EXPLORING INDIGENOUS AND WESTERN THERAPEUTIC INTEGRATION:
PERSPECTIVES AND EXPERIENCES OF INDIGENOUS ELDERS

by

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Abstract

The purpose of this study was to document the perspectives and experiences of five Indigenous Elders on the potential for Indigenous and Western healing paradigms and practices to be integrated in mental health service delivery for Indigenous peoples. Semi-structured qualitative interviews were held with each participant, and a narrative analysis was used to generate research themes and findings. Results indicated that all five Elders perceived a potential for Indigenous and Western approaches and practitioners to work collaboratively together in the future, and Elders reported varying levels of experience with integrated healthcare delivery. However, all five Elders identified numerous issues requiring attention and steps to be taken prior to integrated practice taking place. These included the need to reclaim Indigenous knowledge, an acceptance and respect for Indigenous knowledge and practices by the Western healthcare system, and the need for increased and formalized education related to Indigenous knowledge and healing approaches.
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Table of Contents

Title Page                  i
Abstract                    ii
Acknowledgements            iii
Table of Contents           iv
List of Figures             v
List of Appendices          vi

**Chapter One: Introduction**  1
Statement of Purpose          4
Conceptual Frameworks for Research  5
   Indigenous ways of knowing  5
   Social Constructionism  6
Definition of Terms          7
   Indigenous  8
   Indigenous Elders  8
   Mental health  9
   Western paradigm  10
Summary and Overview of Thesis  11

**Chapter Two: Literature Review**  13
Overview of Indigenous Health in Canada  13
   Before European contact  13
   As a result of European contact  15
   Current health indicators  19
Western Conceptions and Approaches to Mental Health  21
   Western conceptions of mental health  21
   Western psychotherapy  23
   Western psychotherapy with Indigenous peoples  25
   Factors for low therapeutic engagement  27
Indigenous Conceptions and Approaches to Mental Health  30
   Indigenous conceptions of mental health  30
   Indigenous models of healing  35
   Indigenous traditional healing  39
      Indigenous practices for healing  42
      Rates of use of Indigenous healing methods  44
Indigenous Elders          46
   Defining the role of Elder  46
   Becoming an Elder  49
Work of Indigenous Elders
Integrated Healing Movement
  Defining integration
  Rationale for integration
  Levels and forms of integration
  Challenges with integration
Summary and Rationale for Study

Chapter Three: Methodology
Qualitative Approach to Research
  Narrative inquiry and rationale for approach
Research Process
  Researcher position
  Participants
  Procedures
  Preliminary phase
  Phase 1: In-depth interview #1
  Phase 2: Preliminary analysis
  Phase 3: In-depth interview #2
  Phase 4: Final analysis and writing
  Phase 5: Final results and dissemination
Summary of Chapter Three

Chapter Four: Within-Participant Results
Participant One
  Character sketch
  First interview
  Feedback from second interview and final story map
  Final core message and themes
  Indigenous culture as foundation for health
  Go where there is need
  Effectiveness of Indigenous medicine
  Potential for Indigenous and Western approaches to be complementary
Participant Two
  Character sketch
  First interview
  Feedback from second interview and final story map
  Final core message and themes
  Re-aggregating, consolidating and disseminating Indigenous knowledge
  Holistic health
  Weaknesses in the Western health system
  Integration prior to reclamation of Indigenous knowledge
Participant Three
  Character sketch
  First interview
Feedback from second interview and final story map | 118
---|---
Final core message and themes | 120
  Indigenous epistemology | 120
  Effectiveness of Indigenous medicine | 123
  Lack of understanding/respect for Indigenous ways | 124
  Challenges to integration | 126
Participant Four | 128
  Character sketch | 128
  First interview | 128
  Final core message and themes | 129
    Indigenous culture as foundation for health | 129
    Shift in Western attitudes | 133
    Practices integratively, but issues remain | 134
    Need for education | 136
Participant Five | 137
  Character sketch | 137
  First interview | 137
  Final core message and themes | 138
    Lack of understanding/respect for Indigenous ways | 138
    Holistic health | 142
    Diverse healthcare systems | 143
    Need for education | 144
Summary of Chapter Four | 146

**Chapter Five: Discussion of Across Participant Results and Analyses** | 147
---|---
Perspectives on Integration | 148
Rationale for Integration | 150
Conceptual Underpinnings to Integration | 153
Expressions and Experiences with Integration | 158
Challenges to Integration | 166
  Historical relationships | 167
  Differences in epistemology and treatment approach | 168
  Knowledge acquisition and training | 173
Recommendations from the Elders | 177
Summary of Chapter Five | 182

**Chapter Six: Concluding Statements and Implications** | 184
---|---
Summary | 184
Limitations of study | 185
Implications of study | 187
Recommendations for future research | 190
Concluding reflection | 191

**References** | 192
List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Example of Data Unit</td>
<td>82</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Core Story Map</td>
<td>85</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Initial Story Map: Elder 1</td>
<td>91</td>
</tr>
<tr>
<td>Figure 4</td>
<td>Final Story Map: Elder 1</td>
<td>93</td>
</tr>
<tr>
<td>Figure 5</td>
<td>Initial Story Map: Witness 2</td>
<td>103</td>
</tr>
<tr>
<td>Figure 6</td>
<td>Final Story Map: Witness 2</td>
<td>106</td>
</tr>
<tr>
<td>Figure 7</td>
<td>Initial Story Map: Elder 3</td>
<td>119</td>
</tr>
<tr>
<td>Figure 8</td>
<td>Final Story Map: Elder 3</td>
<td>121</td>
</tr>
<tr>
<td>Figure 9</td>
<td>Final Story Map: Traditional Teacher 4</td>
<td>130</td>
</tr>
<tr>
<td>Figure 10</td>
<td>Final Story Map: Traditional Healer 5</td>
<td>139</td>
</tr>
</tbody>
</table>
List of Appendices

| Appendix A | Recruitment letter | 204 |
| Appendix B | Recruitment telephone script | 205 |
| Appendix C | Informed consent form | 206 |
Chapter One: Introduction

The Indigenous peoples of Turtle Island (North America) have had systems and practices in place to address and ensure the health and well-being of their people since time immemorial. While some historians and academics have tended to romanticize the health status of Indigenous peoples before contact with European colonizers, arguing that Indigenous groups did not suffer from any health or mental health problems at all, a large body of evidence has demonstrated that Indigenous peoples did in fact encounter a diverse range of physical and mental health problems prior to contact (Waldram, 2004). More importantly, however, is that these Indigenous groups had comprehensive systems and methods in place for healing, all stemming from an Indigenous conception of health and well-being. It has only been within the last sixty years that the Canadian health system has begun to show an increasing interest and concern in the physical and mental health needs of Canada’s Indigenous peoples. The primary focus of this thesis is to examine a growing practice in the mental health sector, which is the integration of Indigenous and Western approaches to healing as a form of treatment for Indigenous peoples.

As noted above, the existence of both physical and mental health problems among Indigenous groups in North America prior to European contact in the late fifteenth century has been well documented (e.g. Waldram, 2004; Waldram, Herring, & Young, 2007). However, the nature, etiology, and occurrence of such health problems drastically differ from many of the physical and mental health problems seen in many Indigenous communities today. A significant factor for the evolution of health problems was the arrival of European colonizers. In addition to new physical health problems and infectious diseases, such as influenza and tuberculosis, many have argued that the legislated efforts at cultural genocide
have had severe and long-lasting impacts on the mental health of many Indigenous peoples
today, which is reflected in elevated rates of substance abuse, violence, trauma, and suicide,
as compared to non-Indigenous peoples (Kirmayer, Brass, & Tait, 2000). While Indigenous
nations had the knowledge and systems in place to address the health problems of pre-
colonial times, newly introduced physical health problems, and the legacy of mental health
issues resulting from colonization, in addition to the outlawing of Indigenous approaches to
healing, have culminated in a complex, oftentimes dire, situation for many Indigenous
communities across North America today.

While Indigenous approaches to healing were driven underground by Canadian
legislative acts in the 20th century, traditional knowledge and practices continued to be passed
down through the generations. Indigenous Elders, often viewed as the bearers of cultural
knowledge and tradition, have played a pivotal role in the transmission of Indigenous culture,
and the practice of traditional healing. The revitalization of Indigenous traditional healing
practices and community-based approaches to healing over the past 50 years speaks to the
undeniable strengths of Canadian Indigenous communities in overcoming the various
atrocities that they have encountered. While the Indigenous healing movement continues to
grow in strength, and Indigenous peoples continue to use and reconnect with Indigenous
forms of healing, various challenges remain for the widespread use of traditional healing
methods. For instance, accessing the services of Indigenous healers remains a barrier for
many Indigenous peoples (Kim & Kwok, 1998). Indigenous healing methods are not viewed
as a legitimate and empirically valid form of healing by many Western mental health bodies
(LaFromboise, 1988). Despite research that has demonstrated the strong relationship between
health and culture for many Indigenous peoples, the vast majority of mainstream services continue to employ the singular use of Western informed treatment approaches.

The use of Western approaches to healing with Indigenous clients has often proved ineffective, as evidenced by an under-usage of services, high drop-out rates, and Indigenous peoples’ reports of low quality of care and services received (Harris, Edlund, & Larson, 2005; Oetzel, Duran, Lucero, Jiang, Novins, Manson et al., 2006; Shah, 2005; Sue, Allen, & Conway, 1978). Numerous scholars have ventured to offer explanations for why Western approaches to healing have proven ineffective, which have included the absence of an Indigenous worldview and conception of health (Stewart, 2008), culturally insensitive practitioners (Duran, 2006), and difficulties in establishing trust between the client and practitioner (Johnson & Cameron, 2001). In an attempt to tailor and enhance counselling services for Indigenous peoples, researchers, administrators, and practitioners alike have begun to call for an integration of Indigenous and Western approaches to healing (e.g. Duran, 2006; Moodley & West, 2005; Shore, Shore, & Manson, 2009).

The design of an integrated approach, including the specific Indigenous and Western methods to be conjointly used, varies depending on the mental health issue and methods of the practitioners. One common recommendation for integrated service is the collaboration of Western professionals with Indigenous healers (e.g. Constantine, Myers, Kindaichi, & Moore, 2004; Ellerby, 2005; Rayle, Chee, & Sand, 2006). Additional examples of integrated services include the use of sharing circles alongside cognitive-behavioural therapy (Heilbron & Guttamn, 2000); the incorporation of the sweat lodge ceremony and pow-wow with post-traumatic stress disorder treatment programs (Shore, Shore, & Manson, 2009); and the use of sacred Indigenous medicines alongside psychiatric counselling treatment (Mohatt & Varvin,
While integrated programs have begun to grow in number, and the call for integrated services continues to strengthen, what is glaringly absent from this integrative movement are the voices of Indigenous Elders and healers themselves. Indigenous Elders, in addition to traditional healers and medicine people, represent one of the primary collectives of people who conduct healing practices in their communities. They also tend to be viewed by their community as role models and sources of wisdom that hold as their goal the betterment of their communities and people. Their counsel is often sought during difficult decision-making processes, by both individuals and communities alike (Stiegelbauer, 1996). Given their role as cultural leaders, healers, and counsels, it is my belief that obtaining the perspectives of Indigenous Elders on the proposed integrative healing movement is critical if advances are to be made in this effort, and if attempts at integration are to truly represent an equalitarian partnership between Indigenous and Western practitioners. It is therefore my intent to obtain and showcase the perspectives, experiences, and thoughts of Indigenous Elders on the paradigmatic aligning of Indigenous and Western approaches to healing.

**Statement of Purpose**

The purpose of this research is to contribute to the ongoing dialogue around the integration of Indigenous and Western approaches to healing by examining the views of Indigenous Elders. The research question to be answered is: What are Indigenous Elders perspectives on the integration of Indigenous and Western healing paradigms, and what, if any, are their experiences of working in integrated contexts?

The results of this study will inform the academic literature by contributing to the under-researched area of the successes and challenges of integrating Indigenous and Western healing paradigms. The findings will also inform the development of educational materials
and governmental policies related to the formulation of promising mental health practices for Indigenous peoples, and will contribute to ongoing efforts to better service Indigenous peoples in North America. The results from this study will also inform the development of theory and practice when considering how to best integrate Indigenous and Western healing practices, and will be of particular use to mental health organizations, agencies which access the services of Indigenous Elders, individual mental health practitioners and researchers, and Indigenous Elders themselves.

**Conceptual Framework for Research**

This research will be grounded in two conceptual frameworks: Indigenous ways of knowing and social constructionism. Part of my motivation for selecting these frameworks is that they reflect my understanding and conception of how knowledge is created. These two frameworks share several complementary tenets around the construction of knowledge, including the idea that knowledge is negotiated and created in contextual relationships. The following section contains a thorough review of each framework and how these perspectives will inform the current research project.

**Indigenous ways of knowing.** Castellano (2000) has written about the different sources of Aboriginal knowledge, which include traditional, empirical, and revealed knowledge. Traditional knowledge is characterized as knowledge that has been passed down intergenerationally and typically includes creation stories, genealogies, ancestral rights, and stories which teach of a nation’s values and beliefs. Empirical knowledge is knowledge which is gained through observation, and revealed knowledge is spiritual in nature and can be received through dreams, visions, and intuition. In addition to these three types of knowledge, Castellano writes that “Aboriginal knowledge is said to be personal, oral,
experiential, holistic, and conveyed in narrative or metaphorical language” (p. 25). She also asserts that Aboriginal knowledge systems reject notions of universal truths and prescriptive ways of knowing, and instead comments that “the personal nature of knowledge means that disparate and even contradictory perceptions can be accepted as valid because they are unique to the person... people do not contest with one another to establish who is correct – who has the ‘truth’” (p. 26). In comparison to Western scientific notions of knowledge and the search and acquisition of objective truth, diverse ways of creating or obtaining knowledge and multiple ways of knowing are valued and honoured in many Indigenous cultures.

Many authors have spoken of the importance of relationship within Indigenous communities (e.g. McCormick, 1996; Weber-Pillwax, 1999). With respect to the creation of knowledge, Wilson (2001) has also highlighted the critical role that relationship plays. Wilson puts forward the idea that knowledge is relational; that is, knowledge is created in relationship with other entities, which include relationships with other humans, the animal and plant world, the ancestral or spirit world, and the cosmos. Since knowledge is created in relationship with other beings, it therefore cannot be owned, but only shared. This notion of shared knowledge is of particular importance for the research process as it will inform my understanding of how the results of this research may be conceptualized and used in the future, which will be discussed below.

Social constructionism. The second conceptual framework which I will draw on throughout the research process is social constructionism. Gergen (1985) writes that “social constructionism is principally concerned with elucidating the processes by which people come to describe, explain, or otherwise account for the world in which they live” (p. 3). Some of the key principles that are inherent to this process include challenging taken-for-
granted assumptions about the world, questioning the parameters which supposedly define knowledge, and rejecting the notion of objective and universal truth. Instead, social constructionism argues that knowledge is socially and culturally, and therefore contextually, based and created through relationship. Subjective perspectives and experiences are therefore privileged and regarded as legitimate sources for the creation of knowledge and reality. The similarities between social constructionist and Indigenous frameworks therefore suggest their complementary suitability as the conceptual underpinnings for this research project, and will inform various aspects of the research process.

The use of an Indigenous and social constructionist framework for this research has several implications for how the research is conducted and conceptualized. First, these frameworks are ideally suited to my research question as I am interested in exploring the perspectives and lived experiences of Indigenous Elders. An Indigenous and social constructionist framework therefore allows me to acknowledge and accept that there are multiple sources and ways of knowing in the world. These frameworks enabled me in retaining the diversity of perspectives and experiences of the Indigenous Elders that participated in this study, and the results are not be condensed into a universal experience or known truth. My interactions with each participant is of particular importance, as the knowledge that is created through this research project will be done so in relationship.

**Definition of Terms**

A definition of terms used throughout this thesis will clarify specific meanings used in this research. The terms to be defined include: Indigenous, Indigenous Elders, mental health, and Western paradigm.
**Indigenous.** Indigenous is a general term that is used to describe members of three distinct Aboriginal groups in Canada, First Nations, Métis, and Inuit peoples (Statistics Canada, 2008), and will be the primary term used in this paper. Indigenous will also be used interchangeably with the terms Aboriginal, Native, First Nations, Métis, Inuit, First Peoples, Native American, Indian, and American Indian, and will be used as specific authors have cited them in their works.

**Indigenous Elders.** Many different types of healers exist in Indigenous communities in Canada. Anishnawbe Health Toronto (2000) outlined the roles of three distinct types of Aboriginal healers in one of their educational pamphlets: Traditional healers, Medicine people, and Elders. While these three categories of healer share a common trait, the ability to heal, the training process, healing process, and healing methods of each healer will vary. It is also important to note that variability also exists within each group of healer; that is, no two traditional healers or two Elders will have had the same journey towards becoming a traditional healer or Elder, nor will they use the exact same methods for their healing work.

Anishnawbe Health Toronto (2000) stated that a medicine person is someone who principally works with plants and plant medicines to heal, and a traditional healer typically perceives their healing abilities as a gift from the spirit world (or Creator), and may use a range of methods to heal (plants, counselling, laying of hands, ceremony). Alternatively, an Elder is an individual who is recognized by their community as someone who holds the knowledge and teachings of the ancestors. While they may practice or facilitate various healing ceremonies (such as the sweat lodge or use of plant medicines), the sharing of their wisdom is often considered a healing act in and of itself.
A detailed discussion of the characteristics and work of Indigenous Elders is to be provided in section two of this thesis. However, for the purposes of a definition of terms, Indigenous Elders in this thesis are defined as either males or females who are recognized by the community they work in as the holders of cultural knowledge and teachings, whose counsel is often sought, and who posses the ability to heal through various methods (specific ceremonies, story-telling, use of plant medicines, sharing of knowledge). As Ellerby (2005) noted “Some [traditional] healers may not be Elders, while all Elders can be considered Healers” (p. 9).

**Mental Health.** No single definition of mental health exists, and the term is defined differently depending on the context and socio-cultural influences which are informing its conceptualization. For instance, within the Western tradition, mental health has historically been defined in relation to illness and disorder. The American Psychiatric Association (2000) defined mental health as a state marked by the absence of illness or disorder, as noted in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) (p. xxx). The majority of mental health practitioners (psychiatrists, psychologists, psychotherapists, social workers) in North America receive, at a minimum, training in the theory of this text, and many adopt this understanding of mental health and use it as conceptual base to inform psychotherapeutic practice.

Evolutions in the conceptualization of mental health have also occurred over time. For example, with the founding of the World Health Organization (WHO) in 1948, a marked shift was seen in the definition of mental health, as WHO currently defines mental health as “not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can
work productively and fruitfully, and is able to make a contribution to her or his community” (http://www.who.int). The shift from pathology and disorder to an emphasis on strengths and well-being has also been adopted by some Canadian mental health organizations. For instance, The Canadian Mental Health Association (2010) provided a definition of mental health as “striking a balance in all aspects of your life: social, physical, spiritual, economic and mental” (http://www.cmha.ca). This emphasis on holism, that is, the recognition of various dimensions of health, is in greater alignment with many Indigenous cultures’ understandings of health and well-being. Both Western and Indigenous conceptions of mental health and healing will be reviewed in greater detail in the following sections, but the definition of mental health that is informing the current study includes an emphasis on strengths, holism, and well-being, as well as understanding of distress and disorder.

**Western Paradigm.** According to Wilson (2001), the term paradigm refers to a set of values or beliefs that guide one’s actions in the world. Stewart (2007b) states that the current dominant paradigm operating in the North American context is a Western paradigm, as it is based on Western culture. She defines Western culture as referring to the values of European settlers and their descendants, which consists of specific social norms, ethical values, traditional customs, specific artefacts and technologies, and a set of “literary, scientific, musical, and philosophical principles which set it apart from other civilizations…and whose history is strongly marked by Western European immigration” (Stewart, 2007b, p. 55). Western culture and a Western paradigm of thought are therefore understood to inform various aspects of historical and contemporary North American tradition, custom, practice, and thought. The training and practice of the majority of North America’s mental health
professionals therefore stems from a Western paradigm of thought. A Western paradigm of health therefore refers to:

The dominant cultural attitudes and beliefs that are based on Western European philosophies and practices that inform counselling approaches and counsellor training in North America that are based on individual psychology (Stewart, 2007b, p. 55).

This definition is used throughout the remainder of this paper when discussing or making reference to a Western paradigm of healing.

Summary of Chapter One and Overview of Thesis

The voices and experiences of Indigenous Elders are glaringly absent from the mental health profession’s dialogue around the ongoing movement towards the integration of Indigenous and Western paradigms and approaches to healing. The aim of this research is to showcase the perspectives of these Elders, and to provide insight for helping professionals and organizations who seek to collaboratively work with Indigenous Elders and healers.

In the first chapter of this thesis, I have provided a brief background of the relevant issues related to the mental health needs of Canada’s Indigenous peoples, my conceptual framework for the research, and a definition of terms. In Chapter Two, I provide a review of the literature in the following areas: a brief historical overview of Indigenous and Canadian relations, with an emphasis on the development of health related problems; information on the current health status of Indigenous peoples in Canada; Western and Indigenous conceptions of mental health; the role and work of Indigenous Elders; and an overview of the Indigenous and Western integrated healing movement. In Chapter Three I present the methodology that is used in this research, and include a description of the procedures that
were employed in this study. The within-participant results are provided in Chapter Four, which includes a character sketch, comments on the first and second interviews with each participant, and the core message and themes from the individual interviews. In Chapter Five I review the across participant results and analyses, focusing on perspectives and experiences with integration across the five participants. In Chapter Six I present my concluding thoughts, recommendations and implications of the research, and a summary of the study.
Chapter Two: Literature Review

The present chapter contains a review of current literature related to the research topic. I begin with a brief historical overview of Indigenous health in Canada, and current mental health indicators. A discussion of Western and Indigenous paradigms and conceptions of healing follows. The literature related to the characteristics and work of Indigenous Elders in Canada is then reviewed, and I end with an overview of some of the underlying principles and contentious issues related to the integration of Indigenous and Western paradigms and practices of healing.

A Brief Overview of Indigenous Health in Canada

The following section outlines various components of the health and well-being of Indigenous peoples in Canada prior to European contact, during and as a result of European contact, and will end with an overview of current health indicators for Canada’s Indigenous peoples.

Health and well-being before European contact. Waldram (2004) has written critically of some authors’ tendencies to present a utopian view of ways of life and the health status of Indigenous peoples prior to contact with European settlers in the late 15th century. Instead, he writes that both physical and mental health problems existed among various Indigenous groups of peoples during this time. For instance, Waldram, Herring, and Young (2007) stated that fungal, bacterial, and parasitic infections afflicted Indigenous groups to varying degrees before contact. Waldram (2004) also stated that conditions which could be categorized as mental health issues existed during this time, citing the existence of depression and suicide among the Mohave specifically. However, several key points related to the existence of these mental health issues must be addressed.
First, one must take into account the historical and cultural factors which inform the development and conceptualization of psychological phenomena, such as depression and suicide. For instance, Devereux (1940), in his work with the Mohave, documented the psychological condition of *Hiwa:Itck*, or heartbreak (as cited in Waldram, 2004). This condition was characterized “by psychotic episodes and which referred specifically to a condition of older men whose younger wives had left them” (Waldram, 2004, p. 279). If one were to view this particular condition through a contemporary Western lens, one may be tempted, for instance, to categorize this disturbance as schizoaffective disorder. However, in doing so, one would fail to acknowledge the culturally based etiological foundations and symptomatic expressions of the condition. Furthermore, in labelling and categorizing such conditions by Western standards and terms, one runs the risk of over-looking, or even disregarding, the cultural systems and practices that were in place to address such conditions of distress. Scholars would therefore be wise to exercise caution when affixing labels and classifying Indigenous health phenomena as Western disorders, particularly the mental health conditions of Indigenous peoples prior to contact with European settlers.

The second important point related to the existence of health problems before European contact is that Indigenous peoples had specific healing systems and practices in place to address diverse pre-colonial health concerns (Kim & Kwok, 1998; Kirmayer, Simpson, & Cargo, 2003; Lee & Armstrong, 1995; Waldram, 2004; Waldram et al., 2007). For instance, Waldram et al. (2007) cite the use of the Shaking Tent and Sweat Lodge ceremonies as examples of healing methods that pre-date European contact. Waldram (2004), in discussing the occurrence of post-traumatic stress disorder among Indigenous peoples prior to contact, referenced the Navajo Enemy Way Ceremony, which focused on healing the
trauma of warriors’. Waldram continues by asserting that the relative lack of current rates of post-traumatic stress disorder among Indigenous groups may be explained by the existence, practice, and transmission of ceremonies for trauma. The Report of the Royal Commission on Aboriginal Peoples (Royal Commission on Aboriginal Peoples [RCAP], 1996) cited the role and teachings of Indigenous Elders during pre-colonial times as a contributing factor for the maintenance of a well-balanced lifestyle and approach to health and healing. As a result of these various systems and approaches to healing, several authors have asserted that while health problems may have existed before contact with European colonizers, they were far less numerous than the reported health problems of Indigenous peoples today (Kirmayer et al., 2003; Waldram, 2004; Waldram et al., 2007).

**Health and well-being as a result of European contact.** While the year 1492 has been identified as the starting point for relations between the first peoples of Turtle Island and European settlers, Waldram et al., (2007) noted that contact was established at different times in different regions of North America and was principally linked to the establishment of the fur trade and missionary activities. It was estimated that over 7 million Indigenous peoples inhabited North America prior to contact with European settlers, and that an estimated 90% of these individuals died as result of both the direct and indirect effects of European settlement (Kirmayer et al., 2000). The introduction and spread of infectious diseases such as smallpox, measles, influenza, yellow fever, among others, by European settlers has been cited as primary causes for the high death rate, as well as the change from traditional diet to a reliance on European foodstuffs (Kirmayer et al., 2000; Royal Commission on Aboriginal Peoples, 1996; Stewart, 2007a; Waldram et al., 2007). Physical health problems continued to develop and escalate over time, and a shift from infectious to
chronic diseases began during the 20th century. In addition to the various physical health problems that developed in response to European settlement, and that continue to persist today, many have asserted that a diverse number of mental health problems have also developed as a result of colonial efforts.

Legislation that was designed to control and exploit, or “deal with” the Indian problem (Steckley & Cummins, 2001), had been erected long before the founding of Canada in the year 1867. Two notable pieces of legislation, the British North America Act of 1867 and the Indian Act of 1876, enabled the Canadian government to classify Indigenous peoples as wards of the state; determine who may identify as ‘Indian’; eradicate traditional forms of governance; secure title to the land and its resources; create reserves and force Indigenous peoples off their traditional land; and restrict and control essential components of healthy living, such as access to food, recreational activity, and the practice of cultural customs and traditions (including the use of healing practices and ceremony) (Kirmayer et al., 2000; Steckley & Cummins, 2001; Waldram et al., 2007). In essence, the principal goal of this legislation was the assimilation of Indigenous peoples to Euro-Canadian beliefs, customs, and values. In addition to governmental legislation, missionary efforts that were designed to save the souls of Indigenous peoples and civilize the savage were rampant at this time (Steckley & Cummins, 2001). However, the combination of governmental policy and missionary zeal resulted in one of the most abhorrent events in Canadian history: the establishment of the residential school system, and stemming from that, a concerted, controlled, and legislated attempt at cultural genocide.

It was hypothesized that one of the most effective ways by which assimilation could be achieved was the education of Indigenous children. Beginning in the 1880s, residential
schools began to flourish, and along with that, children began to be forcibly removed from their homes, separated from their families, and enrolled in these educational institutions. The curriculum included training in a range of subjects, including carpentry, shoemaking, sewing, knitting, and general household duties, and in addition to the above, children were taught to abide by Christian values and abandon any form of Aboriginal spirituality or custom (RCAP, 1996). Furthermore, Aboriginal languages were specifically targeted for eradication, as they were perceived as a principal vehicle for the transmission of Aboriginal culture. Children were thus severely disciplined, often physically abused, if any attempt was made to speak or retain their language (RCAP, 1996). Rampant physical, psychological, and sexual abuse has also been well-documented and narrated by survivors of the residential school system (Waldram et al., 2007), and in addition to these various forms of abuse, malnourishment, neglect, and medical crises (such as the spread of tuberculosis), were terrifyingly characteristic of the residential school experience and environment (RCAP, 1996). Instead of producing a newly assimilated generation of Canadians, the graduates of the residential school system often found themselves on the periphery of two distinct worlds, ill-equipped to navigate either completely. Efforts geared towards dismantling Aboriginal culture and family have continued since the introduction of the residential school system, only changing slightly in policy and implementation. For instance, Indigenous children continued to be forcibly removed from their homes and placed in the care of the state as they were adopted and placed in foster homes, a time period commonly referred to as the Sixties Scoop (Kirmayer et al., 2003). The effects of these colonial efforts have had long-lasting impacts for individuals, families, and communities as a whole.
As has been noted above, what could be characterized as mental health conditions did exist prior to contact. However, given such legislative acts as the Indian Act, which prohibited the practice of Indigenous ceremonies up until the early 1950s, one can imagine that the health and well-being of Indigenous peoples during the early contact years only grew in complexity. Furthermore, the introduction of hazardous agents by European colonizers, such as alcohol, was arguably a significant contributor to the development of new mental health challenges, such as substance use and abuse (Waldram, 2004). The atrocities experienced by Indigenous peoples in the residential school system have undoubtedly had a significant impact on the mental health of the survivors of the school system, and many have argued that the sequelae of these events continue to impact Indigenous peoples today (e.g. Duran, 2006; Kirmayer et al., 2000; Rayle et al., 2006; Waldram, 2004; Waldram et al., 2007). As Kirmayer et al. (2003) stated,

Narratives and life histories suggest that the residential school experience has had enduring psychological, social and economic effects on survivors. Transgenerational effects of the residential schools include: the structural effects of disrupting families and communities; the transmission of explicit models and ideologies of parenting based on experiences in punitive institutional settings…repetition of physical and sexual abuse; loss of knowledge, language and tradition; [and] systematic devaluing of Aboriginal identity” (p. 18).

The impact of European settlement and colonial initiatives has significantly transformed many aspects of Indigenous peoples’ ways of life, health, and well-being. Current indicators of North America’s Indigenous peoples are to be reviewed next.
**Current health indicators.** According to the 2006 Canadian Census, 1,172,790 people identified as Aboriginal (First Nations, Métis, or Inuit). Over the last ten years, there has been a 45% increase in the Aboriginal population, with the Métis experiencing the largest increase in number. The number of Aboriginal people living in urban areas also rose to 54%, a four percent increase from 1996. As of 2006, Aboriginal people accounted for close to 4% of the total Canadian population (Statistics Canada, 2008).

Although the Aboriginal population represents a small percentage of Canada’s total population, they experience a wide range of health problems at disproportionately higher rates than non-Aboriginal peoples. For instance, they have a 6-7 times greater incidence of tuberculosis, are 4-5 times more likely to be diabetic, are 3 times more likely to have heart disease and hypertension, are twice as likely to report a long-term disability, and have a substantially shorter life expectancy than the non-Aboriginal population (Kirmayer et al., 2000; Kirmayer et al., 2003). Health Canada (2009)\(^1\) recently reported that rates for both pneumonia and influenza were approximately four times higher among the First Nations population than the non-Indigenous population, and that in the year 2000, First Nations hospital separation rates were higher than the non-Indigenous population’s for each of the following chronic diseases: ischemic heart disease, cerebrovascular disease, diabetes, and chronic obstructive pulmonary disease. The shift from infectious to chronic diseases among Indigenous peoples has continued to grow in strength, as rates of cancer, diabetes, and AIDS have all increased over the past few decades (Waldram et al., 2007).

In terms of mental health related concerns, Health Canada (2009) indicated that rates of intentional and unintentional injuries among the First Nations population were four to five

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\(^1\) Report presents information on the health service utilization of the on and off reserve First Nations population in the provinces of British Columbia, Alberta, Saskatchewan, and Manitoba.
times higher than the non-Aboriginal population, and the second leading cause for hospitalization among First Nations women was suicide/self-injury. Examples of additional mental health problems among some of Canada’s Indigenous peoples include depression, anxiety, violence and abuse, and other psychiatric disorders (Kirmayer et al., 2003; Shah, 2005; Stewart, 2007a), and some scholars have also reported elevated rates of substance abuse, trauma, and suicide in certain communities (Kirmayer et al., 2000; Shah, 2005).

While elevated rates of both physical and mental health problems among Canada’s Indigenous peoples have been reported, it is also important to recognize that much variability exists among Indigenous individuals and communities. For instance, Chandler and Lalonde (1998) found that while some First Nation communities reported rates of suicide that are 800 times the national average, the act of suicide is either very low or virtually unknown in other communities in British Columbia. While Chandler and Lalonde reported that cultural continuity is a significant factor for the occurrence of suicide, the important point here is that many Indigenous individuals and communities possess strengths and community-based approaches which prevent and/or remedy mental health problems. However, the vast majority of available mental health services in Canada are rooted in a Western paradigm and approach to health. Therefore, the majority of Indigenous peoples who seek help for mental health problems will be forced to access Western mental health services. The common Western-informed practices and approaches that are used with Indigenous peoples will be explored in the next section, along with the barriers for the effective use of these practices with Indigenous peoples.
Western Conceptions and Approaches to Mental Health

In order for the reader to have an informed understanding of the issues surrounding integrated (Indigenous and Western) mental health service delivery, a thorough examination of both a Western and Indigenous paradigm of mental health and healing is required. Beginning with the Western paradigm, the following section will review Western informed conceptions of mental health and the psychotherapeutic process, common Western approaches used with Indigenous peoples, and indicators and explanations for the ineffectiveness of Western approaches with Indigenous peoples. It is also important to note that while some generalizations have been made in reference to Western conceptions and mental health practices, these comments reflect the theory and practice techniques that are currently offered in the majority of mainstream training institutions and mental health service organizations in Canada.

**Western conceptions of mental health.** One of the principal texts used by Western trained mental health professionals is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), currently in its fourth edition. The majority of mental health practitioners (psychiatrists, psychologists, psychotherapists, social workers) receive, at a minimum, training in the theory of this text, and those with more advanced degrees skilfully learn how to assess and diagnosis individuals in accordance with its criteria. What is strikingly evident, even from its title, is that mental health in a Western context tends to be defined in relation to disorder; that is, the absence of disorder is often an indicator of good mental health. In the opening introduction of the text, a definition of mental disorder is provided:
Mental disorders have also been defined by a variety of concepts (e.g. distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation)...each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress...or disability (American Psychiatric Association, 2000, p.xxx).

Based on the above definition, it becomes clear that there is a tendency to pathologize mental health problems into mental health disorders, and to locate the cause for the disorder internally with the individual. What is strikingly absent from this definition is a commentary or consideration of how other dimensions of one’s social location, such as cultural, social, or historical factors, may contribute to the development or understanding of mental health problems. While cultural considerations are made note of later on in the introductory comments, and how a clinician may work within the cultural frame of reference of their client, the emphasis remains on privileging a pathological perspective in defining and conceptualizing mental health.

