DECONSTRUCTING PSYCHOSIS: DISMANTLING OPPRESSION

by

Emma Heath-Engel

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Abstract

This document deconstructs the term ‘psychosis’ through an exploration of the origins of this term, a personal narrative of this phenomenon, and the exploration of a multitude of perspectives from around the world, on experiences which fall into this category. Integrating the wisdom of five Indigenous and Alternative Health practitioners, and exploring several alternative mental health healing centre models, the limitations of the mainstream Western medical approach are presented. Also discussed, are the diversity and power of these alternatives and their possible combinations. This exploration is carried out using the Two-Eyed Seeing Framework, developed by Mi’kmaw Elders Albert and Murdena Marshall, of the Eskasoni First Nation in Cape Breton, Nova Scotia, which ensures readers appreciate each perspective on ‘psychosis’ in its own right, and invites readers to imagine and notice ways in which the healing perspectives presented, can be and are combined, in order to create new and important healing possibilities.
Acknowledgements

I would like to express my deepest gratitude to Dr. Njoki Wane, Dr. Jean-Paul Restoule, and Dr. Roy Moodley for making it possible for making this research project possible. I would also like to thank my ancestors for supporting me and giving me the strength to complete this journey.
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Chapter 1 - Introduction

Introductory Location

Boozhoo, Emma Heath-Engel indizhinikaaz, Tkarontoindoonjibaa, bezhigooganzhiidodem. My name is Emma Heath-Engel, I am from Toronto, and I am from the horse clan. My Aboriginal heritage comes from the Abenaki Nation. I introduce myself in Ojibwe, an Indigenous language dominant in Toronto, in respect for the Indigenous people of Turtle Island. My birth mother’s family goes back an estimated 220 years in the Eastern Townships of Stanstead, in Quebec, where her relatives of British, Irish, and Scottish descent settled land and intermarried with the Abenaki people who had lived on this land for thousands of years. My father’s family immigrated to Montreal in the late 1920s from Russia and Poland. My maternal heritage is, if traced in the most linear fashion, British, Irish, Scottish, French, and Danish. More distantly, as DNA tracing via the National Geographic Genographic Project has revealed, it includes a plethora of other general localities such as Southwest Asia. My paternal heritage is, most linearly, Russian/Ukrainian (my father’s mother was from Kiev, and area of which the borders have changed frequently throughout history, making it uncertain whether this was Russia or the Ukraine, at the time of my paternal grandmother’s birth), and Polish. Both my birth father’s parents were also of Jewish origins. My paternal heritage is also Asiatic, tracing from areas such as Korea.

I have lived in Toronto all my life, with a considerable amount of time spent in Montreal, Quebec, as well as in the Eastern Township of Stanstead, in Quebec, from which my Aboriginal ancestry originates. In a way, my Metis heritage, and the collage nature of the experience which
inspired this piece of ‘research’ as will be discussed, as well as this piece of research itself, is a reflection of the multi-cultural nature of Toronto. Tkaronto, this city, in which I have grown up, is part of me, and I am a part of it.

**Thesis Overview**

This piece of research is meant to be a tool to be used by all, however, particularly those who have had, are having, or will have, experiences that have been, are being, or will be, diagnosed in mainstream Western mental healthcare, as ‘psychosis’, or any related ‘mental illness’ (please see Index at the end of this chapter for definitions). It is meant to help people resist or supplement these diagnoses, by providing a different perspective concerning these experiences. The research question being answered is how the mainstream Western mental health care concept of psychosis is taken up in Indigenous and Alternative Health and Healing practices.

I will share this perspective by telling my own story of an experience diagnosed as ‘psychosis’, in the context of a historical and cross-cultural exploration of the term ‘psychosis’, drawing from a wide diversity of literature. In addition, the findings and conclusions drawn from a series of unstructured interviews done with five Indigenous and Alternative Health practitioners, will further deconstruct this concept. In sum, this piece of research provides valuable insight into the social, cultural, and historical construction of ‘psychosis’, by exploring the origins of the concept, as well as parallel human experiences and interpretations thereof, in multiple traditions worldwide. Ultimately, it is my hope that this piece of research will reach, and act as a support to, those faced with the diagnosis of ‘psychosis’, or one related, such as
schizophrenia or bi-polar disorder (please see Index at the end of this chapter for definitions), regardless of how each individual wishes to interact with this diagnosis. The term ‘psychosis’ will be in quotations throughout, to emphasize that it is a culturally and historically situated idea. Research Methodologies used in the investigation of this topic are indigenist. These consist of the Two-Eyed Seeing Theoretical Framework, open-structured interview, as well as the Relational Worldview, and associated Medicine Wheel model, used as an analytical tool, for the analysis of interview data.

