

URBAN ABORIGINAL HEALTH: ISSUES, CULTURALLY APPROPRIATE  
SOLUTIONS AND THE EMBODIMENT OF SELF-DETERMINATION

Ph. D. Thesis – J. Skye; McMaster University – Anthropology.

URBAN ABORIGINAL HEALTH: ISSUES, CULTURALLY APPROPRIATE  
SOLUTIONS AND THE EMBODIMENT OF SELF-DETERMINATION

By

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TITLE: Aboriginal Health Issues And Aboriginal Solutions: Developing A  
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## **ABSTRACT**

Urban Aboriginal health and health-related issues are steeped within the sociohistorical, sociocultural, and sociopolitical experiences of Aboriginal peoples since European contact. Thus, urban Aboriginal health issues are very complex in that they consist of aspects associated with collective as well as individual cultural and political life experiences. Therefore, in order to adequately address Aboriginal health issues a comprehensive and multidisciplinary approach is required.

This study examines how Anishnawbe Health Toronto, an urban Aboriginal community health centre, addresses the specific healthcare needs of the urban population through a multidisciplinary culturally appropriate healthcare model. As my research evolved, a few themes emerged from the data. First, the health issues experienced by the clientele were inherently complex and simultaneously infused with a culturally collective and individualistic quality. Second, practitioners acknowledged and addressed the complex nature of the clients' health problems through a unique model of health care created at the centre. Third, the philosophy, infrastructure, and model of health care at Anishnawbe Health Toronto goes beyond the notion of merely offering access to both systems of health care, and instead constitutes an innovative and culturally appropriate system of care which is under Aboriginal control, development and implementation. Therefore, through my analysis of these themes, I conclude that the model of health care developed at the centre is an example of complex solutions designed to address complex Aboriginal health issues and as a result, facilitate the embodiment of self-determination in the area of health care.

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## **1. Introduction**

The conception and rationale for this project evolved in part from my previous research experience at Anishnawbe Health Toronto (AHT). In 2004-05, I conducted research at the centre as a requirement for my Master of Arts degree at McMaster University. The research for my M.A. thesis focused on how cultural identity affects the overall health and well-being of individuals. My examination illustrated that for the majority of clients, the affirmation or establishment of an Aboriginal identity enhanced their ability to effectively address their particular health issues by creating a cultural foundation through which they utilize a culturally appropriate approach to their health care. In addition, my research demonstrated that urban Aboriginal health and related issues are mired in the sociohistorical, sociocultural, and sociopolitical experiences of Aboriginal peoples since European contact. From its inception, AHT has continued to refine and develop its multidisciplinary healthcare model and implement a growing number of services in various areas of health care to adequately address the needs of the urban Aboriginal population in Toronto.

For my PhD project, I wanted to examine how various aspects of Western biomedical and traditional Indigenous healing systems are utilized within a medical pluralistic approach for urban Aboriginal health and well-being. However, I also realized that given the sheer volume of health related services offered at the centre, an all-inclusive investigation was far beyond the scope of a PhD project. Therefore, based on my previous research experience at the centre, I

decided to initiate my research with open-ended inquiries among the clientele and staff about the simultaneous use of traditional healing and Western biomedicine in the belief that the specific focus of my research would evolve as my investigation gathered momentum and the number of participants increased. Fortunately, my intuition was correct and, within a few weeks, a few themes could be gleaned from a running analysis of my data. Firstly, while the majority of clients interviewed during the initial stages of the project alluded to their use of traditional herbal remedies in conjunction with Western biomedicine, they seemed to be more inclined to discuss their use of the traditional services in relation to the spiritual aspects of their healing. Furthermore, correlating with their spiritual experiences, the clientele provided extensive elaboration on their mental health experiences in association with the newly formed Mental Health Unit at the centre. Overall, the pervasive theme that dominated the data was that the centre was viewed by the clientele as a repository for their personal agency to decolonize their health and model of health care. Therefore, based on the context of the data, my examination will utilize the recent implementation of an Aboriginal specific Mental Health Unit at the centre as the primary example, in conjunction with some of the key issues associated with the use of traditional herbal remedies and Western biomedicine, to illustrate AHT's philosophical, theoretical, and infrastructural approach to programs and services which ultimately contribute to the embodiment of self-determination at the centre.

Based on the preliminary information provided by the clientele, the interviews with the biomedical practitioners were thematically oriented according to the refined focus of the research. However, the number of different disciplines employed by the centre would have compounded the analysis of the data beyond the intended scope of the project given the context-dependent individualistic applications of traditional healing practices. Therefore, the purpose of the biomedical practitioners' interviews was to facilitate an understanding from their particular perspective about the application, benefits, risks, and philosophical interpretation of a pluralistic approach for Aboriginal peoples. Thirdly, interviews with the traditional healing practitioners were conducted in the same manner as the biomedical practitioner interviews, with the exception that they were able to elaborate on the particular traditional cultural components of healing practices.

In addition, as a result of my initial strategy and preliminary investigation, a few other general themes emerged, illustrating the unique approach employed at the centre. While there were some universal aspects to the health issues of the clientele, they were inherently complex in nature and deeply interconnected with other aspects of their lives, thereby infusing the issues simultaneously with a culturally specific, and yet individualistic quality. Second, practitioners acknowledge and address the complex nature of the clients' health problems through a unique model of health care created at the centre. Third, the model of health care developed at the centre exemplifies the necessity of complex solutions designed to address complex Aboriginal health issues. The most valuable aspect

of this approach is the ability to address the specific needs of the Aboriginal population while maintaining the integrity of the systems involved. Therefore, Aboriginal control, development, and implementation of all aspects of the multidisciplinary pluralistic model of health care facilitate the embodiment of self-determination within the institution.

### **1.1 Theoretical Orientation**

Within all cultures, there is a system of health care that provides people with the means to address illness and disease in an effort to maintain their survival. These healthcare systems are derived from a particular culture's values and beliefs which influence the ways in which the group will interpret health and disease, as well as how they utilize and receive care. In addition, healthcare systems and beliefs are governed by historical, economic, and environmental conditions (Adelson, 2000; Sobo and Loustaunau, 2010; Ross, 2012).

Any research designed to examine health and related issues among Aboriginal populations in North America must therefore employ a holistic theoretical perspective in order to appreciate the various contextual variables influencing Aboriginal health and well-being. For many Aboriginal peoples, the ideological domain of health and well-being is dynamic, complex, and inextricably linked to culture and spirituality, while often juxtaposed with colonial and neo-colonial relations within Canada (Adelson, 2000). Therefore, in recognition of the inherent dynamic and complex nature of Aboriginal health issues, I utilized the theoretical orientation of medical anthropology as an ideal

approach to the collection and analysis of the data for this project. Broadly speaking, a medical anthropological perspective examines health-related issues and healthcare systems in relation to their particular social and cultural environment (Barfield, 2001; Ross, 2012).

The sub-discipline of medical anthropology is not comprised of a particularly unique theoretical platform and the diverse nature of the research within the discipline is quite extensive. Since World War II, medical anthropology has grown exponentially and is comprised of five approaches: biomedical, ethnomedical, ecological, critical, and applied (Barfield, 2001). The sub-discipline of critical medical anthropology is comprised of two major intellectual approaches. One approach emphasizes how macro socialpolitical and economic powers affect health and the structure of health care. The other approach examines the epistemological and intellectual foundation of biomedical theory and practice (Barfield, 2001). The critical-interpretive approach is an amalgamation of the critical medical perspective's attention to political and economic structures with a cultural interpretive approach to the meanings assigned to health and illness (Joralemon, 2010). In other words, a critical-interpretive approach examines the individual, cultural, and political allegorical conceptions of health and illness, thereby facilitating an illustration of how knowledge in the area of health and health care is influenced and affected by sociopolitical, socioeconomic, and sociocultural change (Lock and Schepher-Hughes, 1990).

The specific theoretical orientation I utilized for this project is best categorized as a critical-interpretive medical anthropological approach (Scheper-Hughes and Lock, 1984 in Singer and Baer, 1995). My particular employment of this approach is inspired by the pioneering theoretical work of medical anthropologists Nancy Scheper-Hughes and Margaret Lock, as described in their famous essay “The Mindful Body” where they advocate for the deconstruction of the Cartesian mind-body dualism in the biomedical sciences as a way to promote insight into the ways of thinking about sickness, health, and how health care is constructed and delivered (Scheper-Hughes and Lock, 1987). Scheper-Hughes and Lock devised a theory they refer to as the “three bodies” and it consists of three perspectives for viewing the body: the individual body or the phenomenological experience of being sick or well; the social body or the symbolic representation of viewing the body in sickness and health as metaphors for natural, social, and cultural relationships; the body politic or as an object of social domination and political control (Scheper-Hughes and Lock, 1987).

I determined that research within the context of AHT required an approach that examines how knowledge of health and well-being is “culturally constructed, negotiated, and renegotiated in a dynamic process through time and space” (Lock and Scheper-Hughes, 1990: 48-49). In addition, the critical-interpretive medical anthropological approach, in collaboration with Scheper-Hughes and Locks theory of the “three bodies”, provided a theoretical lens through which I examined how individual and collective experiences in conjunction with the infrastructure

and the multidisciplinary pluralistic model of health care facilitate the decolonization of health for the clients and simultaneously promote the embodiment of self-determination within the institution.

## **1.2 Situating the research**

Initially, anthropology began as a “cultural salvage” discipline, primarily engaged in recording and documenting “primitive” native cultures before they became extinct as a result of European exploration and colonialism. In time, anthropology evolved and developed into a discipline concerned with describing and interpreting “the other” and the various cultural aspects of the societies of others (Ross, 2012). Contemporary anthropology is distinct in that, in addition to the refinement and development of various sub-disciplines and methods of data collection, it is a discipline that employs a holistic approach which utilizes contextual, reflexive, and critical perspectives (Ross, 2012).

While anthropological study has examined various facets of society, there has always been an anthropological interest in different cultural conceptions of health, illness, disease, and curative therapies (Barfield, 2001). Cultural conceptions of sickness and treatment were used as a theoretical lens to analyze religious beliefs and cultural values as well as the relationship between concepts of illness and social relationships (Barfield, 2001; Ross, 2012). Within the modern era, medical anthropologists examine culturally situated beliefs, customs, and procedures associated with health and illness (Ross, 2012). Within the medical anthropological perspective, health and healing practices are examined holistically

and comparatively as cultural constructs affected by historical, socioeconomic and sociopolitical conditions (Barfield, 2001; Ross, 2012). Anthropological study recognizes that health and healing practices are interconnected with various aspects of culture and acknowledges the significance of traditional Indigenous knowledge and healing practices regardless of scientific affirmation (Barfield, 2001; Ross, 2012).

Aboriginal health and related subjects are a major area of study for Canadian medical anthropologists and those affiliated with the field of study (Haviland, Fedorak, and Lee, 2009). As a result of the discipline's continued intellectual growth and evolution, there have been several contributions to the decolonization of the historical Western academic interpretations of Aboriginal health and well-being, traditional Indigenous healing and spirituality (Adelson, 2000; Angel, 2002; Bucko, 1998; Cohen, 2003; Martin-Hill, 2003; Stiffarm, 1998; Waldram et al, 2006; Waldram 1997; Warry, 1998). My PhD research is unique in that while it will contribute to the decolonization of academic Aboriginal health literature, it will also facilitate an understanding of traditional Indigenous healing and spirituality. In addition, it will also situate traditional Indigenous healing within the proper context in accordance with culturally appropriate health care as opposed to being relegated to a "complementary" or "alternative" option within the field of Complementary and Alternative medicine. My research will demonstrate that for many Aboriginal peoples, traditional healing is their original source of primary and preventative health care and as such it is deserving of a co-



existence with Western biomedicine rather than being considered a foreign entity in relation to the hegemony of Western biomedicine.

### **1.3 The Western Biomedical System**

In order to appreciate the rationale for AHT's particular approach to health care, it is important to understand the historical and political aspects of the Western biomedical system in association with some of the common criticisms of the approach. Although none of the participants in this project denied the efficacy or utility of biomedicine, the majority did convey negative experiences attributed to lack of social and cultural understanding, agency, and communication.

Despite the widely held conviction by biomedical practitioners and researchers that Western biomedicine evolved directly from biological science, social scientists argue that biomedicine is a form of ethnomedicine because its historical foundation can be linked to ancient European civilizations and cultural beliefs (Baer, Singer and Susser, 2003; Hahn and Kleinman, 1983). In addition, the position that biomedicine became an objective paradigm as a result of scientific theoretical development and innovation has been scrutinized by the position that the evolution of the biomedical system was influenced by English political, cultural, and economic spheres (Feldberg, Vipond, and Bryant, 2010). As a result of the increased incorporation of complex scientific theoretical and practical approaches to treatment and health care, biomedicine became increasingly intolerant of alternative approaches to health care (Fledberg, Vipond, and Bryant, 2010; Freund and McGuire, 1998; Sobo and Loustaunau, 2010). By

the late 19<sup>th</sup> and early 20<sup>th</sup> century, biomedicine and its practitioners had established a position of dominance in a number of ways including the formation of Medical Associations, the foreclosure of several medical schools, and the affiliation and support from the upper class of society (Freund and McGuire, 1998; Sobo and Loustaunau, 2010). As a result, biomedicine is often described as being driven by the need to support and maintain social class structure, and political and economic interests (Bolaria, 2009; Janiger and Goldberg, 1993; Sobo and Loustaunau, 2010).

The hallmark of criticism regarding the biomedical system is that it is reductionist, individualistic, and mechanistic, with a tendency to objectify the patient and the disease (Good and DeVecchio Good, 1993). However, studies suggest that the execution of the biomedical approach and its philosophy are not universal among practitioners, and instead are contingent upon the clinical context and personal attributes of the physician (Helman, 1985). Despite proclamations by the American Medical Association Principles and the American College of Physicians Ethics Manual to treat all of humanity equally, studies indicate that discrimination within biomedical institutions persists towards the elderly, less educated, women, minorities, and the poor (Buck and King, 2009; Hahn, 1995; Wen et al, 2007).

In particular, patients believed that they were not heard, understood, or responded to adequately (Hahn, 1995; Wen et al, 2007). Studies in the area of communication between patients and physicians suggest that patients' concerns

are not well heard by physicians. In many instances, patients are not given the opportunity to describe their concerns in detail. In most cases, the physician interrupted the patients less than 30 seconds after they had begun describing their concerns, under the assumption that the patient only has one concern or that they presented their primary concern first (Hahn, 1995). In addition, if the physician asked the patient to elaborate or paraphrased what was said, it adversely affected the patients' ability to complete their list of concerns (Hahn, 1995).

Alternatively, various characteristics of the patient in comparison with the physician and the setting affected the amount and appropriateness of the information conveyed by the physician to the patient (Hahn, 1995). Studies suggest that physicians in the upper echelon of the income scale tended to spend less time with patients, resulting in the physician seeing more patients and thereby increasing their income. However, as a result, the physician gave fewer explanations and less detailed information. In contrast, physicians with a more liberal approach dispensed more information and tailored their explanations to facilitate the patient's understanding. Overall, female patients, older patients, long-term patients, and patients from high socioeconomic background were offered more detailed information and explanations to foster their understanding of their particular concern and subsequent treatment (Hahn, 1995). In addition, other studies have suggested that patients suffering from specific illnesses such as alcoholism, AIDS, and mental disorders, may be subject to a moral bias and receive less than standard care (Buck and King, 2009; Hahn, 1995; Wen et al,

2007). While the physician may not be entirely responsible for substandard treatment, it is probable that they contribute and or perpetuate the behavior in some regard. In an attempt to discourage discriminatory practices, the AMA Council recommended that “physicians should examine their own practice to ensure that racial prejudice does not affect clinical judgment in medical care” (as cited in Hahn, 1995:143).

Cross cultural communication can be particularly problematic, especially within an Aboriginal context where issues with communication can be exacerbated by language differences and culturally specific ways of communication. In addition to problems with translation, in some instances biomedical practitioners tended to dismiss or trivialize patients’ contextual information because it was not relevant according to their perception of environmental or behavioral dimensions of illness or they did not understand the cultural relevance of the context and how it would facilitate their understanding of the problem (O’Neil, 1989).

Similarly, a study conducted among the Mohawk in Akwesasne revealed that the sociolinguistic phenomena known as metalinguistic cues were being used by those whom the authors referred to as speakers of Mohawk English as a reference to bilingual community members (Woolfson et al, 1995). Metalinguistic cues are defined as “words or phrases that preface a remark to give the speaker’s attitude toward what is being said, particularly the degree of confidence in it” while speakers of Mohawk English use it to “indicate the speaker’s precise view

of the statement: whether it is a fact, belief, opinion, or memory... and may also indicate respect for the listener” (Woolfson et al, 1995: 503). The findings of the research suggest that while metalinguistic cues are used commonly in English, Mohawk English speakers rely on metalinguistic cues more frequently and precisely to indicate whether their statement is a belief, personal opinion or unsubstantiated fact. Within the clinical setting, when making reference to their own or relatives’ health and in recognition that the listener was a non-Native physician, Mohawk English speakers felt that an increase in metalinguistic cuing was warranted. Therefore, phrases like “it seems”, “I don’t know”, “I don’t think”, “I think generally”, and “I suppose”, were interwoven among hesitation and carefully worded responses. To the non-Native listener, these kinds of metalinguistic cues may give the impression of indecision, rambling, and ambiguity. In turn, this could lead to misinterpretation and cause the physician to make the wrong assumption about what is being said, thereby possibly affecting the outcome of diagnosis and treatment (Woolfson et al, 1995).

There has been extensive research conducted on the subject of clinical communication and patient satisfaction, and several themes have emerged. As a result, patient satisfaction has been linked to involvement in the decision making process, regard for the patient’s understanding of the issues, and the physician’s ability to meet patients expectations (O’Neil, 1989). Overall, if patients feel that their personal understanding, values, beliefs, and participation in decisions

regarding treatment are respected, then it is likely that they will be satisfied with the clinical encounter.

#### **1.4 Complementary and Alternative Medicine**

Similar to understanding the historical and political aspects of the Western biomedical system in association with some of the common criticisms of the approach in order to appreciate the rationale for AHT's particular approach to health care, it is also important to understand the motivation behind AHT's rationale for maintaining the integrity of the medical systems involved and not advocate for a truly integrated model of health care. In order to comprehend this approach, it is important to understand the context of Complementary and Alternative medicine in relation to Western biomedicine as well as the cultural, historical and political aspects of traditional Indigenous healing and how these factors situate traditional Indigenous healing in relation to other medical systems for Aboriginal peoples. Again, while none of the participants questioned the efficacy or utility of biomedicine, the majority did insist that the two systems co-exist in respectful relationship with each addressing particular aspects of their health-related issues.

On the heels of the European colonial enterprise and the subsequent increase in population density, those who immigrated to North America had to deal with the combined effect of indigenous and imported maladies. As a result of the cultural diversity among the population, they had the ability to utilize a variety of medical treatments and healing practices. Within the literature, the practice of

using the resources of more than one system of health care is often described as a medical pluralistic approach (Waldram et al, 2006). During this time in North America, the approach to health care was predominated by a pluralistic model in which a variety of medical subsystems such as folk medicine<sup>i</sup> and Indigenous healing were used in conjunction with an evolving European medical approach. In time, with the development of the scientific approach to medicine and the subsequent implementation of biomedicine's exclusionary paradigm in relation to other forms of health care and health practitioners, scientific medicine quickly became aligned with the upper class and eventually became established as the dominant form of health care in America (Sobo and Loustaunau, 2010). However, despite the political and legal dominance of the Western biomedical paradigm, patterns of medical pluralism have persisted and varied in popularity over time in accordance with hierarchical relations within society and dissatisfaction with current trends in biomedical treatment (Haugen, 2008).

Research suggests that the initial interest in various medical subsystems other than biomedicine was facilitated by mistrust of institutional medicine and the risk associated with newly developed forms of treatment such as vaccination (Haugen, 2008). Despite the scientific, theoretical and practical advancements of biomedicine, many people still harbor a distrust of the biomedical system either because it has become increasingly depersonalized and or they desire a holistic, preventative approach to their health care (Haugen, 2008).

In the early 1970's, a holistic health movement comprised of a variety of diverse medical subsystems was initiated on the West Coast of the United States and quickly spread to other Western societies including Canada (Baer, 2004). The development of the holistic health movement was perhaps facilitated by the Nixon administration's immigration policy that was also extended to the People's Republic of China. As a result, the movement was heavily influenced by an assortment of Eastern healing practices including traditional Chinese medicine (Baer, 2004). During this time another approach, known as the New Age Movement, was also becoming popular and quickly became integrated with the holistic health movement. In addition to distrust and the increasing lack of personalized care, the mass appeal of these movements is primarily derived from the desire to have more control over one's health by focusing on preventative measures that incorporate a holistic approach (Baer, 2004; Haugen, 2008).

Beginning in the late 1970's as biomedical practitioners began to accept the finite capabilities of biomedicine and recognize that an increasing number of their patients were accessing holistic approaches to health care, a gradual albeit guarded acknowledgement of holistic approaches began to emerge and thus the shift from holistic to complementary and alternative medicine began to develop (Baer, 2004).

### **1.5 Issues with Defining Complementary and Alternative Medicine**

Since its development in the 1970's, the utilization of complementary and alternative medicine (CAM) has been well documented and many industrialized



countries report that nearly half of their population utilizes CAM, including Canada where it is estimated that 70% of the Canadian population uses various forms of CAM (Bodeker, Kronenberg and Burford, 2007).

While various aspects of CAM and its applications continue to become increasingly popular, the inherently complex and diverse cultural theoretical foundation of most CAM therapies is not amenable to generating a single comprehensive definition of CAM (Kumar Pal, 2002; Leckridge, 2004; Ross, 2012). However, that has not deterred scholars and health organizations from developing a variety of definitions and explanations for CAM and its applications (Barrett, 2003; Barrett et al, 2003; Botting and Cook, 2000; Giordano et al, 2002; Kumar Pal, 2002; Leckridge, 2004; Thorne et al, 2002; Verhoef and Sutherland, 1995; Winnick, 2005).

The World Health Organization defines CAM as “a broad set of health practices that are not part of a country’s own tradition, or not integrated into its dominant health care system” (Leckridge 2004:413). While the WHO’s broad definition strives to be inclusive as well as politically and culturally neutral, it does not facilitate the development of a comprehensive explanation of CAM and its affiliated practices.

In contrast, other definitions that offer a more comprehensive explanation overwhelmingly rely on defining CAM in contrast to Western biomedical knowledge and practices. For example, a report by The British Medical Association defined CAM as “those forms of treatment which are not widely used

by the orthodox health-care professions, and the skills of which are not taught as part of the undergraduate curriculum of orthodox medical and paramedical health-care courses” (Leckridge 2004:413). In another example, the relationship to the Western biomedical paradigm is even more overtly expressed by explaining that CAM is an “alternative medicine” and it

*“encompasses a broad spectrum of practices and beliefs. In general, alternative medicine consists of medical practices that are not in conformity with the standards of the medical community, that are not taught widely at North American Medical schools and are generally not available at North American hospitals” (Verhoef and Sutherland, 1995:511).*

Other definitions have employed an approach which emphasizes the complementary perspective in that CAM is explained as “diagnosis, treatment, and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual frameworks of medicine” (Botting and Cook, 2000:41).

Similarly, others have chosen to base their definition of CAM upon the employment of the “complementary” and “alternative” components of CAM and how it impacts the employment of conventional medicine. An example of this approach explains that the “alternative” aspect of CAM refers “to all medical systems or therapies lying outside the purview of biomedicine that are used *instead of it*” while the “complementary” aspect of CAM refers to “medical systems or therapies that are used *alongside* or as adjuncts to biomedicine” (Baer, 2004: xiv).

While the various definitions of CAM are intended to facilitate a comprehensive understanding of diverse approaches to health care, the inherent tendency is to either define or relate these descriptions in relation to what mainstream society is most familiar with; the Western biomedical system. Therefore, by default, CAM therapies are habitually situated within a medical hierarchy and their designation is often produced through a series of historical, political and cultural factors. As a result of the sociohistorical and sociopolitical dominance of biomedicine, it is implied that the efficacy of CAM therapies is questionable due to the unorthodoxy of their practices and their lack of conformity to the scientific standards of Western biomedicine. Thus, the perception is that any therapy that is not an established aspect of the biomedical system is perceived as either subservient or as not having a critical influence on health (Botting and Cook, 2000; Kumar Pal 2002; Ross, 2012). CAM therapies are likely to be perceived as precarious or dubious due to the explicit comparison and contrast to a legitimized medical standard. However, many of these assumptions are not necessarily predicated upon objective scientific theory but rather they are cultural, historical and political in origin, making them value laden and ethnocentric in nature (Leckridge 2004, Kumar Pal 2002).

While CAM therapies have become increasingly popular over time (Baer, 2002; Barrett, 2003; Kumar Pal, 2002; Micozzi, 2011; Thorne et al, 2002; Winnick, 2005), auspicious explanations and labels continue to be used to describe various therapies (Winnick, 2005). Some scholars argue that the terms

“alternative” and “complementary” are alienating (Diamond, 2001 in Baer, 2004; Ross, 2012) and relegate CAM therapies and practitioners as adjuncts and subordinates to biomedicine (Baer, 2004; Ross, 2012). Therefore, definitions and descriptions of CAM therapies need to be reconfigured to remove the ethnocentric and negative connotations.

### **1.6 Who is using CAM and Why?**

Research suggests that the utilization of CAM grew exponentially in the 1990's and is steadily becoming a significant factor in health care in Canada and the United States, with the most popular choices being Chiropractic, Homeopathy, Naturopathy, Ayurveda, Herbal, Traditional Chinese Medicine and Acupuncture (Barrett, 2003; Giordano et al, 2002; Kumar Pal, 2002; Micozzi, 2011; Ross, 2012; Verhoef and Sutherland, 1995; Winnick, 2005). In an effort to explain the widespread use and steadfast popularity of CAM therapies, researchers have developed a number of theories to illuminate the particular variables influencing their utilization. Many researchers believe that the increased incorporation of CAM is indicative of the changing needs and values of modern society (Giordano et al, 2002; Kumar Pal, 2002). Specifically, the prevalence of CAM is explained as a response to the increase in chronic diseases, increased access to health information, the desire to improve quality of life, increased interest in spiritualism and the increased cost of Western biomedical health care (Botting and Cook, 2000; Giordano et al, 2002; Kumar Pal, 2002; Micozzi, 2011).

Research indicates that more women than men access CAM therapies for a variety of reasons, the most predominant being the treatment of chronic conditions. The average age of those seeking treatment is 35 to 49, and most have some level of post secondary education, thereby making level of income an unreliable correlate (Giordano et al, 2002). Additionally, patients are often reported to be “health consumers” wanting to try diverse approaches to health and followers of various social trends such as fitness and self-actualization (Furnham and Vincent, 2000:61). Other reasons for using CAM involve relieving the pain and suffering of chronic conditions that biomedicine has failed to properly address or has developed into uncomfortable side effects. The most commonly reported ailments include anxiety, depression, obesity, arthritis, rheumatism, asthma, gastro-enterology, eczema, hypertension, fatigue, sleep disorders, heart disease, diabetes, cancer and AIDS (Barrett, 2003; Furnham and Vincent, 2000; Mantle, 2004; Micozzi, 2002).

While the diverse modalities and philosophical foundations of CAM, coupled with a variety of personal reasons for accessing it, make developing a comprehensive theoretical model to explain its present popularity impossible, there are some general themes that can be gleaned from the research (Furnham and Vincent, 2000; Kumar Pal, 2002). Regardless of their geographic place of origin and culturally specific theoretical orientations, all CAM therapies share some common characteristics such as a multilayered approach utilizing a number of herbal remedies, personalized diagnosis and treatment, an emphasis on

preventative measures, utilization of self-healing, and a holistic approach to the patient's well-being with an emphasis on mind, body, and spirit (Kumar Pal, 2002; Mantle, 2004; Micozzi, 2011; Ross, 2012).

Scholars suggest that the theoretical orientations of CAM therapies are distinct from Western biomedicine in five major categories. First, Western biomedicine's perception of health is based on the absence of disease whereas CAM emphasizes health as a balance among vital internal and external forces. Second, Western biomedicine interprets disease as a "specific, locally defined deviation in organ or tissue structure" whereas CAM conceptualizes disease as a result of disruption to the aforementioned balance and vital internal and external forces. Third, Western biomedicine arrives at a diagnosis by means of a specific disease etiology whereas CAM utilizes a number of diagnostic pathways including environmental and spiritual approaches. Fourth, Western biomedicine often employs invasive external therapies to eliminate a specific pathogen whereas CAM therapies often emphasize a self-healing approach in conjunction with non-invasive procedures. Fifth, within Western biomedical treatment, the patient often plays a passive role in their recovery while CAM stresses an active role for the patient in the recovery and maintenance of health (Aakster, 1986; Furnham and Vincent, 2000; Micozzi, 2011; Ross, 2012).

Therefore, it seems that the one of the most predominant explanations for the increasing popularity of CAM is the general population's desire for a more holistic approach to health. Specifically, this desire among members of the

general public appears motivated by either dissatisfaction with Western biomedical therapies and the increasing costs incurred with them, or by the desire to find an alternative approach to health that not only addresses physical ailments but the mental and spiritual aspects of health as well.

### **1.7 Traditional Indigenous Healing**

Contrary to popular belief, Indigenous populations have never lived in a pristine, disease-free environment (Jones, 2007; Martin and Goodman, 2000; Roberts and Manchester, 1999; Starna, 1992). Since time immemorial, Indigenous groups in North America have had to deal with a variety of diseases and illnesses and as a result, they have accumulated an extensive knowledge of medicines and treatments for these ailments (Waldram et al, 2006). Centuries before the arrival of Europeans, Indigenous groups in North America had established extensive trade networks and these trade networks enabled Indigenous groups to exchange resources, manufacturing techniques, ceremonies, healing practices and a variety of medicinal pharmaceuticals (Calloway, 1994; Dickason, 2002; Nash, 2000; Salisbury, 2007; Waldram et al 2006). In order to ensure their survival and remedy the various maladies they encountered, Indigenous groups in the Americas developed culturally specific, innovative, and complex healing strategies to sustain their health and well-being (Waldram et al, 2006). As with other aspects of Indigenous culture, traditional Indigenous healing practices also evolved and were adapted to the environmental, economic, and political changes

that occurred as a result of sustained European contact (Proulx, 2003; Warry, 1998; Waldram et al, 2006; Waldram 1990).

The traditional Indigenous approach to health and well-being is comprised of a system of medicinal treatment for ailments and diseases that is interlaced with various aspects of Aboriginal philosophy and spirituality (Cohen, 2003; Martin-Hill, 2003; Waldram et al, 2006). This holistic approach to health is predicated upon the belief that the body and the mind do not exist independent of each other. Aboriginal people believe that the sustainment of health and well-being is contingent upon a collective balance among mind, body, spirit, emotion, and environment (Cohen, 2003; Waldram, 2000; Warry, 1998; Kinsley, 1996; Waldram et al, 2006). Therefore, any disruption to this balance will ultimately lead to some form of illness. Thus, historically, Indigenous groups relied on traditional Indigenous healing practices to restore and sustain equilibrium to achieve optimal health and well-being (Cohen, 2003; Kinsley, 1996; Waldram et al, 2006).

While the subject of traditional Indigenous healing has fostered an extensive literature on descriptions of practices and botanical remedies, the terms and language currently used to describe and define various aspects of the system are inadequate and imprecise (Rhoades and Rhoades, 2000; Waldram, 2000). Although the term “traditional healing” has become the predominant descriptor of Indigenous health beliefs and practices, a concise, comprehensive, widely accepted definition has yet to be developed (Martin-Hill, 2003; Waldram et al,



2006). The intent of the term is to simultaneously encompass and express the psychological, physiological, metaphysical, and spiritual processes involved, as well as the accumulated culturally specific knowledge passed down through the generations (Waldram et al, 2006). The primary source of contention impeding the development of a comprehensive, universally accepted definition primarily stems from the failure of English terminology to accurately depict and describe the multidimensional complexity of Indigenous health beliefs and practices (Waldram, 2000). Terms such as “traditional”, “medicine”, “healing” and “medicine person”, are derived from, and embody a Western cultural understanding of the concept. For example, within a Western cultural context, the term “medicine” can be understood to represent a number of concepts and practices associated with the western medical model such as the study and treatment of disease, the practice of preventing or curing disease, drugs, and surgical procedures (Hahn, 1995). However, while Indigenous peoples use the term to refer to similar concepts and actions within their health beliefs and practices, a major point of divergence between Western and Indigenous conceptions of the term stems from the Indigenous use of the term medicine to not only refer to herbal remedies but to also encompass a wide variety of Indigenous beliefs and cultural practices for the promotion of psychological and spiritual well-being (Cohen, 2003; Cohen, 1998; Kinsley, 1996; Martin-Hill, 2003; Waldram et al, 2006; Warry, 1998) .

Similarly, the term “medicine man” is often used in the literature to refer to Indigenous health practitioners. However, subsuming Indigenous health practitioners under the collective term “medicine man” is problematic in that it not only continues to promote Indigenous stereotypes; it relegates Indigenous healers as a cultural artifact of pre-contact and early colonial periods (Waldram et al, 2006). In addition, the term neglects to convey the diversity and particular areas of expertise among Indigenous healers, thereby implying that their abilities were rather limited (Waldram et al, 2006; Martin-Hill, 2003). However, descriptions of traditional Indigenous healing practices from this era often contain, albeit biased, veiled admissions of the ability of Indigenous healers to promote and maintain the health of their people (Waldram et al, 2006).

Indigenous populations had their cultural beliefs and practices scrutinized, oppressed and outlawed by colonial powers in an effort to facilitate colonial expansion and establish a monopoly over valuable resources. Aboriginal populations were subjected to legal sanctions and restrictions designed to suppress their traditional way of life, including some aspects of their spirituality and health practices (Martin-Hill, 2003; Solomon and Wane, 2005; Starna, 1992; Waldram et al, 2006,).

As a result of the sociocultural, sociopolitical and socioeconomic changes to their way of life, Aboriginal populations have had to adapt and refine their approach to health and well-being (Waldram et al, 2006). Most aspects of traditional Indigenous healing practices have survived the colonial era and there

has been a resurgence of these practices among Aboriginal populations, both on- and off-reserve (Waldram et al, 2006; Waldram, 1990). In most instances, traditional Indigenous healing practices and Western biomedicine are being incorporated pluralistically in that individuals are accessing both systems simultaneously or alternatively (Gagnon, 1989; Gregory, 1989; Stoner, 1986; Waldram et al, 2006; Waldram, 1990). The motivation for employing this type of strategy is often explained as either the dissatisfaction with the biomedical approach and its failure to address the culturally specific health care needs of Aboriginal people, or the re-establishment of a more inclusive and holistic approach to health care within a contemporary context (Gregory, 1989; Martin-Hill, 2003; Stoner, 1986; Waldram et al, 2006).

Due to the perceived, universal cross-cultural application of the ideology and therapeutic modalities, scholars often consider traditional Indigenous healing as an affiliate of CAM and commonly list it under the subheading of “folk medicine” or “ethnomedicine” (Baer, 2004). In many instances, descriptions of traditional Indigenous healing and its practices are oversimplified by emphasizing the spiritual or the ceremonial aspects while physiological treatments, psychological healing, and pharmaceutical knowledge of indigenous flora and fauna receive minimal attention. However, any effort to comprehensibly and concisely explain the major theoretical aspects of Aboriginal health and well-being is very difficult in that the various aspects of health and traditional Indigenous healing are so intricately interlaced with other aspects of Aboriginal

culture that they are often difficult to differentiate from spirituality (Waldram et al, 2006).

In regards to the ever-increasing popularity and development of the pluralistic approach to health care, the subheading of “integrative” medicine has been recently coined to categorize the blending or collaborative approach of biomedical and CAM therapies (Baer, 2004). While the various applications of the pluralistic approach used within Aboriginal health centres may be considered by observers to be indicative of an “integrative” model, within an Aboriginal context, a genuine integrated approach is hampered by a variety of epistemological, philosophical, and pedagogical differences between the two systems (Cohen, 2003; Letendre, 2002; Waldram et al, 2006). From a Western biomedical perspective, in order for the two systems to fully integrate, traditional Indigenous healing beliefs and practices would have to be altered to embody Western biomedical standards (Baer, 2004). Thus, the model of health care at AHT operates according to the notion that the two systems will respectfully co-exist in a parallel fashion thereby providing the clientele the option to utilize culturally appropriate health care to suit their particular individual needs.

