiwin Alberta to meet with him, offer tobacco, and share who I was and what my research was about. I invited him to join my doctoral committee. I told him that I didn’t expect an answer right away and indicated that he could smoke his pipe with the tobacco I offered and “see what they say” implying the Spirits had final approval. He smiled kindly and expressed that he was pleased that I understood our ways and told me that he already knew that he wanted to work with me. This was the beginning of a wonderful relationship in which we shared food, ideas, stories, laughs, books, and critiques. Perhaps the most valuable support I received from him was approval for my thoughts and ambitions to carry out my research. He felt optimistic about my work and inspired my Spirit to continue on my academic path. Our last talks were on the telephone as he lay in his hospital bed—still laughing and enjoying life. Although, he began his journey to the Spiritual World on June 15, 2007, his involvement in my research continues in a meaningful and vibrant way.

### **Cultural ethics and protocols.**

The cultural ethics of an Indigenous researcher are highly important in any research process with Indigenous communities. This research study was guided by the following considerations put forth by Absolon and Willet (2004) for the development of Indigenous methodologies:

- *Respectful representations*: consider how you represent yourself, your research and the people, events or phenomena you are researching;

- *Revising*: consider changing your methods, listen to the community and be flexible and open to processes that are culturally relevant;
- *Reclaiming*: consider asserting and being proud of yourself; trust your traditional and cultural identity to inform and guide your processes of sharing and creating knowledge;
- *Renaming*: consider ‘Indigenizing’ language by restructuring and reworking it to create meanings that are Indigenous;
- *Remembering*: consider journeying into the ancestral memory banks through ceremony, tradition and ritual in order to reconnect and remember who you are;
- *Reconnecting*: consider creating research processes that foster and maintain connections with community and with contemporary issues;
- *Recovering*: consider incorporating our histories, diversities, traditions, cultures and ancestral roots;
- *Researching*: consider innovative Indigenous methodologies, be a trailblazer, have courage, tenacity, and faith. (p. 15)

Indigenous research takes on many forms and routes. It is clearly a journey which requires the researcher to embark on a significant exploration of themselves in an Indigenous world. It is essential that Indigenous researchers learn and implement cultural ethics and protocols. This assists the researcher in grounding the study in ways that are relevant and meaningful for Indigenous communities. It also contributes to an environment in which the research participants are respected and comfortable with the process. This ethic is further supported by Article 11.1 of the CIHR Guidelines (2007) which states, “A researcher has an obligation to learn about, and apply, Aboriginal cultural protocols relevant to the Aboriginal community involved in the research” (Canadian Institutes of Health Research, p. 5, 2007). However, it is important to recognise that there is diversity among Indigenous communities and not all people follow the same cultural or religious orientation. This is evident, particularly if the research study includes the participation of Indigenous people from different Nations—as was the case in my study.



There are many different cultural protocols that are contained in Indigenous research methodologies. Steinhauer (2002) realized “that conducting research using an Indigenous research methodology would not be as simple as it originally sounded. It means that the researcher must know the cultural protocols, values, and beliefs of the Indigenous group with which they are studying” (p. 73). Indigenous researchers should be aware of cultural protocols that should be followed. The lack of knowledge in this area could create a mistrust and uneasiness of the research participants, particularly if the researcher offends the community or local cultural practises. Essentially, Indigenous researchers should be grounded in their own traditions and draw on their own sources of cultural knowledge and practise. This should be declared to the research participants and/or community involved in the project. I proceeded with grounding my research study in Anishinaabe cultural practises, such as Fasting for clarity and research preparations, learning teachings specific to Anishinaabe understandings of psychology, and following the clockwise circle in terms of travelling around Turtle Island to connect with the participants in this study. I also used Anishinaabe medicines (tobacco and sage) during the research process.

It is important to understand that researching in Indigenous communities does not only involve the people, it also involves Indigenous lands, ancestors, and Spirits. Permission must be sought to carry out such work. Offerings should be made in appropriate forms, which could include prayer, medicine, and food. Honouring the research relationship with appropriate offerings is an important element in Indigenous cultures. Fitznor (2002) in her unpublished dissertation *Aboriginal Educators' Stories: rekindling Aboriginal worldviews* acknowledged tobacco as the *first medicine* and offered it to the participants in her research. “I honoured a tradition that includes respect for the value of using ‘tobacco’ as an important bridge to the transaction of drawing from the Elder’s knowledge and expertise, and participants’ stories as ‘good medicine’” (p. 73). Mitchell (1999) explains, “To my people, the act of offering tobacco reinforces the ethic of reciprocity in a cosmological understanding of interdependence, balance, and harmony” (p. 155). In some Indigenous cultures, including Anishinaabe culture, tobacco is considered a sacred medicine and used as an offering before any assistance is asked. Many Indigenous researchers are bringing this practise into research methodology.

Challenges have existed for Indigenous graduate students utilising cultural protocols in their research. Michell (1999) shared his experience of submitting his graduate studies research

proposal to the Ethics Review Board at the University of British Columbia (UBC). His methodology indicated an offering of tobacco and small honorarium in exchange for stories. Much to his shock, the Board rejected his proposal as UBC “did not sanction the use of tobacco in exchange for stories and that there was an element of coercion involved” as the researcher personally knew the research participants. Despite this student was in a First Nations focussed graduate program at a Canadian University that had an established First Nations House of Learning, it seemed that the cultural protocols necessary for conducting research with Aboriginal people were not respected or permitted. It is evident that Indigenous researchers face various barriers in efforts to employ culturally relevant research methodologies. In many cases, these researchers are developing the field by engaging in Indigenous research methods and introducing these practises to academic faculty and research ethics boards. Fortunately, the University of Toronto’s Ethics Office process granted approval for all the cultural protocols that were indicated in my submission.

I felt that it was important to see my research study as an extension of the healing work that is being done in Indigenous communities. It was never to be a project that was isolated from culture, nor was it to be geared toward adhering to Western academic principles. Absolon and Willet (2004) remind us to see research in a traditional sense, in that the seeking of knowledge is usually solution-focused and has an underlying purpose of survival. “Traditionally, research has been conducted to seek, counsel and consult; to learn about medicines, plants, animals; to scout and scan the land; to educate and pass on knowledge; and to inquiry into cosmology” (p. 7). Indigenous research continues to be largely focused around community needs. Research is an opportunity to explore an issue further and generate knowledge and experience from within the community.

Indigenous researchers often have responsibilities to the community that are unique because of the intrinsic relationships and collective histories. Wilson (2001) argues, “Research is not just something that’s out there: it’s something that you’re building for yourself and your community” (p. 179). This responsibility may differ somewhat from the role of a non-Aboriginal researcher. Kaomea (2001) points out that an “outsider researcher” might conduct a study in an Indigenous community and then simply present his or her findings through a written report or academic presentation. She explains that this researcher may have “no further responsibilities to the community, indigenous academics who live and work in their home communities are

inevitably implicated in a set of insider dynamics that make it impossible to present one's findings and walk away" (p. 73). An important responsibility for Indigenous researchers is to conduct a respectful and culturally grounded research inquiry that honours community participation while recognizing their relationship as an insider.

The relationship building elements brought meaning and integrity to my research process. As I travelled around Turtle Island, connecting with the research participants, meeting their families, and visiting their communities, I developed a sense of research responsibility that had little to do with the institution that I was attached to, and everything to do with the Spirits that were involved in this project. I felt a duty to complete this research in a way that honoured the wisdom and love that they offered to share.

### **Storytelling as methodology.**

The process of storytelling was used to inform this research. Stories have emerged and are recognised within Indigenous research methodologies. Fitznor (2002) documented the voices in her research using stories with the purpose of grounding her work in Aboriginal knowings and processes, "Through our stories, we as Aboriginal peoples can think and act in ways that express our voices" (p. 17). Stewart (2007) acknowledges, "Stories allow for the subjectivity, as it is reflected in real life perspectives of individuals" (p. 64). Baskin (2006) writes, "Storytelling is a means by which Aboriginal peoples can name their experiences and have them included in the space for the written word" (p. 122). Bell (2006) notes her dissertation is "one big story" (p. 16). Storytelling is a form of sharing experience and knowledge that is familiar and culturally consistent for Indigenous people participating in research studies. It brings the research participant and the researcher into a relationship that is about stories, rather than about "definitive information." This method enables the research findings to be presented in a forum where knowledge is respected and integrated into a *bigger story*.

The first story told in this thesis was my own story in the form of a prologue. I felt that it was essential that I locate myself as a researcher and share aspects of my lived experience and worldview. Wilson (2008) explains, "When listeners know where the storyteller is coming from and how the story fits into the storyteller's life, it makes the absorption of the story that much easier" (p. 32). I think that as Indigenous researchers we are profoundly connected to our research topics and our own story's bring us into the research circle in a relevant way. It also

helps the reader understand the lens in which the storyteller interprets this story. Mehl-Madrona (2005) points out that “we are our stories. We live them as they live us” (p. 9). This research journey is about creating story, and as noted in the introduction, someone else would tell this story differently.

A storied approach to health and healing situates itself well within the developing field of Indigenous knowledge and Indigenous research methodologies, as Indigenous peoples throughout the world recognise that wisdom is contained in stories (Mehl-Madrona, 2007b, p. 22). There are different types of stories that are told within the Indigenous world. In many ways, we are full of stories. Silverstein and Cywink (2000) point out, “Speakers in the Anishnaabe language distinguish between two types of stories: aadisokaan – traditional tales and legends; and debaajimowin – telling news, personal stories about what happened” (p. 40). Essentially, stories represent voices speaking from a specific location and place in time. Stories are also methods of knowledge transmission and researchers and educators who work with stories in Indigenous communities are story facilitators (Anderson, 2004). For the most part, Indigenous cultures are oral cultures, and thus Indigenous peoples are familiar and comfortable with the process of sharing stories, both as listeners and storytellers. That is evident throughout this study as research participants often acknowledged the stories they hear working with Indigenous peoples, as well as the stories that they shared with those that they are helping.

### **A decolonising approach.**

It is important that Indigenous research methodologies create space for critical analysis and encourages essential dialogue that challenges the influences of colonialism. I chose to draw on a decolonising approach because this research initiated a critique of psychiatry and sought out Indigenous healthcare practitioners that would highlight the cultural strategies that they use in their practises. Kaomea (2001) claims, “The process of decolonisation requires our continual efforts towards questioning and revealing hidden colonial influences in past and current beliefs and practices” (p. 72). Smith (1999) asserts that, “Decolonization is a process which engages with imperialism and colonialism at multiple levels. For researchers, one of those levels is concerned with having a more critical understanding of the underlying assumptions, motivations and values which inform research practises” (p. 20). With this in mind, Indigenous research methodologies may be inherently decolonising as there is an intentional effort to inform research

through cultural contexts. Furthermore, Kovach (2009) asserts that “Indigenous communities demand a decolonizing outcome from research” (p. 86). In this sense, communities want research to assist in education, healing, collective benefits, and the general progression toward healthy sustainable living.

Decolonising research strategies invite those in the research process to draw on their own critiques and put forth Indigenous beliefs and practises as they contribute to the research project. Absolon (2008) expresses that decolonisation is “about both knowing our cultural history and having a critical consciousness about our colonial history” (p. 11). This approach does not need to present itself as confrontational or aggressive. Decolonisation does not need to be violent as Fanon (1979) proposes. Smith (1999) asserts that decolonization does not mean and has not meant a total rejection of all theory, research, or Western knowledge. “Rather, it is about centring our concerns and worldviews and then coming to know and understand theory and research from our own perspectives and for our own purposes” (p. 39). A decolonising research process supports the location of Indigenous worldviews and a conceptual framework that validates Indigenous knowledge without searching for validation from Eurocentric academic authorities.

This research methodology used a decolonising approach based on a model that Smith (1999) developed to advance an Indigenous research agenda. Smith proposes four directions to represent processes: decolonization, healing, transformation, and mobilization. She articulates four major tides: survival, recovery, development, and self-determination (pp. 116-7). These tides were situated in a Medicine Wheel (see Figure 2) and were the guiding objectives of the research process. They were used to organise the chapters and story of this research.



**Figure 2. Decolonising Research Objectives**

These objectives are based on the researcher's premise that decolonising Indigenous trauma work will require us to recognise our *Survival* of colonisation and acknowledge that Indigenous healthcare practitioners are utilising Indigenous worldviews to work with and through trauma (Chapter Four: Joining the Circle: Introduction of the Research Participants); there is a need to *Recover* Indigenous concepts of our way of understanding wellness and wholistic health (Chapter Five: Indigenous perspectives on Wellness and Wholistic Healing); there is a need to *develop* an Indigenous critique of psychiatry and reflect on our current practises of working with and through trauma (Chapter Six: Psychiatry and Indigenous Peoples); and finally, this research is a call for Indigenous peoples to be *self-determined* and honour Indigenous philosophies and culture-based strategies in our healing practises (Chapter Seven: Indigenous Strategies for Helping and Healing).

## **Research Procedure**

### **Collection and merging of stories.**

This study gathered stories during an interview process which encouraged dialogues with Indigenous healthcare practitioners. Once approval was received from the Ethics Review Office (Appendix A), I proceeded to recruit research participants. I then devised a route and schedule to

travel around Turtle Island. The active fieldwork stage was thoroughly enjoyable. The transcripts from the interviews were transcribed and were given back to the research participants for their review and approval. I then proceeded to read the transcripts over and looked for themes and common strategies. I selected numerous quotations from the transcripts and situated them with other voices that appeared in the literature. This is how I formed the bigger story of this research study.

### **Participants.**

Participants in this research were Indigenous healthcare practitioners who are professionals with a therapeutic practise within their communities. These practitioners provide services in urban centres, small towns, rural areas, and First Nation communities. Inclusion criteria accepted participants that were educated culturally and academically, and have a minimum of 10 years experience working with Indigenous peoples. I specifically sought research participants that were psychologists, therapists, psychiatrists, social workers, counsellors, physicians, nurses, and members of other healthcare professions.

The recruitment process used a *moccasin telegraph* (snowball sampling) method to distribute an *Invitation to Participants* (Appendix B) to various individuals. Over the years, I have connected with many Indigenous healthcare practitioners that work within the Indigenous healing movement. I felt that some of these people would like to, or would know others that would like, to participate in my research study. This approach is consistent with Section 6 A(b) of the *Tri-council Policy Statement: Ethical Conduct for Research Involving Humans* which advises that research with Aboriginal peoples should consider: “Leaders of the group are involved in the identification of potential participants” (CIHR, NSERC, & SSHRC, 1998, with amendments 2000, 2002, 2005). This study sought to recruit 6-10 research participants. Ten participants were selected.

### **Confidentiality.**

Confidentiality was guaranteed to participants that chose to remain anonymous; however, in the final presentation of the study, all 10 research participants self-identified. In the research process, participants had the opportunity during the first interview to choose a one-name pseudonym to represent their voice or they could choose to self-identify using their first and last

name. These names were to be documented in this research study. Initially, two research participants chose pseudonyms and all transcripts and written data reflected this. Participants that chose to self-identify in the initial consent process had the opportunity to use a pseudonym in the final written report if desired. This option was provided during the second interview. None of the participants decided to withdraw their self-identifying name. Alternatively, participants who initially chose a pseudonym had the option of self-identifying for the final report. Upon reviewing her transcript, one participant chose to withdraw her pseudonym and self-identify during the second interview. The remaining participant chose to remove his pseudonym after reviewing his contributions that were highlighted in public presentations of the research findings. I was very pleased that all participants chose to self-identify. I felt that the research participants brought forth incredible insight and experience and I wanted to acknowledge them for their contributions. The confidentiality component respects Article 15 of the CIHR Guidelines (2007) which states that, “Community members are entitled to due credit...Publications should recognize the contributions of the community and its members as appropriate, and in conformity with confidentiality agreements.”

### **Consent.**

Informed consent was obtained through the administration of an *Information Letter* (Appendix C) and a *Participant Consent Form* (Appendix D), which was signed by each research participant. Consent was also requested when an interview was conducted on the premises of an Indigenous agency (or First Nation). Four Indigenous agencies were required to sign the *Consent for Interview to be Conducted on Premises of an Indigenous Community* (Appendix E). The remaining interviews were held in non-Indigenous agencies or organisations, participants’ residences, or other public locations. Participants also had the option to withdraw from the study at any point in time. This was clearly stated in the *Invitation to Participate* (Appendix B) and the *Information Letter* (Appendix C).

My initial Ethical Review Protocol that was approved by the University of Toronto that formed the consent process indicated that I would provide each research participant with a copy of their interview transcript for review and approval of the information that was documented. As a researcher, I felt that it was important that participants be given the opportunity to clarify or omit any details from their interview that they were not comfortable with. For myself, this helped



to provide safety and privacy of the participant contributions to this study. However, during the interview process I started to feel that I wanted to give the research participants an opportunity to review the four chapters in which the data from their interviews appeared. Because all the research participants self-identified in their own voices, I wanted to ensure that they were comfortable with how I drew on their stories and strategies and interpreted, analysed, and wrote up their contributions. This was consistent with Section 6B of the *Tri-council Policy Statement: Ethical Conduct for Research Involving Humans* which advises that good practises in research with Aboriginal communities should provide the group with “availability of preliminary report for comment” (CIHR, NSERC, & SSHRC, 1998, with amendments 2000, 2002, 2005). Furthermore, Article 14 of the CIHR Guidelines (2007) states: “An Aboriginal community should have an opportunity to participate in the interpretation of data and the review of conclusions drawn from the research to ensure accuracy and cultural sensitivity of interpretation.”

### **Interview process.**

The interview process occurred in two phases. In keeping with cultural protocols, participants were offered tobacco and together we smudged with sage prior to commencing the interview. At this time, I also offered a copper feather as a gift of appreciation. I chose to offer the gift ahead of time for their participation in this research study because this is what I have learned on my journey—that we make our offerings of tobacco, medicine, and gifts prior to receiving assistance from Spirits, including human Spirits. Each interview was audio-recorded and transcribed. After each interview, field notes were written to enrich data by capturing contextual details and other relevant information

The first interview gathered stories and strategies. Participants were asked to respond to a series of *Guiding Questions* (Appendix F). Interviews were conducted in person at a place of mutual convenience to the participant and myself. The first interviews took between (approximately) 37 minutes and three and a half hours. The second interview was to consult with research participants for accuracy of transcripts, to make revisions if necessary, and give final approval of participation in study. These interviews took between (approximately) two and 48 minutes. Most of the second interviews took place at restaurants, as I wanted to honour the culturally appropriate ethic of sharing food. In two of the interview processes, the sharing of

food took place around the first interview. I looked at this part of the research process as an opportunity to spend more time with the research participants and engage in the relationship building aspect of conducting Indigenous research.

### **Guiding questions for interview dialogues.**

*Guiding Questions* (Appendix F) were developed with the intention of gathering information and knowledge that would answer the larger research question of: how are Indigenous healthcare practitioners and communities supporting Indigenous peoples in the areas of healing and wellness. Because of the importance of worldviews and self-location, I felt that it was essential that I ask the practitioners how they formed their own worldviews. I also wanted to situate the construction of health in an Indigenous framework and thus I asked about their understanding of wellness and wholistic approaches to healing. As Indigenous peoples have often accessed, or been subjected to, Western medicine, I wanted to ask practitioners if they used these approaches. I also wanted to provide an opportunity to critique psychiatry in general. One of the research participants asked why I chose specific disorders as focal points. I explained that I chose the three disorders that I believed that Indigenous people are most commonly diagnosed with (posttraumatic stress disorder, depressive disorders, and schizophrenia or other psychotic disorders). And lastly, I asked practitioners to share their cultural strategies in working with their clients through trauma, depression, and experiences of parallel and multiple realities.

### **Questions: First Interview**

#### **1. Worldviews**

- a) What is your cultural background, current profession, and experience within Indigenous communities?
- b) What forms of cultural experience and education have informed your practise?
- c) What forms of academic experience and education have informed your practise?
- d) How have your worldviews prepared you to work with Indigenous peoples?

## **2. Indigenous Approaches to Wellness**

- a) How would you describe wellness, as understood in Indigenous communities?
- b) How would you describe a wholistic approach to working with an individual?
- c) How would you describe a wholistic approach to working with a community?
- d) Are wholistic approaches part of your practise? And if yes, please describe how.

## **3. Critiquing Psychiatry**

- a) When working with Indigenous clients - do you use any diagnoses as provided for in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) specific to:
  - Posttraumatic Stress Disorder?
  - Depressive Disorders?
  - Schizophrenia and/or other Psychotic Disorders?
- b) If yes:
  - Which diagnosis do you use?
  - What do you find helpful about the diagnosis
  - What is not helpful about the diagnosis?
- c) If no, why do you not follow the DSM criteria in diagnosis?
- d) Are you familiar with the Culture-Bound Syndrome Section in the DSM? And if yes, how do you feel about this application?

## **4. Indigenous Strategies**

Which Indigenous philosophies and cultural healing practises do you use in addressing:

- Trauma
- Depression
- Experiences of parallel and multiple realities

### **Questions: Second Interview**

1. How did you feel reading the transcripts of the interview?
2. Are you comfortable with the information that you have shared in answering the questions that will inform this research study?
3. Is there anything that you would like to add to, or delete from, your previous interview?
4. Would you like to maintain your anonymity through use of a one-name pseudonym or self-identify using your first and last name, as indicated on the original consent to participate form or would you like to reverse your decision?

### **Writing the bigger story.**

As mentioned previously, this thesis was organised within a Medicine Wheel framework. The decolonising objectives of the research design are: *survival, recovery, development, and self-determination*. The stories from the interviews were transcribed, coded, and sorted into themes that formed theoretical and practical perspectives. In the coding process, I spent considerable time *sitting* with the data and reading it over several times. I looked for relevant connections between the data and research questions. I initially proceeded to code the data with colour highlighters which supported the data to be organised in line with the objectives of the research project. I then generated headings and phrases that reflected the contributions to the research study. These were organised and presented as themes that articulated the story. The themes were then situated in a dialogue with the literature and field of trauma work. A concerted effort was made to draw on Indigenous theorists, writers, practitioners, and experts for their insights and contributions. I also sought out literature from non-Indigenous allies and writers whose work brought meaning to this study.

Essentially, my role as researcher was to bring together the voices of the research participants into a circle. This research study was not concerned with making a final statement of truth. It was most important to recognise the different worldviews of individual perspectives and interpretations. The analysis took into account the necessity for stories to emerge as a way that contributes to knowledge production. Rather than using data analysis frameworks found in Western research methodologies, I chose to follow Indigenous storytelling methods to make meaning and create a bigger story. In her doctoral dissertation, Absolon (2008) introduced the concept of *making meaning* to refer to the process of sorting the information that was gathered and harvested. “Making meaning is what we do with knowledge” (p. 16). Appreciating Absolon’s style, I embarked on a journey to make meaning and create story.

It was difficult to edit the contents of the stories as much of the information shared regarding the themes seemed essential. I realised that this was because Indigenous ways of constructing knowledge are profoundly interconnected. S. Wilson (2003) refers to this as *relationality* and explains, “All things are related and therefore relevant” (p. 173). It was also important that I capture the essence of the participants’ contributions and document the stories in a way that I felt was honouring the spirit of the research. I felt that I needed to be responsible and accountable to the research participants. Wilson (2001) writes about *relational accountability* and notes that Indigenous researchers “are answering to *all your relations*” and are not answering questions “of validity or reliability or making judgements of better or worse” (p. 177, see also Wilson, 2008). The research participants conveyed many aspects relating to Indigenous knowledge which allowed this information to be situated into the Medicine Wheel framework of the research methodology. The formulation of the research study challenged me as a writer to integrate these stories that have illustrated how profoundly interconnected we are. It became an inclusive process which intended to honour the stories about decolonising trauma work.

### **Summary of Chapter Three**

Chapter Three presented the research methodology for this study. I first discussed the use of an Indigenous research paradigm and outlined relevant methods relating to the involvement of Elders, cultural ethics and protocols, storytelling, and decolonising objectives. I then described the procedures that were utilised in carrying out this research project. The next chapter introduces the Indigenous healthcare practitioners that participated in this research study.

## **Chapter Four:**

### **Joining the Circle: Introduction of Research Participants**

This Chapter will introduce the research participants and share some of the experiences that have shaped their *worldviews*. These stories were articulated during the interview process. For the most part, I have introduced the participants in their own words, paraphrasing where necessary, and without much of my own commentary. As I began this part of the research, it became very clear that the research participants and myself were forming a circle, building relationships, and sharing stories and strategies that would be woven together to create a bigger story.

Participants shared varying degrees of information about themselves and their worldviews. Some participants requested that certain details about their ceremonial commitments, references to family member's traumatic experiences, and mention of specific individuals, be omitted from the written document. This request was honoured. I understood that the nature of the interviews were to give the participants an opportunity to share their stories so that I, the researcher, could become aware of how they came to understanding the world and develop their practise as a healthcare practitioners.

Participants will be introduced in the order in which I offered tobacco and a copper feather gift to each of them; their acceptance affirmed that they joined the circle of this research project. Each interview began with a smudge using medicine (Sage) that I picked from my home territory in Northwestern Ontario.

#### **Darlene Pearl Auger**

Darlene is a Cree from Wabiskaw, a small community in northern Alberta. Her spirit name is Pîtâpan, which translates to "the light is coming" in reference to "the first sign of sunrise." Through family history research, she learned that she is also related to French, Mohawk and Ojibway peoples; however, she was brought up Cree, speaks Cree and grew up with Cree traditions. In regards to a professional title, Darlene does not put labels on herself and therefore considers herself a therapist/healer/facilitator/teacher. She has incorporated the *Swing* in her healing work, and is often referred to as the "Swing Lady." Darlene also works as a consultant

and accepts contracts that relate to administration, community development, therapy and healing work.

Darlene went to university to become a teacher, and then switched to psychology because she felt a “strong natural connection to be there for people, to listen and help people through their issues.” In 2002, she graduated with a Bachelor of Arts in psychology.

The interview with Darlene took place at the Kumik Lodge at the Department of Indian and Northern Affairs Canada in Hull, Quebec. She was the visiting traditional person for the week. I came to the Lodge the day prior to the scheduled interview as she invited me to sit in on some teachings that she was sharing with students from Quebec. As soon as I walked into the Lodge I felt comforted by the scent of medicine. I sat on the wooden bench and took a deep breath. Prayer was being offered and I knew that I was exactly where I needed to be. Spirit had brought me to the Lodge. I was so grateful that I was able to sit among the sacredness of the medicines, the sacred items, the bears and the people. To sit in a circle and be connected to a circle of learning was a meaningful way to begin my research process. After Darlene had finished her teachings, we had a few moments to get acquainted with each other. I offered her tobacco and we made arrangements to meet at the Lodge the next afternoon.

When I returned the next day Darlene’s Swing (see Figure 3) was positioned at the eastern side of the Lodge. I was immediately reminded of the Swing that my aunt had set up for my son when he was a baby. As I shared that, she explained that’s what it was, “a traditional swing.”



*Figure 3. Therapeutic Swing*

The Swing was large and spanned from one side of the Lodge to the other. It was built using the frame of a hammock. The centre contained a comfortable area where the person receiving treatment would lie down among soft padding and warm blankets. Traditional ribbons hung from the Swing. After we smudged, Darlene told me that she would like to show me what she does, that she would like me to go in the Swing. I welcomed her suggestion. I laid down in the Swing and closed my eyes. She sang songs and swung me. I returned to a time when I was a little baby. It was very comforting. I felt very warm and safe. I wished that I could have stayed there for a long time. My mother had come to visit me. I could see her kneeling down beside the Swing, holding the edge with her hands and looking in at me with thoughtfulness and love. My heart started to race. I felt the fear of separation, the fear of abandonment, and the fear of being unprotected. When it was time to come out of the Swing, Darlene shared with me that she felt that I was afraid. She prayed that I would be provided with what I needed to do this work; she prayed for courage, bravery and strength.

Darlene and I sat in our skirts on the Buffalo hide in front of the Swing and began the interview. Darlene shared how she came to use the Swing in healing work:



It actually came to me in a Pipe Ceremony at a traditional healing gathering for residential school survivors in the fall of 2001. I had just been there to volunteer. The morning on the last day I had gone to sit with these Elders in an early morning Pipe Ceremony, and as they were singing their final song, I saw this *Swing*. I just kind of saw it briefly. I saw the visual in front of me of this great big baby Swing. And I remember my brain was just going, like a hundred miles an hour trying to figure out what that was about; but I had a really, really warm feeling about it.

I heard a grandmother's voice and she said, "poko anima tawîwîpitihtwâw ayisînôwak—the people need to be swung." I didn't understand it in that time. And it kind of scared me, actually. I immediately went in to my human brain and started to doubt myself and doubt that I heard that and doubt that I saw that. And I just took the next eight months or so and hid myself in a pity pot. I didn't wanna talk about it to anybody, and I didn't really know what to do with it. But it kept coming to me. I kept seeing it. And when I saw it, I had seen an adult in there. Like, the adult was wrapped up like a baby. And I think because I didn't understand the message, it kind of scared me—that I would see that.

I confided in these two women. I made an offering to them to just listen to me. And it was hard for me to do that because one of my teachings when I was growing up was that there were kinds of spiritual experiences that you have, and those are not to be shared publicly—those are sacred experiences between you and your creator. And so, I really struggled with this, "Uh, do I share this? Do I just keep this? Do I try to go about understanding it? Do I try to just ignore it?" And in the end, I decided that I would share it with these two women that I trusted. I offered them tobacco just to sit with me and share with me. When I was sharing, the really neat thing that happened, although it was kind of surprising, was that I just started crying. Like, from a really, really deep place—like from the pit of my stomach. And I was wailing, wailing, crying and trying to tell them the vision I had seen. And I felt behind me were many women, like aunties and grandmothers and mothers—lots of them. And I felt their pain. And I was crying their cries. And when I finally got through telling what I needed to say, the one woman, she came

and held me, and she said, “You have to do that. You have to listen to that grandmother that spoke to you. You have to do what she told you to do. You have to build that big Swing and you have to swing the people.” And she told me this in my language. And I remember when she told me that, I just felt so small. And I remember feeling like someone had put a house on my shoulders. And I thought, “How can I be expected to carry *this*? How can I even begin to be *this*? And where does one go and make a big Swing? And how do the people know to come and swing there?” It’s just like my human brain again kicks in and does self-doubt. I couldn’t comprehend it. I could not make sense of it. And I was also a little bit angry and frustrated because I was a single mom; I was going to university; I was working full time, and I had enough on my plate. And I was young. And I still feel young, and I felt like “this is the work of a grandmother. This is the work of an Elder. This is not my work. This is not my place. And besides, I have no understanding of anything!” So, this is my brain. And I was determined that I was just gonna finish my studies, and then I would get my Masters, and then I would get my PhD and I would be a psychologist and I would have my little shingle outside my door. And I felt like, “That’s my life. I have my life before me, and that’s what I’m gonna do. And I’m not gonna worry about this vision ‘cause that’s just silly.”

And so, I just tried to escape it for about eight months to a year. And then I just kept feeling it and I kept hearing that grandmother. And every time I heard her, it just made me cry. After a while, I felt really tortured by it—that I was not listening to it. I felt really pulled by it, and so I went to an Elder and I asked if this Elder would put me out to fast because I felt that’s what I needed to do; I needed to do a fast, because that was the practise of what I had been taught to do; to sacrifice myself for those things that I want and need and for direction. And so, I did that. And during my fast, I had a really hard time. I’m usually always fasting for four days, and of course struggled through it, but I always made it to the fourth day. And this time, I couldn’t. I came out on my third day. And I remember feeling so guilty about it after I was talking to the Elder and just crying and feeling pitiful and being ego bruised because I couldn’t make it through the four

days. And I had this great thing that I was fasting for. And the Elders said, “You know, it’s a sign. Something’s coming for you and it’s gonna be hard for you to do that.” I never told them about this vision, and so, I kinda felt like, “Okay.” I felt prepared to not have an easy time. So, that was that, and that was seven years ago. And a year later, after I fasted, I just surrendered. Like, during my fast, I surrendered to it. I just said, “Okay. Okay, Creator, I’m not understanding this, if you want me to do some work then help me to understand it, and teach me, and provide me with the teachers that will teach me.” And that’s it. Everything just happened after that.

Darlene met many people as she gathered teachings that would help her work with the Swing. One old woman from Saddle Lake told her about a prophecy that was told to her when she was young:

When she’s old, she will see a generation of young people coming with old medicines, old ceremonies and traditional ways of healing people. That’s what she was told when she was a little girl. And she really believed that this is happening now. She encouraged me to really believe in myself, believe in what I saw and to really carry it and to carry it forward and to not be afraid.

As Darlene continued on her journey, she met another woman from Hobemma. This woman told her the original story of the Swing:

She told me that it was told to her by her great-grandmother when she was a little girl and she said that she must have been about eight or nine when she had been asked by her great-grandmother to go and swing the baby, her little sibling. She said that this was always her job and she was tired of it, and she wanted to go and play outside—not sit inside and swing the baby all the time! So, she was sitting there and she said she was kind of mad at this little baby! And her great-grandmother came into the home and she said to her great-grandmother, “Why do I have to swing the baby? Why do we have the Swing anyway? How did we get

it? How did we think of it?” Her great-grandmother sat down and told her the story. And the story is that back in the time of the old, old camps, the old villages when we lived in teepees, there was a major hunt going on in the camp, and a lot of the men had left the camp to go on this major hunt. And some of the young women had gone as well to go help. And she—this young woman—was left with a lot of babies. She was a young mother herself, and she was nursing her baby. She was left with all the other babies that needed to be nursed! There were a lot of children too. This was going on for days, and she was really tired. At night she was praying, and she started to cry ‘cause she was so tired. She was fretting and crying, and then a spirit appeared to her, a grandmother spirit. This grandmother had a bundle, and she said to the young woman, “Take this and build it for your baby and put your baby in there. If you do that, every time you do, I promise you that I will come and swing the baby for you so that you can do your work.

Darlene heard many stories of how women would put their babies in the Swing and when they returned to the room, the baby would still be swinging, seemingly by itself. She acknowledged that, “The people really believe the legend: the story that the grandmother is there swinging the baby.” And this is how Darlene came to use the traditional Swing in her work.

### **Tina Vincent**

Tina is an Algonquin woman from Barrier Lake First Nation in Rapid Lake, Quebec. Through her father, she also has relations in Kitigan Zibi First Nation. Her spirit name is Weweshish (Chickadee). She explains, “In the teachings of the Chickadee, she’s the one that sings many songs. And I think that represents me well because I speak about the violence against women and children issues to the universities, colleges, and mainstream organizations.” Tina is the Program Coordinator for Oshki Kizis Lodge, a women’s shelter in Ottawa. Previously, she was the Children’s Counsellor, and an Addictions Counsellor for Minwaashin Lodge. She has also worked at Wanaki Treatment Centre. Tina has 24 years experience working as a counsellor.

The interview with Tina took place at Minwaashin Lodge in Ottawa. I arrived a few minutes early and had a look around. Once I met up with Tina, she brought me to meet the Executive Director, as we had established previous contact regarding consent to interview in

their space. As a researcher coming in, I felt welcomed and supported in the work that we were doing. I also felt an element of excitement because in 1995 I lived in Ottawa and sought out counselling and support services for myself. I became involved with the Aboriginal Women's Support Centre, one of the few Aboriginal service organisations in Ottawa at the time. In the following years, the women at the Centre organised and evolved into Minwaashin Lodge, which now provides a wide range of services to support women in their healing. It was wonderful to see how Aboriginal women had responded to their community's needs by creating services that are culturally appropriate and community-based. It was a sure sign of the progress that Indigenous peoples were making in taking an active role in healing their communities.

While working for the Department of Indian and Northern Affairs in the early 1980s, Tina received a call from her First Nation. They were looking for an Education Counsellor. Tina accepted the position and agreed to obtain the proper certification as a counsellor. She held the position for nine years. In her community, once children reached high school age, often 12 years old, they leave the community and go to another reserve to attend high school. While away at school, the children live in foster homes. Tina worked with the kids to help them with the transition, and to adapt to their new environment. She also found foster homes and worked with the foster families and parents in the community. Even though Tina hasn't lived in her community for years, her heart is still very much connected and she returns home often for visits. In recent years, her community has called on her to facilitate psycho-educational pieces on residential school, lateral violence, and violence against women issues. Tina appreciates the opportunity to share what she has learned with her community:

I remember the day when I went out to my community and we were talkin' about the effects of residential school and lateral violence, and the people were just sooooo—*they want to know*. They're just so hungry for knowledge and bringing back traditions, like giveaways and feasts. After I left, I came back home and every morning when I woke up, their faces were there. I could still feel their faces. And I think that's empowering for them. It's empowering for me. I felt so good that I was able to give so little. They want me to come back and do this time and time again. And you know, this little community, they felt really bad because

they couldn't pay me to be there. They didn't have money. And it's not about that, it's about giving back what I've been given.

Tina describes one of the important teachings in Indigenous cultures—that of reciprocity. She talked about the importance of cultural teachings and the Sweat Lodge, and how for her it represented “going back to our beginnings.” She feels that culture plays an important role in her life:

I think for myself, it's something that keeps me grounded. It's something that I share with my people when I go back home, we talk about things like that. We talk about what was taken away and how to come back to it again. I think there's a lot of fear from a lot of Aboriginal people in coming back to that, because it was always seen as something bad by the churches. And I think when women come back and are playing their drums, that is their *power*. And when they find their voices—there's nothing that is going to stop a woman when she has her *voice*.

In 1988, Tina received her counselling education through the Ontario Native Counsellors Training Program at Laurentian University:

It was the first time that we ever really did training around residential schools. It was really the first time that people were starting to speak about residential schools. Although, I knew about them, my mom and dad went to residential school. So, we knew about it and never talked about what we knew. We took specific training; it was *The Spirit of the Family*. It was almost like the pages in history were beginning to open and people talked about what went on and how incredibly devastating that period was in our lives and in our history.

Tina has developed a worldview that has helped her understand what is needed to work with Indigenous peoples:

In looking at worldviews, people who work with our people need to get culturally competent. How can you work with someone if you don't know their history? My community has been chock full of non-Indigenous social workers who have come and gone over the years. I think the intentions are good, but when you come armed only with a diploma, you're not going to last long.

### **Janice St. Germaine**

Janice is an Anishinaabe woman from Wasauksing First Nation, in Ontario. Her Anishinaabe name is Neebwekegigdo-kwe (Someone who speaks for many). She is Whaubishishee Dodem (Marten Clan), and is second degree Midewiwin<sup>5</sup>. Janice is a social worker, and is the Concurrent Disorders Case Manager for the Outreach Mental Health Team at Enaahitig Healing Lodge and Learning Centre, in Ontario. Janice is currently completing her Master's in Social Work at Laurentian University. She acknowledges that "we have to constantly educate."

The interview with Janice took place at her office in Orillia. Upon my arrival, she gave me a tour of the building and introduced me to some of her co-workers who were sitting in a circle about to begin a case management meeting. It was great to meet some of the agency staff; and I started to have the feeling that this research was connected to a much larger spirit, the spirit of working together.

Prior to entering the field of social work, Janice worked in politics with the Union of Ontario Indians. There she became involved in a wide range of issues including: policing, social work, welfare, child welfare and land issues. Janice felt that she could relate to these issues because she was born and raised in Toronto. Her parents took their family away from the Reserve because they didn't like the experience they had when they were there. They wanted a better life for their children. When Janice married, she moved to the Reserve of her husband, which was also her mother's Reserve. She appreciated being close to her grandmother and aunt. She shares how it was for her children to experience Reserve life, "They could go anywhere. They played outside and picked berries, and they could walk up to my grandmother's. When I lived in the city with them, I always had to stay near by." Janice appreciated that her children

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<sup>5</sup> The Midewiwin Society is a Medicine Society of the Anishinaabe.

became part of a wider community of aunties and uncles, including “people we adopted as aunties and uncles.”

Janice balanced Anishinaabe teachings with the social work knowledge that she obtained through her post-secondary education:

I went to school to do the Bachelor of Social Work shortly after my daughter passed away. I wanted to change my life. I wanted to do something different. I no longer wanted to be in policy or doing analysis, and I wanted to talk about the good things I had learnt. I chose social work, because it seemed to be what I wanted to do. When I got into the program, I really emphasized a lot of the teachings. I wanted to give my clients some sort of protection, some understanding that “yes, I have [traditional] teachings, but I also can adapt, and I’m going to come with some other knowledge and some credibility.”

Janice graduated from the Native Human Services program at Laurentian University. This program contained a cultural component, and Janice had the opportunity to continue her cultural learning. Janice embraces a teaching that she learned from Anishinaabe Elder and educator Jim Dumont:

He talked about *spirit* and how important our spirit is and how it’s our spirit who coddles us or motivates us to do things. And to help us listen to our spirit, we need our spirit name. So, I heard that, and I understood a lot clearer why my children really wanted their spirit names.

When working with clients, Janice feels that the Stages of Life Teaching really helps her in her practise:

The first Stage is a *good life*, the next one is a *fast life*. I like to draw parallels. Sometimes we can look at some of the good things, and sometimes we look at some of the bad things that have happened. And then I like to move onto the



*wandering years*, then onto the *doing*, the *planting* and what they call “Truth life,” and then onto *Elderhood*. And past that, there’s an additional stage about the days that you *move on* and walk towards the Spirit World, what kind of challenges you’ll be encountering. I like people to think about that maybe they were *wandering around*, and that’s what they were doing. And it’s okay to just stop wandering, it’s okay to look for a teacher because that’s what you’re doing. Your spirit’s talking to you, and your spirit’s asking you to do this.”

Traditional teachings may be learned and experienced in different ways. Sometimes when people have been distanced from cultural learning, they may not be able to immediately recognise when cultural values and knowledge are part of their lives:

Sometimes I meet people and they don’t think that they live much with traditional teachings, and I like to show them that we do. That they are deep in that; some people call it *blood memory*, some people call it *heart memory*. And I like to see the light come on. I like them to see the kindness and love that are in those teachings.

Janice employs the values of respect when working in Indigenous communities, recognising that there are different Nations and different teachings:

The Midewiwin teachings really guide me in my practise. I know that not everybody *wants to be Midewiwin*, I respect that. And not everybody *is* Midewiwin. I do have some clients that are Haudenosaunee, Cree, and Lakota Sioux. It’s all about respect. We’re talking to the same Creator, we just use different ways of getting there.

Janice describes some of the challenges that she has had working in a non-Indigenous mental health agency:

I wasn't allowed to refer clients to Elders. It had to do with liability issues for the agency, nothing to do with me as a worker or the practise of sending somebody to an Elder. They hadn't ever heard of that. I wasn't able to send people to Sweats because I didn't want to have to deal with the liability. That's why I left that agency, 'cause I had such a hard time banging my head against the wall. I was disappointed because then you can't see in those notes or you can't see in that practise that talking to an Elder is a good thing for people. Or that attending a Sweat is a good thing for somebody or participating in a Fast helps bring people to balance.