Introduction to Methodology and Framework

I have decided to work within Indigenous methodologies due to the connection I have by way of being Metis, as well as their crucial place in decolonizing the practice of research, which is essential to the survival of Indigenous traditions, of utmost importance in the field of mental health, and the health of all beings and the earth, as will be discussed in Chapter 2. Although, according to dominant, mainstream, Western thought concerning ancestry, my Aboriginal heritage is only a fraction of my entire ancestry, however, my connection to Aboriginal ancestry has been central to my journey, in terms of my research and otherwise.

The core aspects of Indigenous Research Methodology which I have adhered to in this piece of research are:


Designing my project in such a way that the purpose of the research is to benefit the community and the people of the community (in my case the community is the psychiatric consumer/survivor community, and members of
As is the practice of many Indigenous researchers, within this larger methodological framework, I have engaged in the Western research techniques of interview and literature review (Botha, 2011, Grande, 2008, Restoule et al, 2010, Ruhiwu & Cathro, 2014, Weber-Pillwax, C. 2004, Martin & Miraboopa, 2003). The specific theoretical framework I am writing within is the Two-Eyed Seeing Framework (Martin, 2012). Interviews were conducted using the ‘open-structured conversational approach’ put forward by Kovach (2009). The Relational Worldview, specifically the Medicine Wheel, as put forth by Cross et al, (2000) is used to analyze the data from interviews done with five Alternative and Indigenous Health practitioners.

**A Two-Eyed Seeing Perspective**

The Two-Eyed Seeing Theoretical Framework was developed by Mi`kmaw Elders Albert and Murdena Marshall, of the Eskasoni First Nation in Cape Breton, Nova Scotia. This framework puts forth the idea that, although there exists a vast array of knowledges concerning how to understand the world, it is important that no single knowledge dominates others. Rather, we must learn to appreciate the multiplicity of perspectives which exist, in order to be able to learn and benefit from diverse ways of knowing, and the ways in which these different ways can complement each other. Thus, in becoming able to appreciate diverse knowledges in this way, we become able to ‘see through both eyes’, without either eye dominating, but rather, with both
eyes seeing in a balanced way, respecting that both eyes must work together in order to have clear and accurate vision (Martin, 31, 2012).

The way in which the Two Eyes must work together, is similar to the ways in which all parts of ecosystems, as part of the larger global ecosystem, must work together in harmony, constantly adapting to changes in the overall system, in order for each ecosystem, and the larger global ecosystem to remain healthy (Martin, 2012). In a similar way, all knowledges about understanding the world must be recognized and appreciated in their own right and entirety, in searching for solutions to the health problems of humanity, in order to for these solutions to be found. This is the core principle of the Two-Eyed Seeing Framework (Martin, 2012).

This Framework has shaped my research in process, production, and product. In the process of researching, it made it possible for me to see the diversity and combinations of healing traditions which exist within various traditions and perspectives, particularly those presented by the healers interviewed. Due to this, I was much more able to describe these in their distinction, and with clarity In addition it enabled me to see the mainstream Western mental health model in a new light, as a valid healing method in its own right, despite it’s questionable history. Prior to becoming acquainted with the Two-Eyed Seeing Framework, I often dismissed this model due to its colonial and discriminatory history, as well as my own traumatic experience with this approach. In turn, when this model appeared in some of the interviews conducted, as a modality valued by several healers interviewed, though my initial reaction was to be mistrustful, and to begin to devalue the healer, the Two-Eyed Seeing Framework allowed me to put aside my prejudices towards this model, and see with two eyes, how this model has value, in and of itself, as well as in combination with other healing modalities.
The Relational Worldview: The Medicine Wheel

The Relational Worldview, and the analysis model provided by the Medicine Wheel, have roots in the ways of tribal peoples, going back centuries in time (Cross et. Al, 20, 2000). The constant balancing of all relationships in life, which is integral to the good health of people and community, is central to this worldview. As is stated by Cross et. Al (2000), “Every event relates to all other events regardless of time, space or physical existence. Health exists only when all elements are in balance or harmony.” (20) This model can be related to the health and healing of an individual, as well as to the health and healing of a community as a whole, as it provides a means by which to look at this balance in the context of an individual and/or a community. This worldview and model will be used to analyze interview data collected, regarding the opinions of five Indigenous and Alternative Health Practitioners, on the concept of psychosis, as these interviews indicated that a balancing of all four elements, mind, body, spirit, and context, is integral to the healing of individuals and communities affected by ‘psychosis’. Due to the prominence of these elements in both the data and the Medicine Wheel model, major themes discussed fall into these four categories, following the analysis of interview data, also organized using these 4 elements. Having clarified my approach, I will now tell the story of my journey to, and inspiration for, this research project.
Location – A Personal Perspective on Psychosis