Currently, Aboriginal peoples are ambivalent about having their traditional Indigenous healing practices being subsumed under the label of CAM due to the colonial legacy of suppression, exploitation, misinterpretation, misrepresentation, and negative stereotyping of their cultural beliefs and practices (Cohen, 1998). Overwhelmingly, Aboriginal people are wary of having their traditional healing

practices affiliated with other medical subsystems that may be considered as either subservient or subjected to biomedical scrutiny and exploitation (Cohen, 1998; Solomon and Wane, 2005; Warry, 1998). Instead, Aboriginal people would rather have their traditional healing practices either exist independent of, or respectfully co-exist with Western biomedicine (Cohen, 2003; Waldram et al, 2006; Warry, 1998).

### **1.8 Anishnawbe Health Toronto**

The overall health status of Canada's Aboriginal peoples has consistently been reported as poor in comparison with the rest of the Canadian population. Aboriginal people in Canada experience major health problems that are unique because they suffer from the ill effects of their historical circumstances within Canada (Waldram et al, 2006). As a result of their particular health issues, Western biomedicine and treatment often fail to adequately address all of the health needs of Aboriginal people (Lemchuk-Favel and Jock, 2004; Martin-Hill, 2003). As a result of the need for improved health care, the precursor to AHT was conceptualized.

The idea for a holistic health clinic that would specifically address the needs of Toronto's Aboriginal population was derived from a vision by the late Joe Sylvester. A community Elder, counselor, and recovered alcoholic, Joe developed diabetes and subsequently had a vision concerning his people and their ongoing battle with substance abuse and diabetes (Lowry, 1993). As a result, a nutrition clinic was opened in 1975 and the Toronto Native Centre began a diabetic

education program in 1981. In 1984, Anishnawbe Health Resources was established as a non-profit organization to analyze urban health-related issues and encourage the use of traditional Indigenous health practices. In 1986, Anishnawbe Health Resources was restructured and became Anishnawbe Health Toronto with the resolution to institute a culture based Aboriginal health centre. In 1989, after establishing resources from the Ontario Ministry of Health, the centre gained recognition as a fully accredited community health care centre and has since maintained its accreditation.

Since its inception, Anishnawbe Health Toronto has maintained its primary tenet of providing access to traditional Indigenous healing within a multidisciplinary health care model to meet the demands of the urban Aboriginal population (Waldram et al, 2006; Waldram, 1990). In the past 20 years, the demand for the services provided by AHT has grown exponentially and the centre has responded by developing and implementing a variety of programs and services that include primary care, health promotion, disease prevention, and traditional healing<sup>ii</sup>.

In addition to providing a variety of health related services, the overall vision of AHT is to provide the knowledge and guidance necessary for the urban Aboriginal population in Toronto to develop their personal skills and have the ability to achieve balance and wellness in an effort to self-heal and lead productive and fulfilling lives.

### **1.9 Contextualizing the Urban Aboriginal**

According to data gathered from the 2006 national census<sup>iii</sup>, it is estimated that over 1 million people self-identify as Aboriginal, thereby comprising 3.8 percent of the Canadian population. Out of this total, 26 percent live on a reserve while 53 percent live in an urban setting (FitzMaurice and McCaskill, 2011). Census data indicate that the city of Toronto is home to the largest urban Aboriginal population in eastern Canada with 26, 575 people, or 0.5 percent of the city population, an increase of 279.9 percent since 1981 (FitzMaurice and McCaskill, 2011). However, Aboriginal agencies within the city dispute these numbers and estimate that the population is 70,000 to 80,000 (Proulx, 2003).

Furthermore, the concept of an “urban Aboriginal” is often difficult to define and assign to individuals in that it encompasses a number of variables that may or may not apply to each individual in the population. In addition, Aboriginal people within an urban context rarely identify themselves as “urban.”

Aboriginal identity is an extremely complicated concept that is very political and immersed in conflicting interpretations of modern and historical collective experiences (Skye, 2006). In Canada, laws have been established which serve to distort and negate traditional Aboriginal methods of self-identification. This impedes agreement on a concise definition of an Aboriginal identity which then generates contention on what constitutes an Aboriginal identity, methods of measurement, and the recognition of embodiment (Lawrence, 2004; Mihesuah, 1998; Weaver, 2001). Aside from federally imposed criteria, such as the

certificate of Indian status, most scholars agree that as a result of sociopolitical and sociocultural circumstances, an Aboriginal identity is essentially comprised of four main components: ancestry, appearance, cultural knowledge, and community participation (Lobo, 1998; Mihesuah, 1998; Applegate Krouse, 1999; RCAP, 1996: Vol. 4). Within an urban context, the Aboriginal community is often not comprised of a clearly defined ethnic neighbourhood (Straus and Valentino, 1998; Warry, 2007). The population tends to be spread throughout the city, however small segments of the population tend to congregate in areas near Aboriginal organizations, such as friendship or health centres, as they may serve as a repository for Aboriginal culture and community (Lobo, 1998; Warry, 2007). Therefore, in some instances, urban community acceptance and acknowledgement of Aboriginal identity is contingent upon the aforementioned components of identity in lieu of a direct affiliation with ancestral homelands (Lobo, 1998; Mihesuah, 1998; Applegate Krouse, 1999).

Aboriginal people migrate to metropolitan areas for a variety of reasons, such as unemployment, better employment opportunities, and to pursue a post secondary education (Applegate Krouse, 1999; Proulx, 2003; Warry, 2007). In other instances, some individuals may have moved to seek the anonymity within the city because of past transgressions that caused them to be ostracized by their home community. In addition, some may have found the city to be tolerant of their sexual orientation while others may have developed a mental illness, addiction, or lost their jobs and become homeless (Warry, 2007). Unfortunately,



much of the research in the area of urban Aboriginals tends to focus on inner city or street populations because of their availability in association with friendship and health centres. Not only does this perpetuate the stereotype of Aboriginal peoples as the urban poor, it also fails to illustrate the segment of the urban Aboriginal population that includes middle class or upper class professionals such as leaders of Aboriginal organizations, civil servants, or lawyers. It is also important to mention that the urban population is also comprised of a division among status Indians who either maintain a connection with their home reserve or commute to the city for employment and non-status Indians that may be permanent residents or second and third generation residents who may have lost their affiliation with an ancestral homeland (Warry, 2007).

Therefore, the term “urban Aboriginal” is a misnomer in that when the term “urban” is used as a prefix to Aboriginal, it does not refer to a specific type of Aboriginal person. Alternatively, a more accurate description of the term would be that it is used to describe a collective experience that most Aboriginal people today have had (Fixico, 2000; Straus and Valentino, 1998).

### **1.10 Methodology**

My previous research experience helped to facilitate negotiations to conduct research at the centre as all of the parties concerned were familiar with the integrity of my methods and my personal conduct as a researcher within the facility. In addition, I was also familiar with the rules and regulations associated with conducting research at the centre.

In May of 2007, I booked an appointment to meet with Executive Director Joe Hester to discuss my desire to return to the centre to conduct my PhD research. In the meeting, as per the guidelines for health research involving Aboriginal people stipulated by the Canadian Institutes of Health Research (2007), I explained my research proposal and indicated my desire to have AHT involved in the development of this project by reviewing and approving the methodology and overseeing the implementation of the project within the institution. I also explained that the project would contribute to building Aboriginal health research capacity by educating individuals at the centre in the development and implementation of a research project as well as illustrating how to comprehend and interpret the research results. I also explained that I would disseminate the results of the research to Anishnawbe Health in the form of research reports and the completed PhD dissertation so that it may be used for their future reference.

After the initial meeting, Joe suggested that I email him a synopsis of my proposed PhD research to be distributed to the managers and administrators for their feedback. Within a week, I was contacted by the receptionist at AHT and a meeting was scheduled for May 30, 2007 for me to attend the centre and have the opportunity to elaborate on my proposal and answer any questions that the managers and administrators might have. At this meeting, I explained the scope of the research including objectives, methodology, participants, time frame for the research, and what I required from each of them in order to carry out my research.

At the conclusion of the meeting I was granted permission to conduct my research at the centre. In the ensuing months, I continued to work as a teaching assistant and develop the tools necessary for my research as well as submit my ethics application to the McMaster Research Ethics Board.

After making all of the required adjustments to my ethics application, I received ethics approval on November 27, 2007. The research methodology for this project consisted of a variety of qualitative methods including posters<sup>iv</sup>, intake questionnaires<sup>v</sup>, open-ended ethnographic-style interviews and participant observation. In an effort to expedite the intake questionnaires and client interviews, posters containing my picture and a description of the research project were placed at the front entrance and reception desk. As a result, many clients stopped by my office at the centre to ask questions about my research and fill out a questionnaire. Over the course of 12 months from December 2007 to November 2008, health care questionnaires were distributed to the clients at the Queen and Gerrard Street centres<sup>vi</sup>. The rationale for using intake questionnaires was to solicit the clientele for interviews as well as obtain some background on what services they were using at the centre and their contact information. In total, 200 questionnaires were distributed, 125 questionnaires from Queen Street and 75 from Gerrard Street. Of the 125 from Queen Street, 58 were returned with 53 clients indicating that they would participate in an interview and 5 declining the interview. Out of 75 from Gerrard Street, 22 questionnaires were returned with 16 clients indicating that they would participate in an interview and 6 declining. Of

the questionnaires returned from Queen Street, 19 were completed by males while 39 were completed by females, with an average age 42.2 years among the clients. Of the questionnaires returned from the Gerrard Street location, 11 were male, 10 were female and 1 identified gender as other, with an average age of 39.4 years among the clients<sup>vii</sup>.

In total, 63 interviews were conducted over the course of my fieldwork at AHT including 9 western medical practitioners, 5 healers (4 healers participated in a second interview bringing the total to 9), 4 traditional counselors, 5 concurrent disorder workers, 10 management and program or service leaders, 2 external mental health experts, and 24 clients. The contents of the interviews were transcribed and thematically categorized using N'Vivo 8 qualitative data analysis software.

Of the 24 client interviews, 18 were conducted at Queen and 6 at Gerrard Street. After surveying the responses to the items on the intake questionnaire, suitable candidates were selected for an interview at the centre. In most instances, a client's suitability for an interview was determined by their indication that they were using western medicine and traditional Indigenous healing simultaneously. Clients were then contacted by phone between the hours of 9 a.m. and 6 p.m. Monday through Friday to set up an appointment to come to the centre and participate in an interview with me. With the exception of a few, most clients were readily available and showed up for the interviews.

Interviews with the healers were scheduled according to the protocol set in place by AHT. All appointments are scheduled in advance through the “Oshkabewis” who is the liaison for the healers in addition to other duties at the centre that include assisting the healers in ceremonies, co-ordinating and scheduling ceremonies, as well as harvesting and caring for the traditional medicines. When a client arrives at the centre and informs the receptionist of their appointment with a healer, they are instructed to wait for an Oshkabewis to escort them in to see the healer. Once they are in the presence of the healer it is considered proper cultural protocol to offer a small gift, usually tobacco, when asking for their help. If the healer accepts the gift it means that the healer is willing and able to offer help (Michell, 1999; Waldram, 1997). Each appointment is witnessed and documented by the Oshkabewis and at the conclusion of the appointment the client is given a copy of the report as well as any instructions concerning any traditional medicines that may have been prescribed and the original copy is stored electronically in the clients file on the centre’s computer filing system.

At the time of this study, AHT employed 6 traditional healers and each healer worked one week of each month, seeing clients between 9 a.m. and 5 p.m. Monday to Friday by hourly appointment or emergency walk-ins. Of the 6 healers interviewed, 3 were male and 3 were female. All of the healers came from various Aboriginal backgrounds and each practiced their own particular modality within their area of specialty.

I scheduled each of my interviews with the healers in advance through the Oshkabewis and on the day of my appointment, as per the protocol, I was led into the room by the Oshkabewis. Once I was in the presence of the healer, I offered my gift and explained the purpose and intent of my research. If the healer agreed to the interview, they accepted my gift and I began the interview.

The remaining interviews with the western medical practitioners, traditional counselors, concurrent disorder workers, management and program or service leaders were scheduled in advance either through reception, by internal phone line, or through personal contact with the individual.

My participant observation occurred in many ways throughout the duration of my fieldwork. At the Gerrard Street location, I participated in 2 sweat lodge ceremonies, 1 shake tent, and 1 yuwipi ceremony. As an active participant at the ceremonies, I followed the required cultural protocol and engaged in the ceremony as per the conductor's direction. While I was not required to personally add to the shake tent or yuwipi ceremony, in the sweat lodges I asked the conductor's to perform a general inquiry into my spiritual well-being. The purpose of my participation in the ceremonies was to provide me with a deeper understanding of the ceremonies through first-hand experience as well as facilitate my understanding of the client experience with the healers.

At the Queen Street location, I participated in 4 teaching circles conducted by the healers. Once a week after the medical centre closed, the particular healer that was at the centre for that week would hold a "teaching circle" with a number

of clients where various aspects of cultural knowledge are discussed according to inquiries from the clients or a particular topic chosen by the healer. I was also invited to observe 3 healing ceremonies with clients conducted by 3 different healers, in addition to observing a case consultation among western biomedical practitioners, traditional healers and management. In between appointments or when I had no appointments booked, I capitalized on the opportunity to observe the daily interaction between clients and staff as well as engaging them in informal conversations about a variety of topics regarding their health and health-related issues. Additionally, I also used the opportunity to observe the daily operation of the programs and services offered at the centre.

Altogether, my participant observation enabled me to gain valuable first-hand experience as well as enrich my understanding of the experience of the clients, healers, biomedical practitioners. In addition, I also developed an understanding of the daily operation of the centre and the contributions made by the staff to ensure that the clients' needs are adequately addressed.

### **1.11 Ethical Considerations**

As I stated in the previous section, I adhered to the guidelines for health research involving Aboriginal people stipulated by the Canadian Institutes of Health Research (2007). I actively engaged in Aboriginal health research capacity by having individuals at the centre not only review and help me refine my methodology but also facilitate and implement the project within the institution. The method for distributing and collecting the intake questionnaires was

developed in collaboration with the receptionist at the centre. As she pointed out, she is the initial point of contact for clients at the centre, and therefore suggested that the best strategy for initially engaging the clientele with the research was to have her inquire if they were interested in filling out a questionnaire. If the client expressed an interest, she supplied them with a questionnaire and instructions. At the end of each day she informed me if she had any questionnaires to be retrieved.

Administrators and management were especially helpful in that they ensured that an office space was made available for me to conduct interviews, and readily answered any questions I had about the daily operations of the centre or any of the programming. The oshkabewis were particularly helpful as a liaison with the traditional healers and in providing crucial cultural information regarding the traditional healing program at the centre. In turn, I reciprocated their help by having several meetings with the oshkabewis to discuss academic research and theories surrounding Aboriginal peoples, tradition healing and culture. I also had several meetings with the healthcare practitioners and healers to discuss a variety of topics related to Aboriginal health, research, healing and culture. As a result of these meetings, I was able to increase my breadth of understanding about how the two approaches to health care work in collaboration and also inform the western and traditional practitioners of academic discourse on the subject.

### **1.12 Structure of the Thesis**

Any investigation of Aboriginal health care and health-related issues requires an understanding that the current status of Aboriginal health is rooted in



historical circumstances as well as knowledge of the complex interaction among sociocultural, sociopolitical, socioeconomic, environmental, spiritual, mental, physical and emotional factors. Chapter 2 of this thesis outlines the historical aspects of pre- and post-contact Aboriginal life in order to facilitate an understanding of how sociopolitical and sociocultural changes as a result of colonial imposition have subsequently affected Aboriginal health for many generations. In addition, this chapter examines the major theoretical orientations towards pre- and early post-contact Indigenous health, disease, and cultural orientation, as well as how sustained European contact and the subsequent impact of the fur trade placed a tremendous strain on their cultural beliefs and healing practices, thereby compounding the adverse effects on their health.

Chapter 3 illustrates the philosophy behind AHT's belief that the blending or formal integration of traditional Indigenous healing with Western biomedicine is not an ideal solution to Aboriginal health issues; rather the ideal is to provide a comprehensive approach to health care by maintaining traditional Indigenous healing and Western biomedicine as distinct approaches. This chapter also explains that the healthcare model developed and implemented at AHT is an example of the complex solutions needed to adequately address complex Aboriginal health issues. Additionally, as a result of Aboriginal control, development, and implementation of all aspects of the multidisciplinary, pluralistic model of health care, I suggest that this represents the embodiment of self-determination within the institution.

As an example of the Aboriginal specific approach to health care at AHT, Chapter 4 examines the development and implementation of the Aboriginal Mental Health Unit at the centre. In addition, issues concerning over-diagnosis, over-medication, compliance, and concurrent disorders as discussed through a series of interviews with healthcare providers and clients.

Chapter 5 examines how participation in ceremonies and spirituality is often considered an integral aspect for health, healing and well-being. This chapter will illustrate the client's rationale for participating in ceremonies and the benefits they received as a result based on information gathered in one-to-one interviews at AHT. In addition, the purpose and structure of the most popular ceremonies among the clientele will be examined, as well as the therapeutic value and associated issues as reported by the clients, traditional healers and healthcare practitioners.

Chapter 6 will contextualize my research within a broader political theoretical scope in that the services and model of health care practiced at AHT provides a means of agency for the clients to “decolonize” their health and health care. Within the context of AHT, clients feel that their health and related issues were understood historically, politically, and culturally, and they feel empowered and respected within a clinical environment. Thus, the re-distribution of power within the clinic and the recognition and incorporation of Indigenous healing has provided a platform through which the clientele are able to service the body

politic and decolonize their health and bodies, thereby initiating positive proactive change among the population towards an improved health status.

### **1.13 The Healers**

One of the most debated issues regarding Aboriginal healers is derived from the lack of consensus among Aboriginal community members regarding who should be considered a legitimate healer (Waldram, 1997). In addition to various areas of expertise, there are also a variety of culturally and contextually specific ways in which an individual can become a healer. For the intent and purpose of this research project, anyone introduced to me as a “healer” was defined as such according to the criteria established by Anishnawbe Health Toronto and not by my personal definition.

### **1.14 Notes on Ceremonies**

Due to a history of oppressive colonial policies, disproportionately negative and misinterpreted depictions in the literature, cultural appropriation, and cultural norms, many traditional Indigenous healers will not divulge specific details regarding traditional healing ceremonies. While the healers that participated in the research for this project were willing to provide some information for contextual clarification regarding some of the ceremonies they conduct at AHT, I respected their wishes and did not record or transcribe anything they considered to be sacred, privileged, or private information. In addition, the information they provided was derived from their personal knowledge and particular cultural background. Within the context of AHT, each healer conducts their healing and

ceremonies according to their particular cultural orientation and knowledge base. Thus, the cultural components of health and healing within AHT are not to be considered as diluted or constituting a “Pan-Indian” approach but rather are utilized in recognition of their efficacy in treating particular health issues despite the affiliation with a particular nation or region. Therefore, unless the information is associated with a particular healer in the text, it has been gathered from a survey of relevant academic literature on the subject. Any detailed information about the ceremonies as provided by the literature are solely intended to foster a general understanding of the ceremonies for the reader and are not to be interpreted as an accurate description of the ceremonies within the context of AHT. I am not an expert on the various aspects of healing ceremonies and I accept full responsibility for the information and how it is represented within the text. It was my decision to orient the information in this manner and not by the direction of AHT or any of the staff. I am also responsible for the language used to describe and contextualize Aboriginal culture, beliefs, values, and spirituality. Being a non-expert, it is a formidable task to write about culturally sensitive issues in a respectful manner yet present the information comprehensibly to a non-Native audience to foster an understanding of the material and subject. I would like to offer my sincerest apologies in advance if any of the information contained herein is deemed offensive. It is not my intention to offend, only to foster cross-cultural communication and understanding traditional Indigenous medicine and issues related to Aboriginal health and well-being.

### **1.15 Contextualizing Quotes**

Historically, anthropology was necessarily concerned with incorporating the “voice” of research subjects into ethnographic discourse. However, contemporary ethnographies are increasingly utilizing the “voice” of the other to decolonize anthropological discourse and acknowledge the authority of key informants in an effort to properly contextualize their representation of other cultural practices. Therefore, in recognition of the historical appropriation, objectification, and misrepresentation of Indigenous culture and knowledge by anthropology, I have incorporated the “voice” of research participants for this project in an effort to maintain my promise to include their knowledge and distribute authority as evenly as possible throughout the discourse. Therefore, where it was deemed appropriate, I have included quotes from the interviews from all phases of the research to provide reassurance that my analysis and explanation is an accurate reflection of their information.

### **1.16 Notes on Terminology**

For the intent and purpose of this research project, I use the term “Aboriginal” in a collective sense to refer to Inuit, First Nations, and Métis people. In addition, the term “Aboriginal people(s)” as it is used here is in reference to Aboriginal people as descendants of the original people of North America as well as being recognized as a legal category in Canada. The term “Native” is used to depict the cultural distinctiveness of individuals and distinguishes Native communities from mainstream society. “Indigenous” is used

in reference to Native people in a global context and emphasizes the natural, tribal, and traditional characteristics of various peoples including their culturally specific approaches to health and well-being.

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<sup>i</sup> Within this context, folk medicine includes a variety of herbal remedies and healing practices including those imported from Europe by settlers and those of Indigenous origin incorporated into European folk systems. In addition, folk medicine includes the associated European philosophical and theoretical orientations towards health and health care (Sharp, 1986).

<sup>ii</sup> See Appendix A for a list and description of services and programs.

<sup>iii</sup> In addition to the difficulty of self-identification as Aboriginal on the census form, it has been established that many Aboriginal people do not participate in the national census. In addition, census data on the urban Aboriginal population is particularly suspect due to the transient nature of the population whereby they may be considered part of the reserve census data (FitzMaurice and McCaskill, 2011; Warry, 2007).

<sup>iv</sup> See Appendix B

<sup>v</sup> See Appendix C

<sup>vi</sup> See Appendix D for a summary of client demographic data.

<sup>vii</sup> Interestingly, a similar trend developed in my previous research in that while youth were observed using the services at the centre, none were willing to participate in the research. A similar trend also developed in that more women were inclined to participate. However, as part of the agreement with AHT, I was not allowed to openly solicit the clientele to participate. Had I actively recruited clients, perhaps the ratio of male to female and the distribution of age would have been more balanced, and the response rate might have been higher.

## **2. The Role of Contact and Colonialism on Aboriginal Health Issues**

Research suggests that it is a widely held opinion among Aboriginal peoples that many of the variables associated with a negative influence on current Aboriginal health status can be linked to sociocultural, sociopolitical, and socioeconomic changes as a result of European encroachment and colonial imposition. Therefore, in order to properly address Aboriginal people's concerns about their health-related issues and develop appropriate health care to address those issues, it is important to understand how changes among the sociocultural, sociopolitical, socioeconomic, environmental, and spiritual factors impacted and subsequently altered Aboriginal life (Kirmayer, Brass, and Valaskakis, 2009; Waldram et al, 2006).

Indigenous populations in this era existed within a complex web of trade networks, perpetual cultural development, and endemic disease patterns. Accordingly, Indigenous groups developed a variety of modalities and healing practices to ensure their survival within specific environmental niches. As a result of sustained European contact, the impact of the fur trade, a multitude of cultural changes, and the subsequent decimation of Indigenous populations due to disease epidemics, traditional healing practices and cultural beliefs were placed under a tremendous strain, thereby compounding the adverse affects on health. The residual effects of colonialism still plague Indigenous populations, as they have since experienced a history of poor health compared to the rest of the Canadian population (Waldram et al, 2006). Therefore, to facilitate an understanding of how these factors impact and influence the clientele and services at AHT, this chapter



will outline the major theoretical orientations toward pre- and early post-contact Indigenous health, disease, and sociocultural orientation.

## **2.1 Aboriginal Pre-contact Health and Disease**

Establishing a bounded timeframe for the pre-contact era is fraught with the knowledge that it is highly unlikely that any Indigenous group was completely isolated for any significant length of time. Evidence suggests that Indigenous groups had established alliances, trade and intermarriage with other Indigenous groups prior to any European contact (Dickason, 2002; Wilson and Urion, 2004). Studies of pre-contact health are further complicated by the lack of written documentation given that Indigenous groups relied on oral transmission of knowledge and early European descriptions of Indigenous health issues may be inaccurate or exaggerated (Waldram et al, 2006).

Within the Canadian context, the ability to construct a comprehensive depiction of health and disease among Indigenous populations prior to European contact is difficult, given environmental conditions that are often detrimental to the preservation of most organic materials (Martin and Goodman, 2000). As a result, the majority of studies are from archaeological sites in more preservation friendly areas such as the south eastern United States (Martin and Goodman, 2000). However, some regions in Canada have been more conducive to archaeological analysis and their study has yielded valuable insight into health issues faced by pre-contact populations in Canada.

Palaeopathological analysis has helped to dispel one of the most enduring theoretical assumptions about pre-contact Aboriginal health by illustrating that Indigenous populations in the Americas did not live in a pristine disease free environment

(Jones, 2007; Martin and Goodman, 2000; Roberts and Manchester, 1999). Studies have shown that pre-contact populations suffered from a variety of illnesses and diseases (Jones, 2007; Martin and Goodman, 2000; Roberts and Manchester, 1999; Starna 1992; Waldram et al, 2006). Evidence suggests that tuberculosis, treponemiasis, tularaemia, giardia, rabies, amebic dysentery, hepatitis, herpes, pertusis, and poliomyelitis were present in the Americas prior to European contact (Ortner and Putschar, 1981 as cited in Martin and Goodman, 2000). In addition, pre-contact Aboriginal subsistence strategies utilizing land mammals and marine resources could have resulted in mild to severe cases of food poisoning in addition to potentially harmful parasitic infections such as round worm, tapeworm, flukes, pinworms, hairworms, hookworms and trichinosis (Roberts and Manchester, 1999; Starna, 1992; Waldram et al 2006).

The examination of skeletal remains has provided some clues to the health and well-being of Indigenous groups in the era before sustained contact. For example, palaeopathologists have been able to substantiate the claim that tuberculosis was endemic in the Americas at least 2000 years before European contact (Buikstra, 1999; Prat and de Souza, 2003; Ramenofsky, 1987; as cited in Waldram et al, 2006). In addition, analysis of the pattern and distribution of skeletal lesions on the remains of eleven people recovered at the Cairn site in Manitoba determined that they suffered from a specific treponemal disease known as yaws. The findings suggest that yaws was endemic among the people in the region 2000 years ago (Merrett et al, 2003 as cited in Waldram et al 2006)<sup>i</sup>.

Analysis of teeth from archaeological excavations in southern Ontario suggests that the increased consumption of maize among Iroquoian groups is linked to an increased incidence of caries resulting in abscesses and tooth loss (Crinnion et al, 2003 as cited in Waldram et al, 2006). Another study examining the remains of individuals recovered at the MacPherson site in southern Ontario found a defect in the tooth enamel of two children approximately 3-4 years of age. The defect, termed circular caries, is indicative of children suffering the effects of malnutrition and subsequent chronic diarrhea. The researchers speculate that these children were weaned on a diet that was predominantly maize. This, in turn, predisposed the children to infection and placed their bodies under a great deal of stress. However, aside from the significance of these findings, the researchers have not been able to determine which infectious disease caused their deaths (Katzenberg et al, 1993 as cited in Waldram et al, 2006). It has also been suggested that bone lesions from infections, such as tuberculosis and treponemal disease, peaked in accordance with maize consumption which would have increased population density thereby facilitating the increased transmission of disease (Katzenberg, 1992; Molto and Melbye, 1984; Saunders, 1988, as cited in Waldram et al, 2006).

Archaeological evidence and palaeopathological analysis, therefore, has determined that Indigenous populations suffered from a variety of illnesses and diseases prior to sustained contact. While Indigenous groups did suffer from disease, it is evident that they were able to adequately treat the affects of disease and illness and maintain the population.

## **2.2 The Impact of the Fur Trade: Cultural Change and Disease**

Indigenous groups in the interior of northeastern America had established extensive trade networks centuries before the arrival of Europeans (Calloway, 1994; Dickason, 2002; Nash, 2000; Salisbury, 2007). In addition to the distribution of subsistence items such as obsidian, copper, cherts and flints, trade networks also served to foster good relations, reinforce alliances, and exchange resources, manufacturing techniques, ceremonial practices and a variety of medicinal pharmaceuticals (Dickason, 2002; Nash, 2000; Salisbury, 2007; Waldram et al 2006). In contrast to the European concept of trade, Indigenous trade networks were not intended to exploit resources in an effort to accumulate material wealth; instead they tended to preserve a peaceful reciprocal co-existence among neighbouring groups rather than incite competition and conflict (Calloway, 1994; Dickason, 2002; Nash, 2000; Salisbury, 2007). Subsequent changes in trade items and trade networks after European contact were initiated by the utilitarian aspects of European goods by comparison to Indigenous items (Nash, 2000). For example, the acquisition of steel knives, iron axes, and copper pots would have eliminated the reliance on labor-intensive Indigenous items serving the same purpose.

European encroachment into northeastern Canada began in the sixteenth century and increased exponentially throughout the seventeenth and eighteenth centuries (Dickason, 2002). The influx of European immigrants was precipitated by the increased expansion of the fur trade and the unrelenting push inland in search of more fur-bearing animals to sustain the trade. The dynamics of the fur trade initiated several cultural changes among the Indigenous populations in the area. Many of the changes were

insidious in nature and resulted in concomitant alterations to the Indigenous way of life and residual effects on their health.

One of the most devastating effects to Indigenous cultures as a result of changes wrought by the fur trade was the increased incidence of violence and war. For many Indigenous populations, periodic intertribal warfare was a part of their culture and sometimes occurred as a result of disputes over resources and hunting territory (Nash, 2000). However, the desire for European goods and the increased demand for furs altered the traditional premise of war to one that was economically motivated (Richter, 2007). In turn, this led to the increased reliance on the gun for warfare which increased the number of casualties for all parties involved. In conjunction with the reliance on the gun, the inevitable need for supplies and ammunition increased, thereby creating a need for more furs, which resulted in groups raiding each other for their cache of furs. Over time, disease also began to take its toll and further exacerbated the need to replenish the ranks. Eventually these sustained periods of war exerted a great cultural toll as the loss of knowledgeable elders and leaders happened in quick succession and valuable knowledge and leadership was lost before their roles could be filled by qualified individuals (Richter, 2007).

The insidious nature of the fur trade also caused a reorganization of Indigenous socioeconomic infrastructure. The insatiable demand for furs and the increased reliance on European goods subversively changed traditional values and beliefs towards hunting. In a relatively short period of time, Indigenous groups went from subsistence hunting or taking only what they needed for survival in a respectful way to commercial hunting and

exploiting animal populations for economic motivations (Nash, 2000). This shift in hunting priority created a cascade of changes for everyone in the village. As the fur trade progressed the men had to invest more time in acquiring furs and as stocks became depleted it increased their travel and time spent away from home thereby upsetting the egalitarian structure of labour within the village (Nash, 2000). Thus, women were also subversively drawn into the fur trade because they skinned and prepared the hides for trade. As the demand for furs increased, this activity absorbed more of women's time, thereby greatly hindering their ability to attend to other aspects of village life (Nash, 2000). In some instances, the procurement and transport of furs to trading posts became such a time-consuming endeavour that they neglected other subsistence activities and had to trade furs for food with neighbouring nations or trading posts, and this further elevated the need for furs (Nash, 2000).

Participation in the fur trade also altered the spiritual connection between Indigenous peoples and their ecosystems. In general, Indigenous peoples believed in the symbiotic balance among humans, animals and the environment. Humans were obligated to respect animals and the environment and not take or alter any more than they needed for their survival. If these tenants and spiritual ceremonies expressing gratitude for the gifts nature provided were adhered to, that ensured their survival. However, the purpose of the fur trade was not subsistence but rather economically driven, and to exploit animals for such a purpose was in direct contrast to Indigenous beliefs and values. Therefore, participation in the fur trade placed a great strain on the spirituality of Indigenous peoples (Nash, 2000).

Another commodity of the fur trade that caused cultural strain and adversely affected Indigenous health was alcohol. Prior to European contact, Indigenous people in North America did not make or consume alcohol (Waldram et al, 2006). With the advent of the fur trade, alcohol was introduced in the 17<sup>th</sup> century as a gift item and shortly thereafter became an item of trade (Nash, 2000; Ray, 1998; Waldram et al, 2006). As the fur trade expanded and rivalries developed among European states, traders, and trading posts, the trade and consumption of alcohol also increased (Ray, 1998; Waldram et al, 2006). Rum and Brandy were the primary forms of alcohol traded and soon after their introduction, Indigenous groups became discriminative in their preference for good quality alcohol and would redirect their wares to those trading posts that offered a higher quality product (Nash, 2000; Ray, 1998).

For the Indigenous groups involved, alcohol had a great impact on their livelihood and culture. Historical documents report that alcohol perpetuated incidents of violence including murder and rape. It has also been documented that alcohol consumption led to familial discord, community factionalism, accidents, poverty, and food deprivation (Bishop, 1994; Mancall, 2007; Nash, 2000; Waldram et al, 2006). The majority of the early documentation of Indigenous consumption of alcohol is derived from traveler's accounts, trader's records, and missionary diaries. While these sources are abundant, the colonial bias is inherent throughout and portrays the stereotypical drunken Indian image whereby all Indians were binge drinkers and prone to violence and promiscuity while often ignoring the documented fact that not all Indigenous people involved in the fur trade participated in the consumption of alcohol at the trading posts (Mancall, 2007;

Waldram et al, 2006). The reports also fail to acknowledge that some Indigenous people supported banning the trade of alcohol to Indians (Mancall, 2007; Waldram et al, 2006). Colonial accounts also provide evidence that Indigenous alcohol consumption in the wake of disease contributed to their mortality (Nash, 2000; Mancall, 2007).

The introduction of alcohol among Indigenous groups in North America exacerbated the perpetual erosion of Indigenous health and placed increased stress on a cultural system already experiencing enormous pressure. In some instances, Indigenous people expressed a concern that alcohol had reoriented community members' needs from subsistence and survival to the acquisition of alcohol. In many communities, overhunting and neglect of crops led to famine and, in turn, an increased susceptibility to disease. All of this combined with spiritual and cultural stress continued to affect their health (Wallace, 1956).

Aside from alcohol and its related issues, the fur trade ushered in a cascade of diseases that decimated the Indigenous populations at the time. While the devastating effects of diseases associated with sustained European contact and trade are documented throughout the historical literature, the documentation is incongruous and bereft of crucial information on the socio-ecological changes and mortality rates associated with specific diseases afflicting Indigenous populations at the time. This makes the task of illustrating a comprehensive picture of predisposing factors for infectious disease extremely difficult if not impossible (Waldram et al, 2006).

Another contentious issue affecting the assessment of infectious diseases during this period is the disparity in the literature in relation to Indigenous population estimates



for the time period. Population estimates in America run the gamut from 1 million to 18 million and all points in between (Waldram et al, 2006). Therefore, due to insufficient historical data, precise analysis of death rates and the virulence of infectious diseases for this era are subject to interpretation and bias depending on a number of factors beyond the control of the researcher (Waldram et al, 2006).

Many researchers agree that Old World diseases or diseases of European origin had a tremendous impact on Indigenous populations in America and played a significant role in the colonial history of America (Waldram et al, 2006). The heightened susceptibility of Indigenous populations to these pathogens has been explained by a theory postulated by Alfred W. Crosby in 1976 he termed “virgin soil epidemics” (Jones, 2007). According to researchers who adhere to Crosby’s theory, virgin soil epidemics involve a high level of mortality across all age groups, and occur because the disease is new and the population exposed is immunologically defenseless or because the disease has not re-occurred in a population for so long that individuals with antibodies have since died and community or “herd immunity” has been lost (Jones, 2007; Waldram et al, 2006). Beginning in the 17<sup>th</sup> century, Indigenous populations suffered the ravages of diseases such as smallpox<sup>ii</sup>, measles, influenza, dysentery, diphtheria, typhus, yellow fever, whooping cough, tuberculosis, syphilis, cholera, scarlet fever and a host of other unidentified maladies in the historical record (Jones, 2007; Mayer, 1995; Waldram et al, 2006).

Trading posts were often the hub of disease and served as the distribution center for the spread of disease to other parts of the country (Waldram et al, 2006). Trading posts can best be described metaphorically as a Petri dish that housed all of the pre-conditions

necessary for the creation and spread of infection. Representatives from neighbouring Indigenous populations and European traders periodically converged on the center to barter their wares and also exchanged or acquired pathogens which they then distributed among everyone they came into contact with on the return journey (Waldram et al, 2006). This social network often facilitated and perpetuated the outbreak of epidemics during this era. To clarify, an epidemic is an outbreak of a disease that has an atypically high mortality rate for a specific population. In most cases they are sporadic, short lived and thereby enable populations to return to a normal distribution of age and mortality. However, populations experiencing a particularly severe epidemic will have an increased susceptibility and may go through several successive bouts of the disease and experience dramatic population loss, thus greatly hindering their ability to recover (Waldram et al, 2006).