Lewis-Fernandez and Kleinman (1994) wrote that three culture-bound assumptions bias conceptions of mental health in North America: the egocentricity of the self, mind-body dualism, and culture as an arbitrary superimposition on a knowable biological reality. The concept of an egocentric self suggests that “psychological normality and abnormality are internal to the self,” implying that the responsibility for one’s mental health lies solely with the individual, without an examination of external contributing factors (Lewis-Fernandez & Kleinman, 1994, p. 67). The second assumption, mind-body dualism, speaks to the
fragmentation of an individual. For instance, a clear distinction is often made between the physical health, mental health, and spiritual health of a person, with various personnel assigned to treat each component of the individual separately (medical doctor, mental health practitioner, religious/spiritual figure). And lastly, Lewis-Fernandez and Kleinman noted that culture tends to be viewed as consisting of a set of beliefs that are superstitious in nature, which leads to the “discounting of the disease categories, illness experiences, and healing practices of people in other cultures, reducing them to the status of obstacles in diagnosis, treatment compliance, and outcome” (p. 67-68). McCabe (2008), an established Indigenous scholar, echoed the arguments made by Lewis-Fernandez and Kleinman in discussing the Western mental health system’s preference for a scientifically informed approach which strives for an objective and value-free encounter between practitioner and client, and which tends to segment an individual into pathological dimensions. This is in stark contrast to the holistic, socio-culturally informed, and wellness based conception and approach to health and healing that is adopted by many Indigenous cultures. Having explored the principles of the majority culture’s conception of mental health, I will now explore how such notions inform a Western model of treatment, specifically the psychotherapeutic endeavour.

**Western psychotherapy.** The principles of pathology, autonomy, modernity, and a dichotomous splitting of the mind and body often translate into a therapeutic encounter that can be characterized by several key qualities. First, a strong emphasis is placed on the capacity and intrapsychic processes of the individual client in counselling (LaFromboise, 1988). The client is viewed as the target of change in the therapeutic work, as opposed to other units (e.g. family) or systems (e.g. Canadian child welfare system) that the client may be a part of and that may be contributing to mental health distress (Constantine et al., 2004).
A practitioner may spend time evaluating and assessing the client’s intrinsic properties through the use of psychodiagnostic tools, and interventions are designed to facilitate individual change. A strong emphasis is also placed on the relationship between the client and mental health practitioner, and the quality of this relationship is often cited as one of the most effective elements that supports the client in therapeutic change.

While mental health practitioners may consult with other health professionals, or refer their clients for additional treatment, the current structure of the Western healthcare system is one which supports the splitting of an individual into segmented pieces. For instance, a client who wishes to process a sexual assault and who has lost faith in her religion would most likely be referred to a medical doctor, a mental health worker, and a religious figure, who would all work individually with this woman. It is easy to see how achieving an integrated understanding of oneself and one’s well-being may be difficult as a result of this fractured process.

Western mental health practitioners also attempt to remain value-free and assume an objective position throughout the therapeutic process (LaFromboise, 1988). The obvious contradiction is that each practitioner undeniably holds values which have informed their perspective and their approach to their work. Even the act of attempting to remain value-free represents a value-laden position, a position which has been informed by Western modernist principles of objectivity, rational thought, and the constancy of measurement (Constantine et al., 2004). The above stated qualities that are characteristic of the Western therapeutic enterprise also appear to transcend specific therapeutic modalities. For instance, an emphasis on autonomy and the mind-body split can be seen in the therapeutic frameworks of both
cognitive-behavioural therapy and narrative therapy. A discussion of the common psychotherapeutic modalities employed with Indigenous clients will be reviewed next.

**Western psychotherapy and Indigenous peoples.** Different therapeutic approaches have been used with Indigenous peoples with varying degrees of success. Two Western therapeutic modalities that have been used with Indigenous clients, and that have been discussed in the literature, are cognitive-behavioural therapy (CBT) and narrative therapy. Renfrey (1992) has argued that the action orientation and directive nature of CBT appears to be congruent with the needs, values, and expectations of many Native American clients. Rayle et al. (2006) have suggested that narrative approaches in counselling are ideal when working with Indigenous clients because of the oral tradition and emphasis on story and legend that is characteristic of many Indigenous cultures. However, a growing body of evidence is beginning to challenge assertions that the sole use of Western psychotherapy is the most effective treatment strategy for Indigenous peoples. For instance, Jackson, Schmutzer, Wenzel, and Tyler (2006), in investigating the preferences for and endorsement of cognitive-behavioural therapy among American Indian and European American participants, found that while American Indian clients rated activity scheduling, homework, and present-focused treatment favourable, an emphasis on uncovering the relationship between one’s thoughts and feelings, identifying cause-and-effect relationships, and a structured therapeutic relationship were undesirable qualities. While a more plausible argument may be that certain components of Western psychotherapies are ideally suited to the values and needs of Indigenous clients, what has become strikingly clear is that significant problems and challenges remain in the effective delivery of and retention of Indigenous peoples in Western mental health services.
Many researchers, scholars, and practitioners have voiced statements that Western mental health services have largely failed Indigenous clients (e.g. Duran, 2006; McCabe, 2008; McCormick, 1996; Moodley & West, 2005; Stewart, 2007a; Vicary & Bishop, 2005). This belief has developed in response to research that has demonstrated an under-usage and high drop-out rates from counselling, and studies which have investigated Indigenous peoples’ perceptions and attitudes towards the counselling process. For instance, Sue, Allen, and Conaway (1978) found that 55% of Native Americans did not return for mental health support after an initial consultation. O’Sullivan, Peterson, Cox, and Kirkeby (1989) conducted the same study 12 years later and found that Native Americans had the second highest failure to return rate compared to Caucasian, Black, Hispanic, and Asian American populations. And lastly, Shah (2005), in examining the health status of Aboriginal people in Ontario, found that 78% of the First Nations population considered their health between good and excellent, compared to 90% of the non-Aboriginal population, and that 50% of First Nations people in Ontario do not believe that they receive the same healthcare services as the general Canadian population.

In terms of Indigenous clients’ perceptions of Western mental health services and quality of care received, Harris, Edlund, and Larson (2005), in investigating rates of mental health problems and the use of mental health care services across eight different ethnic populations in the United States, found that while Native American individuals reported the highest rates of mental health problems, they also reported the highest levels of unmet need when discussing mental health services. A study conducted by Vicary and Bishop (2005) found that Australian Aboriginal peoples perceived Western psychotherapy as culturally inappropriate or irrelevant, and lacking validity when used with Aboriginal peoples. And
finally, Price and McNeill (1992), in investigating attitudes towards Western counselling services among 74 Indigenous individuals, found that participants strongly committed to their tribal culture had less confidence in mental health professionals and had significantly less favourable attitudes toward seeking counselling services. Taken together, the results from the above studies clearly indicate that there are inherent short-comings in the Western mental health system when trying to service Indigenous peoples. This has led scholars to investigate and identify factors in the Western psychotherapeutic enterprise that are proving to be detrimental to the counselling experience of many Indigenous peoples.

**Factors for low Western therapeutic engagement among Indigenous peoples.**

Several different explanations have been put forward in attempt to illuminate the shortcomings of Western mental health services in servicing Indigenous peoples. One of the most commonly cited challenges is the absence of an Indigenous worldview in the healing process (Duran, 2006; McCormick, 1996; Stewart, 2007a). In recognizing that a vast amount of diversity exists among the worldviews of the Indigenous peoples of North America, a few over-arching similarities have been highlighted in the literature. Some of the key values that tend to comprise an Indigenous worldview include the importance of relationship and interconnectedness among all things (humans, animal and plant world, the ancestral or spirit world, and the cosmos) (Garrett & Wilbur, 1999; McCormick, 1996); the role of family and community (Kirmayer et al., 2000; Stewart, 2007a); and an emphasis on balance and holism, in both relationships and the four sacred aspects of the self (physical, emotional, mental, and spiritual) (McCabe, 2008; Poowassie & Charter, 2005). While the absence of an Indigenous worldview in the counselling process may be a deterrent for many Indigenous clients to continue with counselling work, Duran (2006) argues that the imposition of a Western
worldview and approach to healing is a continued form of oppression and hegemony: “Lack of understanding of the Native epistemological root metaphor (ways of being in the world, including psychological and spiritual worlds) continues to hinder our profession. Historical narcissism (the belief that one’s own system of thinking must be used to validate other cultural belief systems) continues to be an issue in the relationship between Original People and those who hold power in the academic and clinical life-world” (p. 10). Undeniably, a fundamental divergence in understanding and values between client and practitioner poses a significant challenge for successful healing work, and the responsibility of ensuring that the counselling process is aligned with the client’s worldview rests with the practitioner.

A second obstacle to the effective delivery of mental health services with Indigenous peoples is culturally insensitive practitioners and assessment tools. Duran (2006) stated that stereotypic images and representations of Indigenous peoples in the media bias a great deal of the work of Western clinicians. He also noted that the use of a Western mental health paradigm increases the risk of over-pathologizing Indigenous clients, and Johnson and Cameron (2001) stated that misdiagnosis is almost assured given current assessment instruments. Even the DSM-IV-TR of the American Psychiatric Association (2000) suggests that clinicians conducting diagnostic assessments may “incorrectly judge as psychopathology those normal variations in behaviour, belief, or experience that are particular to the individual’s culture” (p. xxxiv). While strides have been made in increasing awareness and developing culturally competent practice standards for counselling with ethnic minority clients (e.g. Sue, Arredondo, & McDavis, 1992), some state that training in Indigenous specific conceptualizations and approaches to healing is needed (e.g. Stewart, 2007b; Vicary & Bishop, 2005).
Additional challenges which may impact the likelihood of therapeutic engagement with Western services include fear of stigmatization, difficulties with establishing trust, and access and availability of mental health services. Vicary and Bishop (2005), in interviewing 70 Indigenous individuals in Western Australia, found that participants reported being fearful of the Western mental health system and being stigmatized or labelled as mentally ill. Participants stated that their first line of treatment was community-based approaches, seeking treatment from the immediate family, Elders, or healers first, and accessing Western mental health services as a last resort. In a similar vein, Oetzel et al. (2006) found that 46% of their 224 participants, located on three different reserves in the United States, identified privacy concerns as an obstacle in their treatment when accessing alcohol, drug, or mental health services. Privacy focused on the participants’ desire for others to not know about their treatment use, and the authors asserted that the concerns with privacy stemmed from the participants perceived stigmatization of alcohol, drug, and mental health disorders. Oetzel et al. also found that 45% of their participants identified communication and trust issues as obstacles in their treatment, particularly when accessing services for emotional problems such as depression and anxiety. Johnson and Cameron (2001) also asserted that establishing trusting relationships with both individual practitioners and larger institutions poses a great challenge for many Indigenous clients, and in addition to that, access and availability of services remains an issue, particularly for Indigenous peoples located in rural or isolated communities.

One final and significant element of the healing process that appears to define healing for many Indigenous peoples, which is absent from Western conceptualizations and methods for healing, is spirituality and a belief in a higher power (Mail, McKay, & Katz, 1989;
McCabe, 2007; McCormick 1996; Stewart, 2008; Vicary & Bishop, 2005). Duran (2006) writes, “Most Native People believe that they are more than just the cognitions that flow endlessly through the realm of awareness, and it is in these ‘other’ aspects of the personality where there may be a place in which therapy/healing needs to happen” (p. 20). While a more detailed analysis of Indigenous conceptions of mental health is to follow in the next section, the above presented information up to this point illustrates that the structure, conception, and delivery of current Western-informed mental health services are inadequate in servicing and retaining Indigenous peoples in the treatment process. While components of the Western mental health system are assuredly effective and beneficial to Indigenous clients, the task will be to identify these effective elements and redefine the treatment and healing endeavour as both Indigenous and Western approaches begin to merge together.

**Indigenous Conceptions and Approaches to Mental Health**

In the following section I will review Indigenous conceptions and understandings of mental health, Indigenous models of healing, including a review of traditional healing approaches, and studies that have investigated Indigenous peoples’ perceptions and rates of use of Indigenous healing methods. As was noted in the previous section, a vast amount of diversity exists among the 600 Indigenous Nations of Canada. However, some over-arching similarities around conceptualizations of health have been identified in the literature, and will be reviewed here.

**Indigenous conceptions of mental health.** One of the most commonly identified defining features of Indigenous conceptions of health is the notion of holism and balance. An individual is viewed as consisting of four dimensions, the physical, emotional, mental, and spiritual, and it is the balancing of these four aspects of the self that constitutes good health.
and well-being (Garrett & Wilbur, 1999; Poonwassie & Charter, 2005; Waldram, Herring, & Young, 2007). If one of these dimensions is out of balance, for example, if an individual is not eating healthily or routinely, the remaining three aspects of the person will be impacted, and the person may become unwell. Imbalance in one dimension is therefore often perceived as the root source for the development of health problems, and the goal of much healing work is to re-establish balance and harmony among the four aspects of the self (Garrett & Wilbur, 1999). What becomes clear from this view of the self is that the various dimensions of health (physical, mental, spiritual) are not viewed as independent entities, but interconnected elements that comprise an individual’s health. It is for this reason that some Indigenous people struggle to define mental health concretely, because mind-body dualism is not a concept that is readily endorsed by many Indigenous cultures (Vicary & Bishop, 2005).

As was just noted, spiritual health is one of the four dimensions of well-being. This particular dimension, however, is often considered to be one of the most critical pieces to an Indigenous person’s healing, and something that tends to be identified as absent in Western mental health approaches by Indigenous peoples (McCabe, 2007; Vicary & Bishop, 2005). For instance, McCormick (2005) writes “One of the major distinctions between Aboriginal healing and Euro-Western healing is the role that spirituality has in the healing process. For Aboriginal people, spirituality is central…Spirituality takes on such an important role in healing that it is seen as the essence of healing for many Aboriginal people” (p. 294). Spirituality and spiritual work will mean and encompass different things for different individuals. However, one’s relationship with a higher power, often referred to as Creator or Great Spirit, relationships with different spirit beings and ancestral spirits, and one’s own spirit, are elements of spirituality that are often central to healing work (Garrett & Wilbur,
Many authors have spoken of the impact of historical and intergenerational trauma on Indigenous peoples today, (e.g. Brave Heart & DeBruyn, 1998; Menzies, 2008; Wesley-Esquimaux & Smolewski, 2004), and some believe that if healing services are to be effective with Indigenous peoples, efforts must be focused on healing at the soul or spirit level, or as Duran (2006) referred to it, healing at the soul wound level.

One model which encapsulates an Indigenous conception of health, and the importance of relationship and interconnection with all entities, is the Medicine Wheel. Originating with the Plains Natives (Stewart, 2007a), and varying in design and cultural meaning based on the Indigenous nation and community it comes from, the Medicine Wheel is comprised of four distinct quadrants, typically housed within the shape of a circle, that often represents the four aspects of the self, the four directions, the stages of human development, and other beings which humans have relationships with (animals, plants, spirits) (McCabe, 2008; McCormick, 1996; Poonwassie & Charter, 2005). In a study conducted by McCormick (1996), in which he interviewed 50 First Nations people in British Columbia, participants identified the Medicine Wheel as a First Nations philosophy of healing, as it illustrates the importance of attaining balance, harmony, and interconnection with oneself and other entities. Participants also identified relationship and interconnection among and between all things as a key component to the health of First Nations peoples.

An Indigenous individual’s relationship and involvement with their Indigenous community has also been cited by scholars as a significant contributing factor for mental health and well-being (Kirmayer et al., 2003; LaFromboise, 1988; McCormick, 1996; Stewart, 2008). Stewart (2008), in interviewing five Indigenous counsellors about their conceptions of Indigenous mental health, found that participants identified community as a
necessary and specific component of mental health and healing for Indigenous peoples.
Community was understood as any group to which an Indigenous individual belonged (including, but not limited to, ancestral and traditional communities) and that had some link with Indigenous culture. McCabe (2007) wrote that a key component of the traditional healing practices of many Indigenous communities is to introduce or reintroduce the individual to the community, which “connotes identity and seems to be accomplished by the use of group experiences and reminders that one’s community and family are intrinsically connected to an individual’s wellness” (p. 157). Kirmayer et al. (2003) have also noted the importance of community connection, stating that Indigenous cultures tend to be more collectivistic in nature, and that individuals will find strength and solutions to health concerns from community networks and members. An obvious challenge, however, is that many Indigenous individuals find themselves displaced from their traditional cultures and communities as a result of the colonial process. As Stewart’s participants noted, part of the healing work and the job of the mental health practitioner is to support the client in bridging connections to Indigenous community and culture. If an Indigenous client does not have a strong connection to their community, they may also have a weakened sense of cultural identity, which has also been identified as an important component of Indigenous mental health and well-being.

Indigenous identity was identified as a principal site of attack by European colonizers. Indigenous individuals were informed by colonizers that their ways of life, culture and traditions were savage and uncivilized, and that the obliteration of their Indigeneity was the answer to the advancement of their peoples (Waldram Herring, & Young, 2007). According to Hodgson (1990), this historical legacy of colonial domination
has resulted in feelings of shame and worthlessness for many Indigenous peoples about themselves and their cultures (as cited in Stewart, 2007a). Culture may be understood as the “dynamic system of rules, explicit and implicit, established by groups in order to ensure their survival, involving attitudes, values, beliefs, norms, and behaviours” (as cited in Schneider, Gruman, & Coutts, 2005, p. 333). Not surprisingly, there is a growing body of evidence that indicates that a strong sense and affiliation with Indigenous culture, and possessing a cultural identity, are vital aspects to securing health and well-being for many Indigenous peoples.

Goudreau, Weber-Pillwaw, Cote-Meek, Madill, and Wilson (2008) investigated the effects of a cultural hand-drumming practice on the four dimensions of well-being among a group of seven Aboriginal women. The findings demonstrated that the hand-drumming practice was effective in creating change and fostering healing in the four sacred aspects of the self. For example, the women reported that hand drumming enabled them to gain a greater understanding of their cultural traditions. It also increased their sense of self-efficacy and confidence as they began to share these teachings with other Aboriginal peoples and use the hand drum as a teaching tool in ceremonies, workshops, and classrooms. Cultural identity was also something that Stewart’s (2008) participants, Indigenous mental health practitioners, identified as being an explicitly necessary for the mental health of Indigenous peoples: “Having a clear Native identity is part of attaining and maintaining mental health; the act of finding or strengthening Native identity is what healing is about” (Stewart, 2008, p. 15). Acts through which cultural identity may be strengthened or developed include a connection with one’s cultural community and family, participation in cultural activities, such as receiving traditional teachings from the Elders or participating in ceremony, and learning and speaking one’s Native language. However, strengthening a sense of cultural
Indigenous identity can be a challenging task for several reasons. First, time and effort may have to be devoted to processing the internalized oppression and racism that some Indigenous individuals may carry. Another challenge is whether an individual has connections with their ancestral culture and community. Given the importance of both community and culture to the mental health of Indigenous peoples, mental health practitioners are encouraged to explore the ways in which they can support their Indigenous clients in strengthening their relationships with culture and their sense of identity. Practitioners must also be mindful to not assume that all Indigenous clients are interested or have identified their cultural background as an important aspect of their healing or therapeutic work. Just as a mental health practitioner would do with any client, the clinician must meet the client where they are at in their healing work and support the client through the psychotherapeutic process by allowing them to identify key goals and issues that they would like to address, which may or may not include an emphasis on developing cultural awareness and identity. Having reviewed some of the key elements that comprise Indigenous conceptions of mental health and well-being, I will now explore how these understandings are translated into Indigenous frameworks and approaches to healing.

**Indigenous models of healing.** Several authors have demonstrated through research how Indigenous notions of mental health inform Indigenous models or approaches to healing. The first three models examine how Indigenous conceptions of health and healing may inform the practice of psychotherapeutic approaches to healing. I will then explore traditional Indigenous healing approaches as an additional method for meeting the healing needs of Indigenous peoples, and the rates of use of traditional approaches.
McCormick (2005) detailed a conceptual path for healing based on his research which investigated the healing experiences of First Nations peoples in British Columbia, Canada. He identified four stages in the healing journeys of many Indigenous peoples, which include (1) separating from an unhealthy life (2) obtaining social support and resources (3) experiencing a healthy life and (4) living and maintaining a healthy life. In the first stage, an individual recognizes unhealthy ways of being and removes themselves from the unhealthy practices to examine how the problem behaviour is impacting or compromising the individual’s well-being. The second stage entails establishing connections with others as the individual seeks support in overcoming their problem. In the third stage, an individual begins to incorporate healthier aspects of living into their life, such as participating in ceremony, establishing a spiritual connection, and anchoring oneself in their traditions. McCormick writes that the feeling of integration with one’s culture that is characteristic of this stage “provides a strong sense of direction and belonging” (p. 303). And in the final stage, the individual works to maintain and integrate the lessons and experiences from the earlier stages as they continue with a healthier life path. Elements of holistic exploration, community involvement, and strengthening cultural identity are all represented in the various stages of this model. While McCormick noted that empirical support for this model has not been attained, it nonetheless demonstrates how the various elements that comprise health in an Indigenous context may be organized and incorporated into healing work.

In exploring how Native counsellors conceptualized the intersection of Indigenous cultural conceptions of mental health and contemporary counselling practice, Stewart (2008) interviewed five self-identified First Nations and Métis individuals who worked in a counselling or support capacity with Native clients at an Indigenous social service agency.
The counsellors had been trained in Western approaches to professional counselling, but as was illustrated by the findings, consistently integrated Indigenous conceptions and approaches to healing in their work. The results from the study yielded a Model of Indigenous Mental Health and Healing that consisted of four components: community, cultural identity, holistic approach, and interdependence. As has been noted above, the role of community in the attainment and maintenance of mental health for Indigenous peoples is key. Counsellors suggested that healing cannot occur if the client does not have any connections with a community. Community was understood to be a component of a holistic balance which the client is often working towards, and healing work may in fact focus on supporting the client in establishing or strengthening their connections with community. Developing or strengthening cultural identity is the second component of the model, and was perceived as the crux of healing work for many Indigenous clients. Counsellors identified participation in traditional healing practices as a way to strengthen cultural identity, and also identified the need to incorporate traditional healing into Western counselling services. The third element of the model was utilizing a holistic approach in the counsellor’s healing work with their client. Employing a holistic approach meant examining the healing needs of the four dimensions of the individual equally, and not ignoring or solely focusing on one area at the expense of the others. Examples of how the holistic model was used in practice included having food available in the counsellor’s office, using prayer and ceremony during counselling sessions, and taking clients into nature or the community. And lastly, interdependence reflected the belief that relationship and relying on others is an inherent piece of an Indigenous worldview. The relationship between client and counsellor was therefore identified as a significant element to healing work. Furthermore, the counsellors
noted that given the importance of relationship in healing work, they require support from mainstream health services to connect clients with other resources and supports in the community. Once again, the outlined model of Indigenous health presented by Stewart illustrates how some of the key determinants of mental health for Indigenous peoples can be integrated into mental health practice. The counsellors asserted that such practices should be integrated into Western mental health services to more adequately service Indigenous clients.

Finally, McCabe (2007) conducted interviews with four traditional healers and four participants of traditional healing practices to identify the therapeutic conditions of traditional healing approaches. While the model is based on healers’ and participants’ experiences with traditional healing, McCabe used the information from his participants to present what he referred to as a “home-grown” Aboriginal psychotherapy method (p. 158). The results of the study produced twelve therapeutic conditions: (1) readiness to heal; (2) understanding inner and unknown experience; (3) lessons of daily living; (4) challenges to change; (5) empathy; (6) acceptance and respect; (7) role modeling; (8) genuineness, credibility, and legitimacy; (9) trust and safety; (10) the sacred teachings; (11) ceremonies and rituals; (12) belief in the healing spirit. While an explanation of each of these conditions is beyond the scope of this paper, it becomes evident that the various elements of Indigenous conceptions of health and well-being are present in these therapeutic conditions, such as a belief in the healing spirit, exploring culture through sacred teachings, and exploring the various dimensions of well-being throughout the healing process. Furthermore, McCabe’s participants also identified what many Western mental health practitioners consider to be the essential conditions for the practice of Western psychotherapy. These include empathy, acceptance and respect (commonly referred to as unconditional positive regard), genuineness,
and establishing a trusting and safe environment. While McCabe argued that altering Western therapies to meet Indigenous peoples’ needs is not the ideal solution, I would argue that McCabe’s findings support current integrative efforts in the professional helping field. However, I believe that McCabe suggests, to which I would agree, that merely incorporating Indigenous elements into standing Western practice is not the ideal solution. What must occur is a melding of healing paradigms, where multiple worldviews and ways of knowing and healing are accepted as valid and legitimate, if integrative efforts are to be at all successful. One of the most commonly discussed approaches to healing within an Indigenous paradigm is the use of traditional healing practices. It is not uncommon for researchers and practitioners to suggest that Western practitioners collaborate or consult with Indigenous healers or Elders about incorporating traditional components of healing into therapeutic work (e.g. Constantine et al., 2004; Sue, Arredondo, & McDavis, 1992; Vicary & Bishop, 2005). The practice of traditional healing approaches is next to be reviewed.

**Indigenous traditional healing.** A myriad of definitions and understandings exist around the term and practices that constitute traditional healing (e.g. Aboriginal Healing and Wellness Strategy, 2002; Hill, 2003; Wyrostok & Paulson, 2000; Waldram, 2004). For instance, Waldram et al. (2007) commented that no agreed upon definition of traditional healing exists, but that the term generally refers to practices that include psychological, physiological, and spiritual elements that center around healing. Duran (2006) writes that traditional healing consists of ancient forms of healing that have evolved and been passed down through the generations. One definition provided by the Royal Commission on Aboriginal Peoples (RCAP) (1996) summarizes some of principal elements associated with the term and practice of traditional healing approaches:
Practices designed to promote mental, physical and spiritual well-being that are based on beliefs which go back to the time before the spread of western ‘scientific’ bio-medicine. When Aboriginal Peoples in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counselling and the accumulated wisdom of elders (p. 348).

Traditional healing typically refers to the practice of Indigenous forms of healing, which include the use of cultural teachings, ceremony, and specific healing practices that originated with the First Peoples of Turtle Island, and that have been successively passed down through the generations.

While the term traditional healing is commonly used in literary and scholarly circles, both Native and non-Native scholars and community members have voiced critiques and concerns with the term itself, and the implied authenticity of the knowledge and practices it purports to include (i.e. the idea that traditional knowledge and practices have not changed over time or been impacted by colonization). For instance, Waldram (2004) highlighted how the term traditional has come to be socially constructed throughout time when he wrote, “‘Traditional’ as an adjective has changed from a descriptor of a particular kind of ancient cultural formation or individual cultural orientation/lifestyle into a metaphor, and an oppositional one at that, for a particular kind of very contemporary lifestyle and identity, in which culture is no longer as much a lived experience as it is a practice or even a performance” (p. 292). In commenting on this metamorphic process, Waldram highlighted the importance of recognizing that traditional knowledge and practices have been greatly
impacted by colonial efforts, and that traditional healing itself may refer to and connote a healing practice that while rooted in Indigenous knowledge, may have evolved in its contemporary form of practice and expression. Hill (2003) also commented on the term ‘traditional’ when noting that the term was originally introduced by British colonial forces, and that it is disliked by many Indigenous groups today. A group of Elders and healers that were brought together by the National Aboriginal Health Organization (NAHO) to discuss contemporary challenges facing the practice of traditional medicine made it explicitly clear that they felt uncomfortable with the term “traditional medicine” and thought it was not an Indigenous concept (Hill, 2003). According to this group of healers, Indigenous medicine and healing refers to:

A way of life and a collective dynamic. It is spiritual, expressed through the land and ceremonies, and therefore holistic. Definitions included everything from diet, lifestyle, identity, knowledge of language and culture and expressions of love and comfort (hugging and smiling), positive verbal reinforcement, herbal and ritual knowledge, and spiritual doctoring. In short, traditional medicine is connected to all spheres of human activity and good medicine is laughter, good thoughts and a good state of being. Elders and healers were frequently reminding one another that it is not a western ‘medical’ concept disconnected from culture, families, and community (Hill, 2003, p. 24).

Hill highlighted several key points related to conceptions of Indigenous health and healing: (1) One achieves good health through a way of being and living that focuses on relationship and holism; (2) The term medicine in an Indigenous framework refers to a diverse system of sources and practices for healing (which include ceremony, laughter, identity, and culture)
and (3) Indigenous conceptions and practices of health and healing are markedly and significantly different than Western notions of health, medicine, and well-being. An exploration of some of these practices and approaches to healing will be reviewed next.

**Indigenous practices for healing.** It is important to begin by recognizing that each Indigenous community has and uses their own approaches and methods for healing. Furthermore, sources for healing are found in everyday occurrences, such as speaking with friends or laughing. Garrett and Wilbur (1999) expand on the aforementioned notion of Indigenous medicine, where medicine refers more broadly to a diverse array of methods for healing. These may include the use of herbs and ceremonies, but can also be found in the plant and animal world. As Garrett and Wilbur write “Medicine is everywhere. It is the very essence of our inner being; it is that which gives us inner power. Medicine is in every tree, plant, rock, animal, and person. It is in the light, the soil, the water, and the wind…There is medicine in every event, memory, place, person, and movement. There is even Medicine in ‘empty space’ if you know how to use it” (p. 197/8). This understanding of medicine is in obvious contrast to Western biomedical notions of medicine, where pharmacological responses are often the first line of treatment for illness or distress.

Indigenous ceremonies are most frequently discussed in the literature as examples of Indigenous methods of healing. Some ceremonies are facilitated by traditional healers and/or Elders in the community, and the type of ceremony to be performed will depend on the nature of the presenting problem by the individual who is in need. Some of the ceremonies most commonly discussed include the Sweat Lodge, Vision Quest, and various dancing and drumming ceremonies (e.g. Francis, 2004; Goudreau et al., 2008; Jilek, 2004; Smith, 2005). While some research has examined the therapeutic elements of these ceremonies (e.g.
Goudreau et al., 2008; Heilbron & Gutman, 2000; Wagemakers Schiff & Moore, 2006), with favourable results for the empirical efficacy of these practices, conducting research on these traditions remains a contentious issue at best. Some of the concerns related to researching Indigenous practices include the documentation of sacred traditional knowledge and employing a Western research paradigm to examine effectiveness (Gone, 2010; Waldram, 2000). Some have asserted that exercising such caution around researching ceremonies stems from a colonial history in which much Indigenous culture, including ceremony, was outlawed and banned between 1880 and the mid-twentieth century (Hill, 2003; Waldram, Herring, & Young, 2007). Additional concerns are related to the appropriation of Indigenous knowledge and ceremonies by New Age enthusiasts and the capitalist market. Some authors have written about the importance of securing the intellectual property rights of Indigenous knowledges as mainstream forces continue to seek out and capitalize on the resources of many Indigenous communities (e.g. Battiste and Henderson, 2000).

Two final methods for healing that I am going to highlight include the use of story and story-telling and the work of Elders and healers. Several authors (e.g. Mehl-Madrona, 2005; McCabe, 2008; Weber-Pillax, 2001) state that most Indigenous communities and cultures are based on oral tradition, and that story-telling plays a central role in both the transmission of knowledge and the healing of individuals. As McCabe (2008) writes, “Traditional Aboriginal healing is very much the telling of story. The narrative of one’s experience and understanding is connected to the inner dialogue of the mind, body, emotions and spirit and makes the connection between the client and healer” (p. 146). As McCabe alluded to here, it is the personal telling of story, the sharing of story with others, and oftentimes the receiving of storied teachings Elders and/or healers, that can facilitate an
individual’s healing. As has been mentioned above, the use and facilitation of Indigenous ceremonies and practices is often done by healers and Elders, and they therefore play a critical role in the transmission of Indigenous knowledge and healing practices, in addition to the actual performance of such ceremonies. As will be reviewed in the next section, it is fairly common for individuals to access Indigenous healing systems, either independent of or in conjunction with, the use of Western treatment methods.

**Rates of use of Indigenous healing methods.** LaFromboise (1988) asserted that the use of traditional healers among many American Indian tribes in the United States is the principal form of treatment accessed. Vicary and Bishop (2005) conducted qualitative interviews with 70 Australian Aboriginal individuals to examine attitudes and beliefs related to mental health, Western psychotherapy, and the healing process. Participants reported that traditional forms of treatment were preferred over Western mental health services, and Western services would only be accessed if necessary or as a last resort. Instead, participants identified a community-based approach to healing in which the individual’s family, community, Elders and traditional healers comprised the primary network of care to address the health problem or concern.

One study which examined perceptions and levels of involvement with traditional healing practices in a Canadian context was conducted by Wyrostok and Paulson (2000). The participant sample consisted of 99 First Nations students studying in postsecondary institutions in Edmonton, Alberta. Participants were asked to complete a questionnaire which examined 14 different aspects of Indigenous healing practices. Wyrostok and Paulson found that overall, respondents expressed a strong interest in traditional healing practices and over four-fifths said they would like to learn more. Participants also strongly supported the idea
that traditional healing practices should not be forgotten, and felt that Native healing practices could be as helpful as Western medicine. And finally, 80.8% of the participant sample reported previous experience with various traditional healing practices, including participation in the Sweat Lodge, Pipe, and Shaking Tent ceremonies.

A final study which examined rates of traditional healing method use was conducted by Kim and Kwok (1998). The authors investigated the use of Native healers by Navajo peoples located on a reserve in New Mexico. Participants were recruited through an ambulatory care clinic at a rural Indian Health Service hospital located near the reserve. The findings revealed that 62% of the participants had used a Native healer at least once in their lifetime, with 40% of the participants accessing the services of healers on a regular basis. The services of healers were most commonly obtained to address problems related to arthritis, abdominal pain, depression/anxiety, and chest pain, and those who consulted with healers for depression/anxiety were less likely to obtain Western health services. While numbers for concurrent use of both Western and Indigenous health practices were not reported, the participants indicated that they had accessed both services simultaneously, as 21% stated that the medical provider and Native healer had provided conflicting recommendations for their healing or treatment. The majority of individuals who received conflicting treatment plans attempted to follow both sets of advice from the Western and Indigenous practitioner. The main barrier to accessing the services of a Native healer was cost, and one third of the participant sample said they would use traditional services more often if they had the economic resources to do so. As has been demonstrated by this study, and the others reviewed above, Indigenous peoples continue to access the services of Indigenous healers and Elders and healing methods in contemporary contexts. Given Elders’ central role in the
healing process, and their reputation as cultural and spiritual leaders in their communities, obtaining the perspectives of these individuals on the current trends in mental health practice and services for Indigenous peoples is warranted and needed. The following section will review some of the major roles and responsibilities of Indigenous Elders.

**Indigenous Elders**

In the following section, current understandings of the role and work of North American Indigenous Elders are outlined. It is important to note that the process by which one comes to be identified as an Elder will vary across Indigenous communities, and different Indigenous groups have different terms to refer to someone in the position of cultural leader or wise one. For instance, among the Métis people, the term Senator is bestowed on individuals in recognition of their knowledge and insight, yet it carries the same meaning as the term Elder, which is used among many First Nations (RCAP, 1996).

**Defining the role of Elder.** No single definition of the term or work of an Elder exists. The definition process becomes even more clouded as the term elder may also refer to someone who is elderly, or a senior citizen in Western terms. However, referring to someone as an Indigenous Elder is qualitatively different than an elderly person in the community, and several authors have ventured to provide descriptions and understandings of the key characteristics and attributes of Indigenous Elders.

Stiegelbauer (1996) outlined the findings of her dissertation research which focused on examining and identifying the role and work of First Nations Elders in urban community organizations in Toronto. In terms of defining the role of an Elder, she noted “Elders are important for their symbolic connection to the past, and for their knowledge of traditional ways, teachings, stories and ceremonies…In a sense, Elders are ‘experts on life.’” Their exact
expertise may be dependent on the nature of their experience, but in one way or another it involves some aspect of traditional knowledge and culture, *or an interpretation of their experience in traditional terms*” (italicized in original; Stiegelbauer, 1996, p. 40-41). What is evident from this definition is that tradition, culture, and wisdom are all key elements to the role and identity of an Elder.