Six years ago, in the spring of 2009, I experienced what was labeled ‘psychosis’, and was diagnosed with what is known as ‘bi-polar disorder’, though the type was not ascertained (see definitions below). In fact, what I experienced was an unexpected journey to other dimensions, intuitions regarding my life and past lives, and an unexpected surfacing of my own innate healing abilities. ‘Psychosis’, in mainstream Western mental health discourse, is defined as:

“a brief disorder, characterized by delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior, which lasts for at least one day, or less than one month, with an eventual return to premorbid functioning.” (American Psychiatric Association, DSM IV, 2013).

Bipolar Disorder is defined by this same document as a disorder with two types:

“Bipolar I Disorder is characterized by the occurrence of one or more manic episodes or mixed episodes. Bipolar II disorder is also characterized by at least one hypomanic episode. In addition, bi-polar II disorder is characterized by one or more major depressive episode.” (DNA Learning Centre, retrieved April 16, 2014)

I will now provide a detailed account of what happened prior to my hospitalization and diagnosis, in order to illustrate the false nature of these diagnoses, and the true meaning of my experience. Due to the complexity and duration of this experience, some details have been omitted, however those which are most important to understanding and creating a realistic impression of my experience, have been included. The context provided in the following chapters will further illustrate the mentioned falsity and deeper meaning.
During the three days and nights leading up to my hospitalization and diagnoses, I had a vast multitude of experiences, which were completely different from those I was accustomed to, and entered a state of consciousness which I had not previously experienced. Prior to this change in consciousness, I was having strange dreams and intuitions. In addition, at this time, due to a personal interest in healing traditions, I was learning about, and experimenting with, North American Aboriginal and Ayurvedic traditions, and was engaging in practices such as offering tobacco, smudging, and experimenting with different mantras.

Out of frustration, and a desire to understand the memories which seemed to be surfacing, I decided to experiment with some thought reversal techniques which had been communicated to me via an Ayurvedic practitioner, which involved focusing on individual thoughts and attempting to ascertain their truth. This caused me to feel overwhelmed due to the implications of the possible truth of select intuitions I was experiencing. This trigger, combined with not having slept much the night before, nor having eaten much that day, caused me to enter another dimension of reality.

I became preoccupied with healing myself, and began engaging in a variety of activities in order to do this. I was moving very quickly and the number of these activities was great, the complexity of which is too great to recount in its entirety. For instance, I began to get up at sunrise, and to retire and attempt to sleep at sunset. I began to feel that birds, as well as vocalists in music I heard in stores, and listened to at my house, were telling me where I should go and what I should do. I performed a healing ceremony with strawberries and water which, though I created it on the spot, I felt I knew from some time long past.
As my time in this different dimension went on I became overwhelmed with feelings of fear, and surrendered myself to all the deities and Creators I knew of, including the sun, the moon and the stars. I felt the need to buy myself many things such as flowers of particular colours, and ceremonial tobacco, and did so.

After two days and nights in this state, unable to get a solid night’s rest, again I tried to sleep, however I continued to be overwhelmed with feelings of fear. Unable to sleep, I felt I was fighting evil spirits all night. I tried listening to Bob Marley as his music had soothed me in the past, however the music started telling me about my life and future, and it seemed that good and bad spirits were fighting to reach me through the music, and the bad spirits were significantly stronger than the good. The music told me that my life would change due to the experience I was having, and that not everyone would understand, but that some would, and that only these people would be worthy of my time and energy.

While listening to this music and trying to sleep, I felt as though I could, and needed to order all my possessions in terms of colour, while dressed in all white. Despite a strong urge to do this, I felt that if I did, I would open myself up to a spiritual force that would kill me. I actually went to a clothing store to buy this clothing when the danger of completing this process was communicated to me via the voice of a man of African descent in a hip hop type pop song, which was playing in the clothing store. I followed my intuition and the message of this voice, and instead bought clothing in black, deep purple, lavender, gold, and emerald green.