Historical documents from trading posts such as York Factory located on Hudson's Bay reveal that they were often the epicenters for outbreaks of infectious diseases. By the end of the eighteenth century, the Post had acquired a physician in residence and causes of death were documented with greater consistency (Waldram et al, 2006). Analysis of the records revealed that tuberculosis, influenza and dysentery were the forerunners in causing death while diseases such as poliomyelitis, typhoid fever and puerperal fever indicate that sanitary conditions at the post were inadequate and fuelled contagion. The records also revealed that bronchitis and meningitis were circulating among the population and that an epidemic of influenza in 1717 and an outbreak of smallpox in 1782 had a particularly high mortality rate (Ewart, 1983 as cited in Waldram et al, 2006).

In addition to poor sanitary conditions, a number of other factors particular to the cultural lifestyle at the time contributed to the facilitation of infectious diseases. Travel to and from the post to outlying areas would have easily exported or imported diseases among populations. Coupled with travel were the seasonal shifts in population that occurred in relation to the trade network (Waldram et al, 2006). For example, some Cree and Ojibwa groups congregated in larger groups in the summer and this would have enabled pathogens to spread quickly among the group and their subsequent visits to trading posts would have spread the infection to any contacts they may have had there. In addition, stagnant water, refuse and waste would attract and support various insect populations thereby providing another vector for infection (Waldram et al, 2006). Alternatively, during the winter months, the larger encampments dispersed into smaller groups. Any visits to the posts would have exposed individuals to pathogens which they would have transported back to the camp, and due to the smaller size of the group, the ensuing infection could have been devastating. Winters spent at the trading post would have also been conducive to the spread of disease. Overcrowding, poor air circulation, malnutrition, and the close proximity of refuse and human waste to living quarters are prime facilitators of infectious disease (Jones, 2007; Ray, 1998; Waldram et al, 2006).

In addition to being a collection and distribution center, trading posts also became a location for short term and permanent residency. The increased population density in and around the trading post greatly facilitated the prevalence of contagious diseases and ensured rapid transmission from person to person (Waldram et al, 2006). As a result of subsequent cultural changes derived from an increased preference for European goods

and the ever increasing attainment of furs, some Indigenous populations such as the Cree and Ojibwa became dependent on the trading posts to supplement their subsistence during periods of famine while they participated in the fur trade (Bishop, 1994; Waldram et al, 2006). Over time, some groups established permanent residence around the posts in the James and Hudson's Bay areas and later became known as the "Homeguard Indians." Their descendents can still be found in areas around former trading posts such as Moose Factory, Nelson House, and Cumberland House (Waldram et al, 2006). The Homeguard Indians worked at the trading posts as hunters supplying wild game to the posts and as general labourers attending to a variety of chores in and around the post. Employment at the post greatly reduced the need to hunt and trap to obtain European goods. As time passed they intermarried with the traders and became increasingly dependent on the trading post for supplementary income and food (Bishop, 1994; Waldram et al, 2006).

### **2.3 Shifts in Disease**

While European encroachment and colonialism ushered in a cascade of cultural change and an onslaught of oppression to the Indigenous way of life, it had a particularly devastating impact on their health and the residual effects are still felt today (Kirmayer et al, 2009). Despite advancements in the treatment and control of most diseases that afflicted Indigenous populations, many infectious diseases still occur at a much higher rate among this group than for the rest of the Canadian population (Waldram et al, 2006). Additionally, there has been a shift from infectious diseases to chronic non-communicable diseases. Researchers explain this shift as the "epidemiologic transition"

or the “health transition” referring to the longitudinal changes in “the patterns of health and disease in populations” (T.K. Young, 1988 in Waldram et al, 2006:74).

While the amount and quality of health data on Indigenous populations has greatly improved over time, it still presents an incomplete picture since most of the data is gleaned from status Indians living on reserves and research suggests that the majority of Aboriginal peoples now live off reserve in urban areas (Kirmayer et al, 2009; Waldram et al, 2006). However, despite the fragmented nature of the health data, studies suggest that the life expectancy of Aboriginal peoples is much lower than the general Canadian population: 70.4 years for Aboriginal men and 75.5 years for Aboriginal women compared to 77.1 and 82.2 years for men and women respectively in the general population (Kirmayer et al, 2009). Aboriginal people also suffer from higher rates of diseases such as some particular forms of cancer, cardiovascular diseases, hypertension, obesity, drug and alcohol abuse, and type II diabetes compared to the rest of the Canadian population. Elevated rates have also been reported for various forms of intentional and unintentional injuries such as suicide, poisonings, and traffic accidents (Kirmayer et al, 2009; Waldram et al, 2006). In addition to injuries and disease, research also indicates elevated rates of violence including domestic violence, sexual abuse, and rape (Kirmayer et al, 2009; Waldram et al, 2006).

In parallel with the aforementioned health issues, research also suggests that sociocultural and sociopolitical circumstances associated with colonial imposition also greatly affected Aboriginal peoples’ mental well-being. Research in this area indicates

that Aboriginal people suffer from high rates of mental health problems, with depression being reported as the most prevalent among Native populations (Kirmayer et al, 2009).

Early in colonial history, Aboriginal peoples were often perceived as “savages” or “primitive” and uncivilized. In addition to the suppression of spirituality and ceremonial practices, strategies and legislation were created in an effort to “civilize” Aboriginal peoples and assimilate them into mainstream society (Kirmayer et al, 2009). A strategy of forced assimilation was implemented throughout Canada and was specifically directed at Aboriginal children. From 1879 to 1973, the Canadian government mandated church-run boarding schools across Canada. Under the guise of educating Aboriginal children, the schools utilized a highly regimented and disciplined approach, coupled with relentless surveillance, in an effort to suppress and eradicate all aspects of Native culture from the students (Kirmayer et al, 2009). Unfortunately, the residential school experience for many children left them mentally and physically scarred as a result of physical, emotional, and sexual abuse perpetuated by staff at the institutions. Beyond the immediate and individual trauma, residential schools created generations of students who, in addition to being denied their right to develop and maintain their cultural identity, lacked parenting skills and had difficulty integrating back into their home communities.

In addition to residential schooling, a policy was implemented in the 1960’s among Provincial child and welfare services which was focused on preventing child neglect. In regards to Aboriginal families, neglect was primarily associated with the need for adequate care which was evaluated against poverty and other social issues. However, policies at the time did not include measures to deal specifically with Aboriginal issues

and as a result, social workers opted to remove children from their families and place them in foster care. This course of action eventually became known as the “Sixties Scoop” and lasted nearly three decades (Kirmayer et al, 2009). It is estimated that by the 1970’s roughly one in four status Indians were separated from their biological parent(s), comprising 30% to 40% of all the children who were legal wards of the state. Eventually, many of these children were adopted by non-Native families in Canada and the United States. However, many have suffered from physical, emotional, and sexual abuse, as well as identity and self-esteem issues. As a result of their traumatic experiences and being forcibly displaced from their families and communities, many former residential school students and children who were part of the Sixties Scoop became abusers, thereby creating and perpetuating the level of dysfunctional mental health currently observed within many Aboriginal communities.

Collectively, then, the research reviewed here suggests that despite measures being taken to improve the health status of Aboriginal people, they continue to suffer from poor health as a result of a number of historical circumstances associated with colonial imposition and subsequent changes to environmental, social, political, economic and cultural factors. Within the literature, the view that the majority of current mental health issues plaguing Aboriginal peoples are associated with “large-scale traumatic events that followed colonization and forced assimilation” (Kirmayer et al, 2009: 453) has developed from the theory of Historical Trauma. According to Yellow Horse Brave Heart, “Historical trauma is cumulative emotional and psychological wounding, over the lifespan and across generations emanating from massive group trauma experiences”

(2003: 7). Furthermore, Historical trauma culminates in what is known as the historical trauma response, which may be manifested in a variety of ways including substance abuse, self-destructive behaviour, depression and low self-esteem (Yellow Horse Brave Heart, 2003). Recently, researchers proposed a new model for contextualizing the generational transmission of historical trauma and the approach to healing for contemporary Aboriginal populations. The new model is described as historic trauma transmission and proposes that historic trauma be interpreted as a disease in response to “a cluster of traumatic events” and is manifested through a number of “maladaptive social and behavioural patterns” (Wesley-Esquimaux and Smolewski, 2004:iv). Accordingly, researchers have called for assessment methods and therapeutic treatments that not only acknowledge Native history and its cumulative impact across generations, but that also employ culturally-based modalities specifically designed for Aboriginal populations (Archibald, 2006; Yellow Horse Brave Heart, 2003; Wesley-Esquimaux and Smolewski, 2004).

## **2.4 Conclusions**

The vast majority of research participants provided for the unsolicited reasoning that their health issues, as well as the poor health status of the Aboriginal population in Canada, was directly related to various factors associated with the arrival of Europeans and the subsequent establishment of colonialism resulting in a perpetual erosion of Indigenous health and well being. While many scholars and researchers have conducted studies to substantiate and corroborate this line of reasoning, the health care system in Canada has still failed to adequately address the specific health issues facing Aboriginal



peoples, including mental health. Therefore, the colonial impact on the cultural, political, economic, environmental, and spiritual factors of Aboriginal life are reflected in the philosophy and infrastructure of the model of health care employed at AHT. The remaining chapters will primarily use the example of the Mental Health Unit at AHT to illustrate the aforementioned philosophy and infrastructure at the centre.

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<sup>i</sup> Treponemal diseases, such as yaws and syphilis, also induce a specific form of osteomyelitis which results in abnormalities found predominantly on the tibia and skull. Skeletal remains presenting with a yaws infection will display a condition referred to as “sabre shin” and if the skull has been affected the damage may range from crater like depressions on the surface of the skull to destruction of the nasal and upper jaw areas (Roberts and Manchester, 1999). Syphilis, particularly venereal syphilis, is discernable from yaws in that in addition to a deformed tibia, it tends to destroy the knee joints and there is an increased incidence of specific effects seen on the skull. Damage to the skull often presents with a “worm eaten” appearance and there may also be perforations of the skull although the destruction of the skull is not as predominant as that associated with yaws (Roberts and Manchester, 1999). Therefore, intact skeletal remains help palaeopathologists accurately diagnose the particular treponemal disease the individual suffered from.

<sup>ii</sup> Although there is no doubt that Indigenous populations experienced severe outbreaks of smallpox throughout history, there is an ongoing contentious debate among researchers as to whether smallpox was deliberately spread among Native groups by means of infected textiles akin to biological warfare in an attempt to eradicate Aboriginal peoples (see Mayer 1995).

### **3. The Embodiment of Medical Self-Determination**

Since the establishment of Anishnawbe Health Toronto, the Centre has maintained and developed its primary tenet of providing access to traditional Indigenous healing within a multidisciplinary health care model to meet the demands of the urban Aboriginal population. The purpose of this chapter is to provide an understanding of the philosophy at AHT that suggests traditional Indigenous healing practices must remain distinct from Western biomedicine so as to provide a comprehensive approach to health care by increasing the number of potential therapeutic approaches available to clients. The AHT philosophy thus argues against the blending or formal integration of traditional Indigenous healing with Western biomedicine. In addition, the health model implemented at AHT is an example of the complex solutions needed to adequately address complex Aboriginal health issues. As a result of Aboriginal control, development, and implementation of all aspects of the multidisciplinary, pluralistic model of health care, I propose that the infrastructural components in conjunction with the approach to health care at AHT represents the embodiment of self-determination within the institution.

#### **3.1 A Culturally Appropriate Approach to Urban Aboriginal Mental Health**

In 2004, representatives from AHT, Native Child and Family Services of Toronto, Native Men's Residence, and Council Fire, met to discuss the challenges in dealing with the mental health needs of the urban Aboriginal community. Based on frontline experiences and client profile analyses, representatives from all of the agencies agreed that the Aboriginal community in the greater Toronto area was in a state they described

as a “mental health crisis” (Anishnawbe Health Toronto Aboriginal Mental Health Strategy [AHTAMHS], 2005:4).

In an effort to ameliorate the situation, a coalition was formed among these agencies and Native Management Services was commissioned to conduct a study illustrating the mental health needs of the community. Upon completion of this study, the “Needs Assessment and Delivery Models to address Mental Health Needs of the Aboriginal Community of Toronto” report was issued to the agencies. Based on the conclusions in that report, a Multidisciplinary Mental Health Committee (MMHC) was initiated by the Director of AHT, Joe Hester, to develop a “strategy and service model” to adequately address the mental health and addiction issues in the urban Aboriginal community of Toronto (AHTAMHS, 2005:5).

Through an analysis of the report, frontline experience, and additional research, the MMHC recognized that Aboriginal people present with a variety of mental health issues throughout their lifecycle, most often reflecting the effects of colonization and residential schooling. As a result, clients present with issues related to alienation, isolation, marginalization, and cultural dislocation. In addition, the MMHC also reported that the Aboriginal population also suffers from a high incidence of concurrent disorders (i.e. a mental disorder and substance abuse). Through an analysis of the primary health care clinic at AHT, the MMHC documented that most of the clientele present with one or more of the following mental disorders and addictions: post-traumatic stress disorder, depression, anxiety, schizophrenia, bipolar disorder, dementia, self-harming behaviour, suicidal tendencies, family violence, unresolved grief reactions, anger issues, fetal

alcohol syndrome, HIV/AIDS related depression, dual diagnoses (i.e. bipolar disorder and down syndrome), substance abuse and problem gambling (AHTAMHS, 2005).

While AHT does provide a multidisciplinary, culture-based model of health care, the MMHC concluded that AHT did not have the resources or infrastructure in place to comprehensively address the mental health issues in the community. Until recently, AHT dealt with mental health issues in an ad hoc manner, primarily through five different resources: the Babishkhan Unit (formerly the Homeless Initiative Unit), Primary Health Care Unit, Traditional Healers and Medicine People, Traditional Counseling, Addiction Services, and Psychiatric Consultation Services. The MMHC reported that while these services offered some support for mental health, they were limited in scope and did not provide sufficient resources for the promotion and maintenance of good mental health (AHTAMHS, 2005).

Therefore, in recognition of the state of mental health and lack of comprehensive Aboriginal mental health programs in the greater Toronto area, the MMHC was asked to develop a working definition of mental health from an Aboriginal perspective and to develop a “continuum of service system that is collaborative, comprehensive and reflects the ‘circle of care’ holistic approach to service delivery and values” (AHTAMHS, 2005:5). The MMHC recommended a definition for mental health based on their research and the report submitted by Native Management Services. The definition consists of two parts and describes mental health as:

*a) “Feeling vital, full of energy, having social relationships, feeling in control over life and living conditions, being able to do things which one enjoys, having a sense of purpose in life, having a sense of connected-ness to*

*the community and generally feeling happy with one's self" (Dr. Nel Wieman as quoted in AHTAMHS, 2005:10).*

*b) "Recognize that good 'mental health' is more than the absence of illness but a state of well-being which includes appropriate housing, education, employment, childcare, food, supportive family, peer and community relationships" (Mental Health Needs Report as quoted in AHTAMHS, 2005:10).*

Based on the definition proposed by the MMHC, Aboriginal mental health is holistic in that it includes individual, cultural, and community aspects in addition to the absence of disease. Mental health within an Aboriginal context is more elaborate and inclusive of a number of factors including identity, self-esteem, livelihood, cultural values and beliefs. In contrast, Western concepts of normalcy or mental well-being are associated with acceptable behaviours and perceptions of reality within the dominant cultural milieu (Sadock and Sadock, 2007). The diagnosis of most mental disorders are based on western European cultural concepts of normality and mental well-being (Nelson and Manson, 2000). Therefore, the western biomedical perspective tends to exclude factors such as the aforementioned Aboriginal contextual factors for example, and is primarily concerned with discerning the absence of illness in relation to a concept of normality as defined by the cultural norms of western or general society.

The MMHC recommended that AHT implement an "integrated, multi-disciplinary, continuum of care, culture based Mental Health Unit" (AHTAMHS, 2005:33). The Mental Health Unit would be specifically designed for the Aboriginal population in Toronto in that one of its primary objectives is to go beyond primarily treating the symptoms of mental disorders and address the root causes of the disorder. The unit would also offer a continuum of services throughout the life cycle and integrate mental health

programs and services with traditional healing and western mental health services. The Mental Health Unit will be comprised of a three-tiered service network consisting of Primary Services, Secondary (Specialized) Services and Support Services. Within this network, the Mental Health Unit will consist of five components or processes that will include: intake process, coordinated case management, collaborative decision-making, formalized referrals process and the continuum of care.

In accordance with their mandate, the MMHC recommended that the intake and assessment process differ from mainstream approaches in that it is structured on the concept of the medicine wheel. This approach would examine four key areas of an individual's life, such as their emotional, physical, cognitive, and spiritual well-being, in addition to assessing their level of need. Information gathered from the intake and assessment process is derived from responses to questions within these four areas and provides information about the client's mental health history, mental issues presented, and a recommendation of the services best suited to address their needs. This approach would also require the client to be an active participant in that the intake and assessment process is focused on solutions and recovery while the client works with staff to identify their particular needs and construct their personal plan of mental health care. As per the recommendations of the MMHC, AHT has implemented an approach that is distinct from mainstream agencies in that they have elected to have both western and traditional approaches work as a team in the intake and assessment of the client. Executive Director Joe Hester explains the rationale behind this approach:

*“we have our traditional healers at the front end of the system, that system being intake and assessment. They are part of a team that will make those*

*kinds of decisions about how the individual will plug into the organization to access what type of care. So traditional healers are an integral part of that process... Placing traditional healers at the front end of the system is based on what we believe to be the mental health situation in our community. Based on our clinical experience and other data that we were able to bring together, the majority of the mental health issues faced by our people are manifestations resulting from the historical trauma our people went through, whether it be colonization or residential school syndrome. And then, the rest of the mental health issues are clinical in nature, such as bipolar, schizophrenia etc. So it makes sense that if most of the mental health issues are resulting from this trauma, then we need our people, in terms of traditional healers, to be more involved in terms of that initial intake and assessment. If your intake and assessment is designed on the western model then ...everybody falls into that scope of assessment, so you have everybody seeing a psychiatrist or psychologist. When we have our traditional people involved, then I think it's more of a balanced approach, they work together. So we have them working in teams to do the initial intake and assessment and deciding who they will see, it may be a traditional counselor, a psychiatrist, or they may need to see a traditional healer... we have a wide range of practitioners in terms of mental health and addictions but it's a blending of both approaches, the western and traditional, and you have to incorporate it in structural mechanisms to ensure it takes place. We had to put in those systems to ensure that it does occur and it's working great."*

Based on frontline experience and the recommendations of the MMHC, Joe explained that the approach is contingent upon having the traditional healers and western practitioners work as a team, thereby providing a more balanced, individualistic, and sensitive modality of treatment for the clientele. Through the team approach, the clientele can be assured that they will have their issues understood and diagnosed within a variety of contexts including socioculturally, sociopolitically, psychologically, and biomedically. As a result, clients may find comfort in knowing that someone on the team will understand their particular issues as it could possibly relate to the legacy of colonialism or residential schooling. Furthermore, the specific treatment which is tailored for the client may include a rather broad spectrum of modalities that address other aspects of the



clients' life that may have an impact on their mental health. Additionally, a team approach greatly reduces the risk of either system dominating the treatment, and thereby minimizes the chances of misdiagnosis and over-medication.

In addition to coordinated case management and collaborative decision making, the MMHC recommended that a referral process be implemented where clients would be either referred within AHT or externally depending on their specific needs. Clients would consent to referrals based on full disclosure of the services and treatments being offered. The MMHC also recommended that an integrated, comprehensive continuum of care be available to clients. The continuum of care would consist of several services and programs offered at AHT to provide care for clients across the lifecycle from conception to old age, with the latter including chronic and palliative care. Clients would also be encouraged to have family members and external agencies involved in their support network (AHTAMHS, 2005).

As AHT continued to implement the recommendations of the MMHC, it became necessary to expand their operations to a third location on Vaughan road. Due to a lack of space at the Queen and Gerrard Street locations, the Vaughan road location was developed to house services for the concurrent disorders program. This program is intended to supplement services to clients who are dealing with mental and substance abuse issues. Services at the Vaughan road location include: circles and support groups, mechanisms to cope with relapses, communication skills, stress management, anger management, art therapy, nutritional counseling, recreation, referrals, and multidisciplinary plans of care.

At the time of this research project, the Vaughan road location had only been operating for a few months and was still developing in-house programs and beginning to establish a list of clients. Interviews with the workers at the Vaughan road location indicated that there were a few themes beginning to develop among the clientele. The predominant substance being abused by the clientele was alcohol, followed closely by marijuana and in some instances there was multiple drug use which was primarily driven by drug availability. The workers reported that in addition to these forms of substance abuse, a high percentage of the clients were dealing with depression and anxiety related issues in addition to sexual and or physical abuse. It was also reported that men and women were equally represented among the clientele and that the majority occupied a low socioeconomic status. Other themes noted to exist among the clients were previous criminal activity, often associated with violence, and low levels of education. Based on these observations, frontline experience at the other locations and the MMHC report, the staff at Vaughan road continues to refine and develop their programs to address these issues.

### **3.2 Traditional Indigenous Healing within the context of AHT**

During my interview with the Executive Director of AHT, Joe Hester, I asked him to help me understand how traditional Indigenous healing fits within the multidisciplinary approach at AHT. As a precursor to my inquiry, I explained that I was aware of Aboriginal people using a pluralistic approach since first contact and as a result of the residual effects of colonization, the health of Indigenous groups has since suffered. In addition, Indigenous groups had their cultural beliefs and values scrutinized and

suppressed and therefore what Aboriginal people want is for their traditional healing practices to be respected. Therefore, I asked if the model at AHT could be considered “a hybrid approach to our health and well being... where we are using both aspects in harmony to provide an inclusive and holistic approach to health and well-being? Is this the development of a hybrid approach to Aboriginal health and well being?” Joe replied by saying:

*“First of all, as a broad statement, Aboriginal issues need Aboriginal solutions. Time, and time, and time again it’s been clearly demonstrated where the colonizer has always said they have the solutions... they have the answers to whatever the issue... be it social, educational, political, medical... they had the solutions and that has been an abysmal failure. We still have the highest rates of whatever you want to put out there... and whether that has bottomed out or not I don’t know, hopefully it has... and so what is the mixed bag of integration? Now, having said that Aboriginal issues need Aboriginal solutions... I don’t say that in deference to the value of other healing ways... the western model has been pressed for a long time now to open up a little bit here in terms of how we provide health care to people, generally speaking... so it’s a very territorial approach... our health, our bodies, are colonized in a certain respect, for example this is where the dentist is, this is where the chiropractor is... now I’m not stating this in a negative way... I mean you break it down in terms of specialty, and you have a division of labor with respect to that. Now a physician who is the doorkeeper to the health care system in this province and in this country has what perspective? Well, the perspective is I am the gatekeeper and I will decide no, I will not send a person to a naturopath and at one time, no I would not send them to a chiropractor. A hybrid is what by definition? Is it an improvement on one or both? When you talk about the function of a physician... like in terms of education, maybe that’s changing a bit, but you know their approach is paramount to the exclusion of a lot of other potentialities. But to include these other potentialities, it has to be on their terms... now, that’s dangerous because it says that these traditional approaches, these traditional healers, and I’ve heard it said... what is this voodoo? You know, so the system in this country and in this province, is not yet at the stage where it can accept other disciplines, or other ways of healing. And why? Well we can be cynical about it and well... it’s a stakehold, and if you want to give up some of that stakehold... look at how many billions are being spent on alternative practices of health... I mean the writing’s on the wall, this is what the people want but they don’t want to give it up because it means too much monetarily*

*and sure, they can make all kinds of arguments in terms of ethics and all these kinds of things but here you have the difference. And you know we can talk endlessly about the reasons of either camp. So whatever you have in place in terms for providing health care like we have here, it has to be accepting as much as possible of all ways of healing. If it's not acceptable to everybody involved, then something has been diminished... and that's not a good premise to work under. What do you want to call it? Are you looking for a term to capture all that... is it a hybrid? I don't know, to me it's bringing together any number of healing ways... and respecting and valuing them and making them available to the people who we're trying to help. We struggle as a people to continue to say we have to be involved in our own healing. We have to be involved in educating our people, we have to be involved in sitting on benches or providing the legal arguments for our people, we have to be part of the teachers, we have to be part of the physicians. You know, we have to be part of all these things, but we also have to be who we are. I think you can incorporate from other cultures, and still be who you are but don't get lost because you will have let go of a part of you and what that brings is something that is very valuable and that's always a possibility and you don't want that to happen. So if all of these aspects of health, whether it's a chiropractor or a traditional healer, needs to flourish within this kind of environment, and it has to be supported, and you know sometime differences is good. The problem is bringing them together to work together, to complement each other. But the word complimenting and working together wouldn't exist if we didn't have any differences. So sometimes being different is ok, because you bring in another perspective of how to deal with things... a cultural lens so to speak, but you also have to appreciate, and this is part of our culture, where we respected other people ... we shared, so that's the important part in our societies. Back then they valued those kind of things and made it part of their cultural systems... you don't want to lose that so that part of you needs to come to any integrative approach to health care delivery. So I don't think anybody who comes to that conglomerate so to speak should be giving up anything, they should be able to bring everything they have, because if you distill it into something else it loses its originality, and that's the danger to me. We need to be able to continue to evolve as these different approaches, whether it's western or whether its tradition, we both need to continue to evolve, and traditional approaches are evolving. They say we shouldn't do ceremonies in the city. We shouldn't do a sweat lodge in the city. Well, to me, that's colonized thinking. We were able to carry our spirituality wherever we went. It's not connected to a particular place on mother earth; it's connected to mother earth, so we can take our spirituality anywhere. And when we realize that, and start to do that, then we'll know total freedom, but not at the expense of anybody else. So the systems and processes and all those things we set up should encourage that flourishing of all approaches to healing... that's the greater investment, rather than say*

*well how much can you give up? I want to have practitioners to bring everything that they have, including openness to working together... to bring everything they have for the benefit of our community. So, when you start to contain that, you will have something less because then the evolution is stifled.”*

In his response to my inquiry, Joe began by mentioning that mainstream society has never been able to properly address any issues besieging Aboriginal populations, including health-related issues. According to Joe, western biomedicine constitutes a very territorial approach in that it is the dominant form of health care and the infrastructure is such that it is exclusionary to other forms of health care. Joe believes that the primary reason for the adversarial relationship between western biomedicine and other approaches is driven by capitalistic interests and the fear of losing revenue to other forms of health care and practitioners. In contrast, AHT employs an approach where other systems are valued and incorporated because to do otherwise is limiting, possibly excluding a treatment that could prove to be valuable in terms of addressing a particular Aboriginal health issue. In addition, Joe believes that any modality, regardless of origin, should retain its distinct qualities apart from other modalities so that practitioners and their health care practices are free to evolve and offer a diverse range of treatments. Therefore, in regards to considering AHT’s multidisciplinary approach a “hybrid”, Joes response suggests that the approach to health care within AHT is not considered a hybrid nor is the centre interested in developing a hybrid.

Within the CAM literature, scholars have recently developed another subsystem which has been labeled “integrative” medicine. The definition of integrative medicine is that it “refers to efforts on the part of conventional physicians to blend biomedical and

CAM therapies or the collaborative efforts between biomedical physicians and CAM practitioners to address health care needs of specific patients” (Baer, 2004:xiv). While many observers would consider the particular operational characteristics of the pluralistic approach employed by Aboriginal people to be “integrative” medicine, the semantics of the label is a misnomer in that the root term “integrate” suggests that traditional Indigenous healing and Western biomedicine have been blended or reconstituted so as to form a new medical subsystem. However, within the context of an approach to Aboriginal health care, a truly integrated approach is subject to a variety of issues making it an unlikely development at this point in time. In general, a pattern has been established in that in order for any CAM therapy to be considered either a fully legitimate or semi-legitimate form of medicine, it usually has to evolve philosophically and therapeutically to closely resemble the Western biomedical system (Baer, 2004). Therefore, the primary issues that inhibit the development of a formal integrated system are derived from the epistemological, philosophical, and pedagogical differences between the two systems (Cohen, 2003; Kirmayer et al, 2009; Letendre, 2002; Waldram et al, 2006).

The foundation of traditional Indigenous healing is the oral and cultural transmission of knowledge as it pertains to health care, and the cultural beliefs and practices utilized to maintain health and well-being. It is a system, therefore, that operates from a “traditional” cultural perspective in that the effectiveness and application of knowledge, remedies, and healing practices are met with very little skepticism, because in many instances it is believed that they originated from divine gifts from the spirits or Creator and have been empirically tested throughout history (Cohen, 2003; Letendre,

2002; Martin-Hill, 2003; Waldram et al, 2006). While Indigenous healing is a system immersed in tradition, it has always been synergistic in that it is amenable to incorporating new practices and treatments from a variety of sources, although new knowledge is often accumulated and incorporated at a cautious pace (Cohen, 2003; Cohen, 1998; Waldram et al, 2006). In addition, traditional Indigenous healing practitioners and their particular modalities, healing abilities and validity are derived from and governed by Indigenous cultural beliefs and practices. The ability to heal can be achieved or ascribed from a number of sources including inheritance from a family member, transmission from another healer, training and initiation or a spiritual calling (Cohen, 2003; Cohen, 1998).

Traditional Indigenous healers are expected to develop, maintain, and strengthen their healing abilities over their lifetime and while the knowledge base among practitioners has some universal aspects, their approach and application of healing practices are individualistic, cultural, and context-dependent (Cohen, 2003; Martin-Hill, 2003). Therefore, given the number of epistemological, pedagogical, and philosophical differences which would impede a blending of the two approaches, in addition to the sociohistorical and sociopolitical circumstances which have impacted the relationship between Western biomedicine and traditional Indigenous healing, the deliberate evolution to a more westernized approach seems highly unlikely. Additionally, Joe mentioned that “Aboriginal issues need Aboriginal solutions” in that, within the context of AHT, keeping traditional Indigenous healing practices distinct from Western biomedicine actually offers a more comprehensive approach to health care because the system is not diluted in any

way to become amalgamated with any other system, thereby actually increasing the number of potential therapeutic approaches available.

In his response Joe also mentioned how the “colonizer” or more aptly, how non-Native agencies, have made numerous unsuccessful attempts to remedy the social, political, and health care adversity plaguing Aboriginal peoples. Within the Canadian context, health research has established that the overall health of Canada’s Aboriginal peoples is consistently reported as poor in comparison with the rest of the Canadian population (Kirmayer, 2009; Waldram et al, 2006; Warry, 1998). Aboriginal critiques of Canada’s government and health authorities’ approach to the health and health care of Aboriginal people’s often emphasize the lack of availability, adequacy, accessibility, effectiveness, comprehensiveness, quality, and sensitivity. Despite research results and criticisms, agencies in charge of health care assert that they are attempting to address Aboriginal health issues by funding and participating in developing health-care strategies for the Aboriginal population (Waldram et al, 2006). However, the crux of the issue is that Aboriginal people are distinct in that they suffer from the ill effects of their historical circumstances in Canada and as a result, changes affecting the interconnectedness among the physiological, psychological, spiritual, historical, sociological, cultural, economic and environmental factors have had a significant long term impact on their health. Therefore, due to their culturally distinct health issues, the biomedical approach often does not adequately address the health needs of Aboriginal people (Kirmayer et al, 2009; Lemchuk-Favel and Jock, 2004; Martin-Hill, 2003; Waldram et al, 2006; Warry, 1998).



### 3.3 Practitioners, Patients and the Pluralistic Approach

In addition to the sociopolitical and socioeconomic historical circumstances surrounding the establishment of biomedicine as the dominant approach to health care, the development of the compartmentalized structure and subsequent lack of personalized care have instilled the notion that biomedicine and biomedical practitioners either do not understand, or do not bother to understand, the needs of Aboriginal people (Cohen, 2003). As a result, Aboriginal patients often feel that the care they receive is inadequate or misguided due to the approach of the biomedical system and its practitioners.

In the clientele interviews, I inquired about their previous personal experiences with the biomedical system outside of AHT and if they felt that their health concerns were being openly received by biomedical practitioners in a clinical setting. In the series of interviews, 5 clients made specific reference to physicians generally not understanding their particular health issues. Some of the more explicit examples include a 44 year-old female client who explained:

*“Most of the time... I know what’s usually going on... the western medicine doesn’t get it. They will never get it, as long as they think that the pills are the only thing... western medicine can only do so much... there is so much more to a human being than the physical realm”*

Another example was provided by a 42 year-old female client who explained her past experience in the following way:

*“Western doctors don’t care, they depend on science, so it doesn’t matter what you think or what you say, it’s what they see under a microscope, or test results that matter”*

Studies in the area of patient/doctor communication suggest that, in most instances, patients believe that they are not heard or understood, or do not receive an adequate

response (Hahn, 1995; Wen et al, 2007). In addition, many patients are not given the opportunity to describe their concerns in great detail. Often, physicians interrupted the patients shortly after they had begun describing their concerns assuming either the patient only has one concern or that they presented their primary concern first (Hahn, 1995). Within an Aboriginal context, cross-cultural communication can be exacerbated by language differences and culturally specific ways of communicating (O'Neil, 1989; Woolfson et al, 1995). In some instances, biomedical practitioners tended to dismiss or trivialize patient's contextual information because it was deemed irrelevant according to their perception of the illness or they did not understand the cultural relevance of the context and how it would facilitate their understanding of the problem (O'Neil, 1989).

In addition to feeling that they did not have the sociohistorical, sociopolitical, and sociocultural dimensions of their health concerns understood, some of the clientele may have had some reservations about revealing that they were using traditional Indigenous medicine and western biomedicine simultaneously. This trend was primarily reflected in the intake questionnaires as well as some of the interviews. Of the 58 that were returned from Queen Street, 83% reported that they were using traditional medicine and western biomedicine simultaneously. At the Gerrard Street centre, of the 22 that were returned, 91% reported using traditional and western medicine simultaneously. Interestingly, of the 87% that reported using both approaches at the Queen Street centre, only 55% reported that they informed their doctor of their use of both approaches while 51% reported that they informed their traditional healer. At the Gerrard Street centre, 65% reported that

they informed their doctor of their use of both approaches while 55% reported that they informed their traditional healer.

Out of 24 interviews conducted at AHT, 17 clients revealed that they were using traditional and western medicine simultaneously, 11 at the Queen Street centre and 6 at Gerrard Street. When I inquired about their physician's reaction to the disclosure of their use of traditional medicines, some clients explained that their use of traditional medicines did not apply to the context of the conversation so they never told their family doctor or they were never directly asked about using traditional medicine. In other instances, the traditional medicine being used was primarily spiritual in nature so their doctors were either supportive or offered no opinion in the form of letting the patient decide what works best for them. In other cases, the client did not have a family doctor and relied on walk-in clinics for their health care and, in these circumstances, the clients felt that in-depth conversations about health care were a rare occurrence. However, two clients explained that they have experienced some negative undertones when they disclosed their use of traditional medicines. The first example is from a 56 year-old male client who had asked his family doctor's opinion about incorporating traditional medicine to help control his diabetes and alleviate his suffering from diabetic ulcers. He explained that "they didn't recommend it", primarily because he felt that "they don't understand traditional medicine." In another instance, a 21 year-old female client who was dealing with chronic migraine headaches decided to incorporate traditional medicine in an effort to gain some relief. She explained that:

*"when I first approached my family doctor about it, it wasn't received as openly as I thought it would be, he was not with the idea of using natural*

*medicine, and I guess that's probably why I started going to a clinic... because I wouldn't get as many questions about why I'm using this other stuff when I can just prescribe you something that will take care of that."*

When I asked her to describe his reaction she replied:

*"Oh, like really... you're using that kind of stuff? ... I went to the doctor just to get a little bit more help but I felt like I was being judged for using that kind of medicine, maybe because I'm turning to a natural kind of medicine. It didn't feel right, like I said, I felt like I was being judged because I'm using my own medicine."*

While the majority of the clientele interviewed reported that they did not necessarily personally experience an overt negative reaction to their use of traditional medicines, the happenstance interaction experienced by the latter two clients serves to perpetuate the notion among the population that western biomedical practitioners do not understand nor are they supportive of Indigenous healing practices. Studies examining communication barriers in the area of patient/doctor communication about Traditional Medicine or Complementary and Alternative Medicine (TM/CAM) suggest that patients' preconceived perceptions of their physician's reaction to their use of TM/CAM were the most influencing factor in their decision to reveal their use of TM/CAM (Shelley et al, 2009). Overall, patients wanted their doctor to display an accepting and non-condemning attitude toward their personal preferences for health care. If the patient feels that their use of TM/CAM will not be understood or well-received by their doctor, then they are more likely to withhold this information or avoid the discussion altogether (Shelley et al, 2009).