The *Report of the Royal Commission on Aboriginal Peoples* contained a chapter on the role of Elders among Indigenous communities. The report stated that the culture, traditions, language, and rituals of the First Peoples of Turtle Island were orally transmitted through the generations, and Elders played a critical role in this knowledge transmission system. Elders are perceived as having close relationships with the Creator, and are considered “exceptionally wise in the ways of their culture and teachings of the Great Spirit” (RCAP, 1996, p. 110). Elders are often understood to have received gifts from the Creator and these gifts are to be used for the greater good of the Elder’s community and when healing or assisting individuals who seek out their counsel. It was also noted that it is the responsibility of the community or individuals in need to seek out the guidance and counsel of the Elders, as they are perceived to be “the conscience of the community” and are rooted in the morals of the Creator (p. 111).

Ellerby (2005) identified and differentiated between three types of Elders: Community Elders, Elders as healers, and Elders as teachers. He defined a community Elder as someone who has gained a great deal of life experience and possess a wealth of practical knowledge. The wisdom of this Elder may or may not be related to spiritual matters, and the community Elder does not typically facilitate or conduct healing practices; they are most often consulted about cultural practices and knowledge, such as traditional hunting patterns
or diet. The second type of Elder, Elder as healer, tends to specialize in traditional healing practices, such as the use of Indigenous medicines and performing ceremony. An Elder teacher is someone who focuses on the sharing of cultural and spiritual teachings and who may be viewed as a mentor or spiritual leader by their community. Ellerby wrote that both the Elder healer and Elder teacher provide healing services, but through different means: the Elder healer tends to focus on medicines and ceremony, whereas the Elder teacher heals through the sharing of traditional teachings, story, and spiritual guidance.

Some authors have also identified specific characteristics that most Elders tend to embody. These include being able to speak their Native language and know their culture’s traditional ways and teachings; are humble and use humour; lead by example and incorporate traditional ways of living into their lifestyle; can be either male or female; have overcome personal hardships and difficulties that inform their work as an Elder; are evolving individuals who continue to learn and grow; have committed themselves to working towards the betterment of their peoples; and sustain the oral tradition of their communities (Aboriginal Healing and Wellness Strategy, 2002; Couture, 1996; Ellerby, 2005; RCAP, 1996; Stiegelbauer, 1996; Waldram et al., 2007). Stiegelbauer (1996) also provided an itemized list of the principal qualities which characterize the role and work of an Elder:

1. Is knowledgeable about tradition including ceremonies, teachings, and the process of life; is ideally a speaker of a Native language
2. Lives those traditions
3. Is old enough to have reached a stage of experience at which it is appropriate for them to communicate what they have learned from life and tradition
4. Is recognized by the community for their wisdom and ability to help
5. Is still an individual with varying knowledge and skills
6. Is able to interpret tradition to the needs of individuals and the community
7. Is often asked to represent First Nation views as symbols of the culture or through active involvement with issues and individuals.

In summary, Indigenous Elders possess a diverse range of skills which translate into different types of work and activities. Common elements to most Indigenous Elders include a broad depth of knowledge about their culture’s traditions and practices, strong relationships with other beings (humans, plants, animals, spiritual relations), are viewed by their community as sources of wisdom and guidance, and their counsel or specific abilities (such as healing or story-telling) are often sought by both individuals and the community at large. Having reviewed some of the defining features of the role and work of Elders, I will review the process by which one comes to be identified as an Elder.

**Becoming an Elder.** As mentioned above, the process by which an individual comes to be viewed and identified as an Elder varies and depends on the individual person’s life experiences and journey. For instance, learning of one’s traditional teachings and cultural practices may be a life long experience for some, whereas for others, a pivotal moment or encounter in which they are bestowed gifts or called by the Creator signifies their commencement into training and healing work (Constantine et al., 2004; Stiegelbauer, 1996). Ellerby (2005), in writing a manual on how to work effectively with Indigenous Elders, stated that while no formal education or training programs, such as those found in Western institutions, exist for to-be Elders, the training process for Elders is often rigorous, demanding, and life-long. For instance, to-be Elders often apprentice with other Elders or healers starting in adolescence and continue this training for many years, often returning to
their mentors throughout their lifetime for further skill development and the honing of their
gifts. For example, Ellerby wrote, “a person may spend years learning about one particular
herbal medicine – where it’s picked, what it’s called in different places, how it’s used in a
wide variety of circumstances, how it is prepared and how to relate to it spiritually, with
respect – before being allowed to administer it for the first time” (p.20). Furthermore, Ellerby
stated that Elders are expected to have embarked on their own personal healing journey,
achieving mental, spiritual, emotional, and physical balance and wellness, before being able
to counsel or heal others. The training process for many Indigenous Elders can be
characterized as a life-long experiential journey in which specific skills and personal qualities
continue to evolve and develop in response to different life experiences.

The Elders in Stiegelbauer’s (1996) study identified a learning process that was
sparked by a personal, spiritual, or political event which led them to an intensive study of
their traditional ways. These Elders then described being called upon by their community to
share their learnings and teachings, and as such, were recognized by their community as wise
ones and teachers. Several authors have commented that the only way to truly achieve
recognition as an Elder is through identification by one’s Indigenous community (Aboriginal
Healing and Wellness Strategy, 2002; RCAP, 1996; Stiegelbauer, 1996; Waldram et al.,
2007). Identification as an Elder by one’s community is often viewed as a benchmark by
Indigenous groups and organizations for ensuring that a “true Elder,” as Couture (1996)
refers to them, is in good standing. Various authors and organizations have made reference to
ill-equipped or inauthentic healers and Elders (e.g. Aboriginal Healing and Wellness
Strategy, 2002; Hill, 2003; Stiegelbauer, 1996), noting that the prestige and status inferred
upon Elders is desirable by many (although it is often perceived as an undesirable
characteristic by “true Elders”). This has led some healing initiatives and organizations who retain the services of Indigenous Elders, such as the Aboriginal Healing and Wellness Strategy of Ontario (AHWS) (2002), to develop protocols and procedures that are designed to ensure the reputability of their Elders, while also outlining disciplinary measures for malpractice or incidental harm that may be experienced by the client or knowledge seeker. This leads to a discussion of the specific practices and work of Indigenous Elders, which is to be reviewed next.

**Work of Indigenous Elders.** Some of the work activities of Elders have been described above. For instance, one of the principal expectations of an Elder is that they are the bearer of their culture’s traditional knowledge, teachings, and practices (Stiegelbauer, 1996; RCAP, 1996). One of the main services that they provide is to share these teachings with individuals who seek to learn about their culture. Elders often play a pivotal role in keeping their Native languages alive, and often provide instruction for learning the language as well. A second prominent area of work for Elders is healing work. This may include performing or facilitating certain ceremonies, using plant medicines, sharing teachings or story-telling, and offering spiritual guidance (Anishnawbe Health Toronto, 2000; Ellerby, 2005). It is important to remember that Indigenous Elders practice from a holistic perspective, and so while they may have particular gifts and areas of expertise, they will still pay close to attention to the mind, body, and spiritual needs of the individual. Indigenous Elders have also identified the area of education as particularly important to their work, as they strive to educate the younger generations about Indigenous ways and historical realities (RCAP, 1996). They have also become fairly involved in the justice system, providing a variety of services to inmates and the administration system alike, including offering or
facilitating healing circles, participating in community sentencing circles, and acting as justice of the peace (RCAP, 1996; Waldram, 1997). It is this exact diversity of skill, breadth of knowledge, and status within the Indigenous community that has resulted in recommendations for the collaboration between Western professionals and Indigenous Elders. The following section will explore the movement towards integrated mental health services for Indigenous peoples, and the benefits and challenges of doing so.

The Integrated Healing Movement

In the following section I will review various aspects of the current movement towards integrating Indigenous and Western paradigms and practices of healing. First to be outlined is the concept of integration or hybridity, and arguments for why integration should occur. I will then discuss the various levels at which integration may occur, which includes a melding of healing paradigms, epistemologically hybrid practitioners, integrated mental health programs, and collaborations with healers and Elders. The final point of discussion will center on the challenges of integrating services, and the section will end with a summary of Chapter Two and the rationale for the current research study.

Defining integration. One of the principal authors that has practiced and written theoretically on integrated psychotherapy with Indigenous peoples is Duran (2006). In his text *Healing the Soul Wound*, Duran outlined the philosophical tenets of what he referred to as hybrid psychotherapy. He stated that the term hybrid emerged from postcolonial thinking and refers to the idea that there can be two or more ways of knowing, and that these different views can exist harmoniously with one another. He stated his belief that the mental health profession must transcend the practice of culturally sensitive psychotherapy and engage in what he called epistemological hybridism, which is the ability to think or see the truth in
more than one way (Duran, 2006, p. 14). The adoption of an epistemologically hybrid stance implies that the mental health paradigm and individual practitioners take “the actual life-world of the person or group as the core truth that needs to be seen as valid just because it is. There should never be a need to validate this core epistemology or way of knowing by Western empiricism or any other validating tool” (Duran, 2006, p. 14). Embracing and practicing hybrid psychotherapy therefore implies that a mental health practitioner create space for the expression of diverse forms of knowing and healing, while being able to accept the client’s beliefs, perspectives, and experiences as legitimate, valid, and authoritative sources of truth and knowledge. This theory for integration allows both the practitioner and client to meet together and explore the client’s worldview, and identify the healing needs and preferred methods or strategies for healing work. It is this exact collaborative and conceptually flexible space which allows for the co-occurrence, integration, and acceptance of both Western and Indigenous healing knowledges and practices.

While Duran (2006) discussed how multiple forms of knowing and healing may come together in harmony, other authors have spoken about the incorporation of traditional healing methods into Western mainstream counselling approaches. For instance, Moodley and West (2005), in reflecting on the overwhelming failure of the Western mental health system to service ethnic minority clients, and in questioning whether the abandonment of Western services is the only viable option for oppressed peoples, stated “We do not think that this is the answer. We believe that a creative move(ment), a small paradigm shift – the inclusion and integration of traditional healing methods into mainstream counseling and psychotherapy…will also add a new lease of life to psychotherapy and counseling generally” (p. xvii). Gone (2010) questioned how the integration of such healing methods can occur
however, when stating that it would be highly unlikely, even undesirable, for doctoral students to receive training in the facilitation of healing ceremonies. At the same time, he stated that superficial alterations to mental health services, or in other words, “conventional programs with some feathers and beds thrown in” (Waldram, 2004, p. 286), will also not adequately address the required revisions that are needed in Western mental health services. I would echo the assertions of Duran (2006) in arguing that integration at a paradigmatic level is required if an authentic merging or collaboration between Indigenous and Western methods and professionals is to occur. Given that Indigenous methods for healing have been successfully employed by Indigenous communities and peoples for thousands of years, one may question why an integration of healing paradigms is needed at all.

**Rationale for integration.** Two primary arguments for the integration of Indigenous and Western mental health systems are the failure of Western mental health services to adequately serve many Indigenous peoples’ needs (Harris, Edlund, and Larson, 2005; O’Sullivan, Peterson, Cox, and Kirkeby 1989; Sue, Allen, and Conaway 1978), and Indigenous peoples’ perceptions of and attitudes towards Western mental health services (Price & McNeill, 1992; Vicary & Bishop, 2005). Price and McNeill (1992), in investigating attitudes towards Western counselling services among 74 Indigenous individuals, found that participants strongly committed to their tribal culture had less confidence in mental health professionals and had significantly less favourable attitudes toward seeking counselling services. One may surmise that if traditional approaches to healing were made available in mainstream mental health or counselling settings, Indigenous individuals interested in pursuing traditional means for healing may be more likely to approach these services. If Indigenous clients can see Western practitioners working collaboratively with Indigenous
healers and Elders in these settings, one might imagine that obstacles related to developing trusting relationships between client and counsellor may be assuaged.

A second rationale for the integration of services, which was discussed in previous sections of this review, is the absence of Indigenous worldviews from current Western informed mental health services. In addition to the importance that a holistic approach, family, community, and culture play in the healing process of Indigenous peoples, is the role of spirituality. Fostering or strengthening spiritual identity and spiritual relations with other beings (Creator, ancestral spirits, etcetera) has been identified as a core component of healing for many Indigenous peoples (McCabe, 2008; McCormick, 1996) and something that is glaringly absent from Western systems of healing. While Western systems of health tend to fragment the various dimensions of an individual into different treatment sectors (medical, psychological, spiritual), the combination of Indigenous healers and practices with Western mental health services would provide a holistically oriented approach to health and wellness for Indigenous peoples.

While Indigenous healing systems, including the services of healers and Elders, continue to be accessed and identified as a successful option for healing (Kim & Kwok, 1998; Maar, Erskine, McGregor, Larose, Sutherland, Graham, et al., 2009; Wyrostok & Paulson, 2000), relying solely on Indigenous healers and Elders for healing is no longer a viable option. Some of the primary obstacles to accessing the services of Indigenous helpers include the cost and accessibility of traditional services (Kim & Kwok, 1998). Additionally, given the complexity of health, particularly mental health challenges, among many Indigenous communities today, traditional services alone may not be adequate to address new or contemporary mental health problems. McAdam (2009) noted that the term “sexual
“assault” does not exist in the Cree language because its occurrence was relatively unknown among the Cree people before European contact. Given that certain mental health challenges were virtually unheard of during pre-colonial times, such as the sequelae of sexual assault, traditional approaches that are designed to heal this type of distress may also be lacking.

Research has also shown that some Indigenous peoples use both Indigenous and Western services simultaneously, but often fail to inform the helpers of their multiple service use (Kim & Kwok, 1998; Waldram et al., 2007). This poly-service use becomes particularly high risk when one considers the potential for interactions between Western and Indigenous medicines. Developing systems in which both Western and Indigenous practitioners are centralized would provide the client with greater treatment options, which would presumably increase the likelihood of Indigenous peoples seeking and continuing with services. Centralized systems would also allow for communication, case consultation, and treatment planning between helping professionals, which would decrease the chance of a client receiving contradictory information or direction from the healers and practitioners.

A final motivation for the integration of Indigenous and Western healing paradigms is that the two approaches have the potential to complement one another and enhance healing processes. For instance, McCormick (1996) stated that various Western psychotherapies, or elements of these modalities, may be used effectively with Indigenous clients. He gave the example of using emotion-focused therapies to facilitate the expression of emotion, but questioned whether the sole use of this orientation would be suitable in and of itself with Indigenous clients. McCabe’s (2007) study identified 12 therapeutic conditions that facilitated the successful implementation of traditional healing methods. Several of these conditions, such as empathy, genuineness, acceptance of the client, readiness to heal, and
trust and safety also represent what many consider to be the core conditions of Western psychotherapy. One could argue that given the congruence between the required parameters for a successful healing encounter, some of the foundational elements for an integrated approach are already in place. If mental health practitioners or organizations are able to accept and operate from an epistemologically hybrid position, one can only imagine the various benefits and fruitful outcomes that are within reach for the individual client, Indigenous community, and the various helping professions. Having reviewed some of the conceptual tenets of integrated health services, and the rationale supporting it, I will now explore the various levels and forms that integration may take, and provide case study examples of integrated mental health interventions.

**Levels and forms of integration.** As has been discussed above, one level at which integration may occur is the paradigmatic level. Duran (2006) writes that objectives and definitions of healing in Western and Indigenous paradigms are one in the same: the translation of psychotherapist is ‘soul healer’ and the task of the soul healer is to help individuals overcome psychopathology, which translates into ‘soul suffering.’ He feels that the primary objective for helpers is to recognize and “engage in the healing tradition that is part of our genetic memory and be true to that tradition” (Duran, 2006, p. 44). While a meta-level aligning of Indigenous and Western paradigms of healing would be ideal, it seems highly unlikely that Western psychological governing bodies and training programs will abandon the Euro-centric model overnight, perhaps ever. While training programs may work to ensure that practitioners develop the appropriate skills to be culturally sensitive or competent, this is still fundamentally different than a practitioner who is epistemologically hybrid and is able to accept multiple forms of knowing and healing as valid and legitimate.
What is evident here is that paradigmatic integration may occur at either a meta or micro level, where meta-level integration entails an aligning of philosophies within the discipline of psychology and Indigenous worldviews, and micro-level integration occurs among specific individual helpers/practitioners and organizations. If meta-level integration was to occur, one would conclude that the vast majority of individual practitioners would be automatically trained in epistemological hybridism. However, given that the predominant form of training in many institutions is informed by Western standards of practice and philosophy, the task of practicing hybridity often falls to individual practitioners and organizations.

One area of contention within the integration field is whether mental health services (such as specific counselling and healing methods like CBT and the sweat lodge) can be used conjointly if integration at the paradigmatic level has not occurred. For instance, Western practitioners, as part of culturally sensitive training procedures, are instructed to be open to client worldviews and values around healing, and the possibility of working or consulting with traditional healers and Elders (Constantine et al., 2004; Sue, Arredondo, & McDavis, 1992). However, simply because a practitioner refers a client to the services of an Indigenous healer, or communicates with a healer from time to time, does not necessarily mean that the practitioner is practicing from an integrated stance, where Indigenous methods or healers are viewed as reputable sources of healing. For example, in examining the contact and the occurrence of referrals between Western trained nurses and Indigenous healers and Elders, Gregory (1988) found that 52% of the 10 nurses interviewed had referred clients to Elders, and 39% had referred clients to traditional healers. Indigenous healers also visited patients in the hospital, and occasionally spoke with the nursing staff. However, one participant quote
highlighted the Western elitism that many scholars have referred to when commenting on Western helping professionals’ acceptance of traditional forms of healing:

She [medicine woman] came here to the nursing station and saw the patient and decided that he would need several treatments. We have a good medicine lady here. *She’s sophisticated enough to work with the nurses. You almost feel you are dealing with a professional* (italics added, Gregory, 1988, p. 40).

Criticism and scepticism of Indigenous healing methods, and the maltreatment of Indigenous healers and Elders, has occurred throughout history, beginning with European contact in the late 15th century (Waldram et al., 2007). While the Western mental health system and its practitioners have made strides in terms of acknowledging and validating diverse systems of knowledge and healing, some authors have commented that traditional practices continue to be stigmatized and viewed as magical and illegitimate forms of healing (Crowe-Salazar, 2007; LaFromboise, 1988; Waldram et al., 2007). Given the relative newness of the integrative healing movement, questions around how paradigms of healing and actual practices may be integrated continue to be posed, and integrated interventions continue to be experimented with. Paradigmatic aligning represents one level of integration, and the simultaneous use of Indigenous and Western methods and helpers represents a second level.

It has become a commonplace recommendation that Western practitioners remain open to the possibility of referring, consulting, or collaborating with Indigenous healers and Elders (e.g. Constantine et al., 2004; Ellerby, 2005; Rayle et al., 2006; Renfrey, 1992; Sue, Arredondo, & McDavis, 1992). Whether referring a client to an Indigenous healer, without the establishment of a formal relationship between the healer and clinician, constitutes a form of integrative service is questionable. However, consulting with Indigenous healers and
Elders to learn of a client’s cultural background, developing a culturally-informed understanding of the presenting psychological issue, or collaborating with healers in the design of a treatment plan (such as incorporating the use of ceremony as part of a client’s healing work), are more suggestive and representative of an integrated approach to treatment and healing.

A book chapter written by Shore, Shore and Manson (2009) represents one of the first written accounts of how Western mental health practitioners and Indigenous healers establish collaborative working relationships. These two helping professionals were brought together as they worked collaboratively in the treatment of post-traumatic stress among American Indian war veterans in the Northern Plains Tribes of the United States. The authors stated that the University of Colorado at Denver and the Health Sciences Center’s American Indian and Alaska Native Programs, in partnership with the US Department of Veterans Affairs, began establishing mental health clinics for American Indian veterans in 2001-2002. The clinics use live interactive videoconferencing, referred to as telepsychiatry, to allow psychiatrists to work with veterans located on rural reserves in the northern plains states. These clinics offer medication management as well as individual, family, and group psychotherapy to 12 different tribes. Part of the initiative of these clinics, in providing culturally appropriate care, is to collaborate with local traditional healers. The authors noted that both formal and informal collaborations have developed with traditional healers, and that during the early stages of the clinic’s establishment, psychiatrists made multiple trips to the community to begin to establish relationships with community figures, members, and healers. The psychiatrist, with the aid of a cultural informant that is part of the clinical team, attended community events such as pow-wows and sweat lodges. Participating in such events allowed
the psychiatrist to come into contact with healers and demonstrate an interest in traditional activities and culture. Once the initial relationship with a healer had been established, the psychiatrist builds on this relationship by having ongoing meetings with the healer. Examples of how therapeutic integration takes form in these clinics include case collaborations between the healer and psychiatrist to discuss models of healing, perspectives on symptoms, and the development of treatment plans, which includes the use of traditional healing, case consultation between the healer and psychiatrist on specific clients, and client referrals to one another. The authors noted that clients are commonly referred to healers for certain ceremonies, such as the sweat lodge, which has proved to be an effective means of healing for American Indian veterans. It is also important to note that client consent is obtained before any communication between the psychiatrist and healer takes place. The authors comment that this form of integrated care has proven effective for retaining Indigenous clients in mental health services and in the reduction of health problems. While this chapter provides insight into how integrative efforts may take form, the experiences of such collaborations of both the Western professionals and Indigenous healers are absent. Speaking with either of these two helpers would prove beneficial in gaining a greater understanding of the exact elements of the integrative process that are necessary for a successful collaboration, and any challenges that the helpers encounter in working together, and how these challenges are then overcome. Obtaining the experiences of both Western professionals and Indigenous healers who work collaboratively with one another is a fertile area for future research.

In addition to collaborations and integrated service delivery at the professional helper level are programs that have been designed and operate from an integrated stance. Integrated health programs have begun to increase over the last 20 years, as Toronto alone has seen the
emergence of Aboriginal Services at the Centre for Addiction and Mental health, and Anishnawbe Health Toronto, a community health centre which offers access to a diverse range of health care practitioners, including psychiatrists, psychologists, nurses, traditional healers, Elders, and medicine people. While these clinics have begun to grow in strength and number, a paucity of research and formal documentation exists which examines the strengths of these clinics and how they work to successfully care for and retain their clients in their services.

One example of an integrated mental health service which researchers (Maar, Erskine, McGregor, Larose, Sutherland, Graham, et al., 2009) have detailed is the Knaw Chi Ge Win service, a centre which provides healthcare for seven First Nations communities in the Manitoulin District of Northern Ontario. Knaw Chi Ge Win services are coordinated by two regional Aboriginal health organizations which place an emphasis on community-based Aboriginal approaches to care. The Knaw Chi Ge Win core team is made up of professionals working in the areas of psychology, nursing, social work, as well as a coordinator of traditional healing services who has expertise in the area of Aboriginal medicine and healing. The core team is also complemented by visiting consultants on a monthly basis who possess expertise in the areas of psychiatry and traditional Aboriginal healing. The core team’s home office is centrally located within the region, and satellite clinics are located throughout the seven First Nations, and clients can access services through either the home office or various clinics. Services are provided within a holistic Aboriginal framework that acknowledges the various dimensions of a person (physical, emotional, mental, spiritual), while also taking into consideration historical, socioeconomic, and cultural factors. When a new client approaches the centre for service, the core team reviews the client’s presentation and assigns them to the
most suitable healthcare provider(s) (nurse, psychologist, etc.). Services are therefore coordinated at the outset of treatment, and the various providers consult with one another throughout the treatment process to coordinate and complement the healing work of one another. If the service providers feel that a client would benefit from a specialized psychiatric or traditional healing intervention, or if the client expresses interest in traditional healing services, they are placed on a waitlist for the next available appointment with the visiting consultant. Team members attend psychiatric consultations and traditional healing services with their clients to ensure continuity of care and a collaborative approach to healing.

To examine the strategies which support the integration of these services, and the strengths and challenges of this approach to mental health service delivery, Maar, Erskine, McGregor, Larose, Sutherland, Graham, et al. (2009) conducted focus groups with community service providers (e.g. band managers, community health representatives), as well as individual interviews with clients and the Knaw Chi Ge Win core and consultant team members, totalling 54 participants, and conducted a qualitative thematic analysis of the collected research data. Results demonstrated that one strategy for the effective integration of Indigenous and Western healing is that professional helpers must have an in depth understanding of both systems of healing, and ongoing education around each system of healing is critical. For instance, one clinician commented “We need to be working more with traditional models…when a person defines that that’s the way that they want to go…I think we can, [but] it’s a difficult fit…You’re trying to fit in something that just is not really well understood” (Maar et al., 2009, p. 7). The development of protocols around the delivery of traditional Aboriginal healing methods in this organization lifted “some of the mystique that traditional medicine often embodies for clinically trained professionals” and thus advanced
integrative practice (Maar et al., 2009, p. 7). Clinicians reported higher levels of comfort referring clients to traditional services once protocols for traditional healing practices had been established.

In terms of the reported benefits of the Knaw Chi Ge Win mental health service, improved quality of illness management, cultural safety, managed wait times, and reduction in professional isolation were identified. The authors stated that a reduction could be seen in the number of patient admissions to acute care units in psychiatric hospitals, and attributed this reduction to finessed management of localized care and the stabilization of clients. Additional quality of care factors included a client’s ability to choose either Western or traditional approaches to healing and receiving services in their traditional language. Since clinicians in this service are open and accepting of the use of traditional medicine, stigmatization of Aboriginal approaches to healing did not occur. The importance of acceptance of cultural practices was reflected in the clients’ emphasis on feelings of cultural safety in the Knaw Chi Ge Win service, and this sense of cultural safety was identified as a significant marker of difference between the Knaw Chi Ge Win service and mainstream services. Some of the challenges of the Knaw Chi Ge Win service that were identified by the authors included under-funding of Aboriginal mental health services, lack of qualified mental health professionals willing to work in this setting, and lack of community mental health data. While the listed challenges are assuredly legitimate, investigating the challenges in communication or collaboration between professional helpers would have proved interesting and informative as professional helpers continue to attempt to successfully integrate and collaborate. It is particularly important to identify how challenges in integration are overcome, as numerous obstacles face practitioners and organizations as they attempt to
integrate and collaborate. The final section of this review will outline some of the principal concerns and difficulties related to the integration of Indigenous and Western paradigms of healing.

**Challenges with integration.** One of the most obvious challenges related to integration are the differences in epistemological and conceptual understandings of mental health and healing (Crowe-Salazar, 2007; Gone, 2010). As has been outlined in the previous sections of this review, significant differences exist between Indigenous and Western paradigms of healing, including an emphasis on holism versus mind-body dualism, the role that spirituality, relationship, culture, and community play in each paradigm, and the formulation of illness etiology. For instance, Mohatt and Varvin (1998) present an account of an 18 year old Objibwe woman known as H who accessed the services of both Indigenous and Western healers. During the course of H’s treatment, she received services from a Western trained psychiatrist, Lakota medicine man and woman, and two Western trained psychotherapists who provided crisis intervention. While H received a diagnosis of bipolar disorder and was prescribed Lithium and Chlorpromazine by Western practitioners, the Lakota healers’ formulation of her problem was markedly different and was rooted in cultural understandings of illness:

The indigenous conceptualization of her illness saw the problem not only lodged in her, but as reflecting problems in her family, her peer-group, and her tribe, who were all in crisis…The salient elements in the indigenous conception of illness were thus problems of relationship between the spirit and the body and disruption in human relatedness. Her symptoms were, at this level, then
seen mainly as a consequence of her struggle with such problems, not as a cause of an inherent illness (Mohatt & Varvin, p. 90).

Because of H’s and her family’s dislike of the Western approach and conceptualization of her “illness”, they decided to access the services of the traditional healers in their community. Had H continued to receive both forms of treatment, without consultation or coordination between the various helpers, she may have been put at risk as a result of the different treatment plans and approaches, specifically the simultaneous use of Western and Indigenous medicine. Interactions between Indigenous and Western medicines and methods have been identified as an area of concern by practitioners (Crowe-Salazar, 2007; Wieman, 2006), and if Indigenous and Western professionals strive to provide integrated services, much consultation and negotiation would have to occur in order to provide a cohesive treatment plan.

This last point raises the issue of both Indigenous and Western practitioners’ willingness to collaborate and integrate their services. As has been mentioned before, Indigenous methods for healing are often stigmatized and viewed as illegitimate forms of treatment by many Western professionals (LaFromboise, 1988; Waldram et al., 2007). At the same time, RCAP (1996) points out that Indigenous healers are entrusted with the task of healing in their communities, and for some healers and Elders, it is Western medicine that has become suspect. As RCAP (1996) noted, healers and Elders “have seen people become addicted to western medicines or be subjected to uncomfortable or painful treatments with little or no positive results” (p. 13). Suspicions and mistrust may therefore impede both groups of helpers in collaborating and integrating their services. Part of this suspicion may stem from a lack of understanding and awareness of the work and approach that each helper
takes. For instance, Crowe-Salazar (2007), in exploring the experiences and perspectives of an Elder, psychologist, and psychiatrist, found that the psychiatrist, while supportive of a client’s wish to access traditional healing services, would not “go out of my way to say there is this person. I am not sure that would be my role and I don’t know people [healers] well enough… the Psychiatrist is supportive but could neither recommend nor not recommend due to lack of information and resources” (p. 90). Likewise, Indigenous healers too have expressed ambivalence about referring and working with Western practitioners as a result of lack of information. Sima and West (2005) found that among a group of Tanzanian healers, referral was identified as a promising form of collaboration and integration, but the healers were unsure of how successful they would be at referring clients given their lack of knowledge about Western approaches to healing: “It is true that we can co-operate in the use of referral services, but we can still ask ourselves how many traditional healers know what counseling is and how it works?...I have heard about counseling, but I ask myself few things like if we agree that we can co-operate in referrals, which problems shall I refer to counsellors?” (p. 320). Education of each helper’s healing paradigm, approaches and practices has been identified as a critical task when discussing the possibility of collaboration or integration. However, each practitioner and healer must be open to developing their cultural awareness and understanding of each approach, and be willing and interested in integrating their services.

While developing cultural awareness and providing education about Indigenous practices is important, it is also imperative that one is mindful of respecting cultural protocols around the disclosure of sacred rituals, ceremonies, and teachings. As a result of Canadian legislation which outlawed the practice of many Indigenous healing traditions and increased
surveillance of Indigenous peoples and communities, much cultural knowledge and tradition was forced underground (Hill, 2003). Great strides have been taken to protect this knowledge throughout the decades and to also avoid persecution, punishment, or exploitation today. Gone (2010) pointed out that many traditional healers may be reluctant to disclose aspects of their approaches in detail which may be required for effective integration.

An additional complication related to the disclosure of practices is the current movement towards evidence-based practice in psychology, which promotes the idea that valid forms of treatment have an empirical base of evidence that documents their efficacy. Several problematic issues and points of concern have been voiced with regard to empirically evaluating Indigenous healing practices, including the use of a Western informed research paradigm, the documentation of sacred traditional practices, and identifying the variables which will determine efficacy (e.g. the successful use, transmission, and practice of traditional healing practices over thousands of years cannot be ignored). In any event, the growing emphasis on empirical validation of therapeutic interventions and practices has the potential to greatly impact how traditional healing practices will be perceived and supported by Western healthcare systems, practitioners, and government funding agencies. While it seems highly unlikely that specific Aboriginal healing traditions will be empirically investigated and eventually listed as empirically supported treatments by either the Canadian Psychological Association or American Psychological Association (for reasons such as ownership of traditional knowledge), I believe that as the number of integrated mental health services increase across Canada, pressures to ensure that treatments are in line with evidence-based principals will also continue to grow. A related concern to this is the bureaucratization of traditional methods. As Waldram (2004) and Gone (2010) noted, the institutionalization of
traditional practices and services of healers has the potential to result in the formalized surveillance of healers and traditional practices, and leads to concerns related to contracting the services of healers and Elders, remuneration of healers and Elders, and documentation of traditional practices. Again, these various challenges and concerns must be taken into consideration and negotiated when considering the integration of mental health service delivery.

One reason for increased demands for empirical support for specific treatments is to ensure that the potential for harm or risk to the client is reduced, and that the best available course of treatment for the presenting issue is being employed. The issue of identifying skilled helpers, both Indigenous and Western, is always an important element in providing competent services for clients. However it becomes of central importance when attempting to integrate services together in what can be considered ground-breaking and eclectic ways. For instance, a vast amount of cultural diversity exists among Indigenous nations and communities, and each nation will have its own practices and teachings around healing. By centralizing, employing, or obtaining the services of a specific Elder or healer, one must consider how cultural differences between the healer and client may impact the healing process. Mohatt and Varvin (1998) illustrated the challenges of cultural differences between healer and client in their case study of H. H was a young Ojibwe woman who accessed the healing services of a traditional Lakota medicine man. Even though this medicine man was trusted by H’s family, he had little knowledge of the Ojibwe community, and after the second day of this medicine man’s ceremonies, and H’s first sweat lodge, H became acutely psychotic with severe delusions and hallucinations. While one cannot be certain of why H’s health drastically worsened, the authors do note that the second medicine woman that H
received healing from provided a different conceptualization of H’s mental health
difficulties, and different forms of treatment which proved successful in the reduction of her
mental health distress. This example once again reiterates the importance of an individual
receiving culturally appropriate care, by both Western and Indigenous helpers and healers alike.

Within an integrated context, the selection and employment of healers reveals a
number of ethical and legal concerns for the organizing agency, professional helpers
(Indigenous and Western) and clients. For instance, Waldram, Herring and Young (2007)
pose the questions: What legal protection is afforded to the agencies that employ Aboriginal
healing? What legal protection is afforded to a healer? What legal protection does a patient
have that undergoes treatment with an Aboriginal healer? (p. 255). Section 35(1) of the
Ontario Regulated Health Professions Act (1991) states that the regulations of the act do not
apply to “aboriginal healers providing traditional healing services to aboriginal persons or
members of an aboriginal community.” Since no equivalent regulatory document exists
which outlines ethical standards of practice for Indigenous healers and Elders, formal
integration of Western and Indigenous methods becomes complicated, as the vast majority of
Western professionals and organizations are bound by governing rules and regulations which
must be upheld. While some organizations have recommended or instituted the development
of ethical protocols for traditional healing and healers (e.g. Aboriginal Healing Wellness
Strategy, 2002; Maar et al., 2009), concerns related to ethical practice and disciplinary action
for malpractice will continue to arise as attempts at integrated service delivery evolve.

In summary, while some authors have expressed a belief that culturally sensitive
Western psychotherapies may adequately service Indigenous clients (e.g. Sue, Arredondo, &
McDavis, 1992), and others feel that Indigenous community-based models of healing alone are adequate for the healing needs of Indigenous peoples (e.g. McCabe, 2007), calls and demands for integrated services, from both practitioners and clients, continue to be voiced (e.g. Duran, 2006; Johnson, 2006; Maar et al., 2009; Moodley & West, 2005; Poonwassie & Charter, 2005; Shore et al, 2009; Waldram, 2004), and integrated mental health programs continue to grow in number and strength. Having reviewed the conceptual underpinnings of integration, levels and forms that integration may take, current models of integration, and ongoing challenges associated with integrative efforts, the final segment of this literature review will summarize the key points outlined throughout Chapter Two of this thesis, and provide a rationale for the proposed research study.