Upon returning home I felt I had offended the spirit of a peacock, which I had dressed up as for Hallowe’en that year, as the costume, which I had made out of peacock feathers, which I had mounted on my wall, began to seem very menacing to me. In order to appease it, I had to
dress in its colours to appease the spirit, which, coincidentally, were the colours of the clothing which I had purchased. I wore these colours to begin ordering my possessions.

During this process I was periodically overwhelmed with emotions of sadness, fear, betrayal, and anger. These affected me physically – I would tremble violently with waves of fear, feel my heart sink, and become dizzy, from feelings of sadness and betrayal. I began to feel angry due to emotional hurts I felt I had suffered, and began throwing things, such as an earthen wear plant pot, which belonged to one of my roommates, and it broke.

As I continued the healing process, I began trying to clear myself a build-up of experiences which I felt I was remembering. During this process, I connected with what I felt was my own inherent worth; I had a strong recurring feeling that, rather than being nothing, and worthless, as was part of the surges in emotion which I was feeling, I was golden and needed gold and golden objects around me. Connected to these feelings was the conviction that in a past life I had been a queen in Ethiopia, which I knew by recognizing a pattern of colours which appeared around me in objects, namely gold, hot pink, and light green.

Around this time I became hyper-sensitive to colour, and began to know which colours I needed to wear in order to heal myself. I also became scared of certain colours and unable to wear many colours. My roommates at the time were becoming concerned, though instead of connecting me with healthcare, due to the background which many of them had in the arts and alternative medicine, they tried to help me figure out what was happening, and to help me find what I needed. This terrified and confused me to an even greater degree.

Eventually, overwhelmed with the intensity of what I was experiencing, I collapsed, and my roommates moved me up to one of my roommates’ room in the attic of the house we were
sharing, with a sky light, because I could no longer be in my room anymore due to the way I had strewn all my possessions everywhere, as well as the energies which I felt in the space. While there, I connected with a past life from Korea; a woman, though not of royal status, which I saw in a painting in my roommates’ room. I also felt a strong need to understand the legend of Moses as the Bob Marley CD to which I had been listening had been lent to me by a Rastafarian man by the name of Moses.

In this room I had another terrifying night, during which I became afraid of certain numbers on the clock in the room. It was a digital clock with a black background, and red numbers. During this night I also became hyper-sensitive to sound, and began getting startled at every noise. That night the weather began getting colder, and there began to be freezing rain, which I was able to hear on the skylight. The previous day the weather had gone from being mild and overcast, to being cold and rainy, and then changed to freezing rain, which then changed to snow and thunder and lightning. In this hyper-sensitive state I was completely unable to sleep, and became convinced I was going to die. Lying in the dark, in terror, I began seeing animal spirits with my third eye. I felt I saw a raven surrounded with knives and blue, green, and silver light, which I believed to be the mythical trickster which is a part of North American Aboriginal traditions. I was also visited by one of my spirit animals - a tiger, which I felt sitting on the bed beside me, and which caused me to feel some sense of security.

Once the morning arrived, I felt I was unsafe in my house and needed to leave. I called my ex-boyfriend and asked him to come over. When he arrived, I felt an intensification of the negative energy I had felt before, and fought it off with an mbira (an instrument from Zimbabwe with the power to fight spirits), which I had learned to play some months before. My ex began to be affected by my state of mind and the spirits around me as well, and we decided to leave the
house. We went to Kensington Market as I felt I needed to go there, and then he left me at the corner of Spadina and Harbord, despite my having next to nothing with me, as he said he had to go to class. After he left I went to the Native Canadian Centre, as I felt they might understand what I was experiencing, but they weren’t able to help me and obviously did not know what to do.

I decided to go visit my professor of Aboriginal Studies at First Nations House, as I thought she might understand what I was experiencing. I proceeded to tell her that I was a person of all four sacred directions, and that I needed to dress in these colours (Black, Red, White and Yellow), or the colours of a tiger (orange, white, and black). She told me that the experience I was having was normal, and that prior to modern times, people had had the kinds of experiences I was having, all the time. She told me that I was just tired, needed to rest and needed to read a book about the experiences of Aboriginal Medicine People, called The World We used to live in, Remembering the Powers of Medicine Men, by Vine Deloria Jr. She told me to go rest upstairs at First Nations House.