The worldviews that she has developed have prepared her to work with clients in a kind and compassionate way:

I think my worldviews help me be more open, help me be more kind and loving. I meet some really interesting people. I work with clients who are diagnosed with schizophrenia. I walk into some not-so-great living conditions, but I think that all helps me be kind and non-judgmental. And it also helps me be open to somebody who might be diagnosed with schizophrenia and I can recognise that there is a place for this person in our Stages of Life, on our life path, and in the Universe.

She further explains:

I think my worldviews help me know that people have spirit, and my mind is open to dreams. They don't scare me. I might have to go and have the dreams interpreted. And I always ask the person I'm working with "Can I take semaa (tobacco) to somebody and talk [about the dream]?" I also ask them to come with me. So, I think my worldviews help me be a better worker, help me be more loving, more kind, more respectful, and sometimes brave because sometimes you walk into some interesting situations.

## **Gilbert Smith**

Gilbert is Anishinaabe from Naicatchewenin (North West Bay) First Nation in Northwestern Ontario. He considers himself a helper (wiidokaazowin), and is a Cultural Therapist with the Treatment Foster Care Program at Weechi-it-te-win Family Services, in Fort Frances, Ontario. Gilbert was named after the Thunderbeings; and his Anishinaabe name is Baabijigo-neyaash. He is from the Atik Dodem (Caribou Clan). Gilbert has worked in many areas including: the education system, courthouse, probation services, child welfare, mental health, and at the Health Access Centre. He is often called upon to provide cultural and ceremonial support in many communities. The morning of the interview, Gilbert received a request to attend an emergency community meeting as a community Elder. We held the interview during his lunch break at the Venture Inn in Fort Frances.

Gilbert was raised in his community by his parents who were “firm believers in who they are as Anishinaabe people.” His mother became a member of the Midewiwin Society shortly after she was born, and that’s the way she lived until the end of her time. Although his father was not a member of the Midewiwin, he supported her in that way. Gilbert’s father was strong in his beliefs. He was a singer and a member of the community’s traditional drum. He was also gifted and received songs from the Spirit World. He was a woodsman, hunter, trapper and guide; and his family lived off the land. “We always had lots of food: wild meat, deer meat, moose meat, muskrats, fish and wildrice. And I remember having that through the winter—we never ran out.”

Gilbert lived with the traditional values inherent in Anishinaabe societies. When he was just three years old, he remembers his dad shooting a bear. Bear were scarce at that time and would usually take off if they saw people. The bear was seen from a distance, and his father was a good hunter so was able to shoot the bear. Gilbert’s family shared the meat from the bear with the community:

At that time, when someone killed something, like a moose, or deer or anything, they shared that. If someone caught a whole bunch of fish they shared that with other people. And that’s what he did with this bear. The community came together to clean it and cut it up. They didn’t waste anything. I remember seeing

that they used every single thing, even the paws, the ceremonial people collected those.

From a young age, Gilbert was immersed in Anishinaabe culture. His family life included nine siblings. Even though his older sisters were sent to Residential School as young girls in the 1950s, his mom and dad didn't change their ways:

As far back as I can remember, I can't remember seeing a Bible in the house as I was growing up. But they respected that, 'cause I often heard them say that was *their* way—our way wasn't the only way. And that's what I learnt from them. So, to this day, that's the way I work as a helper—my way's not the only way.

Gilbert went to Residential School for one year when he was 14-years-old. But that didn't change his belief system because he already had his culture from a young age. "I'm sorry I left and didn't finish my education. A lot of times I talk about my lack of education. But now I tell people to 'go to school, finish your education, it's important.'" Fortunately, Gilbert was able to earn many certificates through professional development training that was provided in the various fields he was employed in. He particularly valued the Life Skills training. He is also an Anishinaabe language speaker and is never ashamed to speak it anywhere. When asked to speak at an invocation [with non-Indigenous peoples], he first speaks in his language and then tells the audience in English what he had just said.

Gilbert shared some stories of how he had learned to work in Indigenous communities. In many ways he felt that he was tested along the way and that some of the tests that he passed were not easy. And even though he hadn't been formally trained, the root of his education has been in his lived experiences.

Gilbert and his wife have 23 grandchildren, and also a grandson that they lost when he was one-years-old. He shared how he learned so much from the immense grief that came from losing this grandson. He told people that he wanted to "stop doing ceremonies and singing. Just wanted to live life." But people came to him and said "Oh, Gilbert, you can't do that, we know how much you're hurting, but every one of us goes through that." Gilbert acknowledged their

words, “It started makin’ sense, what they were saying. Even though I knew that already, but when you’re hurting, you don’t use the skills that you carry with you because a loss is so powerful.” One day Gilbert went out to the woods, as he often did:

It was in the wintertime, around February, and I was crying. I came across this beautiful bird, the most beautiful bird I ever seen in my life. Nice colours. I saw it fly right in front of me. It stopped, it landed right where I was going. And I stopped and it was just kinda lookin’ at me. And I started thinkin’ about my grandson, and I was thinkin’ “Could that be my grandson?” I started thinking, “Yeah, it is him. It is him.” And then I started feeling good. And I started hearing a tiny little voice, “Grandpa, you gotta keep on. You’re gonna become a better man.” That’s what he told me. And I just cried, when I heard that. In the meantime that bird flew away, and ohhh, this beautiful noise as it flew away to the south. And that taught me a lot. That message that I heard from my own grandson, that I’m gonna become a better man, and that’s when I thought, “I’m gonna have to change my ways and listen more, and work with people with respect and help people in any way that I can”. So, that’s what I’m doing now.

After the interview process, Gilbert said that he wanted to show me the Sweat Lodge that they built in his community. On the morning of my last day in the area, I drove out to Naicatchewenin First Nation. I had been there a couple of times over the years for powwows and ceremonies, since my community was nearby. We met at his house and then drove around the community in his truck and talked more about our lives and connections. Because we are from the same territory, Gilbert has been connected to my family for many years; and in fact he officiated my grandma’s funeral in May 2007. At the end of a dirt road was the Sweat Lodge, in an open area beside the lake. The water was calm and there was a peaceful feeling in the air as we walked around the land. It was an honour to visit the healing place that has helped so many people.

### **Janice Linklater<sup>6</sup>**

Janice is an Anishinaabekwe (Anishinaabe woman), and a member of Couchiching First Nation in Northwestern Ontario. Through her “Uncle Walter” she learned that “you’re born with four things: your name, your colours, your Dodem (Clan) and your Nation.” She has internalized these teachings and that is how she identifies. Her name in the Cree language is Aski-kanipawit (Standing on the Earth), her colours are purple and white, she is from the Atik Dodem (Caribou Clan), and the Anishinaabe Nation. Janice is the Aboriginal Resource Officer in Victims Services for the Saskatoon Police Services. She is also a Resident Counsellor at Tamara’s House, which provides support services to women who have experienced child sexual abuse. Previously, she was an Assessment Consultant conducting psychological testing with kids in the school system. Janice is a provisional psychologist.

The interview with Janice took place at her office in Saskatoon. It was a quiet Sunday morning. We were not able to smudge inside the Police Services building, so we went outside the back door to use our medicines. I couldn’t help but think that Janice’s job must be difficult, as it was fairly recent that the Stonechild Inquiry occurred. This Inquiry exposed how the Saskatoon Police Services had regularly dropped off Aboriginal men in sub-zero weather outside the city limits. There were no convictions in the Stonechild case, or in relation to the other Aboriginal men who were found frozen to death on the edge of town; however, two officers were convicted of unlawful confinement when Darrell Night stepped forward claiming Saskatoon Police officers had also dropped him off outside city limits in January 2000. In the past few years, there have been concerted efforts in response to the Inquiry and the existing tensions between Police Services and First Nations communities surrounding Saskatoon. Fortunately, relations have improved through community working groups and positions such as the one that Janice holds in Victims Services.

Janice began the interview by sharing that she grew up with her family in Ottawa. “All my life I’ve known that I was not White. When we were little, we were always told who we were and where we were from. In my social time, we used to hang around with the Indian kids.” Janice has worked in both mainstream and Indigenous organizations. “I’ve spent a lot of time

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<sup>6</sup> Janice and I are cousins; our grandfathers were brothers.

having to navigate the two different ways, and after I went back to school, that's when I really became aware of the difficulties of that navigation."

When Janice was 16, her dad took her to a Sweat Lodge for the first time. Over the years, she has participated in many ceremonies, including fasting and the Sundance. She feels that participating in ceremonies has helped her to "have understanding and compassion for people." Janice also thinks, "it gives me more of an insight and strength to deal with what people are dealing with. And it's been helpful with the issues that have come forward in my practise and in my work." She also feels that it is about "looking after yourself" in order to help guide people on their journeys:

I can't walk their journeys for them, they have to do that themselves. But I can walk with them along the way, and because of who I am and where I'm from and what I do and how I live my life, I can help them or be with them or provide them some kind of assistance.

Education was very important in Janice's family. "When I was a little girl growing up, my dad told us that we 'had to finish school.' There was no way that we were gonna leave home without at least having our grade 12." Janice completed Grade 12 and then went off to university when she was 18 years old. "But it didn't go over too well. I just left home and was more concerned with partying and goofin' around. So then I went to work for a little while." She then completed two secretarial diplomas, and over a 10-year period, worked her way up in the City's Human Resource Department and got as far as she could; but she always wanted to go back to university:

And all those years, I always wanted to go back to university. And because I had bombed out that one year, I thought, "Oh, yeah, nobody will take me." And my dad used to say that, too, "Oh, you screwed up, nobody's gonna take you." Finally, one day I thought, "Well, he doesn't know! Like, how does he know? I'm older now. I have all this experience. I've gone back, and I did those two diplomas."

Janice eventually enrolled and completed an undergraduate degree in sociology, Aboriginal justice and criminology, with a minor in women's and gender studies. She reflected on the discouraging comments that her father made when she wanted to go back to university, even though she acknowledged "I never held it against him that he said that—I just let it prevent me from moving forward for a while." Fortunately, in more recent years, Janice was able to talk about this with him, and it resulted in an important healing experience:

A couple of years ago me and my dad talked a lot about that and he apologised to me; he said "Oh, I'm sorry I said that." I don't know if he knew that he was going to be leaving this world soon when he said that...I think that he really put a lot of peace in his world before he left and that was one of the ways. It made a *huge* difference to me; to know that I was able to share with him how I felt and he just came out and said, "I'm sorry." No excuses, no nothing.

Janice then worked in the school system, counselling children. Even though she connected with the kids and they liked her, she didn't feel confident counselling children without formal training so she completed a Masters in counselling psychology. Her graduate program did not have any courses that were based on Indigenous perspectives, but it did have a course on Cultural Diversity. However, she felt that it was "geared towards White people working with other races or other cultural beliefs; and it was inadequate for me because I'm not a White woman. So, it's still Eurocentric." Fortunately, she was able to use her thesis as an opportunity to work within an Indigenous context.

In understanding how her worldviews has prepared her to work with Indigenous peoples, Janice asserts:

I never make the assumption that all Indigenous people follow the "Red Road," the cultural ways, our teachings, listening to Elders, following ceremonies, going to Sweats. It's more spiritual then religious. I can't always assume that Indigenous



people follow our spiritual way. Some of them follow their religion—like Christianity. I have to be really aware of that all the time and be respectful of that because that's part of our teachings—to be respectful of other peoples' belief systems.

Janice commented on the research project title, and made a connection between colonisation and Indigenous worldviews:

I looked at the title 'Decolonising Trauma Work,' and I think as Indigenous people we have our own trauma. And the colonisation aspect is so deep within Indigenous peoples and Indigenous communities that it's a long, hard road out of there. I work for Police Service and I used to work investigating complaints against the police as well; and everybody's answer to the problems between police and Indigenous peoples in the community was to hire more Indigenous cops, right? That was their answer. I don't know whether anybody's ever listened to me or not, but I always say, "No, that's not the answer. The answer is you have to hire Indigenous people that have been discriminated against, who have experienced racism, they have to know who they are and where they came from, and they have to understand Treaties and what they mean and the spirit and intent of those Treaties for those Indigenous people to make any kind of difference in that setting." And that's only one example, in the Police Service. But I think you can probably put that out into any profession. Until people have those understandings and have those experiences, they're gonna stay colonised.

### **Yvon Lamarche**

Yvon is a Métis person with an Anishinaabe background and Wendat, Scottish and French ancestry. He is a Registered Nurse, with post-graduate training in psychiatric nursing. Yvon considers himself a *skebewis* (helper), and uses his nursing knowledge, theory, and skills in the work that he does. Yvon has an extensive background working in Aboriginal agencies and organisations, as well as in mainstream agencies, addiction treatment programs and psychiatric

institutions. As an Aboriginal person, he possesses the knowledge and experience of having “one foot in addictionology and one foot in mental health.”

The interview with Yvon took place at his residence in Waubeshene, Ontario. We sat at his kitchen table, drank lemonade, and dialogued for a few hours. I appreciated the invitation into his home and felt that it brought forward a deeper connection to family and community. As we began the interview, a crow joined us from her position on a nearby tree. Later that evening, I checked the digital recorder for his interview and realised that it had not recorded because I had turned on the microphone’s mute button. I shook my head and sighed; surrendering to the fact that every researcher has a tragic story! Fortunately, I was skeptical of these new digital recording devices and used an old-style tape recorder at the same time; so I had recorded about half of the interview. Even more fortunately, Yvon was generous with his Spirit and his time and agreed to let me re-interview him on the lost stories and strategies. I felt that the increased time that it took to complete the interview was a blessing in disguise, as it provided the opportunity to strengthen the relationship building aspect of Indigenous research. By the time we had completed the interview process, I had visited him at his home a few times, shared a couple dinners in restaurants, and spent time with his wife and two sons.

Yvon was raised in a Métis family of eight. In terms of his cultural teachings, he shares, “I’m probably more familiar with Anishinaabe teachings than I am with Longhouse teachings, familiar in the sense of actually living it. I’m familiar with Christian teachings, but I’d never consider myself a Christian.” Given that Yvon has been involved in a number of Aboriginal community organisations, he explains, “I’ve had the opportunity of learning from traditional Elders, healers, resource people just by virtue of my work;” which he found was “certainly instrumental in terms of helping me to understand the work that we do.” Additionally, he shares, “The ethics that I was raised with were *you do what needs to be done to take care of the people.*”

Yvon graduated from Georgian College in 1981. He then went on to do post-graduate training in psychiatric nursing, and also clinical supervision and staff management. Additionally, he completed the *Training of Trainers Program* with the Nechi Training, Research and Health Promotions Institute, which offers specialized training to addictions counsellors working in Aboriginal communities. His Western education has helped to shape his practise with a theoretical framework. Yvon incorporates the perspectives from the work of “Carl Rogers, which

is *humanistic psychology*, and it talks about genuineness and empathy and all of those good humanistic qualities that we take for granted in our Anishinaabe world.” Yvon also draws on conventional psychotherapeutic methods to inform his practise:

I also function from a framework that comes from *reality therapy*; it talks about supporting people to be more responsible, not pathologising everything. So, some *cognitive behaviouralism* in all of that. I’ve had some influence in the past from Gestalt therapy which looks at existentialism a bit more, not completely embracing the whole notion of spirit.

Yvon brings together knowledge that he has gathered from his education and experience working in Aboriginal communities. He acknowledges that “*Spirit* comes from experiences with Elders, and my earlier experiences with the church.” He recalls:

[An Elder] taught me some stuff way back when, and part of what she taught me was understanding about the presence of Spirit, and that whenever you do anything that makes your Spirit vulnerable, like poisoning yourself, or being in the presence of violence, that your Spirit becomes weak and able to be influenced by other Spirits, and sometimes those Spirits present themselves in human form.

While working at an Aboriginal healing agency, Yvon had the opportunity to participate in a community capacity building project. The province of Ontario had established nine Mental Health Implementation Task Forces. Only one of the Task Forces had an Aboriginal subcommittee and Yvon was part of this group. They submitted a report to the Task Force that articulated what they believed mental health *is* and what was needed in order to achieve that:

We came up with a plan, a community design, which included the need for healthy families, the need for frontline workers, the need for a community facilitation team, which basically is a multi-disciplinary community of Aboriginal people. And also the need for an Aboriginal residential treatment program, aka an

Aboriginal psycho-social rehab program. [An important feature] is that there would be a fluidness between the community facilitation team or the Aboriginal multi-disciplinary team and the residential program so that the community members accessing the services are accessing the other services at the same time, which doesn't happen in the mainstream world....Another way of looking at it is the de-psychiatrising of people.

The work of the subcommittee resulted in the implementation of a pilot project, which eventually evolved into an Aboriginal community mental health service, which began with a staff of three. "It was really good for us because it was one of those rare opportunities where you actually got to do culture-based development rather than taking something *White* and making it as *Indian* as possible."

In regards to worldviews, Yvon has had life experiences that have informed his practise and enable him to have insight into the human journey:

I'm actively engaged in the process of healing, recovery, rehabilitating, and treating issues that I have to struggle with on my own. I was orphaned at a young age. So, I've been on my own since I was fifteen. And that has helped me to develop a worldview in terms of being *desperate*. It taught me a lot about the generosity of the human spirit.

Additionally informing his practise are "people that I've come into contact who are on their own healing journeys or *journeys to destruction*... There's been a few people that I've lost along the way, and, you learn a lot about that as well."

### **Sylvia Marcos**

Sylvia lives in Cuernavaca, Mexico. She received her Indigenous roots through her grandmother, who was Tlaxcaltec and part of the Nahuatl speaking people of Central Mexico. She is a trained clinical psychologist and has held many academic positions, including a post-doctoral fellowship at Harvard University. Sylvia is a professor, researcher, and has published

eight books. She has researched the ways Indigenous peoples think and how they construct and perceive their world:

In the last 25 years, I have been using my clinical training to listen, to listen carefully to Indigenous epistemological issues. I have systematised what I could learn simply by listening and trying to find another coherence for grasping the world—that is not of the western philosophical traditions.

The interview with Sylvia took place at the School of Religion, Claremont Graduate University in California where she was a visiting faculty member. We began our session outside in the courtyard where we smudged with medicine and grounded ourselves in a territory that we were both visiting. We held the interview inside the building in an office that was provided for our use. I had first met Sylvia the year before in Malibu, California; we both attended an international event coordinated by the Spirituality and Education Network. I was delighted to be reunited with her again.

Indigenous identity in Mexico is constructed differently than in other parts of North America. In Mexico, *Indigenous* is defined by being “contained to a community.” There has also been an element of discrimination, and an understanding that if one wanted to achieve “upward mobility,” then Indigenous traditions had to be kept a secret. “If you go and live a mestizo life, mixed-blood life, and you go to university and get degrees and are not so poor, you would not be considered Indigenous anymore. This is because everyone could be Indigenous in Mexico.”<sup>7</sup> Sylvia does not want to appear as profiting or privileging from an Indigenous identity, as there are some more recent benefits and financial support for Indigenous peoples. She respects those that live in their communities and have maintained their language and way of life. Nevertheless, she favourably recalls the cultural revival that inspired many to recognise their Indigenous roots. “Not long ago when the Zapatistas emerged there was a demonstration in the streets where people were shouting ‘todos somos Indios’ (we are all Indigenous). These people were in the

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<sup>7</sup> The Mexico Demographic Profile 2008 reported ethnic demographics: Mestizo (Amerindian-Spanish) 60%, Amerindian or predominantly Amerindian 30%, White 9%, Other 1%.

streets of Mexico City.” Sylvia loved Zapatismo because he appeared very publicly, and because of his political movement, it became more acceptable to express an Indigenous identity.

Growing up in Mexico provided Sylvia with a vibrant cultural environment. She notes her cultural connection as “the soil in which I was standing.” She feels that her direct experience has helped her believe in “the possibilities of this kind of therapy.” And despite the influence of colonialism, Indigenous traditions were widely available:

My mother used to do many rituals at home. Mexicans often have an altar full of Catholic images, but they are really a cover up for other ancestral spiritual beliefs; this concealing attitude started in colonial times. Today you have the Virgin of Guadalupe, she is like the religious symbol of Mexico. Everyone will have an altar with the Virgin of Guadalupe at home and do some rituals of cleansings and devotions and prayers—and my mother had all of that. She was a strong believer and she would get healed with healers. So this influenced me very much.

Sylvia completed a master’s degree in social psychology from the University of Puebla. The University was in the early stages of creating the department and brought together many disciplines to educate the students:

They gathered a psychiatrist, a neurologist, a pharmacologist, a Jungian, a Freudian, and a behaviourist; so we had everything. I had pharmacology, neurology, neuropsychiatry, psychiatry, behaviourism, a Freudian psychoanalysis and a Jungian psychoanalysis—and I got trained in all of those. So I really had to fashion my own methods, because it was too many frames of reference.

It was during this period of study that Sylvia was introduced to antipsychiatry, “I had one professor who was a psychiatrist, and read very much about antipsychiatry. He was very sympathetic to antipsychiatry.” She soon discovered that as a clinical psychologist, the main training from clinical practise is to *learn to listen*. “You are hearing in multiple levels, because you have to see what is inside this person or where it is anguishing or pushing or creating

conflict. So you have to listen very seriously to whatever the person tells you.” In her training as a clinical psychologist, she worked in psychiatric wards. And through that experience, Sylvia became very critical of psychiatry and clinical psychology:

I was the representative of the antipsychiatry movement in Mexico and in Latin America for a time. And as representative of this anti-psychiatry movement my voice was always bringing the wisdom of the ancient Indigenous traditions to heal mental illness. We antipsychiatrists call it *suffering, psychic suffering*. We try to define it not with psychiatric terms. I was founder and part of this international network for many years, and really my contribution was to speak or to systematise in which sense Indigenous communities have a better therapeutic response to mental illness; a better response than psychiatry.

During the 1970s and 1980s, Sylvia travelled to Europe and spent time with well-known anti-psychiatrists: Ronald Laing, David Cooper, Franco Basaglia and Felix Guattari. Sylvia lived in Ronald Laing’s *therapeutic communities* in London, England; and this is where she started to learn this *new way* of treating “illness.” She also worked in Italy with Franco Basaglia. He opened up the psychiatric hospitals, removed segregation, and made it possible for the patients to leave the hospitals and participate in community events.

The relationships that Sylvia developed with those in the antipsychiatry movement helped her greatly in the work that she would later do throughout the Americas:

David Cooper was my colleague and personal friend. He was really very close to me. His method with people that were having trouble was also very different from what every psychiatrist does. He was doing very direct interaction with the people and I guess I learnt that from him. He was much older than me so he was like a mentor.

Sylvia returned to Mexico and created a therapeutic community that was based on Indigenous philosophies of community cohesion: *Procesos de Accion Comunitaria* (Processes

of Community Action). This project is discussed further in Chapter Seven. At this time, there was a large anti-psychiatry movement in Latin America. They wanted to have an alternative to the psychiatric hospitals. She was called to different countries to share how they had organised the therapeutic community. “I travelled around in Brazil and some other countries in Latin America and some cities in the United States. I trained locals. Many other psychiatrists and people in our network wanted to learn how we did it in Mexico.”

Sylvia completed a doctoral degree in Latin American studies, which included anthropology. She held a post-doctoral fellowship with the Women and Religions Program at Harvard Divinity, teaching on analysing the capacities of women healers. She made the distinction that her methods viewed “healing *not as* coming from psychiatry and clinical psychology, but looking at it from the anthropological and historical point of view in ancient and contemporary Mexico.”

In terms of worldviews, Sylvia feels that her Indigenous roots have inspired her to dedicate her whole life to studying Indigenous traditions and knowledges. Through her relationship with her grandmother, she had access to Indigenous ways in Mexico. “Grandmothers are very strong in our ancestry I have found. For me as a woman, this grandmother has been a great guide for my interest in academic life with an Indigenous focus.” Sylvia’s grandmother was a valued person, “I guess she was the woman that knew more in her town. She was like the wise person, the knowledgeable person.”

Sylvia’s Indigenous worldviews complemented her academic training and she was able to form an understanding of how to practise as an Indigenous healthcare practitioner, as well as an academic:

I was trained very well on how to do therapy and I learnt that you have to listen carefully. So then I got all these bits and pieces of this belief system. You can say it’s a system, but some people don’t like the word but it is a series of beliefs that structure *who you are* and this is what cosmology is. It is a structure of beliefs that teach you: what is the sun, what is the moon, who you are, and how you are interconnected to earth and the cycles of nature. So I was listening to this cosmology through the healers, or through the people themselves.



Sylvia further explains her experience of growing up in Mexico, where Indigenous traditions were not as deeply oppressed as they were in Canada and the United States where Christian residential schools and government legislation outlawed the practise of Indigenous cultures:

Maybe this is one of the reasons that people keep their own synthesis. They make a hybrid between what they have in their tradition and what they pick up from the contemporary modern world or education. Anyway, it's a different way of growing up. Synthesising all of that without having to silence it.

### **Carrie Johnson**

Carrie is Dakota Sioux. Her family is originally from Spirit Lake in North Dakota. Her maternal grandparents followed Sitting Bull into Canada during the Battle of Little Big Horn in 1876; however, they later returned to their Reservation in the United States. Carrie's mom stayed in Canada and raised her family in Saskatchewan. Carrie's father is Scottish. She is a psychologist and the Director of Seven Generations-United American Indian Involvement, a mental health program in Los Angeles, California.

The interview with Carrie took place at her office. I first walked around the building, which housed different programs and services. It reminded me of the Friendship Centres that exist across Canada. I was welcomed by many smiles and nods, which always makes a newcomer feel comfortable.

Carrie began the interview by sharing that she grew up in an Indigenous community and had the opportunity to attend different ceremonies over the years. She also experienced the intergenerational trauma that is common in many Indigenous families.

When Carrie was looking for a degree program in counselling, she could not find any program in Canada with a focus on multicultural psychology. Twenty years ago "it was all mainstream psychology, and I wanted to work with American Indians. I wanted to look more at the cultural community aspects." She was able find a multicultural community psychology program at the California School of Professional Psychology, "My academics focused more on American Indians and got to look at the cultural aspects. It was just wonderful in terms of

looking at psychology, instead of mainstream, it was more with a cultural aspect to it.” Carrie completed her dissertation on “identity and stress, and its effects on depression.”

After graduating from her psychology program, Carrie worked at Sherman Oaks Indian High School in Riverside California. This school was a residential boarding school for 600 American Indian youth from across the United States. She worked there for three years, and found it quite challenging, but fun at the same time. For the past nine years she has been working with Seven Generations, and focussing on expanding programs and services. She often draws on her graduate education, as she had the opportunity to begin looking at *historical trauma* and the cultural experiences of American Indians:

I always base all of our services on looking at the effects of historical trauma and so we try to incorporate or teach, and make sure everybody assesses in terms of what happened *historically* to families that we meet. Because residential boarding schools wasn't something that happened a long time ago, it was something that was quite recent.

From her experiences, she has come to understand that it is important to ask clients, if they “attended residential school? Did their grandparents? And what are some of their experiences *historically* that they think is continuing to impact them now.”

Carrie also draws on *genograms* to work with people in terms of understanding what happened to their tribe, their people, their community, and their families. This helps the client understand the cycle that exists within their family:

I call it an American Indian genogram that I use because we identify the client. For example, I had this 16-year-old client and we looked at how she started drinking when she was about 12-years-old, and her siblings as well. She had been in and out of treatment centres several times and then with a genogram we looked at her parents, her aunts and uncles. We look at the stressors, the traumas, as well

as the alcoholism, depression, suicides, car accidents, who went to residential school; we would look at her grandparents and she could just see that coming down from generation-to-generation. And then we also go further to see what happened to their tribe, historically.

Carrie worked with this client and supported her to search out the “cultural values that were lost and how can she go back and get those important cultural values and stories” and use them to help in her healing. Carrie expressed that what was taken away “has been replaced with a lot of imbalance and disharmony that came into the family.”

In terms of worldviews, Carrie draws on her life experience, education and knowledge gained from working with American Indians:

My view is that a lot of what we are dealing with today is because of the historical trauma of what happened. That’s how I view what happen to many Indigenous people and we have to really go back to that and heal from that in order for us to continue healing now and for our future generations. We need to talk about it and acknowledge what happened to our family and how it’s impacting us. So that is where my worldview is—really in the historical trauma.

### **Ed Connors**

Ed is Mohawk from the Wolf Clan and a member of Kahnawake Mohawk Territory. His mother is Mohawk and his father is Irish. He was given a Cree Spirit name by one of his Elder teachers, Wabnung benasi kabe twe e tung, which translates roughly into English as “Eastern Thunderbird Sounding or Eastern Thunderbird Coming.” Ed has worked in First Nations communities across Canada and in the United States for 25 years. He is a member of the Elder’s Council for Enaahdig Healing Lodge and Learning Centre and is an Elder Advisor on the Board of Directors for the Native Mental Health Association of Canada. Ed provides support and consulting services to many communities through Onkwatenro'shón:'a Health Planners, a Mohawk name his mother gave to his work many years before which translates into English as “best of friends.” Ed continues to see clients through his private practise as a psychologist.

The interview took place at his residence in Orillia, Ontario. Shortly after I arrived we went outside to his back yard where there was a very beautiful area with a pond, trees and a gazebo. Ed motioned for me to go inside the gazebo. There was a circle of patio chairs and couches. In the centre was a table with sacred medicines and items. We sat down and I offered him tobacco. He thanked me and told me that he was going to put it in the fire. He proceeded outside the gazebo and lit the fire that burned during the time we spent together. We sat and shared stories about our lives and ourselves. We discovered that we had many connections. This affirmed to me that the interview process was very much about relationship building. After a couple of hours we turned on the recorder and began the interview. Ed first shared how my research had come at very interesting time. “I’m now in my 55<sup>th</sup> year, which is the beginning of Elder years and am beginning to slow down.” He also shared that he was “in a time of reflection, and was reflecting on many of the things that [I was] asking.” I commented on how nice it was to smell the fire. Ed shared that he was reading a book called *Finding Your Place by the Fire* and one of the things that the authors wrote about was that people need to *sit by the fire and share their stories*, so that is why he wanted to light the fire.

Ed feels that his life and understandings of the world are shaped by both his cultural locations—Mohawk and Irish:

Having been raised with both and then having to understand myself because I was informed by both—I am of both. And ultimately, in order to become a *healthier full person*, I had to learn to integrate those two in a good way. I had to learn to be able to understand both of my cultural backgrounds—how they informed me in my life and how they informed me of who I am. I’ve seen a lot of people in my life that have struggled with finding that balance because they have only been able to accept a part of themselves. And in a way, because they only accepted a part of themselves, they were rejecting another part. And in rejecting that other part, they weren’t healthy. They struggled because you can’t live *in my mind* in a healthy way by rejecting part of who you are.

Ed grew up off Reserve, and his Reserve experiences were “mostly to go home to weddings and funerals, and summers I’d spend with my grandparents.” Because of the limited

involvement with his community, he felt that the cultural teachings were limited during his childhood years. The cultural teachings that he did receive initially came through his family, and by how he was raised by his mother; although he did not recognise this as a cultural teaching until he was in graduate school. “I started to reflect more on *who I was* and *how I came to think the way I did*.” That is when he realised there was a difference in the way that he was raised by his mother verses his father. “They had different approaches to child rearing and different ways of thinking.”

Ed received his undergraduate degree in psychology from McMaster University. He completed his doctorate in counselling psychology from the University of Toronto during the late 1970s and early 1980s. In his training as a family therapist, Ed was introduced to *systems theory* and *wholistic thinking*:

I was doing it quite intuitively. And yet, I noticed other students struggled with it. And one of the things I realized was that I had *learned differently*. I had been introduced to a different way of thinking about how people relate, how they communicate with each other. Then I focussed on relationships, and I focussed on patterns of relationships. I’d been taught to do that as I was raised. [That way of thinking] primarily came from my mother.

When Ed was a student, he became involved with the Native Canadian Centre in Toronto. It was there he met Elder Joe Sylvester who began to teach him about the teachings of the Ojibway people; “He started with the Creation Story, and he started to tell me the teachings. I didn’t really ask too much, I just mostly listened.” By spending time with this Elder, Ed was able to “find what I needed to find—which was finding myself.” He also experienced his own healing and growth, and sought to understand better *how the Elder was able to help him*. Ed wanted to explore this more and made the decision that he wasn’t going to work in an urban area; and he decided to leave Toronto and accept a position as a psychologist in Northwestern Ontario.

Throughout the 1980s and early 1990s, Ed worked in various mental health agencies and First Nations communities throughout Northwestern Ontario, Manitoba, Saskatchewan, and Alberta. It was during the time when cultural ceremonies were becoming more known and

advertised. “The Sun Dance was already going on, but it wasn’t hidden as much anymore ‘cause the fears had started to dissipate around our ceremonies and our practises, and the fears of having reprisals from the justice system.” During this time, Ed met Elders, teachers, and medicine people, and began to learn more about the ceremonies and the medicines:

I recognize them by name because I honour them for their knowledge and their wisdom that they passed on to many, and for the work that they’ve done in opening the doors for others to follow, to follow in this good healing way. So, Joe Couture was the first and then Alex Skeed and then Art Solomon. Those were the main teachers that I have learned from, spent the most time with and apprenticed with.

Many of the cultural teachings that Ed has learned have been in the context of First Nations healing practises:

I’ve come to understand about the differences in the specialties that we have in our ways because we have people who are medicine people and have different medicines and different ways of practising their medicines; we have people who are teachers, and they teach and they heal through the teachings that they provide, but they don’t necessarily do medicine practises.

Ed was involved with different healing ceremonies such as the Sweat Lodge and Shake Tent. He learned about the effectiveness of these ceremonies in healing work and how “to deal with illnesses and understand the perspectives of illness from the context of illness within our culture and within our environment of our communities in the north.” These teachings introduced him to the concept of “good medicine and bad medicine” and how to “work with those principles and the understanding of healing as a balance.” He has also experienced the usefulness of fasting, “I’ve learned the ways of healing through fasting, and what the purposes are for fasting and how that helps us to find our way and to guide us in our search for where our journey will take us next.”

Ed believes that Indigenous cultures are tied together by a common form of thought, “A common form of understanding the world, and understanding of the world around us, and understanding the world that we are within.” He further shares that, “Indigenous form of thought informs us that we are part of *all of Creation*. That we are an *equal* part of all of Creation: no greater than and no lesser than.”

Ed expressed that in the academic program, “I wasn’t really exposed to anything that I would call pertinent to First Nations healing.” His cultural learning has informed his practise in essential ways, and he has developed a method which draws on both disciplines of healing, “Sometimes I’ll end up using almost primarily ritual and ceremony from a First Nations’ perspective; other times, I’ll use almost purely what we might call clinical psychological approaches; and then other times, I’ll blend them.” He further comments that:

In terms of the work from a clinical perspective of psychology, which has its limitations, generally speaking because a lot of clinical psychology doesn’t encourage people to go beyond the self. It tends to be self-focussed, central, focussed on the “I.” And that’s why the clinical psychology that has been more relevant and informed my work more has been family therapy because it moves us beyond the “I.” And group therapy, those kinds of ways of healing which is more connected to our Indigenous practises of healing.

In keeping with his understanding of systems theory and systems thinking, Ed works with clients in a wholistic nature and will refer clients to other specialists when necessary. Sometimes he will refer people to those that offer spiritual healing or who specialize in Indigenous plant medicine. He also values healing that is provided by naturopaths, massage therapists, reflexologists and iridologists. “We work together. My work is not *on its own*—it’s part of a system, part of a healing system. And there’s a whole connection of relationships of people who are healers that I work with.”

In terms of worldviews, Ed shared that his worldview has evolved without him realising it. And that as he was taught more, it “helped to articulate what I kind of intuitively knew. I’ve been taught and informed as much as I’ve been formed.” He also expressed that “others have

taught me far more than I have taught them.” He reflected on a shift that he experienced when he realised that the *Indigenous worldview* existed beyond North America. He began to understand that there was an Indigenous experience of the world, and he shares this perspective when speaking with non-Aboriginal people:

I remind them that they have Indigenous ancestry, they have Indigenous roots, because they’re so quick to not see that and they’re blinded to it, and they’re so apologetic for all of the things that they’ve done wrong, the harms that they and their ancestors have done to Indigenous peoples of North America. And so I quickly get them to reflect on their Indigenous ancestry so that they can change their perspective and recognize that this is something that we’ve in a sense *all* done—we’ve all done to ourselves and to each other; and we talk about colonization and oppression. And I think as others understand that and connect with that, I think they’ll recognize what *I’ve* recognized which is that there’s hope for the world. Because, we do share a common ancestry, we share common problems, and we also share common solutions, and that is there within the ancestry of *all* of us.

### **Nina Desjardins**

Nina considers herself Cree Métis. Her father is a member of Muskeg Lake First Nation in Saskatchewan. She is a psychiatrist and has been practising for eight years. After completing her residency, Nina provided consultation services to Enahtig Healing Lodge and Learning Centre. She has also worked at the Mental Health Centre in Penetang, Ontario; as well as having a private practise where she provided consultation to communities in Ontario. Nina currently works for the Assertive Community Treatment (ACT 2) program, which is affiliated with St. Joseph’s Health Care-Regional Mental Health Care in London, Ontario.

The interview with Nina took place at her office in London. It was the final interview of the interview process. I was glad that Nina had agreed to be interviewed, as it was hard to find an Indigenous psychiatrist that was able to participate in this research. There are a very limited number of Indigenous psychiatrists that practise on Turtle Island. I felt that it was essential to include an Indigenous psychiatrist as a research participant because an important part of my



research was to critique psychiatry, and initiate a dialogue with Indigenous practitioners that discussed diagnoses and some of the frameworks of psychiatry. Nina's experience in both Indigenous communities and mainstream psychiatric services brought a unique and valuable perspective; and I felt confident that this interview completed the circle of stories and strategies that each participant shared during the interview process.

Nina's began the interview by sharing about her cultural connection. Her grandmother was raised on the Reserve, but her father was raised off the Reserve, so growing up she had little connection with her Cree roots:

I was never brought up as identifying as Métis or Indigenous. Although, once I got into medical school and started learning more about the culture, I think I started to realise that I was more Indigenous than I was identifying with the dominant culture.

When Nina was at medical school, she had the opportunity to go to several conferences. She attended the American Association of Indian Physicians Conference:

It was a great experience. I went to a Sweat Lodge for the first time. I got to meet all sorts of medical students from different Reserves and Nations across the United States. And that was a life changing experience. I think that includes my career decision to go into psychiatry and into mental health. It really opened my eyes to a lot of things that I hadn't seen before.

Nina felt that her academic journey has been "less than pleasant" and was a "pretty challenging road." It was very competitive and she never felt "terribly comfortable" in that atmosphere. She had a difficult experience during medical school, but was able to embark on her own healing and feels that it has made her a better person. Fortunately, she had a positive experience during her psychiatry residency. She had "really good mentors" and a supportive environment.

When she worked at Enahtig Healing Lodge and Learning Centre she had access to cultural teachings and ceremonies. She felt that was a great experience, “they really took me in and taught me a lot.” What Nina liked about being there was that they were very inclusive. “Even though I wasn’t full-blooded and obviously I don’t know everything and I needed to learn, they taught me and they showed me as best they could.” Nina was able to attend several Sweat Lodge ceremonies, as well as a Horse Ceremony led by the late Anishinaabe Elder Peter O’Chiese.

Nina feels that her experiences of cultural learning have informed her practise. Although, she expresses, “I think it’s more just understanding that we’re all human, and it’s important to take a very non-judgmental approach to people, and to people who’ve made mistakes.” Nina acknowledges, “I think that really helped me get past my own problems.” She further explains, “And it’s helped me work with other people as well because really, in the end, all that really matters is that basic kind of spiritual level that we meet on.”

Working at ACT 2 has been a good place for Nina. The team that she works with provides intensive outpatient services, mostly for people that have been diagnosed with schizophrenia and severe bi-polar disorder “who just haven’t responded well to ordinary treatment.” Some of the patients are Indigenous people:

These are the people who’ve gone through the mainstream Western psychiatric services and have been in the system for a number of years. A lot of them came to me when I started here and I just started following them as outpatients, but a lot of them don’t ask for a lot of help, and they don’t really demand a lot of service.

Nina is able to advocate for Indigenous patients and “bump up services” for those that need it. She feels that there are people that have not been provided the services that are available. Some patients “come in and get their meds and they’ll talk for maybe ten minutes every three months and don’t really get seen very much.” She has learned that “the squeaky wheel gets the grease.” She explains:

I find that a lot of the patients that I had in that particular part of my practise were very self-sufficient and didn't like to make waves; and then their families would take over a lot of the care giving responsibilities that the hospital normally would give. And then, they don't come in and say a lot, so they seem like they're gettin' by okay. So, they just never really came to anybody's attention."

Fortunately, within the ACT 2 program, there is room for collaboration with Indigenous families and community health care services, "I have one patient who's out on one of the Reserves, and the family will come in and work with us and let us know what they need."

Nina shares her worldviews in terms of working with the people in her care:

The way I see the world is more like *we're all equals*. I want to meet people on a level playing field rather than in a hierarchical approach. So, I think that's worked well. I think I have more of a sense of *humour*. I think that's helped. And I really think it's *just* respecting people. I was taught to respect everybody and to be kind, take responsibility for myself, but also to help other people as much as I can.

## **Summary of Chapter Four**

Chapter Four introduced the research participants and brought them into the research circle. They shared stories of their journeys through life and expressed the experiences that helped shape their practises as healthcare practitioners. Through this process of story sharing, it became evident that this was a unique group of people that had put much time, energy, thought, and consideration into their work with Indigenous communities. It is acknowledged that their contributions reflect a high degree of cultural and clinical competency. These practitioners are experts in the field of Indigenous trauma work as they provide strategies of working with trauma that are informed by their experience, worldviews, and knowledge as Indigenous peoples. Their motivation to participate in this research study is greatly appreciated, as this study would not have come to light without their wisdom and willingness to share. The next chapter will present the research participant's perspectives on wellness and wholistic healing and situate their voices among the existing literature.