**Summary of Chapter Two and Rationale for Study**

The health status of the First Peoples of Turtle Island was markedly different than the health status of Canada’s Indigenous peoples today. While health, and mental health, conditions and challenges were experienced by the First Peoples, systems and practices for addressing and healing health issues were in place. The introduction of new forms of disease, and the implications of colonial initiatives, such as the residential school system and attempts at the deconstruction of Indigenous culture, have arguably impacted and shaped current expressions of health and mental health issues today. While community-based and Indigenous healing practices continue to re-emerge and grow in strength as a first line of treatment, the majority of Indigenous individuals who seek assistance in overcoming mental health problems access the Western mental health system. Shortcomings in the delivery of Western mental health services for Indigenous peoples have been evidenced by under-usage and high drop-out rates, and some have suggested that the integration of Indigenous and
Western paradigms of healing may serve as a solution for adequate service delivery for Indigenous clients. However, given the distinct differences between conceptualizations, practices, and approaches to mental health treatment in Indigenous and Western paradigms, several questions remain around how integration is to occur and take form. Furthermore, calls for integration have most commonly been voiced by the Western mental health system and its practitioners (e.g. Constantine et al., 2004; Duran, 2006; Johnson, 2006; Moodley & West, 2005). The perspectives, experiences, and opinions of Indigenous healers and Elders are overwhelmingly absent from dialogues around the integrated healing movement. While some Indigenous healers have been cited as participating in collaborative and integrated service delivery, the few studies which have empirically examined the strengths, challenges, and successes of these integrated attempts have failed to obtain the perspectives and experiences of the professional helpers (Indigenous and Western) who are practicing integratively. Given that it is the services of Indigenous healers, including Elders, that are most commonly called upon when developing an integrated intervention, one must question how integration can occur if the perspectives of the Indigenous community’s leaders and healers are missing. If integration is to truly represent an egalitarian partnership in mental health service delivery, it is imperative that the narratives of the Indigenous community’s leaders and healers be obtained at this point in time, during the developmental stages of the integrated healing movement. The purpose of this study is to aid in this effort by qualitatively exploring the narratives, perspectives and experiences of Indigenous Elders on current efforts to integrate Indigenous and Western paradigms of healing.
Chapter Three: Methodology

In this section I review the various components of the research methodology that were employed in this study, including an overview of the methodological framework informing the research, a review of my personal narrative and how it informs the research process, and information surrounding participant selection, procedures, and the data analysis methods to be used.

Qualitative Approach to Research

A qualitative research paradigm was employed in the current research study. Qualitative research allows for in-depth insight and analysis of subjective and personal experiences, and as Morrow (2007) noted, qualitative research is “the most useful approach to understanding the meanings people make of their experiences…Qualitative approaches are able to delve into complex processes and illustrate the multifaceted nature of human phenomena. In addition, audience receptivity to a more narrative approach or presentation can often be an important reason to select a qualitative design” (p. 211). Morrow highlighted the importance of selecting an appropriate qualitative method that enables the researcher to obtain the type of research data that will appropriately address and answer the research question, while also being culturally congruent for the participants involved. Many qualitative methods exist (e.g. grounded theory, discourse analysis), but given the nature of the research question, my participant sample, and the conceptual frameworks that informed this research (Indigenous ways of knowing and social constructionism), it was determined that a narrative inquiry was the ideal qualitative method for the research study.

The focus of this research was to examine the perspectives of Indigenous Elders on current efforts to integrate Indigenous and Western approaches to healing. The research
question was: What are Indigenous Elders perspectives on the integration of Indigenous and Western healing paradigms, and what, if any, are their experiences of working in integrated contexts? As noted by Morrow (2007), research questions that are designed to obtain rich and thorough accounts of phenomena, and questions that examine topics for which little research exists, are well-suited to qualitative approaches. Furthermore, Denzin and Lincoln (1994) pointed out that qualitative research entails studying “things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them” (p. 2). One of the goals of this research study was to explore the meaning that Indigenous Elders make of integrated mental health services and their personal experiences of working in integrated contexts.

**Narrative inquiry and rationale for approach.** The depth and detail focus of the research question required a qualitative methodology that emphasized co-construction and meaning-making in context. It is for this reason that a narrative inquiry was employed. The method of narrative inquiry focuses on examining and understanding the meaning that people make of the world and their lives through the telling and retelling of story (Clandinin & Connelly, 2000).

One of the basic underlying premises of narrative-based approaches to theory and research is that individuals conceptualize and make sense of their identity, experiences, and the world through story (Clandinin & Connelly, 2000; Mehl-Madrona, 2005; McAdams, 2004; Riessman, 2008). Many authors have noted that significant differences exist between the meaning and concepts of story and narrative (e.g. Connelly & Clandinin, 1990; Richardson, 2000; Wiltshire, 1995).
Wiltshire (1995) differentiated between the two terms by stating that stories are casual, informal, and exploratory, but can in fact morph into narratives. He stated, “To become a narrative, a story must be conceptualized, restressed, and completed. A narrative is conceptually more sophisticated and structured than a story…[they are] premeditated, organized, more formal, and have a structure that is their own” (p. 78). Stories refer to the tales individuals tell about themselves and their endeavours, whereas narratives tend to refer to over-arching structured understandings that represent a synthesis of lived experience and the meanings that have been attributed and gleaned from experience (Connelly & Clandinin, 1990; Richardson, 2000; Wiltshire, 1995).

Narrative inquiry was an ideal method for this research project as most Indigenous peoples and communities describe themselves as having an oral-based story-telling tradition (see Mehl-Madrona, 2005; Poff, 2006; Stewart, 2007a; Struthers & Peden-McAlpine, 2005, Weber-Pillax, 2001). As has been discussed in the previous section, knowledge is often transmitted intergenerationally through story, and story-telling has been identified as an important element of Indigenous culture and tradition (McCabe, 2008; Mehl-Madrona, 2005). Furthermore, given that the sharing of teachings and stories is one of the principal forms of work that Elders provide, and based on personal experience working and communicating with Elders, it can be anticipated with a fair degree of certainty that responses to interview questions would be communicated through the sharing of both personal and cultural stories. Finally, it was specifically the stories, perspectives and experiences of Indigenous Elders that I sought to collect and showcase.

Given the philosophical tenets of qualitative research and the conceptual frameworks underpinning this study, a central principle which governed and informed the research was
that together, the participant and I co-constructed the stories and narratives that were shared in the interview and research process. Bailey and Tilley (2002) discussed the importance of recognizing that participants will share stories and narratives that convey meaning as they relate to the area of focus or research. They write, “storytellers select the components of the stories they tell (reconstruct) in order to convey the meaning they intend the listener to take from the story” (Bailey & Tilley, 2002, p. 575). It was therefore my belief that each participant and I would collaboratively participate in the sharing and construction of stories that were meaningful and important in gaining insight into the overarching research question of this study. Since I would be actively participating in the co-construction of stories with my participants, it was important that I situate myself in the research process. In the following section I share aspects of my own personal story so that the reader may gain insight and awareness into how my own life experience informed and guided the research process.

**Research Process**

**Researcher position.** My maternal grandparents immigrated to Canada from Europe (Hungary and Romania) in the early 1950s. My father’s parents were both born in Canada, and their heritage has always been identified as Ukrainian (grandmother) and French-Canadian (grandfather). My paternal grandfather’s Indigenous roots were typically never discussed by my family members as I grew up. During my adolescence, I can remember family members occasionally referring to themselves as Indian, or making comments that my interest in Aboriginal culture was because it “was in my blood,” but I never truly understood what my father’s family were referring to. My grandfather passed away when I was very young, and because of my father’s childhood experiences, my dad typically avoided discussing his family history. It has only been within the last year and a half that I learned of
my grandfather’s identity as a Métis man, and my identity as a Métis woman. As I have worked on the various pieces of this thesis, I have also been working to gather the appropriate documents that I need to apply for Métis Status. I have met with Indigenous Elders, among others, to discuss this process and my evolving identity. While this aspect of my heritage and history feels wholly right, I continue to struggle and negotiate how this element of my being connects and intersects with the other dimensions of my self. I am cognizant of how my identity may inform the development of my relationship with my research participants, and have sought counsel around how to share my personal story with my participants while maintaining appropriate boundaries. While I have participated in Indigenous events in the past, over the past year I have forged relationships with various Indigenous organizations throughout the university and larger Toronto community, and have sought the advice and counsel of various community members throughout the research process to ensure that proper cultural protocols are being followed. I continue to participate and dialogue with cultural informants to gain insight into both my research work and my own healing journey.

Participants. Participants were recruited through a recruitment letter (see Appendix A), snowball sampling technique, and my standing relationships with Indigenous organizations and Elders in the Greater Toronto Area. Recruitment consisted of my circulating a recruitment letter to Indigenous organizations in Toronto that provided cursory information surrounding the research study. I also received referrals for potential participants from community informants (individuals working in Indigenous organizations, Indigenous community members, etcetera) and the initial Elders that agreed to participate in the study.
Suggested referrals were contacted by phone and a telephone script was used in conversing with them about potential participation (see Appendix B).

Inclusion criteria for participation in the study consisted of being recognized as an Elder by the individual’s respective Indigenous community or the Indigenous organization that the individual was employed by. The Elder must also be in good standing, and a determination of good standing would be provided by the community informant that was referring a particular Elder for participation. Both male and female Elders were eligible to participate.

It is also important to note that in approaching Indigenous Elders, proper cultural protocols must be followed. Stigelbauer (1996) noted that when an Elder’s advice or counsel is sought, an offering is made which symbolizes an exchange of gifts between the seeker and Elder (seeker’s offering for the Elder’s teaching and knowledge). Both Stigelbauer and Anishnawbe Health Toronto (2000) identified tobacco as an appropriate offering, as it one of the Indigenous medicines used to facilitate communication between the seeker, Elder, and Creator. Anishnawbe Health Toronto also suggests refraining from the use of substances (alcohol or drugs) at least four days before speaking with an Elder, and that women should avoid scheduling appointments with the Elder if they anticipate being on their moontime (menstrual cycle), as it is viewed as a cleansing and ceremonial process that may interfere with the use of any medicines or communications with the spirit world. It is also important to recognize that each Elder’s culture will dictate proper cultural protocols that are to be followed. Before approaching an Elder to inquire about their participation in the study, I inquired with the Elder themselves, or appropriate cultural informants, about proper cultural offerings and protocols that needed to be followed. Throughout the research process, Elders
were presented with tobacco, or an appropriate cultural offering, at each encounter with me, acknowledging my request for knowledge and symbolizing the exchange of information.

A total of five participants (two male and three female Elders) were recruited for participation in the study. All five participants actively worked with the urban Indigenous community of Toronto in a variety of different ways (professionally and non-professionally) and contexts (community organizations, educational institutions, etcetera). None of the five Elders were originally from Toronto, but all maintained strong connections with their Indigenous communities and nations outside of Toronto. In honorarium of their participation, each participant received a bundled offering of medicines (sage, sweetgrass, tobacco, and cedar) (or a gift of similar value and significance that was more culturally appropriate) as a gift for their participation. Details concerning the individual recruitment process and the formation of research relationships with each participant will be reviewed in more detail in the results section.

**Procedures.** Each phase of the research process, including preliminary steps, interview processes, and data analysis methods, are described below.

**Preliminary phase.** My research process began with my starting a research journal in which I tracked my personal thoughts and reflections on the research process. I also began a field note log in which I documented my initial consultations with community members who provided feedback on my proposed area of research. Upon identifying a research topic and focus, I sought the counsel of Indigenous Elders, scholars, administrators of Indigenous programs and organizations, and non-Indigenous scholars and individuals. Any feedback or commentary that was offered by this collective of individuals was incorporated into my research design. I have also routinely met with an Indigenous Elder to discuss the various
facets of this research project, and have received feedback and approval from various
Indigenous individuals and sources whom have collectively identified this research study as
being important and valuable for the larger Indigenous community of Toronto.

Upon approval of my research proposal, a University of Toronto Ethics Application
was submitted. This research project was also carried out in accordance with the First
Nations Centre’s (2007) guidelines for conducting research with Indigenous peoples. This
document states that Indigenous peoples retain ownership, control, access and possession of
all research data and research products resulting from a study. Accordance with these
principals ensures that the research participants experience a transparent research process in
which they are informed about how the research data is going to be used, are able to refuse or
decline participation at any point in the research process, and receive copies of their personal
research data if they so choose. Participants also received copies of interview transcripts and
research reports for their review and were encouraged to provide feedback throughout the
research process. Participants’ approval of the final research findings will also be obtained
before presenting or publishing the results of this study.

**Phase 1: In-depth interview #1.** Interviews were conducted over a 1 to 2 hour time
frame in a location that was convenient and identified by the participant. I began the
interview by reviewing the informed consent form (Appendix C) verbally and in writing.
Once informed consent had been established, I presented each Elder with the bundled
offering of medicines along with the over-arching research question that I was seeking
knowledge for. Once the participants accepted this gift, I reviewed my list of specific
interview questions with each participant so that they were informed about the flow and
structure of the interview. Any questions or concerns raised by the participant concerning the
interview questions were addressed prior to turning on the audio-recorder. The following interview questions were posed to each participant in an open-ended and semi-structured fashion:

1. Can you share with me your story of becoming an Elder? How do you understand the work and role of an Elder?
2. What are your thoughts around combining Indigenous and Western forms of healing? What would you understand the strengths and challenges to be of doing this?
3. How do you envision this form of collaboration or integration taking shape?
4. What have been your experiences of working in combined or integrated systems, if at all?
4b. Have you encountered any obstacles/challenges in working in these settings?
4c. Can you share with me times/examples of successful collaborations with Western organizations or practitioners? What in your opinion contributed to making this a successful collaboration?
5. What guidelines would you suggest for Western organizations or practitioners who are interested in collaborating with Indigenous healers?

Individual follow-up questions and prompts such as “tell me more about that” were used to encourage open-ended responses which facilitated participants’ narratives. Upon completion of the interview, I shared the next steps to be taken in the research process (transcription of interview, analysis, etcetera), and provided them with an approximate date that I would get back into contact with them.

**Phase 2: Preliminary analysis.** Preliminary analysis consisted of a general process that included transcription of the interview, chunking of the interview into segments, coding interview segments, construction of a story map, and core message and theme identification.
This process can be conceptualized as taking the interview as a whole, breaking it down and reviewing the various elements and points of discussion, and then integrating the distinct elements into a holistic and meaningful whole through the use of a story map. Each phase of analysis will be reviewed in detail below.

I began the data analysis phase by transcribing each research interview verbatim. In this study, verbatim transcription entailed documenting the commentary of each participant, along with personal inflections such as ahh, hmmm, pauses, laughter, and any other behaviours of significance, such as moving across the interview space to select an Indigenous medicine for illustrative purposes. The inclusion of such personal inflections and behaviours was to preserve the richness and complexity of the interview. Once the initial transcription was completed, I re-listened to the interview in its entirety, following along with the transcript and making corrections as needed.

The second step in the analysis involved my chunking the interview transcript into smaller segments referred to as data units. The purpose of chunking the interview transcript within the context of this study was for organizational purposes that would facilitate cross-referencing within and between interview transcripts. Each data unit consisted of approximately 20-30 lines of sequential text, and an attempt was made to retain whole paragraphs of participant responses within each data unit. Figure 1 depicts an example of a data unit used in the study.

<table>
<thead>
<tr>
<th>Data Unit #</th>
<th>Interview Transcript</th>
<th>Corresponding Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>T – Thank you. Okay, so question number two, what are your thoughts around using Indigenous and Western forms of healing together? And what would be the strengths of doing that and what would be the challenges of doing that?</td>
<td></td>
</tr>
</tbody>
</table>
The third step involved coding the interview data. Glesne (1998) described coding as “a progressive process of sorting and defining and defining and sorting those scraps of collected data…that are applicable to your research purpose” (p. 135). Within the context of this study, codes were made up of one or two words and were derived inductively from the data; that is, the syntax or language used by each participant informed the labels or codes that were developed. I reviewed each sentence in the transcript and assigned what Glesne referred to as a major code. Major codes represent concepts or central ideas that are articulated by the participant in a sentence. As noted in the data unit in Figure 1, the major code of “Indigenous Medicine” was assigned to the following text provided by Elder 1: “Ummmm... When you’re in the bush, you’re doing Indigenous medicines. Go with it, go with it, it works. We’ve done it all these years [Indigenous medicine: Effectiveness]. Sometimes there’s some things we can’t, our medicines don’t work, so they have Western medicine coming in and helping. That’s good too. [Western medicine: Strengths]. So we don’t turn down medicine; medicine is medicine [Integration perspective: Both have strengths]
I had captured the essence of the participant’s perspective and experience. All five interview transcripts were coded in this manner.

The next step was to amalgamate and organize the descriptive codes into what Richmond (2002) referred to as a story map. A story map is a schematic picture of the overarching concepts discussed in the interview (horizontal axis), and a time orientation (vertical axis) with past, present, and future designations, that allow both the researcher and participant to holistically review the participant’s shared story and implied meanings. The story map used in this study is a research analysis tool that has been adapted from Richmond (2002) that allowed participant narratives and stories to be retained and structurally organized in a way that allowed both the research participant and investigator to make sense and reconstruct participant experiences in a meaningful way and contextual way.

Based on my literature review and interview questions, I anticipated that participant narratives could be organized under the four following structural headings: Self as Elder, Indigenous culture and medicine, Western medicine, and integration. These headings were plotted onto the story map and placed across the top of the map along the horizontal axis and represented the structural categories of each participant’s story. As Stewart (2007a) noted, individuals’ stories and narratives become meaningful when they exist or evolve over time, and as such, the designations of past, present, and future were depicted along the vertical axis of the story map. Once the core story map had been created (see Figure 1), the next step was to create a story map for each participant by organizing and placing their respective descriptive codes into the map in line with the structural headings and time orientations. Once the participant’s initial story map was created, I reviewed the participants’ interview
transcripts and descriptive codes a final time, revising and refining their respective story maps to ensure a complete and organized map had been created.

**Figure 2: Core Story Map**

<table>
<thead>
<tr>
<th></th>
<th>Self as Elder</th>
<th>Indigenous Culture &amp; Medicine</th>
<th>Western Medicine</th>
<th>Integration (Ideas; forms; experiences with)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Experiences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present Experiences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future Intentions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The final step in Phase 2 of the research process was to examine the story map holistically and identify any overarching core messages or themes that were saliently represented in the map. The core message represented the most prominent idea or concept discussed by the participant throughout their interview. Additional significant ideas or concepts that were noted and discussed by the participants throughout their interviews were identified as themes. The story map, core message and accompanying themes were presented to each interview participant Phase 3 of the research process.

**Phase 3: In-depth interview #2.** In the second interview I presented each participant with a copy of their story map, core message and themes, along with a copy of their transcript and audio-recording of their interview (if they wished). I verbally reviewed the story map with each participant, explaining the descriptive codes, core message, and themes. Each participant had the opportunity to make corrections or additions to their story map and further reflect on the interview questions. The following follow-up interview questions were used in discussing the story map, core message and themes:
1. From your narratives in your interview I have constructed a story map…how does this map illustrate your views?

2. What is missing from your story map? What would you like to add?

3. Do you have anything else to say about your story map?

Upon completion of the second interview, I re-listened to the audio recording of the second interview and incorporated feedback and additional insights shared by the participants into their story maps. This process will be detailed for each participant in the results section in Chapter Four.

**Phase 4: Final analysis and writing.** In the final analysis stage, I reviewed participant transcripts, story maps, and core messages and themes across one another to determine similarities and divergences of opinion with respect to the overarching research question informing this study. This final stage of analysis yielded six areas of discussion related to the notion of integrating Indigenous and Western healing paradigms and approaches, which are detailed in Chapter Five of this thesis. This phase of analysis was completed in my writing the within participant results, across participant results, and the concluding chapters of my thesis.

**Phase 5: Final results and dissemination.** Upon completion of this thesis, the results of this study will be drafted into a research report and provided to each interview participant. It is also my intention to discuss with each participant their perspectives on how the findings from this research study can be best used in servicing the larger Indigenous community. I also intend on disseminating the results of the study through scholarly publications and presentations, and through reports that will be sent to various Indigenous and non-Indigenous
agencies in the mental health sector. Prior to formal dissemination of the findings, I will receive approval from the five participants in this study.

**Summary of Chapter Three**

In Chapter Three I presented the methodological approach that was employed in this study. The theoretical underpinnings and rationale for the use of a qualitative research paradigm and narrative inquiry methodology were presented. I situated myself in the research process by examining how my own personal narrative informs my approach to the research, and the development of my relationships with my participants. Finally, I reviewed the procedures and analysis phases of the research process, which included an overview of the participant recruitment process and participant sample, data collection methods and analyses. I ended the chapter by outlining how the research findings will be disseminated and utilized in future projects.
Chapter Four: Within-Participant Results

Chapter Four presents the individual participant results and within participant analysis. This comprises a brief character sketch, a description of the first interview and initial story map and corresponding core message and themes, a brief discussion of the second interview, and the final story map, core message and interview themes for each participant. The character sketch outlines details related to the nature of my research relationship with each participant, the recruitment process for each participant, and information related to the interview process that is unique to each participant. The core message represents the most prominent theme or idea from the participant’s interview, and other dominant ideas from the interview are noted as themes. Participants are presented in the same order in which they were interviewed.

It is also important to note that the terms “Indigenous medicine” and “Western medicine” were used by most of the Elders in this study as a shorthand to describe Indigenous health and healing systems and Western health and treatment systems. The term “medicine” encapsulates elements of each healthcare system, including theories of medicine, healing or treatment approaches and interventions, and the respective practitioners of each type of health and healing approach. Additionally, while the focus of this thesis is on examining how Western mental health approaches may be integrated with Indigenous healing approaches, the Elders in this study discussed the physical/medical Western healthcare system in addition to the mental healthcare system. As was noted in the literature review, Indigenous conceptions of health are often holistic in nature, and health is understood to be comprised of multiple dimensions of well-being (physical, mental, emotional, and spiritual). It is for this reason that the Elders in this study spoke about the various Western
healthcare systems that Indigenous peoples may access, and discussed how integrative efforts may be practiced at various levels of healthcare. And finally, while the Elders spoke broadly about the Western healthcare system, its treatment methods and practitioners, oftentimes making generalizations about this system, each Elder also recognized that individual Western-trained practitioners practice healthcare differently and some have demonstrated a shift in attitude towards Indigenous health and healing systems.

**Participant One**

**Character sketch.** Participant One chose the identifier “Elder 1” as his preferred pseudonym. My research relationship with Elder 1 begin during the formative stages of my research project, as I often consulted and sought counsel from him while formulating my research question and design. Elder 1 was therefore recruited through my long standing relationship with him, and was fairly familiar with the research topic at the outset of the formal research interview phase. Elder 1 also provided recommendations for other Elders that he thought would be ideal candidates for the project. He attended our first interview as scheduled, and was available for a follow-up interview to review his story map and corresponding core message and themes.

**First interview.** My first interview with Elder 1 was both exciting and thought-provoking. We held the interview in an office space that Elder 1 uses for his teaching and healing work, which created a calming and inspiring environment as many Indigenous medicines and objects were displayed throughout the office. Since Elder 1 had provided me with counsel throughout the research process, I knew of some of his experiences to date and looked forward to hearing about them in more detail. I began the interview by reviewing the informed consent form orally and in writing. Once Elder 1 provided consent, I presented him
with a bundled gift of medicine (sage, sweetgrass, cedar, and tobacco) and presented the (research) question I was seeking knowledge for. Elder 1 accepted my gift, thereby indicating that he felt he had knowledge he could share with me related to my topic. After reviewing the specific interview questions I had, we began the audio recording and Elder 1 proceeded to answer each interview question thoroughly. Elder 1’s answers consisted of traditional teachings, cultural and personal stories, the sharing of personal opinions and experiences related to the subject, and the use of humour. Our interview lasted 90 minutes in length.

The initial story map was constructed during the analysis phase of this interview, as per the process explained in Chapter Three (see Figure 2). Upon completion of this initial story map see Figure 3), I identified a clear core message and three themes from the map and interview. The initial core message for Elder 1 was Indigenous culture as foundation for health. The themes were: go where there is need, the effectiveness of Indigenous medicine, and the potential for Indigenous and Western approaches to complement one another.

**Feedback from second interview and final story map.** Once I completed the analysis of my first interview with Elder 1, and constructed his story map and identified the corresponding core message and themes, I scheduled a second interview to review these findings with him. I began this interview my explaining the analysis procedure to him (breaking the interview data into smaller parts, coding for thematic content, and then reconstructing his narrative into a cohesive story map) and how I came to identify the core message and themes. In reviewing the story map, I presented Elder 1 with the following questions: “From your narratives in your interview I have constructed a story map…how does this map illustrate your views? What is missing from your story map? What would you like to add? Do you have anything else to say about your story map?” In response to these
**Figure 3. Initial Story Map: Elder 1**

<table>
<thead>
<tr>
<th>Past Experiences</th>
<th>Indigenous Culture &amp; Medicine</th>
<th>Western Medicine</th>
<th>Integration (Idea; Forms; Experiences with)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Journey is long and hard (walk the narrow road)</td>
<td>o Indigenous Culture (Story; dreaming; language; being thankful; Ceremony)</td>
<td>o Wary of Indigenous medicine</td>
<td>[On the Idea]</td>
</tr>
<tr>
<td>o Role model (e.g. refrained from substance use)</td>
<td>o What is healing (restoring connection between mind and spirit; healing journey requires commitment)</td>
<td>o Abandons people (“We’ve done all we can”)</td>
<td></td>
</tr>
<tr>
<td>o Raised a family</td>
<td>o Effectiveness of Indigenous Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Lived in traditional way</td>
<td>o Medicines and methods of healing (e.g. Language; prayer; singing; Elders and Healers; etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Leader in the community</td>
<td>o Diversity of healers and methods (finding the medicine you need)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Healing journey (listened to stories)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Assembled bundle / Learned traditions (e.g. listen Elders; learn the drum)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Life experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Garner respect and recognition as Elder from community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Learn to balance life demands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Facilitate change for people</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present Experiences</th>
<th>Indigenous Culture &amp; Medicine</th>
<th>Western Medicine</th>
<th>Integration (Idea; Forms; Experiences with)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Build sacred space - Everything is ceremony</td>
<td>o Has its place (sometimes Indigenous medicine cannot work and Western can)</td>
<td>o At request of Aboriginal people (“Give me my own medicines”)</td>
<td>[On the Idea]</td>
</tr>
<tr>
<td>o Go where there is need</td>
<td>o Has its limits (e.g. cannot feed the spirits – lacks the knowledge)</td>
<td>o Recognition of limits of each and potential to complement</td>
<td></td>
</tr>
<tr>
<td>o Healing work (connecting the mind and spirit)</td>
<td>o Abandons people (“We’ve done all we can”)</td>
<td>o At request of West</td>
<td></td>
</tr>
<tr>
<td>o Knowledge Keeper (honours ceremonial traditions)</td>
<td>o Wary of Indigenous medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Manage stress and demands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Ease of connecting with Western ways (education)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Gratification from work (hearing about changes in peoples lives)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Future Intentions</th>
<th>Indigenous Culture &amp; Medicine</th>
<th>Western Medicine</th>
<th>Integration (Idea; Forms; Experiences with)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Legacy for the next 7 generations</td>
<td>o Has its place (sometimes Indigenous medicine cannot work and Western can)</td>
<td>o At request of Aboriginal people (“Give me my own medicines”)</td>
<td>[How will it occur?]</td>
</tr>
<tr>
<td>o Share experiential stories</td>
<td>o Has its limits (e.g. cannot feed the spirits – lacks the knowledge)</td>
<td>o Recognition of limits of each and potential to complement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Abandons people (“We’ve done all we can”)</td>
<td>o At request of West</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Wary of Indigenous medicine</td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**[Successes with Integration]**
- o Healing for participants
- o Commentary from Western professionals (e.g. jail guards)

**[Issues to be addressed/Steps to be taken]**
- o Build a framework for knowledge
- o Respect for Indigenous ways (E.g. Elders not trained or educated in Western systems)
- o Structural changes
questions, Elder 1 initially commented that he had shared all he could during our first interview together. However, as I reviewed each segment of the story map with him, he added a few additional points to the various sections of his map. For instance, under the Indigenous Culture and Medicine heading for Present Experiences, Elder 1 stated that many Elders today hold what could be considered a Master in Life Experience and Knowledge in Indigenous Ways. In the Future Intentions section, he also added the need to create a registry of Elders and healers working throughout Turtle Island so that those working in more rural areas could be easily identified for referral purposes. Under the Western Medicine heading in the Present Experience section, he noted that the Western health system discounts spiritual knowledge and practice because it cannot quantifiably measure it, but that they do reach out to other health practitioners (e.g. Indigenous healers) when they recognize they can no longer help an individual heal. In terms of Future Intentions for Western Medicine, Elder 1 stated that the Western health system needs to recognize the equivalent amount of knowledge and skills that other practitioners and healers possess, and that relationships with Indigenous Elders and healers working in rural communities need to be strengthened. And finally, under the Integration heading in the Future Intentions section, Elder 1 stated that with respect to next steps towards integrated practice, Indigenous Elders’ and healers’ knowledge and skill sets must be recognized by the Western health system, a referral system between Western and Indigenous practitioners needs to be developed, and programs for Western practitioners that offer training in Indigenous ways (e.g. spending time with an Elder in the bush) should be implemented into educational programs. All of these changes have been noted in Figure 4 and are indicated by the underlined text.
<table>
<thead>
<tr>
<th>Past Experiences</th>
<th>Self as Elder / KK</th>
<th>Indigenous Culture &amp; Medicine</th>
<th>Western Medicine</th>
<th>Integration (Idea; Forms; Experiences with)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Journey is long and hard</td>
<td>o Indigenous Culture (Story; dreaming; language; being thankful; Ceremony)</td>
<td>o Wary of Indigenous medicine</td>
<td>[On the Idea]</td>
<td></td>
</tr>
<tr>
<td>o Role model (e.g. refrained from substances)</td>
<td>o What is healing (restoring connection between mind and spirit; healing journey requires commitment)</td>
<td>o Abandons people (“We’ve done all we can”)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Raised a family</td>
<td>o Effectiveness of Indigenous Medicine</td>
<td></td>
<td>[On the Rationale]</td>
<td></td>
</tr>
<tr>
<td>o Lived in traditional way</td>
<td>o Medicines and methods of healing (e.g. Language; prayer; singing; Elders and Healers; etc.)</td>
<td>o To Honour Indigenous Ways (e.g. practice spirituality in prison system)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Leader in the community</td>
<td>o Diversity of healers and methods (finding the medicine you need)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Healing journey (listened to stories)</td>
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<tr>
<td>o Facilitate change for people</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

| Present Experiences | | | |
|---------------------|---------------|------------------------------------------|
| o Build sacred space - Everything is ceremony | o Many Indigenous Elders hold a Masters in life and Indigenous ways | [How will it occur?] |
| o Go where there is need | o Has its place (sometimes Indigenous medicine cannot work and Western can) | |
| o Healing work (connecting the mind and spirit) | o Has its limits (e.g. cannot feed the spirits – lacks the knowledge) | |
| o Knowledge Keeper (honours ceremonial traditions) | o Abandons people (“We’ve done all we can”) | |
| o Manage stress and demands | o Wary of Indigenous medicine | |
| o Ease of connecting with Western ways (education) | o Discounted spiritual knowledge because it’s not a science (cannot quantify or measure it) | |
| o Gratification from work (hearing about changes in peoples lives) | o Do reach out to other healers (recognize when they are over saturating person with medicine) | |

| Future Intentions | | | |
|------------------|---------------|------------------------------------------|
| o Legacy for the next 7 generations | o Create registry of healers and Elders who are working in rural areas | [Issues to be addressed/Steps to be taken] |
| o Share experiential stories | o Need to build relationships with Elders in more remote areas – develop a referral system to bring rural Elders into mainstream spaces | |
| | o Need to recognize equivalent amounts of knowledge and training that other healers hold | |
| | | o Build a framework for knowledge |
| | | o Respect for Indigenous ways |
| | | o Structural changes |
| | | o Recognize equivalent amounts of knowledge and training that Indigenous healers hold (Masters in life) |
| | | o Training for Western professionals in Indigenous ways (e.g. staying in the bush) |
| | | o Creation of referral system for Elders and Western professionals |
Elder 1 shared that the remaining points in his story map, along with his core message and themes, accurately captured his perspectives and experiences. He commented that he was looking forward to the final results from the study, and shared with me that I must make bold and strong recommendations, as I am now the pen for the knowledge that the Elders have shared with me.

**Final core message and themes.** The core message and themes did not change as a result of the second interview with Elder 1. The core message was Indigenous culture as foundation for health. The themes were: go where there is need, the effectiveness of Indigenous medicine, and the potential for Indigenous and Western approaches to complement one another.

**Indigenous culture as foundation for health.** Elder 1 spoke all throughout the interview about the importance of Indigenous culture as a key determinant of health and healing for Indigenous people. Indigenous culture was characterized by diverse number of things, including traditional knowledge, plant medicines, singing and drumming, spirituality, Elders, ceremony, story, and language:

I do understand the (name of nation’s) language, so with that, that’s traditional knowledge. It is traditional, it is the language that makes us, that gives us voice [...] I do know that when we offer our prayers and burn tobacco it brings everybody into a place of the sacredness of the spirituality of the fire, because ceremony is happening. And the drummers, or whichever group, they have a certain function, and they do theirs and the Elders speak, and we do ours, and we work together (E1 p.6).
When discussing health and how to ensure the well-being of the upcoming generations of Indigenous peoples, Elder 1 discussed the importance of their gathering Indigenous knowledge and being covered in experiential stories. The sharing of knowledge was viewed as a way to support and strengthen the next generation’s identity and sense of self:

The coming generations, like when we say there’s the seven generations, everything that we do is supposed to be for them. To come, as they’re coming, as their faces are coming out of the ground, and as they become more knowledgeable, as they learn those things, they need to be covered with these experiential stories so that they can learn, so that they can become who they are supposed to be. So that they can stand up in their right place and at their right time they will be level headed and they’ll turn around and they become the healers (E1 p. 18).

Similarly, when discussing strategies and practices for healing among Indigenous peoples, Elder 1 spoke about the importance of making Indigenous spirituality accessible to those who are seeking healing. He discussed the work of many Elders who have gone into the prison system to provide teachings and ceremony:

And the other Elders that go to these places, (name of Elder), they’ve all been there, (name of Elder), they’ve all be in these places to bring the traditional ways, traditional Aboriginal spirituality into those places so we could […] So those boys who, boys, who made a mistake and did something wrong, and got caught, they can still have their spirituality. That’s what our, that’s what we do. Ceremony, again I would say ceremony (E1 p.17).
In Elder 1’s opinion, the various elements of Indigenous culture, including traditional knowledge and ceremony, function as key underpinnings to living well and healing from distress. Elder 1 often commented that Aboriginal peoples who are looking to heal need their ceremonies, and it is through ceremony that they can reconnect with the original ways of their people:

Traditional Aboriginal healing methodologies, I guess? Ceremonies?

Ceremonies and stuff. We do ceremony. So if you hear me talking, when we do ceremony it is connecting us to creation again; it’s connecting you back to creation. Connecting you back to the roots of your family. Opening your eyes and opening your mind and your ears so you can hear the music from way back (E1 p. 12-13).

Elder 1 shared that one of his primary tasks as an Elder is to “build sacred space” for his people and prepare the upcoming generations of youth with teachings and knowledge about Indigenous culture.

Go where there is need. A second theme evident from Elder 1’s interview is his belief that part of an Elder’s job is to provide support and assistance wherever there is need. He shared how he personally practices this in stating, “People ask me to come, and okay, I go. I don’t ask why I’m going, don’t ask for anything, just go, because they’ve asked me. That to me is what the Elders do” (E1 p.8). One implication of this belief is that Elders can be expected to work in both rural and urban environments, given that many Indigenous people live off-reserve and in urban centres. Elder 1 commented that while many Elders who work in rural settings still prefer to not travel into the city, there is an increasing number of Elders who are working in urban spaces: “There are lots of Elders who are very
conservative, very knowledgeable, and they won’t leave the reserve…[but there’s those] who are going out there and being with the people in the world, because if they’re there, we need to be right there with them” (E1 p.19). Flexibility in working in urban centres suggests that a number of different venues will be accessed as gathering spaces, and in discussing his ability to speak his people’s language, Elder 1 shared how he is often invited to provide teachings in a variety of settings. He highlighted this by humourlessly citing concrete monuments:

In the traditional ceremonies of the (name of people), people have asked me to stand up because I am a speaker, and will you speak for this now? That’s why a lot of times I speak in (language), because I can speak in my own language. Yeah, I do. I have to, I build sacred space; whether that’s the Longhouse or whether that’s a tipi – there’s different kinds of lodges – or log cabins, or concrete monuments [laughs]. Who am I there for and what is it that’s required? (E1 p.8).