I went upstairs, but still could not rest as all the books and objects in the upstairs space, which is quite small, related to my life and what I was going through emotionally. At first there was no one else in the room, and this caused me to go even deeper into the mental space I was in. Feeling extremely overwhelmed I curled up in a chair and began to cry. Beside the chair I found a plastic bag with cedar in it. Soon after, a young man in his early 20s found me there and began to ask me why I was crying. We talked for a while, and then he convinced me to get out of the chair, and walked me home.
Once he left me at my house, I became extremely anxious, and asked my roommates to take me to the hospital. Though I didn’t want to be taken to the psychiatric ward I was taken there regardless, and put on an involuntary form. During my intake at the hospital, I was extremely mistrustful and fearful. I repeatedly told the nurses looking after me that I was a healer trying to heal myself, and that I was convinced I was going to die. Throughout this experience I reached out to friends and family periodically, however they did not understand how dire the situation was. Once in my hospital room I did not want to see or talk to anyone.

I was given the diagnosis of bi-polar disorder, and the psychiatrist thought I might possibly be schizophrenic. Rather than accepting this diagnosis, I recorded my experience, and maintained my conviction that I had had an experience similar to those had by medicine people of Indigenous traditions, which had been suggested to me by my professor. I was allowed to leave the hospital after one month and withdraw from medication in two, which I had only taken under threat of permanent residence in the ward, and forced injection, despite the fact that I was completely lucid, and absolutely no harm to anyone or myself. Upon leaving the hospital, I had recovered so completely that the psychiatrists were unable to hold to their original attempt to diagnose me, or attempt to label me with anything else.

After arriving in the hospital in total disarray, I was able to quickly regain my emotional and mental balance, through visual arts and beadwork, as well as piano music and yoga (there was a grand piano on the ward!!), as well as holding to my knowledge of the abilities of medicine people in Indigenous traditions. I was extremely lucky to have had knowledge of and connections to the Indigenous Healing Traditions and the Indigenous community in Toronto. In addition, I had the great privilege of having had access to piano lessons, art supplies, books about beading, yoga classes, and university education, which allowed me to take a course in Aboriginal
Studies. While on the ward, I e-mailed with the professor of Aboriginal studies mentioned, who supported my interpretations of my experience.

Despite these supports, my speedy release from the hospital, and withdrawal from medication, the complete healing journey from the experience was lengthy and difficult. I primarily healed from the experience by seeking the guidance of a number of medicine people of Indigenous traditions from a number of places worldwide. These people confirmed my beliefs regarding my experience in the way my Professor of Aboriginal Studies had done, and suggested strongly that I find a teacher of Indigenous healing modalities to learn from. However, due to my mixed heritage, as well as the fact that my Indigenous heritage is some generations back, it was, and has proven difficult to find Elders and teachers among the Indigenous community, who I have been able to apprentice to and learn from. Despite this, I have been learning with two North American Aboriginal Elders. Apart from the guidance of these incredible teachers, I also healed through, visual art, beadwork, music, meditation, nutrition, and physical activity. The Literature Review presented in Chapter 1 will further explain the context, and demonstrate the inherent truth of my experience.

This experience starkly showed to me the extremely oppressive, physically harmful, racist, and colonially influenced nature of the Western psychiatric system, due to my forced medication, the effects of this medication, and the complete rejection by my psychiatrist of my convictions regarding my experience, and my abilities to heal myself from this experience. It also showed me the incredible strength of this system to rip someone’s identity, spirit, and physical health from them, as this came close to happening to me. Since my experience, I have met many to whom this has, in fact, happened, as they did not enter their experiences with the tools I had for the journey to recovery, nor my connections to the Indigenous community. Many
of these individuals have ended up taking medication for life, which is also something I avoided. I have never taken medication after the two months mentioned in my narrative, nor have I felt the need to.

These realizations regarding the psychiatric system, combined with my own experience of sustained success in extricating myself from its clutches (I have never had a similar experience which was not completely within my control), as well as connecting with many who were not as lucky, and feeling that I might be able to contribute to changing this system due to my experience, are the inspirations for this research project, as discussed in the introduction. Before proceeding to the next chapter I need to note that I am not against medication or mental illness diagnosis categories, as I know that these are extremely helpful for many. Also, occasionally, I believe it can be truly in balance for someone to take psychiatric medication, due to what I have learned about the technique of intuitive consumption from Sandi Loytomaki a medicine person of Sami heritage (Loyotmaki, S., personal communication, 2010), as well as from my knowing people who have experienced ‘psychosis’. However, rarely is this consumption healthy in the long term (Whitaker, R., 2010). Chapter 1 will provide the context which is necessary to prove the falsity of the diagnoses which I was given, of ‘psychosis’ and ‘bi-polar’ disorder, and will demonstrate its inherent truth and meaning.