Within the context of AHT, it is understood by the clientele that the staff at the centre are not only cognizant of Aboriginal cultural beliefs and values, but that

Indigenous healing practices are accepted and supported by the biomedical practitioners.

In my interview with Joe Hester, I asked if AHT's approach to hiring biomedical staff differed from other health centers given the cultural component of the centre. Joe responded by saying:

*“Ah... to some degree yes. Unfortunately, the market out there for human resources particularly in the medical, and again even more specifically towards physicians and RNEC's (Registered Nurses Extended Class), the market is highly competitive. So I guess all of us have developed different strategies on that, but generally speaking, what we try to screen in and employ are people who have at least some knowledge and hopefully experience in working with Aboriginal people, and understand Aboriginal issues. And look at and value integration, that is working together, because western medicine is a hierarchical approach, ours and terms of integration really... that's almost a conflicting kind of a structural approach to doing health care. So part of the training and orientation is for people to quickly understand what that means. First of all, our message has to be loud and clear that we value all practitioners who work here equally. Each one is different, each one brings a particular aspect of healing to our community, and that's great. Now, how can we work together is the challenge. So, we've developed models within AHT where in fact that does occur. And once they get that little bit of exposure and experience, then it's not such a big bad thing, you know threatening people's scope of practices or... we take integration to a point where it respects legal boundaries in terms of practice scopes by practitioners, we don't expect them to go beyond that and jeopardize any laws or licensing. Same as with the traditional healers, there's a different responsibility aspect when we look at the two different approaches. Again there's the legal rationale kind of structure to the western model, traditional is a little bit different. But again, no different in terms of obligation and responsibility... ours is of the spiritual nature, that is the healer must abide by the teachings, must abide by the abilities as it comes spiritually speaking. To go against that would not be good. So the responsibilities are the same, the nature of what we are responsible to is different. But we need to respect and understand that. So part of our recruitment strategy does not stop at the door, where a person signs on and is now a staff member. The recruitment strategy has to include one that we offer training, you cannot ask people to work within a cultural based organization and give them no sense of what that means. And we have to be open here where we test our own boundaries, you know we should be able to feel free to take the people who work beside us here from other nations to be able to participate and sit with us in ceremony. What fear do we have of that? And so*

*we do that. It's a valuable investment in terms of developing your staff and practitioners to work together and respect what we have here as a culture based traditional approach. So what has been termed cross cultural training is very important. And it's not only for a 3-month or 6-month period of time, it's ongoing. So if you're able to put all those things together, then hopefully you're going to have staff that will work with you. The recruitment has to be tailored, your interview acceptance process and then afterwards to invest in your staff."*

As a result of AHT's innovative approach, biomedical practitioners at the centre were noticeably at ease with practicing medicine within a multidisciplinary environment and had confidence in their ability to co-exist with traditional Indigenous healing practices. In the series of interviews with the physicians at AHT, it was determined that they not only supported traditional Indigenous healing practices, they often referred their patients to traditional healing practitioners if they felt that the biomedical approach was unable to completely address their particular issue. When I inquired as to whether they had any concerns with patients using both approaches simultaneously, they all indicated that it was not a major concern, especially if the patient was using traditional healing practices to amend spiritual or cultural identity issues. In addition, they also indicated that they have no immediate concerns regarding the use of herbal remedies, primarily because if any concerns over drug interaction arise, they are able to ascertain the information readily due to the access to traditional healers within the context of AHT. However, while the physicians did acknowledge understanding the sociohistorical, sociopolitical, and cultural factors influencing the reluctance of the traditional healers to having their herbal remedies scientifically tested, they indicated that such studies would not only help them illuminate possible interactions, but also understand the specific biological application of the remedy. Additionally, the physicians did mention some mild concerns, regarding

instances where a client is using a pluralistic approach to treat diabetes for example, that the client is taking the necessary precautions to monitor their health to ensure that they are utilizing aspects of both systems effectively. In my interview with Dr. Jeff Mills, I asked if he had any concerns with clients using both approaches and he replied:

*“I don’t have a concern about people seeing both, I guess the... there’s a couple issues, one is that I think it’s important that the patient has to appreciate the disease, has to understand the disease and has to understand where things can fit. I would have concerns if a patient isn’t taking care of themselves, isn’t eating wisely and exercising... if they’re not coming for medical follow up, like they’re not having their blood test done or they’re not seeing their eye doctor and stuff like that to get their eyes checked, so if they’re not doing the medical follow up that’s appropriate I have concerns about them if they have a condition like diabetes. So I don’t have a problem with traditional healers seeing them and talking to them about their diabetes, and counseling them about lifestyle and counseling them about exercise and even giving traditional medicines, I don’t have a concern about that ... it just important that they be adequately followed up in both realms so that we make sure that their interests are being taken care of”*

In addition to inquiring about any concerns the physicians had with clients using both approaches, I also inquired about their thoughts concerning the benefits of using various aspects of both approaches. Overall, the physicians indicated that they felt traditional Indigenous healing practices greatly improved the health and well-being of their patients, and in some instances, it provided their patients with the enhanced ability to care for themselves. In my interview with Dr. Kevin O’Connor he explained:

*“What I think about the traditional healer and the traditional ways... the real benefit is it gets people feeling more engaged in their health care, it gets people more in tune with their culture, identity, it gives them some self-esteem. A lot of the underlying reasons... be it lack of identity, lack of self-esteem, lack of connection, lack of whatever you want to call it... I mean I can’t help people with that, I can try but I can’t really help people with those underlying problems too much but the traditional healers I find get right into the cultural identity, connectedness, which is going to improve your ability to deal with addictions, any type of chronic illness... anything, just looking after*

*yourself. So I find that people who go to a traditional healer look after themselves better. I find people who access the traditional services are more mentally, spiritually, emotionally... whatever, are just healthier and able to look after themselves and take care of themselves better... so I'm a big supporter of the traditional healers in the sense of culture, connectedness, identity, and self-esteem, that type of thing. Sure, some of the treatments I have work, but if people can't take them or won't take them because they are drinking or having serious issues with traumas in their past etcetera, my ability to help them as a GP is limited, until they can get into sort of a headspace where they can look after their health."*

A study examining physician's opinions regarding their patients' use of traditional Indigenous healing practices correlates with the sentiments expressed by Dr. Mills and Dr. O'Connor. The research findings indicate that most physicians surveyed for the project generally agreed with the use of traditional medicines for health maintenance and for the treatment of benign illnesses such as coughs and colds or for palliative care (Zubek, 1994). In addition, nearly half of the physicians agreed with using traditional medicines for the treatment of chronic illnesses, such as non-insulin dependent diabetes. However, over half disagreed with traditional treatment of serious illnesses, such as those resulting in cardiac or respiratory damage (Zubek, 1994). Interestingly, research has illustrated a significant positive correlation between a physician's amenability and whether they practiced within an Aboriginal population (Waldram et al, 2006; Zubek, 1994).

In the series of interviews with the traditional healers at AHT, I asked if they had any concerns with clients using western biomedicine and traditional Indigenous healing simultaneously and if they believed the two approaches could work effectively together. All of the healers explained that they had no major concerns with the clientele using a pluralistic approach and they believed that a pluralistic approach was ideal for treating



certain types of illnesses such as diabetes. In addition, they all advocated for the client to be monitored by practitioners of both systems to ensure a safe and balanced approach. Drug interaction was not a concern among the healers and their reasoning coincided with that of the physicians in that they could readily obtain pharmaceutical knowledge within the context of AHT. However, the healers reported that caution must be exercised with clients participating in certain ceremonies such as the sweat lodge if they have an underlying condition, such as diabetes, which could result in an adverse reaction.

In my interview with healer Geraldine Standup, I asked her if she had any concern with the clients using both approaches and if she thought the two approaches complemented each other. In her response, she essentially summarized the opinions of all the healers in her answer to my question “Do you have any concerns with the clients using both approaches?”

*“No, I don’t have a problem with the approach. As a healer I really don’t care who does the healing, as long as healing happens... you know, if you’re better I don’t care who’s responsible, I’m just glad you’re better. We’re not always 100% successful, I mean, if I’ve got a bad cold and I’ve been taking Echinacea and all kinds of things and if these things aren’t helping, I’ll go see my doctor, and if I’ve been sick long enough I’ll take antibiotics. Normally I don’t touch the stuff, but if I’m at a place where I really need help and this is going to do it... it’s aggressive medicine. Most of the things we practice are preventative in nature. I don’t do surgery, so if anything needs to be dealt with surgically, I’m going to send you to your doctor because I don’t do surgery. We do what needs to be done and I send people to where it can get done”*

“So, you’re saying that these two approaches complement each other?”

*“Yes, actually they can work side by side, you know when somebody’s in a car accident they need to get to the emergency room fast. But there are other aspects that we also need, and that’s the spiritual one. There’s two levels of healing here, one is healing the spirit, healing the personality is probably a better way to say it, and the other one is curing the physical body. They are*

*really two different things. What I do is try to get in there and heal your mind. When your mind is healed, your body is healed. That's what I do. When it comes to cuts and bruises, or accidents and that kind of stuff, I will be there to support you spiritually”*

In accordance with Geraldine's comments, the majority of the clientele interviewed also reported that they believed the two systems of health care could, and do, work well together. While some of the clients expressed dissatisfaction and cynicism towards the biomedical system, all of the clientele acknowledged that the biomedical system did serve a purpose in specific areas of their health care such as emergency medicine, x-rays, surgery and treatment for chronic illnesses. Therefore, in an effort to construct a holistic approach for their health care, most of the clientele reported that they were incorporating various aspects of both systems in accordance with their particular individual needs.

### **3.4 Challenges: The Co-existence of Two Approaches**

In over 20 years of service to the community, the demand for the particular health care model provided by AHT has grown exponentially and the centre has responded accordingly by refining and implementing new programs such as the mental health unit. However, while there has been some general acceptance and support for traditional Indigenous healing among certain regulatory agencies and biomedical practitioners (Kirmayer et al, 2009; Waldram et al, 2006; Waldram, 1990; Cohen, 2003), having the two systems co-exist within a formal or structured environment poses some specific challenges (Kirmayer, et al, 2009; Letendre, 2002).

In some instances, the challenges are derived from issues concerning the validation of traditional healers and the efficacy of their treatments. Throughout the literature on the topic of utilizing traditional Indigenous healing in conjunction with Western biomedicine

to address the specific healthcare needs of the Aboriginal population, questions of efficacy and validation are primarily concerned with herbal remedies and healers. In most instances, those who work within the Western biomedical paradigm often inquire as to whether herbal remedies actually work, or they express a desire to test the concoctions to identify the active ingredients in order to dispel any concerns or doubts about their effectiveness. Aside from the substantial evidence contained within the oral traditions and histories of Aboriginal peoples, the ability to administer an accurate scientific examination of herbal medicines is stymied by the inability of scientists to comprehend and replicate the cultural context of Indigenous healing (Cohen, 2003; Cohen, 1998; Waldram et al, 2006).

As I mentioned earlier, traditional healing and the modalities of traditional healers are culturally diverse, individualistic, and context dependent (Cohen, 2003; Cohen, 1998; Martin-Hill, 2003). Therefore, there is no “standard dose” available for analysis if the remedy is customized to address the specific needs of the patient or if the ingredients and amounts vary from healer to healer. In addition, the therapeutic methodology and the results of the treatment are generally not recorded, and in some instances, cultural norms prohibit the disclosure of this information. In addition, given the unscrupulous behaviour of some pharmaceutical companies, many traditional healers have concerns that their recipes for herbal remedies will be replicated and sold for profit, which stands in direct violation of a cultural norm (Cohen, 2003; Solomon and Wane, 2005). In other instances, healers believe that revealing sacred healing knowledge will weaken the spiritual power of the medicine, thereby causing it to become ineffective (Cohen, 1998).

Perhaps most importantly, the preparation and administration of herbal remedies is often coupled with spirituality and ceremony. The removal of the spiritual component within a scientific examination may adversely affect the cultural context and thereby diminish the efficacy of the treatment (Cohen, 2003; Cohen, 1998; Waldram et al, 2006). An example of the influence of the above-mentioned factors is illustrated in the case of Russell Willier, an Alberta Cree healer who agreed to have his Indigenous herbal treatment for psoriasis scientifically tested to demonstrate its efficacy (Young et al, 1989). While some antibacterial agents were discovered, the overall results of the tests were inconclusive. Willier explained that the inconclusiveness of the tests was a result of the alien cultural circumstances in which he was required to administer his medicine, namely a western clinic with non-Native participants who were entrusted to apply the remedy of their own accord (Young et al, 1989).

In the series of interviews with the traditional healers at AHT, I asked if they would be open to the idea of scientifically testing their herbal remedies. All of the healers responded by saying no and generally stating that they didn't feel it was necessary to prove the efficacy of their medicines according to a Western biomedical standard. However, some healers explained that they would be willing to enter into a respectful, reciprocal dialogue to foster an understanding of their particular modalities.

Similar sentiments are also gleaned from the literature in that traditional healers are opposed to the scientific examination of their traditional medicines and are concerned about the co-option and loss of identity of their traditional practices should they become standardized and regulated in accordance with scientific and biomedical standards

(Cohen 1998; Solomon and Wane, 2005). However, an increasing number of traditional healers are willing to discuss their approach and abilities with biomedical practitioners as long as the western practitioners are motivated by an honest concern for improving health care and that they recognize other medical systems as being able to contribute to that cause (Cohen, 1998, Waldram et al, 2006).

Within the context of AHT, support for a pluralistic approach is exemplified in terms of treatment for chronic illnesses such as diabetes. In an effort to address the epidemic of diabetes among the population in a holistic fashion, AHT provides clients with the option to of utilizing various aspects of traditional Indigenous healing in addition to Western biomedical treatment. In an interview with Dr. Teresa Salzman, a chiroprapist at AHT, she explained that in her practice she sees a lot of diabetic patients who suffer from ulcerations that become infected and do not respond well to western biomedical topical agents. In an effort to remediate the infections, she has incorporated traditional Indigenous medicine with her biomedical approach and gives her patients the option of whether they would like to have a strictly western treatment or use traditional medicine to treat their infection. Dr. Salzman explained that “the one thing that I do use for ulcerations is plantain, the dried weed, and I find that it has worked very well. Again, there are no studies proving its use but just from the clients I’ve seen, it works very, very well.” She explained that initially she was somewhat unsure about using the plantain because she had no prior experience with it, but she had consultations with a another physician and healers at the centre who had experience with the treatment and, based on their recommendations, she decided it would benefit her patients if she incorporated it

into her practice. Dr. Salzman has worked at AHT for over 10 years and has become comfortable with her patients using both approaches and states that, in some instances, traditional Indigenous medicine is more effective than western agents.

Interestingly, in the interviews with the clientele, only one reported that he was diabetic and used a pluralistic approach to treat his diabetes. He explained that he had recently run out of the medicine and was currently in the process of trying to establish a time to see a healer and replenish his medicine. He described the remedy he received as mixture of herbs that he was instructed to make into a tea and that they helped him with circulation to his extremities and helped to maintain his blood sugar levels in conjunction with his insulin. He also reported that neither his family doctor nor the traditional healer had any major concerns about drug interactions, but that both insisted he monitor his blood sugar levels closely.

In the series of interviews with the healers, those who had the ability to work with diabetic patients explained that their particular modalities worked very well with Western biomedical treatment. They described their herbal remedies as having an effect on lowering blood sugar counts and improving circulation. In my interview with healer Jake Agoneh, I asked him to help me understand his approach to diabetic clients and how he advises them to use or balance aspects of both approaches. He replied by saying that:

*“I have a certain interest in diabetes only because both my parents are diabetic, and looking at the disease you know... it’s preventable, people need to take better care of themselves... to be better educated on issues, making better decisions to help themselves... change simple things like eating habits and try to get some more exercise and things like that. I guess my views is that diabetes comes from a change in lifestyle for our people, our people are eating too much refined foods like refined sugar, flour, and grease... and to me that contributes to that illness diabetes.*”

*There's medicines that help to bring the sugar down and help with circulation and things like that. And then if they have sores that won't heal on their legs or feet then what happens is, if their sugar's too high or whatever, then we have to give stuff to help bring the sugar down and have to give stuff to help with the sores.*

*I never tell people to stop taking their medicine like their insulin or anything like that. I tell them they need to monitor their sugar more often because the medicines make it drop and bring down the sugar, and they need to keep an eye on their sugar because you have to watch that it doesn't go to low otherwise you can have a reaction. And then just tell them to do exercise, sometimes it's the best way to keep the diabetes in check. Most important thing is to monitor their sugar levels and try to keep it as normal as possible"*

In his response, Jake made several points that are corroborated with research in the area of diabetes and Aboriginal peoples. Studies suggest that diabetes has reached epidemic proportions within Aboriginal populations in North America since the end of World War II (Garro, 1995; Gittelsohn et al, 1996; Penn-Kennedy and Barber, 1995; Rock, 2003). It has been reported that the prevalence of diabetes among Aboriginal people is at least three times higher than the national average in Canada and the United States (Milburn, 2004; Rock, 2003). A study of a Canadian northern Oji-Cree community revealed that the prevalence of diabetes in this community was five times higher than the national average, while in the United States, a study of the Pima in Arizona revealed that they had the highest prevalence of diabetes in the world (Milburn, 2004; Penn-Kennedy and Barber, 1995).

Much of the research conducted on Aboriginal conceptions of diabetes indicate that overwhelmingly, Aboriginal people believe that the high incidence of diabetes is attributed to the loss of a traditional way of life (Garro, 1995; Gittlelsohn et al, 1996; Hagey, 1984; Chesley Lang, 1989; Mihesuah, 2003; Milburn, 2004; Rock, 2003). In addition, Aboriginal peoples attribute the onset of diabetes to the loss of a traditional diet

and the encroachment of processed foods into their diet, as well as genetic and biological factors (Garro, 1995; Gittelsohn et al, 1996; Chesley Lang, 1989). Allusions to diabetes are often expressed in terms of it being a “new” illness that was not present prior to European contact or it is often embedded within a broader discourse of a “white man’s disease” along with other examples such as measles, chicken pox, tuberculosis, and cancer (Garro, 1995; Chesley Lang, 1989). In an effort to ameliorate the diabetic epidemic among Aboriginal peoples, researchers advocate decolonizing the Aboriginal diet by structuring a diet similar to a traditional pre-contact one and engaging in more physical activity, in addition to dispelling the myths surrounding the disease and developing Aboriginal-specific nutritional guides (Mihsuah, 2003; Milburn, 2004). Unfortunately, due to the previously discussed issues associated with scientific examination of traditional medicines, there are no studies illustrating the influence traditional herbal remedies have on the treatment of diabetes in relation to a pluralistic approach.

As I mentioned earlier, traditional healers are validated and legitimized through a number of Indigenous cultural beliefs and practices. Their healing abilities are either achieved or ascribed from a number of Indigenous sources such as family members, other healers, or a summons from the spirits, and while their knowledge base has some universality, each healer’s modalities are individualistic, cultural and context dependent (Cohen, 2003; Cohen, 1998; Martin-Hill, 2003). In contrast, Western biomedical practitioners have to attain a formal education, obtain a license to practice, practice in a secular fashion and adhere to the scientific method. Therefore, within the context of a



community health centre that provides access to traditional Indigenous healers, one of the most common issues that arises concerns the validity or legitimacy of the healers. In my interview with Joe Hester, I explained these issues concerning validity and legitimacy.

Joe replied that within the context of AHT:

*“That’s the area of recruitment, of traditional healers, and our approach is an integrative approach utilizing the typical processes of interviews, background checks, those kinds of things. But there’s also a traditional aspect to it. For instance, let’s say if I go to Manitoba, and there’s Oji-Cree... different tribes or First Nations, I need to know what they consider a traditional approach to go to a healer, to go to an elder. That has varied from presenting tobacco, to taking a pipe, and so you need to know that and find that out, so it’s a little bit of homework to find out what it is, and then make the appointment to meet the individual... and also to ask the right questions, and then having done that you need to check with individuals in their community or their region, with their approval of course, you’re not doing anything behind anybody’s back, and so you do that credibility check within their own region, their own community. We also use our traditional people, and ask them ‘are you aware of this individual and the work they do?’ If all of that checks out positively what we do next is that we invite the healer in for 3 days. And this is essentially an opportunity for both parties to learn about each other. So, they come in, we explain who we are and how we operate, all those things in terms of awareness of the organization, but we also want to hear from them, what do they do, how do they do things... for instance we’ll have team meetings, like staff will meet with them for that process, so they might present here, up at our other building, and then at our third building just to orient each other to the potential relationship that may be there. As part of those three days we’ll also have staff who will see the healer on a one to one basis, and then we’ll get feedback from that as well. When it involves a healer who has the ability to do certain ceremonies, what I do is that when I go to their community, I’ll ask if I can attend one of their ceremonies, either as a participant or an observer. So the three days, if everything goes well, then we’ll have the healer back for one week, and again here it’s not a commitment to go beyond that, it’s part of the process. So they’re in for one week to see clients, and of course we have a whole system set up to do that and we’ll get some feedback from there as well. The Oshkabewis is fully involved with the whole process there because they attend with the healer bringing clients in etcetera. So if all goes well there, then of course we try to look at, ok what will the relationship be on an ongoing basis? They may come in for one week a month, you know depending on their schedule and availability. So that’s the process, it’s as thorough as we can possible make*

*it. Now, nothing is ever one hundred percent, and you have to of course have policies and procedures in place and it's important when a new healer comes in we make available our policies and procedures manual for them to review so that they understand the relationship of staff to the organization. So that's a fairly involved process, and I ask the difficult questions in the initial interview. For instance and I'll give you an example, for instance our community is made up of many different segments, such as the two-spirited nation, or those who suffer from a variety of serious illnesses etcetera, and I'll ask if they have any difficulty or problems working with all of these segments of our community? If there is... then that's where it ends, because we accept our community in total whatever their views are, whatever their experiences may be, whatever, we're here for the health of our community. So if there's no problems then of course the process continues but I've had instances where some of these things were an issue and the response was that no, it's not a part of their teachings, then I said well with all respect to your teachings I'm not questioning that, however, the important aspect is working with our community in total and you wouldn't be able to serve all of them. So that's where the interview will basically end. So it's hard to ask those questions, but you have to and you have to do it in a respectful manner in terms of you make that initial tie in a traditional way either through a pipe or tobacco or other means, and that's sort of the decorum of how that whole process begins. It's not a standard interview where we're going to measure the acceptability of somebody in terms of points that kind of thing, it's our approach where we utilize those other approaches in terms of background checks that sort of thing and it has worked for us. But if something gets through your systems or processes that you set up you have to act in a decisive way and quickly because the credibility of the traditional approach in terms of our programs and services is at stake. So you have to be steadfast and deal with the issues properly and quickly as they arise."*

In his response, Joe explained that the recruitment process at AHT is quite extensive in that it involves traditional and western aspects in the interview process. By combining both of these approaches, it provides a more substantial representation of the individual being considered for the position. The western aspect provides a personality sketch of the individual somewhat independent of their cultural community status and their abilities as a healer. The traditional component provides information regarding their effectiveness and integrity as a healer. In addition, AHT has policies, procedures, and

insurance in place in an effort to ensure that the healer practices their modalities in the best interest of AHT and the clientele, as well as ensuring that the health and safety of the clientele are protected.

Despite the historically negative treatment of traditional Indigenous healing, federal and provincial governments have recognized the value of Indigenous approaches to health and well-being. In a show of support, in some instances the federal government has funded Aboriginal medical services and, under the non-insured health benefits program of Health Canada, has agreed to pay the cost of travel associated with transporting healers to communities or transporting a patient to a healer (Waldram et al, 2006). However, while the government has made some attempts to facilitate and maintain Indigenous approaches to health care in an effort to improve the current state of poor health among the Aboriginal population, provincial laws and regulations pertaining to medical practice have in some cases caused considerable confusion and angst when it comes to the legalities of practicing traditional Indigenous healing. However, practitioners at AHT fall under Ontario's Regulated Health Professions Act (1991) which exempts "Aboriginal healers providing traditional healing services to Aboriginal persons or members of an Aboriginal community" from the provisions of the act (as cited in Waldram et al, 2006: 256). Therefore, this exemption enables traditional healers to practice within the context of AHT.

Aside from the previously mentioned concerns, the operational aspects of the infrastructure at AHT are quite similar to a strictly Western community health centre. While the infusion of the particular cultural context is apparent in the centre, it is obvious

to the untrained eye that at its core, AHT is a community health centre that has a unique structure in that it houses a variety of health-related sub-disciplines. As a patient, the procedures are the same as they would be at any other community health care centre with the exception that booking appointments with the traditional healers is done through the Oshkabewis. Therefore, any culturally specific activities, such as ceremonies, are maintained and facilitated by the Oshkabewis.

Given the inherent and complex challenges of operating a multidisciplinary model within a community health centre, staff and administrators manage to maintain the internal pace of the centre despite sometimes being placed under pressure by periodic surges in the daily demand for services. In addition, a multidisciplinary model also presents unique challenges to interdisciplinary communication and the awareness of the application of their services by the clientele. In addition to the open communication and standing invitation to cultural participation philosophy at the centre, case consultations and an internal computerized filing system help to maintain the safety and protection of the clientele. For example, as part of my fieldwork experience, I was allowed to observe a case consultation involving a client who had been “red flagged” in the computer filing system for seeing a number of healers within a short time span for mental health and substance abuse issues. The consultation consisted of the Health Unit Manager, a staff physician, a traditional healer, and a clinical counselor. As a result of their collaboration on the case, it was determined that this particular client had issues with compliance and therefore additional support would be made available to the client in addition to adjusting the prescribed medication and a recommendation to see the staff psychiatrist. While this

particular example could be found within any health care institution, it does offer a glimpse into some of the challenges in operating a multidisciplinary model of health care. It also illustrates the cooperation and alertness of the internal operations of the center to maintain the safety and protection of the clientele.

### **3.5 Maintaining a Traditional Pluralistic Approach Through the Embodiment of Medical Self-Determination**

Generally speaking, while the overall health and well-being of Aboriginal peoples remains poorer than the rest of the population in Canada, there have been a number of initiatives and programs developed to improve the delivery and scope of medical services in an effort to positively impact the health of Aboriginal peoples (Kirmayer et al, 2009; Waldram et al, 2006; Warry, 2007). Programs such as cultural safety/competence training and initiatives to develop education and training of Aboriginal medical practitioners, as well as increasing the capacity among Aboriginal people to participate in health-related research, have contributed to improving the health status of Aboriginal people (Warry, 2007). However, many communities believe, as Joe Hester previously mentioned, that “Aboriginal issues need Aboriginal solutions”, or more specifically, “community development and local control of health care systems are needed” (Kirmayer et al, 2009:464; Waldram et al, 2006).

In other words, many communities want to establish self-determination in the area of health care. While Aboriginal people have maintained a sense of control of their health care by preserving various elements of their healing systems throughout history, a myriad of sociohistorical, sociopolitical, sociocultural and socioeconomic changes emanating

from European encroachment have had a devastating impact on Aboriginal health and well-being despite preservation of their healing systems. However, the resourcefulness and resilience of Aboriginal peoples and their culture has been illustrated by their ability to incorporate various aspects of other healing systems with their own to treat the multitude of maladies they have encountered pre and post contact. Aboriginal health and health care practices have always been embedded in the political interaction among various nations, especially European nations after contact. Therefore, self-determination in the area of health care can be thought of as representing a way in which Aboriginal peoples can implement positive sociopolitical change in relation to their health care and begin to decolonize their mental and physical health (Archibald, 2006; Kirmayer et al. 2009).

Self-determination in the area of health care was initiated in 1979 when the federal government issued the new Indian Health Policy and gained substantial momentum in the late 1980's when the federal government introduced the Indian Health Transfer Policy (Waldram et al, 2006; Warry, 2007). The premise of the Indian Health Transfer Policy was that First Nations groups would obtain administrative and authoritative control over health services through a series of incremental stages involving community needs research, consultation, and the development of community programs (Waldram et al, 2006; Warry, 2007). However, since its introduction and despite development over the years, the major criticism of the policy is that it is an “unhealthy health policy” in that claims for facilitating self-determination in health care are merely a veiled policy of “cost

containment” designed to maintain the current state of health services available to First Nations (Warry, 2007:154).

Despite the criticism, since it has been introduced, over 80% of eligible First Nations communities are involved in some aspect of the health transfer process (Waldram et al, 2006). Interestingly, the health transfer policy is intended to be implemented on a community-by-community basis, with speculation that regional associations of First Nations are to be included at a later date. Urban Aboriginal communities are unique in that they occupy a state of liminality, and while there is some acknowledgement of urban Aboriginal communities across Canada, they are seldom considered to be associated with a particular Aboriginal homeland because of their location within major metropolitan areas and the fact that their population consists of members from many different nations.

Therefore, within the context of the city of Toronto, AHT has recognized the sociopolitical and sociocultural disadvantages of the liminal state of the urban Aboriginal community and as a result, has developed an approach to health care that has come to embody significant aspects of self-determination in the area of health care. While AHT is recognized as a fully accredited community health centre, receives funding from all three levels of government, and is expected to operate within the parameters of federal and provincial laws and licensing, the centre has managed to develop and implement a multidisciplinary model of health care which incorporates traditional Indigenous and western biomedical aspects of health and healing practices.

In accordance with Joe Hester’s earlier statement “Aboriginal issues need Aboriginal solutions”, and in association with the failure of the western biomedical

system to adequately address Aboriginal health issues, I propose that one of the main reasons why western biomedicine has not been able to adequately remediate Aboriginal health lies in the narrow focus of its approach. While no one I interviewed for this project denied the efficacy or utility of the western approach, many of the interviewees alluded to its inability to deal with the complexity of their particular health issues. Therefore I propose that Aboriginal health issues are complex and as such, complex solutions are needed to properly address these issues. Therefore, AHT stands as a prime example of developing and implementing complex solutions designed to address complex Aboriginal health problems.

One of the primary solutions offered by AHT is the multidisciplinary, pluralistic approach to Aboriginal health care. Within this model, a collaborative approach is offered between traditional Indigenous healing and western biomedicine, however, the strength of the approach is in terms of its structure to address the specific needs of the Aboriginal population while maintaining the integrity of the systems involved. In addition to the overall approach, in most instances as individual's progress through the system, various elements can be adjusted to accommodate their particular needs thereby providing more of a personalized approach to their health care. Therefore, in order for this system to operate effectively it has to be designed and governed by effective management, administrators and staff who not only have a deep understanding of Aboriginal culture and beliefs but also understand the various aspects of the western biomedical system and how these two systems can work synergistically (Kirmayer et al, 2009).



In addition to the core elements of the health care model at AHT, the centre also conducts periodic in-house research in order to gauge patient satisfaction and needs. This research is part of an effort to go beyond merely controlling the system to designing new programs targeting specific health needs, such as mental health and addiction services and diabetic programs, as well as programs that go beyond the scope of specific health needs to promoting community health, such as programs to assist the homeless and family services programs (Warry, 2007; Warry, 1998)<sup>i</sup>. While these services are intended to augment and support AHT's holistic approach to health care, they also serve to empower the client by providing them with the means to control their health care (Waldram et al, 2006), as well as empower them with the ability to improve their personal and family life (Kirmayer et al, 2009).

While AHT is considered a community health centre, my research indicates that, among the clientele, the centre is representative of a community unto itself but as well is a political forum in which they can de-colonize their health and bodies. AHT offers reliable medical services for the clientele in the sense that the clients can be assured that they will have their particular issues understood at a sociohistorical, sociopolitical, and sociocultural level (Skye, 2006). A sense of community is established through the ceremonies and cultural educational programs which enable clients to establish or maintain their cultural identity. In addition, the sense of community is enhanced by the notion that AHT constitutes a political forum in which the clientele can de-colonize their health and bodies by re-establishing a traditional approach to their health and well-being by utilizing the holistic model at the centre.

While AHT may not be part of the health transfer process, Aboriginal control, development, and implementation of all aspects of the multidisciplinary pluralistic model of health care developed at the centre has facilitated the embodiment of self-determination within the institution. Similar to the lack of research on the impact of the health transfer policy on the overall health status of Aboriginal peoples (Waldram et al, 2006), there is also a lack of research on the impact of a pluralistic approach on the health status of urban Aboriginal people. Most of the research in the area of Aboriginal health and the use of traditional medicine and western biomedicine is unable to arrive at scientific conclusions due to the barriers I discussed earlier regarding the feelings of traditional healers having their medicines and modalities scientifically tested. However, there are a number of studies which suggest that the incorporation of traditional medicine with western forms of treatment in the areas of biomedicine and mental health enhance the benefit of both approaches (Cohen, 2003; Kirmayer et al, 2009; Letendre, 2002; Waldram et al, 2006). Unfortunately at this time there are no specific studies to substantiate the anecdotal claims of the practitioners and clientele that the model at AHT has positively impacted overall health and well-being. Again, the complexity of the model would necessitate a complex, intricate, longitudinal study of the various facets of the model in order to determine how their combined effects impact the overall health and well-being of the clientele. Such a study is rather unrealistic at this time, as it would necessitate, among other things, substantial funding and long term commitment and cooperation in multiple facets of the research from all parties involved.

As AHT will no doubt continue to evolve and refine its multidisciplinary approach, it will continue to set precedents and foster the development of the working relationship between traditional Indigenous healing and Western biomedicine. As AHT continues to embody self-determination, it will be a vital health resource for the urban Aboriginal population in Toronto and it has the potential to be a valuable resource for knowledge concerning the ongoing evolution of traditional approaches to Indigenous health.

### **3.6 Conclusions**

As a result of the sociocultural, sociopolitical and socioeconomic changes to their way of life, Aboriginal peoples have adapted and refined their Indigenous healing systems (Waldram et al, 2006). Most Indigenous healing practices survived the colonial era and there has been a resurgence of these practices among Aboriginal populations on- and off-reserve. However, research suggests that the increased use of traditional Indigenous healing practices had not led to the abandonment of the Western biomedical system (Waldram et al, 2006; Waldram, 1990). Instead, traditional Indigenous healing practices and Western biomedicine are being utilized pluralistically, either in a simultaneous or alternative fashion (Gagnon, 1989; Gregory, 1989; Stoner, 1986; Waldram et al, 2006; Waldram, 1990). The reasons for using this type of strategy are often explained as dissatisfaction with the biomedical approach and its failure to address the culturally specific health care needs of Aboriginal people, or the re-establishment of a more inclusive and holistic approach to health care (Gregory, 1989; Martin-Hill, 2003; Stoner, 1986; Waldram et al, 2006).

Within CAM literature, scholars often consider traditional Indigenous healing as an affiliate of CAM and place it under the subheading of folk medicine or ethnomedicine (Baer, 2004). However, Aboriginal peoples are ambivalent about having traditional healing practices subsumed under the label of CAM due to the colonial legacy of suppression, exploitation, misinterpretation, misrepresentation, and negative stereotyping of their culture (Cohen, 1998). Overwhelmingly, Aboriginal people are wary of having their traditional healing practices affiliated with other medical subsystems out of concern that they may be subjected to biomedical scrutiny and exploitation (Cohen, 1998; Solomon and Wane, 2005; Warry, 1998). Instead, Aboriginal people prefer to have their traditional healing practices either respectfully co-exist with, or exist independent of, Western biomedicine (Cohen, 2003; Waldram et al, 2006; Warry, 1998). As a result of Western biomedicine's secularism, scientific methodology, formal education, and the establishment of licensing and professional associations, the primary issues that inhibit the development of a formally integrated system are derived from the epistemological, philosophical, and pedagogical differences between the two systems (Cohen, 2003; Kirmayer et al, 2009; Letendre, 2002; Waldram et al, 2006).

Since the establishment of Anishnawbe Health Toronto in 1989, it has strived to maintain its primary tenet of providing access to traditional Indigenous healing within a multidisciplinary health care model to meet the demands of the urban Aboriginal population (Waldram et al, 2006; Waldram, 1990). In the past 20 years, the demand for the particular health care model provided by AHT has grown exponentially and the centre has responded by developing and implementing new programs, such as the mental health

unit. In addition, the philosophy at AHT is that the reconstitution or blending of traditional Indigenous healing with Western biomedicine is not optimal; instead, maintaining traditional Indigenous healing practices as distinct from Western biomedicine is ideal in that it provides a more comprehensive approach to health care by actually increasing the number of potential therapeutic approaches available.