## Chapter Five:

### Indigenous Perspectives on Wellness and Wholistic<sup>8</sup> Healing

Wellness is a model to assist us in living our lives. It is a [w]holistic and integrated approach to health and well-being... Wellness is composed of four directions or components: physical wellness, mental wellness, emotional wellness, and spiritual wellness. When we travel this [w]holistic path in all directions, we are in balance with ourselves. It is important to acknowledge that the indigenous peoples of Turtle Island have long understood and lived the *wellness way*. (Rogers, 2001, pp. 1513-1514)

Indigenous people have a unique way of conceptualising wellness and wholistic health. Such philosophies are derived from traditional perspectives and cultural awareness. This chapter explores how Indigenous healthcare practitioners express their understanding of wellness and wholistic healing. During the interview process many themes emerged that reflected common understandings in Indigenous communities. Research participants reported that wellness is directly related to balance and harmony, and the demonstration of care and compassion for oneself and one's community. This study reports strategies related to wholistic health that include the importance of respecting different worldviews, honouring Spirit and spirituality, interconnectedness, identity development, connecting with family and community, drawing on teachings and cultural resources, and restorative justice practises. Above all, cultural perspectives were most prevalent and were clearly reflected in the stories that the research participants shared. The findings of this section reinforce the perspectives at the community level as found in the *First Nations and Inuit Regional Health Survey* which gathered views from on-reserve First Nations in Canada and the Inuit of Labrador. The results indicated that over 80% of the people felt that a return to traditional ways would promote community wellness. Although, *traditional*

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<sup>8</sup> As noted in Linklater (2010) I spell the word “wholistic” with a “w” at the beginning, rather than the dictionary form “holistic.” It was first pointed out to me in 2001 by Alice Olsen Williams of Curve Lake First Nation that I should not be spelling the word without a “w” as it reminds her of *holy* which referenced masculinity, a male god, and the Bible—with further implications of patriarchal power and force. She also expressed that the word described an empty space. Given the context that I use the term, I decided that there were many good reasons to spell the word using a “w” and committed to doing so in all future works. I felt that wholistic needed to convey *wholeness* and describe an all-encompassing perspective that is reflective of Indigenous cultural philosophy. Spelling it as “holistic” seems to limit the notion of wholism and does not accurately represent the concepts being articulated.

*ways* was not explored in the survey, the results suggest that the Indigenous people that participated in the survey valued cultural teachings and healing practises (Svenson & LaFontaine, 1999, p. 193). This chapter first explores the concept of wellness in Indigenous communities and then discusses wholistic healing with Indigenous peoples.

### **Wellness in Indigenous Communities**

In this section, participants share their understanding of wellness. Four broader themes emerged: balance and harmony, being in Creation, care and compassion, and the challenges that Indigenous communities contend with in the pursuit of wellness. In general, there were many consistencies with how the research participants understood wellness. For several years, Indigenous practitioners, theorists, researchers, and communities have been discussing wellness as a way to conceptualise healing and health.

#### **Balance and harmony.**

A common way of understanding wellness in Indigenous communities is by understanding the connection between good health, balance, and harmony. Although it was usual for participants to acknowledge the aspects of the self as: spiritual, emotional, mental, and physical; Darlene explained that she always thinks first and foremost about the Spirit. “When I think about wellness, I think about spiritual harmony. This is something that was taught to me when I was going through hardship in my life and I had approached an Elder for help.” Darlene shared that the Elder told her, “It’s really important to be well in your Spirit before you can be well physically, emotionally, and mentally...the healing always has to start there, *with Spirit*.” Ed reinforced this idea of Spirit being central to our existence. He explains, “We talk about it in terms of the core of human existence is spiritual. The core of human wellness is Spirit and spiritual.” Hodge, Limb, and Cross (2009) also acknowledge the *Spirit* as being at the core of one’s existence (p. 213).

Darlene explained that through the teachings that she has learned in the last seven years, she has come to understand that because of our worldview “we believe that we came from a spiritual place and that we’re gonna go back to that spiritual place...that we are first and foremost Spirits and we’re having a human experience.” Darlene shared that when she thinks about healing and Indigenous health she feels that “spiritual health is the most important.” She also

points out that the “four areas of self—the physical, the emotional, the mental, the spiritual—have to be in balance and harmony with one another in order for you to feel completely well and completely whole within yourself.” Importantly, she explains that “you can’t heal one without looking at all the others, otherwise, it’s just a band-aid cure.”

Carrie shared that she believed that wellness is being in balance and in harmony, “you are just in balance completely in terms of mentally, physically, spiritually...I think that’s how I see it and I think that is how it is often explained when we talk with our community as well.” Ed described wellness in First Nations communities as “the experience of balance.” He maintains that wellness occurs when “we understand how we are a part of everything in the world and that we’re an equal part. When everything is kinda balanced out, then that is a state of wellness.” He further explains, “When things are not in balance and things are out of balance, then there is a state of illness.” He concludes that, “the whole experience of wellness is to be able to identify where the imbalance exists and then to be able to figure out what the ways are to bring balance back into my life.” This is consistent with Hodgson’s understanding as she expressed in her Keynote address to the participants of Healing Our Spirit Worldwide (2006) that healing does not mean that one has to be *sick first*, it is a signal that one needs to get “better balance.” Furthermore, Hart (2002) suggests, “While balance is periodically and momentarily achieved, it is never achieved for an indefinite period of time. The reality that life is ever-changing requires all beings to readjust in the constant pursuit to regain a sense of balance” (p. 41).

Janice L. spoke about the path of wellness according to the teachings. She described it as “physical, spiritual, mental, and emotional.” She explained that wellness can be determined, “If you can keep those in balance, be aware of looking after each parts of oneself, and nurture those parts of your being—as best you can each day.” Nina expressed that “Wellness is balance between all parts of yourself, not just being in balance intellectually or not having negative feelings.” She points out that, “It’s more a matter of being centred and grounded, and connected to everybody and being in harmony with everybody...or, not *with* everybody but *with the way life is*...with your surroundings and with your family.” Balance is acknowledged as part of wellness in other areas of the literature specific to Indigenous health and healing (Hodge, Limb, & Cross, 2009; Rogers, 2001). Mehl-Madrona (1998) claims that wellness is restored when body, mind, spirit, and community are in harmony (p. 247).

Many Indigenous healing programs are based on the principles of balance and harmony. Couture (2005a) discusses core values of traditional healing programs and maintains that the “experience to which each program contributes may be likened to a meaningful step towards attaining to a life-in-balance, to developing a commitment to self-improvement and to healthy relationships with self, others, Mother Earth, the Cosmos, and the Creator Spirit” (pp. 12-13). Accordingly, balance and harmony are essential features in understanding and addressing wellness issues for Indigenous people. These themes are prevalent as underlying aspects common in Indigenous cultural philosophy.

### **Being in Creation.**

Indigenous people often maintain a strong relationship with Creation. This relationship frequently becomes all-encompassing and includes a connection with the Creator, as well as an understanding of one’s place and purpose within the universe. Yvon described wellness as, “Being enough and having enough—being enough in terms of all that you are meant to be.” Yvon explained that the Creation Story talks about our Creation, “that when we’re standing in that Eastern Doorway, coming over here, that there are expectations in place—expectations that we have, expectations that have been given to us by the Creator about what we can expect.” He suggests that the “actualization of all of that” really talks about what we mean by wellness. “Being able to know who you are—being in niikaniganaa (all my relations), which means being in a family way.” This notion is supported by Couture (1991b) as he writes, “Finding one’s path and following it is a characteristic Native enterprise which leads to or makes for the attainment of inner and outer balance” (p. 207).

Ed acknowledges the importance of connection and relationship. He recognises that when we talk and think wholistically, “we’re talking about ourselves as being made up of physical, mental, emotional and spiritual and that we’re looking for a balance between all of that.” Importantly, he points out that, “that’s not all there is to it, that’s only a part of it because that’s only what we see within the context of ourselves.” Ed suggests “then we have to look beyond the context of ourselves and look into the relationships with our family, those who we’re closest to. And we have to look at those relationships and look at the balance and imbalance there.” He broadens the analysis by articulating that we have to go “beyond the balance and imbalance within family. He asserts that we need to:

begin looking within extended family and then look at it within community. And then look at it in the context of community within the surrounding communities, which may be, then, a nation or nations. And then look at it within the context of the world. And not only look at it within the human context, but look at it within the context of all of life...all life forms. And look at it then in the context of all of Creation. And then look at it *again* in the context of all Spirit and most importantly, Creator...relationship with Creator. And that's the core of it.

Ed's perception of our connections and relationships within Creation and with the Creator are important elements relating to health and wellness. Hodge, Limb, and Cross (2009) note that "communicating with the Creator or other metaphysical dimensions of the spiritual world can signify health and well-being" (p. 213). In some senses, it may be understood that relations with the spiritual realm, including a relationship with the Creator, encourages a person to see themselves as part of a larger network—the network of Creation. It also signifies that a person has a greater sense of community and an important place in the world. This reduces isolation and supports individual purpose and responsibility to a network outside of themselves.

Sylvia also conveys a deep sense of connection and responsibility in her understanding of wellness. She points out that, "sometimes the problem is not within the body of the person, it's something outside" and that the person has to "balance the whole." She establishes that "equilibrium" is the concept of wellness. In determining wellness among Indigenous peoples in Mexico (or in the part where she lives), Sylvia explains that it "concerns the balance of social, family, and community." The way they define illness and the way a healer deals with a person is:

Has she done her proper devotions? Her proper rituals? How is she doing with her family? Is she well with the community? Does she have a problem with neighbours? Has she stolen something from someone? So it's all of this—community, family, and social. How is she economically, is she able to survive with whatever she has?



Sylvia communicated an understanding of wellness that reflects one's connection to themselves, their faith in spiritual needs, their behaviour, their community, and their livelihood. Similarly, Adelson (2000) documented that the James Bay Cree word that closest describes *health* or as she translates '*being alive well*' is *miyupimaatisiun*, which is "synonymous with the Cree way of life, and is inseparable from being able to hunt, pursue traditional activities, live well in the bush, eat the right foods, keep warm, and provide for oneself and others" (p. 97). Essentially, wellness is directly related to how one is able to *be in Creation*. According to Yvon, indicators of wellness are the "ability to be flexible and to be open in one's thinking, one's experiences." He posits that "everything is all connected." Yvon puts forth an example of flexible thinking, "I'm a nurse by profession, I'm a scientist by profession. I'm told that the sun is my grandfather. I can simultaneously believe that he is an old man and a burning ball of gas at the same time." In this sense, wellness is inclusive of ways of being, including ways of thinking, behaviours, sustenance, and relating to all aspects of life force within the universe.

### **Care and compassion.**

A very important attribute of wellness is the care and compassion that a person has for oneself and their community. This is demonstrated by one's actions and often the actions of a community during times of crisis. Bent (2004) in her research on Aboriginal women's health issues found that women's understanding of wellness coincided with self-care. A common expression in Indigenous communities is "walk the talk." This often implies that those in a helping profession must exert considerable effort to advance along their own healing journeys.

Gilbert points out that "if you wanna become a helper, you gotta take a look at yourself first." He shares, "I've been saying this at my own community. People need to take a look at themselves in order to get into *wellness*, before they can start talkin' about it." Hart (2002) asserts that "helpers begin the helping process by addressing themselves. They prepare themselves to help others by establishing and maintaining an awareness of their own emotional, mental, spiritual and physical well-being" (p. 105). This importance of healing for helpers and health professionals has become a significant component in the healing environment. Without resolve of core personal issues, there is a risk of safety for clients if the service provider is not able to recognise how their life experiences may be impacting the therapeutic relationship. This may increase complications surrounding issues of transference and counter-transference.

Moreover, a person that has resolved their own issues has greater insight into the process of healing, including aspects of resistance and the expansion of an emotional range. Duran (2006) maintains that, “Your own soul must be healed so that you can attend to the patient who is presenting with a wounded soul. You cannot do for others what you haven’t done for yourself” (p. 44). Hodgson (2008) suggests, “The reward for doing our work is being a people of hope, spirit, and commitment. We do this to ensure that our grandchildren will not have to live with our spiritual, emotional pain” (p. 363).

Community agencies servicing Indigenous people often provide avenues to support workers in accessing healing opportunities. This may be evident in agency policies and benefit programs. Some agencies allow cultural and ceremonial leave for workers to attend to their personal wellness. Other agencies may bring in Elders and healers for their staff to access during work hours. It is also common for Indigenous agencies and organisations to encourage a healing community among co-workers. Carrie explains that the healing practise of the staff and agency at Seven Generations in Los Angeles acknowledges that “if we are out there working with our Indigenous peoples then we have to have that as a part of us as well.” She elaborates, “With our staff, we start off with prayer all the time, smudging, and we are really open to discussing our own beliefs and our own healing. I think that plays a really big part in working with our people.” Weaver (1999) notes that the wellness of the helper “is based on the belief that without balance in their own lives, helpers are not able to provide competent services” (p. 222).

Tina spoke about how she believes that wellness is about “how community takes care of itself” and further “how each person takes care of its community.” She explained how she has learned from her community in that they are a community that, like many others, has “lost its way” and is “tryin’ to find it again.” Tina shared her understanding of how the strength in a community contributes to wellness:

I think when communities pull together or women pull together or men pull together, a community is shown its strength. Children learn from their community, their leaders, or their family members. We role model to our children and we tend to forget that sometimes....And by bringing in younger leaders with

vision, leaders with dreams and goals, and [a responsibility to be] honest to their people, I think that's the way it can take care of itself.

Janice S. felt that her community was “pretty open.” She explained that, “You’re allowed to be a little keebaatis—a little bit crazy. But then, you have to get back to providing for your family, get back to working and looking after yourself.” She related to the idea of wellness and taking care of life responsibilities, such as the need to “provide for your family, you provide for yourself, your head is clear, you have a job or you have some income, and your children are well looked after.” Janice S. also commented on the difficulties of when people aren’t looking after their responsibilities and how “when people cross that line” the community often draws on compassionate methods to address the situation. She shared that “they don’t like to call the CAS [Children’s Aid Society], but they will call other people in our community to go and talk to the mother or the father about how they should be taking care of their children.” Janice S. also noted that this method of speaking to family members is sometimes extended to how “they should be taking care of their grandmother.” She further elaborates that these relationships include “aunties and uncles, blood aunties and uncles, and adopted aunties and uncles.”

### **Challenges for working in the area of wellness.**

A few of the participants spoke of the challenges that they felt existed in the area of increasing wellness at the community level. Janice L. commented that, “The mainstream is always talking about illness and sickness; and there are whole industries built on working within these institutions (social services, correctional) where people are sick.” She articulates:

I think our people have struggled and suffered for so long that many of them don’t know wellness—it is almost a foreign concept to them. I think it is slowly starting to change. When more of our people get educated and teach our children and grandchildren, *then* we can focus on the positives...then we can remember *who we are and where we come from.*

Janice S. revealed some of the challenges that are a result of the colonial history. She explained, “I know that right now in our community, the challenge is that people resist the bringing back of Sweat Lodges or Fasting. People don’t understand, because we’ve had a lot of history telling us that it wasn’t good.” Janice S. points out the resistance that exists in incorporating traditional methods of healing. For many people, they have had generations of family members that have been immersed in Western forms of religion and are not comfortable participating in Indigenous ceremonies or accessing culturally-based services that address the person in wholistic ways.

Tina expressed hopeful thoughts that “the perfect day will come when all front-line workers” understand wellness and ways of understanding health through Indigenous methods that address the whole person. She discussed the effects that history has had on our way of living and acknowledged the importance of non-Aboriginal frontline workers understanding the impacts of historical trauma on Aboriginal people. Tina further suggests that the provision of healing opportunities that inspire wellness within Indigenous communities should be rooted in culturally appropriate experience, practical application, and cultural competency.

### **Wholistic Healing with Indigenous peoples**

The research participants offered many ways of working with individuals and communities in wholistic contexts. Most prevalent was the level of respect that Indigenous healthcare practitioners had for the values, beliefs, and worldviews of the people accessing services. Wholistic healing practises were very centred around the person and the interconnections with oneself, their family, and the community. It was also important to incorporate a teaching component which included cultural resources to compliment the healing process. Additionally, restorative justice practises were highlighted as proactive approaches to resolving conflict and restoring balance.

### **Respecting different worldviews.**

In listening to the research participants share their views on working with individuals and communities with a wholistic approach, I was struck by the kindness and respect that they held for others in the world. There was true acceptance of the lives and experiences that their clients had. And more so, a deep desire to connect with people in a way that was meaningful and healing for both the client and practitioner.

Ed shared the process that he uses in determining how he will engage therapeutically with a client. “I start with recognizing that I have to understand the perspectives that the individual has on the world and how they fit into the world. And then how they think about healing, about their own healing.” He further explains, “From that, I discover how much they’re informed by either a more linear perspective on the world versus a more wholistic perspective on the world or both.” Ed feels that this acknowledgement is a crucial step in healing work with anybody. He feels that being “wholistic” means to “first acknowledge that there is more than one way of thinking in the world; there’s more than one perspective to inform us about the world.” This approach is very client-centred and is not concerned with applying a method to the person accessing therapy. Rather, this approach invites the client into a healing relationship that recognises their lived experience and incorporates a style that is familiar to the client. Ed elaborated on this process and described this method further:

Once I understand how they are informed, how they think of themselves in the world and make sense of the world, then I talk with them about the different possibilities for healing. I begin to explore with them the different options that I see that might be available, that I can offer and that I know of that others might be able to offer. If their direction of thinking and their understanding of the world is more wholistic, then I introduce to them more of what would be approaches to healing that address all of the imbalances. We’re looking to discover what the imbalances are in their lives and where they lie: Are they in the physical, the mental, the emotional or the spiritual areas? Are they in all those areas? Do they exist in terms of their relationships with others in the world around them? Do they exist in terms of their relationships with all of Creation? Does it exist in terms of their relationships with the spirit realm? And then we talk and start to explore where they are, what they then need to do to correct those imbalances, to set those things right, and put them back into balance.

Ed’s approach to working in wholistic ways that respect the individuals’ preference for therapeutic style provides options for the client. It also provides important information to the

therapist about a client's journey and life experience. Duran (2006) supports a tribal or Christian orientation and explains that learning about the clients' worldview provides important information that helps in the therapeutic process. "This exploration will let me know how much of a physical and spiritual support system the client will have during times when therapy becomes difficult" (p. 47). To a large extent, working with Indigenous clients requires the therapist to be flexible and respectful of different worldviews and spiritual orientations.

A central feature in working with Indigenous communities is understanding the varied cultural history and how this influences spiritual beliefs and practises. Janice S. pointed out that she really believes in using the "Medicine Wheel." She recalls an experience when she spoke with a Métis Association that she offered agency services to. "I hadn't really interacted with Métis people before. So, I wanted to assure them that I could respond to the needs of their community." Janice S. felt that it was important to talk to them about how her approach is to use medicines. She explained that she uses "smudging and the Medicine Wheel." In referring to her discussion with the staff of the Métis Association, she explains that:

They let me know that a lot of people were Catholic, that they wouldn't be receptive to smudging or tobacco....and that they would refer staff or their clients to me if the need arose. They were grateful that I was willing to take on clients who were Catholic and that I didn't judge them for how they chose to live their life or how they chose to talk to the Creator.

With the colonial history of Indigenous peoples, particularly the experience of residential schools and missionary influence, many people are accustomed to Western forms of religion. Heilbron and Guttman (2000) caution that counsellors should not assume that all First Nations people adhere to cultural traditions and beliefs and that "individuals should have the option of participating or not participating in cultural ceremonies and practices" (p. 11). As noted in the previous chapter, Janice L. asserts,

I never make the assumption that all Indigenous people follow the *Red Road*, the cultural ways, our teachings, listening to Elders, following ceremonies, going to Sweats. It's more spiritual than religious. I can't always assume that Indigenous people follow our spiritual way. Some of them follow their religion—like Christianity. I have to be really aware of that all the time and be respectful of that because that's part of our teachings—to be respectful of other peoples' belief systems.

Common in Indigenous teachings is the element of respect for other peoples and cultures. Warry (1998) in his work with Anishinaabeg in Ontario found that “people were in agreement that traditional values promote tolerance of other spiritual ways” (p. 217). Poonwassie and Charter point out, “not all Aboriginal people participate in or accept the validity of traditional ceremonies as a component of life or healing. In accordance with traditional values, respect is afforded to those who do not choose a traditional path to healing” (2001, p. 67). Trimble (2010) acknowledges that similar to “many other members of ethnic minority groups and other culturally distinct people in North America, [some] Indians and Natives express the full range of acculturation” (p. 247). The participants in the research acknowledged the range of experience pertaining to cultural history, spiritual beliefs, and religious practises. Essentially, they reinforced values of respect that are inherent in many Indigenous teachings.

It is important to note the effects that colonial history has had on the present day interactions and relationships. Ellerby, McKenzie, McKay, Gariépy, and Kaufert (2000) comment on the impact that Christianity has had on Aboriginal communities and that in some cases “the result has been division and animosity between family and community members who hold traditional Aboriginal values and those who assert Christian values” (p. 847). For example, this conflict may arise in situations involving family decisions, education for children, and burials of family members; as well as community functions such as the procedures for conduct of meetings and construction of traditional lodges or churches. Inevitably these tensions will take decades, perhaps generations, to resolve. Derrick (2005) has arrived at the conclusion that “in all human endeavours, some of us—as individuals, as families, as communities, and as nations—achieve greater wholeness than others” She further explains, “When I travel to communities and First Nations, I remain open to discover where the people, families, and communities are at in

the circle of growth and wholeness” (pp. 45-46). Derrick reiterates an essential aspect that was common in the strategies shared by the research participants: that there is a need to be open and respectful about where people are at in their journeys toward wholeness.

### **Honouring the Spirit and spirituality.**

The role of Spirit and spirituality in healing is a frequent concept that Indigenous healthcare practitioners recognise. Many speak in high honour of the assistance of Spirits in the process of healing. It is also important to honour spirituality as a vital aspect of a person’s healing. McCormick (2009) writes, “Many different Aboriginal healing ceremonies and healing programs stress the need for reconnection with one’s spirituality in order to heal” (p. 339). Hodgson (2008) claims, “it was the combination of laws forbidding participation in ceremonies and the imposition of a residential school system that stripped individuals of their spirituality in the first place: this is at the root of the need for healing today” (p. 361).

Darlene points out, “It’s so different for every individual. You can’t have a structure and impose it on every individual. The individual’s issues or challenges will notify me or tell me how I should work with that person.” She further elaborates:

I have to be with that person for a while and have that person share what’s going on, what’s happening. And then I can say, ‘Okay, this is how I can work with this person.’ In the work that I do with the Swing, when I work with individuals, I really try my very best to leave myself out of it. And so, it’s a very non-intrusive kind of healing that takes place for the individual; and it’s really between the individual and the Spirits.

Darlene expresses that the individual will be healed in the ways that *they* believe the healing will occur. “However they see their higher power, that’s the higher power that will come to work with them. That’s not something that I can dictate to them. Nor do I try to impose any kinds of thoughts or expectations.” Darlene maintains, “I just let Spirit work with them and I just trust the process.” She also explains that if an individual is *really* having a hard time and she can see that there are emotions arising or anger surfacing, then she will either do energy work and things that



she might have learned along the way from her Elders and from her parents. Although she acknowledges, “But mostly, I really allow Spirit to help with that process.” Mehl-Madrone (2003) posits, “Native American philosophy teaches that all healing is first spiritual healing....we need to humbly ask for help from the spiritual realm” (p. 29). There are many ways to seek help from the Spirits. Practitioners are often aware of Spirit helpers that provide assistance on a regular basis. Some will give offerings to Spirits for specific healing. Frequently, prayer and ceremony are methods of seeking spiritual assistance. This process often includes medicine and sacred items and is regularly done together with the person (and sometimes family and community) that requires healing.

Honouring people’s Spirit is another value relevant for Indigenous healthcare practitioners. Yvon discussed the whole notion of writing down people’s stories by doing a family and social history as part of the documentation requirements. “My teaching is that I’m not allowed to do that unless that person gives me permission to put that story down. I have to have people’s permission to even share that story.” He also commented on this process further to include, “Even the whole notion of just somebody sharing their family journey.” Yvon noted that, “I have to work extremely hard to develop that person’s trust, especially if they’ve been traumatized.” He acknowledged that it is important to respect his own journey and use that experience in a traditional way to provide service to community members. Yvon explained, “I’ve shared with you already about my own personal journey. My journey into pain and hurt and my healing, recovery, treatment from all of that. I share that with people, even though as a nurse, that’s not professional.” Honouring Spirits becomes an important part of the Indigenous healing relationship. Many Indigenous healthcare practitioners find it helpful to share aspects of their own life experiences. Hart (2002) supports this process for those in a helping relationship, “It is important that individuals utilizing an Aboriginal approach reflect upon their own lives and be willing to share their life experience to support the healing of others” (p. 54). This helps clients connect with the person providing service while building trust and solidifying a therapeutic relationship.

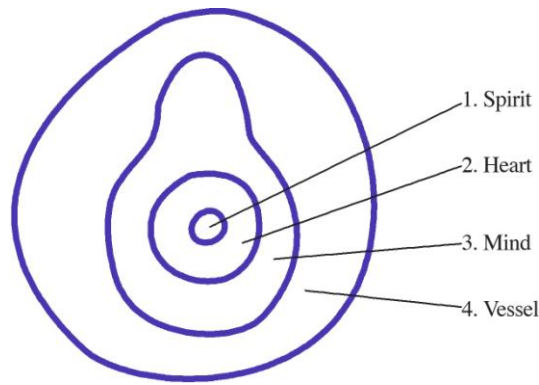
Janice S. connects with clients through spirituality during the therapeutic process. As she works in the mental health field, she explains, “I look at what kind of medications they are on, what kind of diagnosis they have. I try not to have them feel bad, or feel a stigma about what kind of diagnosis [they have been given]...that’s just who they are.” She uses her traditional

knowledge to help clients understand about Spirit and spirituality. “When I talk about that, I bring in the Spirit and talk about Spirit, how Spirit motivates us and how we might be walking with Spirit.” And in honouring the help that the client’s Spirit may need, Janice S. recognises that, “They might need to see somebody who is a therapist on how to deal with maybe some trauma, some grief and loss in their family.”

Indigenous healthcare practitioners’ afford a significant amount of respect for the healing process and thus, the strategies they utilise to honour spirituality. Sylvia asserts, “When I treat Indigenous peoples, I take great care to respect their religious beliefs in the universe and to intervene right from there.” As her method has been anti-psychiatry, she explains, “The only thing that I do is that I never use mental illness psychiatric diagnoses and I never recommend pills; I try to work with the living and the working environment of the person [during the healing process].” In discussing the resiliency of former residential school students who have gone on to lead well-adjusted adult lives, Dion Stout and Kipling (2003) acknowledge, “religious beliefs and spirituality are frequently cited as reasons for their current well-being” (p. 50). Furthermore, many Indigenous practitioners see the honouring of spirituality as an important part of their practise that helps them feel grounded and authentic. Baskin (2002) expresses, “For me not to implement spirituality into my social work roles as educator and practitioner is unnatural. To not be able to do so makes me feel both empty and insecure.” The expression of the need to ground healthcare practises in Indigenous spiritualities reveals an important component in the practitioners own sense of spirituality and wholeness.

### **Interconnectedness.**

The concept of interconnectedness is central in Indigenous worldviews and epistemologies. Although, the practitioners many not have utilised the term *interconnectedness* specifically in their stories, the views that they shared often described the connections that are interdependent or interrelated within the healing process. Janice S. draws on her teachings (see Figure 4) from Anishinaabe Elder and educator Jim Dumont, who is Fourth Degree Midewiwin. She shares, “One of the teachings we have is that Spirit motivates us. And then sometimes our Spirit can’t talk to us because the channels that move through our bodies are blocked.”



***Figure 4. Total Anishinaabe Person<sup>9</sup>***

Janice S. explains, “Our Spirit talks to our heart, and our heart speaks to our mind, and our mind speaks to our body.” She elaborates on the process of unblocking the channels and understanding the interconnections of our beings:

If those channels aren’t clear, we can do that [open or clear channels] by Fasting, we can do that by Sweating, we can do that by Prayer, and we can do that by taking care of ourselves and keep those channels open so our Spirit can talk to the Spirit—the Greater Spirit. [This is] all to do with collective knowledge, heart knowledge, and blood knowledge; and when we’re in tune, that all works. So, I work with individuals to help them understand that it’s really their Spirit that’s asking them to look for help, to reach out.”

Janice S. brings traditional teachings into her practise to aid her clients in understanding what motivates their healing. Essentially, she shares with them the depth of our interconnectedness. Interconnectedness, as an Indigenous philosophy of life, is clearly manifested in healing practises (McCormick, 1997, p. 174). Janice L. discussed a wholistic approach and points out that it is “incorporating all of those four aspects—physical, spiritual, mental, and emotional—and looking

<sup>9</sup> This drawing is my interpretation of the teaching which was first received from Elder Jim Dumont in 2004 at Seven Generations Education Institute in Couchiching First Nation as part of the Master in Indigenous Philosophy program. The course was entitled, “Anishinaabe psychology: Ways of being and behaviour.”

after all of those.” She described the importance of interconnectedness and acknowledged the challenges that have existed:

It’s not easy because I think that spirituality has often been overlooked. I’ve gone to counsellors over the years (non-Indigenous counsellors)...and nobody ever talked about spirituality. I think now it’s more and more that they’re starting to acknowledge spirituality and wellness for everybody, but I think for our people—Indigenous people—we’ve always had that.

Janice L. articulated a common experience that Indigenous people have had in accessing counselling and therapeutic services from non-Indigenous practitioners. She noted that “spirituality” was often absent from the dialogue, albeit, she recognises that this is changing in present healing contexts. Perhaps now that the training and practises of non-Indigenous healthcare practitioners has shifted to include a more spiritual component, the issues of cultural competency and cultural safety have become clearer. For example, a practitioner may have a spiritual practise, but not be culturally competent in providing services to Indigenous peoples.

The notion of interconnectedness in Indigenous philosophy is a broad concept which focuses on the internal aspects of a person, while extending far beyond individual existence. Yvon claims, “When we talk about wellness we use phrases like *wholistic*, for mental and emotional. And wholistic may also include the individual, the family, the community, and the nation.” Duran (2006) states that, “Healing of the body, mind, and spirit is further compounded by the fact that the trauma occurs at the personal, community and collective levels” (p. 21). McCormick (1997) describes interconnectedness as “the individual’s connection to the world outside the self” (p. 178). Thus, applying an understanding of interconnectedness in Indigenous healing begins with a person’s Spirit, and encompasses everything that culminates in a person, such as their emotional, mental, and physical parts of the self; and further, how they are situated among their family, community, nation, and all of Creation.

Indigenous healthcare practitioners that are working in mainstream settings utilise wholistic approaches and broaden the understanding further by going beyond their Western forms of training. Nina expresses, “I think that when it comes to psychiatry, a wholistic approach

would be more than going through a DSM-IV criteria or even just the standard kind of interview that we're taught." She explains that it's important to try "to understand where somebody is in relation to their community, their past, their spirituality. It's trying to really look at them as more than just symptoms or something that you're gonna have an ultimate management plan for."

Mehl-Madrona (2003), also an Indigenous trained psychiatrist, articulates, "When we learn about the interconnectedness of everything we realize that the rugged individualism so valued in Western society is counterproductive to solving problems and reducing suffering" (p. 26). Nina elaborates on her practise and shares that when she's working with people she will address spiritual issues with them and open a conversation up about spirituality. She points out, "there are ways when you're working with people that you can help them become centred and grounded and remind them about what's really important. And...it's not necessarily using CBT [cognitive behavioural therapy] approaches or whatever." Like many Indigenous healthcare practitioners that have been trained in Western medicine and health disciplines, Nina recognises the limitations of the field and employs Indigenous strategies to ground her practise and support the people that she is helping.

Nina considers the interconnectedness of the person's whole health and does not abide only by psychiatry's narrow model of how the person fits into DSM-IV criteria or symptomology:

I think it's more—just being fully present in the room and helping them become fully aware of what they're thinking and feeling and doing....I always look to the physical piece of what's happening. So, somebody'll come in here and say, 'Well, I'm depressed.' And so, rather than giving them a pill, I'll talk to them about taking care of themselves, feeding themselves properly, exercising or going for a walk, vitamins and things like that.

Essentially, Indigenous healthcare practitioners that are grounded within Indigenous worldviews naturally utilise methods that emphasise being interconnected with Creation. Couture (1985) asserts that, "Native ways of life are rooted in a perception of the interconnectedness amongst all

natural things, and all forms of life” (p. 6). Such methods are ingrained in wholistic approaches that consider the universal connection which is fundamental to Indigenous existence.

### **Medicine Wheel approaches.**

Medicine Wheels are contemporary teaching tools that are used to explain concepts, philosophies, and traditional teachings. By nature, they emphasize wholeness and balance (Linklater, 2010, p. 224). Many Indigenous Elders, cultural teachers, healthcare practitioners, scholars, and educators draw on Medicine Wheels and they have now become a common tool for Indigenous people to use in their practise (Bent, 2004; Hart, 2002; Johnson, 2006; Lavallée, 2008; Linklater, 2010; McCabe, 2008; McCormick, 1995; Odjig White, 1996; Nabigon, 2006; Nabigon & Mawhiney, 1996; Struthers & Lowe, 2003). One of the benefits of Medicine Wheels is articulated by Menzies (2004) as he points out that the practitioner is better able to understand Aboriginal cultures and develop effective ways of working with Aboriginal communities.

Historically, the concept of Medicine Wheels arose from sacred sites located throughout central North America, specifically Alberta, Saskatchewan, Montana, South Dakota, and Wyoming (Saltanaviciute, 2000). The English term *Medicine Wheel* was first applied to the Big Horn Medicine Wheel in Wyoming (see Figure 5). However, not all Indigenous people



*Figure 5. Big Horn Medicine Wheel in Wyoming*<sup>10</sup>

accept the English terminology, as my late Uncle Gordon Nelson (Anishinaabe) expressed, “These aren’t Medicine Wheels, they tell stories of the universe” (personal communication: March 12, 2006).

Yvon shared that he uses wholistic approaches in working with people which are either contemporary or traditional. He explains, “Contemporary is Medicine Wheel teachings. Medicine Wheels are not traditional teachings, they’re contemporary. They’re very valuable. I use them all the time.” Yvon recalls how he draws on Medicine Wheels when he attends the Lodge, “I have a class of kids: some of them are Haudenosaunee, some of them are Anishinaabe, some of them are Métis, and some of them are white. And so, I use the Medicine Wheel and I use the Life Cycle Wheel.” However, he is clear in their cultural origination as he explains to the learners, “This is an Aboriginal teaching. It’s not a traditional Haudenosaunee teaching. It’s not a traditional Anishinaabe teaching. It’s not a traditional Métis teaching.” Yvon recognises the validity of using Medicine Wheels to address issues, “it’s not just traditional issues but also contemporary issues.” He suggests that it is important to be “clear about *what* teachings and *why*

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Photograph courtesy of Courtney Milne.

we're sharing those teachings: is it to inform or is it to guide?...Even ceremonies—what ceremonies we enable people to have access to and for what reasons—all of those are important.”

Many practitioners developed models that divide the Medicine Wheel into four quadrants. Sometimes these quadrants are used to represent the four directions: east, south, west, and north; the four sacred medicines: tobacco, sage, sweetgrass, and cedar; or the four aspects of the self: Spirit, emotion or heart, mental or intellect, and physical or body. Johnson (2006) developed a community healing model to aid in the work with Native Americans. She utilised a Medicine Wheel framework, which “enables examination of the healing process from the context of the four directions and focuses on the importance of traditional values and healing to create harmony and balance” (p. 189). In the interview Carrie emphasised, “What we actually do is look at the whole. We use the concept of the Medicine Wheel and we use that in terms of all the trauma and what’s happened with the family and the individual.” She explains, “For us, our care coordinators go in and meet with the families and children and they *ask them* what they want and what they need.” In keeping with a Medicine Wheel approach, Carrie indicates:

They look at everything: mental health, physical health, school. What are their overall needs? They may need a therapist or they may not. They may want to have traditional practitioners. Some of the youth really just want to be involved with our drum group, or beading classes, or things like that.

Importantly, a Medicine Wheel approach opens the discussion between service providers and those accessing services to develop a healing plan that considers diverse needs and overall objectives.

Wholistic approaches often suggest that all of the content in a Medicine Wheel context is relevant and valued. Tina explains that she definitely uses a Medicine Wheel approach. She shared that just before the interview, she was having a discussion with one of her co-workers, “We were talking about someone who’s working at finding her way. Sometimes she feels like she’s dangling by a string. And even when you’re dangling by a string, there’s something to learn in that.” Tina pointed out that it is important to help clients see their strengths and



understand that they are resilient people. She also shared her strategy with some of the clients who've come and talked about how they feel like the Creator has abandoned them:

I try as best I can to remind them, "It's only part of you that feels that way. The rest of you sitting here is feeling something, the rest of you is here thinking of something. And it might feel like that for now, and it's okay to be mad at him or her—whoever the Creator is—and it's okay to get past it. It's okay to see your way to the other side. And that that *feeling* of being abandoned by your Creator is just for now, because when you leave the office or are somewhere down the road and when you have some kind of revelation, you'll be thankful to [the Creator]."

Odjig White (1996) maintains that the Medicine Wheel teaches us to look at negative perceptions in a positive manner (p. 114). With the teaching of respect being inherent in the Medicine Wheel, it provides opportunity for healthcare practitioners to help clients see their experiences differently; and in some cases with more gratitude.

Perhaps the attraction and applicability of using Medicine Wheel approaches is rooted in an inherently deep connection that Indigenous peoples have with circles and circle processes. Janice S. shares, "I use a Medicine Wheel which I learnt at Laurentian University. But I also include some Midewiwin teachings in that. We have a Circle, we don't call it the Medicine Wheel." The Medicine Wheel, Wheel of Life, Circle of Life, Pimaatisiwin Circle are all symbolic expressions of similar, ancient, and sacred Indigenous concepts "of life and universal connectedness which provides a means for individuals to make sense of the world" (Poonwassie and Charter, 2001, p. 65). Drawing on contemporary practises that maintain cultural knowledge seems to provide skills and resources for Indigenous healthcare practitioners to connect with their clients and develop a sense of direction in assisting both clients and practitioners achieve more balance and harmony in their lives.

### **Identity development.**

In recent years, the focus on identity development and cultural healing has become vital in the movement for healthier Indigenous communities and nations. Because of the history of

colonisation, being born Indigenous does not necessarily entail a familiarity with one's culture, music, ceremonies, or language. Restoule (2000) suggests, "This is a reality of living in a dispersed culture where there have been generations of increased pressure not to exhibit these cultural knowledges" (p. 105). Furthermore, Stevens and St. Germaine (2003) write, "Patriarchal governance, education and religious institutions have undermined our connection to the land, culture, values and identity" (p. 162). As a response, Indigenous healthcare practitioners and healing agencies have been developing programs and services that connect people with cultural experiences and teachings that are geared toward strengthening their Indigenous identities.

Janice S. communicates that she likes to help her clients "work on identity." She explains, "I might really want them to find out what their Spirit name is so that we know how to work with them—what is their purpose in life? I also like them to get connected to their clan." Janice S. elaborates on her strategies in this area:

So if they're bird clan—that has to do with spirituality, if they're bear clan—that has to do with healing, if it's Whaubishishee (Marten Clan) like me—then it's thinking, strategizing. Loon is chieftain. I like to go through that role and do that with people. And then it's neat when people see that, "Oh, I can see those traits in myself," and I think that helps them connect with themselves and their Spirit—and that helps them walk in wellness.

Connecting individuals to cultural and ceremonial resources often provides spiritual grounding. Many people feel that learning their Spirit or "Indian" name helps them understand their purpose in life and enhances their life experiences in general. Sometimes a spiritual name can provide protection and healing. In advocating for culturally restorative child welfare practises, Simard (2009) acknowledges that the connection of Anishinaabe identity "is carried within the spirit, and it is the spirit that brings strength, love, ancestral knowledge, and a mode of being on Turtle Island" (p. 55). Developing spiritual and cultural identities restores the Spirits of Indigenous people that were displaced as a result of colonisation. These kinds of endeavours help to initiate a sense of value and belonging.

Cultural programs are becoming widely utilised by community members accessing services through Indigenous counselling and healing agencies. Carrie conveys, “I think that one thing that we’re finding is that our treatments that are *really working* with our American Indian peoples here are the one’s that incorporate the cultural component.” She explains that building the cultural program has helped so much, “We just took about eight of our youth to the Albuquerque Powwow. [We have been] exposing them [to culture], starting the drum group, dance group, teaching them dancing, beading, bringing them to powwows, and bringing them out to the different reservations.” Carrie reveals, “It’s just amazing what’s it’s done instead of traditional psychotherapy.” She acknowledges:

Often times I think that a lot of our people, especially in an urban area such as Los Angeles, have lost a lot of that cultural identity and so exposing them to that has been the most effective in terms of their own overall wellness.

Although cultural devastation is widespread among Indigenous communities, there is a particular isolation that often exists in urban centres. Research conducted by Lavallée (2008) indicates the relevance of identity and documented that the women that participated in her study spoke about their identity being “lost in the city” (p. 70). Fortunately, over the past decades Indigenous communities have been forming in urban centres, often coming together around Indigenous organisations, agencies, institutions, colleges, and universities. These sites for social interaction become important networks for Indigenous people, especially families, who are bound together by shared cultural and historical experience.

As we continue along our journey, it has become apparent that our individual and collective survival is strongly influenced by our access to cultural knowledge and participation within Indigenous communities. Odjig White (1996) shares that, “At Elders’ conferences, cross-cultural education workshops, education and health conferences, we are constantly being reminded that the retrieval of our teachings, traditions, languages, and culture will promote self-identity and healing” (p. 108). Couture (1991a) asserts, “My contention is that indigenous knowing and knowledge, as in past eras, remain necessary to the survival and enhancement of Native personal and communal identity” (p. 55). In essence, access to cultural programming and

services that assist Indigenous people in developing cultural identities has never been more crucial. Moreover, addressing the loss of identity is imperative if Indigenous people are to effectively balance their health and wellness in a wholistic sense.

### **Connecting with family.**

The family system has always been a vital aspect of survival for Indigenous people. In many cases, helping Indigenous individuals requires involving their families. Carrie articulated that wholistic methods were reflected in how they supported clients, “If we have one identified six-year-old client that comes in, we not only work with the client, we work with the family.” She explained, “We have a team approach and do a lot of wrap around. We really intensely work with that client and the whole family and who they *even think* seems to be part of that family.” Indigenous peoples are often part of a wide familial network that includes immediate family, extended family, clan family, adopted family, traditional family, and other community members. Carol Hopkins, Executive Director for the National Native Addictions Partnership Foundation, shares that “the client is the individual *plus* his or her family and community and the treatment goal is to seek re-connection to family and others” (Ross, 2010, p. 10). McCormick (2009) asserts, “Traditional Aboriginal therapeutic approaches, unlike many Western approaches, usually involve more than just the therapist and client. Relatives and community members are often asked to be part of the healing process” (p. 339). Such views regarding connecting with families are consistent with the notion that healthcare, for Indigenous people, is primarily an extended family matter (Voss, Douville, Little Soldier, & White Hat, 1999, p. 80).