Throughout this study I make reference to terms used in various ways by different scholars and mental health practitioners, such as psychosis and bi-polar disorder. In the next section I define my terms, to be clear about how I have used and interpreted these terms throughout this study.
‘Psychosis’, in mainstream Western mental health discourse, is defined as:

“a brief disorder, characterized by delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior, which lasts for at least one day, or less than one month, with an eventual return to premorbid functioning.” (American Psychiatric Association, DSM IV, 2013).

Bipolar Disorder is defined by this same document as a disorder with two types:

“Bipolar I Disorder is characterized by the occurrence of one or more manic episodes or mixed episodes. Bipolar II disorder is also characterized by at least one hypomanic episode. In addition, bi-polar II disorder is characterized by one or more major depressive episodes.” (DNA Learning Centre, retrieved April 16, 2014)

For the purposes of this discussion, the definitions of the terms shaman, medicine person, spiritualist, and herbalist, will be those stated by Dr. Martin Hill, of the National Aboriginal Health Organization, in the document entitled Traditional Medicine in Contemporary Contexts: Protecting and Respecting Indigenous Knowledge and Medicine (2013).

As Martin Hill discusses, regarding the term Shaman:

“Originally, it…referred to those individuals responsible for the health of the community and their relationship (by way of their ability to connect more deeply than
others) to the supernatural world. “(Union of Traditional Yagé Healers of the Columbian Amazon Umiyac, 1999: 45, in Martin Hill, 2013, 7)).

Martin Hill states that the **Medicine Person**:

“… usually engages in ritual, ceremonial activity and prayer. In some societies they are identified as “medicine men/women” because they possess sacred bundles, sacred pipes, sacred masks, and the rights to rituals, songs and medicines that have been inherited from their parents, grandparents, or that they earned through apprenticeship with a respected medicine man or woman. Depending on their nation, they are also conductors of community ceremonies such as Sundance, Dark Dances, Horse Dance, False Face, Shaking Tent, and Sweat Lodge, to name a few. It is normative for these individuals to sacrifice their daily lives to ritual, prayer and healing”. (Martin Hill, 2013, 8)

Martin Hill also states that the practice of a Medicine Person can, and often does, involve the practices of those engaged in by those referred to as ‘spiritualist’, ‘herbalist’, and ‘diagnosis specialist’. These terms are defined as follows:

**Spiritualist** – a practice that focuses on the spiritual health of an individual and intervenes on his or her behalf. Diagnosis often includes lifestyle changes of the individual or family and offerings to various benevolent spirits. Also, this person often serves as a counsellor, mentor or teacher to individuals and families. Their primary focus is on the spiritual well-being of people. Their knowledge of cultural spiritual practices is expansive and highly respected by the community, and they often carry titles of honour.
such as “Faithkeeper, Holy Person or in South America, (Traditional) Priest””. (Martin Hill, 2013, 8).

“Herbalist” – a practice that emphasizes botanical and pharmacology knowledge of the indigenous plants and fauna. Often these individuals work closely with other Indigenous doctors and assist in providing remedies for individuals whom they or others have diagnosed. Their practice can be highly specialized in one field, such as remedies for snakebites, or as diverse as the illnesses themselves. Diagnosis specialist – a practice that often involves communication with spirits, the supernatural and the physical entities that assist in the diagnosis”. (Martin Hill, 2013, 8).

“Diagnosticians” - are often the “seers” or communicators through ceremony who identify the ailments, remedies or ceremonies that are required to restore good spiritual, emotional, and physical health, and well-being. Often they work as referrals to other specialists”. (Martin Hill, 2013, 8).

**Organization**

This document will be organized as follows:

Chapter 1 – Introduction: This section features my location as the creator of this document, as well as an overview of my thesis as a whole, and an introduction to methodology.

Chapter 2 - Methodology: This chapter discusses the theoretical frameworks which I will be using. As I will be using an Indigenous theoretical framework and research methodology, this
This section will include a discussion of the variety within, and history of this approach. This section will also include information concerning how interviews were conducted as well as the analysis of the interviews.

Chapter 3 – Literature Review: This section features a review of the literature on the history and nature of the mainstream Western conception of ‘psychosis’, as well as the way in which ‘psychosis’ is taken up in Indigenous and alternative health and healing practices. This chapter will be divided into three sections. The first will focus on explaining and contextualizing the mainstream Western conception of ‘psychosis’. The second will look at how ‘psychosis’ is taken up in Indigenous health and healing practices. The third will look at how this concept is taken up in traditions of health and healing practices which claim to be alternative to mainstream Western Mental Health.