Therefore, within the context of Toronto, AHT has recognized the sociopolitical and sociocultural disadvantages of the liminal state of the urban Aboriginal community and developed an approach that embodies significant aspects of self-determination in the area of health care. The model implemented at AHT is an example of the development and implementation of complex solutions designed to address complex Aboriginal health issues. Within the multidisciplinary, pluralistic model is a collaborative approach between traditional Indigenous healing and western biomedicine, and its strength is the ability to address the specific needs of the Aboriginal population while maintaining the integrity of the systems involved. Therefore, while AHT may not be part of the health transfer process, Aboriginal control, development, and implementation of all aspects of the multidisciplinary pluralistic model of health care has facilitated the embodiment of self-determination within the institution. As AHT continues to evolve and refine its multidisciplinary approach, it will continue to foster the development of the working relationship between traditional Indigenous healing and Western biomedicine and will be a valuable resource for knowledge concerning the ongoing evolution of traditional approaches to Indigenous health.

The next chapter will explore the client's beliefs and perceptions about their ability to deal with mental health issues and addictions. In addition, issues associated with Aboriginal mental health and how these issues impact and influence the dynamics of an Aboriginal specific Mental Health Unit will be examined, as well as AHT's philosophical, theoretical, and infrastructural approach to programs and services which incorporate various aspects of traditional Indigenous healing and Western Biomedicine.

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<sup>i</sup> For a complete list of services and descriptions at Anishnawbe Health Toronto see Appendix A

#### **4. Aboriginal Mental Health: Issues and a Culturally Appropriate Approach**

Through interviews and informal conversations with the clients, I was able to develop a deeper understanding of their beliefs and perceptions regarding their struggles to deal with mental health issues and addictions. I discovered that for some of the clients, they believed that their ability to deal with their mental health and or addiction problems was compounded by their Aboriginal background. In most cases, these clients had prior experiences with mainstream institutions and felt that their treatment had not worked as well as it could have because mental health practitioners became fixated on categorizing them as Aboriginal and did not know how to properly address their issues. Often this would result in issues with compliance and the eventual abandonment of therapy with the individual or institution. However, for these clients, AHT provided an ideal solution in that the centre was able to address the gaps in western approaches to their mental health and addictions needs.

My research also illustrated that if a client is oriented to traditional beliefs and values, compliance issues will also arise in relation to prescribed medication for mental problems. Clients explained that they had become frustrated with the side effects of the medications<sup>1</sup> because it made them feel disconnected from their emotions or it made them feel out of balance and unable to deal with the root causes of their problems. While this shows great insight on behalf of the client, it also illustrates how traditionally oriented clients need a program and practitioners that understand them and are able to address their concerns in a culturally appropriate manner.



This chapter will draw from the example of the Aboriginal-specific Mental Health Unit at AHT to illustrate the centre's philosophical, theoretical, and infrastructural approach to programs and services which incorporate various aspects of traditional Indigenous healing and Western Biomedicine. In addition, this chapter will examine issues associated with Aboriginal mental health problems such as over-diagnosis, over-medication, compliance, and concurrent disorders, and how these issues impact and influence the dynamics of an Aboriginal-specific Mental Health Unit.

#### **4.1 The Clientele: Mental Health**

AHT's Queen and Gerrard Street locations provide programs and services for approximately 10,000 clients. These centres are located within a four block radius of one another in the inner city area of Toronto and, according to the MMHC report, mental health and addictions issues are more prevalent in this area in comparison with the surrounding suburbs (AHTAMHS, 2005).

In total, I conducted 24 interviews with clients at AHT, 18 at Queen and 6 at Gerrard Street. While conducting the interviews, I maintained a rough running analysis of the material and noticed that an interesting trend of non-disclosure began to develop. I compared the information gathered in the interviews with the information given on the health care questionnaire and it became evident that some clients were not willing to disclose information regarding mental disorders or their treatment on the health care questionnaire. Instead, the majority of clients chose to reveal this information during the course of the interview. For instance, out of 18 interviews conducted at Queen Street, only 4 clients indicated on the questionnaire that they were being treated for a mental

disorder. Conversely, during the course of the interview, an additional 11 clients revealed that they were receiving treatment for a mental disorder. In comparison, out of 6 interviews conducted at the Gerrard Street location, no one indicated being treated for a mental disorder on the questionnaire, however, 5 of the client's revealed receiving treatment during the course of the interview. In addition, out of the grand total of 80 questionnaires returned from both centres, only 7 clients indicated that they were being treated for a mental disorder, 5 from Queen and 2 from Gerrard Street. Unfortunately, I was not able to conduct a thorough investigation to determine the reasons why clients chose not to disclose this information in the written survey. However, I was able to surmise from informal conversations that the stigma of being labelled with a mental disorder may have been one of the primary reasons for not disclosing this information on the questionnaire (Nelson and Manson, 2000; Warry, 1998; Wieman, 2009).

Out of the 24 interviews conducted at AHT, 20 clients disclosed information regarding diagnosis or treatment of a mental disorder, including schizophrenia, depression, personality disorder, bipolar, and post-traumatic stress disorder. Out of these disorders, depression had the greatest incidence with 10 clients divulging that they were receiving help to cope with their depression. Interestingly, 4 clients admitted they were receiving help with “emotional issues” which could possibly be attributed to depression based on the similarities among their reported symptoms and behaviours. These clients may have also wanted to circumvent the stigma of a mental disorder by disclosing it as “dealing with emotional issues.”

In congruence with the elevated Aboriginal representation in other aspects of poor health, studies have shown that a high percentage of Aboriginal people are dealing with mental health problems, and that depression is one of the most prevalent disorders among the population in North America (Duran and Duran, 1995; Kirmayer et al, 2009, Nelson and Manson, 2000; Waldram, 2004; Warry, 2007; Warry, 1998).

Depression is generally defined as “an emotional state marked by great sadness and apprehension, feelings of worthlessness and guilt, withdrawal from others, loss of sleep, appetite, and sexual desire, or loss of interest and pleasure in usual activities” (Davidson and Neale, 1996: 225). According to the DSM-IV-TR, in order to be clinically diagnosed as depressed, an individual must experience a depressive episode lasting at least two weeks and present with at least four symptoms including: “changes in appetite and weight, changes in sleep and activity, lack of energy, feelings of guilt, problems thinking and making decisions, and recurring thoughts of death or suicide” (Sadock and Sadock, 2007:527-528). In addition, depression often occurs concurrently with other mental disorders and medical conditions. For example, an individual with social anxiety disorder may experience depression over their inability to leave the safety of their homes or an alcoholic may become depressed due to their inability to control their drinking and the resultant disruption in their social lives and employment (Davidson and Neale, 1996; Sadock and Sadock, 2007).

In an interview for this project, I asked Dr. Cornelia Wieman, Canada’s first female Aboriginal psychiatrist, whether she believed Aboriginal people are being over-diagnosed and over-medicated. She responded by stating:

*“I think, based on my clinical experience, that it’s probably true. I mean it’s two separate issues, one is being over-medicated and one is being misdiagnosed... I think the physicians and health care providers not understanding that some of these experiences may not have anything to do with psychosis, but misinterpreting it and putting people on medications without taking the time to explore it further, like what does that mean to the person, what does it mean to the family, what does it mean in this community or in the Mohawk culture, how do I understand this?... Even with the hearing voices or seeing things, what we would do, especially if it was a young person, we would spend a lot of time with the family for example, if the person wanted us to involve the family, and just try to really make sure that, you know, how distressing is this to the person, is it making them behave in dangerous ways, does the family feel that they’re at risk, and sometimes we chose not to treat it. We would send them to the healer if that’s what they wanted to do, sometimes people didn’t want to do anything about it. But as long as it wasn’t inciting people to harm themselves or threaten to harm others or actually harm other people, we didn’t medicate them unless the person wanted us to, if they found it bothersome or if they didn’t want to see a traditional healer or have it explained to them, then we would go ahead. But it was very individually based, it’s not that I would ever say someone’s hearing voices and just because they’re Aboriginal means that it’s spiritual thing and that they don’t need help of some sort, you can’t make those blanket generalizations... I think part of the problem is it’s the way that, not just the mental health system, but the way that the health care system is set up that it’s really not geared for people spending a lot of time with people to understand that, and the visiting physicians or psychiatrists, say in the Northern or remote communities, it’s a terrible model because often times it’s not the same doctor going up so every time is a ‘new’ time and when you go into a community, and I’ve done a couple of visits to the James Bay and the South Shore Hudson’s Bay area. I mean you go in for a weekend or two days of doing clinics and everyone wants to be seen, so by the circumstances you can’t spend an hour and a half or 2 hours with just one person. So it’s like do you continue to just provide less than the standard of care or how do you fix it, how do you deliver better care to people? Because I feel that people who have access to Aboriginal health centers are getting access to really good care so it’s very inequitable across the country I think.”*

In some aspects, Dr. Wieman’s response echoes the rationale behind the teamwork approach employed at AHT in the mental health unit. As Dr. Wieman explained, there are two separate issues here: overmedication and misdiagnosis. However, in many instances these problems are the product of the biomedical system in that the

infrastructure does not allow for an in-depth understanding of a patient's background or their cultural beliefs and values (Kirmayer et al, 2009). In contrast, AHT's approach does make allowances for the required understanding through the teamwork approach, as well as not using a fee for service model in the clinic, thereby enabling physicians to spend more time with patients and develop a deeper understanding of their issues.

Interviews conducted with the health care practitioners at AHT revealed that in their opinion, based on their clinical experience, a high percentage of Aboriginal people are diagnosed with depression and they believe that in general, Aboriginal people are over-medicated and over-diagnosed with mental health disorders. When asked to speculate about the high incidence of mental health disorders and over-medication, Dr. Kevin O'Connor, offered his theory regarding this phenomenon:

*“First of all, on the psychiatric diagnoses, I have a slightly contrary view, but I'm not sure there's lots of people who think like this as well for Native and non-Native people, that basically those diagnoses have a lot more to do with the medical culture of today than anything that's going on with them. I mean, bipolar is a popular diagnosis these days, and the treatments are the exact same thing. I think probably 75 percent of the population who are on psychiatric medicines do not need them, have never needed them, and do not have a real diagnosis as far as any type of chemical imbalance in their brain... sure there is schizophrenia, and that's sort of one percent of the population throughout the world, all cultures. Certainly major depression is a serious medical problem and some people do need medicines for that, but I think we're way over prescribed on the medicines... Number two, all the side effects, the dependence on the medicines, so on and so forth are a major issue and a detriment to people. I think a lot of First Nations people have had some serious traumas going on there when they were younger you know, cultural community, complete disconnect, personal abuse, residential school, what their parents may have learned at residential school, all those things, I mean in a lot of communities basically everyone is a victim of abuse in some form. And I don't think that, for the majority of people, medicine is the way to go for that... some yes, some no, I mean it's all very individualistic, I don't believe the majority of people need psychiatric medicines who are on them and certainly I think Native people get over-prescribed because they have anxiety,*

*or just a different way of interacting depending on how, you know, where they grew up and so on. Perhaps they're more reserved, and self-esteem issues, all sorts of things that are more long term community healing issues versus some psychiatric medicine... it's easy for doctors to just write a prescription.... it's easier for the doctor to listen for a little bit, write a prescription, give them a diagnosis, and none of these diagnoses... or very few of them are set in stone. Schizophrenia yes, you would hope if someone gets diagnosed with that, they would have that. So bottom line is Native people end up on a lot of psychiatric medicines, even more than the general population, who also get a lot more medicine than they need... so, bottom line is for the 'psychiatric illness,' I think traditional healers and traditional counselors are much more to the benefit of Aboriginal people who have 'psychiatric illness' than let's say a non- specialist or even a specialist doctor who's more into the pharmaceutical side of things 'cause, I think... it's starting to come out in the last year, the negative publication bias or whatever, the anti-depressants are way over sold in what they can do, I think that most Native people who have some social issues or some symptoms of anxiety, or depression, or dealing with traumas of the past... would be much better served going that route instead of just getting pills. I think there's no doubt about it. Because a lot of doctors aren't in touch with history, or what it's like to be an Aboriginal person, different traumas etcetera, so if there's absolutely no understanding on that front then, I mean you just sort of jump to a diagnosis and get a pill out there. Of course you going to have some people with real chemical imbalance and psychiatric issues and their meds are going to be very helpful but I think they're the minority.”*

The response provided by Dr. O'Connor is very enlightening and insightful in that he believes, in general, people are misdiagnosed and overmedicated and that current trends in medical treatment, which are often profit driven, are prime culprits. In regards to Aboriginal people, this trend becomes especially problematic in that cultural differences, in conjunction with sociopolitical and sociohistorical circumstances, may further encourage and accelerate misdiagnosis which in turn leads to unnecessary medical treatment or management. Correspondingly, Dr. O'Connor believes that, in general, biomedical practitioners lack knowledge of the sociocultural, sociopolitical, and sociohistorical factors which have contributed to the current poor health status of

Aboriginal peoples in Canada and as a result, the ease with which they prescribe psychiatric medicines only perpetuates the problem. Therefore, Dr. O'Connor believes that traditional healers and traditional counselors are better suited to address some aspects of Aboriginal mental health issues because they have the inherent advantage of originating from within the culture and can offer insight that cannot be gained elsewhere.

When the psychiatrist at AHT, Dr. Lawrence was asked about his opinion on the high incidence of mental health disorders and over-medication he explained:

*“...all of these things are massively over-diagnosed and over-medicated, 9 out of 10 people I meet... new clients with bipolar, it's completely bullshit, they don't have it. So, there's something going on here, something really fishy with the way diagnoses are thrown around and the drugs are thrown out like candies to people, so 9 out of 10 people I see, I'm trying to get them off medication. And I think people go into a doctor's office and they're told this after a few minutes... I mean, it's been shown that it takes 3 minutes for a doctor to write a prescription from the time a person walks in... like a prescription for anti-depressants, and then people are on these for years and years and nothing is done. So it's a scandal.”*

Dr. Lawrence's response closely coincides with that of Dr. Wieman and Dr. O'Connor in that he also believes that current trends in medicine are driven by profits combined with the infrastructure of the biomedical system which impedes developing an in depth understanding of a patients' background or their cultural beliefs and values. Therefore, prescriptions are handed out hastily and patients are on unnecessary drug regimens for a substantial length of time.

In addition to having a high rate of depression, many of the clients I interviewed corroborated the views of Dr. O'Connor and Dr. Lawrence in that they felt the anti-depressant medication was a hindrance to addressing their issues associated with depression due to the emotionally suppressive side effects of the medication. In some

instances, the clients elected to either reduce or cease using anti-depressants and experienced adverse withdrawal symptoms further exacerbating their desire to find an alternative method to dealing with their depression.

This was exemplified in the case of a 38 year-old female<sup>ii</sup> client who reported that she suffered from recurring bouts of depression and was eventually put on various anti-depressants. She explained that she had a “horrible” experience with the drugs and, under the supervision of her doctor, she was eventually weaned off the medication. She stated that:

*“ I went on anti-depressants and... I think it made things worse in a way. I felt like I was falling all the time and... it was horrible, everything was bright and everything was really amplified... so I got off of that one (Celexa) and then I went on Effexor... it was an absolutely horrible experience getting off of it, I had shakes, I had sweats, I had violent rages, it was just these really horrible feelings... everything physically too, like headaches and everything was shaky, it was not fun...there were times like if I had forgotten to take a pill, it was like being hung over it was like you're shaking and you're sweating ... and you don't feel like anybody's going to understand you and you feel nuts, like you really feel like I am going to freak out on somebody, I'm going to scream, I was having violent urges, like I wanna punch somebody, I wanna, you know, hit somebody, and I would sit back and go that's not right, it's not healthy. So I never want to do that again...”*

For this particular client, the side effects of the drugs were unbearable and if she missed a dose, the withdrawal symptoms made her feel like she was losing control. In response she decided that the risks far outweighed the benefits and she took measures to come off of the medication.

Another illustration is that of a 52 year-old female client who had been diagnosed with bipolar disorder and over the years had been prescribed Diazepam and Paxil. She explained that the medication made her feel like she was not fully able to deal with her



mental issues, though she does admit that the medication enables her to function because it suppresses her tendency for extreme behaviour. Under her doctor's supervision, she has been able to reduce her medication and be more proactive in dealing with her issues. She explained how she felt when she was on a higher dose:

*“I never wanted to be on pharmaceuticals because there was an instinct inside of me that says, you're messing with chemistry. First of all, that will affect me spiritually, that's what I believe, I could be wrong, the other thing is that what those chemicals do... for me they are like band aids, they give the illusion that they're solving the problem, but what they do is that they may deal with the symptoms but then they create a whole host of other problems... I didn't feel like I was... how do I explain it... it was like I was there but I wasn't there, I felt very disconnected, like it wasn't me, I couldn't feel me...”*

In this particular client's case, her dose was too high and this impeded her ability to proactively deal with her issues. A subsequent adjustment to a lower dose allowed her to reconnect with her emotions while curbing her tendency for extreme behaviour.

A 42 year-old female client who has been dealing with a variety of traumatic experiences and addictions had been prescribed the anti-depressant Paxil a few years ago and did not like the suppression of her emotions. The loss of emotional control frightened her so much that she quit using the medication after 2 months and has not used it since.

She explains her experience:

*“I tried Paxil and I felt like a freak and it was making me numb... I don't know... 'cause for me, I don't learn unless I feel, and even crying is cleansing, it cleanses my soul. So with Paxil I was numb, I would have no emotion, and I don't like that, because either I'm angry or I'm sad, and I wasn't feeling any of that and that's frightening, I didn't like it because I am in control over me, so I felt like the pills had control over me... anything that alters my mind I don't want...I quit cold turkey and I did have withdrawals... physical and emotional, you know what it was, it was like my best friend died. That's sick for a pill to mess with my body like that, I had cramps, diarrhea... it didn't allow me to be affectionate, I was cold, that wasn't healthy at all”*

In this particular case, the lack of a range of emotions was particularly distressing for the client because it created an inner turmoil that she felt only added to her problems. The client stressed that she wanted to feel connected to her emotions so that she could feel a greater sense of control.

In the case of a 44 year-old female client who has been dealing with manic depressive disorder for over 20 years, it was the physical side effects that caused her the most concern. She made the decision to get off the medication fearing that her body could not withstand the effects for the rest of her life:

*“... I have been off the medication for eight years. I was taking medication for depression, but I decided to go off it because my hair was falling out, and there was a lot of different side effects... The drug I was taking was called Epival, and it was a major drug. I mean, I always found myself dried out, and some of the symptoms would be more like dehydration, I couldn't sleep properly, I needed medication to help me go to the bathroom because it would dry you out, and my hair kept falling out so... the doctor told me I needed it for the rest of my life, and I didn't believe that, I just went off it cold turkey, and I seem to function pretty good. If I take care of myself I find I'm not really depressed or anything... you know I'll have my sad days and stuff, but nothing I think that needs chemical drugs to bring me up you know...”*

In this case, the client was concerned about the longterm effects on her health and out of concern that her body could not withstand further trauma from the pills, she elected to stop using the medication. However, her case does raise some question about the validity of her original diagnosis and subsequent prescribed treatment in that she has been able to remain off of the medication for a substantial period of time and has been able to cope without medication.

A 31 year-old male client also dealing with depression has been on the anti-depressant Celexa for approximately 1 ½ years and explained that he takes the

medication intermittently to restore his emotional balance. He uses this strategy because he wants to address the root cause of his depression and believes the pills will only impede his progress:

*“I just went in and said I need something to bring me back up to where I need to be so I can function. I just went to my doctor, and he’s known me for awhile, and he said well, we’ll try this out and see how it works, and so far so good... For a long time I wouldn’t have anything to do with any kind of pills or anything like that... mind you, I’m not relying on them, it’s just to get the out-of-balance feelings back into balance, but then from there, I’ve got to get rid of the root cause of the problem because the way I look at it, all those pills do is that they just deal with the symptom and not the cause... the only weird thing that happens is when I stop taking them, for about a week or so, I go through a withdrawal... kind of like this weird feeling of... dizziness sometimes, like standing in a room with the entire room spinning, kind of like that but that goes away in about a week”*

While the primary concern for this client is his tendency to take his medication intermittently, which is not recommended, his concerns coincide with the previous examples in that he wants to be able to address the root cause of his problems and he feels that the medication is not conducive to this process. Interestingly, he explained his inner turmoil from an Aboriginal context in that he felt that his feelings were out of balance and while the pills help him regain a sense of balance he needs to address the real cause in order to achieve a true sense of balance and inner peace.

All of the examples provided by the clients coincide with research about the side effects of anti-depressants. Aside from Diazepam, which is a sedative, and the mood stabilizer Epival, all of the prescribed drugs mentioned by the clients are known as Selective Serotonin Reuptake Inhibitors (SSRI’s). Serotonin is involved in regulating mood and SSRI’s restrict the reuptake of serotonin which has been shown to be successful in the treatment of depression as well as obsessive-compulsive disorder and

panic disorder (Brands, Sproule and Marshman, 1998; Davison and Neale, 1996; Sadock and Sadock, 2007).

While these drugs are widely prescribed, their efficacy is contingent upon genetic and environmental factors that may influence an individual's response to and tolerance of the drugs. Thus, a drug that can dramatically improve the symptoms of a disorder in some individuals may not be effective for other patients with the same disorder. Genetic research in the area of patients' response to drugs and their side effects is attempting to identify characteristics which will increase the ability of physicians in the future to accurately match patients with drugs (Sadock and Sadock, 2007). Documented side effects of SSRI's include: nausea, diarrhea, constipation, insomnia, drowsiness, headache, nervousness, irritability, tremor, dizziness, dry mouth, sweating and weight gain (Brands, Sproule and Marshman, 1998; Davison and Neale, 1996; Sadock and Sadock, 2007). Side effects associated with SSRI's vary in onset and duration. Some side effects will occur at the beginning of treatment and diminish over time while others appear later in the course of treatment. In some instances, the later side effects will be opposite to side effects presented earlier in the treatment for example, weight loss during early treatment versus weight gain later in treatment. In other cases patients may experience irritability in the initial stage of treatment and over time this will progress to chronic fatigue or apathy. (Sadock and Sadock, 2007).

Another side effect described by the clients is associated with SSRI's and is termed "emotional blunting" (Sadock and Sadock, 2007:1088). Emotional blunting is described as the inability to have the appropriate response to an emotional situation or a restriction

of intense emotions. Patients often report not being able to cry or are indifferent in highly emotional situations. This particular side effect is most often associated with patients' discontinuing treatment, especially when the SSRI's have been prescribed for anxiety and depression (Sadock and Sadock, 2007). Abrupt discontinuation of SSRI's often results in the onset of withdrawal. Symptoms of withdrawal include: dizziness, weakness, nausea, headache, rebound depression, anxiety, insomnia, poor concentration, upper respiratory symptoms, paresthesia, and migraine headaches. In most cases, withdrawal symptoms will dissipate in roughly 3 weeks (Sadock and Sadock, 2007).

The examples from the clients also illustrate issues with “compliance”, which refers to the degree to which a patient follows the recommended treatment by their physician (Sadock and Sadock, 2007). Compliance is developed through a positive doctor/patient relationship and a patient's non-compliance by refusing to take the prescribed medication is often a signal to the physician that the patient is dissatisfied with the current approach. This is a phenomenon that needs to be investigated further (Sadock and Sadock, 2007).

Unfortunately, there is very little research examining issues of compliance within specific ethnic groups. While there have been a growing number of studies on the general population, there have been very few studies examining antidepressant medication use among Aboriginal people in North America and even fewer examining specific Aboriginal populations (Hodgkin et al, 2008; Ruiz, 1998; Wardman and Khan, 2004). In recognition of the absence of specific studies, Wardman and Khan (2004) investigated the use of anti-depressant medication among First Nations people living in British Columbia. Based on information gathered from the Non-Insured Health Benefits

pharmacy database which registers all prescription medication claims for registered status First Nation people living in British Columbia, the study highlighted certain trends among the population.

Based on information for the year 2001, the researchers found that the most frequently prescribed anti-depressant medications were Paxil, Apo-Amitriptyline, Effexor, and Celexa (Wardman and Khan, 2004). The average age of the claimants was 40.3 years and the majority of prescriptions were filled for women with the ratio of 3:1 for females versus males. While the research was limited to the prevalence of anti-depressant use among the population, it does illustrate some key themes that have been reflected in this research project as well. First the researchers believe that the high prevalence of anti-depressant use among this population may be a result of the over-diagnosis of disorders treated with anti-depressant medications. Second, remote communities often lack mental health resources thereby forcing patients to seek help from a primary health care clinic. Therefore, under the duress of time constraints and an obligation to offer some form of help, physicians may be over-prescribing medication and thereby increasing the rate of anti-depressant use among the population (Wardman and Khan, 2004). Overall, what this study clearly illustrates is that more research is needed in the area of mental health disorder diagnosis and drug treatment among Aboriginal peoples.

Throughout the interviews for this project, the issue of non-compliance with regard to anti-depressant medication was prevalent among the clients. Research into this area has highlighted several themes in relation to non-compliance and the use of anti-

depressant medication. Through a survey of published literature on MEDLINE and other search engines, Masand (2003) found that, despite the use of anti-depressant medication, 80% of patients experience a relapse, 40 to 60% of treatment fails, 20% of patients receive inadequate care, 28% of patients discontinue their anti-depressant medication within the first month and 44% discontinue within 3 months.

The American Psychiatric Association recommends that treatment for depression progress from an intense initial stage of therapy for 6 to 8 weeks to alleviate the symptoms followed by 4 to 9 months of maintenance therapy. However, few patients ever complete the recommended course of treatment with the majority experiencing a recurrence of depression (Masand, 2003). In studies examining the reasons for non-compliance in relation to anti-depressant medication, most patients discontinued their medication because of adverse side effects, primarily nausea, and not for issues concerning efficacy. The results of these studies suggest that the majority of reasons for non-compliance can be grouped into 3 categories: physician-specific issues, patient-specific issues and medication-specific issues (Masand, 2003).

Physician-specific issues include educating patients about the time frame of when they can expect the medication to take effect, informing patients of the side effects that they may experience with their particular medication, and that over time the initial side effects will wane, making it easier to take the medication. Patient-specific issues include poor motivation due to feelings of hopelessness as a result of their depression, feelings of being stigmatized, a dislike of medication, lack of social support, lack of symptom relief due to delayed onset of medication, adverse side effects, and discontinuation of

medication due to an absence of symptoms. Medication-specific issues include adverse side effects, complex dosing regimens, delayed onset of medication, and subtherapeutic dosing in an effort to alleviate adverse side effects (Masand, 2003). As a result of this study, an approach that would increase the likelihood of patient compliance would encompass an adequate timeline for treatment, educating the patient in regards to realistic treatment expectations, and administering the proper dose of medication in order to alleviate symptoms while minimizing adverse side effects and preventing recurrent depression (Masand, 2003).

In addition, the rate of compliance may improve if treatment with anti-depressant medication is combined with psychotherapy and or counseling (Hodgkin et al, 2008). The success of a combined approach is contingent on the therapist's acknowledgement that culture plays a pivotal role in the conception of mental disorders, the manifestation of depressive symptoms, compliance with treatment and the need to integrate western health care services with cultural beliefs and practices (Ruiz, 1998). Respecting and acknowledging cultural beliefs and practices will enhance the doctor-patient relationship and increase the therapeutic benefits of the medication and psychotherapy (Ruiz, 1998).

#### **4.2 Concurrent Disorders**

According to the MMHC's report, a high percentage of the clientele present with concurrent disorders (e.g., a mental disorder and substance abuse). My research corroborated this finding in that out of 24 interviews with the clients, 14 reported that they were recovering from alcohol or drug addiction. An analysis of the interview data revealed that alcohol was the predominant substance being abused by the clients with 12



reporting issues with alcoholism. Other reported substance abuse included 3 clients using marijuana, 2 addicted to crack, 3 who abused cocaine, 2 who abused OxyContin and 2 who abused Percocet, 1 reported sniffing solvents and 3 clients preferred to generally state that they abused “drugs.”

It also became apparent that, once again, clients seemed to be reluctant to disclose information regarding their concurrent disorder on the health care questionnaire. Based on inferred reasoning from the interviews and informal conversations with clients, I was able to surmise that the stigma of being labeled a “drunken Indian” was the prime motivator behind their sense of shame. In addition to being labeled, the sense of shame also coincided with their length of recovery from their addictions. Information from the interviews with clients illustrated that those who had been clean and sober for a short period of time were more reluctant to talk about their experiences with addictions as opposed to those who had a lengthier period of sobriety.

According to the psychiatric literature, individuals diagnosed with depression and bipolar disorder are more likely to suffer from a concurrent or comorbid disorder (Sadock and Sadock, 2007). The most prevalent disorders are alcohol and substance abuse, panic disorder, obsessive-compulsive disorder, and social anxiety disorder. In general, men are more likely to abuse alcohol and drugs whereas women most often suffer from anxiety and eating disorders. Concurrent or comorbid disorders, especially substance abuse and anxiety, exacerbate the progression of the illness and also elevate the risk of suicide (Sadock and Sadock, 2007).

The “Needs Assessment and Delivery Models to address Mental Health Needs of the Aboriginal Community of Toronto” report used by the MMHC stated that Aboriginal service providers in the Toronto area reported that the level of concurrent disorders in the population were estimated to be between 75 to 90% (AHTAMHS, 2005). All of the mental health service providers interviewed for this project corroborated the findings of the report and speculated that alcohol was the primary substance being abused by their clientele.

#### **4.3 Discussion and Conclusions**

The interviews and informal conversations with the clientele proved to be very enlightening and led to a deeper understanding of their struggles to deal with mental health issues and addictions. Some clients believed that their ability to deal with their mental health or addiction issues was compounded by their Aboriginal background and mainstream Aboriginal stereotypes, such as the “drunken” or “crazy” Indian. Prior experiences with mainstream institutions left them with the opinion that mental health practitioners overemphasized their Aboriginality, resulting in a failure to adequately address their issues. In turn, clients developed issues with compliance and often abandoned therapy. Clients oriented to a traditional lifestyle also had compliance issues because the side effects of the medication made them feel emotionally disconnected or out of balance and thereby unable to deal with the root causes of their problems.

Data gathered from the interviews with the healthcare providers and clientele corroborated the findings of research in the area of Aboriginal mental health and the MMHC report, namely that there is a high incidence of depression and concurrent

disorders like substance abuse, with alcohol and drug being the primary substances being abused. Health care providers reported that they felt that Aboriginal people tend to be over-diagnosed and over-medicated due to inadequacies in the health care system and the reliance on medications to alleviate the problem. Research suggests that patient compliance increases if treatment with medication is combined with psychotherapy and or counseling (Hodgkin et al, 2008). However, the success of a combined approach hinges on the therapist's knowledge that culture plays a pivotal role in the conception of mental disorders, the manifestation of depressive symptoms, and compliance with treatment and the need to integrate western health care services with cultural beliefs and practices (Kirmayer et al, 2009; Ruiz, 1998). Acknowledgement and respect of cultural beliefs and practices is believed to enhance the therapeutic relationship and yield a positive response to the medication and psychotherapy (Ruiz, 1998). Therefore, for the clients, AHT provides an ideal approach to address their concerns in that the centre is able to address the gaps in western approaches to their mental health and addictions needs by providing culturally appropriate therapeutic tools in coordination with culturally knowledgeable practitioners (Kirmayer et al, 2009) .The culturally specific, combined approach, as well as the traditional beliefs and values involved as employed by practitioners at AHT, will be examined in the next chapter.

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<sup>i</sup> For the majority of research participants that had such issues with their medications, their regimen was issued prior to utilizing the particular approach at AHT. However, in some instances due to the particular nature of their illness, it was decided that it was in their best interest to maintain their regimen while in other instances the dose was adjusted.

<sup>ii</sup> Overwhelmingly, more female clients participated in my research than male. A similar trend was noted in my previous research experience at the centre in that while I observed a greater ratio of men to women, fewer men were willing to participate. Unfortunately the time constraints on this project did not allow for an in-depth investigation into this phenomenon but informal conversations about it with the staff yielded a few interpretations, including the possibility that males may require more time than women to feel comfortable and openly discuss personal issues associated with their health.

## **5 Ceremony and Spirituality: Healing the Spirit, Mind, and Emotions**

In addition to traditional Indigenous medicine and herbal remedies, participation in ceremonies and spirituality is often considered an integral aspect for health, healing and well-being. The purpose of this chapter is to provide an understanding of the clients' rationale for participating in ceremonies and the benefits they received as a result. Based on information gathered in one-to-one interviews at Anishnawbe Health Toronto, the four most popular ceremonies among the clientele are smudging, sweat lodge, shake tent and yuwipi. The purpose and structure of each ceremony will be examined as well as the therapeutic value as reported by the clients and relevant literature. In addition, information gathered from interviews with the traditional healers and health care practitioners as to their opinions and insights regarding the risks and therapeutic value of traditional ceremonies will be presented.

### **5.1 Smudging: Sacred Smoke**

Within the literature it is nearly impossible to find a comprehensive definition of smudging, and most authors often allude to the ritual and flora as a part of Native spirituality associated with prayer rituals or as a purifying precursor to ceremonies and social gatherings (Brass, 2009; Bucko, 1998; Cajete, 2000; Grinnell, 1919; Kemnitzer, 1976; Letendre, 2002; Morse, Young & Swartz, 1991; Proulx, 2003; Stiffarm, 1998). However, a general albeit inclusive definition, proposed by Cohen reads: "Smudging means using the smoke and scent of a smoldering aromatic plant to purify a space of toxic energy, feelings, thoughts, or spirits and to create a fragrant atmosphere that attracts healing and helping powers" (2003:124). The three plants most commonly used for

smudging are sweetgrass, sage, and cedar, with the latter two often used to cleanse a person or space of malignant destructive spiritual forces (Cohen, 2003; Stiffarm, 1998).

Sage is often used to maintain good health and the variety of sage most commonly used by Native peoples for the purpose of smudging are of the *Artemisia* genus (fringed sagebrush, silver sage, and big sagebrush) and not the *Salvia* genus or domesticated garden sages (Cohen, 2003). In addition to using the smoke, some Nations will also rub their bodies with the leaves for purification (Stiffarm, 1998), and in some instances, they will use it to wrap sacred objects because it protects and purifies the object. Other uses of sage include making a tea with it to treat fevers, headaches, arthritis, diarrhea, indigestion, irregular menstruation, menstrual pain relief, alleviate symptoms of menopause, sore throats and colds (Cohen, 2003; Shimer, 2004).

Cedar is used to cleanse the body internally from disease and externally from negative energy. Unlike the aforementioned distinction with the varieties of sage, it seems that many varieties of cedar and juniper are used for ceremonial purposes depending on which species is indigenous to a Nation's homeland. Akin to sage, cedar can also be used to keep ceremonial objects safe, made into a tea for treating coughs, colds, tuberculosis or cholera, and as a mouthwash (Cohen, 2003).

Sweetgrass, otherwise known by its botanical name *Hierochloa odorata*, is a tall green wild grass with a red base and is known for a vanilla, sweet smelling hay-like musty odor. The plant is indigenous to Montana, Alberta, and some areas of South Dakota. Sweetgrass is primarily used to attract positive spiritual forces and is often woven together into three braids symbolically representing the hair of Mother Earth

(Cohen, 2003). In some instances, the significance of the three braids is explained as representing the unity among mind, body and spirit (Waldram, 1997). Sweetgrass may also be considered a conduit for communicating with the Creator and the smoke is used to purify an individual or ceremonial object (Waldram, 1997). In addition, it was made into a tea and used to treat sore throats, coughs, sexually transmitted diseases, and women used it to control bleeding after childbirth. Sweetgrass has also been used as a hair wash and made into baskets and clothing (Cohen, 2003).

## **5.2 The Smudging Ceremony**

While the concept of purification by means of smudging is ubiquitous in many Native cultures, the methods by which it is done may vary in and among Nations. Generally speaking, the primary concept of the ceremony is to distribute the smoke from the smudge over your body. Using a match<sup>i</sup> or a lighter, you ignite the smudge mix in a bowl<sup>ii</sup> or the end of a braid of sweet grass. Once thoroughly ignited, you can either gently blow out the flame<sup>iii</sup> or you can wait a few moments and the flame should die out and smolder. You lace your hands in the smoke for a few moments, then cup your hands in the smoke and move it over and behind your head, down your body, arms and legs<sup>iv</sup> (Cohen, 2003). In the event that more than one person is smudging, an individual may move the smudge from person to person and distribute the smoke over each person using a feather or a feather fan (Cohen, 2003; Morse, Young & Swartz, 1991).