Connecting with the family network provides a supportive system and additional resources to help in the healing process. Ed shared, “When I work with an individual, I’m thinking about them in the context of family and relationships. I’m [also] thinking about them in terms of *their own* experiences mentally, emotionally, physically, and spiritually.” Ed elaborates on this process:

At times, I’m working with an individual, but I’ve got the family there in the room, because I’m learning through them about their family, at least from their perspective. And they’re introducing them to me, through their eyes, through their understanding of the relationships they have.

Yvon describes his teachings about community and that if he is “working with a family” he is “working with several individuals.” He explains:

So, we have a family here—there’s five people, so five Spirits come together and make a *new* Spirit called ‘the family.’ For the community, five families come into the community, so those families have a Spirit, but then there’s the Spirit of the community.

Yvon elaborates further on his understanding of working with family, “I think of the family as a person. How’s this family functioning physiologically? How’s this family functioning neurologically? How’s this family functioning organically?” He adds, “If you have five individuals that you’re working with and three of those individuals are not well...then there’s five people who really aren’t coming from the same perspective.” Yvon shared how he uses traditional teachings with individuals and families. He explains, “I use ceremony when it’s appropriate. What I do varies significantly on *who* it is that I’m working with. I try to be very respectful.” He elaborates further:

For example, when somebody gives me tobacco for help, *they’re* not actually giving me the tobacco—*their family is*. So when I’m working with somebody, I’m remembering that I’m not really working for that person. I’m really working for the family. Hard for me to do that if I don’t actually involve the family, so I try to do that. It’s always a very fine dance because there are some families who don’t want involvement.

As mentioned by Yvon, there are sometimes challenges that exist in connecting families to create a support network for a family member. For various reasons, many families are dispersed and disconnected. There can be geographical disconnection due to apprehension or adoption of children, relocation policies, effects of residential and boarding schools, family breakdown, lack

of opportunity, or social crisis; or there can be emotional disconnection which is often a result of the fallout of colonisation. Regardless of the cause of disconnection, many people yearn to be reconnected with their families and communities. However, because of historical circumstances and the pain that is often involved with separation, reconnection sometimes presents enormous barriers—other times, reconnection is fluid and extremely healing. In acknowledging wholistic worldviews, Connors (1993) recognises that an Indigenous approach “encourages one to look beyond the boundaries of the family into relationships of the community and the surrounding communities” (p. 54). This is an essential option for many individuals as they may need to *create* family and community in search of support, love, and kindness—a fundamental part of a healthy existence.

### **Community involvement.**

Wholistic approaches to working with a community begins with *involving the community*. For many years, Indigenous communities have been inundated with non-Indigenous politicians, *Indian Act* Agents, law enforcement officials, missionaries, doctors, psychologists, social workers, educators, researchers, and many others exerting their power—often with force. In some situations, this has resulted in disempowerment and other damages. Given the exploitative past, current initiatives involving Indigenous communities require sensitivity and respectful relationships.

Nina spoke clearly about involving community in any development regarding services:

I think you need to have the community have a voice in what you’re doing. Like, you can’t just go in there and say, “I feel very strongly about this, I’m here to help you, and I’m going to practise psychiatry here.” Like, you’re not going to get anywhere. You have to meet their needs and you have to let them tell you what they need. So, have it driven by the community rather than by your training.

Supporting Nina’s assertion, Edwards, Jumper-Thurman, Plested, Oetting, and Swanson (2000) argue that in order for prevention programs to be successful, communities must become deeply involved in the planning and implementation process, “Efforts by *local* people are likely to have

the greatest and most sustainable impact in solving *local* problems and in setting *local* norms” (p. 292). As a professional, Nina is aware that her training does not provide all the solutions. She recognises the importance of having communities decide on what needs they want to address and how they want to address those needs.

Darlene respects the ability of the community to initiate their own healing program and decide on what services they would like to access. She put forth, “I think it’s important for communities to request that work be brought into their community or that type of healing brought into their community.” In terms of her own involvement in community healing, she expresses, “A community has to want to work with me. I can’t even imagine going into a community and saying, ‘Here’s what I can do.’ I really believe that communities need to be empowered to do their own thing.” Community empowerment must come from within. Empowerment can be achieved when the detrimental power structures in communities become flattened and the natural leaders and community workers are able to bring forward ideas for growth, healing, and sustainability. Darlene shared, “I believe there are natural healers in every community.” She acknowledges, “There’s been many times where people come from the outside and then the capacity is not built within the community because that person just leaves with their gifts and their medicines—then there’s nothing for the community.” Darlene explained that she really tries to “tread carefully in those kinds of situations.” She expressed that, “If I’m invited to stay in the community for a while—I’ll always try to watch if there’s someone in that community that I can teach, that I could leave something with.” This is consistent with a human-centred approach, which is described by Sainnawap, Winter, and Eprile (1991) as an approach that recognises that “the people themselves have within them the ability to do something about their own needs, to become self-determining, if given a meaningful opportunity” (p. 12).

Involving a wide range of community members creates a strong support network and reduces the stress for frontline staff. Janice S. commented, “I don’t think I have to do all the work. I think my job is to find other helpers.” She explained that there were two suicides in one of the communities and it was quite devastating, “One was very visible: the young man hung himself right near the community store, so the community was in shock.” Janice S. shared that there was a mixed reaction in community response. “Working with the staff, some people were able to process that easily, some people were shocked—they thought they were insensitive to the process and that they were becoming numb because this was a regular occurrence in their

community.” Janice S. noted how the community moved forward to ease the confusion and pain around the recent suicides. “They connected to an individual who has some knowledge of suicide, whose interest is suicide and uses the traditional teachings. He’d been working with that community regarding the suicides and how they can respond.” Janice S. described another community’s strategy to address two other suicides:

Our community responded by setting up a Crisis Intervention Line and for a while there it worked 24/7. Then we thought that we needed to move it just down to a weekend. And so, we had that line for a couple years, just on the weekends. And people would just call in. They were just touching base—making sure that they were okay. And it was kind of neat. So I really believe community is involved. And it was community people who manned the phone, it wasn’t always the staff. The trick is to find those people who are the natural helpers, and they’re not always working in the Band office.

Indigenous agencies and organisations often consult the community to determine what programs and services are needed. These consultations can take many different forms and can include: sharing circles, community gatherings, focus groups, surveys, interviews, and suggestion boxes. Carrie stated that she believed that working with a community wholistically requires “involving the community [by] getting the community’s input.” She described a three year research study that her agency did with the American Indian community in Los Angeles, which has about 160,000 American Indians dispersed throughout the County:

It was kind of challenging to get out there. We tried to find people that just didn’t come to our agency or the powwows. So we did a lot of work, focus groups and interviews, asking the community a lot of these types of questions like: what do they think of wellness? and what are their views around healing? and what did they want to see? That’s actually how we started to come up with this program that we are now implementing. So it’s really important to reach out to the



community and bring the community in and get their input. Even today I still tell them “this is *their* program, this is how *they* wanted it.”

Community involvement often results in the community feeling a sense of pride and ownership of a program. It also increases participation as community members enjoy being part of something that they helped to create. Poonwassie and Charter (2001) highlight that, “Initiatives which originate in Aboriginal communities and which espouse those communities’ worldviews, cultural imperatives, and traditional approaches have proven to be most successful in meeting their peoples’ needs and in facilitating change” (p. 69). It also signals to community that they are capable of addressing their own needs and contributing to their own destiny.

There are also challenges to working with communities in wholistic healing contexts. Careful consideration should be given when determining a method of working with specific communities. Yvon pointed out:

One community may be in a different place *culturally* than the next community. The community may more traditional or be on the fence between Christian and traditional. Or a community could be still predominantly Christian. So it just depends on the community you’re dealing with and what their worldview is. And where are they in their recovery.

Darlene suggests that prior to coming and doing healing work, “it’s important to feel out where the community is at—is this community ready for this? or do we need to take a few steps back and do some teaching first? maybe some information sessions.” In community healing it is essential to move at the rate that the community is prepared for. Bringing in intensive trauma treatment programs when a community does not have the capacity or sustainable resources to facilitate proper care will only result in harm and further traumatising. Connors (1993) discussed the complex interdependent connections of Indigenous families and advocates that given the extended family networks, healing within Indigenous communities often must encompass interventions which recognise the entire community as the group receiving treatment, “Individually-focused models of treatment, such as behavioural therapy approaches fall far short

of addressing the complex relationship issues that must be attended to if significant and lasting changes are to be effected” (p. 64). Many factors must be considered when a community is preparing to initiate a healing strategy. Edwards, Jumper-Thurman, Plested, Oetting, and Swanson (2000) have developed a model detailing nine stages of community readiness that are useful in determining intervention implementation and helping communities mobilise for change.

Also presenting challenges to wholistic healing with communities is the level of contention that sometimes exists between community groups. Janice L. points out, “I think it’s a tough thing to do with a whole community because politics always gets in the way. Because of colonisation and oppression, the old ‘divide and conquer,’ [the competition for] funding, and that kind of thing gets in the way.” Many times community agencies and organisations are competing for the same funding dollars to fund their programs and services, despite they may have different goals and be servicing different populations within the community. Indigenous people have often articulated that this is a government strategy to cause tension and distress among Indigenous communities—weakening Indigenous Spirit and enabling the government to continue to exploit Indigenous lands, lives, and resources. Confronting the challenges around involving community in wholistic healing initiatives will undoubtedly support the movement toward decolonisation.

### **Drawing on teachings and cultural resources.**

Many Elders, healers, cultural educators, teachers, community workers, and other resource people are utilising teachings and cultural resources in their work with Indigenous communities. Indigenous healthcare practitioners are finding these strategies particularly helpful in supporting people in their healing. Tina shared that she thinks that a wholistic approach involves educating people, “And we’re not talking about a textbook. It’s understanding history, where we came from—understanding that there’s resiliency here, and there’s generations and generations of it. That talks values and of the strength that we have.” Goforth (2007) advocates for the delivery of workshops that teach culture, language, parenting skills, communication skills, anger management and problem solving skills, “For community healing to occur, resources that address what was taken away need to be made available” (p. 23). Because of colonisation, Indigenous people were not able to continue to educate their children in cultural and practical knowledge. Foreign educational systems replaced traditional systems. In recent

decades, there has been a resurgence in Indigenous education and much value is now placed on Indigenous pedagogy, andragogy, and cultural knowledge.

Janice S. shared how she draws on teachings and cultural resources when she is helping her clients. In her practise, she uses her sacred items, “In my bundle I carry my shaker, I might sing. I have my tobacco, I also have my eagle feather.” She explains that she encourages people to use medicines, “I like to teach people about smudging. We use sweetgrass in the morning for positive thoughts to open the mind. I like them to use semaa (tobacco) in the morning to do their praying—to ask for that focus.” Janice S. elaborates on many ways that Anishinaabe medicine can be used, “I might encourage somebody at night to light some sage before they go to sleep if they’re having difficulty sleeping, to take off anything they might have picked up, to even smudge their houses.” She also explained, “I like to encourage people to have a cedar bath, drink some cedar, wash some cedar over their hair if they’re needing another way of releasing.” Many people find the use of traditional medicines remarkably comforting and healing. This not only recognises the power in these medicines, but acknowledges that blood memory can be actualised to provide the return to our longstanding connection to Indigenous ways of healing.

There are many cultural practises that were set aside during the period in time when Indigenous ceremonies were outlawed by colonial governments. In some areas, Indigenous people continued to conduct ceremonies, often in fear of being persecuted by law enforcement officials. Evidently, this underground movement played a large role in protecting and preserving Indigenous knowledge. In addition to drawing on the use of medicines, Janice S. also promotes the inclusion of traditional foods and ceremonies, “I encourage people to always have berries.” She explains further, “I might bring in the Berry Fast and [share] how, as young women, it got us ready for our role.” In her work, she honours teachings regarding the different roles and responsibilities of women and men. She explains that she has learnt from Elders like Jan Longboat, an Iroquois herbalist, who did some work with them and gave teachings about their roles as women. Janice S. asserts, “It’s my role to look after my family, my children, and my responsibility *traditionally* would be to garden and to care for the home.” She explained that Janice Longboat teaches “*together*—parents know how to look after children.” Janice S. commented that she likes bringing that kind of information to her clients and showing them that it’s not difficult to do. She explains to her clients, “What we now need to do is bring ourselves *back into that harmony—into that balance.*”

In her teachings, Janice S. brings in her personal story which helps communicate the application of cultural knowledge, “I like to talk about what men could do as the providers...and I [tell the story] about my son being fifteen years old and getting his first deer, so he knows he could provide for his family.” She also shares, “I like to talk about that and how men look after the fire.” There are many gender specific responsibilities that operated in traditional systems of living. Power inequities did not exist, nor did notions of dominance or oppression. Janice S. asserts that in “this time of all this knowledge, [concepts of] feminism—people get confused.” In research undertaken by Ouelette (2002), she points out that the conflict of views between Aboriginal women and feminism is “mainly to do with the way that Aboriginal women perceive their roles as women” (p. 88). In a traditionally influenced context, many Indigenous women reject the acceptance of feminism. This does not deny that there has been oppression, abuse of power, and use of violence against Indigenous women *by* Indigenous men; rather that phenomenon is understood to have been generated through the rise of colonisation. Fernández (2003) writes that prior to colonisation male and female roles were equally important and necessary for survival, “This symbolic relationship between men and women both created and supported an environment of gender equity. Colonization undermined the position of women by instilling values and practices that displaced their important roles within the community” (p. 244). Furthermore, Hart (2002) indicates that to devalue one gender was to devalue your society and in turn yourself. “In particular, as women were the life-givers through birthing, they were held to be closer to the Creator. Men had to work at developing this closeness since they could never understand creation as closely as women understood it” (p. 48). Cultural teachings that address the roles and responsibilities of women and men are often an essential part of understanding one’s place within Creation. Although in contemporary times, and as Indigenous cultures evolve, gender specific roles and responsibilities have, in many cases, adapted to support current survival needs. However, maintaining culturally relevant responsibilities as they pertain to ceremonial knowledge is of utmost importance. For example, women should maintain the responsibility to *care for the water* and men should maintain the responsibility to *care of the fire*. Reversing these responsibilities ignores cultural protocols, and more severely, distorts cultural knowledge—perhaps *forever*.

For some people, gaining access to teachings and cultural resources is sometimes challenging. Not all communities promote traditional forms of healing. According to Aboriginal

Peoples Television Network's (APTN) National News, in November 2010, a Cree community in northern Quebec passed a resolution banning the Sweat Lodge and all forms of First Nation spirituality after a local family built a Sweat Lodge in their backyard. The community, which is predominantly of Christian faith, circulated a petition calling for the removal of the Sweat Lodge. This is one example of the resistance to traditional knowledge and cultural practises that exists in Indigenous communities. Fortunately, the majority of Indigenous communities are open to creating opportunities of access to cultural resources. Even when local resources are scarce, communities often bring in Elders, healers, and cultural teachers from other communities to facilitate cultural activities and ceremonies.

Nina shared that she believes that working with clients holistically meant that the practitioners need to be open to forming partnerships. She explained that when she worked at an Aboriginal healing agency she was able to partner with traditional healers who were part of the agency. "There were things that were obviously beyond my scope of practise [as a psychiatrist]...I knew [the traditional healers] could help people with a lot more." It has become increasingly important to connect with resources that can expand healing opportunities for clients as it enhances the experience of wholistic healing; however, the choice to explore different options is imperative. Although, Poonwassie and Charter (2001) note that, "For some Aboriginal clients, decolonization may include the validation of traditional and cultural practices, if they wish to return to those value and belief systems" (p. 71). The option to participate in teachings and cultural resources may help individuals contend with colonial history and current traumatic experiences, while using Indigenous knowledge and ceremony as active elements in their healing processes. Janice L. shared her recent experience with a client that had experienced a tragedy in her family. She explained that they were able to talk about options for support:

She wanted help in the cultural area. I did what I could to help her that way...and I guess I would wait for them to ask for it instead of—I can't just say, "Oh, well, do you want this or do you want that?" So, I guess that's how we do it: if they ask, then we'll help them with it. So, either looking for an Elder or having circles or taking them to a ceremony or whatever—if that's what they want.

A general understanding of wholistic approaches to wellness involves ceremony and community. Janice L. shared, “I think it has to be done just like what my Uncle Walter does. He has a community Sweat Lodge out there and the people go. It’s not always the same people.” She explains, “I guess it’s kind of like *if you touch one person*, then maybe that’ll make a difference somehow.” Janice L. comments on her practise, “Like, my work here, we do it from a cultural perspective and we try and keep that always in our view...we talk to the people that way.” She points out, “And if we can help them to stay healthy or look at being healthy or even *consider it*, then I think that we’re doin’ okay.” The benefits of offering teachings and cultural resources to people that are seeking healing opportunities is that there is potential to support and help people live healthier lifestyles. It is also important to connect people to community through participation in ceremony as this creates avenues to be part of a *healing community*. Gilbert shared that the community are the one’s to determine if ceremony is helpful. He feels that if the community believes and sees something in the ceremonial process, then “it’s gonna work.” As a traditional person, Gilbert is often drawn on by his community. He shares that he is called upon because “they see the results of my work if I do healing.” Gilbert explains further, “For example, if I do a sweatlodge or a ceremony...drum ceremonies...sometimes I get interrupted while I’m talkin’ when they start seein’ eagles flyin’ around out there, coming from four directions and they’ll start pointing over there.” Gilbert feels that if we use ceremony in the proper way, then we are acknowledged by the animal world and that becomes part of the results that the community experiences.

Drawing on teachings and cultural resources is not always a straightforward process; particularly if the Indigenous community is being serviced by mainstream agencies, organisations, and institutes. Janice L. asserts, “It’s easier to do it in some places, than others. And you always have to approach it very carefully.” She recalls, “When I was workin’ in the schools, it’s easier to smudge with kids and talk about our ways than when you’re working here, for the police...even though these mainstream agencies say they want to be more inclusive.” Referring to our need to go outside to smudge, rather than smudging in her office, Janice L. discussed a common issue that is often present in mainstream settings:

They can smudge in hospitals, all they have to do is close off the water sprinklers and let the maintenance people know. So, I don't know why we wouldn't be able to do it here [in the police station]. Whereas, when I was workin' at the schools and on the Reserve, we could smudge in our offices *any time we wanted*.

The issue of smudging in shared spaces has raised many conflicts that are often misunderstood. In some situations it has inspired political dialogue to occur between Indigenous and non-Indigenous peoples, which can result in an agreement on procedures for smudging. In other situations, administrative policy dictates a ban on smudging, often further entrenching conflict and misunderstanding.

Another aspect of working with wholistic strategies that presents challenges is the repertoire of a person's teachings and cultural experience. Janice S. shares that she experiences this challenge because people know that she is Midewiwin, "I don't want them to think that I'm trying to have *them be* Midewiwin. But it is Midewiwin teachings that guide me and help me in my practise." She explains:

I'm always trying to show that I am open and I am respectful to other approaches. We do all pray to the same Creator and this is how I understand that. I open the door and welcome other teachings. So I might have somebody that I know who follows Lakota Sioux teachings offer a prayer for us and talk about their teachings. I try to always be inclusive. Really just taking a step back rather than trying to be the one who knows it all.

Involving other people as resources is essential for wholistic approaches that honour the values of respect and collective participation. It is also an important contemporary element as it is common for different Indigenous peoples and their traditions to be present at the same time. I had the opportunity to witness a discussion among a group of women Elders (grandmothers as they would refer to themselves) at a healing gathering. It was time to begin the opening circle; however, they were unsure of which way to proceed *around the circle* as there were both Mohawk and Anishinaabe Elders present. Traditionally, Mohawk people proceed counter-

clockwise and Anishinaabe people proceed clockwise. After a very gentle discussion which was influenced by deep appreciation and respect for others, the grandmothers decided to proceed counter-clockwise as they recognised that they were on *Mohawk territory*. Even though this decision may have been apparent (for some) at the onset, the process demonstrated a kind and welcoming nature by both hosts and guests of the gathering.

### **Restorative justice practises.**

Since the early 1980s, restorative justice initiatives have provided important healing opportunities for Indigenous communities across Canada. Philosophies behind these practises have existed in Indigenous cultures since time immemorial; however, with the operation of colonial institutions and the erosion of traditional practises, such systems were often displaced and not utilised. Although, in areas of less colonial influence and control, some Indigenous practises continued to exist. Restorative justice initiatives are also referred to as community justice initiatives because the programs are developed, implemented, and run by communities. “These programs typically focus on repairing the harm that has resulted from crime, and attempt to facilitate the healing process of the offenders, victims, and the community as a whole” (Rugge, 2003, p. 1).

Motivated by a need to shift from the Canadian criminal justice system, which alienates and punishes individuals, to a process which engaged healing and restored relationships; many Indigenous communities have brought back traditional forms of restoring justice. The Community Holistic Circle Healing of Hollow Water, sentencing circles in the Yukon, and Bidaaban (Aboriginal Corrections Policy Unit, 1997; Couture, 2001; Couture & Couture, 2003; Couture, Parker, Couture, & Laboucane, 2001; Ross, 2006; Rugge, 2003; Zannis & Thakur, 1997) in Ontario are examples of restorative justice initiatives in Canada. Two of the research participants shared their views that wholistic strategies to healing involved restorative justice approaches.

Ed shared the story of how two women inspired a restorative justice program in their community. Previously, they had been sexually abused by a community member that held a position of authority. This person was seen as a community leader and it was felt that he took advantage of his position. Ed explained:



As they got to be older they recognized what had happened and the abuse of power. They charged him and it ended up in the courts. And in the process in the courts, they recognized fairly quickly that they weren't getting what they wanted and they likely were *not* gonna get what they wanted. Because what they really wanted was him to acknowledge and take responsibility for what he had done. They wanted him to be able to recognize how he had hurt them and hurt their families. And they wanted to hear from him—that he was sorry, that he was sorry for what he had done, apologize to them, and then to make things right with them. Those were things they wanted. But they weren't able to get that. They believed they weren't going to get that from the system because the courts were leading him into a position of denial and he was entrenched and locked into that. And indeed, that's what ended up happening. He went to jail denying what he had done, and then half the family and the community took a position of supporting him and then revictimizing them and saying that they were lying and that they had caused him harm. It was out of that experience that they came to us and they said, "Can you help us?" They were saying that to the social work people in the community or people they knew who were working as healers. And so, they came to me and they asked me if I knew of anything we could do. I had been working in the north and with Hollow Water and other communities where we introduced the concept of restorative justice; I understood how that worked, *and could work*, and so I introduced that to them.

Ed and others did training for a long period of time and then established what is known as *Biidaaban*, a restorative justice healing program. This program, similar to other restorative justice initiatives, requires a guilty plea to proceed through the healing process. Couture and Couture (2003) note that formal integration of *Biidaaban* was meant to wholistically "heal or balance and reintegrate into the community those who have harmed" (p. 24). Ross (2008) advocates the need to move out of the "crime-and-punishment box and into the justice-as healing model" (p. 12). Akin to the women in Ed's story, many people were experiencing frustration with the criminal justice system as they were not able to gain sufficient resolve of the violations and conflicts that they endured; nor were they able to feel that their situation was adequately

addressed in regards to long-term sustainability. Ed points out that wholistic approaches to justice issues have healing capacities. “It influences far more than just restorative justice. It’s a whole way of thinking. It is wholistic thinking about healing and it brings us back to our ways of making the wrongs right *in a healing way*.”

The next story of restorative justice is shared by Sylvia. She explains that these local practises are being utilised in Chiapas and in many other Indigenous communities in Mexico. She asserts, “In fact there is a certainty that Indigenous ways for reestablishing justice is undoubtedly *retributive justice* which means *retribution* and not *punishment*.” Sylvia suggests that there is an imbalance that results when someone does some sort of abuse to a neighbour. Similarly, Connors (2007) and Ross (2002) acknowledge that when harm has occurred within families and communities it disrupts the existing relationships. Sylvia explains, “In the community they make a circle and the people concerned stay in the centre. I think this is part of the therapy when there is a circle around them.” Sylvia elaborated on the community process:

The community is around them and there are two people that are complaining about something with each other. The extended families participate too, because you can say that each one of them represents a family. The families are backing them and the whole community is also supporting them to find the solution. The whole community is listening to the problem. The whole community gives opinions to how they should solve this problem. Then the Elders synthesise and concretise the solutions.

Sylvia offers some of the solutions that have been generated through these processes. She puts forth that the Elders have addressed a person implicated by expressing, “We have decided that you should leave the community because you abused a woman.” Or in another case, “You are a person that has stolen a chicken and you have to give back the chicken.” Sylvia described a punishment given in a more severe situation, “You killed her husband in a fight and now you are in charge of taking care and sustaining the widow and her children forever. You will be like the surrogate father to them because they cannot survive without him.” Sylvia claims that this is called “retribution.” She asks, “What good will it be for the family if the man is dumped in jail

forever?” She contends, “They need to survive and his punishment is to be obliged to feed them and take care of them in every sense.” Sylvia explains that in towns where customary laws are not respected and where Indigenous peoples don’t have the last word because the State judiciary legal system comes in, she has known that the family of a man killed will come and talk to the police authorities and say “please don’t put him in jail.” As noted above, the family’s survival is dependant on having a provider for the family. Sylvia upholds that community-based initiatives are wholistic and necessary strategies for restoring balance. “This is the customary way of recuperating the balance of the whole community because the balance of this person is related to the balance of the community. And so the whole community is integrating solutions.”

Sylvia’s last example is similar to that of an *old story* that was shared in *Circles*, (Zannis & Thukar, 1997) a National Film Board production about sentencing circles in the Yukon. In this story about traditional justice systems, Chief and Council sentenced a young man for murder. The sentence they decided on was that he would have to *become the son* to the people who lost their son to him. Because of that act of kindness and humanity, he ended up being the perfect son for those people. Restorative justice initiatives have been instrumental in providing community solutions to community problems. Despite the interruption in these practises, many communities are looking to reinstate old ways of addressing current problems. However, as Connors (2007) points out, the key to successful implementation “is that they must occur within [w]holistic community healing models that are created by each First Nation community with the assistance of experienced community healing facilitators with proven track records” (p. 15). Moreover, the opportunities to address justice issues through healing initiatives should be considerate of the circumstances of the imbalance and disharmony that has arose from the harmful events.

Careful consideration must be put forth in deciding what types of injuries and impactful incidents are dealt with through community justice initiatives. Sylvia suggested that it may be difficult to “transpose this type of community solution from a clinical setting.” She points out:

For example, a person that is hearing voices, seeing visions, or is creating conflict, will never be referred to this kind of community solution because the Elders will refer him to the healer. They will refer him or her to some sort of ritual specialist to help him or her get over hearing voices that are often interpreted as a

Spirit bothering him. He has to get rid of this Spirit, but this will not be done within a full encircling community but rather within an extended family collective. The collective is interpreted through the healer. The healer may bring in the community, but the community does not do the healing [in this type of context].

Sylvia explains that the community may be involved in a person's healing, such as through—Procesos de Accion Comunitaria (Processes of Community Action) a project that she created based on the approaches of the antipsychiatry movement. This subject will be explored further in Chapter Seven. Briefly, in this situation a person goes and lives with some family while he stabilizes. If a person requiring this type of service is brought for community circle, Sylvia explains, "Very often the Elders will say that this person is in a bad state here and that there are probably too many bad Spirits around him." She further explains that the Elders will suggest, "If we send him to another place, to another family, he will feel better. Or maybe he just stays in the wider community, sleeping wherever." Sylvia asserts that this could be some sort of option for the community to help restore the wellness of the person, but it is outside of retributive justice.

### **Summary of Chapter Five**

Chapter Five discussed the conceptualisation of wellness and wholistic healing in Indigenous communities. The Indigenous healthcare practitioners that participated in this study shared many stories of how they worked with Indigenous peoples in ways that addressed their wellness by using wholistic strategies. Many themes arose that are deeply connected to Indigenous worldviews and epistemologies. It was evident that Indigenous strategies involve a pursuit of balance and harmony within Creation. It was also clear that Indigenous communities consider healing initiatives an inherently spiritual process which recognises the interconnectedness of Spirit, family, and community. The next chapter will discuss the area of psychiatry and Indigenous peoples.

## **Chapter Six:**

### **Psychiatry and Indigenous Peoples**

Indigenous people have recognized from time immemorial that simple ideas of cause and effect are rarely useful. One elder told me, “If you think you know what’s going on, you’re wrong. If you know what’s wrong, it’s trivial. It’s always much more complicated than you could ever understand. The spirits don’t even let us know why things happen, so whatever explanation you can think of isn’t right. (Mehl-Madrona, 2007b, p. 32)

The aim of psychiatry is to identify and treat mental disorders. Unfortunately, this has resulted in pathologising the experiences of Indigenous peoples who may be responding to colonisation. Indigenous healthcare professionals that have been trained in Western medical disciplines have had to contend with methods that may not serve their communities well in terms of diagnoses and treatment. Nonetheless, very little opportunity has existed for Indigenous peoples to critique or even challenge the role of psychiatry and psychopathology. As this research takes a decolonising approach to trauma work, it is essential that Indigenous healthcare practitioners engage in a dialogue to critique psychiatry and its implications for systemic application to Indigenous people.

This chapter presents the stories and strategies that Indigenous healthcare practitioners shared during the research process. The main areas identified in the discussion are: psychiatric diagnoses, psychiatry and culture, and psychotropic medication. While some of the research participants reported that they utilised psychiatric diagnoses, others discussed why they did not. Participants also shared their critiques of psychiatry and advocated the need for cultural strategies. It was also revealed that psychotropic medication can be helpful in achieving balance; however, it should be prescribed with discretion as it is not always the answer.

#### **Psychiatric Diagnoses**

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) provides categories in which medical professionals diagnose patients based on a range of indicators that fit into specific criteria. The DSM-I was first published in 1952 by the American Psychiatric Association. The DSM-II was published in 1968, followed by the DSM-III (1980), the DSM-III-

R [Revised] (1987), the DSM-IV (1994), and the DSM-IV-TR [Text Revision] (2000) (Malik & Beutler, 2002). The DSM-IV-TR has become a widely used international instrument and has been translated into 22 languages.

The DSM has received criticism since its inception. The first two editions were relatively short volumes that provided a list of psychiatric disorders with brief descriptions and were critiqued for low reliability and validity. The DSM-III made efforts to link diagnoses to research findings and provided more diagnostic categories with specific criteria to be used in assessment. However, critiques surfaced regarding the increase in diagnostic categories and it was questioned if there was enough research knowledge to generate more diagnoses. Malik and Beutler (2002) point out that this concern has been accompanied by the observation that the designers of the DSM-III and DSM-III-R, and to a lesser extent DSM-IV-TR, “were still predominately senior White male psychiatrists who embedded the documents with their biases” (p. 6). In an attempt to address these criticisms, the writing of DSM-IV involved several hundred mental health professionals, including a 27-member taskforce and 13 work groups. The process also involved women, peoples from different racial and ethnic backgrounds, and nonpsychiatric mental health professionals such as psychologists and social workers (Malik & Beutler, 2002, p. 7).

This section presents the responses of the research participants in relation to the questions that were asked regarding the usage of psychiatric diagnoses in their practises with Indigenous people. The interview questions asked practitioners if they used DSM-IV diagnoses specific to Post traumatic Stress Disorder, Depressive Disorders, and Schizophrenia and/or other psychotic disorders. Participants offered various responses which inspired a broader dialogue. Whereas some practitioners used diagnoses as part of their own practises, others were versed in diagnostic language and used the terminology with other medical professionals or funding agencies. Participants also problematised the use of diagnoses and shared their thoughts on the impacts and limitations of diagnoses.

### **Using DSM diagnoses.**

The usage of diagnoses varied from practitioner to practitioner. Almost half of the research participants indicated that they used, or had used, diagnoses in the duration of their work as healthcare practitioners. Alternatively, some practitioners did not use diagnoses at all

because they had not been trained in diagnostic procedures, did not believe in diagnoses, or did not practise from a position that required formal diagnoses.

In her work as Concurrent Disorders Case Manager, Janice S. explains her use of diagnoses, “I use the DSM book. It helps me understand where a person is. I use depressive disorders, schizophrenia, and the psychotic disorders.” She emphasises, “I do like to use the Medicine Wheel and to show them that this is a part of who they are, it’s part of the wholistic [approach] of their being, their whole, entire being.” Janice L. shared that when she worked in the school system administering psychological tests, she used diagnoses. “We didn’t like to do it. It was really hard because the Indigenous community had difficulty with us coming in. They thought that was our job to come in and put labels on their kids.” She explained that they rarely gave diagnoses, “I tested ninety-some kids, and I think I only gave maybe seven or eight diagnoses. Even then, we had long discussions over whether to put them in or not, so if we could stay away from it, we did.” In the diagnoses that they did use, Janice L. recalls, “They were kids, so there was some depressive disorders and one kid had these psychotic episodes. He was in grade seven and was having difficulty. I don’t think there were any posttraumatic ones that I was aware of.” She also noted that some of the kids were diagnosed with “ADHD [Attention-Deficit/Hyperactivity Disorder], Conduct Disorders, and OCD [Obsessive-Compulsive Disorder].”

As a psychiatrist, Nina is in a position where it is expected that she conduct psychiatric assessments and apply diagnoses. With that, she explains, “Sometimes I’ll use just plain posttraumatic disorder and sometimes depression or dysthymia.” She mentioned that she rarely gives the diagnosis of schizophrenia, “I’ll use psychotic disorder NOS [not otherwise specified] because a lot of the people I see who are Indigenous don’t really fit into the typical kind of schizophrenia criteria.” Nina pointed out, “I think the most common [diagnosis] that I’ll use is complex posttraumatic stress disorder, so not acute, but the other disorder described by Judith Herman.” In 1992 Judith Herman introduced the concept of Complex Post-Traumatic Stress Disorder. Herman (1997) argued that there needed to be a new diagnosis which captured the effects of prolonged and repeated trauma. She writes:

All too commonly, chronically traumatized people suffer in silence; but if they complain at all, their complaints are not well understood. They may collect a virtual pharmacopeia of remedies: one for headaches, another for insomnia, another for anxiety, another for depression. None of these tend to work very well, since the underlying issues of trauma are not addressed. (Herman, 1997, p. 119)

The concept of Complex Post-Traumatic Stress Disorder was validated in the field trials for the DSM-IV; however it was not listed in the Manual given that the DSM-IV committee didn't like it because they didn't know where to put it. "Is it an anxiety disorder, a dissociative disorder, a somatoform disorder, or a personality disorder?" (Herman, 2006, p. 82). Despite, that it is not an official DSM diagnosis, many practitioners continue to draw on its criteria in efforts to understand and treat their clients. It is speculated that the diagnosis may be listed in the upcoming DSM-V. Importantly, the DSM-IV diagnosis of PTSD is the only diagnosis that implies that something has *happened* to the individual in distress. Unlike other diagnoses, which indicate that such disorders are chemically related and best regulated by medication. Understanding that a traumatised person is responding from a place of injury creates a need to develop an effective healing plan, which may or may not include medication. Many suggestions have been put forth that call for trauma assessments to consider *trauma* as a response, rather than an illness. Ross (2009) notes that in many circles, Herman's diagnosis has now been altered to read Complex Post Traumatic Response, rather than disorder (p. 7). Mitchell and Maracle (2005) argue for Posttraumatic Stress Response. Burstow (2005) critiques DSM diagnosis and argues, "It demonstrates that the category of PTSD is confused, reductionist, contradictory, and arbitrary and that it pathologizes purposeful and valuable coping strategies commonly used by people who are traumatised" (p. 429). Importantly, Burstow (2003) problematises the rejection of psychiatric diagnoses claiming that "doing so jeopardizes insurance coverage and compensation claims" (p. 1316). In effect, diagnoses provides legitimisation of damages that are often assessed in court proceedings and benefit entitlements.

Indigenous healthcare practitioners are sometimes limited by DSM-IV diagnostic frameworks and seek other diagnoses to work with their people. Carrie discussed the application of diagnoses and commented on the relevance that they have in relation to Indigenous people, "I think these diagnoses often just show that you have *these symptoms* and that's it, but there is so much more that I feel is going on with the client." Unlike Nina, who drew on complex post-



traumatic stress disorder, Carrie indicated that the concept of historical trauma (Brave Heart, 1998; Brave Heart-Jordan, 1995) was most applicable, “None of these diagnoses capture the historical trauma like historical trauma response. And besides, they have PTSD or they’re depressed, but there is more that is going on with them. And so the diagnoses just don’t capture that.” Indigenous practitioners often seek cultural frameworks for understanding trauma. Brave Heart (1999) argues the need for a Lakota historical trauma response theory “rather than utilizing proposed concept such as [Herman’s] complex PTSD” (p. 3).

Many Indigenous healthcare practitioners indicate that as a consequence of colonisation, including residential/boarding schools, Indigenous people suffer from symptoms of PTSD (Brave Heart and DeBruyn, 1998; Chansonneuve, 2005; Duran and Duran, 1995). Gagne (1998) advocates the application of PTSD to Indigenous peoples, “It is because First Nations citizens have experienced so many of these events in their lifetime that such a high percentage of their population suffers from PTSD and other anxiety disorders” (p. 369). Furthermore, Wesley-Esquimaux and Smolewski (2004) note, “Many communities have requested that PTSD be considered a diagnostic tool in the newly created healing centres across Canada” (p. 2). It is clear that Indigenous trauma practitioners and theorists have found use in applying the diagnosis of PTSD. However, the full implications of accepting a mental illness approach and how to treat this in a cultural context has yet to be discussed. Despite the acceptance of PTSD by Indigenous practitioners, Waldram (2004) points out the contradictory data that studies have indicated when testing Native Americans for PTSD:

An adequate explanation for the apparent discrepancy between exposure to traumatic events and prevalence rates of PTSD still eludes us. This discrepancy suggests several possibilities: that these individuals are dealing with trauma without evidence of psychiatric dysfunction; that they are experiencing and then recovering from PTSD without psychiatric intervention; that they are expressing the consequences of trauma in ways that existing diagnostic procedures miss; or they are not measurably traumatized by the kinds of events that the DSM anticipates. (p. 220)

Indigenous practitioners accepting the medical model applications of mental illnesses, and utilizing these diagnoses in their practises, perhaps unintentionally, promote the idea that Indigenous people who exhibit *symptoms* which fit into the DSM criteria are declared *mentally*

*ill.* DSM diagnosis does not accommodate the multitude of circumstances that is reflected in the literature that indicates Indigenous peoples have been traumatized by colonization.

Yvon shared that as a nurse the diagnoses that he uses relate more to functioning rather than psychopathology, “I don’t really use the DSM-IV other than to better inform me and/or to better inform the people that I’m involved with.” He explains, “A part of my role as a nurse is to help people to better understand diagnosis through education and/or to assist people in being able to navigate the cornucopia of conditions that they may come across.” Yvon asserts, “I don’t necessarily worry too much about those diagnoses, but many of the people that I come into contact with appear to be obsessed with the diagnoses.”

Not all healthcare practitioners are trained in DSM procedures. Tina shared that at the agency that she works with, “We’re not allowed to be diagnosing because we’re not qualified.” She explained that a psychologist comes in to help in a supervisory role with case managing and case consults. Tina pointed out, “If a staff person was qualified to do diagnoses, then, yes—they would be allowed to use diagnostic tools. But, we don’t have a person on staff.” She added, “If somebody is diagnosed as PTSD or depression or schizophrenia, then we would be working in collaboration with the client and a psychiatrist.”

Evidently, Indigenous healthcare practitioners utilise DSM-IV diagnoses in their practises; albeit, some indicated that it was done so with caution. It was also expressed that some of the current DSM-IV diagnoses did not adequately reflect what was being experienced by Indigenous people and that other diagnostic procedures were used such as complex post-traumatic stress disorder and historical trauma response. Mehl-Madrona (2005) explains that in order to understand what will work for a person, we need to hear his or her story, “The diagnosis is one marker of the journey that he or she has travelled. That particular road sign, however, doesn’t tell us anything about how the person traveled to get to that point” (p. 13). While Indigenous healthcare practitioners are looking for culturally appropriate ways to provide services to Indigenous people, there is growing recognition that the usage of DSM diagnoses has many implications.

#### **When diagnoses are helpful.**

A few of the Indigenous healthcare practitioners were able to recognise specific instances where diagnoses were helpful. Yvon expressed, “If the only treatment that seems to be available

is Western in terms of somebody becoming stable. There is usually a corresponding relationship between diagnoses and treatment.” He elaborates, “And so, sometimes community members who are receiving a particular treatment may be receiving a treatment which does not in the literature seem to correspond with their diagnoses.” Yvon uses the example of people who may have a diagnosis of schizophrenia receiving anticonvulsive medication, “They know that anticonvulsants are for seizures, but they don’t seem to understand why they’re receiving seizure medication when they don’t have seizures.” Yvon helps his clients to understand how a healthier lifestyle is directly related to the treatment that they receive.

It was also pointed out that many people who have struggled with issues of living and prolonged imbalance may feel validated by receiving a diagnosis. Nina shared that, “They seem more relieved [on hearing a psychiatric diagnosis]. I’ve never really had a negative reaction.” She elaborates further on how she uses the diagnosis with her patients, “I think the most important thing is if people feel like they’ve been heard. And I always say, ‘This isn’t what you *have*—it’s more how I see things.’ So, it’s a very different kind of approach.” Similarly, Janice L. indicated that sometimes diagnoses were helpful if individuals and families were able to access other supports, “I think the mother of the boy that experienced psychotic episodes found it helpful because it helped her get [mainstream] services for her son.”

Nina also pointed out that discussing a diagnosis with a patient sometimes provided the opportunity to delve into deeper issues. In using complex post-traumatic stress disorder, she found it most helpful in opening the dialogue with patients and devising a treatment plan:

I’ll have somebody come in who wants a disability form filled out because they’re depressed. And then when you start to dig a little deeper, that’s where the cluster of symptoms comes out. And you start to realize that what they’re suffering from isn’t necessarily a quick, acute onset of a depression but something that’s been chronic, ongoing, and obviously the result of a lot of different factors that we know about intergenerational trauma, trauma from sexual abuse, or accidents, or things like that.

Working within the medical model has various constraints for practitioners who are doing their best to employ approaches that address the needs of those seeking professional help. Nina expressed, “Unfortunately, in my business, you have to give a diagnosis of some kind. I need a diagnosis just because I’m still trained in Western medicine.” She further asserts, “You kind of need to know what you’re treating or to have something in your mind to organize your approach.” The need to access disability benefits is a major necessity for certain individuals. Most often, these benefits require medical documentation and a diagnosis. In some situations, a diagnosis may be extremely helpful for an individual to be able to receive benefits that provide a living allowance at a higher rate than would be provided by the social welfare system. Access to financial resources can directly relate to a higher standard of living, a healthier diet, and a safer residence. However, in other situations, diagnosis and disability benefits may support individuals to remain in a cycle of dependency and isolation—with little motivation to become self-supporting and connected to the world around them.