Chapter 4 – Findings – Emerging Themes: This chapter features a discussion of the findings of my research, as well as the emerging themes. This will consist of the information collected from interviews.

Chapter 5 - Implications, Recommendations, and Conclusion: This chapter consists of the implications and recommendations stemming from the interviews conducted, in conjunction with the literature References.

As per the organization of this study, Methodologies used in this study will be discussed in the following chapter. As Indigenous Research Methodologies were chosen, an overview of the history and diversity of Indigenous Research Methodologies will also be featured in the next chapter.
Chapter 2 – Methodology

This section provides context for my choice to conduct research using Indigenous Research Methodologies, and write using an Indigenous Research Framework, building on my reasoning, as stated in the Introduction to Theoretical Framework in Chapter 1. Different Indigenous Research Methodologies will be presented, interwoven with my reasons for using these methodologies for my research. To recap, I made the choice to use these methodologies, as I felt they were most relevant to my subject matter, due to a main focus being Indigenous health and healing practices. I also chose to use them due to being Metis, and feeling a strong connection to the Indigenous traditions which are part of my ancestry, and which made it possible for me to reject mainstream Western mental illness categories, and medication.

Indigenous research methodologies are relatively new to the European and Western tradition of ‘research’ (Steinhauer, 2003). They are part of a larger movement for the reclamation of the ways of life of Indigenous peoples worldwide, which were fragmented by the various colonization processes that happened, and continue to happen throughout the world (Martin & Mirabooopa, 2003, Steinhauer, 2003, Wilson, 2001). They are also part of the movement to decolonize this way of producing knowledge, (‘research’), and to make it into a beneficial and respectful tool for all people (Restoule, 2010).

Regarding how research has been a powerfully oppressive force concerning Indigenous peoples, Martin (2012) provides a strong example of this in her article concerning Indigenous research methodology. She describes how conceptions of knowledge which dominate European Western ‘research’ effectively made her lived knowledge of her Indigenous traditions, and experience as an Indigenous woman, irrelevant and obsolete. This was her experience, when, as
an executive member of the Quandamooka Land Council, she attempted to contribute to proving that her people were the rightful owners of land which was being disputed, as attempts were being made by her people to register this land under their name. Due to Western conceptions of Indigenous traditions of ownership dominating the process of land registration, the knowledge she brought forth was completely ignored (Karen & Miraboopa, 2003). Examples such as these illustrate the damage done by ‘research’ performed ‘on’ Indigenous peoples, the dire need for Indigenous research methodologies, and the way in which these research methodologies can be powerful tools for the decolonization, and reclamation of Indigenous ways of living.

Despite this need, as numerous Indigenous researchers and scholars discuss, due to the reality of the very concept of ‘research’ being simply an aspect of the worldview of the colonizer of Indigenous peoples, creating an Indigenous research methodology has proved problematic (Martin & Miraboopa, 2003). Due to these differences in worldview, many Indigenous research methodologies interweave Western research methods with Indigenous worldviews, as will be discussed.

This is not to say that there are not Indigenous modes and methods for gathering knowledge, which preceded the mainstream Western concept of ‘research methodology’ as there most definitely are (as is illustrated by the sources listed in the overview below). However, as these sources also illustrate, due to the discourse of ‘research’ having roots in colonial practices, and having been used to abuse, and discriminate against Indigenous communities, using this term in relation to Indigenous ways of knowing, is a process which has taken time, and has not been simple, nor without challenges.
**Indigenous Research Methodologies: An Overview**

Linda Tuhiwai Smith (Ngati Awa and NgatiPorou) is a Professor of Education and Maori Development, and Pro-Vice-Chancellor Maori at the University of Waikato in Hamilton, New Zealand. She is renowned for her work concerning Indigenous Research Methodologies. In her work, such as *Decolonizing Methodologies: Research Methodologies*, she discusses the concept and practice of ‘research’, exploring the destructive implications and historical realities which this practice has had and currently has for Indigenous People, due to its centrality in the colonization process.