Smudging is also used to purify a space or a home. Generally speaking, the concept remains the same in that the intent is to dissipate negative energy; however, the progression throughout the house is variable depending on the context of the ceremony

and individual preference. For example, some people believe that it is necessary to open a window during the ceremony to allow the negativity to escape (Cohen, 2003) while others do not adhere to this practice. In other instances, the belief is that the rooms or space are to be smudged in a certain order or direction, while others feel that the most important aspect is to be certain that the smoke is distributed in all areas of the space or home. Thus, personal preference and cultural variation will determine the execution of the ritual, though the purpose of the ceremony remains the same.

### **5.3 Traditional Healers: Smudging and its Purpose**

In a series of interviews with the Traditional healers at Anishnawbe Health Toronto, I provided them with a synopsis of themes regarding clients' desire to reduce or cease using western medications for their mental health due to adverse side effects. I explained that in many instances the clients informed me that they were using smudging for their mental health needs, thereby enabling them to address issues with the side effects of the medications. I asked the healers about the specific purposes of smudging and what it does for the clients. I also inquired about the applications of different types of smudges.

When I asked his opinion about the differences between sweetgrass and sage, Traditional healer Jake Agoneh stated:

*“Well, sweetgrass... it's love, kindness, and caring. It comes from the earth and is part of mother earth's hair and that is why they braid it. It calms you down when you smell it whereas sage is more medicinal, it helps you more than smudging... it's like different powers of the earth, to me a lot of these medicines that we use, we offer tobacco and pick those medicines so we're asking the spirit of those medicines to help us, each one has its own spirit”*



In his response to this question, Jake refers to the specific qualities of each plant and their individuality as a healing entity. Sage is often regarded as being more powerful than sweetgrass in its ability to promote good health and disperse negative malignant spiritual forces (Cohen, 2003). For example, it is common for people to burn sage first to expel negative energy and then follow this up by burning sweetgrass to attract positive spiritual forces (Bucko, 1998). This example illustrates what Jake meant when he said that sage is more medicinal and each plant has its own spirit. While there is some overlap in their uses and applications, each has their own particular strengths depending on the ceremonial context. Therefore, one may be favored over the other depending on one's needs at a particular time (Stiffarm, 1998).

During an interview with Traditional healer Wendy Hill, I asked her to explain what she feels smudging does for a client. She explained it as:

*“ the smudge and the sage in particular, what I know of it anyways, is that it's a medicine and the smoke of that medicine... it's job is to clear away any negative energy and so when you prepare your smudge and when you put it into your hand there's an energy that goes into it, and that energy is... 'help me, I'm not feeling good' ... and this is your thinking. So when you light it, the smoke is the medicine and when you take it into your personal space, you're sending away all that negative energy. And so you take it around your head because your head is the most important part to you, to a certain degree, because that's what generates the energy. And the next part is your spirit and your emotions, and so you take it in and clear it off... it's almost like, if you had a bunch of snakes wrapped around you, and they're squeezing off your energy, your good energy to move around. That's what negative energy does. It takes away your physical energy, when you don't have physical energy you don't feel like doing anything. You can't play, you can't work, you can't do stuff, so when you use that smudge and you clear yourself, what you're doing is freeing up your spirit to come in and give you energy and your spirit helps you to feel happy, it helps you to feel at peace, it helps you to feel calm, confident, like there's a lot of benefits to having a strong spirit. A lot of people and families don't know how to take care of their spirit, or the benefits of having a strong spirit, and so that's what they're doing*

*when they're smudging, they're taking care of that and they're clearing off any of this negative energy that holds you down. And when you smudge your home, you do the same thing, if there's any negative energy in that home you send it out"*

Wendy expresses similar sentiments to Jake in acknowledging sage as particularly efficacious in removing negative energy. Wendy also mentions the widely held belief that it is important to communicate your desire or intent either verbally or mentally while you prepare a smudge mix or while executing the ceremony. This is derived from the belief that an appeal for a plant's healing power must be made by the intended beneficiary. In addition, it is important to show reverence for the sacred nature of the plant as this affects the overall healing qualities of the plant and its ability to address your particular needs (Cohen, 2003; Williams, 2007). In this instance, it is understood that by stating your desire and reasons for seeking help, you provide direction for the spiritual and medicinal nature of the smudge. Wendy also explains that smudging not only clears away negativity within your personal space but it also clears your spirit and emotions. This in turn strengthens your spirit, which contributes to elevating your energy levels and restores your sense of confidence, peace and calm.

In the interview with Traditional healer Jake Agoneh I asked him to also explain the specific purpose of smudging. Jake responded by saying that:

*"The smudging helps clear the air of the negativity in it, and around people, or even within your own mind. When you smudge, it's like you're pushing those negative thoughts away. So one of the things they say is that people have thousands and thousands of thoughts that pass through their head each day and it's up to each individual what they want to keep in their heads. So if they start dwelling on negative thoughts, negative things, or bad things that have happened then it's going to start to come out in their daily routine, they'll start looking at everything in a negative way. So when they smudge, it's like pushing away those negative thoughts... it's like if you've*

*ever been in a place where people are always angry, it's almost like you can feel it... so when we give them medicines sometimes we need something stronger than the sage or sweet grass, so there are different kinds of smudges. Sometimes I give the person some medicine and say if you're having a real tough day and you're feeling overwhelmed, then put a pinch of that on your sage and just breathe it in as much as possible, it adds a little extra boost to get rid of the negative stuff, like lavender... the lavender helps deal with a lot of the emotional issues because all of the emotional stuff will sit in your lungs. So when you think about it... when you smudge, that's where it's going, right inside your lungs, so it pushes a lot of that negative stuff out of there, and also just the smell remind us there are a lot of better things in life"*

Jake's explanation corresponds with Wendy Hill's in that smudging enables a person to cleanse internally as well as externally. Jake also points out that, in some instances, traditional smudge plants may need to be enhanced through the addition of other substances such as lavender to help address a person's specific needs. In the example provided by Jake, it is believed that the smoke and fragrance of lavender enhances the strength of the smudge, thereby increasing its soothing and calming effects.

#### **5.4 The Clientele: Smudging and Mental Cleansing**

In the series of 24 interviews with the clientele, 10 clients mentioned that they smudged on a regular basis. Of those, 9 explained that they used smudging as a means to cope with depression or general malaise, thereby enabling them to reduce their dose of anti-depressant medication or cease using it altogether. Additionally, 2 of the 10 clients reported that smudging has become an entrenched part of their daily routine.

When clients stated that they smudged on a regular basis, I asked them to elaborate on their particular experiences with the ritual in an effort to understand why they do it and how it makes them feel during and after. In all instances, when I asked the clients why they smudged, their primary response was that they used smudging as a means to

remove negative energy. When I asked them to provide a specific example of when or why they would smudge, a few clients explained that smudging helps alleviate mental or emotional issues, in some instances enabling them to reduce or cease their reliance on mood stabilizing drugs.

Among those clients who stated that they utilized smudging instead of western medication to address their mental health needs was a 44 year-old female client who reported that, after years of dealing with the adverse affects of the medication, she became determined to cease using anti-depressants. She stated that she has been off of the medications for 8 years and explained that she has since developed the ability to determine when she needs to address her mental state. She explained her rationale as:

*“Everyday there's going to be some kind of trigger, some kind of memory... and I know that I don't feel sorry for myself anymore and that I have the power to get up and do something, and sometimes I have to physically get up and go do something else to get myself out of that memory or that thought... and sometimes it's just my sweetgrass... and I do that morning and night, and whenever pressures are building up I find myself smudging my house, going for a long walk, just trying to do healthier things, and be in a good place...”*

The majority of clients for whom smudging was used to help them deal with their mental health while alleviating the effects of the medication substantiated this line of reasoning. The clients explained that over time, with the help of counselors and doctors, they have been able to develop their self assessment skills to determine when it is necessary to smudge or engage in an activity to remediate lethargy, bad thoughts, anger, or irritability.

When I asked the clients to describe how they feel while performing the smudging ceremony, many found it quite difficult to clearly articulate what they felt at that moment. However, a 21 year-old male client recovering from a drug and alcohol addiction in

addition to struggling to reconnect with his traditional culture was able to offer some insight into what he experiences:

*“I look at it as... not just a physical inanimate object, I can feel it's something powerful like an entity, it's a medicine and I have a lot of respect for it. I'm so grateful that I have these things that were given to our people to use and when I'm using these things, I know it works and I know it's helping me 'cause that's what it's for... I admit that when I started, I still was a bit skeptical 'cause I used to be so negative thinking about it before but I felt it work... just knowing that it did work, it re-established my faith... when my thinking is driving me crazy, or if I'm focusing on all this bad stuff, it clears your mind, it really does. I do feel a sense of calm, just breathing it all in and I can feel its purpose and I can feel its power like in my mind a sense of harmony, calm and peace, which is exactly what it is”*

In his response to the question, the client admits that he struggled with his skepticism in the beginning but over time he was able to re-establish his faith in the traditional healing qualities of the smudge. When I asked the client to elaborate on his skepticism and the subsequent re-establishment of his traditional cultural beliefs, he explained that he was raised in a traditional cultural environment but as a result of the deterioration of his home environment, he drifted away from his cultural belief system and began abusing drugs and alcohol. After acknowledging that his behavior was problematic, he turned to his cultural roots for strength and support to overcome his addictions. Smudging became a source of strength for him in that it helped him get through times when he desired drugs or alcohol and enabled him to remain focused on sobriety. While he believes that smudging clears his mind and re-directs his focus, he also believes that cultural protocol plays a vital role in that, in order gain the benefits of smudging, he must have respect and reverence for it (Cohen, 2003; Williams, 2007). This in turn requires him to do several things that will promote his success in overcoming his addictions. For example, in

addition to stating your desire and reasons for seeking help, you need to be honest, humble, and grateful for the ability to use the smudge. Most importantly, you must be clean and sober for a period of time before using the smudge, otherwise it will not work for you (Cohen, 2003; Duran and Duran, 1995). Therefore, due to the very personal nature of the smudging ceremony, its impact and ability to be a source of strength can be powerful.

When I posed the question to a 42 year-old female client who has been dealing with a history of personal trauma, addictions, and who has quit using anti-depressants because of the adverse side effects, she explained how she felt when performing the smudging ceremony as:

*“I feel safe, I feel cleansed, I feel hopeful... I feel very hopeful... I don't know, it's so hard to explain because it's an internal feeling, I feel... I feel positive...when I don't smudge, I'm crusty, when I do smudge, I'm happy... I'll smudge in the morning, I'll smudge at night... if I'm having a bad thought I'll smudge”*

Her explanation reflects the sentiments many clients provided to this question in that they had difficulty expressing the internal dynamics they felt while smudging. In the majority of the responses, the clients resorted to explaining how they felt by describing how the ceremony changed their state of mind and or mood from negative to positive. Again, this change illustrates the belief that smudging removes negativity and encourages a positive replacement.

## **5.5 Traditional Counselors and Mental Health Workers: Smudging and Mental Health**

In the interviews with the traditional counselors and mental health workers at Anishnawbe Health Toronto, I provided them with the synopsis of clients' desire to reduce or cease using western medications for their mental health due to adverse side effects. I explained that the clients reported using smudging to assist their mental health needs and helped to alleviate the side effects of the medications. All of the traditional counselors and mental health workers were aware of the rationale behind the use of smudging and some explained that in certain circumstances, they incorporated smudging with their clients.

Diane Martin, a certified psychiatric and mental health nurse with over 9 years of experience, has been working as a mental health nurse at the Gerrard Street location for just over 2 years. Diane is primarily responsible for pre-psychiatry assessments and ascertains what resources the client needs to address their specific mental health concerns. After presenting Diane with a synopsis of the information gathered from the interviews, I asked her opinion regarding to how smudging helps clients deal with their issues:

*“I think the traditional people would describe it as the power of the medicine, I don't see a problem in believing that... because even if you don't believe, if you just go through the motions of smudging, it still has beneficial effect. It's tremendously calming, and I keep the smudge bowl here and I will often smudge my office at the start of the day or the start of the week or if I've had somebody come in who's very emotional, I might offer them a smudge. The healers have given me special stuff to use in the smudge to help with agitated anxious individuals or even for myself, you know, if somebody's come in and I'm all bent out of shape... I wonder if, because while you're doing it you're praying and you've got that tangible connection to the*

*Creator with the smoke and you can see it, so when you've got effects that you can see, I think it's easier to get the intended benefit from it because you can see the smoke, you can smell it as well... you know the pill acts in a physiological way but this way you're more proactive in taking charge of how you feel, and how you deal with your feelings. Just taking a pill is very passive, so I guess to answer your question, the act of doing something is beneficial, but I really think it's the fact that you can see it, it's tangible, you can smell it, you can taste it, and you can imagine it carrying away your stress and anxiety”*

In addition to the calming and soothing aspects of the ceremony, Diane also mentions how she believes that the physical aspects of smudging are especially beneficial for the clients. She believes that the tangible aspects of the ceremony, such as the sight and smell of the smoke, offer a psychological dimension that cannot be obtained from the medications. Diane believes that the engagement of the senses such as sight, smell, and taste empowers the client, thereby creating a frame of mind that places them in control and not at the mercy of pharmaceuticals. Clients often alluded to feeling defenseless against remediating their mental health issues while relying solely on a pharmaceutical regime. Duran and Duran explain that when clients supplement their therapeutic regime with cultural devices, it abates feelings of defenselessness thereby providing them with an proactive approach to their health and well being (1995). In this instance, the clientele preferred an offensive approach rather than defensive medicated approach. Additionally, Diane pointed out that she keeps a smudge bowl in her office for her personal use as well as for her clients. As I conducted this series of interviews, I observed that nearly all of the health care practitioners at the centre kept a vessel for smudging in the workspace as part of their repertoire for administering health care. By keeping a smudging vessel accessible



and actively engaging in the ceremony, the practitioners become role models for the utility of incorporating traditional culture in daily life (Duran and Duran, 1995).

In an interview with Kelly Trajlovic, Concurrent Disorders Case Coordinator at the Vaughan Street location and former mental health worker at the Gerrard Street location, I asked for her opinion regarding the clients' use of smudging. She replied:

*“I think it's really important, it's something that I do daily, and I also do it with clients when I have them, I recommend it to people all the time. Other than the usual which everybody says kind of like negativity, I think it helps a person balance in their spirit and be in the moment and not think about all the things that are around them that are affecting them. And that's been kind of my experience when I use it is it helps me to really focus in on that moment and let go of everything around me that I feel the stress from... so it's negative for sure, it's energy, but it's bringing you into yourself and your spirit, and I think because if people can do that for a few moments...they let go of all that stuff around them and go on with their day and deal with what they need to deal with rebalanced”*

Kelly maintains that in addition to the cleansing aspects of smudging, an equally important aspect of the ceremony is that it requires the client to focus on being in the moment and subsequently release any external sources of stress. By having the client stop, and focus their attention on themselves and what is causing their distress, they are re-claiming a sense of control of their emotions and most importantly, their state of being. This enables the clients to move from being a passive victim to a state of revived energy and proactive attitude (Duran and Duran, 1995).

### **5.6 Biomedical Practitioners: incorporating smudging**

Interviews with the biomedical practitioners at Anishnawbe Health Toronto were conducted in a similar fashion as the interviews with the traditional healers, traditional counselors and mental health workers. The biomedical practitioners were briefed in

regards to the client use of the smudging ceremony and their rationale for using it to alleviate the side effects of the medications. All of the biomedical practitioners supported the use of any cultural devices that could be utilized to help clients improve their mental health while reducing their dependency on pharmaceutical controls.

Dr. Jeff Mills, a family physician for over 20 years with past experience working with Aboriginal populations throughout northern Ontario and Quebec, offered his insight on the clientele's use of smudging:

*“I think we have to acknowledge that for the patients, for a lot of people, spirituality or religion... those sort of seemingly unexplainable things by books and by science, those sort of things mean something to people so I think when we're dealing with people, as healers if you will, as physicians, we have to realize that's important to some people, and we have to acknowledge that there's a role perhaps for that. Basically, in terms of mental health, and traditional healing, I don't have a problem with traditional healers being more involved with people with mental health issues... the important thing for the client, for the patient is that they be properly assessed... if we're going to be mixing models in a sense then I think it's important that they be properly assessed by both parties, and that there be a dialogue, a communication. I think it is not a good idea if somebody has been seen by... say a doctor before, and they've been put on medicines, that they just go off the medicines without having some kind of supervision from a doctor, I'm not saying that the doctor is running the show, and I'm not saying that we always diagnose people right, and I'm not saying that medicines are always right... maybe people don't need medicines a lot of the times sometimes we're just writing prescriptions and maybe that's not what they need. That's where traditional healing comes in because its addressing something that perhaps we're just not addressing when we're prescribing medications, so I'm open to the idea that people need less medications, I'm certainly open to that managing their mental health. Again, they need to be properly assessed, and it's important that they be monitored by both, if they're going to come off these medicines or cut down or whatever, so I think it's really important that there be the dialogue but there also be the ongoing follow up, I always have concerns about people and this is true of people with high blood pressure or diabetes, if they're on a medicine, and they go to another provider, it doesn't have to be a traditional healer it can be any provider, and they start coming off their medicines and I don't know about it and I'm supposed to be their doctor... again, if they're not happy about a*

*medicine, if they're not comfortable with a medicine, if they're having side effects from a medicine, it's important that I be aware of it, and that I'm making sure that I'm supervising things along with the other providers so that we're making sure the patient gets well served. There's no point in coming off a medicine and it's not properly supervised and then the patient has something bad happen to them... so you want to make sure there's a safety net if you're making a change. So I'm very open to the idea of minimizing medicines... if people have anxiety problems or if people have sleep problems or maybe people have mood problems, or depression, it may very well be that they don't necessarily need medications, it may very well be that other things that can be done for their life can help them and maybe they don't need medicines. I think it gets more difficult when you get to mental health problems where people have been diagnosed on more than one occasion with like psychotic problems, you know like they're schizophrenic or things like that, again that maybe more of an issue with them coming off their medicines but again it needs to be properly supervised by a medical person if the traditional healing is going to sort of in a sense temporarily take over... a medical person has to be involved in supervising things to make sure that the client is being looked after completely”*

Dr. Mills maintains that it is important to acknowledge the cultural beliefs and practices of the patient because they may play a vital role in one's overall health and well-being.

As long as the traditional practices are not known to cause harm to the patient, then it is recommended that they should be respected and accommodated (Hahn, 1995). Research in the area suggests that traditional practices may enhance western approaches and improve the chances of successfully addressing the particular health issue (Hahn, 1995).

Dr. Mills also mentions that traditional healing practices may address certain issues that western health care does not. The western biomedical model advocates an approach that is oriented upon the compartmentalization of the body and illness or disease contained therein, whereas the traditional approach is predicated upon restoring balance to an individual by treating the body as well as the mind and spirit (Davies, 2001; Hahn, 1995).

Therefore, an approach that incorporates aspects of both models would be much more

efficacious in addressing all of the needs of an Aboriginal client. While Dr. Mills supports incorporating various aspects of traditional healing and western biomedicine, he maintains that the safety and well-being of the patient must be the highest priority and both parties need to be involved in this process. Most researchers agree that respectful, open collaboration among healers and biomedical practitioners is paramount and would result in increased rates of compliance and safe, informed holistic health care (Hahn, 1995).

In an interview with Dr. Lawrence, the psychiatrist at AHT, I explained that some clients expressed dissatisfaction with prescribed mood stabilizers because of the adverse side effects and, in an effort to alleviate the symptoms, they utilized various aspects of their culture including smudging. I asked Dr. Lawrence to reflect on this course of action and how the act of physically doing something (smudging) helps the client:

*“Well, I guess the analyst in me... would go along with what you’re saying. It’s an enactment, it’s a ritual and rituals do help people, they fill a kind of void, and you’re right, just swallowing a pill is a pretty empty experience and it creates this kind of numbing whereas actually acting upon the world and doing something to make yourself feel better is much healthier, so that totally makes sense to me. But it is an enactment, it’s a ‘doing’ rather than a ‘knowing’, so I can see that would really help some people. The problem in this business is that people are very suggestible, you tell them they have bipolar and that’s the answer. It’s like the saying, ‘everything works, nothing lasts.’ The pills work for awhile but the pills don’t really fill that void if this thing lasts, the smudging making yourself feel better keeps working that’s great, let’s see and I’m sure it could work everything works, nothing lasts, maybe that would be for her the beginning of learning more about culture and spirituality and really exploring it so that just the act of smudging would expand to other things, that again would hold her, these things kind of hold people together... I’m all for it, I think it makes a lot of sense. People need things to do, they need to feel they’re acting upon the world, instead of being acted upon, because taking a pill is very passive, I’m just going to sit here and the doctor’s magic and all their research companies... you know what I mean it’s so, talk about losing your sense of control and power over*

*yourself. It's turning yourself into a kind of totally passive subject of science which doesn't seem right so the point about the cultural, and again I know you really can't divide things up but there's the spiritual, the problem with spiritual is it's one of those words that could mean anything to anybody, but there's also an ethical dimension about how to be a good person, and that never comes from science that's from culture, culture's tell people what they should be doing, what does it mean to have a good life and to be a good person, and this is probably the one thing people need the most I think, is a better sense of their purpose, and what they should be doing and it's like something to work towards... so every time she smudges she could be feeling 'yeah, I'm becoming a better person, you know I'm purifying myself and if I keep doing this I'm going to become better and better', it's part of a cultural practice that could lead people towards more control and more connection... so there's another aspect, so there's spirituality which can be difficult to define, there's the ethical practice of what I believe I need to do to be a good person, and there's a third which is community, a community of people I do things together with, in common with, we all believe this about smudging and so I think a lot of times in the city, for Aboriginal people in the city, this is a particular kind of alienated experience, they often come from elsewhere, it's hard to come to the city, and people need a community, and a community is shared values, beliefs, activities... so I'm not playing down the spiritual part I just think that's really hard to pin down but certainly the ethical and the community aspects are really important for people"*

Dr. Lawrence suggests that rituals serve as a means for people to “act upon the world” and make them feel better. Aside from the narrow definition that cultural rituals are used to communicate with supernatural powers or appease spiritual beings, rituals may also serve to establish or maintain cultural identity, promote group solidarity, create social networks, relate to the natural environment, develop spiritual connectedness, and exchange traditional knowledge (Poonwassie and Charter, 2005; Thomas, 2001).

Therefore, as Dr. Lawrence suggested, the smudging ceremony could be viewed as a means for the clientele to re-connect or establish a part of their cultural identity and also serve as a conduit for the clientele to learn or become more involved with their culture and spirituality. Dr. Lawrence also explained that the ethical dimension of spirituality is

important in that it is derived from culture and provides the concept of what it means to be a good person and lead a good life within a particular culture. The ethical dimension of spirituality is created from a set of shared values, beliefs and activities. Participation in ceremonies provides an opportunity for an individual to embody the ethical dimension of spirituality and to develop values such as sharing, caring, honesty, and humility (Poonwassie and Charter, 2005). This, in turn, leads to the development of a cultural identity which is an identity developed from the personification of the cultural beliefs and values of a particular society, thereby instilling within an individual an emotionally significant attachment to a particular group (Mihesuah, 1998). Dr. Lawrence's observation coincides with one of the tenets of AHT in that the development of a cultural identity is essential for an individual's overall health and well-being.

### **5.7 External Interviews: Incorporating Cultural Beliefs and Practices**

In an effort to gain further insight and understanding into the practice of utilizing cultural beliefs and practices to address mental health issues, I interviewed McMaster University psychiatry resident Dr. Ryan van Leishout. I provided Dr. van Leishout with a synopsis of the themes derived from the interviews with the clientele and their use of smudging as a means to address their concerns with the medications. I asked Dr. van Leishout for his opinion on the use of smudging and its effects on the clientele. He explained that a lot of people tend to have difficulty coping with the side effects of the medications. If his patients experience side effects, he encourages them to see him and discuss their options, one of which is a possible switch in medications. However, he admits that compliance rates are rarely better than 50%. Dr. van Leishout believes that

having a frank discussion with patients about the benefits and drawbacks of the medications increases the compliance rate and may prevent them from abruptly stopping their medication which can be dangerous in some circumstances. While Dr. van Leishout supports a therapeutic approach that incorporates various aspects of cultural beliefs and practices, he cautions that it should be administered on a case by case basis according to the specifics of the patient's diagnosis. He explained that:

*“...unfortunately, because of the fact that there are not necessarily a lot of talking therapies... because of the lack of availability of talking therapies, we default to the medications a lot of the time. For some people medications aren't necessarily the right thing and for a lot of people they are and they can be helpful. If they have a diagnosis that doesn't require chronic medication, like schizophrenia and bipolar disorder, then the door is open to try and approach the problem from a way that utilizes the expertise of the physician, and/or healer, and the patient's preferences, if you have the resources to then work out a treatment plan that is optimal for that person. Not everyone will be safe off their medication, some people with major depression have such serious depressions they get suicidal and they will kill themselves. Those sorts of people, and there are guidelines for this, some of them should be on medications for the rest of their lives.*

*I think part of the reason why so many people are on medication and not getting the sort of talking therapy that meets their needs is partly a resource issue, because we don't have enough people to provide that sort of treatment... and that's unfortunate, it really is. And because of the stigma attached to mental illness, there aren't a lot of people who are necessarily willing to... not everyone is willing to jump up and down and say let's give money to people with mental health problems. Not everyone necessarily benefits from every talking treatment, and I'm not saying that talking treatment is necessarily the cure all, but talking treatments and medications that are tailored to meet the needs of the individual. So I think it's to be taken on a case by case basis”*

The lack of resources to adequately address issues associated with mental health is even more prevalent in most Aboriginal communities across the country, with some communities not able to access mental health care within their communities at all (Poonwassie and Charter, 2005). Research suggests that an effective approach with

Aboriginal clients is one that often helps clients to reconnect with their traditional values and beliefs, although the therapist must tailor the approach to suit the client's needs and mesh with their life experiences and particular culture (Duran and Duran, 1995; Poonwassie and Charter, 2005).

In an interview with Aboriginal psychiatrist Dr. Cornelia Weiman, I described the aforementioned themes and rationale in regards to smudging and medications. I also described an incident I observed at AHT when a traditional healer helped a very distraught woman through a family crisis and how the smudging ceremony was used to alleviate her emotional turmoil. I asked Dr. Weiman why she thought smudging had such an impact and if she encouraged her clients to smudge. She explained that she will conduct a smudging ceremony with a client if they want to, but she does not do it on a regular basis. Dr. Wieman explained that performing the ceremony on a regular basis could cause her clients to consider her as a healer in a traditional cultural sense and that is not how she should be regarded. While Dr. Wieman finds the use of smudging important in her own life, she admits she finds it difficult to explain why it works. She believes that because smudging is recognized as a part of Native culture, it often resonates on a deeply emotional level with people and therefore they consider it to be a part of them as a Native person, thereby garnering a tremendous amount of respect.

While research in the area of the smudging ceremony and its therapeutic applications has yet to be developed, my research suggests that the smudging ceremony plays a very important role in the therapeutic process among Aboriginal clients. In addition to being a highly revered aspect of Native culture and traditional healing,



smudging provides the opportunity for the client to maintain the therapeutic process outside of the centre thereby empowering the client with an additional means to address their mental health issues. Therefore, the beneficial attributes of smudging go far beyond purification of individuals and ceremonial objects.

### **5.8 The Sweat Lodge**

One of the most prevalent ceremonies described within the literature is the sweat lodge (Bucko, 1998; Cohen 2003). Ethnographic accounts spanning from the 1600's through to the present day offer an abundance of descriptions and documentation. However, ethnocentric bias often over-generalizes the purpose of the sweat lodge as simply a purification ritual primarily associated with other ceremonies such as the Sun Dance or Vision Quest (Bucko, 1998; Paper, 1987). While the Sweat Lodge ceremony is used to purify an individual or group for a ceremony, it may also be used to facilitate physical, mental, or spiritual healing (Bucko, 1998; Cohen 2003; Lewis, 1990; Lux, 2001; Paper, 1987; Pflüg, 2000).

Although the basic structure of most sweat lodges is comparatively consistent, there is some variability in the materials used depending on regional resources and the specific preferences of the ceremony conductor or a particular Nation's tradition (Bucko, 1998; Cohen, 2003). The lodge is often described in the literature as a low, circular dome-shaped structure about seven to ten feet in diameter, around five feet high at the apex with an entrance facing a cardinal direction as stipulated by the ceremony conductor. The frame of the lodge is constructed from twelve to twenty-eight one-inch diameter pliable willow, cherry, cottonwood, or cedar saplings. The saplings are bent and tied together at

the center with one or more rows of horizontal bracing saplings tied to the vertical poles (Bucko, 1998; Cohen, 2003; Lewis, 1990; Lux, 2001; Young et al, 1989). Early ethnographic descriptions depict the frame as being covered with animal hides, bark, sod or combination thereof. Today the frame is often covered with a variety of materials such as tarps, blankets, canvas, or heavy sheets of plastic with a flap fashioned for the entrance to block any light and retain the heat within the lodge (Bucko, 1998; Cohen, 2003; Young et al, 1989). The floor of the lodge may be covered with sage or cedar and a pit is dug in the center of the lodge floor to house the heated rocks that are brought into the lodge for the ceremony (Bucko, 1998; Lewis, 1990; Young et al, 1989). In some instances the earth from the pit is used to construct an altar a few feet from the entrance and it is often adorned with sacred items (Bucko, 1998; Cohen, 2003; Young et al, 1989). A fire pit used to heat the rocks is constructed a short distance away from the lodge and is often in line with the altar and the entrance. The best rocks to use for a sweat lodge ceremony are round igneous rocks<sup>v</sup> because they can withstand being heated to a red hot glow without splitting or exploding (Cohen, 2003).

While the ceremony that takes place within the lodge is also comparatively consistent, there will be some variability in how the conductor will orchestrate the ceremony based on how they were instructed, or the specific purpose of the sweat lodge, such as a healing sweat versus a purification sweat (Bucko, 1998; Cohen, 2003). In general, the maintenance of the fire pit and the heating of the rocks for the ceremony are the responsibility of the fire-keeper, a participant in the ceremony although he does not enter the lodge (Cohen, 2003; Young et al, 1989). In addition to heating the stones, it is

the fire-keeper's task to transport the specified number of red-hot stones from the fire pit to the entrance of the lodge, as well as any other items requested by the person conducting the ceremony (Young et al, 1989). Once the rocks have been placed inside the entrance, the person conducting the ceremony designates their placement and the conductor's helper will place them inside the pit, often using traditional implements such as deer antlers (Cohen, 2003). Once the stones are in place, the fire-keeper closes the flap over the entrance and the inside of the lodge becomes pitch black except for the faint red glow of the stones. In general, a ceremony consists of pouring water on the rocks, drumming, singing, and then opening the door. This sequence is often carried out four times, commonly referred to as four "rounds" (Bucko, 1998). After each round, the door flap is opened and participants may smoke a pipe or have a drink of water. During each round, specific songs are sung that pertain to the specific purpose of a particular sweat lodge. The ceremonial leader may invite the participants to pray or speak whenever it is deemed appropriate (Bucko, 1998; Cohen, 2003; Lewis, 1990; Young et al, 1989). In general, individuals participate in a sweat lodge ceremony to release physical, emotional, mental, and spiritual burdens in order to re-establish a sense of harmony.

### **5.9 Traditional Healers and the Sweat Lodge**

In the series of interviews with the Traditional healers at Anishnawbe Health Toronto, I explained that information gleaned from the client interviews indicated that they were incorporating cultural devices such as the sweat lodge into their mental health regime. In an effort to understand how the sweat lodge is used in this fashion I

interviewed conductors of sweat lodges at AHT and inquired about the specific purpose of the sweat lodge and what it provides for the clients.

Traditional Healer Jake Agoneh refers to his ceremony as a “healing lodge.” In my interview with Jake, I asked him to explain the healing clients received while participating in his sweat lodge. Jake’s response was:

*“Well, a lot of it is cleansing... it not only cleanses the physical part of a person’s being but cleanses the spirit, mental and emotional. A lot of times people come in there if they have stuff to release...they all get a chance to speak so if they want to talk about something that’s really bothering them, then they can talk about it in there. The main thing that comes out of it is they get to release because the lodge is really cleansing...being in the darkness, the mind really opens up in there and also the person connecting with all the stuff that is going on within the lodge... the rocks are heated and we refer to them as Grandmothers and Grandfathers, and they have a chance to speak to those ones in there... When we do the lodge, in a sense, were not worshipping anything in there, it’s not religion that we’re doing in there, it’s spirituality, so we talk to those one’s that are doing the healing and coming in, and we tell them what’s wrong and then we try to help other people but we also help ourselves in the process by healing that’s passing through us by way of those words. So by helping others we’re helping ourselves at the same time but, then again, people will talk about what they’re going through, issues, what they’re feeling, and a lot of times they’ll get rid of a lot of emotional stuff, that’s what they need to deal with”*

In accordance with Jake’s response, within the contemporary literature on the subject the sweat lodge is often associated more with healing than it is with purification, although in some instances healing and purification are considered synonymous (Bucko, 1998). In addition to seeking physical healing within the lodge, participants also often seek psychological or spiritual healing to restore their mental harmony by expunging pent up mental anguish or trauma. The healing that occurs within the lodge is precipitated by prayers and appeals to ancestor spirits that enter the lodge (Bucko, 1998; Cohen, 2003; Lux, 2001; Young et al, 1989). Jake explained that participants in his lodge often speak

with or appeal to the Grandmothers and Grandfathers<sup>vi</sup> that enter the lodge. The stones are considered sacred spiritual entities and the steam that is produced by pouring water on the rocks is their breath (Bucko, 1998). Jake explained that when participants pray to the Grandmothers and Grandfathers, they must be truthful and speak from the heart. He states that when they have a chance to speak in the lodge, “that’s the time when you have to be as honest as possible, not a time for bullshitting anybody about anything.” In addition, Jake explained that the heat from the rocks is considered to be the love and kindness radiating off and when water is poured on the rocks you are giving them a drink. In some instances, traditional medicines are infused in the water and the resultant steam is their breath, which permeates the participants inside and out thus providing physical and spiritual healing.

Oshkabewis James Carpenter also conducts sweat lodge ceremonies at Anishnawbe Health Toronto. In my interview with James, I asked him to explain his sweat lodge to me and what it provides for the clients. James replied:

*“You know it’s by client, you could go into a sweat and just want to give thanks...now in my lodge, it don’t matter, whatever you’re going for you’re going to get it. When I do my lodge, the spirits tell me to tell people to be selfish, tell them to ask, tell them to stop beating around the bush... different lodges we’re taught for healing, you use a certain amount of rocks, different ways, people have been taught different things, those spirits have shared different things, releasing sweats, cleansing sweats, balancing sweats, grieving sweats. Those are all different sweats that people have been given; the difference in my lodge is I do each and every one of those things in any sweat; it doesn’t matter because that’s what they’re for, that’s what those spirits are coming in for, it’s the spirits that come in and the people decide what they want. If the people want it then those spirits come in because everyone has helpers. I myself have helpers and my helpers come in to help their helpers, their helpers come in and tell them what they need, what they want, it’s a communication, so depending on what the person wants in the lodge, and what they need and if their helpers are willing to give them that,*

*they communicate with my helpers and decide if the person is ready or if they need to do something first, so I let them know, things are going to be a little rough, you got to keep working at it, these helpers might say he needs to fix something with his mother, because his helpers that walk with him know that he doesn't have a relationship with his mother, that's good, so they tell my helpers and my helpers come back and tell me, and I'm not going to lie to them. I'll tell them you need to fix the relationship with your mom, and that's just one example. So the guys that come into my sweat lodge, it doesn't matter who they are and if they've been doing sweats their whole life, if they want something then that's what happens"*

Similar sentiments within the literature provide explanations of the spirituality involved in the ceremony. Ethnographic descriptions often discuss the psychological aspects of the ceremony in addition to the physical dimensions (Bucko, 1998). Participants are often asked to maintain a positive frame of mind in the sweat and not enter with negative, angry or hateful thoughts as negative thoughts can affect the outcome of the ceremony. Participants are reminded that they are participating in the ceremony for a purpose and they are instructed to reflect on why they are there and what they seek (Bucko, 1998; Cohen, 2003). Participants are also actively engaged in the ceremony in that they assist with the singing, prayers, and are invited to invoke spiritual assistance in restoring their health and well-being (Bucko, 1998; Cohen, 2003). Ethnographic research suggests that spiritual intercession generally manifests in one of two ways. In some instances, the individual conducting the sweat lodge ceremony has the ability to summon specific spirits into the lodge and these spirits intervene on behalf of the conductor to facilitate the healing needs of the participants. Conversely, other sweat lodge conductors do not summon specific spirits into the lodge, either because they are not traditional healers and thus may not have the ability to summon spirits or they rely on the power of the ceremony and the prayers of the participants to attract the spirits (Bucko, 1998).