### **Diagnoses and funding.**

Many Indigenous healing centres and other institutions that address health issues require government funding for their programs and services. This funding has to be substantiated based on criteria set by the funder. Because of the validity that psychiatry and diagnoses implies, a few of the research participants indicated that collecting and reporting data on diagnoses was necessary in securing program funding. Janice L. commented on the helpfulness of diagnoses, “I think it was more helpful for the school, for their dollars, than it was for the kids. Diagnoses equals dollars, which equals more staff.”

Carrie affirmed that the agency she worked with uses diagnoses because one of their main funders is Department of Mental Health “and just about any of our main funding sources require a diagnosis.” Carrie noted that they see a lot of people with PTSD and their agency receives specific funding support to assist their clients that have been traumatised, “We have a domestic violence program, child abuse program, so about 80% of our clients have had some type of trauma and abuse and show a lot of PTSD. So it is helpful.” Although, she commented, “When a client comes in we try to use a diagnosis that is not so *impactful*. Such as adjustment disorder or something like that.” Carrie expressed, “We will often try and do that because that’s all we need—just a small diagnosis and we can get the funding.” She shared that the questions

around using diagnoses came up with their community. The community discussed how they felt about diagnoses and wondered if “there was another way that we could explain it or talk about it, but they couldn’t agree. They said ‘let’s just stay with the DSM’ and we [the staff] could find our ways to work around that.” Carrie relayed that the community “knew it was a big part of funding and that we have to have a diagnosis before we can bill them for anything.”

Different funding agencies have varying requirements and not all adhere strictly to DSM-IV diagnostic language. Ed maintains, “I don’t have much use for the DSM-IV and what I *do* use is on a limited basis.” He explains, “Most of my work in terms of individual work is funded through First Nations Inuit Health Branch. We have to provide a treatment request. It’s an assessment report that requests the services and we’re asked to provide a diagnosis.” Ed elaborates on his methods of providing the assessment report:

You can use the DSM-IV diagnosis if you wish, but I tend to *describe* more often than not. I’ll describe what the condition is in terms of *what the problem is* as opposed to short forming it into such a little piece. A lot of times it will fit somehow because I’ll use the terms such as *anxiety* and *depression*. There are a lot of common terms that are general and they fit. I talk about grieving and sexual abuse. But I won’t get into the DSM-IV classifications and getting it defined and refined.

Using descriptive methods to submit requests for services is an appropriate way to secure funding while not legitimising DSM-IV’s focus on pathology. However, in the absence of recognised alternatives, and because of the value placed on Western medical knowledge, funding agencies often require formal diagnoses to justify administering funds for service delivery.

The issues around diagnoses and funding are not specific to obtaining funding. In some agencies and institutions, a healthcare practitioner will have to hold membership in a regulated health profession and have the ability to apply diagnoses. This factor has limited services in many Indigenous communities because the majority of regulated health professionals are non-Indigenous people who provide services based on the Western medical model. It has also created challenges to secure funding for traditional healing services. Darlene shared a story about her

experience of working with a First Nation community in Canada. They had eight children in the group home ranging in age from about four to seventeen. The children had been going to see a psychiatrist twice a week, every week, in the nearest city, which was about two-and-a-half hours away. The Director of the Health Authority for the First Nation had come to try the Swing therapy at a conference that Darlene was at. Darlene recalled, “She really had a very good experience, a very good healing experience. And so, she thought that maybe the children would benefit from this because it’s based in cultural philosophies and old cultural practises.” She expressed that the Health Director felt that “they might take to it better than they were taking to their psychiatric appointments because they weren’t seeing any changes in these children; and these children did not want to go for these appointments.”

The Health Director asked if Darlene would be willing to work with her community. The Director wanted to do a pilot run of the Swing healing and not take the children to their psychiatric appointments for a period of about four months. Darlene agreed and began to work with the children twice a week. She shared her process of working with the children:

I would put these children into the swing for about a half hour to an hour at a time. I would just work with them in a really loving, kind way. After awhile, I noticed that when I would arrive at their building, they would all come running outside, and they would help me bring in the Swing and help me set it up. They were really excited to see me, really happy to get in there, and they would fight over who’s gonna go first. It was really great. I started to have a really wonderful connection with these kids and I just absolutely loved them—every one of them. I really got to know their Spirits and what was troubling them. And I really felt that what they needed *most* was just love, nurturing, and understanding. And they were really taking to that.

The children were progressing well during the months that Darlene brought her Swing to the group home. However, after the four month period, the Director was very upset and informed Darlene that they couldn’t continue the work with the Swing because the funding agency had come down hard on them for not taking their children to the psychiatrist. Darlene was dismayed

that the funding agency said that they were not going to fund her services, “They called me *unprofessional* and said that because I didn’t have my credentials as a psychiatrist or psychologist that I shouldn’t be working with children in this way.” Upon hearing this information, Darlene expressed, “I was sooo upset because I really wanted to keep working with those kids. I really felt like I was just starting to make headway with them.” She was concerned about the impact that ending the services would have on their progress, “Some of them were teenagers and they were really difficult. They had that shell and I was breaking through their shells. And they were coming out and sharing things with me.” Despite Darlene, the Director, and the workers of the group home recognised the efficacy of the Swing, she conveyed, “It didn’t matter. It came down to the money. It’s really frustrating.”

The legitimacy of expertise assumed in regulated health professions has severe implications for Indigenous people offering traditional healing services. Although, many times traditional healing services can be funded under specific circumstances; much of the funding for *mental health* or *psychological* services is only available if services are provided by a regulated health profession. This discounts the long-standing effectiveness of traditional healing methods which have been used by Indigenous peoples since time immemorial. Darlene expressed her frustrations regarding society’s construct of legitimacy:

Why can’t I, as an Indigenous woman, as an Indigenous healer, work with people the way I know how, the way I’ve been trained by my Elders, who have been doing this kind of work for hundreds of years. Why do I need to have credentials behind my name in a field that I’m not gonna work in? In a structure that doesn’t work for a lot of Indigenous people...this work that I’m doing has become so popular because it’s based on Indigenous philosophies, Indigenous teachings, Indigenous healing practises, Indigenous parenting practises, and it speaks to the Indigenous Spirit that needs to be healed—in an Indigenous way.

Essentially, Indigenous healers and traditional healing methods should be recognised as legitimate forms of healing and funded accordingly. There is currently a gap in regulatory bodies which address these issues. Although, Section 35(1) of Ontario’s *Regulated Health Profession Act* (1991) exempts Aboriginal Healers and Midwives from having to follow the provisions

under this Act, it does not address the funding aspects or set criteria of any sort. Durie (2009) suggests that there is interest in establishing a college in New Zealand with a set of standards to guide Māori health practitioners, managers, and providers. Nonetheless, mainstream authorities, such as regulatory bodies and funding agencies, need to support the movement for Indigenous peoples to provide traditional healing services to their communities.

### **Impact of diagnoses on identity.**

The impact of diagnoses on identity was relayed by a few of the participants. It is a particularly important issue given the loss of identity for many Indigenous people. There are also cultural implications regarding identity development. An Elder expressed concern about the impact of labelling on the formation of identity and the subsequent harm that comes from negative identity development and self image, “in our traditional way we never label anybody” (Crowe-Salazar, 2007, p. 90). This concern is especially relevant in regards to young people who are forming their identities and are highly influenced by their environments.

Janice L. shared the story of a sixteen year old girl that had been diagnosed ADHD, “I don’t know whether that’s helped her or not, to have that label attached to her. Like, she is the way she is...And now, they want to add more labels on her—like conduct disorder.” Janice L. pointed out that using diagnosis with older kids should be done so with caution, “when they’re in that identity phase in their teens, it’s a fine line to balance;” and in the case of this teenager, she points out, “I don’t know how that’s gonna help her navigate her way by having more labels added to her.” As diagnosis usually corresponds with treatment, medication is often part of the diagnostic process. Janice L. noted the difference in this young person’s personality when she was on and off medication, “She’s a beautiful girl. She’s funny and she makes us laugh. She’s got her problems, but she’s hilarious and she’s a riot to be around.” In contrast, “I saw her when she was on her meds and she was *not the same girl*. She was all like ‘yyyhhhhnnn,’ you know—like comatose? And so, when she was on her medication, it just was *not her*.” This girl took herself off medication which generated a discussion between Janice L. and her mom, “I think that she just needs to learn how to manage without [medication]...but she hasn’t learned how to manage...At the same time, she doesn’t want to go see a counsellor either.” Many issues have been raised regarding young people and how to best work with them while supporting their health and wellness needs.



Complicating the identity issues is the unfortunate reliance on psychotropic medication to regulate the behaviour of young people. However, it is possible that treatment plans are based on assessments which do not consider the larger issues of healthy development. Maté (2010) acknowledges that, “For the first time in history, large numbers of kids are being medicated because we don’t know what to do.” Additionally, pharmaceutical companies are large beneficiaries in the medication of children and young people. In fact, Eli Lilly, makers of Prozac, used National Depression Awareness Days to educate high school students about their antidepressant product. “Representatives of Eli Lilly handed out Prozac pens and notepads” and had them fill out and self-grade questionnaires that asked if “they ever thought of death, or ever felt inadequate, unsure, and moody” (Neugeboren, 1999, p. 137). Clearly, the administration and marketing of antidepressants to young people sends contradictory messages as society promotes catchphrases, such as: “say no to drugs” and “war on drugs.” Nevertheless, children and young people receiving diagnoses and medications are conditioned to shape their identities around *illness* and *drug dependency*. Much work needs to be done to reverse the effects on identity development.

Many people living with a diagnosis have endured years of stigma and shame. Indigenous healthcare practitioners often help them develop healthier perspectives of themselves with stronger Indigenous identities. Janice S. pointed out, “I think there’s a lot of stigma, so sometimes when I meet somebody and they’re embarrassed.” She elaborated, “I have one client who does not like to be called *schizophrenic*. And nobody does. I like to say that she *lives with schizophrenia*, she prefers to be considered to have a *mood disorder*.” Janice S. discusses the diagnosis with her client and explains that it “helps us understand that she doesn’t handle stress very well.” She shared her strategy of helping a client who tends to become stressed:

If she calls me on the phone, then I can ask her a few questions, like “What’s happening? Where are you?” And I’ll know exactly how stressed she is by the level—the *high-pitchedness* in her voice. So, to bring her down, I have asked her to smudge. She smells the sage, it calms her, helps her focus. And then she’ll call me back a little while later and say, “Okay, I’m in a good place now.”

In helping individuals to understand the purpose of their diagnosis, Janice S. asserted, “I really try hard not to use western European words to define people...[or] to have [diagnoses] define my helping relationship.” As a case manager, she explains that when she gets a client’s Intake Assessment, “somebody has already gone through that and told me what their diagnosis is. Then I go to the DSM to let me know what it is...But that’s in the back of my mind.” Janice S. also noted, “I also like to work with a person not to have them totally *defined* by the diagnosis...So they’re not gonna define themselves as *post-traumatic stress disorder*.” Her method of helping them understand that diagnosis is something that they *live with*, rather than are *defined by* enables clients to develop an identity that is rooted in their own Spirit, rather than accept an identity that is a result of a label that a professional has applied. This approach is similar to Duran (2006) who suggests that his clients are visited by the “spirit of depression,” which then allows the client to see the depression as something objective that “doesn’t belong to the patient and can be moved into another place” (p. 84).

There is recognition on part of Indigenous healthcare practitioners that the psychiatric system has its own language. Ed explains, “I’m *very* cautious and I’m *very* limited in sharing those kinds of diagnoses with people that I’m working with.” He explains further, “If it’s to their advantage and they understand it for what it is and they understand it in a healthy way, then I will explain it to them in terms of what that means from a psychiatric perspective.” Ed shared that he is very cautious in sharing diagnoses “because *too* many times I find that people have become trapped in those diagnoses so that their efforts to become whole, healthy, and healed are limited because they end up taking on the diagnoses as part of their identity.” When problems and conditions become a large part of people’s stories of themselves they provide people with a sense of identity (Mehl-Madrona, 2007b, p. 126). Ed is concerned that for some people, “It becomes a part of *who they are* and sometimes it becomes the *core* of who they are.” He indicates, “When it becomes the core of who they are, I don’t know *how* we manage to get them into a state of healthiness because they’re trapped, I think, in a state of illness.” Ed pointed out, “Even the medicines that are available in terms of the psychotropic drugs, even those at times will have limited ability to change them if they become health identified as being schizophrenic.”

Ed shared that much of his work has been to “de-mystify the psychiatric system and to help people to realize what it is and how it has entrapped them in a state of illness.” He has found that, “If they understand it well enough, they can free themselves from it. They can actually

overcome the system that has told them that *this is who you are and this is who you will remain*. Ed recognises this transformation as *miracle work*:

There are people who have been identified for many years as being psychiatric patients, as being *bipolar* and believing in that state, that that's all they'll ever be. And that it's only the medication that helps them to be anything but what they are—and that's just stabilized. And my position is, “No, you're much more than that and you can become much more. The medication can help you, but it's not all that you need.” I've seen people who are in those states for many years come to a point of realizing they can be something much more than the label.

Ed notes that “through therapy, counselling, healing work, [people] come to understand that they *are* much more, *become* much more, *grow* beyond those labels, *grow* beyond those limitations, and realize that they are healthy human beings.” He shares the story of working with a client over a number of years. When they began the therapeutic relationship, she claimed that she was bipolar. Although, he noted, “She's had probably six or seven different diagnoses. But bipolar is the one that's stuck with her.” Initially she was so incapacitated by her involvement in the psychiatric system that she spent most of her time in psychiatric care. Her whole circle of friends, her whole place of socializing was all the people in the psychiatric hospital. For many years she had been disconnected from her family. Ed pointed out the connection between this client's history and her family system, “All her family were disconnected from each other—they were all struggling. And it all goes back to the whole history in the family and how they had been raised as children and what happened with their parents.” Over the years, Ed worked with her to reconnect to the community and she eventually moved into an apartment (independent living) where some of her siblings also lived. “She ended up connecting with her sisters and then started to connect with some of the [cultural] programs and circles.” She was also connecting with some of her extended family that were also participating in these programs. The reconnection to family and community often generates rippling effect that strengthens the family system. Ed noted that recently, “They had a family reunion which was unheard of for them to actually *connect as family*. Now it's at a point where she's living in a community and

reconnected to family.” Ed continues to provide service to this client. He has witnessed the changes in how she defines herself, “She doesn’t talk much about being bipolar anymore. Periodically she has her ups and downs. I’ve redefined it and normalized the changes in her mood with her into a more, I think, a healthier perspective.” He explained further, “She talks about it more now as highs and lows; and talks about it in the context of what she can do and how she can be constructive and creative...and what she needs in order to be in the healthiest state at those times.” Ed also pointed out that “the medication is only a small part of it now.” As a result “That’s how she’s changed her perspective on *who she is*. She’s slowly, over time, demystified the psychiatric label and lessened its impact so she’s not so much *that label* anymore. And she’s living a healthier life in many ways.”

Many of the concerns related to diagnoses and identity have arisen with clients who perhaps did not have a strong identity to begin with. Indigenous cultures contain many practises that help young people form healthy identities, which promote a strong sense of purpose, self-worth, and a grounded Spirit. In the absence of cultural frameworks, many people did not have the opportunity to develop strong Indigenous identities and as such, many of the identity forming customs became replaced by external beliefs and practises. Duran (2006) refers to the diagnostic procedure as a *naming ceremony* and asserts that this results in an “identity of pathology” (p. 31). Given the importance of obtaining a *spiritual name* within Indigenous cultures, it is understandable that diagnosis can negatively influence identity development. It is for this reason that Overmars (2010) cautions against using DSM-IV diagnoses with Aboriginal peoples.

### **Limitations of diagnoses.**

Participants offered a number of critiques of diagnoses and the DSM. Engaging in this dialogue provided an opportunity to explore *what* Indigenous healthcare practitioners thought about diagnoses, regardless if they used them or not. It was evident that some of the participants did not find it helpful to use diagnoses. In fact, there were two participants that rejected the use of diagnoses altogether. Others seem to point out the limitations of diagnoses and problematised the DSM.

In the general use of diagnoses, Janice L. pointed out, “I didn’t find it helpful. I don’t know whether the parents found it helpful or not, they never really said.” It is not surprising that the parents did not indicate their thoughts on the diagnosis that their child had been given. Many

times Indigenous peoples are taught, by consequence of colonisation, not to challenge authority, particularly medical authority. Darlene asserted that she doesn't use diagnoses because "she doesn't believe in it." Even though she began her post-secondary education in the field of psychology, she soon discovered that she was not comfortable with the use of diagnoses, "It didn't sit well with me when I was learning about it in class. It really labels people and compartmentalizes them. It breaks down people's Spirits." Darlene elaborated:

When you label a sick person, like a person that's already feeling so low, like lacking balance and lacking confidence, to then come along and put them through all these tests, and then label them—it's like putting them into a box that they can never heal from because now *they're this*. I just think it can be so detrimental to the Spirit.

Sylvia clearly articulated that she doesn't use psychiatric diagnoses or "terms such as *schizophrenia, depression, manic or bi-polar*." Instead, she proceeds to work with the individual to understand their personal story:

What you want to know is: how can this person pull their self together again? Where are the pressures coming from? Where is the anguish? Where did she get entangled in earlier years in some kind of suffering that made her dissociate? How did she get alienated from herself that she needs to have two selves?

Sylvia concludes that "this is often caused by very intense suffering, intolerable, and sustained anguish." She advocates that healing requires the person to "go back to that time and try to resolve that anguish." She puts forth, "It is my experience that slowly they will come back together again" and that "we don't need psychiatric labels." Mehl-Madrone (2007b) concurs that psychiatric labelling does not advance a healing paradigm, "DSM-IV is frustrating in that the stories that it generates through its diagnoses have no magic or power to change people. They embed them in a label of disease to the exclusion of healing" (p. 162). Whereas, Sylvia and other

Indigenous practitioners seek to understand the experience of the person and help them find healing in resolve of their turmoil, rather than remain entrenched in diagnoses and pathology.

Adding to the dialogue of diagnoses and healing approaches, Nina asserts, “I think that we pathologise a lot, and I just think the diagnoses are kind of *false constructs*. Like, they’re not really all that accurate.” She comments that psychiatry “has become very biologically oriented and consultative, so it’s kind of like a hands-off approach.” Although she notes, “I think that there is a movement coming in now from the younger generations for psychotherapy or at least having some knowledge of dynamics and of the working relationship with your patient.” But her experience as a psychiatrist has taught her that, “Psychiatry, for the most part, is diagnosis and you have a plan; and then everybody else [carries out the plan] because the doctor’s time is too valuable.” Nina expresses, “For me, that’s not fun. Well, not only that, it’s not really valuable because you don’t really get to form a relationship with the client.” Indigenous healthcare practitioners point out time and time again that *relationship* is an essential part of the healing process.

Nina comments that working in a hospital often involves “writing prescription after prescription after prescription and order after order after order.” Psychiatry in general upholds its focus on pathology and treatment, and does not encourage psychiatrists to take an inventory of their cultural biases. Brant (1990) warns that the general psychiatrist’s failure to recognise cultural behavioural traits may result in unperceived errors in diagnosis and in treatment, and cautions against the “overuse of antidepressants and the all too frequent diagnosis of personality disorders” (p. 534). In her practise, Nina is able to proceed with caution in the administration of psychotropic medication. She has also found that diagnostic criteria were not largely applicable to Indigenous people, “A lot of my Indigenous patients, I’d say the majority of them, don’t fit the diagnosis [of personality disorder]. But if you just look at a snapshot of their history, they definitely look like borderline.” Nina is careful not to deduce a diagnosis from standardised assessment tools without considering the wider context of the individual’s journey. She is also mindful in how she discusses diagnosis with her patients. Her method is to give them a background as to what she thinks is causing their symptoms. If it’s somebody who might otherwise get diagnosed with borderline personality disorder, Nina would say to them, “Well, you know, this is what you’ve told me, right? You’ve had these difficulties and this is how it’s affecting you. And this is the diagnosis that would be given to you.” She then discusses the usual

treatment methods. Nina maintains, “I always just kinda put it in common terms.” In her explanation, she shared that she would say, “Some people have mood difficulties because of a chemical imbalance, and sometimes people get that chemical imbalance for no reason, and sometimes they get it from the experiences they’ve had over their lives.” Nina acknowledges that the historical context of the person’s life becomes imperative in the assessment process.

Carrie shares her experience with diagnoses and treatment:

We will have a lot of kids come in [who have been] diagnosed with ADHD, [and have been] put on Ritalin and *that’s it*. So they kind of say, “Here is your diagnosis from the DSM and here is what we need to do for you,” and then that’s going to be all. We find lots of parents come in here in that situation and they feel that they never got help anywhere at all. [The kids have not been assessed for] historical factors and trauma...So I think that [diagnosis] just focuses on *here’s your symptoms, your diagnosis, and your intervention*.

In addition to assessments that exclude a history of trauma, Yvon asserts, “In fact, if anything, I would say that my biggest criticism of the DSM-IV, is it tends to be merely concerned with psychopathology without giving much consideration to neurobiophysiology.” The wholistic nature of helping Indigenous people is far outside the realm of psychiatry. Indigenous healthcare practitioners are apt to draw on methods that listen to the stories of their clients and employ cultural frameworks that address all aspects of the person: spiritual, emotional, mental, and physical.

The value that is placed on the experience of living with complex health concerns should not be undermined by diagnoses and treatment. Yvon pointed out that diagnosis is not helpful “when the practitioner makes it the client’s focus.” He recognised that it can be problematic for the client, “If [diagnosis] becomes a preoccupation rather than focussing on peoples’ quality of life issues: living, working, learning, socializing....It doesn’t mean the diagnoses are not important and that treatment is not important, but that it’s not the only thing.” He adds, “You know, in the world of recovery we talk about that being the thirteenth step. There’s more to life than recovery. It’s called *living*.” Reflecting on the issues of quality of life, Yvon asserts, “I’m

not necessarily convinced that somebody knowing that they have schizophrenia and who needs to be on psychotropic medication is necessarily connected to their quality of life.” He puts forth an important question that is primarily concerned with helping family members be supportive, “How do I teach somebody’s auntie to be able to relate to somebody who actively hallucinates and has delusions?” Essentially, Yvon suggests that it is important to assist clients and their families to maintain relationships. He suggests a further look into the insights of an individual:

I would even argue that it’s conceivable that there is some degree of influence from the quality of life that we have around the messages that come through from people who are “psychotic.” [Sometimes] the voices that they’re hearing are saying, “You’re a dirty, god-damned bitch. You should die,” and I’m wondering whether or not those voices are echoing the messages that this individual is receiving from the people that are within their environment. And maybe if the messages that that schizophrenic were receiving were, “Oh, thank God you’re here. Hey, I’m so happy to see you”...whether they’re from Spirits or whether they’re from the person’s synaptic processes, might be positive and life affirming. It always concerns me when other people’s preoccupation with a way of seeing the world takes precedence over that person’s ability to be *in* the world.

The research participants expressed their general concerns with psychiatry’s lack of attention to the lived experiences of Indigenous people that have come into contact with the medical system. Mehl-Madrona (1998) asserts that people’s experience interact with their biology to produce mental illness (p. 149). While Kirmayer, Tait, & Simpson (2009) point out, “Current trauma theory and therapy tend to focus on the psychiatric disorder of posttraumatic stress disorder and give insufficient attention to the other dimensions of experience that may be profoundly transformed by massive trauma and abrogation of human rights” (p. 27). Furthermore, research by trauma theorists clearly demonstrates that, in many cases, there is a DSM diagnosis following traumatic life experience. For instance, Rosenberg and Mueser (2008) observe that clients with schizophrenia are rarely assessed and treated for trauma, despite “trauma exposure is close to universal in clients with schizophrenia and other severe mental illnesses, and multiple



traumatization over the lifespan is the rule rather than the exception” (p. 447). Moreover, Judith Herman and Bessel van Der Kolk found that borderline personality disorder “was strongly and specifically related to a history of childhood abuse” (Herman, 2006, 81).

### **Residential School Syndrome.**

Research participants were not asked specifically about their thoughts on the concept of *residential school syndrome*; however, one of the participants acknowledged its development. I felt that it was important to include residential school syndrome (Brasfield, 2001) as a theme because the concept is being used by some healthcare professionals, healing agencies, and others in the Indigenous community.

The term *residential school syndrome* became popularised during the 1990s. However, writers such as Chrisjohn and Young (1997) reject the idea that the residential school experience results in mental illness. They suggest that pathologising the life contexts of former residential school students “slanders and misguides people who are seeking help and understanding” (p. 83). Despite opposition, Brasfield (2001), a psychiatrist and psychologist in British Columbia, published suggestions for diagnostic criteria in the *BC Medical Journal* advancing the need to identify appropriate care and treatment for those suffering from this illness. The diagnostic criteria are similar to that of PTSD, but include additional symptoms, such as: avoidance of anything that might be reminiscent of the Indian residential school experience; detachment from others and relationship difficulties; diminished interest in Aboriginal cultural activities and a markedly deficient knowledge of traditional culture and skills; and increased arousal in sleep difficulties, anger management, and impaired concentration (p. 79). Furthermore, Brasfield argues that PTSD and residential school syndrome share requirements of “reexperiencing, avoidance, and increased arousal” yet differ because residential school syndrome indicates “a significant cultural impact and a tendency to abuse alcohol or other drugs that is particularly associated with violent outbursts of anger” (p. 80). Also worth noting, this diagnosis is applicable to former students or persons “who are closely related to or involved with a person who has attended residential school” (p. 80).

The move to create such criteria may also be intended, at least in part, to substantiate damages as documented in a number of legal claims pursued for settlement through the court system and through the Independent Assessment Process for the residential school experience.

Robertson (2006), a Métis psychologist and supporter of the concept of residential school syndrome, notes, “The federal government has acknowledged its culpability where victims of physical and sexual abuse in residential schools have symptoms of post-traumatic stress disorder” (p. 8). He further argues that residential school syndrome, rather than historical trauma, “offers a better framework from which to offer individual and family therapy” (p. 21). Despite advocates of residential school syndrome acknowledge compensation and treatment benefits, there is a lack of discussion around the implications of creating a diagnostic category which has the potential to pathologise former residential school students and their families.

In the interview with Yvon, he points out, “If we call it a *residential school syndrome*, we’re still labelling that *person* pathological rather than the *process* pathological.” Yvon suggests, “Why don’t we call it a *genocide response*? That changes the whole dynamic. The question becomes ‘Who’s *sick*,’ then? Is it the person experiencing residential school syndrome? or is the people perpetuating residential school syndrome?” In their critique of residential school syndrome, Chrisjohn and Young (1997) put forth a sarcastic version of diagnostic criteria for inclusion in the upcoming DSM-V that suggest that the syndrome be applied to the officials, administrators, and general non-Aboriginal society that established and maintained the residential school system. The diagnostic features indicate that those with the syndrome are considered to have a “personality disorder....a grandiose sense of self-importance and unjustified feelings of moral superiority....a lack of empathy and have difficulty recognising the desires, subjective experiences, and feelings of their victims” (pp. 84-85). Given the implications of pathology, serious consideration should be raised in the clinical use of residential school syndrome. Furthermore, creating a diagnostic category to accommodate the needs of psychiatrists and psychologists to understand symptomatic responses of former residential school students further entrenches the pathology of Indigenous peoples within the DSM. Hopefully, the DSM-V does not contain a diagnostic category for residential school syndrome. Essentially, the responses that are a result of colonial experiences, including the residential school system, will be best tended to by perspectives and methods that place Indigenous peoples on a continuum of wellness, rather than illness.

### **Culture-Bound Syndromes.**

As discussed in the previous sections, it is evident that the DSM, in general, is problematic for use among Indigenous peoples. The section on *Culture Bound Syndromes*, DSM-IV-TR (2000) Appendix I puts forth a list of syndromes, also called folk illnesses, that denote “recurrent, locality-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category” (p. 898). There are 25 culture-bound syndromes listed, which are intended to represent cultures originating from Africa, Asia, and north, central, and south America. Three syndromes were specific to Indigenous peoples of the Americas: firstly, *Ghost Sickness*, which is characterised as, “A preoccupation with death and the deceased (sometimes associated with witchcraft) frequently observed among members of many American Indian tribes.” With symptoms, “including bad dreams, weakness, feelings of danger, loss of appetite, fainting, dizziness, fear, anxiety, hallucinations, loss of consciousness, confusion, feelings of futility, and a sense of suffocation” (p. 900). Secondly, *Pibloktoq* which is reported as being observed in arctic and sub-arctic “Eskimo” communities, described behaviour as, “An abrupt dissociative episode accompanied by extreme excitement of up to 30 minutes’ duration and frequently followed by convulsive seizures and coma lasting up to 12 hours.” The syndrome indicated that the “individual may be withdrawn or mildly irritable for a period of hours or days before the attack and will typically report complete amnesia for the attack.” Furthermore, “During the attack, the individual may tear off his or her clothing, break furniture, shout obscenities, eat feces, flee from protective shelters, or perform other irrational or dangerous acts” (p. 901). A third syndrome is *Susto* (fright or soul loss) common among Latinos in the United States and among people in Mexico, Central America, and South America. This syndrome refers to illness that is attributed to “a frightening event that causes a soul to leave the body and results in unhappiness and sickness.” Importantly, this description notes, “Ritual healings are focused on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance.” Also relevant is the mention that this syndrome may be related to, “Major Depressive Disorder, Posttraumatic Stress Disorder, and Somatoform Disorders” (p. 903).

Given the nature of culture-bound syndromes, I was curious to know what Indigenous healthcare practitioners thought of these syndromes being included in the DSM. None of the research participants used these syndromes in their practise. Most had not heard of them (in

terms of being defined in a mental illness context) and a few indicated that they would look into this section out of curiosity.

Sylvia was clear in that she does not use the DSM as a reference. However, she noted that when she did study the DSM “it was totally incapable of understanding a culture-bound syndrome. Simply because the cosmology is not there to understand it. It’s a very different epistemological universe, so how can they adequately define a culture-bound syndrome?” It is argued that there is value in identifying specific culture-bound syndromes because it is critical to recognise the existence of conceptions of distress and illness outside traditional psychiatric classification systems (U.S Department of Health and Human Services, p. 138). Conversely, defining culture-bound syndromes in the DSM clearly reflects psychiatry’s need to *appear* to understand and address cultural content in a multicultural context. However, it seems more evident that this section demonstrates the extent that psychiatry has pathologised Indigenous knowledges and experiences. Moreover, by including such syndromes in the DSM it implies that these are mental disturbances, or more specifically *mental illnesses*, when in actuality, these disturbances are most likely of a spiritual nature and require healing that addresses the Spirit and/or spiritual realm.

In response to hearing about the culture-bound syndrome section, Carrie reflected on her practise. She felt that she didn’t know if she would use that framework in diagnosing because it may not be accurate in assessing some of the symptoms that they see:

For example, we had a person who had been diagnosed with schizophrenia. He comes in and he’s having all these visions. It’s more of a cultural thing that he is going through so I wouldn’t give him any one of those culture-bound diagnoses. He had been on medication, but he went off the medication and he is doing fine [with the cultural support provided by agency].

This situation raises many questions in relation to the psychiatric assessment and treatment of Indigenous peoples. It is interesting to note that the above mentioned individual had a diagnosis of schizophrenia and had been medicated for this condition. However, once connected with healing services for Indigenous peoples, this person no longer required

psychotropic medication and was living a stable culturally-connected life. It may be suggested that this person was *misdiagnosed* and perhaps did not meet the criteria for schizophrenia, as happens with others in mainstream society (Siebert, 2000). Janice S. recalled a situation where a healthcare professional was using a culture-bound syndrome. “He was a non-Aboriginal therapist who worked out of a mainstream mental health agency and he was working with a woman experiencing rape memory.” Janice S. explained that she asked him not to use culture-bound syndromes with this client and he was cooperative. She took this opportunity to offer him resources that could help him understand the cultural context of this client, “I gave him the AFN (Assembly of First Nations) study on Residential schools so he read that.” Additionally, she noted, “I also gave a psychiatrist the *Mishomis Book* [Benton-Banai, 1988].”

Waldram (2004) sheds some light on the formulation of the culture-bound syndrome section and states that the link between contemporary psychiatry and older anthropological views of these cultures is clear, “early anthropologists and psychoanalysts viewed Indigenous peoples as inherently superstitious, irrational, childlike, and anxious; psychologists and psychiatrists, it seems, accepted these essentialisms when it came time to pathologize indigenous knowledge and beliefs” (p. 208). Pathologising the “symptoms” described in the cultural-bound syndromes and putting them under the umbrella of mental illness, most definitely conflicts with Indigenous worldviews and traditional healing practises. This is not to dispute that there are various reactions to circumstances, however, the reactions must be seen and understood using a cultural paradigm and not a framework that has been developed by a foreign body that is not adequately or culturally qualified to assess. Nonetheless, the field of psychiatry will likely continue on their pursuit to devise assessment and treatment for Indigenous people. As stated in a publication by the U.S Department of Health and Human Services, “The question becomes how to elicit, understand, and incorporate such expressions of distress and suffering within the assessment and treatment process of the DSM-IV” (2001, p. 87). Despite Western clinician’s genuine interest, and perhaps Eurocentric need, to provide treatment to Indigenous people, psychiatry is treading in an area that they know very little about. I don’t think any Western oriented psychiatrist or psychologist would argue that they are currently competent to *culturally treat* any of the disturbances that are suggested in the culture-bound syndrome section of the DSM-IV.

## Psychiatry and Culture

The issues involved with psychiatry and culture are plentiful. Notwithstanding the implications of diagnoses and psychiatric procedures, many Indigenous healthcare practitioners identified other areas of contention. This section presents stories and strategies that emerged as separate themes during the dialogues regarding psychiatry and Indigenous peoples. Of particular relevance to culture are the areas specific to: antipsychiatry, difficulties with psychiatric assessments, and the need for culturally competent treatment.

### **Antipsychiatry.**

Modern psychiatry has emerged in the past few hundred years out of European thought processes. Naturally, critiques of psychiatry existed alongside the development of the field of psychiatry. Two kinds of powerful social-cultural institutions, the Church and the legal system, dominated the initial philosophical debate. While the Church maintained that “man struggled between God and Satan,” psychiatrists eventually grounded their medical model in a framework that considered the mind a function of material brain and distinct from the soul (Dain, 1989, p. 4). As such, psychiatry became an entrenched medical profession which employed various methods including compulsory admission to state institutions, psychotropic medication, psychoanalysis, and procedures such as electric shock treatment, lobotomy, and forced sterilisation.

Rismler and Rismler (2006) assert that antecedents of an antipsychiatry movement began in the 1950s, when deep divisions were developing between biological psychiatrists and psychoanalytic psychiatrists. The term *antipsychiatry* was coined in 1967 by David Cooper, a British psychiatrist. Cooper essentially named a social movement that was engaging in the criticism of psychiatry “which emerged in Britain, and elsewhere, during the 1960s and 1970s” (Crossley, 1998, pp. 877-878). Much of the movement was motivated to dismantle the psychiatric system which was viewed as being overly abusive and oppressive. Dain (1989) and Rismler and Rismler (2006) recognise antipsychiatry as being a part of the “counterculture” movement that was already challenging political, social, sexual, and racial injustices. While Dain (1989) notes influential writers such as R. D. Laing, David Cooper, Michel Foucault, Erving Goffman, and Thomas Szasz as questioning the “medical model of ‘mental disorder’ and the concept of mental illness itself” (p. 8); Rismler and Rismler (2006) acknowledge the

international promoters of antipsychiatry as being: Michel Foucault in France, R. D. Laing in Great Britain, Thomas Szasz in the United States, and [Franco] Basaglia in Italy (p. 863).

Sylvia reflected on her involvement with the antipsychiatry movement. She recalled that there were many abuses that she saw regarding the treatment of people who were involved with the psychiatric system. She is convinced that the efforts of the antipsychiatry movement have positively influenced the field of psychiatry. Sylvia comments on current psychiatric practises, “They don’t usually put people by force into hospitals like they used to do. They used to come for them like they were criminals and tie them up and put them into cages—like animals.” She elaborates, “I saw these cages in hospitals in Italy with Franco Basaglia, in Trieste. They were still in use in the late 1970s. If people were considered violent, they were beaten or put into freezing water. They were really tortured.” Many of the psychiatric procedures and attitudes in Europe were replicated and enforced in other parts of the world, and thus, the antipsychiatry movement was particularly important in challenging the treatment procedures that were impacting a portion of the global population.

With European settlement in the Americas, psychiatry became part of the colonial assault on the Indigenous peoples of Turtle Island. Yellow Bird (2001) writes about the *Hiawatha Asylum for Insane Indians* in Canton, South Dakota, which existed between 1899 and 1933. This was the first and only federally funded institution in the United States for American Indians. Many of the *inmates* were there for reasons that had nothing to do with mental illness. The majority of individuals were under the age of thirty, including many children. Some were admitted for a physical ailment such as tuberculosis, epilepsy, senility, or deformity; or had argued with a reservation agent, school teacher, or spouse; or because they refused to give up their ceremonial or spiritual way of life; or refused to allow their children to be carted away to government boarding schools. Yellow Bird also notes that, “Of the average ten discharges per year at Canton, nine were due to death” (p. 5). In response to multiple staff complaints of neglect and cruel treatment of patients, administrative mismanagement, and sexual harassment charges filed by female coworkers against the Superintendent—a psychiatrist in charge of the Asylum since 1908, the Secretary of the Interior launched an investigation in 1929, with a subsequent investigation in 1933. The investigator’s report documented his findings that children were:

strait-jacketed and chained to beds, lying quietly in their own excrement; he found one young epileptic girl chained at the ankle to a hot-steam radiator with shackles borrowed from the local sheriff, and said that it was a “miracle” she had not been severely burned; he found calm, well behaved and mentally healthy patients who had been locked in their rooms for periods of up to three years; he found every single window locked and barred—not even in the wards, where each bed had an open and full chamber pot beneath it, was fresh air allowed; he discovered institutional policies that allowed attendants, hired from local farm families, to make decisions on the application and use of physical restraints of the patients—such decisions were not open to revision or review by professional staff. (p. 6)

This Asylum instituted a concentrated impact on the Indigenous inmates that were detained.

Other involvement of Indigenous people with the psychiatric system was more individualised.

As a trained psychologist and active participant in the antipsychiatry movement, Sylvia rejected psychiatry’s models and practises, despite that she had to study them as part of her academic training. “My way of working is that I never use the references of psychiatry that I learned. I had to learn them. I had to show that I knew them and in my final examinations.” She explains, “I even had to do the diagnosis of a person in front of the whole class. I did the normal psychiatric diagnosis, but I did not believe in it. I had to do it because I needed the grade.” Sylvia maintains that she never started with questions such as: “Is this schizophrenia? Or is this manic-depression?” She asserts, “I think some people go through stressful periods in their lives. They don’t sleep well some days. Why reduce everything to pathology—to very strict pathology that you need pills to get over it?” In her psychological practise, Sylvia points out, “I have trained many people to be without medication. Even after being on medication for years I helped them to get rid of it. This is part of my strategy.” She elaborates, “I know how to lower the dose gradually, how to provide psychological support so the person goes through these periods with my help and then I get them off drugs.” She also acknowledges, “Some people are impossible to treat other ways. And it is difficult to get some depressed people off medication.”

Despite the closure of Asylums and residential schools, an understandable resistance to institutionalisation and general mental health services remains a part of many Indigenous peoples. Chansonneuve (2005) indicates that former residential school students are especially vulnerable to revictimization due to the ongoing marginalisation and discrimination against Indigenous peoples. Discussions among former students in Ontario acknowledge that they have



felt revictimized by, “Any institutional environment or setting that replicates the long, echoing hallways, closed doors and sterile, dormitory settings of residential schools, such as hospitals psychiatric wards and some homeless shelters” (p. 61). Furthermore, they indicated that, “Restraining practises in psychiatric or police facilities meant to protect people from self-harm, such as physically wrestling them to the ground, pinning their arms and/or using straitjackets, replicate aversive restraints against children in residential schools” (pp. 61-62). The history of forced institutionalisation deters countless Indigenous peoples from accessing potentially helpful services. Duran (2006) suggests that, “Many Native People shy away from mental health systems unless they are in crisis, because they fear that being pathologized also will result in the loss of freedom—being either physically locked up or immobilized by medication” (p. 42). Indigenous peoples all over the world are confronting difficulties with mainstream practises. In a study completed by Vicary and Bishop (2005), which aimed to address gaps in knowledge and provide insight into improved psychological intervention by non-Indigenous practitioners, acknowledged the lack of spiritual beliefs in Western mental health practises as problematic for Indigenous peoples in Australia. They also noted:

Many Indigenous people were fearful of the Western mental health system because they felt that there was a stigma attached to being labelled mentally ill, and were concerned about possible treatment outcomes (e.g., involuntary hospitalisation, medication). Participants stated that they actively withheld mentally ill family members from Western services because they were concerned about the possible outcomes. The family managed the ill individual by sharing their burden and accessing traditional or culturally appropriate services. (p. 12)

Issues relating to the pathologisation, forced treatment, and involuntary hospitalisation are primary reasons that Indigenous peoples resist psychiatric services. Although, terms such as *antipsychiatry* may not be common in the decolonising language of Indigenous peoples, acts of resistance certainly are prevalent.

In regards to language and philosophical understandings, Sylvia reveals an essential belief common in the antipsychiatry movement, while at the same time, she acknowledges the contradictions in therapeutic developments. She explains that when she was an antipsychiatrist, she used to say, “Look here, we read mystic like Santa Theresa of Aorta or Juan de la Cruz.

These are Spanish mystics and probably in our time Santa Theresa of Aorta would be called a *psychotic*.” She claims, “Because she was hearing voices—she was transcending and floating and going into another world. All that is a mystical experience, or transpersonal as they call it now in psychology.” Sylvia referred to “transpersonal therapy” and pointed out that this therapy “includes these kinds of experiences as positive experiences.” Furthermore, she asserts, “All of these feelings and experiences of mystics would be translated into mental illness. So I don’t believe in mental illness.” The rejection of the concept of *mental illness* is a founding philosophy of antipsychiatry, whereas Szasz (1974) writes in *The Myth of Mental Illness*, “in modern medicine new diseases were *discovered*, in modern psychiatry they were *invented*” (p. 12). R. D. Laing, as cited in Rissmiller and Rissmiller (2006), noted that a patient with psychosis could be viewed in one of two ways, “One may see his behaviour as ‘signs’ of disease [or] one may see his behaviour as expressive of his experience” (p. 864). For the most part, the challenges regarding psychiatry and culture are a result of differences in deeply embedded worldviews and beliefs. They are also influenced by the history of colonisation and the general assaults that Indigenous peoples have been subjected to. Nonetheless, Indigenous people will continue to access general psychiatric services, some by choice and some by involuntary hospitalisation. For this reason, efforts should be made to address the conflicts that exist in treatment procedures and service protocols.