It is these concrete monuments that most resemble mainstream health spaces, such as hospitals or prisons. For Elder 1, going and helping wherever there is need also entails working in mainstream venues and institutions at times, and also providing services to individuals of different Nations than his own. In describing his work at a hospital with Indigenous peoples visiting from another part of Turtle Island, Elder 1 shared:

One time people came down from (name of community) and (name of hospital in city) called me. They said we have this family and they want Elders to come in and do things, will you come please? This is Western medicine, a hospital, calling me. So I go there, and I went there […] And they were so touched, they
were so moved that I knew them, that I knew their territory. So I offered prayers” (E1 p. 10).

In this example, Elder 1 shared how his being able to work in urban and mainstream locations greatly benefited those who were in need. Flexibility in working in diverse environments is clearly an important issue when considering whether Indigenous and Western healing approaches can be integrated, and will be addressed in the upcoming chapter.

**Effectiveness of Indigenous medicine.** All throughout his interview Elder 1 spoke about the various types of Indigenous medicines and healing methods that many Indigenous peoples access and practice. As has been noted earlier, Indigenous medicine is distinctly different than Western biomedical notions of medicine. Indigenous medicines can include things such as specific plants, healing objects, or spiritual practices, but also more broadly encapsulate human behaviours such as laughter or being kind (Garrett & Wilbur, 1999). Individual people, such as Elders and healers or family members, can be identified as medicine, and the natural world (trees, plants, sun, wind) are often a source of medicine for people.

When I returned for my second interview with Elder 1, he asked me to review the list of different medicines that he had spoken about during his first interview to ensure that he did not leave anything significant out. The specific Indigenous medicines that Elder 1 identified included the use of story, Indigenous language, singing, drumming, feasting, prayer (of all faiths), making offerings and being thankful, ceremony and ceremonial objects (such as ritual purification and turtle rattles), and Elders and healers themselves. Elder 1 spoke about the effectiveness of these various types of medicine and how they have been
practiced since time immemorial in stating, “When you’re in the bush, you’re doing Indigenous medicines. Go with it, go with it, it works. We’ve done it all these years” (E1 p. 8). However, the underlying commonality between all of these different forms of medicine and the key to their effectiveness is their strong connection with a higher spiritual being, which Elder 1 referred to as Creator. These various types of medicine were understood to be tools for connecting an individual with the Creator, which is the primary source of healing and well-being:

The best medicines come from our people. The other medicines, scientific stuff, is scientific. But our people, really our medicines, we get it through dream, dreams. The Creator comes and speaks to us. Actually, He just takes us to a place and brings us back to now so we can know that everything… And so I don’t feel short changed anywhere or by anybody else (E1 p.14).

In discussing how Indigenous medicines are often gifted to Indigenous people by the Creator, Elder 1 asserted his belief in the power and effectiveness of these medicines and also commented that he does not “feel short changed” when thinking of the other types of medicines or healing approaches that exist. For instance, in discussing some of the differences between Indigenous medicine and the Western health system (referred to here as Western medicine), Elder 1 shared how Indigenous medicine is often more effective than Western medicine, and Indigenous peoples are often referred back to their communities for healing when Western medicine is no longer proving effectual:

They send sick people back and they ask for – at least the (name of) people – because they’re the ones who believe in that way, and so they come in and they have a feast. They put on a feast and they feed the spirits, they feed the spirits
and they feed the soul. They feed the {inaudible} and in doing that some people are healed. Western medicine can’t do that. Western medicine can’t do that.

They can, it can be done, you just have to know how to do it (E1 p.12).

In discussing the ceremony of feasting, spirit and ancestral relations are identified as facilitative aspects for healing, something which Elder 1 indicated is lacking in much of Western healthcare treatment services. It is important to note that he does not believe the Western healthcare system is incapable of providing spiritual care to their clients, but this vital element of healing for many Indigenous people is currently absent from much of mainstream treatment.

**Potential for Indigenous and Western approaches to complement one another.**

Elder 1 was of the opinion that Indigenous and Western approaches to health and healing can potentially complement one another. He commented that both Indigenous and Western medicine have limits in terms of the type of healing or treatment they can provide:

“Sometimes there’s some things we can’t, our medicines don’t work, so they have Western medicine coming in and helping. That’s good too. So we don’t turn down medicine; medicine is medicine” (E1 p.8). While Elder 1, an Indigenous healer himself, was open to the idea of using each type of approach to address healing needs, he noted that the Western healthcare system tends to have more difficulties with Indigenous medicine and are more reluctant to collaborate, “Western medicine generally has trouble dealing with Aboriginal medicine” (E1 p.9). Nonetheless, some of Elder 1’s experiences with the Western healthcare system to date have included receiving referrals from Western practitioners when they could no longer provide adequate treatment, “There’s times when Western says we can’t do anymore. They need to be ministered to or use the medicines, and that’s what I’ve done, that’s my job” (E1
Elder 1 also identified challenges to the integration of Indigenous and Western approaches, which will be discussed in more detail later, but believed in the potential for each method to complement one another.

**Participant Two**

**Character sketch.** Participant Two chose the identifier “Witness 2” as her preferred pseudonym. While Witness 2 is recognized as an Elder and Traditional Teacher by the Indigenous community of Toronto, and as a Knowledge Keeper by her own people, she felt that the term Witness most accurately described her knowledge and experiences with Western and Indigenous paradigms of health. My research relationship with Witness 2 began during the formal stages of participant recruitment for the study. In seeking participant recommendations from my community informants, Witness 2 was identified as a knowledge keeper with experience in working in both Indigenous and Western health and healing settings. Prior to my formal invitation to participate in the study, I met with Witness 2 on two separate occasions to discuss my research topic. Witness 2 shared a great deal of knowledge with me during these informal meetings, and when I inquired if she would be interested in formally participating, she said she would be willing to sit for an interview. While both the initial and follow-up interviews had to be rescheduled due to various circumstances, Witness 2 and I were successful in holding an initial and follow-up interview.

**First interview.** My first interview with Witness 2 was marked by an air of eagerness and anticipation, as we had rescheduled several times. We held the interview in an office space that Witness 2 was familiar with. I began the interview by reviewing the informed consent form orally and in writing. Once Witness 2 provided consent, I presented her with a bundled gift of medicine (sage, sweetgrass, cedar, and tobacco) and presented the (research)
question I was seeking knowledge for. While Witness 2 agreed to participate in the study, she shared that these medicines are not generally used by her people, and that a gift of a blanket would have been more appropriate. I shared with Witness 2 that I was visiting an Indigenous women’s organization that she had worked with in the past, and offered to present these medicines to this organization on her behalf as thanks for her participation in the study. Witness 2 agreed with the suggestion and we proceeded to review my interview questions together. Before turning on the audio recorder, Witness 2 asked that we first discuss the idea of whether Indigenous and Western approaches can be practiced together before turning to anything else. We were interrupted twice by incoming telephone calls during the first half hour of the interview, but Witness 2 had no difficulty in resuming where she had left off prior to the interruption. Witness 2’s answers consisted of cultural and personal stories, the use of symbolism and analogy, humour, and personal opinions and experiences related to the subject. Our interview lasted 140 minutes in length.

The initial story map (see Figure 5) was constructed during the analysis phase of this interview and upon completion of this initial map, I identified a clear core message and two themes from the map and interview. The initial core message for Witness 2 was aggregating, consolidating, and disseminating Indigenous knowledge. The themes were: holistic health; weaknesses in the Western health system; and integration is occurring too soon.

Feedback from second interview and final story map. Once I completed the analysis of my first interview with Witness 2, and constructed her story map and identified the corresponding core message and themes, I scheduled a second interview to review these findings with her. Having remembered Witness 2’s comments regarding the gift I had presented her with, I located a blanket from her territory between interview one and two,
**Figure 5. Initial Story Map: Witness 2**

<table>
<thead>
<tr>
<th>Past Experiences</th>
<th>Self as Elder / KK</th>
<th>Indigenous Medicine</th>
<th>Western Medicine</th>
<th>Integration (Idea; Forms; Experiences with)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accumulation of knowledge</td>
<td>Epileptics, residential school, breakdown of family structure, Potlatch Laws (colonization) led to breakdown of knowledge transmission systems and outlawing of healing practices</td>
<td>Appropriated Indigenous knowledge and altered and transformed it into dangerous medicines (e.g. opium and opiate drugs)</td>
<td>Integrated efforts have occurred too early</td>
<td></td>
</tr>
<tr>
<td>Knowledge expertise (her peoples law)</td>
<td>Altered knowledge transmission systems (individuals carrying bits of knowledge; knowledge without context)</td>
<td>No empirical foundation for mental disorders (e.g. bipolar)</td>
<td>Indigenous knowledge has yet to be aggregated, so programming is built on fractured knowledge (Nearly Empty Basket)</td>
<td></td>
</tr>
<tr>
<td>Recognition as Knowledge Keeper by her people</td>
<td></td>
<td></td>
<td>Integrated efforts are not based on equality (e.g. those with degrees are held with more prestige than Indigenous healers)</td>
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<tr>
<td></td>
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<td></td>
<td>Power rests with Western professionals</td>
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<tr>
<td></td>
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<td></td>
<td>[On the idea]</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Believes there is a potential for two systems and knowledges to work together</td>
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</table>

| Present Experiences | | | | |
|---------------------|---------------------|------------------|--------------------------------------------|
| Knowledge expertise (her peoples law; Western Law) | Disconnection between peoples and Indigenous knowledge (e.g. with traditional diet; medicines; ceremonies) | Lack of focus on prevention methods for health issues | Western knowledge and practice is outweighing Indigenous knowledge and practice (Full basket crushing Nearly Empty Basket) |
| Diminished position in current territory (outside of her territory) | Indigenous peoples health is drastically different than Original Peoples | Abandons people (e.g. severe mental health issues) | Western practitioners currently shift practice to work with Indigenous peoples |
| Knowledge of other nations’ traditions | Holistic health (physical, mental, emotional, spiritual) | Mental health workers view individuals through conceptual frameworks and theories, instead of holistically and as individuals | Discrimination still occurring in some Western settings (e.g. not being able to smudge in hospital) |
| Traditional teacher | Examples of Indigenous medicines: -Scanning; Tracking Back; Traditional Diet; Counselling; Various strategies for discovery | Over-reliance on medication (medication as primary intervention) | Organizational/system Change has occurred (e.g. some space for smudging) |
| Healer (Counselling, scanning, tracking back) | | Diagnosis is strength (physical health) | Primary form of integrated work for Elders/healers is teaching |

| Future Intentions | | | | |
|------------------|------------------|------------------|--------------------------------------------|
| People must be self-reliant and responsible for their health and well-being | Research and acknowledge origins of contemporary medicine (e.g. Willowbark is Aspirin) | First Step: Indigenous knowledge must be aggregated (identification of venue), consolidated, and disseminated (development of curriculum) to individuals and communities, and then discuss how sharing might occur | |
| Must employ an Indigenous framework for understanding health and healing (spirit logic and four dimensions of self) | Re-evaluate treatment interventions (e.g. medication; use of diagnostic systems) | Second Step: Discussion around fundamental beliefs and theories of health and healing | |
| Empirically validate Indigenous practices and methods of healing (shape shifting) | Rigorous inquiry into Western psychology | Differences in logic and theory systems (mathematical vs. spiritual logic) | |
| | | Storied example of dissociation | |
| | | Third Step: Discussion around particular issues (e.g. what is health?; treatment interventions) | |
| | | Empirically validate theories and practices (both Indigenous and Western) | |
| | | Development of new evaluation methods and standards | |
| | | Concatenation of theories, knowledges and practices (Baskets Woven Together) | |
| | | Indigenous peoples will be leaders in integration efforts | |
and presented it to her at the beginning of our follow-up interview. Witness 2 accepted the blanket and expressed great thanks for my gift. I then presented Witness 2 with her story map and shared how I had come to identify the core message and themes. In reviewing the story map, I asked Witness 2 the following questions: “From your narratives in your interview I have constructed a story map…how does this map illustrate your views? What is missing from your story map? What would you like to add? Do you have anything else to say about your story map?” Under the Indigenous Medicine heading in the Past Experiences section, Witness 2 added that appropriation of Indigenous medicine by a number of different peoples and cultures has occurred. Under the Western Medicine heading in the Present Experiences section, Witness 2 changed “lack of focus on prevention methods for health issues” to the absence of a holistic understanding of health and the interrelationships between these dimensions (physical, emotional, mental, and spiritual). Witness 2 also pointed out that the emphasis should not be on how to prevent illness, but how to live well, and if illness does develop, examining its etiology in line with the different dimensions of well-being. Witness 2 also added that Western mental health workers conceptualize individuals through frameworks and narrowed theories instead of holistically and in their social and physical contexts. In the Future Intensions section of Western Medicine, Witness 2 stated that a rigorous inquiry into Western psychology’s theories and science is required.

Under the Integration heading in the Past Experiences section, Witness 2 commented that the point “integration is occurring too soon” was too simplistic. She changed this point to state that integration is occurring prior to the reclamation of Indigenous knowledge. She also asked that all the references to “aggregating Indigenous knowledge” be changed to “re-aggregating Indigenous knowledge,” as the term aggregate implies that Indigenous
knowledge is now just being consolidated, as opposed to recognizing that colonial processes forcefully fractured it. And lastly, in the Future Intentions section, Witness 2 added that health systems should be focusing on the integration of knowledge and health practices of all peoples worldwide, not just Indigenous and Western paradigms. Two changes were made to the core message and themes from Witness 2’s interview. First, the core message was changed to re-aggregating, consolidating and disseminating Indigenous knowledge (as opposed to aggregating), and the third theme was changed from “integration occurring too soon” to integration occurring prior to reclamation of Indigenous knowledge. Witness 2 said that the remainder of the story map accurately captured the salient points from her interview. All of the above noted changes have been made in Figure 6 and are indicated by the underlined text.

**Final core message and themes.** The final core message for Witness two was re-aggregating, consolidating and disseminating Indigenous knowledge. The final themes are: holistic health; weaknesses in the Western health system; and integration occurring prior to reclamation of Indigenous knowledge.

**Re-aggregating, consolidating and disseminating Indigenous knowledge.**

Indigenous knowledge was something that Witness 2 spoke about all throughout her interview, and was an underlying thread that ran throughout most of her points of discussion. Witness 2 began the interview by discussing how various historical and colonial processes (epidemics, residential school, outlawing of Indigenous ceremony, etcetera) have impacted Indigenous knowledge as a whole, and the structure of the transmission systems specifically, that were in place prior to European contact:
### Figure 6: Final Story Map: Witness 2

<table>
<thead>
<tr>
<th>Self as Elder / KK</th>
<th>Indigenous Medicine</th>
<th>Western Medicine</th>
<th>Integration (Idea; Forms; Experiences with)</th>
</tr>
</thead>
</table>
| **Past Experiences** | ▪ Accumulation of knowledge  
▪ Knowledge expertise (her peoples law)  
▪ Recognition as Knowledge Keeper by her people | ▪ Epidemics, residential school, breakdown of family structure, Potlatch Laws (colonization) led to breakdown of knowledge transmission systems and outlawing of healing practices  
▪ Altered knowledge transmission systems (individuals carrying bits of knowledge; knowledge without context)  
▪ Appropriation of Indigenous knowledge and medicine by a number of cultures | ▪ Appropriated Indigenous knowledge and altered and transformed it into dangerous medicines (e.g. opium and opiate drugs)  
▪ No empirical foundation for mental disorders (e.g. bipolar)  
▪ Integrated efforts occurring prior to reclamation of Indigenous knowledge | ▪ Integrated efforts occurring prior to reclamation of Indigenous knowledge  
▪ Indigenous knowledge has yet to be re-aggregated, so programming is built on fractured knowledge (Nearly Empty Basket)  
▪ Integrated efforts are not based on equality (e.g. those with degrees are held with more prestige than Indigenous healers)  
▪ Power rests with Western professionals |
| **Present Experiences** | ▪ Knowledge expertise (her peoples law; Western Law)  
▪ Diminished position in current territory (outside of her territory)  
▪ Knowledge of other nations’ traditions  
▪ Traditional teacher  
▪ Healer (Counselling, scanning, tracking back) | ▪ Disconnection between peoples and Indigenous knowledge (e.g. with traditional diet; medicines; ceremonies)  
▪ Indigenous peoples health is drastically different than Original Peoples  
▪ Holistic health (physical, mental, emotional, spiritual)  
▪ Examples of Indigenous medicines: -Scanning; Tracking Back; Traditional Diet; Counselling; Various strategies for discovery | ▪ Absence of holistic health perspective and understanding of interrelationships between four dimensions  
▪ Mental health workers view individuals through conceptual frameworks and narrowed theories, instead of holistically and in their social and physical contexts  
▪ Lack of focus on prevention methods for health issues (teaching people how to manage emotional, spiritual, mental, physical health)  
▪ Abandons people (e.g. severe mental health issues)  
▪ Mental health workers view individuals through conceptual frameworks and theories, instead of holistically and as individuals  
▪ Over-reliance on medication (mediation as primary intervention)  
▪ Diagnosis is strength (physical health) | ▪ Western knowledge and practice is outweighing Indigenous knowledge and practice (Full basket crushing Nearly Emptied Basket)  
▪ Western practitioners currently shift practice to work with Indigenous peoples  
▪ Discrimination still occurring in some Western settings (e.g. not being able to smudge in hospital)  
▪ Organizational/System change has occurred (e.g. some space for smudging)  
▪ Elders and Healers primary form of integrated work is teaching (not equipped to do integrated work otherwise) |
| **Future Intentions** | ▪ People must be self-reliant and responsible for their health and well-being  
▪ Must employ an Indigenous framework for understanding health and healing (spirit logic and four dimensions of self)  
▪ Empirically validate Indigenous practices and methods of healing (shape shifting) | ▪ Research and acknowledge origins of contemporary medicine (e.g. Willowbark is Aspirin)  
▪ Re-evaluate treatment interventions (e.g. medication; use of diagnostic system)  
▪ Rigorous inquiry into Western psychology’s theories and science | ▪ First Step: Indigenous knowledge must be re-aggregated (identification of venue), consolidated, and disseminated (development of curriculum) to individuals and communities, and then discuss how sharing might occur  
▪ Second Step: Discussion around fundamental beliefs and theories of health and healing  
▪ Differences in logic and theory systems (mathematical vs. spiritual logic)  
▪ Storied example of dissociation | ▪ [Issues to be addressed/Steps to be taken]  
▪ First Step: Indigenous knowledge must be re-aggregated (identification of venue), consolidated, and disseminated (development of curriculum) to individuals and communities, and then discuss how sharing might occur  
▪ Second Step: Discussion around fundamental beliefs and theories of health and healing  
▪ Differences in logic and theory systems (mathematical vs. spiritual logic)  
▪ Storied example of dissociation |
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<td>Third Step: Discussion around particular issues (e.g. what is health?; treatment interventions)</td>
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<td>Development of new evaluation methods and standards</td>
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<td>Concatenation of theories, knowledges and practices (Baskets Woven Together)</td>
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<td>Indigenous peoples will be leaders in integration efforts</td>
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<td></td>
<td>Integration of all knowledges and medicines of peoples throughout the world</td>
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What residential school did was disconnect young people from the centres of learning and in the end, with the implosion of the family, the breakdown of the transmission systems from the Elders to the youth […] and there were a number of epidemics going on which was killing the people who had the knowledge, so that our knowledge was threatened. The third thing that happened at the same time was the banning of the Potlatch or what they called the Potlatch Laws, which meant that we couldn’t practice our healing modalities. So that destruction of our transmission systems, the destruction of the structures in our communities, the death of knowledge keepers, all led to a tremendous disconnect of all knowledge amongst our people (W2 p.1).

These politically legislated attacks on Indigenous knowledge led to alterations in the traditional knowledge transmission systems that were usually practiced between Elders/knowledge keepers/family and youth. These alternations have resulted in fractured sets of knowledge among many Indigenous people today:

No one child was given the whole, and they were given the skeletons. I mean it totally made sense under the conditions of siege and illegalization. Each child was burdened with a bit and a skeleton, and then the hope was that they would get together at some point with other children and aggregate this knowledge and resynthesize it and then work to flush it out. The problem with the plan is that each child didn’t know who the other child was (W2 p.1).

As was discussed in the review of the literature, Indigenous culture, community, and identity, have been identified as key determinants of health and well-being for Indigenous people today. As such, the disconnection between many Indigenous peoples and their
culture/knowledge has been identified as a contributing factor for elevated rates of both physical and mental health problems today. Witness 2 gave several examples of gaps or disconnections with traditional knowledge, which included knowledge related to sacred medicines, healing and ceremonial practices, and traditional diet:

> How many generations does it take to completely alter your diet? Well more than four, more than four. Doctors know that, and that’s what’s happened to us. They killed the buffalo, they destroyed our camas, they killed the cod, they’re killing the salmon, and so on and so forth. And we don’t have alternatives in their world. All our sea vegetables are gone and there’s no alternatives, except maybe asparagus, it’s about as close to an alternative that we have. So we’re kind of screwed either way. And we have to be able to get our knowledge back so that we can look at and solve these problems. They’re medical problems, yeah? Instead, they’re saying, well you have diabetes take this insulin. No, that’s not the problem. Type II Diabetes, the kind we have, is completely solvable. No, they get better drugs (W2 p.11).

In speaking about rates of diabetes among Indigenous peoples, Witness 2 identified the absence of traditional diet as a source for the development of health problems as well as a potential solution. It is for this reason that she believes concerted efforts need to be focused on re-aggregating, consolidating, and disseminating Indigenous knowledge today.

One of the challenges to re-aggregating Indigenous knowledge that Witness 2 identified as occurring in the past is that Indigenous people have not had an opportunity or a venue to gather and discuss their knowledge:
So you know, in the context of pushing back on colonization, we were never afforded another venue, an alternative venue, to the one that was destroyed. That’s what we need before we can do anything. I can’t be sure that what I know is what I know unless I can sit with other knowledge keepers, and really sit down and aggregate what we know and put it to the test of time (W2 p.2).

What is critical for Witness 2 is being able to share, compare, and confirm the individual knowledge pieces that each knowledge keeper, Elder, or healer possesses, thereby strengthening Indigenous knowledge systems as a science and as a whole. Once the gathering of knowledge keepers has occurred, the next step in this process is to disseminate the knowledge to Indigenous communities and people so that they are empowered and informed about how health and healing issues have been, and continue to be, addressed within an Indigenous framework:

We first have to aggregate the knowledge but then we have to disseminate it as well. We have to figure out a way to transmit it so that the communities have their own knowledge about how we dealt with health before there was a medical health system, before there was a European medical health system. What did we do before? So we need to get that in place and then we need to disseminate it (W2 p.21).

One method for dissemination which Witness 2 identified is formalized education and the development of curriculum for Indigenous knowledge. She discussed how the knowledge transmission systems of the past may no longer be an ideal format for sharing knowledge, given the structural changes in community and family units that have occurred as a result of colonization, especially if the goal is widespread education:
It has to be in a formal way. It has to be organized and formal. Absolutely. We don’t have time to bugger around and follow – I mean this is what they’re doing now. You go and be a helper to an Elder and learn as much as you can. Well that worked 200 years ago when you had a community that basically knew what was going on and had access to all that knowledge everyday, all the time. Well we don’t have that now; we have to create that. And the only venue we have is schools, that’s it. So it has to be formal (W2 p.10-11).

Through programmatic organization, Indigenous knowledge would be disseminated in a streamlined and expedient fashion, with the hope that overall health and well-being would be improved and strengthened. However, one might expect that various challenges and issues may arise with such an endeavour, such as the content to be conveyed, given the diverse number of Indigenous peoples in Canada (e.g. Ojibway, Cree, Iroquois, Métis, Inuit). Nonetheless, Canada has seen the development of some Indigenous specific curriculum and programming (e.g. Aboriginal Head Start; Indigenous Studies programming in universities), and additional formalized educational programs would assuredly be an asset to current educational efforts. In summary, the reclamation of Indigenous knowledge and its dissemination to Indigenous peoples was identified as a key area of action by Witness 2, and also represented the first step in any movement towards the integration of Indigenous and Western health and healing paradigms:

I always put the emphasis on reclaiming our knowledge and figuring out how to disseminate it. Because the other thing, the acquisition of Western knowledge is happening; it happened to me, it happened to you, all kinds of us, thousands of us have Western knowledge, thousands and thousands. So our
push should be for acquiring Indigenous knowledge and elevating it, constantly elevating it by, and I don’t mean elevating it in the sense of holding it up higher than Western knowledge, but at least equal to. And then augmenting it, increasing it, always increasing it (W2 p.29).

**Holistic health.** Witness 2 spoke about an Indigenous understanding of health and wellness as being comprised of four dimensions of self: emotional, mental, spiritual, and physical. Each one of the dimensions of well-being is of equal importance in maintaining health, as well as the interrelationship between them. For instance, in speaking about how individuals process traumatic experiences, Witness 2 explained how a weakened physical body complicates the psychological processing of trauma:

There’s no separation between physical and mental health. If you got a strong body then you will be able to withstand whatever traumas come your way. Your body gets scared if it’s not in optimum shape. So then you experience trauma and you add a frightened body and that’s when you get unresolved trauma (W2 p.17).

Additionally, Witness 2 shared that an Indigenous understanding of health tends to focus on how to live well and maintain health, as opposed to being centered on and addressing only illness as it develops. She provided an example of this in discussing how to nurture the four aspects of self in everyday life, “Little things you know, the little things we can control […] to download those stressful feelings is very very important. And to upload more vitamins and more positive food, you know the right kind of food […] We’re mentally ready for it, we’re emotionally ready for it, we’re food wise ready for it” (W2 p.26).
This holistic understanding of health also impacts how health problems are conceptualized, and the healing methods that are selected to address the health issue. Instead of examining just the symptomatology of a problem and then treating it, an Indigenous health perspective entails examining the etiological factors of the health problem in line with the four dimensions of the self, and the interactions that occurred between these dimensions. Witness 2 referred to this process as re-tracking back:

Re-track back. Say someone has diabetes, we track back what happened and we connect what happened with you emotionally, and psychologically, and spiritually, with your digestive system. We connect those two things right away. Well obviously if you’re emotionally upset you’re not digesting your food, so you’re creating a toxic waste dump in one third of your body and it’s spilling into all of your organs, making them all go crazy, overwork and shut down. So go ahead and take those shots because you need them right now, but we’re going to undo this. And there’s communities, I think (name of community) is a good example, who are working with traditional diet and diabetes, and of course winning the war (W2 p.6).

Using the example of diabetes, Witness 2 highlighted how emphasis is placed on exploring the contextual factors that were present at the time of onset of the health problem. Witness 2 juxtaposed the method of re-tracking back with a standard form of treatment for diabetes today, which is insulin therapy. As opposed to treating the diabetes through management of the problem, Witness 2 identified traditional diet as an intervention to “undo” the diabetes. The emphasis with this approach is to holistically examine the development of the health problem and identify strategies to correct the initial imbalance in the individual.
**Weakness in the Western health system.** Witness 2 identified weaknesses in both the physical/medical and mental health sectors of the Western healthcare system. One perceived weakness that was evident in both the physical and mental health sectors was the absence of a holistic understanding of health. Instead of examining the root cause of health problems and addressing these factors, “what Western medicine is is quarantine, isolate, and repair and remove” (W2 p.16). While the diagnostic system in the physical health sector was identified as a strength in healthcare, current treatment interventions were perceived as hazardous to one’s health, “Now I understand that they diagnose things much quicker than we do […] The diagnosis is a powerful strength. They get it so fast. But the treatment is so harmful” (W2 p.15). Witness 2 expressed grave concerns related to the use and even over-reliance on medication as a primary form of treatment and intervention in the Western healthcare system:

> We got a pill for that. Take another pill. And they’re trying to get pills for everything and you end up with a pill that has all these side effects, so you got to take another pill and another pill (W2 p.15-16).

The issue of medicating individuals was also raised in relation to the treatment of mental health disorders. Witness 2 expressed several criticisms of the theory and practice of Western psychology, including a lack of empirical evidence for classifications of mental health disorders, the use of medication to treat mental health issues, and its narrowed conceptualizations of psychological phenomena. In reflecting on a recent interaction with a panel of Western mental health professionals, Witness 2 elaborated on some of her beliefs in stating:

> I know we did a discussion in (name of city) with a number of psychologists and psychiatrists, and you know we eventually had to tell them that there is no
scientific proof for any of your theories. Don’t call our stuff voodoo, because this guy says, ‘Well it sounds like voodoo.’ You know? The way you’re saying voodoo sounds like voodoo is a bad thing, first of all. What’s wrong with voodoo? And what you’re doing is no different. It’s no different; it’s all theory. Like they can’t scientifically test you for bipolar disorder, but they’re treating you with drugs for it. What the hell is that? Now who tells us what’s acceptable behaviour and what’s not? (W2 p.9).

Witness 2 expressed a desire for a rigorous inquiry into the theory and practice of Western psychology and stated that differences in theory and knowledge systems, conceptualizations of health, and approaches to healing and treatment, are all issues that need to be addressed prior to the practice of integrated Indigenous and Western healthcare.

Integration prior to the reclamation of Indigenous knowledge. Witness 2 expressed at different points throughout her interview that she believes there is some potential for a relationship to develop between Indigenous and Western approaches to health and healing. However, in discussing current programming which has integrated the two systems, Witness 2 stated that she believes both Indigenous and Western professionals have rushed into practicing integratively. Prior to collaboration, Indigenous peoples and communities, and particularly the Elders and healers, must re-aggregate and consolidate their knowledge. Witness 2 explained why the reclamation of Indigenous knowledge must first occur by using the analogy of full and emptied baskets:

We have an almost empty basket because we’re disconnected from our original knowledge. And they have it in their hands, bowdlerized and transformed into useless information as far as we’re concerned. But their basket is full, so it’s
going to sit on top of our empty basket and we’re going to be the savage younger brothers or the savage younger sisters with the less knowledge. So they’re going to call the shots, they’re going to determine what’s the scientific requirements (W2 p.14).

For Witness 2, the Indigenous knowledge basket has been emptied as a result of colonization, whereas the Western knowledge basket is full, as the last several hundreds of years have been dominated by European rule and thought. According to Witness 2, it is important for both the Indigenous and Western entities to be equally equipped with knowledge bases to ensure that collaboration is truly egalitarian in design, and that a particular system does not wield more authority or power than the other, “That’s what they want to do now, by jumping the gun. The first people in line are going to be those with degrees recognized by Europeans, not our people. So I’m not in a hurry to do any of this sort of thing” (W2 p.5).

Witness 2 shared with me that even though some collaboration and integration has taken place, it is our responsibility to remind individuals that a great deal of work must still occur before moving forward, “It’s also important for people like us to be aware that there’s a lot, a lot, a lot of work to do before we can start talking about bringing the two knowledges together, because we don’t have all our knowledge” (W2 p.11).

**Participant Three**

Character sketch. Participant Three chose the identifier “Elder 3” as her preferred pseudonym. I was familiar with Elder 3 from some of the community events she had attended and provided teachings at. I therefore already had a pre-established relationship with Elder 3, and she was familiar with me when I approached her during the formal recruitment phase about participating in my study. During an initial meeting with Elder 3 to discuss the
possibility of her participation, she shared her willingness to participate because of the importance of the research topic at this time in our history. She invited me to a residence one weekend to conduct our initial interview, and we were also able to hold a follow-up interview to review her story map, core message and themes.

**First interview.** Elder 3 and I began our interview by reviewing the informed consent form orally and in writing. Once Elder 3 provided consent, I presented her with a bundled gift of medicine (sage, sweetgrass, cedar, and tobacco) and presented the (research) question I was seeking knowledge for. Elder 3 accepted this gift and expressed her eagerness to discuss the issue of Indigenous healing. She retrieved some of the tobacco from the pouch I presented to her and laid some to the ground, offering a prayer of thanks to the Creator and asking that our interview be conducted in a good way. We reviewed my specific interview questions together orally before turning on the audio recorder. This initial interview lasted 60 minutes in length, and Elder 3 spent the majority of the time sharing traditional teachings and explaining the importance of Indigenous knowledge with respect to health and healing. Since my first interview with Elder 3 was held outdoors at a home, Elder 3 provided a number of concrete examples when answering her questions, as she could draw on her environment around her (e.g. by discussing our relationship with the natural world as part of healthy living). Once we reached the 60 minute mark, Elder 3 requested that we stop the interview as she was beginning to fatigue. She said that she would like to hold a second interview to answer my remaining interview questions. She also said that she would like to receive some guidance from her personal teachers before discussing the idea of Indigenous and Western integration.
The initial story map (see Figure 7) was constructed during the analysis phase of the initial interview. Since Elder 3 did not answer all the interview questions, there are a number of gaps in this first map. I was able to identify a core message and one theme from this interview: Indigenous epistemology (core message) and the effectiveness of Indigenous medicine (theme one). I presented this initial map, core message, and theme to Elder 3 during our second interview for her to review.

Feedback from second interview and final story map. Elder 3 and I met for our second interview in an office space that she was familiar with. I provided a summary of the things we had discussed during our first interview and the remaining questions that I had. I also presented Elder 3 with the initial story map I had constructed and the corresponding core message and theme. Under the Self as Elder heading, in the Present Experiences section, Elder 3 added that she currently works as a healer, providing doctorings and teachings to those who request her services. She also continues to practice her belief system and live in a good way (i.e. in accordance with her beliefs and teachings). In the Future Intentions section, Elder 3 shared that part of her ongoing work is to decolonize the belief systems of many Indigenous peoples who are wary or critical of Indigenous healing methods. However, she said that she does not force Indigenous ways upon anyone, and respects people’s individual choices for the type of healing and healthcare system they wish to access. Under the Indigenous Medicine heading, in the Past Experiences section, Elder 3 added that Indigenous people have become disconnected from their knowledge as a result of colonization, and that protocols have been established for working with healers and must be followed if the healing work is to be fruitful. In the Present Experiences section, Elder 3 shared that many Indigenous people continue to be sceptical of Indigenous medicine, but a lot of work is being
### Figure 7. Initial Story Map: Elder 3

<table>
<thead>
<tr>
<th>Self as Elder</th>
<th>Indigenous Medicine</th>
<th>Western Medicine</th>
<th>Integration (Idea; Forms; Experiences with)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Parents as teachers</td>
<td>o Indigenous epistemology as foundation for life and healing practice</td>
<td>o Doesn’t believe in spirit</td>
<td></td>
</tr>
<tr>
<td>o Keen to learn</td>
<td>o Must know the cultural teachings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Training (self-trained; by herbalist)</td>
<td>o Strong relationship between teachings and healing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Healed herself</td>
<td>o Teachings shared:  - Creation story  - Parenting and childhood  - Family medicine  - 7 prophets and gifts  - Spiritual pathway  - Medicine Bundle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Activated medicine bundle</td>
<td>o Medicines for all problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Present Experiences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Healing journey</td>
<td>o Doesn’t believe in spirit</td>
<td>o Does not practice integration</td>
<td></td>
</tr>
<tr>
<td>o Practice belief system (e.g. use of sweatlodge)</td>
<td></td>
<td>[Challenges to Integration]</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Differences in epistemologies as challenge</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Differences in training/gathering knowledge/Finding solutions for healing (e.g. fasting)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Examples and Experiences of Integration]</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Request hospital to give miscarried foetus to woman</td>
<td></td>
</tr>
<tr>
<td><strong>Future Intentions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
done by individuals, communities, and organizations to educate and decolonize beliefs about Indigenous approaches and practices for healing.