### 5.10 The Clientele and the Sweat Lodge

In the series of interviews with the clientele, 9 of the 24 clients interviewed stated that they often participated in sweat lodge ceremonies. In an effort to understand their rationale, I asked each of the 9 clients to describe their experiences while participating in the particular ceremony they attended. Interestingly, sentiments similar to those described in clients' experiences with smudging evolved in that the clientele found it difficult to articulate their particular emotional and spiritual experiences within the lodge. A few of the clients stated that they felt emotionally and physically drained after the ceremony but they also felt that emotional and mental burdens had been lifted, leaving them spiritually rejuvenated and energized. All of the clientele explained that their participation in the ceremony was primarily derived from a need for spiritual, emotional, or mental cleansing and healing.

In my interview with Traditional Healer Jake Agoneh, I asked him to explain what would motivate him to recommend that a client participate in a sweat lodge ceremony.

He replied:

*“Well, for mental and emotional problems, because they need to feel something more in life and when they go in the lodge they will feel the power that is in there. The power of the one's that are healing ... it's a spiritual thing where the spirits come in, they can feel that more because it's also a spirit lodge... it's based on some of the same principals as the shaking tent because of the darkness, it's so dark that you can't see and sometimes that reminds people of their... like ignorance in life. If you can see things you tend to judge them, and if you can't see anything then you can't judge it. You also put medicine on the rocks and it helps people open up in there and helps them see things differently. A lot of it ties into teachings about life and where everybody fits into the cycle of life and the lodge just helps to teach everybody about that as well because we have all the tools there. We have the medicines, the water... we use the basic elements, fire, air, water, and the earth, that's the building blocks of this earth, the main elements of this life are the four*

*elements I just mentioned, ... and some of it goes back to the time of creation where they talk about that darkness, before the Creator made the universe, it was just darkness and then when they had those shakers that's the sound and that's all that could be heard at that time, so what came next is smoke and matter, ... so it's almost like going back to the time of creation, and you've got songs in there and teachings... I always remind them that it's so easy to be weak, you have to try and one of the easiest things you can do is give up, stop when things get too hard, so in the lodge when it starts to get hot I tell them to lay down and put your head close to the ground, you'll be alright, but a lot of people are caught up in this materialistic world they begin to see things a lot differently in life, so to me it helps anybody and everybody that goes in there, they teach themselves about themselves, they begin to see things differently, how they feel instead of how they think, there's a big difference between thinking and feeling”*

While the sweat lodge is one of the most widely cited aspects of Native spirituality in the literature, there are very few details available concerning the ceremonial variations of the ceremony. In my interview with Oshkabewis James Carpenter, he explained that there are several variations of the sweat lodge and he mentioned a few distinguishing features, such as the purpose of the sweat and the number of rocks involved. Traditional Healer Jake Agoneh explained that, aside from the particular ceremonial preferences of the sweat lodge conductor, one of the primary differences is the number of rocks involved in the ceremony. According to Jake, using 7 rocks is considered a cleansing sweat, 14 rocks is a healing sweat, 18 is a helper's sweat also known as an Oshkabewis sweat, 21 is a hunter's sweat, and 28 rocks is considered a truth sweat.

In addition to declaring that they actively participated in sweat lodge ceremonies, 2 of the 9 clients divulged that they also participated in a very distinct form of the ceremony known as a “releasing sweat.” The clients were female, 44 years of age, and both were receiving counseling at the centre to address particularly traumatic experiences such as sexual abuse and rape, as well as depression and substance abuse. Each client had



also worked on decreasing their reliance on anti-depressant medication in order to deal with the root causes of their problems more effectively. Each client explained that a releasing sweat was recommended by their counselors as the next step in their particular therapeutic process. Both clients described the releasing sweat as a hot, emotionally and spiritually intense one-on-one therapeutic experience with the conductor. During the ceremony, the clients explained that they were instructed to frankly discuss the emotional turmoil caused by their past traumatic experiences. They were also instructed to pray for forgiveness for those who have hurt them in the past and to “release” the pain, hurt, and anger they harbor within towards the perpetrators. They explained that although the ceremony was highly emotional and physically draining, it was a very uplifting, pivotal experience that provided them with the ability to continue making progress in their therapy and subsequently helped them improve the overall quality of their lives. The clients reported that they participated in the releasing sweat conducted by Kelly Trajlovic, Concurrent Disorders Case Coordinator at the Vaughan Street location.

In the interview with Kelly I asked her to describe a typical releasing sweat. She explained it as:

*“It's a sweat that's done one-on-one with just the conductor and the person that's participating. And the reason for it is usually for people to let go of stuff, so whether it's they're grieving and they kind of need to let go of that sadness, they have a lot of anger or pain from past trauma, and they've done enough counseling that they're at the place where they're a little bit stuck, and they need to take that next step. The releasing sweat will actually help them release that and be able to move on with their lives. So, and it's through the songs that are sung, the prayers that are said, and the things that you talk about...so it's kind of like an intensive one-on-one counseling session in a sweat that is really hot...it's still four rounds, it's actually more grandfathers though, so most sweats are 16 to 20 grandfathers, releasing*

*sweat is 32. So it's pretty hot. But the people I've done them for managed to stay for all four rounds and they have left feeling better.”*

I then asked Kelly to explain what was involved in each round of the releasing sweat. She replied:

*“Everybody does them different, and even the same conductor will do them different all the time too because it is what the spirits say needs to happen, but basically the four directions correspond to an event in their life, so you might start out at childhood, where they would talk about some stuff that's happened in their childhood that's hurt them, or stopped them from growing that they need to release. So you start with that and they literally move in the four directions in the lodge and the next phase is youth, so all the things they need to let go of that they have been working hard on releasing but haven't then they would do that in that direction, and then as an adult, the things that people have done to hurt them, and where you end with is on a positive, so it's like now look at the things that are really good in your life that you're thankful for, the gifts that you have or the things you have been blessed by, so that you're always ending on a good note. And then after the sweat I also spend time talking to people about what they may have experienced in there, cause it can be pretty emotional for people especially going through the childhood/youth doors for them. So that's the way I do it, anyway, is to get rid of all the unresolved stuff they have and let it go.”*

Kelly's releasing sweat is rather unique in that it is deliberately structured to be a very intense ceremony, specifically designed to motivate an individual to discard the traumatic shackles that may be impeding their therapeutic progress and preventing them from moving on and improving their lives. Based on my participant observation, I believe that the intense heat and darkness play crucial roles in that in order for a participant to become comfortable with the heat they are forced to concentrate on the task at hand and the darkness serves to amplify their concentration by removing any visual distractions. The drumming and singing add the spiritual dimension thereby making the client feel safe and protected, which enables them to deal with highly emotional and traumatic issues that would otherwise be avoided. In addition, the sweat lodge is considered a sacred space and

is often described as the womb of mother earth and as such, when the client “releases” their trauma within the lodge, they may consider it as a “re-birth” as they exit the lodge with an improved outlook on life.

Much of the literature attempts to deconstruct the sweat lodge from a western scientific paradigm and proposes a variety of explanations for the therapeutic benefits of the sweat lodge. One of the most popular explanations for the effects of the sweat is that, overall, it acts as a placebo which makes an individual more susceptible to subsequent treatment and suggestion (Waldram et al, 2006). It is also suggested that the sweat lodge provides a platform for the participants to achieve an altered state of consciousness. The altered state is achieved through a combination of sensory deprivation from not being able to see once the flap to the entrance is closed, along with sensory stimulation from the intense heat, steam, drumming, and the burning of herbs (Waldram et al, 2006). This causes the body to release endorphins, which are known to create euphoria and pain relief, thereby precipitating feelings of a spiritual intervention. Other explanations focus on the intense heat of the sweat lodge. One suggestion is that the intense heat elevates the internal temperature of the body mimicking that of a fever killing bacteria and viruses. Another suggestion is that the steam produced in the lodge causes salicylic acid, a compound used in antiseptics, to be released from the willow saplings used to frame the lodge (Adair, 1969; Young, 1988 as cited in Waldram et al, 2006).

Another school of thought explains the effects of the sweat lodge as a form of symbolic healing. From this perspective, Aboriginal spirituality is considered a form of symbolic healing in that it is derived from the interpretation and manipulation of cultural

symbols to facilitate healing (Waldram, 1997). Thus, traditional healing from an Aboriginal perspective is concerned with the cultural constructs of “healing” and “illness” rather than the western biomedical scientific approach of “curing” and “disease” (Waldram, 1997). Therefore, symbolic healing in this context is primarily concerned with addressing the social construct of illness and providing people with the means to cope with traumatic experiences and a dysfunctional lifestyle. The central figure in this approach is the traditional healer who is responsible for assuring the client that his or her problems can be overcome, understood, and controlled, thereby providing a means in which they can improve the quality of their lives (Kirmayer, 1993). Symbolic healing is reliant on the use of rhetorical language and metaphor in that both devices are used to establish a cultural connection among the Aboriginal worldview, the healer, and the client (Waldram, 1997). Upon establishing a cultural connection, the healer will often work with the client to refine their conception of the outside world and also redefine their problems in relation to larger issues that are particular to the Aboriginal population, such as colonialism and oppression (Dow, 1986; Waldram, 1997).

As a psychotherapeutic device, the sweat lodge has several benefits. In broad terms the sweat lodge may provide a foundation for the establishment of a cultural identity and promote social cohesion among the community or group. The sweat lodge can also help an individual associate meaning with experience, promote self-esteem, increase morality, and provide individuals with a means to address trauma in a culturally meaningful way (Duran and Duran, 1995; Smith, 2005; Waldram, 1997).

### **5.11 The Shake Tent or Conjuring Lodge**

Although not as numerous within the literature as those about the sweat lodge, ethnographic descriptions of the shake tent ceremony date back to the voyages of Samuel de Champlain (Angel, 2002; Deloria Jr., 2006). The purpose of the ceremony is to provide participants with an opportunity to receive information and guidance on issues concerning a variety of personal problems, predictions about the future, and in some instances information about how to heal illnesses (Angel, 2002; Cohen, 2003; Deloria Jr., 2006).

In general, the ceremony takes place at night and the basic elements consist of a healer, a lodge or tent like structure, and the singing of sacred songs to summon the spirits to the ceremony. However, variation in and among these elements occurs depending on the particular beliefs of a Nation and the healer responsible for conducting the ceremony (Deloria Jr., 2006; Flannery, 1939). The construction of the lodge generally consists of a predetermined number of timber poles<sup>vii</sup> ten to twelve feet long firmly planted into the ground in a circular pattern measuring from four to ten feet in diameter (Angel, 2002). The poles are then secured to bracing around the circumference of the frame in the middle and at the top (Angel, 2002; Flannery, 1939). The frame is then covered with heavy cloth, tarps, blankets, or hides and in most circumstances the top of the structure is left open (Angel, 2002; Deloria Jr., 2006; Flannery, 1939).

Within the literature there is considerable variation in descriptions of how the ceremony is initiated. In some accounts, pipes are smoked, prayers are offered, a sacred song is sung and then the healer crawls into the tent. In other instances, the healer crawls

into the tent first and then songs and prayers are used to summon the spirits (Angel, 2002; Deloria Jr., 2006; Flannery, 1939). Additionally, some healers may have their hands bound with leather straps before entering the lodge (Angel, 2002; Flannery, 1939). Aside from any variations in the initial rites to begin the ceremony, after the spirits have been summoned there may be a period of time ranging from a few minutes to a half hour before the spirits make their presence known. The arrival of the spirits is indicated by the “shaking” or movement of the tent, primarily at the top. Initially there are subtle movements but then as the spirit enters the tent it begins to shake, sway and twist so violently that it appears it will become dislodged and tip on its side (Angel, 2002; Deloria Jr., 2006; Flannery, 1939).

After the spirit has entered the tent it communicates through the healer, often in a language only known by the healer but it can be clearly heard by all those present at the ceremony. At this point in the ceremony, the healer asks the spirits questions that have been posed by those in attendance. The answers are often comprehensive and contain personal information and details not previously disclosed to the healer. After all of the questions have been answered, the closing rites of the ceremony are performed and the spirits leave and the tent becomes still. The healer then emerges from the tent, often totally exhausted (Angel, 2002; Deloria Jr., 2006; Flannery, 1939).

As part of my participant observation, I was able to attend sweat lodge, shake tent and Yuwipi ceremonies at AHT. A detailed account is provided in the personal experiences and observations section below.

### **5.12 The Yuwipi or Tie Up Ceremony**

While the Yuwipi or Tie Up ceremony is conceptually similar to the Shake Tent, the structural aspects of the ceremony are slightly different. The purpose of the ceremony is similar to the shake tent in that it provides participants with an opportunity to receive information about lost items and advice on personal problems, predictions about the future, and information about how to heal illnesses (Deloria Jr., 2006; Hurt Jr. and Howard, 1952; Lewis, 1990; Powers, 1982).

In this ceremony, the practitioner is securely bound and wrapped with rawhide rope and blankets. The practitioners hands are placed behind the back and the fingers of each hand are interlaced and tied together and then the wrists are tightly bound. In some instances the feet are bound in a similar manner (Deloria Jr., 2006; Hurt Jr. and Howard, 1952; Lewis, 1990; Powers, 1982). The practitioner is then tightly wrapped in blankets and tied with rope, some practitioners prefer to have their head covered and tied as well whereas others do not. The practitioner is then placed on the floor either face down or face up depending on their preference (Deloria Jr., 2006; Hurt Jr. and Howard, 1952; Lewis, 1990; Powers, 1982). The ceremony is always held in a dark place, so the room or dwelling is sealed in order to achieve total darkness once the lights are turned out. People attending the ceremony are seated around the outer perimeter of the room behind a line of small tobacco pouches that encircle the practitioner. In addition to establishing a perimeter around the practitioner, the tobacco pouches are gifts to the spirits who will come and participate in the ceremony (Deloria Jr., 2006)

The practitioner initiates the ceremony by singing his sacred songs, or in some instances the practitioner may have a number of helpers who sing the sacred songs (Deloria Jr., 2006; Hurt Jr. and Howard, 1952; Lewis, 1990; Powers, 1982). Once the spirits have arrived, then questions posed by those in attendance are answered either by the practitioner or his helpers. At the end of the ceremony sacred rites and songs are performed and the spirits exit the room. When the lights are turned back on the practitioner is free of his bonds which have been untied by the spirits in the darkness. In some cases, the blankets and rope are neatly folded and stacked while in other instances the blanket will be folded but ropes will be tied in such a way that they cannot be untangled or the ties will have been removed from the practitioner without being undone (Deloria Jr., 2006; Hurt Jr. and Howard, 1952; Lewis, 1990; Powers, 1982).

### **5.13 Personal Experiences and Observations**

In each of the interviews with the clients, I asked them about participating in ceremonies at the centre. My reasoning for the inquiry was to learn about what kinds of ceremonies they participate in, their reason for participating and the nature of the benefit they received from the ceremony. Interestingly, the majority of the clientele had very little or no reservations about discussing their personal ceremonial experience especially when it concerned smudging. However, a few clients had some apprehension about disclosing specific details about their experiences in the sweat lodge and all of the clientele were especially concerned with disclosing specific details of their experiences in the shake tent or yuwipi ceremony. In all but two of the interviews, the clients were not comfortable with having descriptions of their experiences recorded. Of the two that were



recorded, specific details were withheld and they offered a general response stating that they attended the ceremonies to have some personal questions answered.

While clients rarely stated that they had reservations about disclosing detailed information, it soon became apparent that they had some apprehension about disclosing the details of their participation in the shake tent or yuwipi ceremony. This trend became evident when, at the conclusion of the interview after the recorder was off or during an informal conversation outside of the interview, clients would openly discuss their experiences in the shake tent or yuwipi ceremony. Initially I was concerned that it was the structure of my interviews that was causing apprehension among the clients. However as a result of the informal conversations and a review of the relevant literature, I discovered that their apprehension was not derived from my line of inquiry but rather it stemmed primarily from the cultural belief that in most instances, matters disclosed or prayed about during a ceremony are not to be discussed outside of that context (Bucko, 1998). In this particular context, the majority of the clients explained that they believed it might bring bad luck or misfortune upon them if they reveal too much information about any spiritual revelations they may have received. When I explained this phenomenon to the traditional healers and asked for their opinion on the subject, a few of them corroborated the aforementioned concern of the clientele while the others explained that it may be derived from their request to have confidentiality among the ceremonial participants in order to create a safe and trusting environment for the clients to address their problems.

While the clients may have been cautious about disclosing explicit detail about their experiences in the ceremonies, the information they provided in the informal conversations enabled me to construct some general conclusions. Many of the clients I spoke to participated in these ceremonies seeking advice to help clarify aspects of their own healing journey. For instance, a few clients who were recovering from addictions sought advice on how to maintain their sobriety or, if they had a relapse, how to regain their resolve to stay sober. In some instances, individuals went to seek information regarding their cultural identity such as the identification of spirit helpers or guidance regarding future spiritual endeavors such as seeking a spirit name or undertaking a fast. Others indicated that they went to seek advice on how to obtain closure with deceased relatives or how to resolve conflict within their personal relationships using a cultural approach such as ceremony and spirituality. In other instances, clients sought predictions about what the future holds in store for them. Therefore, it can be surmised that the shake tent and yuwipi serve a variety of functions including maintaining or developing a cultural identity, providing a forum for interpreting personal experience, instilling and maintaining morality, counseling for important decisions, and providing individuals with an alternate means to deal with personal problems and trauma.

While conducting fieldwork for this project, I had the opportunity to participate in one shake tent and two yuwipi ceremonies. The ceremonies were held in the evening at the Gerrard street location and each ceremony was well attended by the clientele, their families, and community members. The ceremonies are held in a large room on the main floor and all participants were required to wait upstairs until the healer was ready to begin

the ceremony. At the yuwipi ceremony, we were instructed by the Oshkabewis to leave any sources of light such as our cell phones and lighters in the room as they were not permitted in the ceremony in order to ensure total darkness. This was not required at the shake tent ceremony, as the healer conducted his ceremony with the lights on. We were then led downstairs and sat on the floor on the outer perimeter of the room. Once everyone was seated, the healer explained how he became a practitioner of the ceremony and how the ceremony would progress. The healer also gave instructions on proper conduct during the ceremony. After the preliminaries, the ceremony was set to begin.

At the yuwipi ceremonies, I was always intrigued and somewhat unsettled at being cast in total darkness when the lights went out. Since I had never participated in a shake tent or yuwipi prior to my research, I could not anticipate how I would feel at the ceremony. I had never been in a room before where it was so dark I could not see my hand in front of my face. I discovered that having your sense of sight suddenly disengaged is rather unsettling and I found that I spent the first few minutes focusing all my attention on becoming comfortable with my loss of vision. Eventually I was able to find solace in closing my eyes, putting my head down and focusing on the sounds within the room. A few minutes later, the singing of the sacred songs and drumming helped me to completely transcend my initial reaction by engaging my attention on the intent and purpose of the ceremony. As the ceremony progressed and people posed their questions to the spirits, I found that being engulfed in total darkness not only enhanced my ability to listen without distraction, it also gave me a sense of privacy in a very public context. Thus, the setting of the yuwipi ceremony is especially conducive to help an individual

overcome their apprehension about seeking help for their personal problems in a public forum. The darkness provides a cloak of anonymity for the participant that prompts openness and honesty, which facilitates the healing process by removing the emotional barriers that could otherwise hinder progress.

While there are some parallels in the structure of the sweat lodge and shake tent or yuwipi such as total darkness and the summoning of spirits, my experience in the sweat lodge was quite different. One of the primary factors that make the sweat lodge unique is the use of heated rocks and steam. As part of my fieldwork for this project, I had the opportunity to participate in three sweat lodge ceremonies at the Gerrard street location with two different ceremony conductors. I had no prior experience with the sweat lodge ceremony so again, I could not anticipate my reaction.

All of the sweat lodge ceremonies were scheduled to begin at 6 p.m., so I would arrive 15 to 20 minutes early to allow enough time to change into a pair of shorts as required. The ceremonies are gender specific and each was attended by 8, 6, and 5 men respectively. After everyone changed, we all sat around and talked while waiting for the conductor to announce he was ready to begin the ceremony. The mood was always light and jovial, punctuated with teasing and jokes. In this context, humor helps to create a relaxed atmosphere and perhaps relieve pre-ceremonial anxiety among the participants. Joking and teasing among the participants also helps to foster spiritual and interpersonal congruity in the group, which is important especially if someone wishes to address a very personal and emotional issue in the lodge (Bucko, 1998). After receiving word from the conductor that he was ready to begin the ceremony, we all entered the lodge according to

his particular ceremonial protocol. Once we were all settled inside, the fire-keeper handed in the designated number of rocks for the first round and a bucket of water, then the flap was closed and the ceremony was set to begin.

Similar to my experience at the yuwipi ceremony, I was initially preoccupied with being in total darkness, though I soon became acutely aware of the heat radiating off the rocks in the center of the lodge. It was only a few seconds after the door flap was closed that the temperature inside the lodge rose exponentially. Within a few minutes, I was completely drenched in sweat but I found I was able to cope with the heat by again averting my attention to the singing and drumming. After the first song, the conductor began his teaching and poured a few ladles of water on the rocks. As the steam filled the lodge the temperature again rose exponentially, this time quickly pushing me to the brink of my tolerance. Although I struggled with the heat, I found that within a few minutes I was able to alleviate my anxiety by intensifying my concentration on the songs and teachings being offered by the conductor. Each lodge that I participated in consisted of four rounds lasting an average of 20 minutes each with approximately 15 to 18 rocks in total being incorporated as the ceremony progressed. At each ceremony, everyone was given a chance to speak and make requests for spiritual guidance or healing. At the conclusion of the ceremony, I simultaneously felt physically drained and rejuvenated. Reflecting on my experience, I believe that the first ceremony I participated in was the hardest for me physically and mentally. However, I found that in each subsequent ceremony, I was able to tolerate the heat more efficiently and the ceremony became less of a physical and mental drain. My experiences have enabled me to have a deeper

understanding of the therapeutic benefits of the sweat lodge. As a participant in the ceremony, I learned the value of patience and humility, and how they are interconnected. Traditional healer Jake Agoneh explained to me that the first round of the sweat lodge often teaches the participants patience as they learn to tolerate the heat. In my initial experience, I quickly learned that I had to embrace the heat mentally and physically, as resistance would only elevate my anxiety. Once I was able to mentally pacify my resistance, my anxiety was replaced with a sense of calm that enabled me to fully appreciate all aspects of the ceremony. My sense of humility was instilled as a result of overcoming the physical and mental challenges of the ceremony. Jake Agoneh explained that the sweat lodge often has a humbling effect in that you can be physically strong but spiritually weak, and your physical strength is not what will help you endure the ceremony. My firsthand experience echoed this sentiment in that I had to consciously elevate my inner strength or my spirit to help alleviate my anxiety, physical strength was not enough. Thus, I learned that I could not access my inner strength or spirit until I learned to be patient. I also learned that I could not exert my patience until I allowed myself to be humbled by the elements within the lodge.

Prior to conducting research for this project, I had never reflected on my past experiences with smudging. While smudging was never a part of my daily routine, I have participated in the ceremony when it was called for. Smudging is unique in that it has the potential to greatly affect an individual's disposition and create group solidarity. I personally find the scent of sweetgrass and sage to be comforting and calming. Taking the time to pause and be in the moment while I smudge provides a chance for me to

transcend the pace of life and re-connect with myself. Although it is a brief ceremony, the physical and mental aspects can provide you with a sense of being re-focused or re-establishing your mental clarity. The utility, portability, and personalization of the ceremony make it a very popular choice among the clientele.

#### **5.14 Conclusions**

Based on information gathered in the interviews with the clientele at AHT, it was determined that many clients preferred to address their mental health needs in a culturally appropriate manner by incorporating Aboriginal ceremonies and spirituality as part of their mental health care regimen. The ceremonies being utilized in this manner by the clientele are smudging, sweat lodge, shake tent, and yuwipi, with the smudging and sweat lodge ceremonies being the most popular.

The smudging ceremony is popular among the clientele for a variety of reasons. Smudging has the potential to simultaneously reorient an individual's disposition, promote self-esteem, and foster a positive cultural identity. In turn, the tangibility of the ceremony is often preferred over the more passive pharmaceutical approach, resulting in either the client ceasing their reliance upon, or substantially reducing their dosage of medication. In addition, the sight and smell of the smoke offer a psychological dimension that cannot be obtained from the medications. The engagement of the senses of sight, smell, and taste empowers the client thereby creating a frame of mind that places them in control and not at the mercy of pharmaceuticals. Clients often cited feeling defenseless against remediating their mental health issues while relying solely on a pharmaceutical regime. Research suggests that when clients supplement their therapy with cultural

devices, it abates feelings of defenselessness thereby providing them with an engaged and proactive approach to their health and well being (Duran and Duran, 1995). Therefore, due to the very personal nature of the smudging ceremony, its impact and ability to be a source of strength can be powerful.

The sweat lodge ceremony was regarded by most of the clientele as a means to achieve spiritual and emotional healing. In some instances clients reported using a form of the sweat lodge ceremony known as a “releasing” sweat as a supplement to their existing counseling regime. The releasing sweat is very specific in that it is recommended for individuals who have reached a plateau in the counseling process and would benefit from a culturally therapeutic intervention in which they can “release” the pain and turmoil of past traumatic experiences. The releasing sweat as it is practiced at AHT is specifically designed to motivate an individual to abate the traumatic experiences that may be disrupting the therapeutic progress and preventing them from moving on and improving their lives. Based on my participant observation, I believe that the intense heat and darkness play crucial roles in that, in order for a participant to become comfortable with the heat, they are forced to concentrate on the task at hand and the darkness serves to amplify their concentration by removing any visual distractions. The drumming and singing add the spiritual dimension, thereby making the client feel safe and protected, which enables them to deal with highly emotional and traumatic issues that would otherwise be avoided. In addition, the sweat lodge is considered a sacred space and is often described as the womb of mother earth and as such, when the client “releases” their trauma within the lodge, they may consider it as a “re-birth” as they exit the lodge with



an improved outlook on life. As a psychotherapeutic device, the sweat lodge promotes self-esteem, increases morality, and enables a client to deal with trauma in a culturally meaningful way.

The shake tent and yuwipi ceremonies often provided clients with the opportunity to seek clarification and advice in regards to various aspects of their healing journey. Many clients reported participating in the ceremony to obtain information regarding their cultural identity and spirituality. Some clients sought to obtain closure with deceased relatives or to resolve conflict within their personal relationships. Others went to receive predictions about their future. In addition, the shake tent and yuwipi help clients to maintain or develop a cultural identity, derive meaning from personal experience, instill and maintain morality, and provide an alternate means to deal with personal problems and trauma. Similar to the sweat lodge, the setting of the yuwipi ceremony is especially conducive to help an individual overcome their apprehension about seeking help for their personal problems in a public forum. The darkness provides a cloak of anonymity for the participant that prompts openness and honesty which facilitates the healing process by removing the emotional barriers that could otherwise hinder progress.

Increasingly, researchers and many health care practitioners are lobbying for the recognition and acceptance of traditional Indigenous healing practices given that the incorporation of cultural practices into patients' health care regimes can have a positive impact on their overall health and well-being (Kirmayer et al, 2009; Poonwassie and Charter, 2005; Waldram et al, 2006). Research suggests that traditional Indigenous healing practices provide guidance and assistance for clients having a particularly

difficult time dealing with intellectual, psychological, emotional, and or spiritual anguish (Poonwassie and Charter, 2005). Participation in ceremonies is often considered an essential aspect of healing and either re-establishes or affirms an individual's cultural ancestry and spiritual connectedness. In addition, participation in ceremonies helps individuals to develop and implement traditional Indigenous sacred values such as generosity, empathy, honesty, and humility (Poonwassie and Charter, 2005).

Nonetheless, while cultural practices are becoming more widely accepted, many health care practitioners, aside from those employed at AHT, are justifiably concerned with the health and safety of their patients. Health care practitioners are trained within a western scientific paradigm which is founded upon scientific scrutiny and evidence-based conclusions. Therefore, western practitioners are trained to feel some trepidation in openly embracing cultural practices due to their professional ethical obligations. Many researchers have recognized this dilemma and have called for further research into the efficacy and components of traditional healing practices.

<sup>i</sup> Some people believe that it is more natural to use a match instead of a lighter.

<sup>ii</sup> It has become a common practice to use abalone shells for smudging. Many elders believe that abalone shells should not be used because they represent water or Grandmother Ocean therefore they should only be used for ceremonies with water and not burning. Instead it is recommended that a clay or stone bowl be used.

<sup>iii</sup> Some people believe that by blowing out the flame you are unnecessarily forcing the ceremony along thereby interfering with the natural progression of the elements. Therefore some people believe it is best to let the flame die down on its own.

<sup>iv</sup> Some people like to also move the smoke over their eyes, ears and heart to remove any negativity in these areas.

<sup>v</sup> These rocks are usually the size of a large cantaloupe.

<sup>vi</sup> In a gender specific ceremony, women will refer to the rocks as Grandmothers and men will refer to them as Grandfathers.

<sup>vii</sup> The number of poles is determined by the healer conducting the ceremony. Ethnographic accounts report a range between 4 and 40 poles with an average number of 8 to 12 poles.

## **6. Conclusions**

Initially, the primary focus of this thesis was to investigate how Western biomedical and traditional Indigenous healing systems are utilized within a medical pluralistic approach. Specifically, I examined how the clientele at AHT manage and incorporate various aspects of Western biomedicine and traditional Indigenous healing to address their specific health needs. Additionally, I also investigated the clients' perceptions about the value of using a pluralistic approach as well as the challenges, risks, and benefits perceived by practitioners of both systems. As my research progressed and evolved, it became apparent that the philosophy, infrastructure, and model of health care at AHT went far beyond merely offering access to both systems of health care. The model of health care developed at the centre is an example of a conglomerate of complex approaches specifically designed to address complex Aboriginal health issues.

The major health problems of Aboriginal people in Canada are unique in that they suffer from the ill effects of their historical circumstances within Canada (Kirmayer et al, 2009; Waldram et al, 2006). Colonialism and the oppression to the Indigenous way of life fostered a perpetual erosion of Indigenous health and well-being that continues to plague the population today, as many diseases often occur at a much higher rate as compared to the rest of the Canadian population (Kirmayer et al, 2009; Waldram et al, 2006). As a result of the often culturally specific nature of their particular health issues, Western biomedicine and treatment often fail to meet the health needs of Aboriginal people (Lemchuk-Favel and Jock, 2004; Martin-Hill, 2003). In an effort to remediate their specific health care needs, many Aboriginal people are using a medical pluralistic

approach (Gagnon, 1989; Gregory, 1989; Stoner, 1986; Waldram et al, 2006; Waldram, 1990) to establish a more inclusive and holistic approach to their health care (Gregory, 1989; Martin-Hill, 2003; Stoner, 1986; Waldram et al, 2006). Interestingly, research suggests that the increased reliance on traditional Indigenous healing practices has not led to the dismissal of the Western biomedical system by Aboriginal patients nor has it diminished their use of the biomedical system to address specific health problems (Waldram et al, 2006; Waldram, 1990).

For over 20 years, AHT has developed and implemented a variety of programs that utilize traditional Indigenous healing practices within a multidisciplinary health care model to address the health care needs of the urban Aboriginal population. However, the epistemological, philosophical, and pedagogical differences between traditional Indigenous healing and western biomedicine prevent the establishment of a formally integrated system (Cohen, 2003; Kirmayer et al, 2009; Letendre, 2002; Waldram et al, 2006). Therefore, AHT advocates maintaining traditional Indigenous healing as a distinct approach from Western biomedicine because it provides a more comprehensive approach to health care by maximizing the number of potential therapeutic approaches available by not diluting existing modalities. While acknowledging the ability of western biomedicine to cure certain diseases and illnesses, practitioners, staff, and clients at AHT also recognize that any approach to health care is subject to its inherent limitations. Given that Aboriginal health-related issues are often associated with sociohistorical, sociopolitical, and sociocultural circumstances (Archibald, 2006; Kirmayer et al, 2009; Wesley-Esquimaux and Smolewski, 2004; ), the philosophy at AHT is that traditional Indigenous

healing and western biomedicine are capable of supporting and augmenting each other, thereby providing a comprehensive health care model.

The findings of this research project coincide with other research that suggests either the absence of, or a barrier to establishing, a connection to Aboriginal culture is often cited as a contributing factor for many health-related issues (Chandler and Lalonde, 1998; Frideres, 2011; Skye, 2006). In their research on the rates of youth suicide among British Columbia's First Nations, Chandler and Lalonde (1998; 2009) coined the term "cultural continuity" in reference to their theory that when circumstances impede or undermine an individual's ability to maintain and develop a sense of self or cultural identity, they lose a sense of connection with their cultural past and they feel that their future is inconsequential and subsequently, those individuals will engage in self-destructive behavior. However, they found that communities with a high level of cultural continuity factors, such as self-government, control over education, health, police, fire departments, and land claims achieved or in process, had higher rates of well-being compared to communities that had low levels of cultural continuity factors (Chandler and Lalonde, 1998; 2009). Additionally, in a follow up research project, they found that the number of women involved in community level government and child services resulted in higher levels of community well-being (Chandler and Lalonde, 2009). Therefore, those communities with members actively enrolled in community participation, family relationships, and social networks have an enhanced sense of belonging and cultural identity thereby fostering a healthier population.

Interestingly, the findings of my research coincide in part with Chandler and Lalonde's cultural continuity theoretical orientation. For example, one of the primary tenets of the comprehensive model practiced at AHT is the development and enhancement of Aboriginality or cultural identity, which is believed to be an essential resource in assisting clients in dealing with the sociohistorical, sociopolitical, and sociocultural aspects of their health (Kirmayer et al, 2009). Through a variety of programs and resources at AHT, the development and enhancement of a cultural identity may include the establishment of Aboriginal ancestry in addition to the acquisition of cultural knowledge, spirituality, beliefs, and values for those clients that have either become disconnected or have never established a connection with their Indigenous culture. A strong sense of cultural identity coincides with the cultural continuity concept in that a stable cultural foundation has proven to be a valuable asset for the client. It helps them to deal with their particular health issues by establishing a sense of connectedness to their cultural past, thereby providing a source of inner strength to improve their health and well-being as well as motivate them to strive for a meaningful, prosperous future (Kirmayer et al, 2009).

Throughout my research, healers and clients indicated that they believe many of the health-related issues that afflict Aboriginal peoples can be linked to historical trauma and the subsequent destruction of their traditional livelihood (Wesley-Esquimaux and Smolewski, 2004; Yellow Horse Brave Heart, 2003). One of the most popular examples cited among the healers and clients is the onset of diabetes among Aboriginal peoples, which they explained as being derived from a series of events initiated by colonial

oppression and then exacerbated by life on reserves, a sedentary lifestyle, and a reliance on processed foods. Therefore, diabetes is regarded as the physical manifestation of colonization and the nearly inevitable reliance on some aspect of western treatment for the disease is yet another example of the ubiquitous subjugation of Indigenous peoples in that they are forced to rely on western medicine to treat a disease that was borne of western imposition. Much the same can be said for their views on a variety of health issues, including mental health, and many healers and clients believe that in order to improve the overall health status of Aboriginal peoples, reclamation of their health and traditional approach to health care is needed.

As a result of the affiliation between colonialism and health-related issues, in conjunction with AHT's culturally inclusive healthcare model, many clients regard the centre as offering much more than merely access to health services. In addition to establishing various forms of cultural connectedness, my research suggests that the services and model of health care practiced at AHT provides a means of agency for the clients to "decolonize" their health and health care (Archibald, 2006; Kirmayer et al, 2009).

Many of the clients expressed a notion that they had a history of a relatively antagonistic relationship with the western health care system and practitioners, in part because they felt that their particular health needs were not understood from a sociopolitical and sociocultural perspective, which affected the quality of health care they received. In addition, many clients explained that their frustration with the western biomedical approach was perpetuated in part by the philosophy and infrastructural



constraints of the system which made them feel powerless and subjugated within a western clinical environment. However, clients reported that within the context of AHT, they felt that their health and related issues were understood historically, politically, and culturally, and they felt they were empowered and respected within a clinical environment. Similar sentiments are expressed in research examining Aboriginal patients' utilization of a medical pluralistic approach, which suggests that pluralism empowers the patient by providing them with a measure of control over their health care and with the option to access a different system if they find treatment from the other unsatisfactory. In addition, patients have their cultural beliefs and values validated and understood within the context of healing (Kirmayer et al, 2009; Waldram et al, 2006).