### **Difficulties with psychiatric assessments.**

Many of the difficulties in applying psychiatric assessments to Indigenous people arise from a Eurocentric misunderstanding of behaviours and responses. In addition to the obvious issues surrounding spiritual experiences, cultural protocols, and the exclusion of historical analysis; behavioural traits of Indigenous peoples are often misinterpreted. Couture (1985) captures the challenges that non-Indigenous peoples may have with Indigenous behaviour. He acknowledges that Indigenous peoples have subtle behaviours, such as a perceived *aloofness* that “is really a reluctance to ask for or receive help other than in an emergency or crisis; a tendency not to interfere, on a basis of live-and-let-live, for to do so is to become discourteous, threatening, or even insulting” (p. 9). Couture also notes, that Indigenous people often exhibit “confrontation avoidance, which is sometimes interpreted as noncooperation, or immaturity, but which is a tendency to avoid direct disagreement with the individual, agreeing while

disagreeing” (p. 9). The above mentioned traits are cultural behaviours which are embedded in the regulatory functions of social conduct.

A cultural analysis is often required when assessing wellness issues. Yvon explained that there is a way that Indigenous people look at being *unwell* from a traditional perspective which is more *wholistic* in its nature. He points out, “If you go to see a traditional healer because you have a joint pain, they’re doing more than just prescribing *Devil’s Foot*; they’re also looking at it from a physical, mental, emotional and spiritual point of view.” In an Indigenous framework of assessment, Yvon maintains that healers will often ask, “What’s the meaning behind this immobility?” Although, Yvon didn’t specifically mention the terms *soul wound* or *blood memory*, or other influences common in Indigenous worldviews, the question of *immobility* often inspires an assessment from a traditional perspective that may include this type of analysis. Essentially, an Indigenous assessment is wholistic in nature and all encompassing; whereas, a psychiatric assessment is standardised and calculative, and therefore, does not provide an adequate assessment for Indigenous peoples.

In discussing psychiatric assessments, Gilbert shared that he views assessment from a different perspective, but he was clear in that he asserted, “I’m not saying they’re wrong.” Gilbert expressed a common element of Indigenous social protocol in that he was not interested in challenging medical knowledge, rather he felt that it was important that he advocate perspectives that are rooted in Indigenous worldviews. Gilbert recalled a long discussion between himself and his supervisor, “He asked me the same question that you’re asking me.” He shared his conversation, “I told him, ‘Well, sometimes when working with kids, they’re right at that age and they receive something—like if they’re going to become medicine man; they’re given that right from that age and they grow up with that.’” He explained further, “As they grow up, lot of times things happen that makes them do things and people don’t understand why they’re like that—the way they are. They act out, and that’s what they call it: *they act out*.” Gilbert maintains, “When they start acting out from the contemporary point, they do an assessment on them. And then that’s where these *terms* come in.” Gilbert elaborated on the psychiatric labels that he has heard while working in the field of child welfare. He also shared his perspective of the lack of cultural assessments that are being conducted:

Sometimes they are *schizophrenic* and sometimes they're other terms. But in the meantime, that's not what it is...*they're receiving*. They're receiving something from their culture: who they are as *Anishinaabe people*. But that's been overlooked too many times because we're never being asked, "What's going on with this person? Can you help?" Elders are always being bypassed, that's what I'm finding all the time.

It is important to note that different worldviews present different conceptualisations. Yellow Bird (2001) points out Indigenous peoples generally do not have a notion of *insane* or *mentally ill*, "The closest I can come is a word more closely aligned with 'crazy,' and that means that someone is either very funny, or too angry to think straight" (p. 4). Gilbert shared his experience of telling someone about his four-day Fast. He had explained what he went through in terms of receiving different visions. Gilbert was surprised, and disappointed, that this person responded with, "So, you hallucinated. You hallucinated because you didn't eat or drink water." Gilbert was upset that this individual was "looking at our culture that way." He asserted that, "For me, it was the spiritual stuff that was coming—the teachings." Gilbert reflected on this experience and shared that, "A lot of times when the kids tell stories of '*hearing this and that*,' they're being told 'You have hallucinations.' But in the meantime, they're not, they're receiving a teaching." Crowe-Salazar (2007) points out, "From a current mental health perspective it is important that clinicians become aware of the differences between visions and hallucinations" (p. 90). Furthermore, Mehl-Madrona (2007b) asserts that many Indigenous people "feel a deep oppression from the largely white, dominant culture when our understanding of our relatedness to nature is labeled psychotic or primitive" (p. 47). What some clients see as spiritual strength is often pathologised by practitioners. Clients learn that they cannot discuss their spiritual beliefs and experiences for fear of being judged as *crazy* (Baskin, 2002).

In his role as a psychologist, Ed shared a story of a situation that took place years ago in which he was called in to give testimony at a hearing in a psychiatric hospital. The story was about a woman who had been institutionalized in the psychiatric facility by her husband who believed that she was psychotic. During this time, she had been consulting a medicine man—a healer that Ed also knew. Ed explained, "The healer had been doing some healing work that *she* felt was quite effective in that it was helping her to effect changes in the condition that *they* were

calling a psychotic state.” The healer recognised it as being “more of a spiritual possession that had to do with circumstances that had happened within her family and within her community.” The medicine man was doing ceremonies to help her to heal:

However, when she went into one of these states, her husband looked at it as a psychotic state. That’s the way *he* understood things and he had her institutionalized. The psychiatrist agreed with him. She wanted to be let go after seventy-two hours...her husband along with the psychiatrist were opposing her release, so she had to have a hearing.

Ed explained that they asked him to come and to give testimony in the hearing. They wanted to better understand the woman’s situation because “those who were presiding over the hearing were lawyers and people who were *not* clinicians and *not* familiar with our work of healing.” In his testimony, Ed shared his understanding of the situation and explained how Indigenous ceremonies are a valid form of healing. He also pointed out that Indigenous healing methods have been successfully utilised “for longer than Euro-western approaches to psychiatric healing and to mental health.” Both Ed and the medicine person—the healer—gave their testimony, but in the end they didn’t release her. Ed recalls, “They kept her in because they felt that the psychiatric argument and the psychiatrist were more valid. They kept her in against her will. She was present in this hearing and so she heard our testimony.”

A few years after the hearing, Ed was conducting a workshop in northern Ontario. During a break, a woman who had been sitting in the audience approached him and asked, “Do you remember me?” Ed replied, “No.” The woman went on to explain that she was the person Ed had attended the hearing for at the psychiatric hospital. She said, “I just wanted to come to thank you for when you came to give testimony at my hearing, because I *wasn’t* crazy.” She said, “I was struggling with those issues that that medicine person was helping me with.” The woman shared with Ed that the [psychotropic] medicines that they gave her in the hospital “didn’t help” and made her “feel more sick.” When she left the hospital, she went back to the healer—the medicine man and she claimed “that’s what helped me to get grounded in reality, to be connected. That’s what’s made the change, made the difference.” She also said, “I knew that and I was tryin’ to tell

them that, but they wouldn't believe me. I just wanted *you to know* that." Ed affirmed, "I *knew* it, otherwise, I wouldn't have given that testimony and I believed that firmly." He concluded his story by acknowledging that the "system couldn't understand it well enough then. They didn't have that kind of faith in it or that kind of knowledge about it. They couldn't validate it in their own context to be able to accept it." In this story, it was clear that the psychiatric assessment was more valued by the authorities than the assessments that were put forth by Ed, an Indigenous psychologist, and the medicine man that provided the healing.

In terms of the spiritual aspects that are often distorted by psychiatric assessments, Yvon acknowledges *Windigo* as "a spiritual sickness" and points out that "psychiatry does not consider this understanding relevant." Windigo, a well-known malevolent spirit within the Indigenous world, can assume independent form or possess a human being. Windigo is obsessed with cannibalistic desires. Although, Waldram (2004) indicates that there has been discussion about a *Windigo psychosis* among anthropologists, psychiatrists, and others in the medical community, this concept is not included in the culture-bound section of the DSM (p. 204). Moreover, true to the medical fields' nature of pathology, such discussions framed Windigo psychosis around being a mental disorder, rather than the spiritual illness as pointed out by Yvon. Yvon is not suggesting that Windigo be included in the DSM, he is acknowledging that, "Psychiatry doesn't give any lasting place for Windigo [in a spiritual context]." In his understanding of Windigo, he puts forth that, "Windigo is hungry. It's a *spirit* that is *spirit* both in noun and verb. And it steals light. And you can sort of sense that coming because the whole atmosphere is going to change." Yvon explains further the effects of being in the presence of Windigo, "You can sense fear. You can sense grief even before the loss has occurred. Sometimes it's very pronounced." Yvon recalls that as a result of the work that he has done, he has had the "misfortune" of *being* in the company of that spirit. "I've worked in forensic psychiatry and have been in the presence of people who were very ravaged, for want of a better word. Sometimes you can even look into a person's soul and see that they have been dispossessed." Similar to psychiatry, forensic psychiatry, the subspecialisation of psychiatry that deals with criminology, does not accommodate perspectives that reflect spiritual influences or interferences. In Indigenous worldviews, it is completely possible to be *inhabited* by another Spirit, including Windigo, and therefore, cultural assessment and cultural healing would be essential.

### **The need for cultural strategies.**

What has become evident is that Indigenous people accessing health services should be provided culturally relevant care that goes beyond standard psychiatric assessment and treatment. Ross (2010) argues that healing programs in Aboriginal communities need strong cultural foundations that contain the wisdom and sophistication found in the traditional perspectives on health and healing, “Even if strictly western treatment approaches proved capable of relieving people from individually-experienced trauma, they cannot hope to touch the *deeper* socio-cultural demons that haunt so many people” (p. 15). Bringing in cultural resources and recognising cultural strategies is an important function of Indigenous healing.

As discussed in Chapter Five, Indigenous healing begins with the Spirit. Yvon was particularly aware of the need to use culturally appropriate language in acknowledging the Spirit of the clients. Yvon noted that he “would never use [psychiatric] language *on people*. I would probably use that language with mainstream people.” He explained, “The language that I use with community members around this whole notion is I would say to people that it’s my view that they are *ultraabled* in someway.” Yvon shared that they began to use the phrase *ultraabled* in their community about fifteen years ago in referring to “people who were physically disabled but who were *abled* in other ways.” He explained the term actually came from a couple of Anishinaabe people from Wisconsin. “They were deaf, and they talked about that culture, the deaf culture, and them not wanting to learn to speak because when they speak, they sound funny. And they would much rather use sign language which doesn’t sound funny.” Yvon pointed out:

Somebody who is disabled is always *sick*, so to speak. They make adaptations, but they’re always *disabled*. Somebody who’s *ultraabled* is not somebody who is sick—they’re *different*. They’re spirits. They’re born in this existence, and they come here and they take form—physically, mentally, emotionally, and spiritually—and each one is very unique in their way of being—each of them providing a gift, or gifts really, to the relationship. They share something with us that has never been shared before.

Yvon recognised that this strategy of using culturally appropriate language “talks about being true to the way that you are with how the Creation has unfolded.” He also commented on the importance of people becoming reconnected to *spirit*. In a discussion with mainstream mental health workers that revolved around a client that was transitioning between children’s services and adult services, Yvon advocated the importance of the individual becoming reconnected to family and community. In speaking about cultural repatriation, Yvon asserted, “I’m talking about *spiritual repatriation*, I’m not talking about him learning the Ojibwa language.” He clarified, “I’m talking about him coming in and feeling connected to the *love*, to the *spirit* that we have as Anishinaabe people when we come together. It’s that *verb* spirit, not the noun Spirit.”

In the school system, Janice L. shares that they had an Elder on staff that could be available to the families. She explained that the team of Indigenous psychologists that she worked with put forth recommendations regarding cultural treatment. “The psyche reports included diagnoses and recommendations of the cultural aspect....We recommended taking the child to Sweat Lodge, the ones that had ADD tendencies—whether there was a diagnosis or not.” She also asserted that the recommendations also included that the children “sit and talk with Elders in circles, sit in healing circles, and participate in picking medicines.” These recommendations became a record in the student files.

In some situations, perhaps even occasionally, non-Indigenous healthcare practitioners recognise the limits of their abilities and refer Indigenous patients back to their communities for healing. Gilbert pointed out that in his local area there is a medical doctor who will ask Indigenous patients, “What’s wrong?” And he will proceed to treat them. But if they go home and are still sick, and later return to the doctor two or three times, the doctor will say, “Go see your Elder, spiritual Elder. He’ll help you.” Gilbert acknowledges, “A lot of times he’s done that.” Examples such as this are encouraging and reveal that Western trained medical practitioners sometimes do recognise the validity in Indigenous healing methods.

Currently, there are a number of inequities that exist between Western medicine and Indigenous healing. McCormick (2009) cautions about integrating both systems as Western medicine will likely overwhelm and assimilate traditional medicine, “Western medicine has the power of the government, the law, and the medical system behind it...A more balanced and appropriate form of partnership may be a complementary one in which both systems collaborate,



working side by side” (p. 344). Fortunately, some hospitals are becoming more receptive to Elders and medicine people attending to Indigenous people that are hospitalised. In some cases there are spaces for “traditional ceremonial practices both within the healthcare facility and outside on hospital grounds” (Voss, Douville, Little Soldier, & White Hat, 1999, p. 81). In situations where collaborative relationships have been established between Indigenous communities and mainstream mental health professionals, Trimble (2010) points out, “Indian and Native community leaders demand that collaboration with mental health specialists occur under their direction and control” (p. 253). This ensures the sharing of results that have practical value while establishing a relationship that is grounded in the needs of the community.

### **Psychotropic Medication**

The use of psychotropic medication emerged as a theme in the dialogue regarding psychiatry and Indigenous peoples. Although there were not specific questions that were asked about medication during the interview dialogues, the emergence of this theme was anticipated. This section is particularly vital because the views and thoughts of Indigenous healthcare practitioners pertaining to psychotropic medication have not been represented in the literature. It is also a fundamental component of psychiatric treatment, and the general treatment of mental health disorders, and therefore it is essential that Indigenous healthcare practitioners participate in a discussion around the use of medication. This section presents three main areas of thought: medication can be helpful for a balanced life, using discretion in prescribing medication, and medication is not always the answer.

#### **Medication can be helpful for a balanced life.**

It is recognised among Indigenous healthcare practitioners that medication can be helpful for individuals who struggle to live in a healthy balanced way. Even those who have tried to live without medication often find that they are not able to, especially if they have been diagnosed with disorders such as bi-polar (Mehl-Madrona, 2007a). Janice S. asserted, “I would never encourage anybody to come off their medication, it’s just too risky.” She puts forth that it’s important that the client understands what that diagnosis means, so she will say, “When you [have been diagnosed with] schizophrenic, don’t come off your medications. You could try if you are using wholistic approaches, but a part of that Medicine Wheel is the mental health—mental wellness.” She explains to clients, “This is what helps you maintain your mental wellness

and your balance. And yes, I'll connect you with Spirit, but it's all to help you live your life and continue to practise that *every day good living*."

Some of the participants were able to recognise that medication was valuable for clients. Ed noted, "I work with the psychiatric system and I do think that the medicines that they have—have value. And I don't believe that the Creator would have allowed us to find those medicines if they didn't have a good purpose." He added, "I believe that in the right hands with the right healers, they can be an effective part of the healing process." Ed explained that he has worked with many people who, in the psychiatric system, would be understood as being *psychotic*. He has seen "how the medicines that they have can help those people to become freed of their demons and become grounded in reality again—whatever that is." Ed elaborates, "Whether we call it grounded in reality and it is a physical/emotional process, or whether we see it wholistically and understand that it is a process that is physically, mentally, emotionally, and spiritually based—it doesn't matter." He points out, "It effects what we need in terms of helping that person to come back to this life, to be grounded in this life, to be able to function and interact with people in a healthy way." Ed acknowledged that over time the field of medicine has developed more effective psychotropic medication. He commented that he believed that the greatest contribution of the mental health system from a psychiatric perspective is the development of medication that can assist in psychosis and especially "in terms of shifting the realities from disconnection with this world back into this world."

In some cases, medication may help reduce a person's depressive symptoms and make their day-to-day living more manageable. In regards to antidepressant medication, Nina pointed out, "If somebody's got clear-cut depressive symptoms, with the clear-cut onset and *a lot* of the neurovegetative symptoms, I will say to them, 'You know, maybe this would be of benefit.'" She also noted, "I've seen some people do really well on some of the medications and get their life back." Nina recognised that many people that she sees have been on antidepressants for ten or fifteen years and it's almost impossible to get them off. "There are some people who have already been on a lot of medications for a long time, so I don't know what they're like without them. I'm very wary about withdrawing them." Nina talked about the reality that there are people who are really tortured by what they're experiencing and she will prescribe medication in those situations; however, she also commented, "I certainly never make promises about medication helping, but I've seen some people who are *soooo* tortured by their flashbacks and they're so

activated that there's nothing else that you can do until they calm down." Nina also commented that about half of the patients she sees want to come off their medication, but she evaluates the patient history and issues in regards to safety:

There are people who tried to burn down their apartments with them in it or have seriously injured somebody or tried to jump off balconies or starved themselves when they were off their meds, and it's not even just the first time—this is a pattern. And they're the ones that I say, 'No.' And I'm not afraid to use community treatment orders when necessary. I will declare them *incapable*, even though it's very difficult for me, coming from a position where I like to respect a person's autonomy as much as possible. But sometimes you just have to *for safety*. I think that's where psychiatry comes in—is the safety issues that we have to address.

Despite the hard line that the antipsychiatry movement would take against the use of psychotropic drugs, Sylvia recognises, "Some people need medication, but then again I have taken a more middle ground on the pills. Now no one dumps the quantities of medication that they used to into patients at mental hospitals like they did 20-30 years ago." Sylvia also claims, "They have learned from us. Anti-psychiatry forced the psychiatrists to find good cocktails and minimum doses. They also learned not to leave people on medication forever. This they learned through the pressure of the international movement of antipsychiatry."

### **Using discretion in prescribing medication.**

Treatment options in mainstream psychiatry often focus on prescribing the most effective formula of medication, whether that is a single medication or a combination of two or more. Mehl-Madrona (1998) points out, "It's no surprise that drugs are the only reasonable choice to psychiatric professionals, when most are incredibly pessimistic about the capacity of human beings to change" (p. 164). There is also a history in mainstream psychiatry that psychotropic drugs provide universal benefit. The advertisement in Figure 6 for Ritalin was published in a 1979 issue of the *American Journal of Psychiatry*. This advertisement is particularly revealing as

it focuses on the generational benefits of Ritalin. It also portrays that medication will result in satisfaction and happiness.



*Figure 6. 1979 Ritalin Advertisement*

Indigenous healthcare practitioners that utilise a wholistic framework and recognise that cultural forms of healing are most successful with Indigenous peoples exert purposeful discretion in prescribing psychotropic medications. Nina recalls, “I just think about some of the discussions I’ve had with people coming in and wanting benzodiazepines or antidepressants, and I don’t want to give them to them because I don’t think that’s the issue.” She points out, “Some people just want to make the bad feelings go away and I don’t necessarily think that’s a helpful thing.” In some situations, individuals are seeking reprieve from troubling emotions; however, psychotropic medication, or other drugs, may act as a barrier to reach the emotional turmoil which interferes with the healing process.

Carrie explains that they have an Indigenous psychiatrist on staff at the counselling agency that she works with. She noted that if clients need to be on medication then they are referred to him. “He’s really great in terms of working with our clients. He’s not just all about the medication. If he doesn’t have to put them on medication, he doesn’t.” Sylvia asserted that

for those on medication, it's a very delicate process. "It is necessary to monitor the intake of medication until you find the exact amount of what is needed for this particular person—body and mind as a whole." She also comments, "I don't see very many doctors doing it. Especially with the medical insurances available, you don't even get half an hour with a doctor. They will immediately give you a prescription and that's it."

Nina shared a story about a patient that she had who came from a very traditional family. They were involved with his care and they wanted him *on* medication. She explained that when she saw him, "He said, 'You know, I'm not depressed. I don't need this.' He didn't have any depressive symptoms, so I said 'Okay.' And people weren't very happy with me for telling him he could go off his antidepressant." Nina pointed out that it is important to listen to the patient and complete an assessment if necessary to determine if medication should be prescribed or continued.

### **Medication is not always the answer.**

There was recognition that medication had its purpose; however, it is not always the solution to health and healing issues effecting Indigenous peoples. For some people, the answer may be found through cultural teaching and other educational experiences. Gilbert pointed out, "I know the symptoms when people are receiving something from the traditional side of things. Sometimes they're not able to sleep because they're frightened and are full of fear." If these individuals come into contact with the mainstream medical system, they are often prescribed medication "to calm them down." Gilbert expressed, "The medications do a lot of damage, because it interferes with the cultural teachings that they are receiving. Our way is powerful, but when there's something pushing that away things start getting worse." Many people who are going through a spiritual awakening have an extended period of spiritual activity which could involve communication with other Spirits, vivid dreams, and an intensive connection with the natural environment. These experiences are not an *illness*, and therefore will not be aided by psychotropic medication. In another example, a Cree Elder who was helping a woman who had been *diagnosed with bi-polar disorder* by doctoring her in a Sweat Lodge ceremony told her that "the spirits told him that the medicines were making her worse instead of better" and that she needed to "get off those medications." In this case, a Native American psychiatrist who supported the Elder's suggestion gradually, over a two-year period, decreased her medications

until she was completely off psychotropic drugs. She was also encouraged to participate in ceremony and a cultural community. The psychiatrists noted that she still displays some vulnerability; however, “She is immersed in traditional spirituality, and she is living well without medication” (Mehl-Madrona, 2007a, p. 17).

There is a common understanding among Indigenous people that psychotropic medications and other drugs alter one’s capacity to fully experience the world in a natural way. In some situations it may be helpful to *medicate* as an individual’s turmoil can interfere with their ability to be stable and productive. In other situations, the use of medication and other drugs may inhibit a person’s health and prevent them from being connected to resources that could enhance their wellness. Sylvia puts forth that she doesn’t believe in chemical reductionism. “The psychiatric profession is moving more and more towards reducing *mental imbalances* to *biochemical imbalances*. They treat them biochemically and this is why it doesn’t get anywhere.” Sylvia asserts that treating people with psychotropic medication “forces people to function in an alienated way—alienated from their own being. And they can function and go on and do whatever work, but they are drug dependant and they are not truly grounded in themselves.” She points out that there may be residue “that has left an imprint in a person who has lived with a problem for many years without being able to solve it adequately. In this case, maybe a very small quantity of chemical might help.” Sylvia doesn’t deny that biochemical imbalances may exist, “but you cannot say to start with assuming that it is a chemical imbalance.” Sylvia promotes that the psychiatrists have to do extensive assessments before determining a chemical imbalance. She indicates, “I have seen psychiatrists doing this now. Some of them are very good, but what I reject is instantly recommending massive doses of pills.” The use of psychotropic medication should be used with a high degree of discretion. Mehl-Madrona (2007b) writes, “I frequently point out to doctors in training that psychiatric drugs do not cure poverty, homelessness, isolation, or loneliness. They merely take the edge off the pain caused by these conditions” (p. 24).

There is merit in supporting people to live without medication. Nina claims, “If there’s somebody that’s not hurting themselves and not hurting other people and they’re okay with their experiences, I’m not going try to medicate that away.” She also commented, “I think sometimes the staff here find that a bit difficult because I don’t want to jump on every symptom and I don’t panic if somebody’s delusional one day.” Nina shared an experience of working in a shared care

program which is a new model where psychiatry is now going out into the community and partnering with family practises. This program involved an Indigenous agency serving three local communities. The agency determined that they wanted her to come in and provide diagnoses. Her role as a consultant was limited to completing a 45 minute DSM-IV interview with each patient. Nina found this experience frustrating:

The reality is that you get out there, you do your consultation, but they can't implement. So, they still end up coming back to you and you're out there without a multi-disciplinary team, you're just a consultant with very limited time to actually carry out a plan. It's like you're an outpatient department without really being one. So, the whole point is to do two or three visits just to do your diagnoses, but what it comes down to, then, is just meds. But what they need is a whole lot more than meds.

Nina captures the difficulties that some Indigenous healthcare practitioners face while working in mainstream fields that do not operate in wholistic contexts. She clearly recognises that medication is not the only answer, and more importantly, Indigenous people often require a more comprehensive healing plan. Mehl-Madrona (2007a) reports that a study that looked into the narratives of people with a diagnosis of bipolar disorder that have successfully managed without medication found that “the stories reveal that recovery without medication requires a more substantial life change than does management with medication. Such a non-medicated recovery becomes an all-encompassing life project” (p. 12). The study also revealed that those who did not use medication “had more of a sense that their disorder resulted from disharmony and imbalance in their lives” (p. 13). The idea of an *all-encompassing life project* related to healing and wellness is often a welcomed journey for Indigenous people. The sense of disharmony and imbalance will be best tended to by accessing wholistic, culturally-based healing strategies that are being generated in Indigenous communities. The opportunity to participate in a healing community is becoming widely available as Indigenous people actively engage in the movement to heal from the devastation of colonisation.

## Summary of Chapter Six

Chapter Six presented the dialogue regarding psychiatry and Indigenous peoples. The use of psychiatric diagnoses varied among the Indigenous healthcare practitioners that participated in this study. Generally, those who used the diagnoses did so because they were working in mainstream settings or were case managing clients that were accessing mainstream services. Practitioners used diagnostic language with caution as it was clearly recognised that psychiatric *labelling* has implications on how *one sees themselves* and contributes to the forming of an identity based on a pathological diagnosis rather than a validated lived experience. The area of psychiatry and culture was discussed and practitioners shared their thoughts on the antipsychiatry movement, difficulties with psychiatric assessments, and the need for cultural strategies. Research participants also shared their views on the use of psychotropic medication.

The literature in this area of psychiatry and Indigenous peoples was limited. This was anticipated as early literature searches found that Indigenous peoples have not participated in the critiques of psychiatry in an extensive manner. Nonetheless, there were select writers that have contributed to the literature and this was reflected in this chapter. The next chapter will present the strategies that Indigenous healthcare practitioners utilise in helping their clients through trauma, depression, and experiences with parallel and multiple realities.



## **Chapter Seven:**

### **Indigenous Strategies for Helping and Healing**

The people and communities who have continued to move toward a place of spiritual peace—or reconciliation—have understood that while Canada took these things away from us, it is our personal responsibility to strengthen ceremony within our families, communities, and society. Hodgson, 2008, p. 364

It is becoming widely recognised that Indigenous strategies for helping and healing are most successful in supporting Indigenous individuals, families, and communities. By helping from an Indigenous worldview and providing healing opportunities that are grounded in cultural practises, Indigenous healthcare practitioners are connecting with their clients in meaningful and profound ways. According to Warry (1998), Indigenous healing continues to accelerate as communities find new ways of nourishing the spiritual and cultural well-being of their members (p. 206). Sones et al. (2010) assert that there is growing recognition that culture and cultural approaches are achieving positive results (p. 57). Thus, it is imperative to put forth healing strategies that help people move through their pain and into a place of increased wellness. Simard (2009) conveys that as First Nation people, “we are cautioned by our elders to not stay in the pain of history too long. They teach us to to look at the internal strengths of our nations, as it is the cultural laws that have guided how First Nation people govern themselves, their families, and their communities prior [to] the beginning of colonization in 1492” (p. 45). As opportunities increase for Indigenous peoples to share experience and learn how to bring in Indigenous knowledge into current healing practises, communities will continue to increase the range of healing and health services.

This chapter presents the stories and strategies that Indigenous healthcare practitioners shared in helping their people through trauma, depression, and experiences of parallel and multiple realities. The strategies contained in this chapter originate from Indigenous worldviews and reflect important aspects of Indigenous knowledge. It is important to note that not all research participants had specific strategies for each of the areas. Janice L. pointed out, “I don’t think I differentiated between trauma and depression...That’s the difference between mainstream and Indigenous; mainstream always compartmentalizes and Indigenous [relates to] connection.”

Darlene also shared a similar response. She expressed, “I trust that whatever comes up, whether it’s trauma or depression or multiple realities...I deal with it, however I’m being asked to deal with it.” Darlene also put forth, “If a person came to me with depression, I might be asked to deal with it in a different way for the next person who has depression.” This is an important element in Indigenous healing in that there is no prescription formula for resolving a person’s issue. Mehl-Madrona (2005) refers to narrative medicine or a *storied approach* and insists that the answers lie within each and every person who has a problem, suggesting that the “proper role of the external healer is to draw out those answers” (p. 42). As such, it was clear that participants’ contributions revealed that Indigenous healing occurs in the context of *relationships within Creation*. Each of the strategies in this chapter recognises the wholistic nature of Indigenous healing.

### **Helping with Trauma**

This section presents the stories and strategies that relate to helping with trauma. It is recognised that Indigenous peoples have lived experience in a multitraumatic context; and therefore this section applies to healing trauma that is personal, collective, and historical. For the most part, the field of trauma work has been centred on mainstream approaches which have been derived from Western knowledge and practise. Indigenous cultures contain many strategies to help those who have been traumatised. This is now becoming recognised by mainstream practitioners. Psychiatrist and trauma specialist Bessel van der Kolk (2006) writes in his brief autobiography that he has learned about trauma treatment by looking at how people in other countries and cultures deal with trauma. He acknowledges “that there are other treatment options besides drugs and exposure that are rooted in other traditions and that are practiced in different ways in virtually every culture around the globe” (p. 224). van der Kolk was amazed by the similarities in healing ceremonies among peoples in Southeast Asia, South Africa, and Native American communities in southwestern United States. He noted, “Maybe there was something about the communal movement, music, singing that restored an inner equilibrium once disturbed by trauma” (p. 225). Sharing Indigenous knowledge and practise regarding trauma work will assist practitioners in understanding how to incorporate cultural strategies into their practises.

### **Prayer.**

Prayer is recognised as an important part of healing (Rogers, 2001) and Indigenous practitioners, both traditional healers and formally trained psychologists, often help their clients in prayer (Gone, 2010). Janice L. put forth, “People forget about prayer. I’ve told people to pray because that’s a huge part of our philosophy—is just to pray.” Carrie explains that the Indigenous ways of healing that they offer “focus on prayer and spirituality.” Although, she notes, “It’s up to the clients....if that’s what they want to do.” Carrie affirmed, “We are finding how helpful it is [to pray] with the family.” She also recognised that prayer had “power.” Mehl-Madrona (1998) writes that the power of prayer has been proven effective even when the person being prayed for knows nothing about it (p. 125). Gilbert shared that he uses tobacco to help with prayer and healing, “When you’re being real with your tobacco, when you’re sincere, when it’s coming from [your heart], people will get healing.” He told a story of how he helped a woman who was in great pain. When he offered his tobacco he was given direction about what he should do and what medicines to use for the following four days. Gilbert explained that he smoked his pipe on the first night to help with the healing process. He also smoked his pipe on the last night to give thanks to the Spirits. Gilbert believed this woman received healing through offerings of tobacco, prayer, and smudge. “Her pain went away because I was really sincere...I really wanted *her* to get well.” In situations where people are at advanced stages of illness and there is no expected recovery, prayer is exceptionally important. McCabe (2008) found that the use of prayer and tobacco are essential to helping a client feel less troubled and supported, “Even if it turned out that the illness claimed her life, she would have been given the strength in her last days as she prepared her journey to meet her ancestors” (p. 146). Prayer plays an important role in helping and healing by affirming connection to others and gathering support and assistance from the Spirit World.

### **Spiritual connection.**

Establishing and maintaining a spiritual connection is sometimes pivotal to the healing process. Many Indigenous people feel that they could not heal until they developed a spiritual connection (McCormick, 1997, p. 179). Becoming involved in a spiritual community is often an important element of healing. Mehl-Madrona (1998) points out, “Medicine people are principally concerned with cultivating spiritual well-being” (p. 261). Focussing on spiritual connection is

particularly important for Indigenous people accessing healing services. Unfortunately, those accessing mainstream services are often at a spiritual health shortfall because their wholistic needs may not be tended to. Letendre (2002) articulates, “Unlike Aboriginal traditional medicine, addressing the spiritual needs of a person does not fall within the domain of western medical practice” (p. 82). In general, Indigenous healthcare practitioners honour spirituality and spiritual connection in their healing practises.

Ed shared that his belief is based on what he has experienced in terms of healing and “our connection with the Spirit.” He acknowledges the term *Creator*, but recognises that we “have many different names or ways of identifying [and] recognising that Spirit.” He also acknowledges, “In some people’s understandings of that Spirit—and connection with Spirit—that it may not be one Creator but may be multiple Creators or Beings that are of that spirit realm.” Ed speaks about the human condition:

The connection to health and wellness and that whole [human] condition—not just the mind...the whole being as we talk about it as mental, physical, emotional, and spiritual—the true connection to the spirit realm and to the Creator or to whatever it may be is the *essence of what healing is about*.

Ed also shared that those who lack a spiritual connection to something greater than themselves “don’t live a very healthy life [and] they’re not very well.” Yvon discussed another aspect of spiritual connection. He pointed out, “If you have a really good connection with your Spirit and you know where your Spirit is, your Spirit is able to pick up on other spiritual phenomena that are occurring.” He also indicated, “Your spirit knows that something *not* good is coming. Your spirit also knows that something *good* is coming.” Yvon explained, “Very few people are actually able to make the connection between where their Spirit is at, where their mind is at, where their heart is at, and even where they are at physically.”

The value of helping others connect with Spirit and spirituality should never be underestimated. Tina shared a story of helping a client through her trauma and finding peace during her journey. In her story, Tina emphasised the importance of teaching women how to become grounded. She recalls:

There's a woman who came to see me a few years ago. Sometimes when she would talk about the sexual violence [which happened to her]...we did some visualisations. She didn't like me to call them that, so we just called it "That thing we do." It was about bringing her to a lake and washing herself off. Washing the child, drying her off, using the light from the Creator, the heat from the Creator's light to dry her, and then to get her to dress in her regalia, put on her little moccasins, her regalia, and her hairpieces. She had them in her daily life, but she would put them on this little girl that she was taking care of—which was her—or her Spirit. It was definitely her Spirit that she was caring for.

Tina explained that this client had gone into palliative care when her HIV progressed to AIDS. She asked Tina to be there when she passes on. That morning, Tina went to see her at the hospital:

She was wiggling and squirming. And she was making sounds like "rrummm, uhhmmm" like...there was something on her mind. And I asked her, "Do you want to do *that thing we do*?" And she knew what I was talking about—I could tell. And I could see her nodding. And I brought her to the child—brought her to the lake and washed her off and put her regalia on and her ribbons and her hairpiece and her moccasins. And then we brought her...this time we went further though and I asked her to follow the drums. She could hear them. When we got there, when we found the drum, there was a pow-pow and you could see the dancers...she was nodding, "Yeah." I said, "Do you wanna dance?" She said, "Yeah." So I said, "You follow—just let yourself dance, just go." And then she went into the pow-pow arena. I said "Just follow the drums...that's where your mom is...look in the bleachers...the children are looking at you, the kids are watching you." And about a minute later, she passed away *in peace*. I know that she had peace—and maybe for the first time in her life.

### Love.

The recognition that *love heals* is a unique strategy used by Indigenous healthcare practitioners. Darlene shared her belief that, “Over time, I’ve just come to believe that I’m here to share the medicine of love and nurturing of people.” She explains the process of bringing people into her Swing who have experienced trauma. Darlene feels that a person is often brought right back to childhood “because they’re now being put into a place that is associated with the womb of the mother, with being a child that was loved and nurtured, and with being wrapped and cuddled and kept warm.” She also explains that while a person is in the Swing, traumatic issues will often surface either through the person or through herself. If a person starts to cry or scream in the Swing, then Darlene helps them process that pain. Darlene shared her method, “Usually I just hold them and continue with the love. I always say to people, ‘that’s the medicine that’s at work here...the medicine of love. And that’s the strongest medicine that we have on the earth.’” Darlene believes that love “can break down anything.” She also thinks that people feel safe in the Swing. “They’re there, their Spirit is there. They connect. And then in that place, they can begin to really look at those issues that are maybe limiting them from moving on, moving forward with their lives.” Darlene also explains that as the person shares their story, sometimes she will “get pictures or words or just messages, images, and I’ll write those things down and when that person comes out of the Swing, I’ll share those things with them.” She also explained that she uses smudge and other tools from her culture, “I’ll use my eagle feather fan, medicines—sage and cedar. People usually bring an offering of tobacco and I pray with that tobacco. The tobacco leads that way. Those spirits see that and they come and help that person.” Darlene expressed that she strongly believes in this healing work and really trusts the process.

Janice S. acknowledged that when a person has experienced trauma, hurt, and pain, the Spirit has a hard crusty shell around it, “We need to take that hard crusty shell away from that Spirit so it can be talking to our heart, our mind, and our body.” She uses this analysis as an opportunity to talk about Fasting and about the Sweat Lodge. “I also talk about love. Love is what will help you crack that hard crusty shell.” Bent (2004) notes that love is one of the sacred teachings as spoken from the Elders (p. 10). McCormick (1995) advocates that the definition of health and healing must be expanded to include components such as love, belonging and balance (p. 252). Although the usage of *love* might seem odd to mainstream therapists, Indigenous

healthcare practitioners recognise the special relationship of helping their people in a healing context.

### **Relationships.**

Relationships are a significant aspect of Indigenous healing. Mehl-Madrona (1998) acknowledges that relationship is important to healing process. It has been noted throughout this research that Indigenous worldviews and practises emphasised the importance of connection to others and to Creation. Couture (1991a) writes, “being in relationships is the manifest spiritual ground of Native being. In traditional perception, nothing exists in isolation, everything is relative to every other being or thing” (p. 59). These understandings support healing through developing and maintaining relationships.

Many Indigenous healing agencies provide opportunities to support relationships and connect people to other community members. Yvon expresses, “I would try to bring them into relationship with people and with traditional ceremony makers.” Carrie shares, “We have a lot of cultural events [and] family stuff that they can go to. Then they start getting more and more involved and then they start healing from that.” In many ways, Indigenous agencies offer programming that enhances collaborative approaches and reinforces relationships among programs. Tina explains that their counselling program complements the culture program, the employment program, and the sacred child program. She also points out, “We have a Grandma here on staff who people can just come in and see.” There is a growing recognition of the value of having resident Elders in healing agencies and institutions. This provides clients and community members with access to traditional teachings and intergenerational relationships. Tina shared that everyone looks forward to their women’s gathering that happens in the summertime. She explained that it is a “weekend of women just getting together; learning and teaching each other—and *feasting*. And if there’s anything Aboriginal women do well, *it’s feast*. We cook and we eat. We have fun, tell crazy jokes, and stuff like that.” It has been a longstanding tradition in Indigenous communities to maintain environments that strengthen relationships.

Tina also commented that important aspects of community work entail flexibility and respect in the relationship that practitioners develop with their clients. She explains, “In this kind of work you have to be flexible—you have to be able to know that you’re going to wake up that

morning and might be going to bed with a totally different experience than you set out for.” She explains further, “I walk down the streets of Ottawa sometimes with [my family] and it’s not unusual to have one of the women that’s working the streets come up and give me a big hug because she’s glad to see me.” The relationships that develop between Indigenous healthcare practitioners and their clients are somewhat different from the Western oriented therapist-client relationship. Because Indigenous people are connected through a shared cultural history and often interact in various community, social, or ceremonial settings, practitioners and clients become accustomed to engaging in relationships outside the clinical setting. This often contributes to the process of healing through community building. Mehl-Madrona (2007b) suggests that we reconceptualise development as evolving through our interactions, “People grow and change to become better matched to their physical, social, and spiritual environment. Growth and change occur as the by-product of our relationships with others and the ways in which we are changed through relating” (p. 207). It is also understood within Indigenous healing practises that both helper and client may transform through the therapeutic relationship.

Struthers and Lowe (2003) assert that to assist an individual experiencing historical trauma a relationship must be formed in which the nurse and the client honour each other and work in unity (p. 268). Sylvia discusses her therapeutic relationship as being primarily based in antipsychiatry methods which respect the individual’s experiences. “The way I proceed is that if a person gets violent, I start with the assurance that there is a *reason to be violent*.” She acknowledges, “It might be exaggerated by the mental moment he is going through, but there is a reason. If you address the reason, then the violence will diminish. I have treated many people who are very violent and suicidal.” Sylvia also shared that she treated a woman that thought that she had a radio inside her head, “She was really troubled and I could pull her out of it without medication and without putting her in a hospital.” Gone (2010) suggests that future psychological explorations of traditional healing would benefit from careful analysis of the “centrality of the ‘therapeutic relationship:’ the active and interactive roles of both healer and patient” (p. 209). Essentially, the relationship that emerges between Indigenous healthcare practitioners and their clients may be inherently healing as a naturally occurring element of authentic connection.



### **Cultural and ceremonial resources.**

Indigenous forms of education have sustained culture and community since time immemorial. It is evident that there is a strong connection between learning and healing; and therefore, sharing knowledge is a significant aspect related to the work of Indigenous healthcare practitioners. Furthermore, connecting people to culture and ceremonies is an effective way to facilitate healing (McCormick, 2009). Each of the research participants shared examples of the cultural and ceremonial resources that they utilised in helping people that had been traumatised.

Tina described strategies to help clients develop skills to live healthier, balanced, and culturally-connected lifestyles. She asserted, “What we as counsellors give our clients is skills, life skills, psycho-educational tools.” She expresses, “They take the information, they go away, and they want to do well. Sometimes they’ll trip and fall and dust themselves off and get up and go again.” Tina feels that this strategy is *nonjudgmental* and *nonconfrontational*. She describes it as “patience” and recognises that “it shows what the seven Grandfather teachings are about...[Wisdom, Love, Respect, Bravery, Honesty, Humility, and Truth] it’s all those things.” Tina also shared that she uses a wholistic approach and that “having clients understand that they’re a whole person and that when you begin to divide it, it becomes complicated for them.” She also feels that Aboriginal people are very visual. In recognising this, she often will sit with clients in a counselling session and make a Medicine Wheel. She notes, “Sometimes it might take eight sessions to complete a Medicine Wheel. Then it’s just something that’s put away which she thinks about or he thinks about between sessions and then adds to it [in future sessions].” Tina pointed out, “When people are able to make their Medicine Wheels, they’re more connected to themselves, so there’s less dissociating.” Using wholistic approaches helps clients understand themselves in a culturally connected way. McCormick (2009) maintains, “Traditional cultural values provide Aboriginal people with teachings on how to attain and maintain connection with creation. Many of the mental health problems experienced by Aboriginal people can be attributed to a disconnection from their culture” (p. 348). As such, using cultural and ceremonial resources are vital to healing.