The vast majority of my second interview with Elder 3 focused on discussing the Western healthcare system and the notion of integration. Several points were added to both the Western Medicine and Integration headings and have been noted in Figure 8 by the underlined text. Elder 3 agreed with the core message and initial theme that were derived from her first interview and stated that they should remain as part of her final analysis. Two additional themes were identified upon analysis of my second interview with Elder 3, and were confirmed with her over the phone shortly after our second interview.

**Final core message and themes.** The final core message for Elder 3 is Indigenous epistemology. The themes are the effectiveness of Indigenous medicine, lack of understanding/respect for Indigenous ways, and challenges to integration. While the core message and first theme remained the same from my initial interview with Elder 3, the final two themes emerged after our second interview.

**Indigenous epistemology.** The core element of Elder 3’s interview was sharing Indigenous ways of knowing and her understanding of the world, or an Indigenous epistemology. For instance, Elder 3 shared her belief that all human beings are placed on the earth for a spiritual journey, and that gifts or a medicine bundle (a collective of skills, teachings, individuals, etcetera, that each person possesses) are bestowed to each individual by the Creator for growth and spiritual development:

> What are you going to be doing in here, the purpose of your walk here, and then your spiritual tools, the kind of tools you’re going to be using – sweatlodge, or pipe, tobacco, you know all of these things, tobacco, all of these
### Figure 8. Final Story Map: Elder 3

<table>
<thead>
<tr>
<th>Past Experiences</th>
<th>Self as Elder</th>
<th>Indigenous Medicine</th>
<th>Western Medicine</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Parents as teachers</td>
<td>o Indigenous epistemology as foundation for life and healing practice</td>
<td>o Doesn’t believe in spirit</td>
<td>o Has not done healing work in Western spaces (the spirit is not there)</td>
</tr>
<tr>
<td></td>
<td>o Keen to learn</td>
<td>o Must know the cultural teachings</td>
<td>o Does not respect/understand Indigenous medicines or practices (e.g. smudging?)</td>
<td>[On the idea]</td>
</tr>
<tr>
<td></td>
<td>o Training (self-trained; by herbalist)</td>
<td>o Strong relationship between teachings and healing</td>
<td>o Focus of programming is on cost effectiveness – not the healing needs of the person</td>
<td>o Western spaces not ready or sometimes willing to work integratively (e.g. prohibit smudging)</td>
</tr>
<tr>
<td></td>
<td>o Healed herself</td>
<td>o Several teachings shared</td>
<td>o Protocols for working with healers</td>
<td>o Choice for both health systems should remain</td>
</tr>
<tr>
<td></td>
<td>o Activated medicine bundle</td>
<td>o Medicines for all problems</td>
<td>o Indigenous people disconnected from knowledge because of colonization</td>
<td>o Historical relations impacting potential to build relationships today (original commitments not being honoured)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present Experiences</th>
<th>Self as Elder</th>
<th>Indigenous Medicine</th>
<th>Western Medicine</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Healing journey</td>
<td>o Indigenous people disconnected from knowledge</td>
<td>o Doesn’t believe in spirit</td>
<td>o Does not typically do healing work in Western spaces</td>
</tr>
<tr>
<td></td>
<td>o Practice belief system (e.g. use of sweatlodge)</td>
<td>o Decolonize minds to accept traditional ways</td>
<td>o Does not respect/understand Indigenous medicines or practices (e.g. smudging)</td>
<td>o Would be open to working in Western spaces if respect and understanding was present</td>
</tr>
<tr>
<td></td>
<td>o Healing work (doctorings; teachings)</td>
<td>o Living and practicing traditions in a good way</td>
<td>o Focus of programming is on cost effectiveness – not the healing needs of the person</td>
<td>[Challenges to Integration]</td>
</tr>
<tr>
<td></td>
<td>o Decolonize minds to accept traditional ways</td>
<td>o Does not discount peoples choice to access and use diverse healing systems</td>
<td></td>
<td>o Differences in epistemologies (Western medicine does not believe in spirit)</td>
</tr>
<tr>
<td></td>
<td>o Does not discount peoples choice to access and use diverse healing systems</td>
<td></td>
<td></td>
<td>o Differences in knowledge acquisition (e.g. by curriculum vs. with seasons, life stages, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Future Intentions</th>
<th>Self as Elder</th>
<th>Indigenous Medicine</th>
<th>Western Medicine</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Decolonize minds to accept traditional ways</td>
<td></td>
<td>o Focus of programming is on cost effectiveness – not the healing needs of the person</td>
<td>o Moving towards higher level of consciousness; all knowledges and healing practices integrated, and healing of all peoples, animals, objects, and the planet</td>
</tr>
</tbody>
</table>
spiritual tools that are going to help you, because you’re here for a spiritual
journey. You’re here to experience something with life. And so you have your
spiritual teachings […] all of these teachings, they are all in your medicine
bundle (E3 p.4).

According to this belief, each individual is destined to have experiential moments of learning
in which the gifts they have received, and the knowledge they have accumulated, are
strengths for overcoming challenges and learning. Some of the traditional teachings that
Elder 3 shared included the creation story of her people, how a person’s gifts or medicine
bundle is received and assembled, and the purpose of certain Indigenous ceremonies, such as
the sweatlodge. Elder 3 stressed throughout her interview that receiving and being familiar
with Indigenous knowledge and teachings are vital to living life in a good way, and stated
that individuals who are in search of knowledge or answers need to return to the original
teachings, as the solutions will be found there, “So you have to go back. In order for you to
learn everything you can […] you have to go back to the teachings, you have to go back to
the teachings. And that’s where you learn everything, that’s where you learn everything,
because everything is in that teaching (E3 p.3).

For Elder 3, an explicit connection exists between Indigenous ways of knowing and
health and healing. Similar to her instructions to return to original knowledge when searching
for answers, individuals must return to traditional teachings for their healing needs as well:

So before anybody goes into the healing they have to know the origin of the
creation story. All creation stories in the world, and all creation stories are,
they’re all the same, they’re all true. Because if you don’t know the history, if
you don’t know the origin, how can you explain, if somebody comes to you, how can you explain about your healing, the healing aspect of it? (E3 p.3).

According to Elder 3, her worldview and perspective as an Indigenous Elder and healer requires that she practices and shares the original knowledge of her people. Elder 3’s particular belief system places great emphasis on spiritual knowledge and practice, which as she described, is foundational to achieving health and living well. Indigenous knowledge is understood as an incredible strength, and also acts as a method of healing for the individuals that she works with.

**Effectiveness of Indigenous medicine.** A key theme for Elder 3 was the power and effectiveness of Indigenous medicine. She asserted that medicines or healing practices exist for virtually all problems, “And there’s medicines used and all kinds of stuff for all that. If you’re having problems, there’s medicines we use” (E3 p.6), and that they can be found in a diverse number of forms and practices, “And I see others, what they do. They express themselves through, the healing is through dancing, and arts, and all that. Music, drumming, or guitar, any kind of expression of the spirit” (E3 p.8). However, as Elder 3 noted here, it is not the practices in and of themselves that are effective, it is the belief in the power of the spirit, or Creator, which facilitates healing. She identified all of the tools that are used for healing today as being gifts from Creator that assist individuals in communicating with the spiritual realm, and highlighted how she has personally been healed as a result of her strong faith and belief in this system:

The Creator gave us everything, every every thing for any kind of illness that we have, there’s a cure for it, there’s a cure for everything. We have cures for AIDS, we have cures for cancer, you know? Everything. Look at my cancers,
they were all cured. I should have died they said, they said in 10 days time. But my belief system is so strong. This is the spirit. I know spirit can heal, can heal us. I have seen loved ones get healed. But then we have to be schooled on how to do that (E3 p.9).

Elder 3’s reference to “being schooled” on how to effectively work with Indigenous medicine also forms the basis of one of her primary critiques of the Western healthcare system, which is the absence of spiritual knowledge and healing in treatment, and a lack of understanding of how Indigenous healing is practiced.

**Lack of understanding/respect for Indigenous ways.** Elder 3 discussed at various points throughout her interview some of the differences between Indigenous and Western approaches to health and healing. One of the principle differences she discussed was the absence of a holistic understanding of health and the importance that relationship with other entities (e.g. animals, the natural world, the spirit world) play in maintaining health. As discussed above, spirituality is a key component to well-being, and Elder 3 associated effective healing with relationships with the spirit world. The absence of spiritual knowledge and healing in the Western healthcare system is perceived as a lack of understanding, even disrespect for, Indigenous approaches to health:

So when you look at the dominant culture, what does the dominant culture say? They’ll say well, you know the earth, oh we don’t want the dirt. Nothing has spirit, nothing has spirit. So if they don’t believe that there’s nothing in this spirit, they’re just going to cut down everything. They’re not going to offer the tobacco, they’re not going to offer thanks, they’re not going to respect that,
respect that, those berries, or the medicines, you know. Anything that grows out there has a special purpose (E3 p.9).

Another example of disrespectful practice by the Western healthcare system which Elder 3 discussed is current policies which prohibit the use of certain medicines and ceremonies in mainstream settings (e.g. hospitals, prisons). One of the most commonly discussed examples by all of the Elders in the study was a ritual purification ceremony, more commonly referred to as smudging, in which sacred medicines (most commonly sage, cedar, sweetgrass, or tobacco) are burned with the intention of cleansing and purifying a person, object, or physical space. In inquiring about whether she ever works as a healer in mainstream spaces, Elder 3 commented:

I will choose not too because they don’t believe in purifying, they don’t understand or they don’t want to understand our way of life. And it’s respect eh? […] Before you heal, you have to open up that person and heal that person, detoxify that person, and people don’t understand that. What is smudging? It’s detoxifying that person before the spirit, you don’t want to invite a healing spirit to come in, because they travel from long ways to come and heal you, and then it’s in a dirty place (E3b p.3).

It is clear that Elder 3’s experiences to date of working within the mainstream healthcare setting have been marked by an air of disregard for Indigenous knowledge and practices. This lack of understanding and outright refusal to accommodate Indigenous healing practices has been understood as a form of disrespect by many Indigenous Elders and healers, and is one of the many issues which Elder 3 identified as an obstacle to practicing collaboratively with Western healthcare professionals.
**Challenges to integration.** When asked about her perspectives and experiences with working integratively with the Western healthcare system, Elder 3 shared that she tends not to work in these settings for a variety of different reasons. As was noted above, the lack of spiritual practice and understanding about the importance of spirituality for many Indigenous people is one obstacle to collaboration for Elder 3:

I will just not go there and say hey, I’ll work for this non-native organization and use our way, I’m just wasting my time because I know the spirit is not there. If the spirit was there, if they believed in the spirit, I would, but they don’t want to, they don’t want to (E3b p.2).

It is important to note that Elder 3 is not completely opposed to integrated practice as she highlighted that she would be willing to work in mainstream spaces if spiritual healing was recognized as significant to healing processes.

Another challenge identified by Elder 3 are differences in training standards for Indigenous healers and Western practitioners. Many Indigenous epistemologies contain the belief that each individual is bestowed with gifts and skills that are unique, such as the gift of singing, or story-telling, or healing. Sometimes these gifts are received at a young age, as Elder 3 noted, “So they have that gift, they have their gifts. Maybe you learned it when you were young, maybe somebody passed it onto you, but it’s a gift. Some people are gifted, they have that gift of healing, and others, the mind, and herbs” (E3 p.11). Individuals often spend the remainder of their life developing and practicing the gift, often working and training with other Indigenous healers for years. However, this form of training is distinctly different than the Western education system, which only recognizes a specific type of knowledge with progress marked by diplomas or degrees. While some Indigenous societies also have a degree
system which connotes levels of Indigenous knowledge and training, such as the Midewin Lodge Society, this type of training and degree level is often not recognized or regarded as of the same calibre as Western education. Levels of training and education often become an area of challenge when the issue of remuneration of Elders and healers is raised, “They don’t respect that, they don’t understand that, they don’t want to, because they say oh well we have to pay these guys” (E3b p.3). Both recognition of diverse forms of training and skill level, as well as compensation, are issues that currently stand as challenges to integration for Elder 3.

A final challenge that Elder 3 identified was the nature and structure of the current programming and treatment services offered in the Western healthcare system that Indigenous practitioners would be attempting to integrate with. Elder 3 shared that the majority of treatment programs offered today have been developed by administrators of treatment centres, as opposed to consulting with Indigenous Elders and healers, “So what they have tried to do is create programs for us. We haven’t created those programs, they have created those programs for us, still under the power and control. There is no equality in there” (E3b p.2). Elder 3 also discussed how funding tends to impact the content of a program, which she also believes explains why Indigenous spirituality is absent from a great deal of programming, “It’s all government funded. The programs, they’re programmed by the government. It hasn’t been done spiritually. That’s really really the sad part of it” (E3b p.5). Moving forward, Elder 3 stated that if integrated practice were to occur, programming would have to be developed equitably and in line with Indigenous ways. One example that she provided was of a drug and alcohol treatment program:

Go somewhere for long healing, not just 28 days, not just a two week thing where they can go to a healing centre […] It took a long time for that person,
say an alcoholic, it takes seven years for that alcoholic to detoxify themselves, take that medicine out. So it takes a long long, it’s a long process […] because you have to go through the cycle, you have to go through the seasons, the stages of life, you got to go through that (E3b p.4).

It is clear from Elder 3’s comments that there are still many challenges and issues that must be addressed prior to considering full-scale integration of Indigenous and Western approaches.

Participant Four

Character sketch. Participant Four chose the identifier “Traditional Teacher 4” (TT4) as his preferred pseudonym. A community informant suggested that I contact TT4 to inquire if he might be interested in participating in the study. I had had met TT4 several years prior to my academic studies through my involvement with the Toronto urban Indigenous community, but had not had any contact with TT4 since then. I emailed TT4 sharing that he had been recommended to me by a community informant, and provided a brief description of my research topic and asked that he re-contact me if he had any interest in participating. TT4 responded and expressed interest in sitting for an interview, and we scheduled our first interview shortly thereafter. While TT4 and I were able to hold an initial interview, we did not hold a second interview. However, his story map and corresponding core message and themes were sent to him over email for his review.

First interview. I looked forward to my interview with TT4 as it had been many years since I had spoken with him last. Before conducting our interview, TT4 and I had lunch together and chatted about our personal lives. After visiting, we travelled to a community centre and used a group room to conduct our interview in. I began the interview by reviewing
the informed consent form orally and in writing. Once TT4 provided consent, I presented him with a bundled gift of medicine (sage, sweetgrass, cedar, and tobacco) and presented the (research) question I was seeking knowledge for. TT4 accepted this gift and shared that he would try and answer all the questions to the best of his ability. He also informed me that he would be citing the names of the mentors and teachers that he has received many of his teachings from, and that much of his knowledge is shared knowledge that he has received from others. We reviewed my interview questions together orally before turning on the audio recorder. TT4 was very articulate and thorough in answering each of the interview questions, using several traditional teachings, personal and cultural stories, and sharing his perspectives and experiences related to the subject matter. Our interview lasted 120 minutes in length.

The initial story map (see Figure 9) was constructed during the analysis phase of the initial interview, and a core message and three corresponding themes emerged from this interview. Since TT4 and I currently reside in different cities, we decided that the story map, core message, and themes should be emailed to TT4 for his review, and any feedback or revisions would be emailed back to me. At this time I have not received any additional feedback from TT4 and the story map depicted in Figure 9 is considered the final version of his story map.

**Finale core message and themes.** The final core message for TT4 is Indigenous culture as foundation for health. The three themes are: shift in Western attitudes; practices integratively, but issues remain; need for education.

**Indigenous culture as foundation for health.** Traditional Teacher 4 described a number of different elements of Indigenous culture (plant medicines, ceremony, Elders,
## Figure 9: Final Story Map: Traditional Teacher 4

<table>
<thead>
<tr>
<th>Self as Elder / TT</th>
<th>Indigenous Culture &amp; Medicine</th>
<th>Western Medicine</th>
<th>Integration (Idea; Forms; Experiences with)</th>
</tr>
</thead>
</table>
| **Past Experiences** | o Organizational and political involvement  
 o Keen to learn  
 o Healing journey – remembering his song  
 o Assembled Bundle (learned traditions; Elder’s helper)  
 o Role of Elders as Mentors (listened to stories; as healers)  
 o Embarking on journey with partner  
 o Participation in ceremony (sundance; fast; sweat)  
 o Honoured Story-telling tradition  
 o Recognition as Elder from community  
 o Healing work (healing circle; ceremony; Elders) | o Intellectual and intuitive-spirit logic systems  
 o Indigenous medicines (Elders and their orality/story; ceremony, community, cultural identity)  
 o Effectiveness of Indigenous medicine  
 o Levels of healing: individual, family, community, clan, Nations, Mother Earth  
 o Spiritual and pastoral care requires practice of ceremony (e.g. smudging)  
 o Conducting ceremony in urban spaces  
 o Aboriginal peoples disconnected from traditional knowledge and practices | o Attempt to prevent use of Indigenous healing practices (e.g. smudging in hospital)  
 o Disrespect healers and medicines | o Have been refused the right to smudge in mainstream settings  
 o Traditional people not treated with respect or recognition that they deserve  |
| **Present Experiences** | o Story-teller  
 o Learning from contemporaries as well as Elders  
 o Integrate traditional knowledge with contemporary events  
 o Pride in culture and gifts of Aboriginal peoples  
 o Strength from relationship with partner  
 o Healing Work (perform ceremonies) | o Indigenous knowledge and practices being legitimized by Western science  
 o Aboriginal peoples disconnected from traditional knowledge and practices  
 o Specializations of healers and Elders  
 o Healers and Elders are being over-worked in some cases | o Fail to show appropriate amount of respect for Elders/healers  
 o Beginning to recognize validity and legitimacy of Indigenous knowledge and practices  
 o Some shifting in attitudes  
 o Western professionals still display resistance to use of medicines | o Foundation is respectful relationship  
 o West must recognize effectiveness of Indigenous ways  
 o At request of Aboriginal peoples  
 o Services requested by West  
 o Does see shift in attitude toward Indigenous practices and beliefs  
 o Storied example of The Great Law |
| **Future Intentions** | o Share teachings with coming generations and non-Indigenous peoples  
 o Working and training youth in traditional ways | o Indigenous peoples as leaders in healing the earth  
 o Knowledge and medicines to be shared with others, if asked in a respectful and appropriate way | o Will look to Aboriginal peoples for guidance around healing the earth and individual healing | o Differences in logic and theory systems  
 o Structural changes are needed to make allowances for spiritual practices  
 o Budget costs  
 o Remuneration for Elders and healers  
 o Increase training and education related to Indigenous knowledge, medicine, practices, and protocols for engaging with traditional people |
story-telling, community, cultural identity, spirituality) that provide a solid foundation for being well and healing. He shared numerous examples of how these different aspects of Indigenous culture have aided him personally in overcoming mental and physical health issues:

I often tell the story that I am a member of the (name of) clan, member of the (name of) nation, and I was this burdened man who had forgotten his song. And it was due to a lot of trauma, a lot of negative things that happened in my life, and I know that it all happened for a reason and that I could heal from that. And through my culture, through the ceremony, through a lot of {inaudible} tears, through a lot of grief work, trauma therapy, ceremonial inflation of the ego, I started to, I started healing. I started to understand my humanity and I understood that Creator has some purpose for me. And I used to think I was garbage and then people said Creator didn’t create garbage, that’s all in your mind. Creator created everything in the beautiful image of Himself, Herself, so you have something in you that is of worth that you have to find, because that’s your contribution, that’s your gift, that’s your purpose (TT4 p.10).

Here we see that Indigenous culture provided TT4 with a sense of purpose and anchors for an identity. TT4 also spoke about the importance of possessing a strong Indigenous identity in elevating one’s self-esteem and self-worth when discussing his reclamation of the spirit name he had received as a young man, “Now I can do something with that name. And I’ll make it a name that one of my descendants will be proud to want to carry and have that as their name, as their title. So ever since then I went through a change, I began to change, and I started to, I started falling into the story-telling tradition” (TT4 p.12). The power of story and the story-
telling tradition was something that TT4 discussed throughout his interview, and in conjunction with that, Elders as mentors and a type of Indigenous medicine.

Traditional Teacher 4 reflected on a number of different experiences of working and studying with several Elders throughout North America. He expressed thanks for their knowledge and role as emblems of Indigenous culture and spirituality, as they often represented the roots for growth that many Indigenous peoples were searching for, “So all these people stuck together to help our people because they knew that’s what we, we were all searching for something about our identity and who we were, and I was so glad that they came into my life” (TT4 p.8). TT4 also identified the sense of community, caring, and support, that the Elders conveyed and created, which in and of itself was healing:

Here is an Elder who took the time to make me feel like this is where I belong, I’m home here, and that now, if I surround myself with the right people, all these good people, and I take care of them, they’ll take care of me. And I’m part of community now, and that’s how we heal (TT4 p.9).

TT4 was very explicit in his belief about the power and effectiveness of Indigenous healing methods, describing the role that ceremony and Elders have played in his personal healing journey:

We started the day off with a sunrise, sometimes sweat, and I had never done that before. We get up at the break of dawn and go into the sweatlodge, it was fantastic. But I was home again, all of a sudden I didn’t need to drink eh? That was the thing about it, I knew that this was special when I felt that I didn’t need to drink and alter my moods. So I loved it. So spending time with (name of Elder) was really powerful medicine for me (TT4 p.4).
As has been discussed elsewhere, Indigenous culture, which is comprised of many different
elements and is also unique in its formation for each individual, has been identified as an
important aspect of healing for many Indigenous peoples, and also serves as a protective
factor for the development of health issues. In TT4’s case, strong connections with his
culture have assisted him in identifying a purpose in life, and an accompanying lifestyle
which serves to balance and maintain health and well-being.

**Shift in Western attitudes.** Traditional Teacher 4 discussed how in the past, and even
still today, Western institutions have prohibited, or attempted to prohibit, the use of
Indigenous healing practices, “we’ve all had stories about what we’ve had to go through
wanting to try to smudge, and the bottom line is that we had to go outside, couldn’t do it
inside” (TT4 p.25). However, TT4 believes that a shift in attitude and practice has begun to
occur, discussing how many Western professional bodies have accommodated Indigenous
individuals in their healing needs, and have also approached and invited Indigenous healers
to perform ceremony or give teachings in their respective establishments. One example of
this shift in attitude which TT4 has observed has been through his work with Chaplaincy
groups, and at times, with the Western healthcare system. In describing a case where an
Indigenous woman in a hospital requested to have a smudging performed, and was initially
refused by the nursing staff, TT4 stated:

Well the minister on the reserve went into the hospital and said no, she doesn’t
have to go outside. She’ll be doing it right here in her room. I will go and get
permission from her doctor, and if he says okay will you then approve it? [...] And the nurses said if the doctor says it’s okay, then we’ll allow it. Well in this
case the doctor says yes, definitely let her do it, and she was able to do the
smudge. But the minister said, look, if you don’t do this, to the nurses, if you
don’t let her smudge I will bring the media in here, I will bring the Native
media in here, and they’re going to see how you’re treating your Native
patients here (TT4 p.27).

While some of the Western healthcare staff still displayed resistance to Indigenous practices,
the Chaplain and attending physician both supported the practice to smudge. In addition to
demonstrating a shift in attitude, one could argue that some Western professionals, including
healthcare practitioners, have become allies for Indigenous healers and clients/patients,
through supporting, sometimes demanding, the right to practice Indigenous healing in
mainstream spaces. In reflecting on why this shift has begun to occur, TT4 shared, “I think
more and more these institutions are starting to understand why we need to do this” (TT4
p.28), this being reconnecting Indigenous individuals with their culture through the practice
of Indigenous spirituality and culture.

Practices integratively, but issues remain. When asked to reflect on whether he
believes Indigenous and Western paradigms of health and healing can be integrated, TT4
shared that he does not have a problem with the conjoint use of each approach, but stated that
Indigenous practitioners will have to shift their practice as well:

I have no problem with it. It’s just that you’re working in a different
environment because the medicines will go anywhere. The medicines will work
anywhere, and it’s just you being able to work in a different kind of
environment. Instead of working outside in a sweat, in a lodge, you’re working
inside of an institution now (TT4 p.34).
TT4 shared some examples of how he currently collaborates and practices integration, which includes performing ceremonies in Western spaces (hospitals, prisons), such as conducting a pipe ceremony for a patient or providing a traditional opening for a prayer room in a hospital, and working closely with other groups of professionals to lobby for client/patient rights:

So we began working with this (name of group), and we know a lot of the people there because we’ve worked with a lot of these Chaplains over the years […] And we know who the Chaplains usually are. So if someone calls us up and wants to do a pipe ceremony, then we can arrange it right away (TT4 p.25).

While TT4 believes that integrated practice is occurring, he shared that successfully practiced integration will most likely occur when strong respectful relationships have been established between Indigenous and Western practitioners:

I think it [integration] is happening in a lot of places where there is a good relationship between the Western and the traditional people and they have a good respect for each other. I think it all stems from respect. Respect is the first Grandfather/Grandmother teaching that we all have to be mindful of and if we don’t have that, it’s not going to work (TT4 p.29).

As has been discussed by many of the Elders in this study, one of the primary obstacles to practicing integratively is the absence of respectful working relationships and an understanding of Indigenous healing practices. TT4 identified some additional obstacles and issues to integration which included budgetary costs (such as funding for the cost of medicines and remuneration for Elders), differences in knowledge systems (intellectual versus spirit logic), and the acceptance of Indigenous knowledge and healing as a valid and
legitimate entity. One strategy that TT4 identified to address these issues is increases in education and training for Western trained professionals.

Need for education. While TT4 believed that some shifting of attitudes and practices has occurred, full-scale acceptance of Indigenous ways has not taken place and professionals continue to display resistance or attempt to prohibit the practice of Indigenous medicine. TT4 identified the need for more education for Western professionals to demystify Indigenous practices and create a space for open dialogue and communication. He shared that Indigenous healers and Elders are often not afforded the amount of respect that they would otherwise garner from their community, and additional education related to protocols for working with traditional people is also needed:

I know that when our people, our healers, are say going into a hospital, people should be knowledgeable about who this person is […] but sometimes they don’t get the respect accorded to what the knowledge system that they’re bringing in can help this person or this patient. And that’s because people don’t legitimize our ways of doing things because they don’t know. And the only way we’re going to educate them into our ways of indigenizing the institutions is to come in and teach them. Like we have to open up that kind of conversation, communication with them, and I think that’s something that we need to do. We need to do it better, we need to do it better (TT4 p.31).

While educational sessions are currently provided by some institutions, TT4 believed that this could be done in a more effective way. It would be interesting to examine how many educational programs involve Elders or traditional people, versus administrative individuals or academics facilitating the teaching and training. TT4’s hope is that by providing more
education and training, greater understanding, respect, and acceptance of Indigenous ways will occur. The need for more education and training was a recommendation that was cited by several of the Elders in this study, including the final participant to be reviewed.

**Participant Five**

**Character sketch.** Participant Five chose the identifier “Traditional Healer 5” (TH5) as her preferred pseudonym. When discussing possible participants with a community informant, TH5 was suggested as an Elder who practices traditional medicine who has worked extensively in integrated contexts. I had met TH5 briefly in the past, but did not have a well-defined personal relationship with her. I emailed TH5 sharing that she had been recommended to me by a community informant, and provided a brief description of my research topic and asked that she re-contact me if she had any interest in participating. TH5 responded and shared that she thought my research topic was very important and interesting and said that she was willing to sit for an interview. TH5 and I completed a first interview together, but have not had the opportunity to date to schedule a second interview. However, TH5’s story map and corresponding core message and themes were sent to her over email for her review.

**First interview.** TH5 and I met for dinner before conducting our scheduled interview to get to know one another better. Since I had a standing relationship with most of my other participants, I found sharing a meal with TH5 to be helpful in establishing rapport and building trust between one another. Since TH5 does not currently live in the same city as I do, we held our interview in the room of the hotel that she was currently spending the week in while working in the city. I began the interview by reviewing the informed consent form orally and in writing. Once TH5 provided consent, I presented her with a bundled gift of
medicine (sage, sweetgrass, cedar, and tobacco) and presented the (research) question I was seeking knowledge for. TH5 accepted this gift and said that she had a lot of knowledge to share related to the topic. We reviewed my interview questions together orally before turning on the audio recorder. TH5 thoughtfully answered each interview question, often checking in with me to ensure that she had answered adequately. Most of TH5’s responses were personal perspectives and experiences related to the subject matter, with some uses of humour. The interview lasted 90 minutes in length.

The initial story map (see Figure 10) was constructed during the analysis phase of the initial interview, and a core message and three corresponding themes emerged from this interview. Since TH5 and I currently reside in different cities, we decided that the story map, core message, and themes should be emailed to TH5 for her review, and any feedback or revisions would be emailed back to me. At this time I have not received any additional feedback from TH5 and the story map depicted in Figure 10 is considered the final version of her story map.

**Finale core message and themes.** The final core message for TH5 is lack of understanding/respect for Indigenous ways. The three themes are: holistic health, diverse healthcare systems, need for education.

**Lack of understanding/respect for Indigenous ways.** TH5 spoke at multiple points throughout her interview about the lack of understanding and respect for Indigenous medicine and healers that the Western healthcare system commonly demonstrates. TH5 noted that she is comfortable with acknowledging and recognizing the strengths of the Western healthcare system, and also makes referrals to Western practitioners if it is appropriate for her clients. However, she feels that the majority of Western healthcare practitioners are
### Figure 10: Final Story Map: Traditional Healer 5

<table>
<thead>
<tr>
<th>Past Experiences</th>
<th>Present Experiences</th>
<th>Future Intentions</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self as Elder / TH</strong></td>
<td><strong>Indigenous Culture &amp; Medicine</strong></td>
<td><strong>Western Medicine</strong></td>
<td><strong>Integration</strong></td>
</tr>
<tr>
<td>- Interest in knowledge</td>
<td>- Indigenous epistemology (on spiritual journey)</td>
<td>- Does not respect/understand Indigenous medicines or practices (e.g. Most practitioners do not know what a healer does)</td>
<td>- Has worked in different integrated contexts</td>
</tr>
<tr>
<td>- Mentored and taught by many (family, Elders, medicine people)</td>
<td>- Holistic health (physical, emotional, spiritual, mental)</td>
<td>- Does not show interest in learning about Indigenous medicine/ways</td>
<td>- Has experienced effective and successful integrated working relationships</td>
</tr>
<tr>
<td>- Differentiated from others</td>
<td>- Effectiveness of Indigenous Medicine</td>
<td>- Absence of holistic perspective</td>
<td>- Has experienced ineffective integrated working relationships where she was viewed as threatening</td>
</tr>
<tr>
<td>- Received gifts (dreams, communicating with spirits, healing hands)</td>
<td>- Medicines and methods of healing (e.g. tracking back; spirit guides; ceremony; medicines; healers)</td>
<td>- Emphasis is on expediency (focus on trying to fix problem, not examine root causes of problem)</td>
<td><strong>[On the Idea]</strong></td>
</tr>
<tr>
<td>- Strong support system (family, teachers, spirits)</td>
<td>- Diversity of healers and methods</td>
<td>- Medical system structured so individuals become reliant on it for health and healing needs</td>
<td>- Can work together – each type of medicine has its strengths</td>
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<tr>
<td>- Critical life events</td>
<td></td>
<td></td>
<td>- Choice to access diverse systems must remain (individuals of different belief systems will access the corresponding medicine system)</td>
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<tr>
<td>- Healing journey (overcoming self-doubts)</td>
<td></td>
<td></td>
<td><strong>[On the Rationale]</strong></td>
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<tr>
<td>- Assembled bundle / Learned traditions (e.g. listened to the Elders; developed gifts)</td>
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<td></td>
<td>- Provide different treatment options to individuals</td>
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<tr>
<td>- Employment (healing centre)</td>
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<td><strong>[How will it occur?]</strong></td>
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<td></td>
<td></td>
<td></td>
<td>- Respectful working relationships</td>
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<td>- Education and training for Western practitioners</td>
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<td>- Streamlined referral systems</td>
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<td></td>
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<td></td>
<td><strong>[Examples and Experiences of Integration]</strong></td>
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<td></td>
<td></td>
<td>- Teaching Western professionals/practitioners</td>
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<td>- Integrated place of employment</td>
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<td></td>
<td></td>
<td>- Have experienced effective and successful integrated working relationships</td>
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<td>- Have experienced ineffective integrated working relationships where she was viewed as threatening</td>
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<td></td>
<td></td>
<td><strong>[Issues to be addressed/Steps to be taken]</strong></td>
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<td>- Differences in notions of health</td>
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<td>- Credential recognition and training differences</td>
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<td>- Diverse treatment approaches</td>
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<td>- Remuneration for Elders and healers</td>
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<td>- Education/training for Western practitioners</td>
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<td></td>
<td></td>
<td>- Empirically validate practices (both Indigenous and Western)</td>
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<td>- Respect demonstrated by Western professionals for Indigenous medicine</td>
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</table>

**Present Experiences**
- Employment (healing centre)
- Healing work (throughout North America; visiting communities)
- Provide teaching and training for Western practitioners
- Common practice to make referrals to Western practitioners if needed or appropriate
- Need for evaluation of healers
- Effectiveness of Indigenous Medicine
- Has its place and strengths (e.g. mending bones)
- Has its limits (e.g. cannot heal all)
- Does not respect/understand Indigenous medicines or practices
- Does not show interest in learning about Indigenous medicine/ways
- Absence of holistic perspective
- Emphasis is on expediency
- Continues to support individuals’ reliance on medical system (e.g. rely on practitioners to fix problem instead of making changes in lifestyle)

**Future Intentions**
- Encourage communities to recognize credentials and value of healers/Elders
- Encourage communities to evaluate different practitioners (both Western and Indigenous) to ensure that they are receiving adequate service
- Individuals need to become more self-reliant and attuned with themselves concerning their health and healing needs (e.g. identify and describe pain in stomach)

**Integration**
- [Idea; Forms; Experiences with]
unable to identify or even describe the work of Indigenous Elders and healers, and fail to recognize the strengths and effectiveness of Indigenous practices:

For me as healer, I acknowledge what the Western world does. I acknowledge that a doctor can fix a broken bone, I acknowledge that they can do surgery and they can fix whatever, if something’s wrong with your heart, brain tumours, whatever. So I know about those things. But the struggle I find is that that world don’t know about our world, and so they don’t have a lot of understanding about how what I do is different than what they do, but it can be just as valuable because I’ve helped people that they couldn’t help, that the doctors couldn’t help (TH5 p.6).

TH5 discussed how part of the reason for why Western practitioners fail to see the value in the work of healers is that they do not respect Indigenous knowledge systems and are not required to familiarize themselves with them in formal educational or professional settings. TH5 shared her experience of attempting to teach Western medical professionals about her peoples’ traditional practices for handling deceased bodies, and how Indigenous knowledge has not only been disregarded by individual practitioners, but by the political and structural systems in Canada and the United States:

So when Western physicians, or whatever, you know the ones who are filling up these bodies with formaldehyde and all of that, when they do this, and I know Canada made it a law, or at least in Ontario, that you have to get embalmed, that was against our beliefs, because you’re supposed to put that body back in the ground the same way you got it. And so explaining this to a doctor or a coroner, or whatever you want to call them, they had a hard time
with that. And that’s what I mean, it’s the respect of the spiritual knowledge of Indigenous people that isn’t happening. And to me, it’s because they don’t have to respect it. They’re not going to be tested, they’re not going to fail if they don’t get it, it’s just kind of like a bonus; okay if you understand this part, great. But there’s no discipline to them if they don’t get it or if they don’t follow it. And I find that it’s that same way all over this country and in the United States – Indigenous people, we have knowledge, we have laws that have been given to us, and it’s not being valued or acknowledged or there’s no discipline for not listening to it (TH5 p.12).