Thus, my research suggests that the level of understanding, respect, empowerment, and control experienced by the clientele at AHT is the product of the deliberate re-distribution of power vis-à-vis the infrastructural re-alignment and specific model of health care developed AHT. Critics of the western biomedical model from the sociological medicalization perspective suggest that the position of power held by biomedicine has been gained at the expense of exploited and oppressed social groups (Lupton, 1997). However, from a Foucaultian perspective, power as defined within the medical context is the product of the particular strategies employed by the discipline. Namely, through the physician's observation, examination, measurement and comparison against an established norm, patients are relegated to a less powerful position within the clinical context as opposed to physicians who serve as a conduit for the power of the discipline. Although Foucault argued the impossibility of shifting power from physicians

to patients, in addition to proclaiming that power is ubiquitous and not monopolized by any one particular social group but rather that it is imbued and disseminated through all of society, critics argue that the underlying notion of this perspective suggests that individuals are perpetually mired in power relations with biomedicine (Lupton, 1997). In response, critics encourage the empowerment of patients by re-establishing control over their health by utilizing preventative health measures, adopting a ‘consumer’ approach within the clinical environment by seeking clarification on treatment and prescriptions, as well as enrolling in patient advocacy groups and seeking advice from alternative practitioners (Lupton, 1997).

Through a system specifically structured to address Aboriginal health related issues that is under Aboriginal control, development, and implementation, clients are able to exercise their agency and decolonize their health individually and collectively (Kirmayer et al, 2009). From the perspective of the clientele, there is a symbiotic relationship between a healthy body and a healthy society or conversely, a diseased body and an unhealthy or malfunctioning society (Kirmayer et al, 2009; Scheper-Hughes and Lock, 1987). Therefore, the ability to improve the collective health status of the Aboriginal population is initiated by individual effort. My findings for this aspect of my research coincide with Scheper-Hughes and Lock’s (1987) proposed theoretical orientation of the body politic. From this perspective, the body represents both instrument and message and is endowed with political significance and power in that in addition to their desire to no longer be passive recipients of health care, clients want to be active and engaged in their health and well-being and as a result, they are contributing to the service of the body

politic. Within this context, the body politic is primarily concerned with addressing issues of balancing power within the medical context and enhancing control over health-related issues and health care.

Within the context of AHT, I suggest that the infrastructure of the institution embodies the self-determination of health care and thereby empowers the clientele by offering them the opportunity to have more input and control over their health care in collaboration with the health practitioners at the centre. Through this approach, clients are able to reclaim, incorporate, and validate traditional healing as part of their health care regimen. Research indicates that many researchers and many health care practitioners advocate the incorporation of cultural practices into patients' healthcare regimes as it can have a positive impact on their overall health and well-being (Poonwassie and Charter, 2005; Waldram et al, 2006). Research also suggests that participation in spirituality and traditional Indigenous healing practices is often considered an essential aspect of healing and is especially helpful in assisting these individuals in developing a positive and healthy lifestyle (Poonwassie and Charter, 2005). Thus, the re-distribution of power, and the recognition and incorporation of Indigenous healing, has provided a platform through which the clientele are able to service the body politic and decolonize their health and bodies, thereby initiating positive proactive change among the population towards an improved health status (Kirmayer et al, 2009).

As I have illustrated throughout my thesis, in addition to providing a basis for understanding the multi-dimensional application of traditional Indigenous healing in conjunction with the western biomedical approach to address the specific health related

issues of Aboriginal peoples, my work also has utility for future research within the context of urban Aboriginal health and traditional Indigenous healing. While there has been research conducted that has focused on a variety of topics concerning urban Aboriginal populations, it is rather sparse compared to studies concerning reserve populations. In addition, the research tends to be overly concerned with issues of efficacy, amalgamation, and the application of traditional Indigenous healing within a western biomedical context. In contrast, the core message from my research and one that is often bypassed or not even considered as a viable option by researchers in the area is that an amalgamation of the two systems is highly unlikely given all of the circumstances I have outlined in this thesis. However, my research has illustrated that under the right circumstances, the two systems can work very well synergistically and provide an ideal approach to Aboriginal health and health care. Therefore, I propose that research efforts need to be re-organized and re-conceptualized to reflect the low likelihood of and potential costs associated with amalgamation, and focus on developing understanding and pragmatic solutions to further perpetuate a cohesive working relationship between the two systems. My research also has implications for future study in the area of the efficacy of traditional healing in that it must be recognized and acknowledged that the two systems are, for the most part, mutually incompatible when it comes to measures of efficacy. Therefore, I suggest that if future research calls for a measure of efficacy to substantiate conclusions, that the researcher employ the theoretical orientation proposed by Waldram (2000) in which any notion of efficacy must be situated within a particular

healing context and be a fluid rather than fixed concept to reflect the beliefs and expectations of all those involved.

My research also indicates that any future anthropological studies of Aboriginal health as they relate to the methods and approaches used by Aboriginal peoples should incorporate a broad critical interpretative lens to enable the researcher to understand all of the historical, cultural, and political factors influencing the modalities used. AHT is a prime example of how the inherent complexity of Aboriginal health issues necessitates a broad inclusive approach to adequately address Aboriginal-specific health-related issues. As AHT will no doubt continue to evolve and refine its culturally specific approach, it will not only continue to foster the development of the working relationship between traditional Indigenous healing and Western biomedicine, it will also serve as a valuable resource and inspiration for other Aboriginal community health centres to achieve the embodiment of self-determination in the area of health care.

If AHT is to continue evolving and setting precedents, the continuation and expansion of in-house research is important in order to strengthen future efforts to lobby for greater funding to accommodate the increased demand for services among the clientele, especially traditional healing services. In addition, future research will only serve to enhance cross-cultural understanding of traditional Indigenous healing as well as illustrate how western biomedicine and traditional healing can not only co-exist, but also evolve, as the two models will no doubt have their modalities refined within the institution. Finally, it was mentioned by Joe Hester that ideally the services at AHT should be housed within a single building at a strategic location. I believe that this needs

to become a reality, not only for the benefit of AHT but for the benefit of the clientele. A central location providing access to all of the services would not only motivate the clientele to utilize more services, it would also continue to perpetuate the improvement of their overall health status and thereby improve the overall health and well-being of the community.

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## **Appendix A**

### **Programs and Services offered at Anishnawbe Health Toronto**

- Registered Dietician - The Registered Dietician provides diabetic clients, their families and supports with 1:1 nutritional counseling and educational/support groups.
- Diabetic Nurse Educator - The Diabetic Nurse Educator provides holistic culture based educational programming for the prevention of complications of diabetes. The programming includes 1:1, group and community education.
- Physicians Assistant - The PA is a health care provider trained as a physician support. The PA functions under the supervision and direction of the physician.
- Diabetic Initiative - The Diabetic Initiative is a traditional culture based program for the prevention of complications of diabetes. The program provides diabetic clients, family and supports with access to traditional, western and complimentary care. The goals of the program are to prevent complications of diabetes, through education and supportive services.
- Traditional Family Services - The TFS program was initiated, in partnership with MCYSS for children/youth in care of child protection services, their families/caregivers and foster parents to access Traditional culture based services and programs. Services and programs include:
  - Naming ceremonies
  - Rites of passage
  - Family reunification ceremony
  - Family sweats
  - Traditional Adoption Ceremony
- Aboriginal Mental Health and Addiction Services - Aboriginal Mental Health and Addictions Service places Aboriginal culture and traditions at its core while utilizing a client centered, strength based approach to assist in one's recovery. This assists clients to build their identity as an Aboriginal person, learn about their culture and tradition in order to begin and then maintain them on their wellness journey. Teachings include but are not limited to:
  - Assessment for Substance Use
  - Traditional Healing

- Sweat Lodges
  - Coping with Triggers
  - Individual, Family and Group Counseling
  - Circles & Support Groups
  - Traditional Ceremonies and Teachings
  - Psychiatric Consultation
  - Coping with Relapses
  - Better Communication
  - Stress Management
  - Anger Management
  - Multidisciplinary Plans of Care to guide the Healing Path
  - Art Therapy
  - Nutrition
  - Recreation
  - Referrals
- FASD Diagnosis and Assessment - In partnership with St. Joseph's hospital and Breaking the Cycle, AHT provides a FASD Diagnosis and Assessment Clinic. A multi-disciplinary team consisting of a Physician, Nurse, Psychologist, Circle of Care Worker, Traditional Healers and Traditional Counselors provides assessment where there has been pre-natal exposure to alcohol and /or drugs.
  - Nurse Practitioners: RN(EC) - As a member of our health team, the nurse practitioner provides a range of services which include the ability to:
    - Diagnose and treat illness and/or injuries
    - Perform physical check-ups
    - Order and interpret diagnostic tests
    - Write prescriptions
    - Provide counseling and education
    - Provide supportive care through illness

- Provide treatments and/or procedures, and
- Make referrals to family physicians, specialists and other health professionals
- **Mental Health Services** - Our service model fully integrates Traditional and Western approaches to assess, diagnose and treat mental health problems across the life cycle. A multidisciplinary team of mental health professionals work together to go beyond treating only symptoms, by identifying and addressing the underlying issues; for example residual trauma and identity issues due to colonialism, assimilation and Residential Schooling. Mental Health Services are for all people with concerns about emotional, psychological, behavioural or cognitive health. Priority groups include people who are homeless, people affected by FASD/E, people in mental health crisis, seniors, and people with substance use or problem gambling concerns.
- **Babishkhan: Circle of Care Workers** - Babishkhan is our service model that works with individuals who wish to escape rather than survive homelessness. It is a long term circle of care (case management) solution model that provides responses which consider the spirit, mind, body and emotional needs of clients. This wholistic approach helps staff and client to better understand the underlying causes contributing to the client's cycle of homelessness.

Our staff provide Circle of Care (Case Management) services for homeless people who are sleeping rough and strive to stabilize their lives and leave the streets.

- **Nmakaandjiiwin (Finding My Way)** - Finding My Way is a training program available to those individuals who are seeking to escape homelessness. Individuals are provided opportunity to better understand and gain insight of homelessness issues and how these may relate to their lives. Other course content includes subjects that help with culture identity and historical issues of Aboriginal people.
- **Community Health Worker Training Program** - This training program provides participants with culture based training in community work.

Through a partnership agreement with George Brown College, graduates of the Community Health Worker Training Program receive college certification after successful completion of the first year and are eligible for admittance to the second and final year of the College's Community Worker Diploma Program. The combination of on-the-job training and course work covers four main subject areas:

- Traditional Health



- Community Development
- Health Promotion, Advocacy and Counseling
- Communication and Presentation Skills
- O Ta Ti Baen Program (O Tay) - The O Ta Ti Baen Program supports the efforts of people who are working towards a life away from homelessness.

Participants earn credits by providing services in several areas, including Administration, Kitchen and Environmental Services and Home Visit (Outreach) Services. Credits are then applied towards their housing, clothing, recreational and other needs.

- Diagnostic Clinic - In partnership with St. Joseph's Hospital and Breaking the Cycle, AHT provides a FASD Diagnostic Clinic.

A multi-disciplinary team consisting of a Physician, Nurse, Psychologist, Circle of Care Worker, Traditional Healers and Traditional Counselors provides assessment, diagnostic and support services where there has been pre-natal exposure to alcohol and/or drugs.

- Fetal Alcohol Spectrum Disorder Services - To promote awareness and prevention of Fetal Alcohol Spectrum Disorder (FASD), AHT provides services which include:

- Community information workshops
- Support groups
- Referrals to assist the families of FASD children
- Nutritional counseling
- FASD Diagnosis and Assessment

In partnership with St. Joseph's Hospital and Breaking the Cycle, AHT provides a FASD Diagnosis and Assessment Clinic. A multi-disciplinary team consisting of a Physician, Nurse, Psychologist, Circle of Care Worker, Traditional Healers and Traditional Counselors provides assessment where there has been pre-natal exposure to alcohol and /or drugs.

Community members are invited to access information on FASD support services and resources at our program office. It takes a community to prevent Fetal Alcohol Spectrum Disorder and its effects and to support expectant mothers to be alcohol free.

- Circle of Care Workers - Circle of Care Workers assist people who are homeless to develop, achieve and maintain a life free from the cycle of homelessness.

Together the participant and Circle of Care Worker develop a 'circle of care' which addresses their spiritual, physical, mental and emotional needs, promoting self-confidence and self-reliance.

- Chiropractor - As foot care specialists, Chiropractors assess and treat foot disorders related to structure or function and those associated with disease, infection or injury.
- Naturopaths - In partnership with the Canadian College of Naturopathic Medicine, our team of Naturopaths provide a coordinated approach to health care, including disease diagnosis, treatment and prevention, using natural therapies which may include:
  - acupuncture
  - homeopathy
  - herbal medicine
  - nutritional counseling
  - Eastern medicine
  - lifestyle counseling
- Physicians and Nurses - Our team of Nurse Practitioners, Registered Nurses and Physicians provide primary health care which includes:
  - Health examinations
  - Care for people with acute and chronic conditions
  - Well Baby care
  - Immunizations for all ages
  - Anonymous HIV testing
  - Routine screening for diabetes and other conditions
  - Health promotion and illness prevention
  - Referrals to intensive care, specialized services, or diagnostic/testing procedures
- Chiropractors - In partnership with the Canadian Memorial Chiropractic College, our team of Chiropractors assess and treat disorders related to the spine, nervous system and joints.

- Dentist - The Dentist provides diagnosis and treatment of problems associated with teeth or mouth tissue.
- Psychiatrist - The Psychiatrist provides assessment, diagnosis and counseling services to assist with a broad range of mental health issues.
- Traditional Counselors - Our Traditional Counselors use traditional and western counseling approaches.

They provide non-judgmental, compassionate support, working with individuals on a broad range of issues, which include:

- Physical, emotional, sexual, intellectual or spiritual abuse
  - Residential school survivor issues
  - Substance abuse
  - Adoption/foster care issues
  - Heritage identity; self-esteem
  - Relationship issues
- Traditional Healers, Elders, and Medicine People - Through our culture and traditional healing methods, Traditional Healers, Elders and Medicine People help individuals, families and community strive for balance, harmony and good health.
- Traditional Doctoring
  - Traditional Medicine
  - Guidance and Counseling
  - Teaching and Healing Circles

Healing approaches include the mind, body, emotions and spirit. The healing path begins with and includes many spiritual ceremonies, some of which are:

- Sweat Lodge
- Shaking Tent
- Full Moon Ceremony
- Naming Ceremony
- Clan Feasts

- Yuwipi Ceremony
- Pipe Ceremony
- Vision Quests
- Enaadamged Kwe (Woman's Helper) - The Enaadamged Kwe program provides support for mothers and family during the gestation period, at birth, and until the baby is six months of age.

This traditional and culture-based program celebrates the sacredness of life and honours the spirit of women.

- Massage Therapists - In partnership with Sutherland-Chan School and Teaching Clinic, our team of Massage Therapists advise on selfcare and provide a service to improve health and well-being by a hands-on manipulation of muscles or soft tissues of the body.

## Appendix B

### Research Participant Recruitment Poster

# **Research Participants Needed**

Research participants are needed to learn how Aboriginal people use Western Biomedicine & Traditional Healing.

**Part 1:** completion of a questionnaire about your use of Traditional Healing practices and Western Biomedicine.

**Part 2:** people who finished the questionnaire may be invited to take part in a one-on-one interview with the researcher at Anishnawbe Health Toronto. (Participants will receive \$15.00 towards their transportation and other costs for the interview).

Participation in this study is voluntary and will in no way affect the care or service you receive from Anishnawbe Health Toronto. You can stop being part of the study at anytime.

If you are interested, a brief questionnaire will be given to you at reception.

- ▶ Completed questionnaires should be placed in the envelope provided, sealed and given to the receptionist who will place it in a box for safe keeping.
- ▶ If you said you want to be interviewed, the researcher will contact you within a few weeks.
- ▶ Thank you for your time and consideration. This study has been reviewed and approved by the McMaster Research Ethics Board.



Researcher: Jairus S. Skye, PhD Candidate,  
McMaster University.

Contact information: (905) 869-1968

Email: [skyejs@mcmaster.ca](mailto:skyejs@mcmaster.ca)

## Appendix C

### Research Participant Intake Questionnaires

October 2007



#### Letter of Information / Consent Form

##### *A Study of How Aboriginal People Use Traditional Healing and Western Biomedicine*

**Principal Investigator:** Jairus S. Skye  
Department of Anthropology  
McMaster University  
Hamilton, Ontario, Canada (905) 869-1968

**Research Sponsors:** University of Toronto/McMaster University Indigenous Health Research  
Development Program funded by the Canadian Institutes of Health  
Research-Institute of Aboriginal Peoples Health  
  
School of Graduate Studies McMaster University

#### **Why am I doing this study?**

I am asking 20 to 25 clients of Anishnawbe Health Toronto about how they use Traditional Aboriginal healing and Western biomedicine. I want to know why clients use Traditional healing and Western biomedicine and how this makes them feel.

#### **What will happen in this study?**

If you decide to be part of this study, you will be invited to do the following:

1. You are being asked to complete the brief questionnaire attached to this form. This questionnaire asks for information about you, your health and well-being, and your use of Western biomedicine and Traditional Aboriginal healing practices. If you are willing to supply this information, please put the questionnaire in the sealed envelope so that your answers can be kept private and seen only by the researcher.
2. To participate in a one to one audio taped interview with the researcher, Jairus Skye, at Anishnawbe Health Toronto. The interview will be 45 to 60 minutes long and will be a discussion about your use of Traditional healing and Western biomedicine and how this affects your health and well-being. Your words may be used and printed in a write up of this study, though your identity will remain private and not be printed. You will receive \$15.00 in appreciation for your time to participate in the interview.

#### **Are there any harms, risks, or discomfort involved in the study?**

You may feel somewhat uncomfortable about disclosing personal information about your health, well-being or your experiences with the services provided by Anishnawbe Health Toronto. You do not need to answer questions that make you uncomfortable or that you do not want to answer.

#### **What are the possible benefits of this study?**

This study may be used to help Aboriginal and non-Aboriginal people understand how or why Traditional Aboriginal healing is used for health and well-being. This study will also help urban Aboriginal community health centres such as Anishnawbe Health Toronto to improve or maintain Traditional healing programs and services.

#### **Who will know what I said or did in the study?**

It is up to you to decide whether you want to participate. Nobody at Anishnawbe Health Toronto will know whether you participated or not. I will keep the information you tell me private and I will keep it safely in my office. Also, I will not tell anyone your name, even after the study. To maintain your privacy I will not use your name or any information that may identify you in my written report.

**What if I change my mind about being in the study?**

You can decide to be part of the study or not. You can also decide to stop anytime, even before or after you sign this consent form or part way through the questionnaire. If you decide to stop, nothing will happen to you, and nothing will change about how you are treated at Anishnawbe Health Toronto. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

**How do I find out what was learned in the study?**

After this research study has been completed, you can obtain information about the results of the study by contacting either the researcher Jairus Skye or Joe Hester at Anishnawbe Health Toronto.

**My Rights as a Research Participant**

If you have questions or you want more information about the study, please call Jairus Skye at (905) 869-1968.

This study has been reviewed and approved by the McMaster Research Ethics Board, which is a group of researchers and people from the Hamilton community. They make sure that the study is done in a way that protects the people who take part in it. If you have concerns or questions about being part of this study or how we did the study, please call:

McMaster Research Ethics Board Secretariat  
Telephone: (905) 525-9140 ext. 23142  
C/o Office of Research Services E-mail: [ethicsoffice@mcmaster.ca](mailto:ethicsoffice@mcmaster.ca)

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CONSENT

I have read or have had explained to me the information presented above about a study being run by Jairus Skye of McMaster University. I had the chance to ask questions about being part of this study and I had a chance to get more information about the study. If I choose to do so, I can stop being part of the study at any time. Understanding all of this, I agree to be part in this study. I have been given a copy of this form.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

**A Medical Pluralism Approach to Health Care Questionnaire**

*Please answer the following questions to the best of your knowledge. Check all that apply. You can skip any question that you do not feel comfortable answering.*

- 1) Gender: \_\_\_\_\_ Age \_\_\_\_\_
- 2) Do you live in Hamilton \_\_\_\_\_ or the Greater Toronto Area \_\_\_\_\_ or other (please specify) -  
\_\_\_\_\_
- 3) Are you an Aboriginal person? Yes \_\_\_ or No \_\_\_ If **yes**, then please specify your  
Nation \_\_\_\_\_ Status \_\_\_ or Non-Status \_\_\_
- 4) Are you seeing a Traditional healer at the Health Center for your health and well-being? Yes \_\_\_ or  
No \_\_\_ If **yes**, then what do you see the Traditional healer for?  
To treat a physical illness \_\_\_ to provide herbal medicine \_\_\_ to provide spiritual healing \_\_\_  
other, please specify \_\_\_\_\_
- 5) Are you seeing a Doctor at the Health Center for your health and well-being? Yes \_\_\_ or No \_\_\_ If  
**yes**, then what do you see the Doctor for? To treat a physical illness/disease \_\_\_ to treat a mental  
illness \_\_\_ are you currently taking any prescription medication? Yes \_\_\_ or No \_\_\_
- 6) Are you currently using, or in the past used, both Traditional Medicine(s) and Western  
medications for your health and well-being? Yes \_\_\_ or No \_\_\_ If **yes**, approximately for how long?  
One week \_\_\_ one month \_\_\_ more than one month \_\_\_ one year \_\_\_ more than one year \_\_\_  
If longer please specify \_\_\_\_\_
- 7) Have you informed either your Traditional healer or Doctor that that you are using both  
Traditional medicine(s)/healing and Western medications? Yes \_\_\_ or No \_\_\_  
If **yes**, who did you tell? Traditional healer \_\_\_ Doctor \_\_\_
- 8) If you are using both Traditional medicine(s)/healing and Western medications do you feel that it  
has improved your health and well-being, a lot \_\_\_ a little \_\_\_ made no difference \_\_\_ or made it  
worse \_\_\_
- 9) Why did you decide to use both Traditional medicine(s)/healing and Western medications for your  
health and well-being? (check all that apply) Advice of family/friend \_\_\_ advice of Traditional  
healer \_\_\_ advice of doctor \_\_\_ personal decision \_\_\_

*Thank you...please turn to the next page*



**Thank you for completing the questionnaire. This research project also has a second phase that will take place over the next few months. In this second phase, I would like to conduct personal interviews at Anishnawbe Health Toronto with some of the participants who responded to this questionnaire. These interviews will focus on topics similar to those of the questionnaire you just completed, including the use of Western biomedicine and Traditional healing practices and how they contribute to the health and well being of Aboriginal people in an urban setting. Please choose one of the three options below, regarding this second phase of the study.**

- Yes, I would be interested in participating in a personal interview. Please contact me to set up an appointment. My name is (please print) \_\_\_\_\_ and the telephone number where I can be reached is (\_\_\_\_\_)\_\_\_\_\_.
  
- I would like to learn more information about these personal interviews before I decide if I would like to participate. Please contact me to answer my questions about these interviews. My name is (please print) \_\_\_\_\_ and the telephone number where I can be reached is (\_\_\_\_\_)\_\_\_\_\_.
  
- I will call the researcher (Jairus Skye) at (905) 869-1968 to ask whatever questions I may have about these interviews. Collect long distance calls will be accepted.
  
- No, I am not interested in participating in a personal interview.

## **Appendix D**

### **Client Demographic Data**

*Tables containing raw data appear on the following pages, for Queen Street and Gerrard Street locations of Anishnawbe Health Toronto respectively.*

PHD Health Care Questionnaire - Toronto: Queen Street									
Participant #	Male	Female	Other	Age	Reside in Toronto	Other location	Aboriginal	Nation	Status
1		1		44	1		1	Lac Seul	1
2		1		34	1		1	Ojibway	1
3	1			48	1		1	Upper Cayuga	1
4		1		47	1		1	Oneida of the Thames	1
5		1		41	1		1	Ojibway	1
6	1			32	1		1		
7				58	1		1	Wikwemikong	1
8		1		32	1		1	Inuit	1
9		1		44	1		1		
10		1		45	1		1		
11		1		47	1		1	Cree	1
12		1		55		Coldwater Ont.	1	Whitefish River	1
13		1		38		Pickering Ont.	1	Cree	1
14		1		44			1	Cree/Algonquin	1
15		1		52	1		1	Algonquin	
16		1		38	1		1	Ojibway	
17		1		60	1		1	Ojibway	1
18		1		59	1		1	Ojibway	1
19		1		25	1		1		
20		1		31	1		1	Ojibway	
21	1			61	1		1		
22		1		37	1		1	Ojibway	1
23		1		37	1		1	Metis	
24		1		53	1		1	Okanagan	1
25		1		35	1		1	Ojibway	1
26	1			36	1		1	Mik Maq	
27		1		38	1		1	Cree	1
28		1		47	1		1	Ojibway	1
29	1			63		Parry Sound	1	Ojibway	1
30		1		42	1		1	Ojibway	1
31		1		31	1		1	Anishnawbe/Ojibway	1

PHD Health Care Questionnaire - Toronto: Queen Street									
Participant #	Male	Female	Other	Age	Reside in Toronto	Other location	Aboriginal	Nation	Status
32		1		42		Innisfil	1	Ojibway	1
33		1		46	1		1	Cree	1
34		1		55	1		1	Six Nations	1
35		1		46	1		1		1
36	1			41	1		1	Cree	1
37		1		40	1		1		1
38		1		29	1		1		1
39	1			31	1		1	Anishnabek	1
40		1		42		Walpole Island	1		1
41	1			31	1		1		1
42	1			60	1		1	Metis/Ojibway	1
43		1		43	1		1	Ojibway	1
44		1		62	1		1		
45		1		41	1		1	Cree	1
46	1			32	1		1	Oneida of the Thames	1
47	1			31	1		1	Maya	
48		1		31	1		1	El Salvador	
49	1			22			1		1
50	1			56			1	Sagarnok	1
51	1			31		Barrie Hamilton	1	Ojibway/Pottawami	1
52		1		51	1		1		1
53		1		28	1		1		1
54		1		49	1		1	Sagarnok	1
55		1		45	1		1	Ojibway	1
56		1		56	1		1	Ojibway	1
57	1			21	1		1	Mohawk	1
58		1		30	1		1		1
<b>AVERAGE</b>	<b>19</b>	<b>39</b>	<b>0</b>	<b>42.17</b>	<b>51</b>		<b>56</b>		<b>39</b>
<b>COUNT</b>	<b>33%</b>	<b>67%</b>			<b>88%</b>		<b>97%</b>		<b>67%</b>
<b>% TOTAL</b>									

Participant #	Non-Status	Seeing Healer	Heal phys illness	Heal herb med	Heal spiritual	See Doc	Doc phys ill/disease
1		1					
2		1			1		1
3		1	1	1	1	1	
4							
5		1	1	1	1	1	1
6		1	1				
7							
8		1			1	1	1
9		1		1	1	1	1
10		1		1	1	1	1
11	1	1	1	1	1	1	1
12		1			1	1	1
13		1			1	1	1
14		1	1	1	1	1	1
15	1	1			1		
16	1	1	1	1	1		
17		1	1	1	1		
18		1	1	1	1	1	1
19	1	1			1	1	1
20		1			1	1	1
21		1		1	1		
22	1					1	1
23							
24	1					1	
25						1	
26		1			1	1	
27	1	1			1		
28		1			1		
29		1		1	1	1	1
30		1	1		1		
31		1	1	1	1	1	1

Participant #	Non-Status	Seeing Healer	Heal phys illness	Heal herb med	Heal spiritual	See Doc	Doc phys ill/disease
32	1	1			1	1	
33		1	1	1	1	1	1
34		1			1	1	1
35		1	1	1	1	1	1
36		1	1	1	1	1	1
37		1		1	1	1	1
38		1			1		
39							
40						1	1
41						1	
42		1					
43		1		1	1		
44		1			1		
45		1			1		
46		1			1	1	1
47							
48		1	1	1	1		
49		1	1	1		1	1
50		1	1	1		1	
51		1			1		
52							
53		1			1		
54		1		1	1	1	1
55		1			1	1	1
56		1	1		1		
57		1			1	1	1
58		1			1		
<b>AVERAGE</b>	<b>8</b>	<b>44</b>	<b>16</b>	<b>20</b>	<b>40</b>	<b>34</b>	<b>25</b>
<b>COUNT</b>	<b>14%</b>	<b>76%</b>	<b>28%</b>	<b>34%</b>	<b>69%</b>	<b>59%</b>	<b>43%</b>
<b>% TOTAL</b>							

Participant #	Doc mental ill	On meds	Use Trad & West	How long?	one week	one month	> one month	one year	>one year
1			1						1
2			1						
3			1		1				
4			1			1			
5			1						1
6									
7		1	1			1			
8		1	1						1
9		1	1						1
10			1		1				
11	1	1	1				1		
12			1				1		
13			1						
14		1	1						1
15			1						1
16									
17			1						1
18		1	1						1
19		1							
20			1						1
21			1			1			
22			1					1	
23									
24		1	1						
25	1		1		1				
26	1		1						
27			1						1
28			1						1
29		1	1						1
30			1		1				
31		1	1						1

Participant #	Doc	mental ill	On meds	Use Trad & West	How long?	one week	one month	> one month	one year	>one year
32				1						1
33			1	1		1				
34				1			1			
35			1	1						1
36		1		1						1
37				1						1
38										1
39			1	1						1
40										
41		1	1	1						
42				1						
43				1						1
44			1	1						
45			1	1						1
46			1	1				1		
47				1						
48				1			1			
49				1			1			
50			1	1						1
51				1						1
52				1						1
53										
54				1		1				
55			1	1						1
56				1						1
57			1	1		1				
58				1						1
<b>AVERAGE</b>				<b>48</b>		<b>7</b>	<b>6</b>	<b>4</b>	<b>2</b>	<b>24</b>
<b>COUNT</b>				<b>83%</b>		<b>12%</b>	<b>10%</b>	<b>7%</b>	<b>3%</b>	<b>41%</b>
<b>% TOTAL</b>		<b>5</b>	<b>21</b>							
		<b>9%</b>	<b>36%</b>							



Participant #	Inform heal	Inform Doc	Improve Health	Why? advice of fam/friend	healer	doc	personal decision
1	1	1	a lot				1
2			a lot	1			1
3			made no difference				1
4			a lot				1
5	1	1	a lot		1		1
6	1		a lot			1	1
7			a little				1
8	1	1	a lot			1	1
9	1	1	a lot				1
10	1	1	a lot	1			1
11	1	1	a lot				1
12		1	a lot				1
13			a little			1	1
14	1	1	a lot				1
15	1		a lot		1		1
16							1
17	1	1	made no difference				1
18	1	1					1
19							1
20	1	1	a lot	1	1	1	1
21		1	a little				1
22	1	1	a lot		1		
23							
24							
25	1	1	a lot				1
26	1		a lot		1		1
27		1	a lot				1
28			made no difference	1			
29			a lot				1
30		1	a lot				1
31	1	1	a lot	1	1	1	1

Participant #	Inform heal	Inform Doc	Improve Health	Why? advice of fam/friend	healer	doc	personal decision	
32			a lot					
33		1	a lot				1	
34	1	1	a lot		1	1	1	
35	1		a lot				1	
36	1	1	a lot				1	
37	1	1	a lot			1	1	
38								
39	1		a lot		1		1	
40								
41								
42				made no difference	1			
43			a lot		1		1	
44								
45			a lot		1			
46			a lot			1		
47								
48	1	1	a lot				1	
49	1	1	a lot				1	
50				made no difference			1	
51	1	1	a lot				1	
52	1	1	a little		1	1	1	
53								
54	1	1	a little				1	
55		1	a lot				1	
56	1		a lot				1	
57			a lot				1	
58			a lot		1		1	
<b>AVERAGE</b>	<b>27</b>	<b>28</b>			<b>12</b>	<b>10</b>	<b>7</b>	<b>40</b>
<b>COUNT</b>					<b>21%</b>	<b>17%</b>	<b>12%</b>	<b>69%</b>
<b>% TOTAL</b>	<b>47%</b>	<b>48%</b>						

PhD Health Questionnaire - Toronto: Gerrard Street									
Participant #	Male	Female	Other	Age	Reside in Toronto	Other location	Aboriginal	Nation	Status
1		1		46	1		1	Gitsxan	1
2	1			23	1		1		1
3			1	35	1		1	Ojibway	1
4	1			56	1		1	Cayuga/Mohawk	1
5		1		30	1		1	Ojibway	1
6	1			42	1		1	Cree	1
7	1			55	1		1		1
8	1			49	1		1	Cree	1
9		1		25	1		1	Mohawk	1
10		1		23	1		1	Ojibway	1
11		1		21	1		1	Ojibway	1
12	1			56		Mississauga	1	Cree	1
13	1			49	1		1	Ojibway/Potawatomi	1
14		1		30	1		1	Odawa/Potawatomi/Ojibway	1
15	1			44	1		1	Ojibway	1
16		1		25	1		1	Gitsxan	1
17	1			38	1		1	Oji-Cree	1
18	1			31	1		1	Ojibway	1
19		1		45	1		1	Metis	1
20	1			52	1		1	Ojibway	1
21		1		66	1		1		1
22		1		25	1		1	Gitsxan	1
<b>AVERAGE</b>	<b>11</b>	<b>10</b>	<b>1</b>	<b>39.364</b>	<b>21</b>		<b>21</b>		<b>15</b>
<b>COUNT</b>	<b>50%</b>	<b>45%</b>	<b>5%</b>		<b>95%</b>		<b>95%</b>		<b>68%</b>
<b>% TOTAL</b>									

Participant #	Non-Status	Seeing Healer	Heal phys illness	Heal herb med	Heal spiritual	See Doc	Doc phys ill/disease
1		1		1	1		
2		1	1	1	1		
3		1	1	1	1		
4		1			1	1	1
5		1	1	1	1		
6		1			1		
7	1	1		1		1	
8		1		1	1		
9						1	
10							
11		1			1		
12		1			1	1	1
13		1			1		
14							
15	1	1	1	1	1	1	
16	1	1		1	1	1	1
17		1		1	1	1	1
18		1	1	1	1	1	1
19	1	1	1	1	1	1	1
20		1			1		
21		1	1		1		
22	1	1	1	1	1	1	1
<b>AVERAGE</b>							
<b>COUNT</b>	<b>5</b>	<b>18</b>	<b>7</b>	<b>11</b>	<b>17</b>	<b>10</b>	<b>7</b>
<b>% TOTAL</b>	<b>23%</b>	<b>82%</b>	<b>32%</b>	<b>50%</b>	<b>77%</b>	<b>45%</b>	<b>32%</b>

Participant #	Doc mental illness	On meds	Use Trad & West	How long?	one week	one month	>one month	one year
1			1					
2			1				1	
3			1					
4		1	1					
5			1					
6			1				1	
7		1						
8			1					
9	1	1	1				1	
10			1					
11			1					
12			1					
13		1						
14			1					
15		1	1					
16	1	1	1					
17			1					
18			1				1	
19		1	1					
20		1	1					1
21			1					
22			1					
<b>AVERAGE</b>								
<b>COUNT</b>	<b>2</b>	<b>7</b>	<b>20</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>1</b>	
<b>% TOTAL</b>	<b>9%</b>	<b>32%</b>	<b>91%</b>	<b>0%</b>	<b>0%</b>	<b>18%</b>	<b>5%</b>	

Participant #	<one year	Inform heal	Inform doc	Improve Health	Why? advice of fam/friend	healer	doc
1	1	1	1	a lot			
2	1	1	1	a lot		1	
3		1	1	a lot			
4	1	1	1	a little			
5	1		1	a little		1	1
6			1	a lot			
7							
8	1	1	1	a lot		1	1
9			1	a little			
10	1			made no difference			
11	1	1		a lot			1
12				a lot			
13	1		1				
14							
15	1	1	1	a lot			
16	1	1	1	a lot		1	1
17	1			a little			
18		1	1	a lot			1
19	1	1	1	a lot			
20				a lot		1	
21	1	1	1	a little			
22	1		1	a lot		1	1
<b>AVERAGE</b>	<b>14</b>	<b>11</b>	<b>13</b>			<b>6</b>	<b>6</b>
<b>COUNT</b>	<b>64%</b>	<b>50%</b>	<b>59%</b>			<b>27%</b>	<b>27%</b>
<b>% TOTAL</b>							<b>5%</b>

<u>Participant #</u>	<u>personal decision</u>
1	1
2	1
3	1
4	1
5	
6	1
7	
8	1
9	1
10	1
11	1
12	1
13	
14	
15	1
16	1
17	1
18	1
19	1
20	1
21	1
22	1
<b>AVERAGE COUNT % TOTAL</b>	<b>18 82%</b>