It is important to recognise the efficacy of cultural approaches. Koptie (2008a) suggests, “Ceremonies and cultural rituals orient First Peoples to a strength based worldview” (p. 72). Mehl-Madrone (1998) advocates that “ceremonial treatment methods are the most powerful” (p.

248). Janice L. explains that she helps clients to connect with cultural resources such as prayer, healing circles, and Sweat Lodge ceremony. “I’ve talked to women who have gone to those ceremonies and talked about their experiences with it. It was an opening for them. It opened up a new way to do our work together.” In her work with clients, Janice S. uses her sacred bundle, “I carry my shaker. I might sing. I have my tobacco, I also have my eagle feather. I like to teach people about smudging. We use sweetgrass in the morning for positive thoughts to open the mind.” She also encourages her clients to use tobacco in the morning to do their praying and to ask for focus. “I might encourage somebody at night to light some sage before they go to sleep if they’re having difficulty sleeping, to take off anything they might have picked up, to even smudge their houses.” Janice S. also encourages people to have a “cedar bath, drink some cedar, wash some cedar over their hair if they need another way of releasing.” She also encourages people “to always have berries.” Traditional medicines and food are a large part of cultural healing practises.

There are many cultural tools that Indigenous healthcare practitioners can utilise when helping their clients. Darlene’s way of helping is often guided by Spirit, “Sometimes I might be asked to use my stone, and then I put that grandfather stone maybe on the head, because I’m told to put it there. Or maybe on the heart or the stomach.” She also explained that sometimes she is asked “to use my fan–feather that person down–and I’ll do that. Or I have other medicines that have been shared with me by other healers if the person is having confusion...[or] is seeing Spirit.” Darlene noted that she believes when a person talks about seeing Spirits, “We don’t really believe in schizophrenia. If a person can see Spirits and see things going on that we might not see, it doesn’t mean that it’s not real for them. And we don’t judge it.” Darlene has learned how to use discretion with the information that Spirit shares with her during a healing session. She has also developed her practise to respond to the person’s comfort level. In one story she shared:

One time I was asked to put my hands around this woman’s neck, and I just did that. I didn’t question. I didn’t really understand why I hadn’t asked her anything. And when I put my hands on her neck, I was just going pray. I closed my eyes and I saw a car accident. So I just worked with her neck and gave her lots of

energy there...Afterwards... I just said, “You know, you got this neck injury when you were in a car accident,” and I said, “Spirit wants you to know that you need to do some more work there, to strengthen it.” And she was just freaking out!!! And that was really hard on me when I actually started doing the work because it kind of felt *intrusive*, that I should know something that I wasn’t told, right? And so now, I’m careful to explain to people, “Things might come up through me for you, and then, is that okay?” And usually people say “Of course, that’s fine. I’m here.”

Yvon noted that he uses smudging with his clients. He also seeks to bring them into relationships. “I don’t conduct Sweat Lodge ceremonies, but I accompany people [who want to attend the Lodge].” He also helps people to process what’s experienced in some of the ceremonies that they participate in. Yvon expressed, “That doesn’t happen very often which, quite frankly, is 70% of the value of the experience.” He engages in talking and other activities while he is helping clients. “We might go for a walk in the bush or go sit by the river. I fundamentally believe that our environment is constantly communicating with us.” If Yvon is helping somebody that is having difficulty then he may take them to the beach, “There’s already a lot of stuff that’s going on at the beach that’s giving them messages about what their experience is. So, for example, if there’s a *loon*, we’ll talk a little bit about what the loon means.” He’ll help a client to make a connection between the loon and their experiences by asking “What’s the message that the loon is giving you right now in relation to what we’re talking about?” Yvon concludes, “I try to make that connection so that people can heal from whatever it is, based on what’s happening in their environment. Those are the *real healers* out there.”

Connecting to the experience of trauma is an essential factor in healing. Ed acknowledges, “There are many times when people come to me and they may not be acknowledging the abuse for various reasons. They may be struggling to identify the imbalance that they’re suffering from.” He works with individuals to help them “connect to the experience, to actually identify it, to begin by identifying what the imbalance is and where it comes from.” Ed emphasises, “If it’s a person that understands themselves primarily from an Indigenous perspective, and who understands the world in that way and their place in the world, then I may

do a Pipe Ceremony with them.” He also noted that he may take them into a Sweat Lodge. Ed acknowledges, “I find that doing a Pipe Ceremony and/or a Sweat with them, to begin with, usually will help them to *feel safe enough and comfortable enough* to talk with me about the traumas that they’ve experienced.” Ed often finds that “those are the experiences that will help them to connect more clearly to the traumas, to the imbalances, and to gain more clarity on *their story* of what has happened, the trauma that’s occurred in their life.” Ceremony has long been an important part of healing within Indigenous cultures. In discussing group counselling with First Nations women, Heilbron and Guttman (2000) note that the inclusion of traditional ceremony and beliefs appeared to increase therapeutic effectiveness (p. 9).

A Shake Tent (or Shaking Tent) ceremony is sometimes utilised when people have difficulty understanding where their problem originates. Ed explains that when people are struggling and don’t seem to be able to define some of the answers within the context of the Sweat Lodge or Pipe Ceremony, he sometimes feels “that the Shaking Tent ceremony is more powerful to help them.” He explains further, “The person who’s conducting [the ceremony] will connect into the spirit realm and you ask them your questions of what it is that you’re trying to understand...why is this occurring. And the answers come through them.” Ed noted that he has gone through this ceremony a number of times to “find answers to questions we had when people were struggling and they just couldn’t understand why these things kept happening to them and were happening to their family or happening to a group of people that were working together.” Gilbert also expressed, “If I can’t find why this person is sick, if I go to a Sweat...use a rattle or ceremony and if I still can’t detect it, then I’d use a Shake Tent—that’s kind of a last resort.” Although, he noted that he hadn’t utilised that resource yet because so far he has been able to determine the cause of illness, “but I know there’s going to be a time when I’m going to have to do this, because it almost came to that point before, but something told me, ‘No, you’re going to find out. You don’t need to go there yet.’” Accessing ceremony is a form of treatment that Indigenous peoples have been utilising throughout history. With the recent cultural revitalisation, many Indigenous agencies are providing access to ceremony and cultural resources for healing. Hodgson (2010) points out, “The Aboriginal Healing Foundation’s program evaluation clearly stated that the majority of former students accessed traditional ceremony holders and Elders in their treatment for trauma” (p. 368). Providing these opportunities for Indigenous people

increases healing options and strengthens Indigenous identity which has already been recognised as increasing a sense of individual and community wellness.

It is essential to respect the diverse life experiences of Indigenous people. Carrie acknowledged, “We always have to be very careful about stereotyping Indian people [and not assume] that they all use [Indigenous] ways to heal.” She emphasises that it is up to the individual to decide what type of healing services they want. She also recognises that the Native American community is very diverse because there are over 180 different tribes in Los Angeles, “Some of them have been here for several generations and don’t have much connection to their healing ways or practises—and some do.” Carrie expressed, “I think the most important part of our practise here is bringing in the cultural and the tribally specific stuff for our clients, whether that is different ceremonies, [such as] the Sweat Lodge....talking circles.” She also recognised that connecting people culturally and helping them connect with their traditional territories is “a huge part of treatment.” Carrie shared that they offered a summer program where they brought a whole group of kids to Mexico and Arizona so they can increase their cultural experience. She also acknowledged that several of their clients want to talk to one of the traditional practitioners—the Medicine People. Carrie pointed out that they use a lot of different healing practises, but maintained that it depends on the individual and what the individual wants. “[They can see a psychiatrist] if they want to get on meds or do more traditional evidence based treatments...But we do find that the people that do more of the cultural [programming] do *so much* better in their healing.” The efficacy of cultural and ceremonial healing is reflected in the experiences that are being relayed by Indigenous healthcare practitioners. Mehl-Madrona (2003) writes:

From the sun dance to Mexican Catholic masses, ceremony can facilitate the sudden transformation that can heal body and spirit. These have been called ‘quantum changes’ because they represent a sudden, instantaneous change in the whole person that defies logical progression. (p. 115)

Depending on the agency, access to readily available cultural resources may be limited, especially if practitioners are working within mainstream settings. Nina shared that she provides referrals to culturally appropriate services when she can, “I will refer to the [Aboriginal] social workers, mental health services on the Reserves, and [the traditional counsellor at the]

Friendship Centre...we actually support one of our patients in getting to appointments there as best as we can.” Drawing on available resources, both within an agency and among the wider community, enables Indigenous healthcare practitioners to connect their clients to culturally relevant services.

Providing opportunities for Indigenous people to access cultural and ceremonial resources is perhaps one of the most important factors within Indigenous healing. However, because of colonial history, there may be resistance for some people to acknowledge their beliefs. Sylvia shared her experience of working with Indigenous women in Mexico, “You would never acknowledge in public that you believed in all of that cosmological background. It’s shameful even today.” Although she pointed out that the Indigenous women that she currently works with share all their beliefs with her. But she has found that they will first test her and if she proves herself to be empathic and understanding, then they will share, “Otherwise they will say ‘that’s nonsense...do you believe in that?’ and then if I say ‘no it is not nonsense, it is another way of thinking’ then they will start to share with me.” Often opening up a dialogue around cultural forms of healing becomes part of the healing process and an avenue to begin to honour Indigenous worldviews and knowledge.

### **Cultural assessment.**

The cultural assessment process often involves different analyses than the standardised assessment tools of mainstream disciplines. Identifying the imbalance is a common understanding in Indigenous healing and wellness. Darlene points out, “When we do healing, we really heal with Spirit because we feel that if the person is suffering some kind of physical ailment, then the Spirit must be out of balance.” She advances, “We need to bring the Spirit back to balance in order for that physical ailment to be healed.” Darlene adds that when she is working with a physical issue, she is also “working with the Spirit, I’m working with the emotions, and I’m working with the intellect—the mental capacity. I’m working with all those things all at once.” Ed shared that he begins by talking with a client about their story and allowing them to tell him what they know, what they remember, and any insight that has come to them. He explains, “That’s the beginning of the unfolding of *what the imbalance is*. Then we start to look at what needs to be done to make things right, to bring things back into balance.” Ed also notes that this exploration is particularly helpful “in cases of abuse, as most traumas are some form of

abuse, some form of harm that has been caused to them—sometimes by self, most often by others.” After helping his clients with the traumatic content, Ed will often introduce the process of restorative justice as a way of helping them address the harm that they have experienced. He acknowledges that this “would bring them into a process which includes their extended family, the individual or individuals who have caused them harm, and their family and potentially their community.” Identifying the imbalance is an important concept within Indigenous healing. Bringing the person back into balance requires wholistic approaches that include all aspects of the person, and often times their family and community.

The connection with the Spirit World is a significant aspect of cultural assessment. Yvon expressed, “I believe that when people are traumatised, there’s a whole bunch of bad spirits around them. So, part of the feasting is feasting their *good Spirits*...their helpers. And bringing those helpers into the relationship.” He also acknowledged the “*not good spirits* in the relationship” and the importance of “sending them on their way.” Yvon elaborated, “Often times I believe there are spirits in relationship because they haven’t been respected; and so, they’re *looking* for that recognition and respect...we can do that—we can feast a bad spirit that’s here and foster their moving on.” It is vital to understand that negative energy often attaches to traumatised people; and the cleansing of such energy is often crucial in creating a healing space that is calm and supportive.

Indigenous worldviews understand that the Spirit World coexists with the physical world. Gilbert shared, “I always talk about Onjine (spiritual sanction). You know, when you do something wrong or when you mistreat the little creatures that are around us—little snakes, maybe frogs or little things that go around.” He pointed out, “Sometimes when you mistreat those little things, people get sick from that.” Gilbert feels that we need to look more into *why* people get sick sometimes. “A lot of times these clients are being assessed from professional people and they never really know why they’re like that.” He also pointed out, “But we sometimes fail to go to our Elders, to do a ceremony for them, to try and find out what it is going on, and why they sometimes act out in weird ways.” Gilbert feels that the content that arises from a person’s distress is necessary to understanding the problem, “They are doing that for a reason—they are trying to tell us something.” Ed shared his experiences of learning about Onjine and how they were advised to *make things right* through offerings and ceremony, “Sometimes we didn’t even realize what we did—how we had caused harm to somebody or to something. We were told to

make it right. There were different ceremonies that we had to do at times.” Ed elaborated on the process of spiritual correction:

One time we had to take a small cedar sapling out of the bush, place semaa (tobacco) down, offer our prayers and thanks for that life and bring that small cedar tree to where we were—where we worked. And we put it at the door, and then we hung little bundles of semaa (tobacco) on the little tree and then we offered our tobacco every morning and asked for those things to be put right. I think it was a week that we did that. And then on the seventh day we had to take it out and bury that tree out in the bush.

There’s many different ways that these corrections can be done. It is worthy to note that these offerings are sometimes made to Spirits after offending or harming an animal, person, or other being in Creation. Ed maintains that these are approaches that help people who understand things in an Indigenous way, “If you were to introduce those or impose those upon people who don’t, it’s like any medicine: if you don’t believe in what the medicine is, it’s likely not going to work, no matter how effective that medicine is.” As such, cultural assessments and remedies are often set in the context of Indigenous knowledge. Moreover, cultural learning is a fundamental part of the healing process and many people experience a transformative life change in their pursuit of wellness.

### **Cultural identity.**

In the context of helping with trauma, Indigenous healthcare practitioners utilise strategies that support Indigenous people in developing a strong cultural identity. Stewart (2008) maintains that “the act of finding or strengthening Native identity is what healing is about” (p. 15). Tousignant and Sioui (2009) point out, “Resilience is closely related to cultural identity and continuity” (p. 49). Ed acknowledged, “What I do has a lot more to do with issues of decolonisation. That really is a core of what I do...and it underlies all that I do.” He adds, “The starting point for me is always in the area of helping people to understand the history, our histories, and starting with finding where they’re at...in terms of what they know...and how they’ve tied that into their understandings.” Ed noted that he moves into specifically how



[colonisation] has impacted on them and then how they can make changes. Warray (1998) maintains, "For communities to heal, people must understand community history, and the ways in which European governments and institutions have influenced, and continue to influence, life on reserve" (p. 216). Ed acknowledges, "A lot of that has to do with the issues of identity and issues of building self-esteem, strengthening their self-image. And that often ties into colonisation and understanding their cultural identity." He points out that all of this is connected to "who they are and how they define themselves. And ultimately, accepting yourself—all of who you are, all of your history, all of your ancestries, and those are the key parts of what I do with people." The process of developing a strong cultural identity often requires a significant amount of learning and personal reflection. Warray (1996) claims that there is an "intense link between cultural identity, self-esteem, and feeling of personal control" (p. 221). Essentially, cultural identity has important implications for healing and wellness.

Gilbert shared a story of a twelve-year old boy that was referred to him by mainstream professionals. He explained that he began by just talking with him, "I started asking him if he had a name, *ceremonial name*, and he didn't even know what I was talking about. And I asked him about *his clan*, again, he didn't know what I was talking about." Gilbert recalls, "He started telling me about his visions...and his experiences. Sometimes he hears someone saying something—he looks—nobody there. So, it kind of fit and that's where I got my answers from." Gilbert explained his analysis:

This child is searching for a ceremonial name. So, that's what people did, someone gave him a name. After he received that name, things started to change, his behaviours started to change. We noticed that. And they also did a search on his clan and that was discovered through that family tree.

Gilbert felt that ceremonial names (Spirit names) and the understanding of one's clan membership were essential pieces in helping people develop strong cultural identities. He also noted, "If you neglect those, then something goes wrong." The impact of residential schools and the child welfare system posed an immense interruption in the development of a strong cultural identity. Simard (2009) recounts the impacts of a mainstream child welfare agency on cultural

identity in terms of service delivery to First Nation people with the absence of cultural understanding. She points out that “children were often removed from their homes, placed in non-Native homes, displaced from their communities, often times losing their identity as Anishinaabe thereby suffering a loss of attachment to the resiliency that exists within the Anishinaabe culture” (p. 52). Resiliency is noted as an important factor in navigating through traumatic experiences. Cultural identity is strongly linked to a cultural community; and thus, maintaining cultural connections reduces the longevity of effects that trauma has on the individual.

It is important to acknowledge that colonial history and the impact of historical trauma has caused tension and resistance around cultural identity. Nina pointed out that many of the patients she sees in the hospital are assimilated, “A lot of the time, they don’t even want to talk about their culture; they don’t want to acknowledge it. So, even to get them talking about it or start thinking about their identity is a big deal.” Nina shared a story about an Aboriginal client that was not interested in traditional practises and didn’t identify with being Indigenous at all. He had been depressed for about twenty years and was using substances on a daily basis. Despite the fact that mainstream healthcare practitioners had worked with him over the years, employing different strategies and therapies, she felt that “he had just really given up on himself.” Nina explained that a shift in his cultural openness occurred after he was diagnosed with cancer and *could* be dying. She relayed that the diagnosis “renewed his whole interest in life. And so now, he’s talking about his traumas and about what it was like to grow up. His dad was [European] and his mom was from one of the Reserves.” Through a therapeutic process, he was able to talk about Christianity “and the impact it’s had on him and how it made him see himself and the traditional piece.” Nina noted that he is more culturally interested and actually willing to meet with a traditional healer, “He’s come full circle...but it took something major like that and I just happened to be able to point him in the right direction when the time came.” Cultural learning and identity development can occur at any stage in the life cycle. Many people find healing in developing their cultural identity. In situations where people may have had a previous socially constructed identity, perhaps generated by an illness, and with much of identity being socially constructed, the ability to develop a healthier identity that is rooted in culture is entirely possible as no socially constructed identity is static. Everything is in motion (Mehl-Madrona, 2005, p. 168). Couture (2005a) asserts that the primary goal is to “provide and maintain opportunities and

environments within which the hurt/fear/anger complex may be addressed, assuring a place within which to untangle childhood traumas, to rebuild a person's identity within his/her life history within family, community, and First Nation" (p. 14). If identity is the story that we tell *ourselves* about *ourselves* (Mehl-Madrona, 2007b, p. 146), then helping people connect with a community that is inherently cultural will help them heal their feelings of isolation and disconnection. Furthermore, it will contribute to healthier identities that are consistent with Indigenous Elders' view of cultural identity being a state of mind, centred in the heart (Couture, 1991b).

### **Helping with Depression**

This section presents the strategies of the research participants that articulated how they work with clients who were experiencing depression. Firstly, the process of *understanding depression* will be discussed, followed by the cultural approaches that are utilised.

#### **Understanding depression.**

I want to make special mention of a conversation that I had with the late Dr. Joe Couture, Cree Elder and psychologist, as we discussed the term *depression*. I was explaining *why* I wanted to critique psychiatry and psychiatric language in general. Dr. Couture acknowledged the challenges of using psychiatric language in the therapeutic relationship; he explained, "I no longer use the word *depression* while working with our people. Depression implies that it is up here (holds his hand up in the air indicating that there is a disconnect between the person's experience and their depression) and is something that we use drugs to medicate. I use the word *disappointment* because that gives us something to talk about" (personal communication, January 16, 2006). Dr. Couture's method of assisting clients to connect with their disappointments helped me understand that there were therapeutic ways to work with depression that were outside of pathology and pharmacology. This perspective is consistent with Indigenous ways of understanding depression as communicated by the research participants and others in the field.

Ed described that helping with depression is a process "of beginning to search out and find where it began...[and helping them to] understand what it is that has brought sadness to them—that is a lasting sadness." Ed also pointed out, "The way I work with depression ultimately

is to know where the imbalance is and then understand how to get back into balance.” Ed elaborated on the imbalance that exists in depression:

Sometimes you’re putting things back into balance that have to do with not just the human realm and the experiences of relationships in the human realm, but it can be with the animal realm or with the spirit realm. It can be in different places, in different relationships. It can be with Mother Earth and with all of Creation.

Ed helps his clients to understand the depression and where it’s coming from. This process often reveals what they need to do to resolve the feeling of sadness.

Practitioners often see a wide range of presenting emotions among their clients. Yvon noted that clients often experience “the blues or sadness,” which he points out “are all perfectly healthy and normal emotions.” He comments, “You would be amazed at the number of people who want a pill as soon as they feel sad about something—sad about loss.” The notion that depression is directly related to disappointment and sadness is an important aspect in understanding it.

Elders and medicine people have expressed that the roots of depression are due to an “abandonment of respect for a spiritual way of life in exchange for materialistic things which overwhelm people, preventing them from seeing themselves as they really are” (Baskin, 2002). The overall loss that has been experienced by many Indigenous people has had profound effects on the sense of self and general feelings of wellbeing. Depression, like trauma, has become a common portrait illustrative of the lived experience. It is expressed in the sense that *depression* is a result of socially constructed circumstances such as historical trauma, residential schools, fractured families, and lack of opportunity; rather than strictly as a chemical imbalance. Mehl-Madrona (2007b) declares that he suspects “that we also learn how to do depression—when to label ourselves as depressed. We learn what useful functions depressive actions play in social life and how to be depressed” (p. 205). There is a danger in accepting a pathological perspective of depression because it can be utilised to limit therapeutic options, as well as a person’s ability to be active in the world. Given this, it is necessary to utilise strategies to understand depression that assist in determining a practical approach to helping and healing.

### **Cultural approaches.**

Important strategies may be developed using a cultural approach for addressing depression. As Yvon points out, “One key factor that I think is really important in both trauma work and working in the area of depression and even altered realities has to do with understanding the fundamentals of self: physical, mental, emotional, and spiritual.” He elaborates, “There’s no way that you’re able to restore or be restored if you’re not addressing all four aspects. So, you cannot recover from depression if you are starving. It’s a process that requires fuel.” Yvon explained that one of the things that he almost always did when he would do psychotherapy is have food with him and feed people before a session. “So, usually that’s time that I would spend with them eating and building a trusting relationship. Sharing a little bit about myself, making people feel comfortable while feeding them at the same time.” He also stressed, “Even understanding what level of tiredness that people are at—if people are physically, mentally, emotionally, or spiritually *tired*, there’s limitations in terms of what [therapeutic work] you can do with people.” Yvon asserts that his intention may be “to work with them, to assist them in terms of processing their pain, but if they don’t have the resiliency to do that, then my job really, then, is to restore them.” He explained that this process includes, “inspiring them, feeding them, loving them, filling them up. And if that’s all that I can accomplish, then that’s all I can accomplish. I can’t expect people to work when they don’t have the resources to do it.” Yvon declared that it is important for people to have the physiology to do the work that needs to be done. He also indicated that he would strive “to inspire through Spirit.” He pointed out that it is important for people to have access to skills, to be able to grieve in a healthy way “through song, through ceremony, through the seven natural ways of healing: talking, sweating, yawning, sighing, crying, shaking, and laughing.” Although he noted that from a “traditional point of view, we wouldn’t say to somebody, ‘you need to sweat’ or ‘you need to shake;’ we would invite them to participate in singing; invite people to participate in activities that would bring about a sweat.” In terms of sweating, Yvon gave the example of “walking in the forest...if it’s a warm day.” He also asserted that it is important to “give people the opportunity to experience those seven natural ways of healing, *naturally* rather than artificially.” Cultural approaches to helping those experiencing depression are valuable tools that promote balance and relationship within Creation.

Cultural approaches include “talk therapy,” which Ed notes “is going back into the past of their memories, their childhood, of what they recall and just having them tell their story.” He also pointed out that it is important to help them where they get stuck, where they have blanks in their memory by using different approaches of ceremony and ritual to help them clarify their experiences. Ed explains, “Sometimes that [clarity comes] through a Pipe Ceremony, it can be through the Shaking Tent, or it can come through a Sweat Lodge.” Utilising strategies that connect individuals to cultural knowledge and spiritual practises increase healing opportunities and advances efficacy. Baskin (2002) emphasises that depression is considered to be a “spiritual illness and spiritual practices must be a part of the healing process.” Janice S. notes that for depression she draws on cultural teachings, such as the “Stages of Life.” She also asserts, “I’m always encouraging people to put down their semaa (tobacco) on the ground or in the water and to smudge with sage if they’re dealing with a memory or a trigger.” Janice S. described a process in the Lodge where they get bundles together in the spring when the ice is leaving:

You get rocks and if you had issues you’re still hanging onto, then you put those rocks in a bundle. And you could have as many rocks as you want. Then we throw [the bundle] into fast-moving water—toss it over your shoulder—and you never look at it again. Showing people that you can give your hurt away. And teaching them to walk—not look back, but walk away.

Janice S. acknowledged that there could always be threads that might still be hanging onto an issue. She suggested, “That’s where you might have a Sweat...you can ask for a specific healing Sweat and water’s thrown on your back to break any of those ties that you might still carry from those issues.” Helping clients move out of depression is an important aspect of the healing process. Duran (2006) writes about the Spirit of depression, which implies that one can be visited by *depression*, rather than suffer from an ongoing illness. Mehl-Madrone (2005) writes in reference to a client’s depression that it was a partial answer to her inner turmoil, “Depression allowed her to better tolerate her incredible frustration. It quieted her creative drive sufficiently to tolerate a social situation in which no solutions could be found. When different stories showed her solutions, she forgot to be depressed” (pp. 177-178). In the context of depression and

disappointment, creating a new story, or even revisiting an old one, can often help individuals shift their perspective and gain new insight into their life journey.

### **Helping with Experiences of Parallel and Multiple Realities**

As discussed in Chapter One, the use of the terms *parallel* and *multiple realities* is intended to replace the psychiatric classifications of *psychoses* and *psychotic episodes*. Despite the wide-spread use of the above mentioned terms, it is imperative to note that Indigenous practitioners do not automatically assume pathology when utilising psychiatric language. A situation prompting a person to enter into parallel or multiple realities is a type of spiritual experience. Sometimes this can come about through ceremony or even as an ability that an individual may attain; however, sometimes this prompting is a result of trauma. The trauma may have occurred in childhood or may be a current trauma; it may even be multigenerational or have been passed down through blood memory. It is important that these experiences not be viewed solely within a pathological framework, as there is often important content that arises that is vital to restoring the balance of the individual. Also, if an individual is articulating what could be considered an experience of parallel or multiple realities it is imperative not to assume that this is a problem that requires restoration. The person may be completely in balance and not in need of therapeutic assistance.

Spiritual experiences are often common and healthy aspects of Indigenous life. Yvon commented, “*disorder* is more specifically related to pathology. And not all conditions are pathological. In fact, some conditions are constructive in terms of people being able to actualize.” He also points out, “When we use the phrase *condition*, it’s intended to acknowledge circumstances that may require some remediation and/or facilitation...Healing is not about the removal of pathological circumstances—it’s about being in wellness.” Mehl-Madrona (2007b) explains that the psychotic symptoms being experienced by one of his patients were a necessary flow of energy that could not be released any other way, “New stories allowed that energy to flow in different ways and the psychotic symptoms diminished” (p. 150). Helping individuals who are experiencing parallel and multiple realities often requires a shift in understanding and the utilisation of strategies that acknowledge the essence of Spirit and spiritual relationships.

### **Experiencing Spirit.**

Many people experience Spirit throughout their lives. Sometimes this is an ongoing experience and other times the occurrence is for a short period only. Indigenous cultures contain the understanding that there are helpful Spirits and *not-so-helpful* spirits. For example, a helpful Spirit may be a person's ancestor or spiritual helper; and a *not-so-helpful* spirit could be a wounded spirit that is antagonist and toxic. Gilbert shared that sometimes people come to him and tell him, "Oh, I'm hearing this and that." He explains to them, "That's what the Elders are always talking about when they talk about Spirits. Spirits are all over. And sometimes they let us know that they're there." Gilbert encourages people not to be afraid of noises. He shared the story of a traditional drum that he has at home. He often shares this story with others that are learning about spiritual experiences:

I have a place, a little bed, for the drum. I keep it in my room. One time my little girl was six years old and mom and I were in the kitchen and she came running out of her room, "Dad, there's somebody in your room!" It scared her. And I told her, "yeah, I have that drum there." She said, "It's a lady dressed in a kind of a brown outfit." "Well, don't worry, it's that drum Spirit that you saw there," I said. She asked, "Who?" I follow her back to her room, so she felt comfortable. And she started telling me, "Well, that drum, I hear it once in awhile, someone knocking, knocking when there's nobody there, when you're not there." I told her, "The drum Spirit is letting you know that she's there with you."

Learning about spiritual experiences can expand our connections within Creation. In some situations, it can challenge our assumptions and transform our knowledge constructs.

For those who are having difficulty with their experiences, they may require other supports to help them achieve comfort and balance. Ed expressed that he focuses on helping people to become contributing members of society in whatever way they're meant to be, "I think as long as people are communicating...it's when they become non-communicative, then we have to start to look at what else we can do to help them to stay healthy, to stay connected to this world." Janice S. shared that she is working with a woman who has been diagnosed with



schizophrenia, “She walks with a Spirit. She says she’s had this person since she was nine years old. She doesn’t like the person because she thinks the person tells her bad things.” Janice S. explained her method of talking about Spirit with this client, “I acknowledge that she walks with somebody and *that’s okay*. I could see a big change in her. I could see the relief...she cried because she’s never ever had anybody say that that was okay...it was always wrong.”

Yvon shared that he draws on traditional teachings as a form of support. He expresses, “I most often try to remember that we are Spirits on a human journey. There are other Spirits on a journey that are *not* human.” He pointed out, “When I encounter people who are having difficulties with their human experience, I draw upon other spiritual experiences to help ground them.” Yvon put forth an example for people who are adversely affected by chaos, “I try to bring them *literally* into relationship with other beings—*like trees*. There’s nothing in the world that’s more grounding for someone who is *frightened* or distressed by their difficulties in dealing with multiple realities.” There is a direct link to the health of Indigenous peoples and their connection to the land (Adelson, 2000). The relationship to the land also provides a spiritual element in that the land is alive and contains Spirits (K. Wilson, 2003, p. 91).

The challenges that exist for practitioners working with people encountering parallel and multiple realities are often related to understanding the experiences and having a repertoire of options for creating balance and wellness. Importantly, Yvon asserted, “For us as helpers who are working with people who are experiencing multiple realities...first of all, we have to have the capacity to deal with multiple realities.” He also advocated, “That’s also true for other people who are adversely affected by multiple realities. We mustn’t assume that since it’s normal for them, that they’re comfortable in that.” Yvon acknowledged, “The part of the *multiple* that they may be having difficulties with is not the *irrational*—it’s the *rational*.” Yvon explains that part of what he does with people who are having difficulties around dealing with multiple realities is to “give *them* the knowledge and the skills to be able to deal with people who are rational and not irrational.” Mehl-Madrona (2003) writes about how we live in a society where connection to spiritual reality has been taken away from us and to talk about spiritual experiences “is a sure way to get yourself labelled psychotic, especially when the person being talked to is of a rational materialistic mind-set, or is a psychiatrist”(p. 227). Because of this, many Indigenous peoples have either been cautioned, or learned from experience, not to disclose spiritual content to others who do not have an understanding of Indigenous worldviews and ways of connecting to Spirit.

Mehl-Madrona (2003) suggests, “The first thing that someone who is undergoing a dramatic spiritual opening with elements of altered reality might be advised to remember (if possible) is that the world that he is experiencing is not necessarily accessible to other people” (p. 226).

### **Being open to a different reality.**

It is important for healthcare practitioners to be open to supporting individuals who may exist in a reality other than what the practitioner is familiar with. Yvon shared a story of helping a client that has been diagnosed with fetal alcohol spectrum disorder. He noted that this client also exhibits symptoms consistent with schizophrenia. Yvon recalled that when he arrived at the client’s residence the client had put his clock on the couch and pulled the couch away from the wall. Yvon asked him “why that is” and the client explained that he “took the clock off the wall because the people in the attic were talking to him [through the clock] and telling him that he’s a homosexual and he’s bad and he should get out.” Yvon learned that despite he had taken the clock off the wall, the voices hadn’t stopped, so he encouraged him to put the clock in the closet. Yvon acknowledged that his training as a psychiatric nurse would suggest that he is “feeding his delusions” because the client is “hallucinating.” Yvon feels that his professional training was irrelevant in helping this client, “What was relevant was the phenomena was disturbing for him and so I looked to the solutions that he has used in order to minimize the disturbance that he was experiencing from the parallel reality.” He was not interested in trying to talk him out of his delusions and tell him that his hallucinations are a biological process going on in his brain, which Yvon recognised “happens in psychiatry all the time.” He explained, “That’s not my mission...My mandate is to try to restore him to being comfortable or *bimaadiziwin* (living in a good way) is the only word that comes to mind, so to build *bimaadiziwin*...putting the clock in the closet brings that about.” Yvon asserted that this is what culturally-oriented practitioners do instead of “upping his antipsychotic meds.” Yvon recognised that this *client’s* reality is completely different from his own reality and “it’s not my job to impose *my* reality on him.” He elaborated, “It’s my job to facilitate *his* reality in a manner that is not disturbing to himself or to others but, even more so, that’s actually [helping to] fulfil his prophecy.”

As a psychiatrist, Nina modifies her treatment processes to be considerate of Indigenous worldviews. She will articulate to clients, “Okay, so you’re in your reality” which is a way to acknowledge their experience without pathologising it. She points out, “Where my line is—is just

as long as they're not hurting themselves or somebody else. If there are goals they want to reach and those experiences are keeping them from that—that's when I would want to intervene." She also commented, "Some people are so closed, they won't even talk about what they're experiencing. Especially when they've already *been* institutionalized. They've already been through the worst of it." The approaches shared here acknowledge experiences without applying a clinical psychiatric pathology or treatment. This kind of Indigenous approach provide important opportunities for clients to express themselves and gain insight into their journeys. It also honours their own solutions and abilities to see the world from their own realities without having professionals discount the roots of their behaviour and knowledge.

There are social and cultural differences in terms of understanding and accepting the way that a person may interact with his or her surroundings. Sylvia recalled that there was a man in Cuernavaca, Mexico, "He would pretend he was a traffic policeman. He was stopping cars and signalling them to go and everyone just took it easy and they followed him. He never had to be put into a hospital." She explained that he lived in his world and everyone just accommodated his behaviour. Sylvia attributed this to the way Mexico is, "It's a country where everything is not as *normed* as in America or in Canada...where if you deviate a little bit you get *treated* separately." Mehl-Madrona (2003) notes his observations in a small village community that "a wider range of behaviour is tolerated, simply because everyone has known each other since childhood and knows each other's families, and therefore the fear of the unknown is taken away" (p. 228). Such tolerance is usually not found in larger urban centres where there is a greater sense of anonymity and disconnection. Covan (1994), chief psychologist at Bellevue Hospital's psychiatric services in New York City, writes of his experience while heading to work one morning on his motor scooter through the routine chaos of Manhattan traffic. A commotion ahead peaked his curiosity when he heard a host of comments coming from individuals also trying to reach their daily destinations. "Hey, Mistah. Ya know where you belong? Bellevue!" Dr. Covan manoeuvred his way through the traffic, only to discover that the heckle through the air was quite accurate, in that the commotion was being caused by a recently discharged psychiatric patient who was directing traffic on Fifth Avenue.

### **The use of psychotropic medications.**

Psychotropic medications have been useful in helping people achieve balance and harmony. Although, as discussed in Chapter Six, it is important to prescribe medication with discretion. In terms of people experiencing parallel and multiple realities, Ed shares, “There are times where I do believe that they’re only going to benefit from having a psychotropic medication that will help them to get grounded and then [cultural] approaches will also help them further.” He explains that in those situations, “I would refer them to a psychiatrist and then I would work along with them with the psychiatrist and/or the physician.” Ed has witnessed the benefits of psychotropic medication and asserts, “I think we’d be remiss if we were to say as First Nations people that we’re going to reject all of that knowledge, that wisdom, that form of medicine because I think that many of our people would suffer.” He further advocates, “We just need to be mindful of it and understand its place and its purpose and how to use it in a healthy manner within the context of wholistic health and healing.”

Nina explained that she listens when clients share stories of bad medicine. Some professionals would automatically pathologise these experiences and advocate for the prescription of medication. However, two of Nina’s patients had diagnoses; one was diagnosed with alcohol hallucinosis and the other with schizophrenia. She asserted, “I don’t necessarily try to medicate that belief away [of bad medicine]...The one fellow was working right alongside a traditional healer at the same time. And the other one was in [an Aboriginal healing agency].” Nina expressed, “I don’t try to alter it. I let them work it out in a more appropriate way. I’m not necessarily going to try to medicate it away.” Nina also shared the story of a patient that had been on many medications. She expressed, “It’s just horrible. I tried to cut back her meds, but every time I’d try to cut back, she’d act out. So, it’s hard to say how much the medications were doing.” She questioned, “whether or not the meds were actually helping or if they were just sedating her so she wasn’t aggressive.” Nina acknowledged that this patient had such difficulty managing her own emotions:

When you tried to do any reality-based therapy, she’d just slip into the psychosis. So, the approach I had tried to take was grieving, helping her grieve. But she couldn’t even tolerate that. So then, I would just let her talk. I tried to help her

contain it. But that didn't help either. She never could identify a reality-based trauma. It was all in her delusions. She'd been raped in her delusions. I'm sure she's probably very, very traumatised.

It is accepted that psychotropic medications can be helpful in the stabilisation process as well as to regulate emotions that are particularly disruptive. Many people remain on psychotropic medication for long periods of time. For some, the decision to live without medication often requires a significant lifestyle change and considerable supportive services. Mehl-Madrona (2007b) notes that a patient with a previous diagnosis of bi-polar disorder engaged a healthier lifestyle which was embedded "in community and participation in ceremony [which] served to regulate her mood better than pharmaceuticals and with fewer side effects" (p. 18). Nonetheless, psychotropic medications are sometimes a necessary part of a treatment plan that helps individuals reach a greater level of balance and wellness.

### **Consulting with Elders and medicine people.**

It is recognised that Elders and traditional healers are important community resources and bring vital knowledge and experience to the healing process (McCabe, 2008; Menzies, 2004). Ed shared that he helps people to make sense of what their experience is from a "wholistic perspective—from an Indigenous perspective." He helps them to understand what they can do to effect healing in their own lives. At times he will introduce ceremony to them. Ed also explained that if his method doesn't seem to be effective, "I will then introduce them to other healers, medicine people who I know have gifts that I don't have, to work with them on issues that may be more focussed, in a sense, of a spiritual nature." Connecting clients with Elders and medicine people brings them into healing relationships where they learn cultural protocols, which translates into Indigenous knowledge. Gone (2010) recognises that traditional healing often includes more than the client and healer alone, and that "most forms of traditional healing assume that therapeutic knowledge and practice are essentially dependant on *relationships* with more Powerful others who compassionately share gifts of healing in exchange for respectful offerings and ritual observances" (p. 206).

In some situations, an individual may be accessing mainstream services alongside traditional healing. Nina shared the story about a client who came into see her one day. In his bag

he had a rope tied in a noose and he had a bottle of cedar water from a healer. She explained, “The healer had told him to see me because he was on the verge of trying to hang himself because of bad medicine.” Nina ended up admitting him to the hospital and he was there for about a week. She recalled, “He gave himself a cedar bath every day in the hospital.” Nina noted that she always had a really good working relationship with this client. She also pointed out, “He was on an antipsychotic medication all along. I didn’t even do a major med change. He was just in for a week and then was out. He went on his way and everything was fine.” Nina expressed that “sometimes he still has those beliefs, but they’re not interfering with his well-being anymore.” Fortunately, some of the people accessing mainstream psychiatric services are able to maintain connection to Indigenous Elders and medicine people. Menzies, Bodnar, and Harper (2010) discuss an innovative model of a mainstream addiction and mental health hospital that includes a fulltime Elder on staff as part of Aboriginal Services. Mehl-Madrona (2003) points out that in traditional healing, “Medicine and spirituality are not separated as they are in our modern world” (p. 20). Collaborative approaches support clients through difficult times in their lives; however, these supports require a willingness to work together while recognising available resources.

Encouraging and assisting clients to access Elders and medicine people is an important part of the healing process. It also provides clarity on issues and circumstances. Janice L. asserted that she has encouraged parents to consult with medicine people when their children are sharing experiences of being in parallel or multiple realities “because to our people those are real things and we believe in that whole heartedly.” Janice S. shared that she also takes their story to an Elder for consult. “I had another lady who was on antipsychotic medication. She had lived in a residential school and she kept reliving a rape, but it was not coming out as a rape.” Janice S. recalled, “The non-native helpers kept thinking that she needed to up her dose of medication.” Janice S. helped her to speak with an Elder who had knowledge of residential school experiences. She explained, “The Elder helped her understand what she was experiencing, she was reliving trauma—the memory.” Drawing on resources that aid in the process of connection often provide opportunities to understand issues from relevant contexts while acknowledging spiritual and cultural support. Gone (2004) points out that “much of Native America views disorder and healing in the context of spirituality and religious practise, local consultation with

medicine persons, ritual leaders and even Christian clergy may be essential to the implementation of any form of psychotherapeutic practice” (p. 16).

In another situation, Janice S. consulted with an Elder to determine if a client was receiving a teaching or some kind of knowledge, “I had a young man who was diagnosed as a paranoid schizophrenic and he did really well. And then all of a sudden, he hit a wall and I had an Elder speak with him.” She recalled, “One of the clinicians asked me if I knew what a trigger word was for him. And it was ‘space.’ [The client] thought we were all going to be taken over by aliens and that he was an alien.” Janice S. noted that this client had to be on medication and stabilise so the Elder could sit and talk with him. As a result of the consultation held between herself, the client, and the Elder, Janice S. explained, “What we found out was that *no*, that wasn’t a teaching and it wasn’t any kind of knowledge—he was being influenced by a movie.”

One of the challenges of consulting with Elders and medicine people is the limited availability in communities. Yvon asserted, “Finding Elders who are comfortable and capable of working with people who live in multiple realities is very difficult, just as finding an Elder who’s able to work with a woman who’s suffering from trauma.” He spoke about an Elder “who appears to exist in a state of parallel realities.” He described his Spirit as “so bright and so pure and so uplifting.” Yvon noted that when he is helping people who need to have their *Spirit fed*, “I’ll bring the person into relationship with this Elder. And I’ll get them ready for that in the same way that I would with any other Elder.” He expressed that it is important to prepare people to come into relationship with an Elder and he shares teachings on how they should conduct themselves. Yvon also commented, “It’s about Spirit work as opposed to going and getting a teaching on the process of grief. It’s not about grief work, it’s about dancing with Spirit—dancing in that light.” It is important to recognise that Elders and medicine people have their specialised areas of knowledge and experience; however, these resources are often sparse and challenging to access.