Oftentimes the issue of understanding or being wary of Indigenous knowledge and practices has more to do with a lack of education or understanding. However, it is when knowledge and information is shared but continues to be disregarded, or when invitations to share knowledge are extended yet refused, that many Indigenous Elders and healers feel that they themselves, along with their belief systems and practices, are being disrespected:

So all peoples have gifts to offer, knowledge to offer, and that’s where I find that they’re not coming and asking. And even though we try to offer it, it’s still not valued, to the point of putting it into the mandatory educational setting. It’s almost like they don’t want to acknowledge any wisdom or knowledge that Indigenous people have because a lot of it is deep (TH5 p.14).

As noted in this quotation, TH5 feels that one way to address the lack of understanding and disrespect is to formally integrate and expose Western practitioners to an Indigenous paradigm of health and healing through formal education.
Holistic health. TH5 described Indigenous health as being comprised of four elements (mental, emotional, physical, spiritual) with no one dimension being greater than the other. She contrasted this understanding of health to a more fractured conceptualization of health that is commonly employed in Western healthcare settings:

I know in the Western world they separate and categorize. Like for instance the mental well-being. So if you go to a doctor and say for instance you have a stomach problem, that’s all they look at, and they don’t look at, okay why are you eating this way, where did that come from? Did it come from your mother, did she raise you to eat this way, or is it something you’re going through? So they don’t delve deeper into the mental, emotional, spiritual, and finally the physical of how that happened (TH5 p.6).

What is evident from this quotation is that not only is health conceptualized holistically, but when health problems do develop, they are explored in line with these four dimensions of self and treated holistically. TH5 discussed how she personally practices from this perspective:

So I’m somebody who knows that everything that happens to us physically, just about everything, I mean there’s the odd accident and things like that, but just about everything that happens to us physically comes from something that happened to us in our lives that was scary or hurtful or traumatic […] So when I work with people, that’s the way I work with people. It’s more of a okay, we got to back up, and that takes time. And then to actually get to the physical part of fixing somebody, if you just fix them and you don’t go to the root of it, it’s
like snipping a dandelion; it’s going to come back. And so you got to get to the root of why they began this pattern of behaviour (TH5 p.6).

TH5 also shared that while the healing intervention employed will obviously differ depending on the gifts and abilities of the healer who is doctoring, it is standard practice for healers to holistically examine and then treat health problems:

All of us healers do something different. Some just strictly do doctoring and herbal medicine, but then there are some who just do mostly counselling and that kind of stuff. But you know, overall, most healers do it all, they do the whole, they go from the body to the mind to the emotional to the spiritual (TH5 p.14).

One can therefore see how a holistic understanding of health is used from health problem conceptualization to treatment design and then healing implementation.

**Diverse healthcare systems.** When asked to share her thoughts on the idea of integrating Indigenous and Western approaches together, one theme which emerged out of TH5’s comments are that diverse health systems (Western, Indigenous, and others) must remain in order to service individuals of varying belief systems. For instance, while some Indigenous peoples seek to have their health examined holistically and are open to using traditional methods, others either prefer to address singular health issues in isolation, or are sceptical of Indigenous approaches and healers. As TH5 stated, “So in a way you kind of need both unless you can change all the people in the world, beliefs, and their understanding about life and their perception about life, unless you can change all that you’re going to need both” (TH5 p.9). However, TH5 was also supportive of the idea of collaborating with
Western healthcare professionals and discussed the use of a referral system between the two as a promising form of collaborative work:

I think that they should keep trying to work together because for one thing, it’s like what I was saying earlier, that if the mentality of a person is that okay, if I get an illness or if something happens to me and the doctor wants to see me for 10-15 minutes and give me a pill, I don’t want that. It’s like they know as human beings, we know that there is something more to why we are depressed, why we are getting sick in our stomach [...] And those ones who are aware of there’s something deeper and they want to look at an alternative way of dealing with their problem, other than what the doctor or psychiatrist or psychologist has to offer, they want to look deeper at it, when you come across people like that, to me that’s when that’s an opportune time to have a healer there, because that’s what healers are meant to do. They’re meant to look at those four aspects of somebody and bring it into their spiritual part and help that person to sort those things out (TH5 p.11).

The role of the individual’s belief system is once again noted as an important determinant for which type of healing approach may be accessed, and TH5 identified those who are looking to holistically examine the root cause of a problem as ideal candidates for referral. However, TH5 shared that Western practitioners are often unsure of when to make a referral, which is why there is a need for more education and training at this point in time.

**Need for education.** TH5 spoke all throughout her interview about the need for more education and training for Western healthcare professionals. She cited a lack of knowledge as one reason for disrespectful practice by Western professionals, and strongly supported the
idea of developing curriculum on diverse approaches to healing for individuals training in Western institutions:

I think that somewhere in the education system of doctors, nurses, all these Western practitioners, if they plan to work in a more holistic setting, that somebody, somewhere, they need to be educated. These institutions should be bringing in traditional healers or Elders and giving them an understanding of the value of them […] Why can I explain what a nurse does, what a doctor does, all of that? Because of education. But why can doctors and nurses, or psychologists and psychiatrists, not explain what a traditional healer does? It has to do with education or training (TH5 p.12-13).

In addition to formalized education, TH5 identified the need to provide individual healers and Elders who are working in mainstream spaces the opportunity to provide a presentation or workshop on their methods to the other professionals they will be working with:

So the best way that Elders and healers can be more, I guess, most supported and effective even is when they bring a healer in, they need to set aside a day that that healer can do a presentation or whatever, a teaching, to all of them who is going to work with people, the clients, and explain to them what they do, how they do it, or the best they can about how they do it, and who can they recommend to them or something along those lines (TH5 p.15).

TH5 stated that this is standard practice in one of the healthcare settings that she has worked in which operates from an integrated stance:

We would have an orientation day where they’d say okay you’re going to talk about you and we got some new chiropractic students and we have a new nurse
joining us, and so it was up to us to educate them as to what we do and who they could recommend […] Or even if they wanted to come and see us, what we do and what’s the protocol? Why do you bring tobacco, and all of that (TH5 p.15).

TH5’s comments suggest that both the Indigenous and Western practitioners are equally responsible for making sure that they understand each others’ type of work, and that they are open to teaching and answering questions about their work. Respect for each other is at the core of this type of collaboration, and respectful working relationships were identified as foundational to successful practice across different healing systems.

Summary of Chapter Four

The within participant analysis was presented in Chapter Four for the five participants interviewed in this study. Participants shared perspectives and narratives about themselves as Elders or traditional people, Indigenous culture and healing, the Western healthcare system, and the possibility of integrating Indigenous and Western approaches to health and healing. Information about each participant was conveyed through a character sketch, along with a description of the first and second interviews. Initial and final story maps, core messages, and themes were detailed, along with a discussion of each message and theme. Chapter Five will contain my presentation of across participant results and analyses.
Chapter Five: Discussion of Across Participant Results and Analyses

In Chapter Five I present a discussion of the across participant results, highlighting similarities and divergences in opinion and experience as related to the overarching research question being answered in this study: What are Indigenous Elders perspectives on the integration of Indigenous and Western healing paradigms, and what, if any, are their experiences of working in integrated contexts? Across participant results will be examined in the six following areas: Perspectives on integration; rationale for integration; conceptual underpinnings of integration; expressions and experiences with integration; challenges and issues to be addressed; and recommendations from the Elders. Across participant results and analyses will also be contrasted and compared to current theories and literature where relevant, and the chapter will be concluded with a summary.

The term “Elders” is used to describe the five participants as a whole. While each participant has selected their own preferred pseudonym to be used when discussing their individual results, each participant has also been recognized as an Elder or Knowledge Keeper (a term connoting similar stature and level of knowledge as an Elder) by their communities, which is why I have selected the term Elders to refer to the five participants. As was noted in the Results section, the terms “Indigenous medicine” and “Western medicine” were used by most of the Elders as a shorthand to describe Indigenous health and healing systems and Western health and treatment systems, and the term “medicine” encapsulates elements of each healthcare system, including theories of medicine, healing or treatment approaches and interventions, and the respective practitioners of each type of approach. As well, the Elders discussed how integrative efforts may be practiced in the
various Western healthcare systems, given their holistic understanding of health, despite the initial focus of this thesis being solely on the Western mental health sector.

**Perspectives on Integration**

All five Elders believed that there is the potential for some form of collaborative or integrated practice between Indigenous and Western health and healing paradigms to take place. However, the Elders reported a diverse number of perspectives and experiences with integrated practice, and each Elder defined integration differently. For instance, while Elder 1 and Traditional Teacher 4 expressed support for attempts to integrate practices today, and shared several examples of how they themselves have practiced it, Witness 2 shared her belief that individuals and organizations have rushed into merging the two approaches together. As was identified in her core message, Witness 2 feels that Indigenous peoples must first reclaim their knowledge prior to collaborating with the Western healthcare system so that each system is equipped with equal amounts of knowledge and no abuses of power occur:

> I don’t think that with two completely different transmission systems like that that it can work right now. Unless we have the time, the space, and the opportunity, and the finances, to reclaim all of our knowledge. Not just the bits about tobacco and sweetgrass and cedar, you know what I’m saying? I mean the science, the whole system. And then once that’s done, once our people then have access to our knowledge, then all of us together can talk about, now how does this fit with Western knowledge (W2 p.5).

While Elder 3 commented that she would be open to practicing Indigenous healing in Western spaces, “Like I would go to (name of hospital) if I could smudge and all that” (E3b
p.3), she tends to not presently work in mainstream spaces as Indigenous knowledge and healing practices, in her experience, are prohibited and disrespected. She also expressed, along with Traditional Teacher 4 and Traditional Healer 5, the belief that diverse healthcare systems must remain in order to service individuals of different belief systems or those who do not wish to heal in an Indigenous informed manner: “let’s say cancer, okay, it is your choice whether you want to choose the dominant culture way or our traditional way” (E3b p.1). Several of the Elders commented that many Indigenous people are disconnected from traditional knowledge systems and sometimes express scepticism or disinterest in Indigenous ways, “unity is our biggest problem facing us today, unity, number one I think across the board. A lot of our own people don’t even believe in the traditional Indigenous knowledge systems” (TT4 p.29). The significance that is afforded to Indigenous culture, Indigenous identity, and methods of healing will obviously differ across individuals, and it is important to not assume that every Indigenous person will want to access traditional methods when addressing health problems. It is for this reason that three of the five Elders indicated that it is important to not pressure an individual into one form or way of healing, and that if interest is expressed in Indigenous methods, that those systems then be made accessible through referrals to healers or integrated programs in existence:

A lot of our own people don’t even believe in the traditional Indigenous knowledge systems, and that’s fine, that’s okay. We allow freedom of choice, and (name of person) and I always explain this, none of this is forced on anybody. You have a choice, you don’t have to do this if you don’t want to do this. If you do choose to do this, good, we’ll explain what we’re doing (TT4 p.29).
The overarching message that was expressed by the Elders is that while Indigenous and Western approaches to healing may be successfully practiced at some point in time, it is important to not assume what a client’s treatment preferences will be based solely on cultural background. Instead, an array of options for treatment must continue to be presented to meet individual peoples’ healing needs, which ultimately may or may not be an integrated form of treatment.

Rationale for Integration

In discussing motivations or a rationale for the integration of Indigenous and Western paradigms, Traditional Teacher 4 shared his belief that strengths exist in both Indigenous and Western approaches and that utilizing the advantageous aspects of each system can potentially deliver more powerful healing for his people. Traditional Teacher 4 illustrated how he personally practices a form of integration by smudging his insulin:

When I get my insulin, like I’m diabetic, when I get my insulin I smudge it because I know I’m going to be injecting it into me to help breakdown those sugars and carbohydrates. So I mean I accept that we walk in both worlds so it makes sense that we should be taking the best from the Western world and using the best from our world and bringing them together to help ourselves so that we can go out there and help others (TT4 p.31).

Traditional Teacher 4 highlighted the fact that many Indigenous peoples perceive themselves as walking in two worlds, which oftentimes entails the use of dual medical systems for health and healing needs.

All five of the Elders spoke throughout their interviews about the critical role that Indigenous culture (plant medicines, community, cultural identity, traditional diet, ceremony,
Elders and healers, spirituality, etcetera) plays in fostering and maintaining health and providing healing for health problems, which has been well documented in the literature (e.g. McCabe, 2007; Garrett & Wilbur, 1999; Kirmayer et al., 2003; LaFromboise, 1988; Poonwassie & Charter, 2005; Vicary & Bishop, 2005). However, Elder 1 and Traditional Teacher 4 cited spirituality as particularly vital to healing. Traditional Teacher 4 shared a teaching that he received from one of his mentors who used the term “spiritual pastoral care” to describe the essential nature of spiritual practice for many Indigenous peoples. In discussing how purification ceremonies (such as smudging) are often a primary aspect of spiritual pastoral care, Traditional Teacher 4 also outlined why the practice of smudging should ideally be made available in Western healthcare settings:

And I remember him saying that our spiritual and personal care requires that we smudge and it’s part of our belief system, it’s part of our protocol, that we do this to let go of all of the burdens of life, the distractions, because now we will be going into surgery and we want to have a good mind and good faith that everything is going to work out. So it became important, especially in a setting like that, that smudging be made available (TT4 p.25).

Several authors and researchers have also identified the importance of Indigenous spirituality in health and healing (e.g. Duran, 2006; Garrett & Wilbur, 1999; McCormick, 2005). One study conducted by McCabe (2007) resulted in his eight research participants identifying several elements of Indigenous spirituality (e.g. understanding inner and unknown experience; the sacred teachings; ceremonies and rituals; belief in a healing spirit) as core conditions for successful healing work. With respect to the idea of integration, Elder 1 and
Traditional Teacher 4 cited the need to practice spirituality as a rationale for integrated practice:

I think more and more these institutions are starting to understand why we need to do this. If we go in there with the right attitude and sharing that this is how our people will become culturally acclimated to finding your spirit, and that’s basically what we want. We want to be able to connect with your own spirit and we can do that, if you can help them, accommodate that to do that, then that’s what you should be doing, and we’re here to tell you that’s one way to do it. So let’s do it, let’s do it together (TT4 p.28).

In describing the goal of much healing work as re-establishing an individual’s connection with their culture and spirituality (through the use of Elders, ceremony, medicines, etcetera), Elder 1 and Traditional Teacher 4 expressed that these spiritual practices should be made available to Indigenous peoples who are doing healing work in Western spaces.

Related to the importance of making spirituality available to Indigenous clients is the need to provide holistic forms of treatment to Indigenous individuals who are looking to explore the interrelationships between dimensions of health (physical, emotional, mental, and spiritual). Given that the Elders in this study tended to discuss all four aspects of well-being in relation to health and healing (despite the initial focus of this thesis on mental health needs), and often commented on the healthcare practices of many different Western-trained healthcare professionals and organizations, one suggestion for integrated care is to not solely focus on how one element of well-being can be integrated with Indigenous practices (e.g. mental health and Indigenous healing), but how a movement towards multidisciplinary treatment and care can be organized and implemented. Traditional Healer 5 raised this as a
point of discussion in suggesting that efforts need to be focused on developing streamlined referral systems between Western and Indigenous practitioners for individuals who are looking to examine their health holistically. I would go one step further in suggesting that emphasis should perhaps be placed on assembling circles of care (or treatment teams made up of diverse healthcare professionals such as psychologists, doctors, nutritionists, Indigenous healers) for patients/clients who are seeking to access both healthcare systems or who wish to examine their health holistically. Referral systems and multidisciplinary team approaches to client care represent two potential expressions of integrated practice, yet the foundational elements for building such relationships must first be identified before any attempts at organizing such multidisciplinary networks of care can occur.

**Conceptual Underpinnings to Integration**

All five Elders identified some foundational underpinnings that would need to be in place in order for successful working relationships to develop between Indigenous and Western parties. First, recognition of the strengths and limitations of each approach would need to occur by both Indigenous and Western practitioners. While four of the five Elders identified several strengths of the Western healthcare system, all five Elders shared their felt experience of the Western system’s failure to recognize the effectiveness of Indigenous ways. This lack of acknowledgement continues to occur despite a growing body of research which has demonstrated the efficacy of Indigenous approaches to healing (e.g. Goudreau et al., 2008; Heilbron & Guttman, 2000; Wagemakers Schiff & Moore, 2006), something which the Western healthcare system often insists on, despite the historical legacy of Indigenous healing systems and personal testaments to the efficacy of Indigenous approaches. All five Elders provided several examples of successful healing outcomes, for a diverse number of
health problems, through the use of Indigenous practices, and discussed achieving success
with ailments that the Western healthcare system failed to remedy:

When it came to, for instance, degenerative disorder, or whatever that’s called,
where the discs start to deteriorate, they couldn’t operate on him because it was
in too much of a sensitive area with the nerves. And I did doctoring on them
and they were without pain; it had stopped, like what the doctor said was going
to happen, it stopped and they were okay (TH5 p.6).

Three of the five Elders discussed the Western system’s treatment limitations when
addressing certain health problems (such as specific types of cancer), and how the system
often turns away or abandons their patients if they have exercised all of their resources,
“We’ve had many occasions where Western medicine, where doctors have said, ‘Well we’ve
done all we can for this person.’ The way they say it is ‘It’s up to them now’” (E1 p.9). At
the same time, a growing shift in attitude and an openness to Indigenous methods has been
demonstrated by some professionals, including clergy and religious figures working in prison
systems:

I went to (name of detention centre). The guy came right to me, right next door
to my wife’s apartment on (name of street) there. We had a Chaplain who was
telling me that there’s things that he as a Chaplain, realizes that his message
isn’t the right message for many of the Aboriginal men who were in the jails.

And if you would come, we’d pray you come (E1 p. 15).

Elder 1 continued to describe how this Chaplain’s request for services resulted in a powerful
healing experience for the Aboriginal male inmates who participated in the weekly healing
circle that Elder 1 facilitated. What was unique to this collaborative encounter was that in
addition to the Chaplain’s recognition of the strengths of Elder 1’s approach, and the limitations of his own, he also exhibited an acceptance of another worldview, epistemology, and method for healing.

All five Elders repeatedly discussed the lack of understanding, respect for, and acceptance of Indigenous knowledge and approaches to healing by the Western healthcare system. According to the Elders, in order for any type of collaborative work to occur, full-scale acceptance of one another’s approach must take place. In recounting a conversation with a Western healthcare professional about how Indigenous and Western practitioners can work together, Witness 2 described how a belief in the potential power of each approach is crucial if symbiotic work is to occur:

He says okay I get it, I get it, so I have to shift. And I said what you have to do is face that both medical approaches require beliefs that have no foundation. In order for me to go to a Western doctor I have to believe that pills are appropriate, and so I go and I know that he’s going to prescribe me pills (W2 p.30).

The requirement for unconditional acceptance of diverse understandings and approaches most closely resembles Duran’s (2006) notion of epistemological hybridism, which is the idea that two or more ways of knowing can co-exist harmoniously. As was discussed in the review of the literature, the practice of epistemological hybridism does away with the idea of attempting to prove or demonstrate the legitimacy of experience through various methods (often Western empirical processes) and recognizes knowledge or experiences as valid merely because they represent the real life world of another. All five Elders identified the ability to practice epistemological hybridism as a structural requirement for collaborative or
integrative endeavours. Furthermore, several of the Elders associated acceptance of Indigenous ways as a form of respect, which was the third foundational element for successful working relationships. Without a receptivity and regard for Indigenous knowledge systems and Indigenous practices and practitioners, collaborative work is not possible. This notion has direct implications for policy and legislation, as acceptance and respect for Indigenous approaches would see organizational or structural changes in creating space for the practice of Indigenous methods, and adherence to the lawful rights of Indigenous peoples to practice their spiritual belief systems. As has been noted above, the prohibition of Indigenous ceremony (e.g. smudging) in Western spaces is often interpreted as a sign of disrespect by certain Elders, and a form of racism by other Elders in this study.

Two Elders spoke metaphorically about the conceptual underpinnings for integration. For instance, Witness 2 used the analogy of woven baskets to describe how an Indigenous approach and a Western approach could be blended together, while speaking about the need to reclaim Indigenous knowledge: “It’s like my basket’s nearly empty, their basket’s full. And we’re going to bring them together? That means that their basket is going to be on top of our basket, as opposed to woven together” (W2 p.11). Witness 2 conceptualized possible integration, or what she referred to as a concatenation of theories, as consisting of knowledge systems which are equal in depth and strength and that are meticulously or strategically fused together to create a new entity. Traditional Teacher 4, in sharing a historical teaching about a constitutional document which is referred to as The Great Law, described how Indigenous and European peoples were able to come together to collaborate in translating this Indigenous constitution into English:
He said I’ll do that on the condition that you learn the Onondaga language. So Goldweiser had some work to do. It took him eight years but he learned it. He came back to Six Nations, he knocked on (name of person)’s door and he spoke to him in Onondaga…So he started talking, laughing and joking like old friends right? And he says well, you kept your end of the promise, your side, I guess I should keep mine. So over the course of time they proceeded to translate […] they would have these areas in the recitation of the Great Law that they could not find a good translation that reflected accurately what they wanted to say. So Goldweiser, it took him two years, taught them German, taught them high German. So they all learned how to speak German. So when they came to these areas of translation problems, they would include German mode, and they were able to come to words that would satisfy everybody. So that’s how they got over those rough areas (TT4 p.11).

In this teaching, Traditional Teacher 4 outlined some of the challenges and the type of commitment that is required by both collaborating parties to ensure a successful outcome is achieved. While the European individual in this story was required to learn an Indigenous language, difficulties still arose in the translation process. It was with the introduction of a third language (German), an alternative method for thinking and communicating, that challenges were overcome. In thinking about the endeavour to blend Indigenous and Western approaches together, it might be expected that as challenges arise, innovative means and new forms of relating and communicating will have to be identified, as new land is charted between Indigenous and Western worlds.
Expressions and Experiences with Integration

All five Elders indicated that they had at one point in time practiced collaborative or integrative work with either Western healthcare practitioners or organizations/institutions. However, four of the five Elders also described poor or unsuccessful attempts at integration. Before describing the successful experiences and various expressions or levels of integration discussed by the Elders, two examples of unsuccessful attempts to practice alongside Western circles are reviewed.

Unsuccessful or poor experiences with attempted integration included prohibiting or attempting to prohibit the performance of ceremony or use of Indigenous medicines in Western spaces, and the maltreatment of Indigenous healers by Western healthcare professionals. Traditional Teacher 4 shared an example of a patient requesting to have a purification ceremony performed, with the request for the smudging initially being refused:

I remember down here at (name of place), there was one lady, Ojibway lady from (name of place), her last wish was to be able to smudge in her room because she knew she was dying. And they said no, she’s got to go outside. The nurses said this, she has to go outside (TT4 p.27).

Traditional Teacher 4 stated that with the aid of the hospital’s Chaplain and the patient’s attending physician, the request to smudge was eventually approved. This type or level of integration, which was discussed in the review of the literature, is an example of attempting to introduce Indigenous healing methods without a paradigmatic aligning of approaches. It will remain to be seen whether the practice of Indigenous healing methods in the absence of an epistemologically hybrid stance is possible.
Traditional Healer 5 also described poor experiences with attempted integrative practice in describing the willingness of Western healthcare staff to collaborate with a traditional healer, “I’ve worked in places where a lot of the Western practitioners saw me as a threat or saw me as a waste of space” (TH5 p.15). This example raises the issue of individual practitioners’ level of readiness and enthusiasm to practice integratively, and along with that, poor attitudes or scepticism of the strengths and effectiveness of Indigenous approaches, which has been discussed by other researchers and authors (Crowe-Salazar, 2007; LaFromboise, 1988; Waldram et al., 2007). As highlighted here, even though movement towards integrated practice may occur at an organizational or administrative level, challenges may persist at the individual practitioner level. Recommendations for how to address these challenges will be discussed in the upcoming section.

In the review of the literature, I described multiple levels or potential expressions of integrated practice, which included a paradigmatic aligning of approaches, the introduction of Indigenous healing methods and healers into Western spaces, the formation of collaborative working relationships between Indigenous and Western professionals for either the purposes of referral or building a treatment team of care, integrated programming, and organizations which have been established on the premise of an integrated approach to healthcare (e.g. Anishnawbe Health Toronto). All of these levels or expressions of integration were discussed by the Elders, oftentimes through the retelling of personal experiences of working in these diverse contexts and systems.

A paradigmatic aligning of Indigenous and Western approaches would entail an exploration and identification of shared and dissimilar understandings of the health, and healthcare systems, that are currently in place, followed by a revision and unification of
approaches into a coalesced paradigm and approach. Witness 2 identified the term concatenation as best representing her understanding of this endeavour:

I think it’s concatenate really, is probably a better word. I think it’s linked. I think the links need to be made. But the link is in the theory of each medicine. It has to come together in a different way (W2 p.16).

Concatenation here refers to a linking in the theory of each approach, which would then inform practice, and Witness 2 noted that the two systems must “come together” in a different way. In discussing one method for paradigmatic aligning, Duran (2006) advocated that Western mental health workers revisit the original meaning of psychotherapist (soul-healer) and psychopathology (soul suffering), and shift root metaphors from psychologizing to spiritualizing (p. 19). As has been well-established by the literature and the participants in this study, the role of spirituality for Indigenous peoples in health and healing cannot be overstated, but is one aspect, among many, that need to be addressed and discussed if an aligning or concatenation of Indigenous and Western systems is to occur.

Four of the five Elders described experiences with practicing Indigenous healing methods (specific ceremonies as facilitated by Elders and healers) in Western spaces. For instance, Elder 1 stated that he often receives phone calls from the hospital system to come in and provide healing for one of their patients:

So even now I get calls from the hospitals: ‘Sometimes they’re not… So could you?’ Okay. So I come, I come with my bundle of medicines. Some of them see me, they just see me come in and right away they start that healing, that healing process starts, when they see me come in. Whatever I say, or whatever I do, it’s all healing to them because it’s a transition time (E1 p.9).
This represented a successful form of integrated work for Elder 1, however, as has been noted above, other Elders have been mistreated or denied the opportunity to practice their medicines in hospital environments. One of the key differentiating factors with the example provided by Elder 1 is that the hospital demonstrated a willingness and acceptance of this approach in asking him to perform ceremony in its space. It would appear that the introduction and use of Indigenous methods in Western spaces may be successfully practiced as long as the foundational element of acceptance of Indigenous methods is in place.

Two of the Elders described forming collaborative relationships with individual Western healthcare professionals as a form of integrated practice. For instance, Traditional Healer 5 described how in one workplace setting, the Western healthcare staff were required to make appointments with the traditional healers to discuss the nature of their work and when it would be appropriate to make referrals:

> When a doctor, a nurse, any of them, I think the psychologist too, when they came on board to work at (name of Native organization) what they had to do was come make an appointment with a healer and find out what we do so then they can recommend people based on what they know (TH5 p.14).

Traditional Healer 5 identified the use of a referral system as a potentially powerful form of collaborative work that would be of great benefit to Indigenous clients.

Traditional Teacher 4 provided several examples of how he has collaborated with Western professionals. He described two instances of providing Indigenous medicines to Chaplains working in both the prison system and hospital systems so that Indigenous healing was possible for the inmates and patients: “We worked with the prison, the jail (name of jail), and we’ve done the same thing. Through their Chaplain we try to make smudging available
to the Native inmates. So we provide them with sweetgrass if we can get it” (TT4 p.25).

Traditional Teacher 4 also described a type of collaborative work not commonly discussed in the literature, which is working in partnership with Western professionals for the purposes of advocacy and policy development:

Well there’s this group that we belong to […] but it’s like a spiritual care advisory committee that works with all the churches, and it’s all the Chaplains again. And through them we’re able to get a lot of things, we’re able to move a lot of things on our agenda, try and get accommodation, but we couldn’t do it on our own. It just wouldn’t happen. So fortunately the Chaplains who approached us saw the validity and legitimacy of what we’re doing and they says hey, you’re on to something and we should be doing that (TT4 p.27).

Several key points of discussion are highlighted in this example of collaborative work. First, Traditional Teacher 4 stated that the Chaplains recognized the strengths of Indigenous approaches, which as discussed above, represents a foundational underpinning to the establishment of successful working relationships for the Elders in this study. Second, Traditional Teacher 4 commented that it is with the aid of this group of professionals that he and other traditional healers are able to advocate for the needs of Indigenous peoples, and without their support at this point in time, he questioned how successful their lobbying would be. The fact that Traditional Teacher 4 feels that his and other traditional healers’ attempts to create policy change would not be successful without the aid of this group of professionals is indicative of the current lack of respect and acceptance of Indigenous healing systems and its practitioners by larger society. However, this type of collaborative work was identified as a successful form of practice by Traditional Teacher 4, and also formed the basis of his belief
that changes in attitudes towards Indigenous healing systems are occurring, and that some Western professionals are regarded as allies for Indigenous peoples in supporting their healing needs today.

Elder 1 and Traditional Teacher 4 described running formal programs, both of which were group or circle based, and consisted of either an Indigenous healing circle being run in a Western space, or a healing circle which integrated both Indigenous and Western philosophies and approaches together. Elder 1 described some of the healing work that he has performed in the jail system and the positive outcomes for the inmates in this program:

And the first time I went in there, (name of detention centre), I had about five or six Aboriginal people come. And they were so glad for my medicines! I had my medicine bundle thing [motions to medicines laid out on floor], and it was probably a different bag, but I had everything out there, and I had my drum, I used to have a waterdrum, and I shared it. And they just liked my stuff so much! They listened and they listened, and I talked about the medicines (E1 p. 15).

In addition to noting the successes of this program for the inmates, Elder 1 communicated some of the comments he received from the prison staff who worked closely with the Aboriginal men that participated in the circle, “The jail guards and stuff like that, ‘That’s the best thing ever done, when you come here. The whole thing seems to go peaceful’” (E1p. 17). Given that all three parties (Elder, inmates, and guards) observed the successes of a program such as this being run in a Western space, more research designed to examine the successful implementation and the beneficial aspects of this type of programming are needed and represent a fertile area for future research.
One final expression of integration which was discussed by Traditional Healer 5 was her experience as a traditional healer at an agency which was based on an integrated approach to healthcare. Traditional Healer 5 referenced her experiences of working at this agency all throughout her interview and discussed the processes in place for educating Western healthcare staff about the work of traditional healers, how streamlined referrals between traditional healing and Western practitioners were established, and how Western and Indigenous practitioners worked together as part of a treatment team to consult and design treatment plans for clients:

I’ve had instances where if I was seeing a client that one of the Western doctors was seeing and he or she wanted to give me a heads up about this client, like ‘I’ve been seeing this client for four years, this is the medication they’ve been taking, this is what they’ve said is happened, da da da, but I’m thinking maybe this has happened. Do you think maybe you could see like go towards that direction and see whatever has happened?’ So I’ve had conversations with doctors and psychologists and psychiatrists, and all of that, where we actually make a team effort on somebody to best help them (TH5 p.15).

One similar treatment agency that was discussed in the review of the literature was the Knaw Chi Ge Win service located in Northern Ontario (see Maar et al., 2009). Similar to Traditional Healer 5’s comments and recommendations, education for Western healthcare professionals was identified as a key component to effective integrated practice and good working relationships between Indigenous and Western trained staff. The use of a referral system was also discussed by both the staff of the Knaw Chi Ge Win service and Traditional Healer 5, and may represent one of the primary expressions of integration currently in
practice today. As more agencies and organizations that specialize in integrated treatment grow in number, the need for research which examines how Indigenous and Western staff work together and negotiate challenges as they arise will be critical to enhancing the success of these programs.

Given the amount of experience with integrated practice that the five Elders in this study reported, and the growing demand for their services in Western spaces, one area of inquiry that was addressed was how these integrated and collaborative endeavours would occur or develop. Elder 1 shared his belief that it is Aboriginal people themselves who are going to be the force behind the movement to practice their spiritual needs in Western healing spaces: “Our people will bring them together. Our people. Aboriginal people in these care facilities, or whatever, they need to say, ‘Ah, you’re medicines don’t work. Give me my own medicines!’” (E1 p.11). Several of the Elders also identified that Western professionals were the ones who initially approached them to provide services, often after recognition of the limitations of their own approach. However, three of the five Elders discussed how Indigenous protocols are in place for establishing working relationships with Indigenous healers, and that while many Elders and healers are willing and available to work collaboratively, the establishment of relationships must be done in a respectful way:

We’re available, our healers are available, but they have to come to us and ask us in the right way. They have to respect us. They can’t just expect something to happen without there being some kind of respectful protocol of how we’re going to work together (TT4 p.33).

These protocols are often in place to facilitate the negotiation of a working contract, which all five Elders identified as a significant element of collaborative work:
If Dr. Smith wants to work with a healer then they have to find a healer to work with. And the very moment they find them, that person and him have to negotiate an arrangement, and that’s a contract (W2 p.31).

Shore, Shore, and Manson (2009) outlined the process by which Western mental health practitioners established working relationships with traditional healers when attempting to work integratively with American Indian war veterans. While the authors list the specific activities that the mental health practitioners participated in, the findings from this study indicate that the core component for successful relationships is an epistemologically hybrid stance, which entails an acceptance and respect for diverse knowledge and healing systems, a frankness in identifying the strengths and weaknesses in each approach, and a willingness to explore how the beneficial elements of each approach may be blended together. Processes for establishing relationships will obviously differ depending on the Elder’s or healer’s willingness to work collaboratively, and their specific protocols for relationship development. While the Elders in this study reported a great amount of success with integrated healing work to date, they also identified various challenges and issues with the concept and practice of Indigenous and Western integrated healthcare.

**Challenges to Integration**

All five Elders identified various challenges or issues which need to be addressed prior to the wide spread practice of integrated healthcare. Witness 2 highlighted some of the different areas which require attention in stating:

First there’s knowledge that has to be put in our basket, we have to put knowledge in our basket. The second thing is we have to quarrel about whose beliefs we’re going to start with or are we just going to accept each others
fundamental belief? And thirdly, what are some of the issues. So those steps have to be taken. I don’t think we’re going to be doing it in a big hurry (W2 p.11).

The various challenges listed have been grouped under the three following headings: Historical relationships, differences in epistemologies and treatment approaches, and differences in knowledge acquisition and training, and will be explored in the following paragraphs.

**Historical relationships.** Elder 3, who expressed the most reservations about the idea of integrated practice, cited historical events and the failure of the Canadian government and Canadian society to honour the original agreements made between Indigenous peoples and European settlers as an obstacle to forming relationships with the Western healthcare system today:

So we had the treaties, we have the encounters with the settlers, and we smoked our pipes with them, we made treaties with them, the two row wampum, and all that, but how many of them really respect that now? Do truly really believe in that? Because our people went in there with a respect, tobacco was given, but there was no understanding from the settlers in there. Now we don’t even have our rights. How can they heal when they disrespect another culture? (E3b p.2)

For Elder 3, the continued denial of Indigenous people’s rights as Nations, communities, and individuals is too large an injustice to ignore and does not provide a solid foundation from which to build new relationships with healthcare professionals today. This concern has informed Elder 3’s decision to not typically practice in Western spaces, and while she
remains open to the idea, a number of challenges must first be addressed prior to her practicing integratively.