In the early 1990s, Couture (1991b) asserted that the decrease in true Elders is “most alarming.” Many of these Elders have returned to the Spirit World without passing on their knowledge. Couture notes that there now exists *instant Elders*, “overnight wonders who, with limited ceremonies and an abundance of clichés, confuse and stall many [individuals] in their personal journey.” He also pointed out that true Elders are those that “have gone through painful

encounter with spiritual realities, and who become thereby, in the perception of the People, intermediaries between their respective cultural communities and the spiritual forces of the universe, and defenders of the community's psychic integrity" (p. 211). With this in mind, the selection of Elders and medicine people for referrals by healthcare practitioners and community agencies will need to be done carefully. Policies and procedures which protect the health and wellness of clients will need to be developed and adhered to.

### **Connecting with family and community.**

Common themes in this research have acknowledged the importance of relationships and interconnections among Creation. Indigenous healing practises focus largely on these aspects. Ellerby, McKenzie, McKay, Gariépy, and Kaufert (2000) conclude, "healing is not possible without spirituality, nor without relationships to family and community, and to the cosmos" (p. 848). Without meaningful relationships and connections, people often feel isolated. Nina shared the story of a patient that had been in the hospital for three or four years. She felt that she was being stalked and that a medicine man was using bad medicine on her. Nina explained, "They weren't able to discharge her because every time they did, she'd end up back in emerg having hurt herself or hurt someone else." In one of the discharges she had been out of the hospital for six months. Nina commented that in that time "we hadn't really connected her very much to the community because she hadn't been that interested." When the woman was admitted back into the hospital, Nina had arranged a day pass for her to see a traditional healer from one of the nearby First Nation communities. However, the staff cancelled the day pass, without Nina's knowledge, after the patient had a conflict with one of the staff members. The staff claimed that seeing the traditional healer was "just a recreational activity." Nina disagreed with the decision and proceeded to involve the Patient Advocate which resulted in the patient obtaining the day pass to see the traditional healer.

It is often essential to connect Indigenous people to culturally appropriate services, particularly if they have been disconnected or isolated from traditional healing opportunities. These opportunities result in connecting people to family and community, which is a vital part of the healing process. Nina shared that the above mentioned client continued to be involved in the Aboriginal community after her initial visit with the traditional healer. Her doctor helped to facilitate the relationship with an Aboriginal healing agency which enabled her to attend circles



and Sweat Lodge ceremonies. She was eventually discharged from the hospital and is living independently; despite that she still has all her symptoms. Nina credits the connection with the Aboriginal healing agency as pivotal in her progress, “the support that they’ve been able to offer her with the traditional practises and just their approach—they were very tolerant of her psychosis, so she has a community now.” With the immense disruption of Indigenous life, the connection to family and community is often absent. New relationships are necessary to support healing and healthy relationships. Participants in research conducted by Stewart (2008) referred to community “not solely or specifically as clients’ ancestral or traditional community but as any community of other Native peoples to which they might belong” (p. 15).

There are cautions, however, to connecting people to community if they or the community are not prepared to be in a relationship. In terms of the helpfulness of bringing people into relationships with ceremony and community, Yvon asserted, “It depends on where the client is at in terms of their connection to *this* reality, who’s doing the ceremony, and how connected the Elder is to multiple realities.” He noted that, “More often than not, it’s difficult because of other people who may be connected to the ceremony, either as helpers or other participants.” Yvon pointed out, “Sometimes it’s best not to take somebody to a ceremony, because I fundamentally believe that one of the things that underlies delusion has to do with *how* that individual experiences other individuals.” He elaborated, “When an irrational person is in the company of a rational person, they’re able to pick up on the emotions that are coming from the rational person. It’s not usually nice or kind; it’s usually mean, actually.” Yvon acknowledges that the client is “able to pick [those emotions] by virtue of the way they are. They try to make sense out of what is nonsensible. And that feeds, I believe, the basis of delusions.” He concludes, “It’s not good for me or for the people that I’m helping to bring them into a relationship where they’re going to experience that kind of distress.” Given these possibilities, it may be important to prepare individuals, Elders, and community members prior to engaging in a relationship which might involve parallel or multiple realities. Mehl-Madrone (2003) acknowledges that someone in a highly sensitive state “might perceive somebody else’s energy field and psychic wounds, even sense her emotions very strongly. He might even be aware of entities in the spirit world that are present or feel the energy of a particular place” (p. 226). Furthermore, Hodge, Limb, and Cross (2009) recognise that people exist in relationships with positive and negative spiritual forces, “Although typically unseen, these forces are real and

influence people for both good and bad in this material dimension of existence” (p. 214).

Nonetheless, it is still important to connect people that experience parallel and multiple realities with family and community. Albeit, more care and compassion may need to be put forth in terms of helping them be in relationship together.

The final story shared in this research reflects the experiences of Sylvia during the 1970s and 1980s. Sylvia, along with a group of people in Cuernavaca, Mexico created a project that was called *Procesos de Accion Comunitaria* (process of community action). This project was inspired by the therapeutic communities of antipsychiatrists Ronald Laing and David Cooper in London, England. In her study of antipsychiatry methods, Sylvia had the opportunity to live with Laing and Cooper in one of the therapeutic communities, which housed and supported people in crisis outside of the hospital system. She asserted, “All these people were treated like human beings, they were not in a hospital. They were helped through their critical moment.” She explained, “We had knowledge that this kind of psychic crisis takes three to four weeks to resolve, but if you enclose a person in a hospital then they will have a lifetime of problems and will remain on medication.” Sylvia noted, “But if you follow them and support them then they will be able to continue their normal life—it is just transitory period.” Sylvia and a group of others in Mexico wanted to create a type of therapeutic community “but not within a closed place.” She explained, “I wanted to give the opportunity to live in the community like the Indigenous people do.” Essentially, Sylvia wanted to create a supportive environment, rather than the unstructured nature of the British therapeutic communities. Robinson (1972) captured the environment of Laing’s therapeutic community in his film *Asylum*. During medical school, Mehl-Madrona (2005) discovered that traditional medicine people treated insanity in much of the same way that R. D. Laing did, except traditional medicine people were more compassionate and provided more support, whereas Laing “seemed to leave his patients adrift in their unbearable emotions with little direction and few guideposts” (p. 188). Sylvia and her colleagues were successful in developing a process that supported people in crisis—outside of the hospital. Although this project was based on the therapeutic community model of Laing and Cooper, the project in Mexico was designed to reflect the true essence of healing within the Indigenous community.

Sylvia explained that the *Procesos de Accion Comunitaria* project “was a community response to therapy, it was not *closed inside* like Ronald Laing’s communities in London. We recreated a community with 40 families that would take in people who were going through a

crisis.” Sylvia shared that the families were mostly students in clinical psychology at the university and other committed community activists. They were all volunteers. She noted, “Some of them were Indigenous and some of them were not. Some of them lived in Indigenous communities. And some of the patients were Indigenous.” Sylvia explained that they always introduced a new person in pain through a party with everyone from the 40 families coming together. “They observed carefully with whom this person felt more at ease. They immediately established a better relationship with some people than others. So some people more often had to host or to accompany people who were under stress.” Once it was established that there was a good supportive connection, the person in crisis would return home with the volunteer family. This was pivotal in the stabilisation and healing process. Sylvia shared that the families would “take them to work and support them so the people didn’t have to stay within their conflictive families which could be related to some of these painful situations that they go through.”

The project operated for four years. As head of the project Sylvia had to meet with every person that came into the project because she was the only fully trained person in the group. “It was very absorbing. I would have people in my home all the time. The 40 families were scattered in small towns around Cuernavaca.” Sylvia expressed that this was “a whole new strategy” in Mexico of assisting people in crisis. She pointed out that they received many referrals “because we didn’t put people into mental hospitals and the people we cared for did well.” Sylvia expressed that it was very inspiring to witness what Indigenous peoples do with those that are experiencing the “de-structuring of self and extreme anguish; and sometimes hearing voices and seeing visions.” She maintained, “Coming from the Indigenous perspective, poor mental state is believed to be impacted by a spirit that has come to imbalance this person, or sometimes it’s a call to follow a mission that he has to do.” Sylvia met with each of the participants in the program to be “in touch with them, and see where they were, and understand the origin of their psychic suffering.” She would also see the individual on a more regular basis and provide clinical therapy. She also kept in mind that there could be a calling, a transcendent calling, or that there was a bad spirit that was really invading them. She expressed that it was important to “take all these categories from the Indigenous world as real—as true. Not saying that is superstition and backwardness.” Sylvia often worked in coordination with healers, “very often I had to refer a patient or a person to a healer and the healer would do a series of limpiezas (cleansings).”

Sylvia shared the story of one of the people that participated in their program. He was an Indigenous engineer that worked at a large corporation. He became extremely distressed and was admitted into a hospital for psychiatric services. Sylvia and her colleagues went to the hospital and asked if he wanted to continue with the hospital services. He said “No, I don’t want to continue.” They helped with his discharge from the hospital and proceeded to create a support network for him. “He lived for a time with some people in the countryside in a small Indigenous town. They took care of him when he was very anguished. He also partially lived with me and he lived with other people.” Sylvia felt that this man needed to see an Indigenous healer, so she took him to see a healer that was part of their project:

As a healer, she did a diagnosis from a cracked egg in a glass of water. From the designs made by this egg she was able to see that his coworkers had thrown *mal aire* (bad air) at him. There were terrible problems within the institution where he worked because it was very corrupt. They wanted him to sign that the project was done when it was not done. He was honest and didn’t sign, so then they harmed him.

The healer did her therapy for this kind of harm. Sylvia continued to see him for the psychological issues and helped him deal with his visions. There was a sharing between the traditional Indigenous healing and the clinical support that Sylvia was able to provide. Sylvia concluded that he recovered and “twenty years later he is still doing well. He has his life back. He was an engineer and he went back to his career.” She further explained, “He’s still vulnerable—psychically. This is why he got so bad because he had a certain vulnerability, but he is living a normal life now and not permanently highly medicated and living inside a mental hospital.” Sylvia felt that this man’s trouble occurred because he was an honest person. “He was not meant to be corrupt like other people. He maintained an Indian structure, which is quite often the case.”

Sylvia’s story, like many of the other stories and strategies shared by the research participants, reinforce the need for Indigenous people to have access to culturally appropriate services that are grounded in Indigenous worldviews and practises. The changes brought on by

colonisation have displaced many of the traditional healing practises that were once regular customs of community life. Despite cultural disconnection, many Indigenous peoples are reviving traditional ways and utilising culture and ceremony as part of their healing processes. It is also recognised that healing requires the power of community (Mehl-Madrona, 2003, p. 164). Indigenous strategies for helping and healing are essential components for the Indigenous healing that will guide us into wellness.

### **Summary of Chapter Seven**

Chapter Seven presented Indigenous strategies for helping and healing trauma, depression, and experiences of parallel and multiple realities. A couple of the research participants expressed that they did not differentiate between those areas. Nonetheless, all participants shared Indigenous strategies that they utilised in their practises. The strategies for helping and healing originated from within the depths of Indigenous worldviews. The participants advanced strategies that are largely foreign in mainstream practises such as recognising prayer, spiritual connection, and love as essential to the healing process. All of the research participants shared how they utilise cultural and ceremonial resources in their practises. They also established the importance of helping the client through analysis that is grounded in cultural knowledge and understanding of relationships within Creation. The next chapter presents a discussion on *Decolonising Trauma Work*, implications of the research findings, and my concluding thoughts.

## **Chapter Eight:**

### **Conclusion**

This chapter presents the final phase of discussion and inquiry generated by my research in *decolonising trauma work*. The conclusion will include the implications of the research findings and my concluding thoughts. The goal of this study was to explore and demonstrate the validity of Indigenous knowledge and cultural health practises that are necessary to restore wellness for Indigenous peoples on Turtle Island.

#### **Discussion of decolonising trauma work.**

The title of this thesis, *Decolonising trauma work*, emerged years ago when I was initially interested in focussing on critiquing psychiatry and highlighting cultural strategies and philosophies that Indigenous healthcare practitioners were utilising in their practise. What became apparent is that *decolonising* had a dual meaning in this research. Firstly, it emphasises the need to challenge the mainstream disciplines of psychiatry and psychology and its influence on healing and wellness in our communities; and secondly, it advances principles of self-determination and community control in regards to Indigenous health in the context of healing. Above all, this research puts forth purposeful strategies of what decolonising trauma work entails. It is decolonising in both process and in providing concrete examples of useful and effective healing strategies which Indigenous healthcare practitioners have shared in their stories.

This research study invited Indigenous healthcare practitioners to join in a dialogue about healing and wellness. Participants were asked about their worldviews; understandings of wellness and wholistic health; critiques of psychiatry; and their cultural strategies of helping clients through trauma, depression, and experiences of parallel and multiple realities. Many of the approaches and cultural strategies shared by the participants can be readily used by Indigenous healthcare practitioners that are familiar with cultural teachings and philosophies. There is also a wide recognition of the importance of connecting clients to cultural and ceremonial resources through referrals and partnerships with Indigenous communities. As it is not culturally appropriate to write down ceremonial knowledge in detail (Solomon and Wane, 2005; Gone, 2010), this research was not concerned with documenting healing ceremonies or even giving explanation of specific ceremonies that were mentioned by research participants.

The intention was to acknowledge the importance of ceremony in healing; and not to generate research that might be taken out of the context in which the understanding was shared (Voss, Douville, Little Soldier, & White Hat, 1999, p. 89). Further, what can be recognised in the results of this research are the culturally complex issues around integrating traditional healing methods with conventional medicine associated with Western treatment styles. Trimble (2010) writes that this integration is not without problems. “For many Indians and Natives, the idea of sharing their traditional healing and spiritual traditions with outsiders would not be acceptable and would be met with fierce resistance” (p. 253). The protection of Indigenous knowledge must be recognised in intellectual property rights, and specific efforts to avoid exploitation and appropriation must be employed at all times.

It is imperative that this research not be interpreted as a pan-Indian practise template. Importantly, it should be accepted that each of the participants shared their stories and strategies from specific cultural locations. Although some participants explained that they learned their teachings from more than one Indigenous tradition, or from Elders of Nations other than their own, these strategies are rooted in the self-location of each participant. Whereas pan-Indianism implies that there is a melting pot of traditions among Indigenous Nations, and this is simply not the case. Even though there may be similar teachings among different Nations, or even common ceremonial practises or medicines, it is important to recognise each Indigenous Nation as distinct and unique in culture, language, and tradition.

Many themes emerged throughout the research study and were then organised into the story of this research. However, there were inherent themes which did not warrant independent sections, such as dreams and circles as they are an integral part of Indigenous life, and thus are represented in many contexts. This is consistent with the understanding asserted by Cardinal (2001) as he describes how Elders sat in circle and reflected on their dreams as a way of determining an answer. “This whole process of Circle work and Dream work are methods: Indigenous methods that speak clearly to an Indigenous perspective, an Indigenous world view” (p. 181).

Indigenous philosophies and worldviews appeared in themes throughout this research which supported Indigenous knowledge and research methodologies. Poonwassie and Charter (2001) note the natural ways that cultural approaches exist in Indigenous practises, “Storytelling,

teaching and sharing circles, participation in ceremonies, and role modelling are among traditional Aboriginal approaches to helping and healing” (p. 67). Recognising that these approaches are consistent with Indigenous healing strategies, the themes of this research reflect practical examples and understandings found in the practises of Indigenous healthcare practitioners.

For the most part, this research sought to contribute to the field of *working with* trauma by providing frontline workers with insights and strategies that will increase their repertoire of therapeutic skills. Chapter Five brought forward clear understandings of wellness and wholistic health as Indigenous healthcare practitioners acknowledge important worldviews and knowledge and shared how to apply these concepts to clinical practise. Chapter Six revealed important findings on the impact of DSM diagnoses on individuals and the problems of applying Western psychiatric treatment in a cultural context; yet, research participants also recognised the usefulness of psychotropic medication for those that struggle to find balance in their lives. And finally, Chapter Seven presented the strategies of how Indigenous healthcare practitioners were helping their clients through trauma, depression, and experiences of parallel and multiple realities. Significant themes in this research which span across each of the areas were: connection to Creation, spirituality and the existence of Spirit, cultural and ceremonial practises, relationships with family and community, and Indigenous identity.

### **Implications of the research findings.**

This research highlights significant implications relevant to the areas of health policy initiatives, agencies programming, and educational bodies that deliver training. However, it should be noted that the approaches and methods suggested may create an element of tension and resistance. Many mainstream practitioners, agencies, and institutions are beginning to recognise the efficacy of Indigenous healing. Nevertheless, the mainstream medical model of clinical diagnoses and treatment continues to prevail in healthcare policy, services, and education. This factor continues to impact funding, program development, and training design. There may also be resistance from both Indigenous and non-Indigenous healthcare professionals as the vast majority have been routed through mainstream systems and continue to place value in dominant structures. Still, some may not have sustained energy necessary for pursuing the struggle to advocate and ensure Indigenous healing philosophies are recognised and validated. Nonetheless,



Indigenous strategies are beginning to emerge in the forefront of healing initiatives as wise practises for Indigenous peoples. Evidently, non-Indigenous practitioners and individuals are beginning to accept the legitimacy of Indigenous knowledge and are looking to integrate new methods of working with trauma.

Perhaps at the forefront, the implications of the research findings are those that pertain to health policy initiatives. Governments and other bodies responsible for the distribution of funding should consider the efficacy of Indigenous healing strategies in consideration of healthcare delivery. This includes hospitals and healthcare centres serving Indigenous peoples. In many cases, policies exist that recognise traditional healing methods; however, putting policy into practise is a different story. For example, a government may have a policy to improve Aboriginal health through the provision of culturally appropriate health services, but a local ministry delivery agency may not consider traditional healing activities as qualifying for program funding. In another example, a hospital may have a policy that recognises and supports Indigenous people to receive care in a respectful manner, but the hospital may not allow clients or patients to smudge on the premises during the course of their treatment. Research should be undertaken to determine the accountability of whether the policies and practises are consistent.

The issues around diagnoses and funding should also be addressed, particularly when quantitative diagnostic measures determine funding levels. This issue was raised in both Canada and the United States. One of the research participants explained that despite his training as a psychologist, he did not use diagnoses rationale for funding; rather he tended to *describe* the clients' difficulties in the documentation submitted for insurance coverage. The value that has been placed on DSM diagnoses has become, in many situations, a primary tool for determining funding approval and compensation levels. This occurs in healthcare, social welfare, and justice systems. Essentially, this legitimacy encourages the wide-spread use of diagnoses on individuals that have experienced trauma; and for Indigenous people, much of this experience is generated in a multitraumatic context.

As discussed in Chapter Six, applying diagnoses pathologises the person, rather than the process that they experienced which brought about the injuries. Furthermore, diagnoses complicate identity development. Given these issues, and the fact that the majority of unbalance and disharmony experienced by Indigenous people is a result of external colonial forces, it is

important to reframe current realities in ways that support healing and wellness. Drawing on examples of resilience and placing these experiences within the context of a traumatic environment will lessen the negative impact of psychiatry, thus reducing the tendency to pathologise Indigenous peoples.

The implications of the research findings will be useful for Indigenous agencies that offer traditional healing as part of agency programming. By learning about the work of other agencies as shared by the research participants, agencies may increase their range of services. For those already employing the majority of these strategies, it will reinforce the strength of the Indigenous healing movement. For mainstream agencies and other providers in the healthcare system, opportunities to collaborate on client care will improve existing services. Indigenous healthcare practitioners advocate the incorporation of cultural practises of mental health and healing be more accepted and incorporated into mainstream (Stewart, 2008). This study offered practical examples of how Indigenous healing agencies and mainstream services could work together to meet the needs of Indigenous people. Trimble (2010) points out that collaboration with an Indigenous healing system may include (a) supporting the viability of traditional healing as an effective treatment system, (b) actively referring clients to Indigenous healers, or (c) actively working together with Indigenous healers (p. 247). This study contributes to the discourse on traditional healing methods and mainstream services that is forming in the literature (Gone, 2010; Menzies, 2004; Voss, Douville, Little Soldier, & White Hat, 1999).

Finally, the findings of this research will contribute to the education and training needs of healthcare practitioners and frontline workers at the community level. The vast majority of healthcare curriculum in post-secondary programs is largely based on Western constructs of knowledge, and more specifically, the medical model. Where programs do recognise the importance of Indigenous knowledge, it is usually discussed in terms of knowledge diversity, rather than teaching the practical application in clinical practise. Albeit, there has been a recent emergence of Indigenous faculty in the fields of counselling, psychology, and social work that are bringing Indigenous paradigms into the classroom, for the most part this research discovered that there is a particular gap between existing Indigenous trauma theory and practise. This is the result of education and training programs not adequately integrating Indigenous knowledge and practise in the academy. It also signals a lack of curriculum. Although there is a growing body of literature pertaining to Indigenous trauma, and an increasing number of academic programs

focusing on Indigenous epistemologies and healing practises (designed and delivered by Indigenous people), there still remains numerous Indigenous healthcare professionals that have not had access to culturally appropriate curriculum.

It is interesting to note that in gathering the stories and strategies pertaining to this research, the methods of working with trauma that participants were familiar with did not include Duran's (1998, 2006) theory of the *soul wound*. Although, for the most part, the training received by the research participants likely preceded Duran's publication of soul wound, and therefore, this trauma theory would not have been in the curriculum that informed their practises. In addition, only one participant talked about the impacts of historical, intergenerational, and multigenerational trauma; although most recognised colonisation as a dynamic in the healing context. This indicates that there is a gap between Indigenous trauma theory and practise. Interestingly, Gone (2010) asserts that Duran's culturally specific psychotherapy "remains largely unavailable to Native clients owing to severe constraints with regard to its practice, training, and dissemination" (p. 213). What is needed to remedy this gap are specific curricula, courses, and workshops that focus on content that is relevant to the lives of Indigenous peoples.

The findings of this research support the work being done in the area of cultural competency. Each of the research participants clearly described relevant aspects of their practise in a way that reflects the fundamental underpinnings of cultural competency. In discussing a culturally competent practise, Sones et al. (2010) posit, "Culturally adapted approaches to mental health and wellness are based in cultural identity and spirituality as the primary framework for treatment approaches, aimed at restoring balance of the individual with family and community" (2010, p. 55). However, it is important to acknowledge the question raised by Gone (2010) of how much "cultural" is "cultural enough?" (p. 227). This is an important question in the area of cultural competency. Particularly when many Indigenous healthcare practitioners work in clinical settings with Indigenous clients outside their own Nations and cultural frameworks; for example, a practitioner who is culturally competent to work with Anishinaabe people, and perhaps Cree people, may not be culturally competent to provide services to Inuit people. While recognising the common experience that Indigenous peoples share in terms of colonisation, oppression, and systemic violence, perhaps there are different layers of cultural competency that will need to be better understood as the field develops.

Despite the Western orientation of much of the education and training that Indigenous healthcare practitioners have accessed, many demonstrate that they provide culturally appropriate and culturally grounded healing services to their clients. This has occurred only because they have sought out Elders, cultural teachings, ceremonies, and remained connected to their families and communities. Their efforts have been vital in the realm of Indigenous healing and wellness. What is clear is that Indigenous peoples need options for healing; and Indigenous practitioners that are both culturally and clinically competent are most able to provide effective services to a wider range of clientele. McCormick (2009) recognises that some clients will always prefer the traditional approaches to healing and will seek out traditional healers, whereas others will opt for treatment via mainstream psychological therapies. “Aboriginal people seeking help now have a third option: to see a therapist/healer who is able to use and combine aspects of both teachings in a complementary way” (p. 337). With this in mind, educational programs need to include curriculum that advances practical application of Indigenous trauma theory and healing strategies in the training of Indigenous healthcare practitioners.

### **Concluding thoughts.**

As I prepared to write my concluding thoughts of this study I reflected on my initial goals behind engaging in research. Most of all, I wanted to produce research that would benefit Indigenous communities. I became interested in the field of trauma and healing after learning about the extent that colonisation had impacted our lives as Indigenous peoples. I also persevered through my own healing process, which was crucial to completing this research. I had often thought of the amazing healing work of individuals and communities. I was constantly inspired by their capacity to endure challenging circumstances while drawing on love and compassion that resulted in healthier Nations. It became clear that the Spirit of healing and well families is returning to Turtle Island (Rogers, 2001, p. 1514). I began to recognise this strength as *resilience*. Despite the health inequities, social disintegration, and economic disparities, I realised that Indigenous people demonstrated a high degree of resiliency. I felt that it was crucial to present this research through a lens that recognised this fact, as well as the significant contributions of Indigenous knowledge and experience.

Many people, perhaps unintentionally, focus on the dreary circumstances of Indigenous life, which portrays current realities in a hopeless and victimised realm. While it is essential to

acknowledge the injustices that have occurred and recognise that many of the deep-held attitudes prompting discrimination and racism toward Indigenous people continues to exist, I believe that it is most beneficial to move forward in ways that honour Indigenous cultures and contemporary experiences. With this in mind, I knew that there were countless people within Indigenous communities that were *living their lives* in ways that were supporting their people in healing and wellness. I recognised that some of these people were considered healthcare practitioners. I was inspired to invite them to participate in research that would enable them to share their knowledge and experience so that their stories and strategies could benefit others in the healing movement.

It was important that I utilise an Indigenous research paradigm. Through consultation with Indigenous Elders and cultural teachers, I grounded myself in ceremony and maintained my connection with Creation. Above all, I was mindful of carrying out this research in ways that respected cultural protocols and ethics. As I neared completion, I realised that Indigenous researchers that chose to use Indigenous frameworks had a much greater task than the standard academic that could draw on a variety of Western research methodologies. Indigenous researchers recognise that they have a responsibility to their research participants, families, communities, ancestors, and Spirit helpers. These relationships take time to nurture. There is also a sacred element of conducting research that involves prayer, medicine, and ceremony. This process cannot be rushed or the spiritual intent may be lost.

The findings of this study were presented in a format of storytelling and dialogue, rather than the standard report of results and compartmentalisation common in Western research approaches; such as a separate literature review. This study is an example of decolonising research. While recognising the academic requirements, my foremost intention was for community-based people to be able to comfortably absorb the stories and strategies presented in this research. As an Indigenous researcher and academic, I feel that it is imperative that we write *for* our communities. As the field of Indigenous education and research continues to develop, students and researchers will need to be strong in challenging the institutional structures to make room for Indigenous worldviews and cultural paradigms.

The research participants that came forward to generously share their time and wisdom are remarkable leaders in healing and wellness. Their contributions to this research shed light on culturally grounded strategies that are most appropriate and successful for individual and

community healing. As I journeyed through the interview process, I became aware of the immensely valuable ways that these healthcare practitioners were helping their clients through histories of pain and injury. What was most prevalent, were the connections and relationship that were formed; and how particularly healing this was. Each of the research participants described unique approaches that were derived from *their* Indigenous worldviews and experience. The ability to develop a practise based on cultural foundations is of utmost importance in the field of Indigenous healing. The documentation and conclusions of this research support the findings of the *First Nations and Inuit Regional Health Survey* that concluded that Indigenous people desire an approach to healthcare that is based upon *traditional ways* and *wellness* (Svenson & LaFontaine, 1999, p. 203).

As we continue to decolonise and heal from the devastation that has visited our lives, Indigenous people continue to journey forward bringing ceremony and culture to future generations. As Elders, knowledge carriers, and wisdom translators continue to enlighten those seeking cultural teachings, the experience of wellness spreads throughout Turtle Island. Indigenous strategies to helping and healing will bring comfort, nurturing, and peace to those seeking balance and harmony. My final thought in presenting this research study is that the *Spirit of healing is alive within Creation*.

Miigwech, gakina nindinawemaaganag (Thank you, all my relations)

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**Appendix A**  
**Ethics Protocol Approval**



UNIVERSITY OF TORONTO  
Office of the Vice-President, Research  
Office of Research Ethics

PROTOCOL REFERENCE #21103

October 19, 2007

Prof. Edmund O'Sullivan  
Dept. of Adult Education  
and Counselling Psychology  
Ontario Institute for Studies in Education  
of the University of Toronto  
252 Bloor Street West  
Toronto, ON M5S 1V6

Ms. Renee Linklater  
Dept. of Adult Education  
and Counselling Psychology  
Ontario Institute for Studies in Education  
of the University of Toronto  
252 Bloor Street West  
Toronto, ON M5S 1V6

Dear Prof. O'Sullivan and Ms. Linklater:

Re: Your research protocol entitled, "Decolonizing trauma work: Indigenous practitioners share stories and strategies"

ETHICS APPROVAL

Original Approval Date: October 19, 2007  
Expiry Date: October 18, 2008

We are writing to advise you that a member of the Education Research Ethics Board has granted approval to the above-named research study, for a period of **one year**, under the REB's expedited review process. Ongoing projects must be renewed prior to the expiry date.

The following consent documents (revised October 10, 2007) have been approved for use in this study: Invitation to Participate, Information Letter, Participant Consent Form and Consent for Interview to be Conducted in the Community. Participants should receive a copy of their consent form.

During the course of the research, any significant deviations from the approved protocol (**that is, any deviation that would lead to an increase in risk or a decrease in benefit to participants**) and/or any unanticipated developments within the research should be brought to the attention of the Office of Research Ethics.

Best wishes for the successful completion of your project.

Yours sincerely,

Bridgette Murphy  
Research Ethics Coordinator



## University of Toronto

Office of the Vice-President, Research

Office of Research Ethics

PROTOCOL REFERENCE #21103

October 28, 2008

Prof. Edmund O'Sullivan  
Dept. of Adult Education  
and Counselling Psychology  
Ontario Institute for Studies in Education  
of the University of Toronto  
252 Bloor Street West  
Toronto, ON M5S 1V6

Ms. Renee Linklater  
Dept. of Adult Education  
and Counselling Psychology  
Ontario Institute for Studies in Education  
of the University of Toronto  
252 Bloor Street West  
Toronto, ON M5S 1V6

Dear Prof. O'Sullivan and Ms. Linklater:

Re: Your research protocol entitled, "Decolonizing trauma work: Indigenous practitioners share stories and strategies" by Prof. E. O'Sullivan (supervisor), Ms. R. Linklater (PhD candidate)

### ETHICS APPROVAL

Original Approval Date: October 19, 2007

Expiry Date: October 18, 2009

Continuing Review Level: 1\*

Renewal: 1 of 4

We are writing to advise you that the Social Sciences Humanities & Education Research Ethics Board (REB) has granted annual renewal of ethics approval to the above referenced research study through the REB's expedited process. Please note that all protocols involving ongoing data collection or interaction with human subjects are subject to re-evaluation after 5 years. Ongoing projects must be renewed prior to the expiry date.

**Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible.**

Best wishes for the successful completion of your project.

Yours sincerely,

*Marianna Richardson*

Marianna Richardson  
Research Ethics Coordinator

\*See Continuing Review Guidelines on the Office of Research Ethics website -  
[http://www.research.utoronto.ca/ethics/pdf/human/nonspecific/Continuing%20Review%20Guidelines\\_approved%20version.pdf](http://www.research.utoronto.ca/ethics/pdf/human/nonspecific/Continuing%20Review%20Guidelines_approved%20version.pdf)

## **Appendix B**

### **Invitation to Participants**





ONTARIO INSTITUTE FOR  
STUDIES IN EDUCATION  
OF THE UNIVERSITY  
OF TORONTO  
252 Bloor Street West  
Toronto, Ontario  
Canada M5S 1V6  
Telephone: (416) 923-6641

## Research Participants Needed: Indigenous Healthcare Practitioners

- Are you an Indigenous healthcare practitioner originating from Turtle Island (North, Central and South America) with at least 10 years experience working within Indigenous communities?
- Have you been trained as a psychologist, psychotherapist, psychiatrist, social worker, counsellor, physician, nurse or other healthcare practitioner and currently offer therapeutic healing opportunities within Indigenous communities?
- Do you have difficulty applying psychiatric diagnoses (such as: Posttraumatic Stress Disorder, Depressive Disorders, Psychotic Disorders) to Indigenous clients and prefer to use Indigenous philosophies and cultural healing practises?
- Are you willing to share your stories and strategies in a research project that critiques psychiatry and advocates that Indigenous philosophies and cultural healing practices provide the most appropriate and successful therapeutic techniques for individual and community healing?

If you answered yes to all of these questions, I would like to invite you to participate in my doctoral research. My name is Renee Linklater and I am a member of Manitou Rapids-Rainy River First Nations (Anishnaabe) and a doctoral student at the Ontario Institute for Studies in Education of the University of Toronto. My research project is titled "*Decolonising trauma work: Indigenous practitioners share stories and strategies.*"

This research study will explore Indigenous worldviews, approaches to wholistic wellness, critiques of psychiatry, and cultural strategies for addressing trauma, depression and experiences of parallel and multiple realities. It is hoped that this research will contribute to the growing understanding of healing and wellness work in Indigenous communities, will provide non-psychiatric strategies for working with Indigenous peoples, and encourage education and training programs to include and promote Indigenous strategies as legitimate forms of healing.

If you agree to participate in this study there will be an initial one-to-one interview with myself that will take approximately 1½ - 2 hours of your time. The interview will be at a mutually agreed upon place and time. After your review of the interview transcript, there will be a 2<sup>nd</sup> interview to verify your contributions to the study.

Participation is strictly voluntary and you may withdraw at anytime. All interviews will be audio-recorded with the consent of the participant. Your name and comments will remain confidential and you will be given the opportunity to choose a pseudonym to ensure anonymity, unless you would like to self-identify and have your voice publicized in this research study as a contributor to Indigenous trauma theory.

If you are interested in participating, or require further information, please contact Renee Linklater or Dr. Edmund O'Sullivan:

Principle Researcher: Renee Linklater  
Email: [linklater@oise.utoronto.ca](mailto:linklater@oise.utoronto.ca) or confidential cell phone 705. 875-3845

Supervisor: Dr. Edmund O'Sullivan  
Department of Adult Education and Counselling Psychology  
Ontario Institute for Studies in Education of the University of Toronto  
Email: [eosullivan@oise.utoronto.ca](mailto:eosullivan@oise.utoronto.ca) or telephone 416.538-8309

## **Appendix C**

### **Information Letter**





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OF THE UNIVERSITY  
OF TORONTO  
252 Bloor Street West  
Toronto, Ontario  
Canada M5S 1V6  
Telephone: (416) 923-6641

## Information Letter

Thank you for expressing interest in participating in this research study. My name is Renee Linklater and I am a student in the Department of Adult Education and Counselling Psychology with the Ontario Institute for Studies in Education of University of Toronto. This research study is titled "*Decolonising trauma work: Indigenous practitioners share stories and strategies.*"

The purpose of this study is to explore how Indigenous healthcare practitioners are helping to support their peoples in areas of wellness. This research will critique the use of psychiatry and argue that Indigenous philosophies and cultural practises provide the most appropriate and successful therapeutic techniques for individual and community healing. The goals of this research are to contribute to the growing understanding of healing and wellness work in Indigenous communities, to provide non-psychiatric strategies for working with Indigenous peoples, and to encourage education and training programs to include and promote Indigenous strategies as legitimate forms of healing.

You are invited to participate in this research because you have indicated that you are an Indigenous healthcare practitioners originating from Turtle Island (North, Central and South America), and have been culturally and academically trained in your field, with at least 10 years experience within Indigenous communities. If you agree to participate in this study there will be an initial one-to-one interview with myself that will take approximately 1½ - 2 hours of your time. The interview will be at a mutually agreed upon place and time. After your review of the interview transcript, there will be a 2<sup>nd</sup> interview to verify your contributions to the study.

As a participant, you will be asked about your worldviews, Indigenous approaches to wellness, critique of psychiatry, and Indigenous philosophies and cultural strategies for addressing trauma, depression and experiences of parallel and multiple realities. As a participant, you may decline to answer any question(s). In keeping with Indigenous research and cultural protocols, as I am Anishinaabe, I will be offering participants tobacco prior to commencing the interview, and participants will receive a gift for sharing their stories and strategies. There may also be a sharing of food as part of the research process. There will be no financial compensation for participating in this research study.

There will be 6-10 participants interviewed in this study. Participants may include psychologists, psychotherapists, psychiatrists, social workers, counsellors, physicians, nurses or other healthcare practitioners who currently offer therapeutic healing opportunities within Indigenous communities. Participation is strictly voluntary and participants may withdraw at anytime, without any negative consequences. All interviews will be audio-recorded with the consent of the participant. Participants' name and comments will remain confidential and you will be given the opportunity to choose a pseudonym to ensure anonymity, unless you would like to self-identify and have your voice publicized in this research study as a contributor to Indigenous trauma theory.

There is no foreseeable risk of harm for participants of this study. The benefits to participants will be the opportunity to share stories and strategies that you have experienced and developed. Additional benefits of this research study will be to Indigenous communities, the medical field, education and training institutes, and society in general, that will have available a contribution from Indigenous peoples on issues of wholistic wellness, critiques of psychiatry, and suggestions of strategies for addressing trauma, depression and experiences of parallel and multiple realities. Of particular benefit, is the recognition that will be received by participants that choose to self-identify, as they will be publicized as contributors to Indigenous trauma theory. Each participant will receive a copy of their interview transcript and a summary of findings.

Miigwech (thank you) for your interest in participating in this research study,

Renee Linklater

**Appendix D**  
**Participant Consent Form**





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## Participant Consent Form

I have read and understand the Information Letter and consent to participate in this study.

Please initial if you agree to be audio-recorded: \_\_\_\_\_

Would you like to self-identify in publications of this study? Yes ☐ No ☐

If no, please indicate a one-name pseudonym for study publications: \_\_\_\_\_

I, \_\_\_\_\_ agree to participate in the research "*Decolonising trauma work: Indigenous practitioners share stories and strategies*" conducted by Renee Linklater, under the supervision of Dr. Edmund O'Sullivan of the Ontario Institute for Studies in Education of the University of Toronto.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you would like to receive a copy of the summary of research findings, please include an email or mailing address: \_\_\_\_\_

Principle Researcher: Renee Linklater  
Email: [rlinklater@oise.utoronto.ca](mailto:rlinklater@oise.utoronto.ca) or Confidential cell phone 705. 875-3845

Supervisor: Dr. Edmund O'Sullivan  
Department of Adult Education and Counselling Psychology  
Ontario Institute for Studies in Education of the University of Toronto  
Email: [eosullivan@oise.utoronto.ca](mailto:eosullivan@oise.utoronto.ca) or telephone 416.538-8309

If you have any questions about your rights as a participant, please contact the Ethical Review Office at [ethics.review@utoronto.ca](mailto:ethics.review@utoronto.ca) or 416. 946-3273

ARBOR

**Appendix E**

**Consent for Interview to be Conducted on Premises of an  
Indigenous Community**



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## Consent for Interview to be Conducted on Premises of an Indigenous Community/Agency

Dear [First Nation, Agency or Institution],

My name is Renee Linklater and I am a student in the Department of Adult Education and Counselling Psychology with the Ontario Institute for Studies in Education of University of Toronto. I am currently conducting research for my PhD thesis, and a member of your staff has expressed interest in participating in my research study. This study is titled "*Decolonising trauma work: Indigenous practitioners share stories and strategies.*"

This form is to request consent for myself to enter your premises and conducted this interview within the property of your First Nation, agency, institution]. Giving consent for this interview to take place at your location does not imply, in any way, that [name of First Nation, agency, institution] supports, agrees with, or is part of, my research study.

The participant, at all times, will be representing his or her own views as contributions to the study.

The purpose of this study is to explore how Indigenous healthcare practitioners are helping to support their peoples in areas of wellness. This research will critique the use of psychiatry and argue that Indigenous philosophies and cultural practises provide the most appropriate and successful therapeutic techniques for individual and community healing. The goals of this research are to contribute to the growing understanding of healing and wellness work in Indigenous communities, to provide non-psychiatric strategies for working with Indigenous peoples, and to encourage education and training programs to include and promote Indigenous strategies as legitimate forms of healing.

Please keep a copy of the Consent Form and Information Letter for your files.

Do you give consent for this interview to take place at [First Nation, Agency or Institution]?

Please check:      Yes    ☐      No    ☐

I, \_\_\_\_\_ (name) am authorized by [First Nation, Agency or Institution] to give consent for Renee Linklater, to conduct an interview on our premises for her PhD research study "*Decolonising trauma work: Indigenous practitioners share stories and strategies*" under the supervision of Dr. Edmund O'Sullivan of the Ontario Institute for Studies in Education of the University of Toronto.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you have questions or require further information, please contact either Renee Linklater or Dr. Edmund O'Sullivan:

Principle Researcher: Renee Linklater  
Email: [rlinklater@oise.utoronto.ca](mailto:rlinklater@oise.utoronto.ca) or Confidential cell phone 705. 875-3845

Supervisor: Dr. Edmund O'Sullivan  
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Email: [eosullivan@oise.utoronto.ca](mailto:eosullivan@oise.utoronto.ca) or telephone 416.538-8309

## **Appendix F**

### **Guiding Questions for Interview Dialogues**





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## Decolonising trauma work: Indigenous practitioners share stories and strategies

Guiding questions for research participants

Researcher: Renee Linklater – PhD Candidate

### Interview 1

1. Worldviews
  - a) What is your cultural background, current profession, and experience within Indigenous communities?
  - b) What forms of cultural experience and education have informed your practise?
  - c) What forms of academic experience and education have informed your practise?
  - d) How have your worldviews prepared you to work with Indigenous peoples?
2. Indigenous Approaches to Wellness
  - a) How would you describe wellness, as understood in Indigenous communities?
  - b) How would you describe a holistic approach to working with an individual?
  - c) How would you describe a holistic approach to working with a community?
  - d) Are holistic approaches part of your practise? And if yes, please describe how.
3. Critiquing Psychiatry
  - a) When working with Indigenous clients - do you use any diagnoses as provided for in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) specific to:
    - i. Posttraumatic Stress Disorder?
    - ii. Depressive Disorders?
    - iii. Schizophrenia and/or other Psychotic Disorders?
  - b) If yes:
    - i. Which diagnosis do you use?
    - ii. What do you find helpful about the diagnosis?
    - iii. What is not helpful about the diagnosis?
  - c) If no, why do you not follow the DSM criteria in diagnosis?
  - d) Are you familiar with the Culture-Bound Syndrome Section in the DSM? And if yes, how do you feel about this application?
4. Indigenous Strategies
  - a) Which Indigenous philosophies and cultural healing practises do you use in addressing:
    - i. Trauma
    - ii. Depression
    - iii. Experiences of parallel and multiple realities

### Interview 2

1. How did you feel reading the transcripts of the Interview?
2. Are you comfortable with the information that you have shared in answering the questions that will inform this research study?
3. Is there anything that you would like to add to, or delete from, your previous interview?
4. Would you like to maintain your anonymity through use of a one-name pseudonym or self-identify using your first and last name, as indicated on the original consent to participate form or would you like to reverse your decision?