**Differences in epistemology and treatment approach.** Differences in logic systems, conceptualizations of health, philosophies of treatment, and treatment interventions were cited as challenging areas requiring discussion by the Elders in this study. First, Witness 2 and Traditional Teacher 4 identified differences in logic systems as an area requiring attention. For instance, Witness 2 stated that much of Indigenous culture is based on spiritual logic, whereas Western culture is based on mathematical logic. In discussing the types of research endeavours of Western and Indigenous researchers, she stated:

So what’s the rules, that’s the thing. If we have to accept their logic, then they should have to accept ours. Ours is a spiritual logic and theirs is a mathematical logic. If they say well this is research because it’s going to make the pharmaceutical companies rich, I’ll accept that, but this is also research and it’s not going to make anybody rich, but it’s as valid. And we’re going to research, say shape shifting, or something. Yeah, we’re going to apply Einstein’s theory of relativity to shape shifting and see what we come up with. And it should be just as valid, but it’s not. So what’s the level of belief and validity that we need to have between us even to engage in the conversation? (W2 p.9)

The significance of differences in logic systems is that knowledge, its creation and dissemination, is informed by and investigated through different avenues or means. For instance, Witness 2 highlighted the fact that much of Western knowledge and research is accepted as valid because it is mathematical and quantifiable in nature. However, methods for researching spiritual knowledge are limited, and the idea of spiritual knowledge or
spiritual relations is often disregarded by Western modes of thinking as illegitimate and nonsensical. Dismissal of spiritual logic and knowledge poses a significant challenge to any attempts at integration, as it is a fundamental aspect of many Indigenous epistemologies and one of the four elements of well-being generally considered to be a factor for health and healing. As Traditional Healer 5 stated:

So that’s the problem I can see as a challenge, is I guess one, the Western practitioners aren’t knowledgeable enough about what traditional healing or spiritual healing or holistic, or whatever you want to call it, is and how it works and the value of it […] I think a lot of practitioners don’t understand what makes my work effective, more effective, because it goes into all of that, the spiritual aspect, the spiritual needs, mental, emotional, physical, all of that is combined (TH5 p.7).

A difference in conceptions of health represents a second area of divergence between much of Indigenous and Western thinking, and has been discussed by other researchers and authors in the literature (e.g. Crowe-Salazar, 2007; Gone, 2010). However, it is not only conceptualizations of health (segmented vs. holistic understandings) that are different, but how health problems themselves are understood (isolated issues vs. interconnected with other areas of health). Witness 2 provided an example of how psychological phenomena is understood and approached differently in discussing the processing of traumatic experiences:

We need to know how you reacted to that. You’re obviously traumatized but how did you react to it? What was the first thing that you did? Well lots of people jump out of their body. White society recognizes that happens, but they don’t recognize it as a phenomena. Now how that works is quite beyond me in
the same mind, but I’ve seen it. They’ll say, ‘If they did jump out of their body you have to get them to come back. Well they’re not actually out of their body, they just think that.’ But you just told me that person jumped out of her body, so actually you don’t believe it. Is that the deal? Me, I believe it, so I got to get this person back into their body. And so I’ll ask the person, so when you jump out of your body where do you actually go? And you know some of them float on the ceiling (W2 p.27).

Here one can see how the spiritual dimension is implicated and informs the processing of psychological trauma; if the person’s spirit is not within the body, the problem persists. In this example, the first step in healing work for Witness 2 is to restore the individual’s connection with the spirit and examine the emotional elements in conjunction with that. In Western psychological terms, this is often conceptualized as dissociation from the body, however, as Witness 2 pointed out, it is not commonly regarded as a disconnection from spirit, but instead, a shift in levels of consciousness. Such diverse views of health and health problems also have implications for how practitioners understand the goals of healing work.

Elder 1 described the focus of much Indigenous healing work as restoring the connection between the logical and spiritual aspects of being, “A lot of times there’s a disconnect here [motions to head] and there [motions to heart/spirit], and a lot of times I think that I’m that connection; that I restore that connection, along with this [motions to Indigenous medicines that have been laid on floor], and the language, the prayers, and the smiles” (E1 p.9). Elder 1 once again articulated the importance of interrelationship between different dimensions of health, and the diverse methods or medicines that are used to facilitate the healing process. Traditional Teacher 4 also identified the various levels of
healing that are related to community and the larger cosmos in citing one of his teachers,
“(Name of person) used to always say, first we heal as an individual, then we heal as family,
then we heal as community, we heal as clan, then we heal as Nations. And as Nations, when
we heal, it’s up to us to heal mother earth” (TT4 p.9). Several authors have identified the
importance of community with respect to individual healing (e.g. Kirmayer et al., 2003;
LaFromboise, 1988; McCormick, 1996; Stewart, 2008), but community level healing is
often an important area for focus as well, as interrelationships with other human beings,
Nations, and entities (e.g. earth) impacts well-being on an individual level. Differences in
understandings of the purpose of healing work also informs the philosophy and approach to
healing or treatment that is taken, and was identified as another area where dissimilarity often
exists between Indigenous and Western systems.

Witness 2 and Traditional Healer 5 shared their belief that the current Western
healthcare system has created a milieu of over-reliance and dependence in which individuals
rely on the system for all their healing needs. Witness 2 stated:

I mean on the one hand a medical plan is great because it allows people to get
attention when they need it, but what it did was make us completely reliant on
seeing a doctor. Consult your physician […] There’s lots of ways to heal
something and we have to take more responsibility for our wellness. If you’re
34 and you’re in good shape, how do you maintain that? (W2 p.16-17).

Related to the idea of reliance is the notion of assuming personal responsibility for health and
wellness, which Witness 2, Traditional Teacher 4, and Traditional Healer 5 all spoke about.
While all three Elders felt it was important to seek medical attention when one is concerned
about their health, they also discussed how the individual must be accountable for
implementing changes in their attitudes and/or behaviours to ensure that health problems are corrected (e.g. reducing weight to avoid cardiac difficulties, versus medication use alone).

One resultant challenge of the current structure of the healthcare system is that the system is commonly overtaxed, as it is fairly common to find that individuals must wait weeks at a time to access certain healthcare programs or specialists. One implication of this, which several of the Elders identified, is that much of the medical healthcare system is focused on expediency and treating symptomatology, versus thoroughly examining the root or underlying causes of health difficulties:

> What I find is, for the most part, they just want to get somewhat of an idea of what the problem is and then guess at a prescription, or try this and try that. Like it’s more about time. What I find is they don’t like to spend a whole lot of time with somebody to get to the root of the physical problem (TH5 p.6).

The use of medication as a primary form of treatment was identified by three of the Elders as a troubling form of practice. As has been noted throughout, a diversity of Indigenous healing methods or medicines exist, which vary from ceremony, to the use of story, to singing and drumming. As Elder 1 noted:

> If we pray or sing, because to sing is to do medicine upon the body, because singing, if you’re plus-minus, plus-minus [motions polar opposites in body], they’re all jumbled up, and so you straighten them up and make it in a line, and that’s healing, because you heal the energy fields, and energy all of a sudden flows, and you get the energy fixed up [laughs] and that person is better again! (E1 p. 9)
The use and acceptance of diverse healing or treatment interventions is another area in need of discussion and consensus. As was discussed in the review of the literature, the movement towards empirically based practice in the Western psychological profession raises a number of concerns related to the evaluation of Indigenous healing methods. This issue will be further discussed in an upcoming section, however, agreements will have to be made with respect to the empirical base required for the use of certain interventions or healing approaches when practicing integratively. Additionally, the practice of epistemological hybridism is of crucial importance in being able to recognize the powerful healing potential of diverse methods.

**Knowledge acquisition and training.** All five of the Elders discussed issues related to processes of attaining knowledge and acquiring gifts and the honing of skills for Indigenous Elders and healers. In discussing the steps that need to occur prior to integration, Witness 2 highlighted some of the differences between Western and Indigenous forms of knowledge acquisition in stating:

> The distribution of knowledge amongst Europeans is very different. You have to earn knowledge, which is stupid, you know? Like you have to get an A to move on to the next level of acquiring knowledge […] That’s not how it works in our community. Any, all knowledge belongs to everyone […] I don’t think that with two completely different transmission systems like that that it can work right now (W2 p.4-5).

Witness 2 referred here to the elitist nature of the Western education system and contrasted it to Indigenous methods for knowledge sharing. Elder 1, who possesses a Western graduate degree, reflected on how this type of education has removed barriers to his working in the
Western healthcare system, as his degree is recognized and accepted by Western healthcare professionals:

Maybe they [other Elders] haven’t gone to education, university, stuff like that, but they’ve got their stuff. With myself, coming through with the Masters degree, I just get, I sort of ride a wave. I’m able to make contact with the hospitals, university hospitals, because of the degree. I qualify as a Chaplin automatically. And it’s really a difficult thing to get into the chaplaincy because you got to have so many things, and that’s what the education is (E1 p.5).

Elder 1 highlighted that many Indigenous Elders and healers, while not possessing Western education, are gifted, skilled, and knowledgeable in their own belief systems and healing methods, referring to this as a Masters in Life and Indigenous Knowledge. However, without the stamp of approval from a Western institution, Indigenous Elders and healers are often greeted with scepticism by Western healthcare professionals and organizations:

But anyways, everywhere I’ve went, this is how it’s been and I’ve been challenged. But I’m not afraid, like I’m not afraid one iota to be evaluated, my work, because I know why I’m there, and it has nothing to do with money, Sure money is nice, but the things that have happened to me in my life that has shown me why I need to do this work, and it has nothing to do with money. So my work quality, it doesn’t come from me. That’s what I acknowledge. And I think that’s where a lot of Western practitioners struggle, because a lot of them become, the ego can take over (TH5 p.17).

In reflecting on her experiences with having demands placed on her to have her work evaluated, Traditional Healer 5 raised the point that many Indigenous Elders and healers
perceive their abilities as being gifted to them by a higher power, which is in stark contrast to the idea that skills can be developed and acquired through formalized educational settings. In comparison to formalized academic study and skill development, Elder 3 reflected on one Indigenous concept that describes a process that many Indigenous Elders and healers partake in, in terms of acquiring knowledge and skills, which is commonly referred to as assembling one’s medicine bundle. As was discussed in the results section, a medicine bundle is often made up of real life objects that are of personal significance or power (such as an eagle feather, drum), and figurative gifts, skills, cultural teachings, and knowledge that the individual possesses, has accumulated, or received from other teachers or the Creator. Elder 3 described how the gifts that are endowed in one’s medicine bundle are to be shared for healing with others in need:

We come through creation, through our medicine bundles. And in our medicine bundles we are given gifts, what to use on our trail. And on our trail we may have a disease of something. So the spirit says well I gave you that medicine, use that medicine. But share it. Share it with the world. Share it with people.

Teach people (E3 p.10).

Ellerby (2005) discussed in detail some of the processes by which Indigenous Elders acquire knowledge and skills, with the learning journey often beginning in adolescence and lasting throughout one’s lifetime (as opposed to an eight year trajectory for graduate level degrees). With respect to the credential recognition and abilities of a healer, or an Indigenous Elder or healer who is in good standing, Ellerby stated that this tends to be provided by the individual’s community, as opposed to educational degrees that are conferred by universities. However, differences in types of knowledge and training are of central importance when
discussing the issue of remuneration. Indigenous Elders and healers are often not equally remunerated with Western healthcare professionals as Traditional Teacher 5 noted:

Another thing is the value of the healers. Right now that’s one of the things that I’ve really made a statement with, especially in the (name of place). In this one community they would bring in a psychologist and they were paying her $800 a day to come in. She saw four people in one week […] the government is willing to pay that kind of money to send psychologists into these communities that the people aren’t using, but when it comes to healers, they don’t see the same value, and I’m booked […] the government, their policies about health, don’t see the same values for healers as for psychologists or doctors (TH5 p.16).

A multitude of issues and points of discussion stem from differences in the knowledge acquisition and training of Indigenous and Western professionals, and if these systems are to be integrated and practiced together successfully, shared understandings and the acceptance of the different means by which healing/treatment abilities are acquired will have to be established and reflected in governmental and organizational policies.

Unless the various challenges and issues outlined above are not collaboratively discussed and reviewed, a number of different theoretical and practical problems will likely develop when attempting to integrate Indigenous and Western approaches. In the following section I review some of the recommendations put forward by the Elders to address some of these challenges. Next steps or action items which the Elders identified as being important for proceeding with integration are also reviewed.
**Recommendations from the Elders**

Elder 1 and Witness 2 identified the need for a framework of Indigenous knowledge to be strengthened. Witness 2 spoke throughout her interview about the need to re-aggregate Indigenous knowledge, and stated that the only way Indigenous peoples will be able to make informed choices about the possibility of integrated practice is to be informed about their own health and healing systems. When Elder 1 was asked about how respect and acceptance of Indigenous methods of healing will take place, he cited the need for an established base of knowledge, which he believes many people, including students and Elders, are working to build and strengthen today:

> You students who are gathering this information are the ones that are going to do this framework that houses Aboriginal healing practices and you will construct this in a way that it will become accepted practicing medicine […] you’ll be there and you’ll have this framework. You will write for grants, you will write for grants and research more and in that researching you will have Elders come in there and they will do their, and they will… And you will have created the space for them, and our knowledge will be respected. Our knowledge will be there because you will have written in your framework, and your pillars of knowledge is what you have learned from this, and it will be housed in Western medical practices (E1 p.19)

Elder 1 cited ongoing research as a means to strengthen and build this framework for knowledge. With an increased research lens and focus on Indigenous approaches to health and healing, the perspectives and experiences of our Indigenous Elders and healers will continue to be showcased as powerful and influential sources of knowledge. Elder 1’s
suggestion for continued research efforts is related to a second recommendation, which is the empirical evaluation of Indigenous and Western theories and practices.

Witness 2 and Traditional Healer 5 shared their belief and support for having both Indigenous and Western theories, practices, and practitioners evaluated. Traditional Healer 5 shared that she often encourages the communities that she is working in to evaluate her work to ensure that she is the appropriate healer for their community. However, she recounted an experience in which a health director requested that only her work be evaluated, despite the presence of several other Western healthcare practitioners working in the same space as Traditional Healer 5:

The health director, she said to me well you know what, maybe we should evaluate the program. Maybe we should evaluate how effective your work is […] And I said to her, yeah, that’s a great idea, I want you to do this, but I also want you to see how effective your doctors are and your psychologists are (TH5 p.17).

The assumption that Western interventions are effective is an example of the differential treatment, sometimes prejudicial treatment, which Indigenous Elders and healers often encounter. Given low service utilization rates and poor perceptions of Western psychotherapy by many Indigenous peoples (e.g., Harris, Edlund, & Larson, 2005; Price & McNeill, 1992), it is a reasonable expectation that both Indigenous and Western practitioners would have their work evaluated, as opposed to assuming that one approach to healing is more effective than the other.

The review of the literature provided a summary of problematic issues related to empirically evaluating Indigenous methods, which include the recording and disclosure of
sacred knowledge and practices, identifying the variables which will determine efficacy, and
the use of a Western informed research paradigm. However, Witness 2 conceptualized some
of the reluctance expressed by Indigenous individuals to evaluate Indigenous approaches as
self-racism in stating:

I think that we’re terrified of finding out that we’re inferior, that’s what I think
that is, I think it’s a bunch of self-racism. These people that are saying that
think they are inferior and so they don’t want Western standards applied to
them. I think it’s even more than that for me though. I don’t want Western
standards applied to it because I think they’re way too low. I think we need a
whole new set of standards and a whole new way of looking at things because
their medicine is inadequate, it can’t create a healthy society. They’ve proven
that (W2 p.19).

The comments from Witness 2 and Traditional Teacher 5 are in contrast to much of the
writing in the area of evaluating Indigenous approaches to healing. However, if integration is
to occur between Indigenous and Western approaches, it is likely that some formal practices
for evaluation will have to be designed and employed. Witness 2’s assertion that new
measurement standards are required is a fitting and well-timed suggestion, and several
Indigenous researchers have begun to articulate what an Indigenous informed research
paradigm may look like in practice (e.g. Wilson, 2001; Weber-Pillwax, 1999). A study
how Indigenous informed research methods may be successfully used to examine the
therapeutic benefits of Indigenous cultural practices.
A third recommendation put forward by four of the five Elders is an increase in education and training programs for Western healthcare practitioners. This was most commonly suggested when the Elders were queried about how Indigenous methods will come to be regarded as legitimate and valid approaches to healing. In discussing his support for integrated practice, Traditional Teacher 4 commented, “So let’s do it, let’s do it together. And if you need to have us come in and do a workshop or a {inaudible}, we’ll be glad to do it. So we make ourselves available (TT4 p.28). While some researchers and academics have expressed concerns related to the disclosure of traditional and sacred knowledge, the majority of the Elders in this study were adamant supporters of sharing knowledge about their practices and educating Western practitioners. The findings from Crowe-Salazar (2007) and Maar, Erskine, McGregor, Larose, Sutherland, Graham, et al. (2009) also demonstrated a willingness on behalf of Western professionals to learn more about Indigenous healing methods. The willingness of both Indigenous and Western practitioners to provide and receive education is a promising finding for the development of successful collaborative working relationships in the future.

With respect to formalized education, Traditional Healer 5 expressed her belief that Indigenous specific approaches to health and healing need to be implemented at an institutional level:

I really think that training or the education of Western practitioners that’s going to work with Indigenous people, or even if they’re going to work in a centre where there’s a more holistic approach, they need to be educated in what that means because although we might think we know what it means, how do you
work with it? How do you work with that spiritual part, how do you work the mental, physical, emotional, how does all of that work together? (TH5 p.15)

Elder 1 also put forward the notion of developing training and curriculum which would see Western healthcare professionals leaving the academy and studying alongside Indigenous healers and Elders in diverse settings to gain an appreciation of their practice and methods. While some researchers (e.g. Stewart, 2007b; Vicary & Bishop, 2005) have suggested that training in Indigenous specific conceptualizations and approaches to healing is needed, very few programs currently exist which offer this type of education and skill development. This type of course or curriculum development and its evaluation represents a rich and vital area for future research and program development.

One final point of discussion which was raised by both Witness 2 and Elder 3 is the idea of aggregating and sharing all knowledge systems and approaches to healing of peoples worldwide, not just Indigenous and Western systems. With increasing rates of certain health epidemics (HIV/AIDS, cancers, diabetes, etcetera), both of these Elders expressed their belief that it will only be through a unification of diverse approaches to healing that we will be able to meeting the healing needs of people at a global level:

What is walking to the good life? What does that mean and how does everybody get on board? And how are we going to make this map, if you will, so that everybody is heading in the same direction and we’re going away from the deadly direction that we’re travelling in and toward a better direction?

That’s going to take more than Aboriginal thinking and more than Western thinking, that’s going to take a lot of people thinking about it and facing that we are right this moment inadequate. Yeah? And it’s not that it’s Western
methodologies or Aboriginal methodologies, it’s that the knowledge base is inadequate. Once we start aggregating Aboriginal knowledge and Chinese knowledge and all these other knowledges, then we can figure it out. Now we may not have that much time, but we need to at least advocate in that direction (W2 p.20).

While Western mental health workers are currently trained to practice cultural competence when working with people of various cultural backgrounds, Witness 2 and Elder 3 asserted that all current theories and practices are inadequate as diverse physical and mental health problems continue to persist. Assumptions regarding the superiority and inferiority of knowledge systems and its practitioners must be abandoned, and it will take a unified effort to determine current best and promising practices for health problems. Energy and resources must be allocated to building a theoretical and practical framework of knowledge, revising methods for evaluation, and sharing information about each others’ belief systems and practices.

Summary of Chapter Five

In Chapter Five I presented the within participant results and analyses as related to the overarching research question of this study. Results indicated that all five Elders conceived of the possibility of integrating Indigenous and Western health and healing approaches together. Each Elder had varying levels of experience with integrated practice, which included both successful and poor experiences. The rationale and conceptual underpinnings for integrated efforts, as identified by the Elders, was reviewed. All five Elders also identified current challenges and issues that need to be addressed prior to moving forward with the implementation of integrated practice. Recommendations for how to proceed at this
point in time were provided, which included building a framework for knowledge, evaluating
Indigenous and Western theories and practices, and increasing education and training
programs for Western healthcare professionals. The final chapter contains my concluding
statements, implications, and recommendations for future research.
Chapter Six: Concluding Statements and Implications

In this chapter I present my concluding statements, which include a summary of the study, limitations of the study, implications of the study, future directions for research, and a final concluding reflection.

Summary

What are Indigenous Elders perspectives on the integration of Indigenous and Western healing paradigms, and what, if any, are their experiences of working in integrated contexts? I have attempted to answer this research question by employing a qualitative research paradigm and conducting a narrative inquiry, as the conceptual frameworks informing this study are Indigenous ways of knowing and social constructionism. I interviewed five Indigenous Elders about their understandings of the growing trend to merge Indigenous and Western approaches to mental health together, and documented their personal stories and experiences with integrated practice. A narrative analysis of the interviews, which included the use of a story map as a research tool, yielded within and across participant results. While participants reported diverse perspectives and experiences with integrated practice, all five Elders identified a potential for Indigenous and Western approaches to be used successfully together in the future. The rationale for integrating these paradigms of health included the role of Indigenous culture as a determinant of health for many Indigenous people, and the need for spiritual practice in healing endeavours. The conceptual underpinnings of integrated practice included recognition of the strengths and weaknesses of each approach, acceptance of each approach as valid and legitimate, and the establishment of respectful working relationships between Indigenous and Western practitioners. All five Elders identified a diverse number of experiences and expressions of integrated practice,
including the use of Indigenous healing methods in Western spaces; collaborations or referrals between practitioners; integrated mental health programming; and organizations that employ an integrated approach to healthcare. While the Elders expressed some support for the idea of integrated practice, they all identified several issues or areas of concern that require attention prior to advancement within the integrated healing movement. Issues that were discussed included the role of historical relationships between Indigenous peoples and Canadian society, differences in epistemology and treatment approach, and differences in knowledge acquisition and training for Indigenous and Western practitioners. The Elders provided recommendations for next steps, which included the need to re-amalgamate Indigenous knowledge and strengthen Indigenous knowledge frameworks, the design and implementation of evaluation methods for both Indigenous and Western approaches, and increases in educational programming for Western trained healthcare professionals. The narratives shared by the Elders in this study are a significant contribution to research and healthcare communities, as their personal accounts represent authentic experiences of knowledge keepers and Indigenous healers who have years of experience working in the healthcare fields.

**Limitations of the Study**

The purpose of this research was not to create quantifiable or objective truths about perspectives and experiences with integrated healthcare. Rather, the use of a qualitative research paradigm facilitated a concentrated exploration and study of the notion of Indigenous and Western integration as understood by five Indigenous Elders. My goal was to obtain the personal narratives of these Elders so as to gain greater insight and a depth of understanding about the topic at hand. As such, the perspectives and experiences reported by
the Elders in this study should not be generalized to other Indigenous Elders. As was
delineated in the results and discussion sections, the five Elders reported a divergence of
opinion with respect to integrated healthcare, suggesting that an overarching consensus does
not exist at this point in time and further study exploring the narratives of Indigenous Elders
is needed.

While the five Elders in this study represented diverse Indigenous Nations and
peoples, their knowledge and belief systems represented a small sample of the 600 First
Nations currently in Canada. Furthermore, all five Elders were of First Nations background,
and the perspectives of Métis and Inuit Elders were not included in this study. While the five
Elders in this study have worked in both urban and rural environments, most of the Elders
currently work in urban centres providing teaching and conducting healing work. One might
anticipate that the narratives of Elders working in predominantly rural environments would
der differ significantly from the opinions expressed by the Elders in this study.

A final limitation to the study was the potential for researcher bias. As noted in
Chapter 1, the conceptual underpinnings of this study were Indigenous ways of knowing and
social constructionism. These frameworks represent my personal assumptions of how
knowledge is generated and shared. While I acknowledge my active role in the co-
construction of knowledge and the implied meaning of the narratives reported in this study, I
employed various research protocols and precautions to guard against researcher bias, which
included the use of multiple cultural informants, validity checking with participants, and a
triangulation of research methods (researcher journal, interview data, participant feedback).
Implications of the Study

There are several implications of the findings from this study. One of the main implications is that ongoing dialogue and research related to examining the ways in which Indigenous and Western approaches may be blended together are needed and warranted at this time. Theories of how Indigenous and Western methods may be used together are still being formulated, and the exact levels or expressions of integrated healthcare are still evolving in practice. However, the findings also indicated that the Elders believe we are still in the very early formative stages of integrated healthcare, and several of the Elders expressed reservations about moving forward, in terms of program development, without first addressing foundational elements and areas of concern related to integrated practice. This would entail, for example, the acquisition of funding for purposes of Indigenous knowledge reclamation, which would include funding for gatherings of Indigenous Elders and healers and the development of dissemination protocols and educational programming, that would facilitate the widespread distribution of Indigenous knowledge related to health and healing among Indigenous individuals and communities.

Another critical implication of the study is that Indigenous Elders and healers, Western healthcare professionals, and governmental bodies for healthcare, must meet to discuss the various challenges related to integration (differences in epistemologies, treatment approaches and interventions, acceptable standards of practice, professional standards and remuneration) and develop strategies and protocols which would see changes in current healthcare policy that would allow for successful integrative work to occur. For instance, current policies related to the prohibition of Indigenous healing methods in many Western healthcare settings remains a large obstacle to integrated work and healing for many
Indigenous peoples. Efforts in this area are beginning to occur, as can be seen with the Aboriginal Healing and Wellness Strategy in Ontario, but it is clear that ongoing discussions and meetings of these representatives must continue to occur at this point in time.

A third implication of this study is related to certain Elders’ desire for the development of evaluation methods to assess the strengths, weaknesses, and beneficial aspects of both Indigenous and Western approaches to health and healing. Two of the five Elders expressed strong support for the need to evaluate both Indigenous and Western methods. As was discussed in the review of the literature, Indigenous and non-Indigenous researchers, scholars, and practitioners have expressed concerns about the evaluation of Indigenous healing practices. While some of these reservations stem from concerns related to the use of a Western research paradigm and the documentation of traditional knowledge, some researchers have begun to empirically explore Indigenous healing methods through the use of Indigenous research methodologies (see Goudreau et al, 2008). It is clear that both Indigenous and Western health systems and practitioners share the same goal of delivering effective and non-harmful treatment or healing interventions. Research is in fact needed that examines how integrated healthcare systems and programs are currently operating, and what beneficial health outcomes are being achieved by individuals accessing these services. The task going forward will be the use, perhaps development of, evaluation methods that effectively assess Indigenous, Western, and integrated methods for healing.

Another key finding from this study was the general felt experience of all five Elders that Indigenous approaches and practices of health are viewed as illegitimate or disregarded by the Western healthcare system and the majority of its practitioners. This was often interpreted as a sign of disrespect by many of the participants. As was described in the results
and discussion sections, respectful relationships was identified as a foundational element for successful collaborative work. Lack of understanding or respect for an approach to healthcare was oftentimes attributed to a lack of education, and several of the Elders in this study called for an increase in educational programming for Western trained healthcare professionals. One Elder suggested the development of a training component which would see Western healthcare professionals training alongside Indigenous healers in their working and practice environments. A second Elder identified the use of Indigenous Elders and healers as instructors in graduate level training programs and the use of workshops or seminars to inform currently practicing professionals about Indigenous approaches. As was discussed in the discussion section, both Western healthcare professionals and Indigenous Elders and healers have expressed a desire for more opportunities to discuss Indigenous approaches to health and healing, a positive finding which supports the potential for collaborative practice. While some scholars and practitioners have expressed concerns related to the disclosure of traditional knowledge, several of the Elders in this study expressed enthusiasm for open discussions and a demystifying of Indigenous approaches for non-Indigenous professionals. The implications of these findings would see the development of new educational curriculum and programming for Western trained healthcare professionals, and opportunities for currently practicing professionals to regularly receive additional training or consultation with Indigenous Elders or healers about Indigenous health and healing.

In summary, the implications of the findings from this study include a need for ongoing discussions between Indigenous, Western, and governmental parties to delineate potential theories and practices of integrated healthcare. Changes in current policy and educational programming are needed, as well as the identification of appropriate evaluation
methods that accurately assess therapeutic effectiveness while also being culturally informed. Finessed channels of communication between Indigenous and Western healthcare practitioners are needed to strengthen collaborative and respectful working relationships.

**Recommendations for Future Research**

A primary recommendation for future research would be to replicate the study with Indigenous Elders of diverse backgrounds throughout Canada, including those working in both rural and urban contexts. While individual interviews provided for depth and thoroughness, conducting focus groups with a collective of Elders would also yield a wealth of knowledge and understanding about the topic. In addition to Indigenous Elders, other Indigenous practitioners and health organization administrators are additional potential participants with knowledge related to integrated healthcare approaches.

Research that examines the strengths, weaknesses, and beneficial health aspects of current integrated programming are needed. While there is a growing number of examples of integrated programming in the literature (e.g. Shore, Shore, & Manson, 2009), these studies often fail to examine the strengths and challenges which the individual Indigenous and Western practitioners encounter when forming relationships, and how challenges are addressed. Additionally, virtually no data exists which has documented changes in health outcomes or client experiences in receiving integrated healthcare interventions. This area represents a fertile area for future research as integrated programming continues to be developed.

And finally, the development of new research methodologies and educational programming related to Indigenous healing were identified as action items by the participants in this study. Given the newness and innovative practices of integrated healthcare at this
time, alterations in approaches to research and training will also likely develop and require evaluation as time progresses.

**Concluding Reflection**

My intentions with this thesis have been to document the voices of Indigenous Elders on the idea of Indigenous and Western therapeutic integration. My motivation for selecting this topic was that as a mental health clinician in training, working in the area of Indigenous mental health and integrated care, I was surprised that the wisdom and counsel of our knowledge keepers has been absent in much of the documented discussions around integrating health paradigms to date. The Elders in this study supported the notion of integrated healthcare, but also identified several key concerns that must first be addressed so that decisions are not made hastily or without a solid and respectful foundation in place. All five Elders spoke openly and honestly about their perspectives and experiences, and demonstrated an enthusiasm for the work that is being done to address the healing needs in many Indigenous communities today. One teaching that I received from an Elder many years ago is that in order to move forward we must look back to see where we have come from, and to use the knowledge of our mentors in informing our choices. As a mental health practitioner, and a Métis woman, I believe that it is crucial that the powerful healing strengths that currently exist in Indigenous communities be accessed and utilized in transforming current mental health practices to enhance the health and well-being of our people today.
References


by the First Nations Information Governance Committee, Assembly of First Nations.


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Ottawa, Ontario: Aboriginal Healing Foundation.


Appendix A

INDIGENOUS MENTAL HEALTH RESEARCH

Are you an Indigenous Elder who is interested in research related to Native ideas on mental health and healing?

I am from the Métis Nation of Ontario and am currently a graduate student in Counselling Psychology at OISE – University of Toronto. I am interested in exploring Indigenous Elders’ perspectives on the use of Indigenous and Western healing approaches together.

To participate in my project you must:
1) Be identified as an Elder by your community or workplace

If you might be interested, please contact me by phone or email. Miigwetch - Thank you very much!

In Spirit,

Tera Beaulieu
Telephone: 416-889-6918
Email: t.beaulieu@utoronto.ca
Appendix B

Telephone Script for Potential Participants

Hello ____:

My name is Teresa Beaulieu and I am Masters level graduate student in the department of Adult Education and Counselling Psychology at OISE – University of Toronto. My reason for contacting you today is to inquire about your potential participation in a research study entitled “Exploring Indigenous and Western therapeutic integration: Perspectives and experiences of Indigenous Elders.”

The purpose of this research project is to gain an in-depth understanding of the ways Indigenous and Western mental health and healing practices can complement one another in order to successfully meet the healing needs of Native peoples today. An additional focus of the research is to explore the successes and challenges faced by Indigenous Elders who have worked in integrated (Indigenous and Western) healing contexts or mental health service agencies.

You are being invited to participate because you are a community identified Indigenous Elder. If you agree to voluntarily participate in this research, your participation will include two 1-2 hour audio-taped interviews that will take place in your community workplace. The total time commitment is approximately 2-4 hours, and participation in this study should not cause you any inconvenience other than the interview time.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time, or refuse to answer certain questions without any consequences or any explanation. In the event that you withdraw from this study, your audio-taped interview and all accompanying notes will be destroyed. Your confidentiality, including your name and the information you share, is also assured. This project has also received ethical approval from the University of Toronto.

I will leave my phone number (416-889-6918) and email address (t.beaulieu@utorotno.ca) with you so that you can contact me if you have any additional questions or are interested in participating.

Many thanks for your time and consideration
Appendix C

Participant Consent Form

Exploring Indigenous and Western therapeutic integration: Perspectives and experiences of Indigenous Elders

You are being invited to participate in a study entitled “Exploring Indigenous and Western therapeutic integration: Perspectives and experiences of Indigenous Elders” that is being conducted by Teresa Beaulieu.

Teresa Beaulieu is a Masters level graduate student in the department of Adult Education and Counselling Psychology at OISE – University of Toronto. This research project is being carried out in partial fulfillment for Ms. Beaulieu’s Masters level degree. Should you have any concerns about the research, you may at any time contact Dr. Suzanne L. Stewart (supervisor) at (416)-978-0723 or Teresa Beaulieu at (416) 889-6918 or by email at t.beaulieu@utoronto.ca

The purpose of this research project is to gain an in-depth understanding of the ways Indigenous and Western mental health and healing practices can complement one another in order to successfully meet the healing needs of Native peoples today. An additional focus of the research is to explore the successes and challenges faced by Indigenous Elders who have worked in integrated (Indigenous and Western) healing contexts or mental health service agencies.

Research of this type is important because research has demonstrated that there is an under use of mental health services by Indigenous peoples due to cultural differences, and the integration of Indigenous and Western paradigms and approaches to healing has been suggested as a viable alternative. However, there is currently a lack of empirical research related to the successes and challenges of integrating Indigenous and Western approaches to healing. The results of this study will therefore contribute new information to the research literature on Indigenous health and well-being, and will inform the development of teaching materials for community counsellors, support workers, psychologists, and other community members and health professionals who are supporting Indigenous peoples in mental health and healing.

You are being invited to participate because you are a community identified Indigenous Elder. If you agree to voluntarily participate in this research, your participation will include two 1-2 hour audio-taped interviews that will take place in a setting (e.g. home, workplace, etcetera) of your choice. The total time commitment is approximately 2-4 hours, and participation in this study should not cause you any inconvenience other than the interview time.
There are no known or anticipated risks to you through participating in this research. You will be discussing general everyday work-related topics related to your professional knowledge and work experience, and the interview will not breech confidentiality regarding particular topics or clients with whom you work.

The potential benefits of your participation in this research include clarification of your own views of cultural mental health and healing in your work. Potential benefits to society include informing education and policy about promising mental health practices for Indigenous peoples in Canada, and informing academic literature about Indigenous and Western mental health relations.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time, or refuse to answer certain questions without any consequences or any explanation. In the event that you withdraw from this study, your audio-taped interview and all accompanying notes will be destroyed.

As a way to show respect and thank you for your participation, you will be presented with a medicine bundle (sage, sweetgrass, cedar, and tobacco) at the time of the interview. Should you decide to withdraw from the study at any time, the honorarium is yours to keep.

To preserve your confidentiality, your name will not appear on any of the data, as a code will be assigned to replace your name on the interview audio tapes, on the interview transcripts, and in all notes. Alternatively, you may choose to select a pseudonym of your choice in place of your name that will be used in the research study and all research documents (e.g. interview transcripts; final research reports). The key for all coded names will be kept separately from the interview data. Signed consent letters will also be stored separately from any data. You may also choose to revoke your right to confidentiality and use personal identifiers in both the interview transcript and final research report. Please note, however, that you are free at any time throughout the research process to exercise your right to confidentiality and the use of a code or a pseudonym.

Your confidentiality will be protected by storing interview audiotapes and the transcribed data in a locked filing cabinet. Only the researcher will have access to the data. The audiotapes from your interview, the transcribed data, and any notes taken during the interview will be destroyed after five years.

It is anticipated that the results of this study will be shared with you and others in the following ways: directly to participants by hand delivery of results in a research report, through published articles in scholarly journals, in policy reports to Native and non-Native governments and health organizations, and at scholarly conferences/meetings.

In addition to being able to contact the researcher and her supervisor, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Office of Research Ethics, 416-946-3273 or ethics.review@utoronto.ca.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.
Participant Signature   Date

Participant Name (please print) ________________________________.