It is this aspect of Smith’s work which has been most influential in my research, in terms of my deciding to use Indigenous Research Methodologies. In addition to being Metis, as Indigenous traditions have been central to my healing, and are prominent in my research, after learning about the history of research in relation to Indigenous people, via Smith’s work, I decided these methodologies would be most appropriate for my research, in respect for my Indigenous ancestors, as well as the Indigenous practitioners and traditions which feature so prominently in my research. Smith also discusses the dire need for Indigenous Research methodology, and presents a number of ways in which Indigenous Research Methodology has been realized, by discussing numerous case studies worldwide.

Jean Paul Restoule, member of the Anishinaabe First Nation, is Associate Professor of Aboriginal Education, at OISE and a former Program Coordinator of Adult Education and Community Development, and co-director of the Transformative Learning Centre. In collaboration with several other professionals, he presents principles of an Indigenous research methodology (Restoule et al, 2010). This methodology frames Western research methods such as survey, text analysis, and interview, within principles informed by an Indigenous worldview. These principles, which indicate how the ‘researcher’ should proceed, are many of which I presented in the Introduction:
Locating myself, as a researcher, as well as my research, in relation to spirit
Locating myself, as a researcher, as well as my research, in relation to the community I will be working within
Locating myself, as a researcher, as well as my research, in relation to my family.
Emphasizing the journey of my research and how I have come to know what I know regarding my research and what it is connected to personally
Seeking guidance from Indigenous Elders about the value of my project, as well as for insight regarding the project.
Committing to work with faith and trust in spirit, and an acceptance of whatever outcome happens, success of my project or otherwise.
Ensuring that I am accountable for the effects of the research project on the lives of the participants in my research
Writing in narrative and storytelling modalities

These points are included in order to give a clear idea of the Indigenous Research Methodology presented by these authors. In addition, I used this list in deciding how to conduct my research. I made an effort to use each point, in how I conducted my research, though some figured more apparently in my research. For example, the points concerning location, emphasizing my journey as a researcher, and writing in narrative, are more apparent in my research. The remaining points, concerning seeking guidance from Indigenous Elders, committing to work with faith and trust in spirit, and ensuring my accountability, appear less directly.
For example, I did meet with an Elder, however this involved discussing my research in relation to my life as a whole, and, due to this, our discussion was not relevant enough to include in my research Similarly, concerning committing to work with faith and trust in spirit, and being accepting of any outcome, this was an attitude I decided to take towards my research, however writing about this in depth did not make sense, as I felt it was simply an attitude, rather than a research topic about which to be written, in the context of my research topic and sub-topics. Ensuring accountability was something I achieved through the ethics process for interviews conducted, as well as via referencing sources, as well as via locating myself as a researcher.

**Cora Weber Pillwax**

The Indigenous research methodology presented by Cora Weber-Pillwax, who is Metis, Associate Professor of Educational Policy Studies, at University of Alberta, complements that presented by Restoule et al, in that it emphasizes that the researcher should design the research project in such a way as to benefit the community which is the focus of the research. This was something I took to heart in my research.

The community which is the primary focus of my research, is that of people who have, or continue to experience, ‘psychosis’, labeled as such in mainstream Western mental health contexts. My seven years of activism in alternative mental health activism with Mind Freedom International, and the Coalition Against Psychiatric Assault, has taught me that socioeconomic status is a major issue in the incidence of ‘mental illness’ such as ‘psychosis’. It has also taught me that this is a major issue in accessing alternatives to mainstream mental health care, particularly in Western contexts, where such alternatives are generally unaffordable to many.
In addition, much of the literature concerning alternatives, is written in complex academic language, which also makes it inaccessible to many. Thus, I did my best to make this document accessible to people regardless of education level, or academic background. I attempted to do this by deciding to omit flowery, overly complicated academic language, as well as by dividing topics into topic-centred, small sections, which I have learned is helpful in communication (D. Oaks., personal communication, 2012). I also included narrative style writing, as this is more accessible to a larger group of people. Without works such as mine, which attempt to bridge the academy with communities which do not have access to much of academic literature because of socioeconomic status, particularly in the area of mental health, many people continue to be forcibly medicated, without access to information concerning alternatives to mainstream mental health.

In addition to this community, the communities of Alternative and Indigenous health practitioners were also a focus of my research. In terms of designing my research project in such a way as to benefit this community, I was not able to compensate the members of these communities who I interviewed. However, their names appear in this document, along with descriptions of their work, which provides an opportunity for exposure as health practitioners.

Karen Martin & Booran Miraboopa

Karen Martin, who is of the Nonuccal and Bidjara Indigenous peoples of Australia, presents an Indigenous Research Methodology, based on her beliefs. Similar to the framework presented by Restoule et al, and Weber Pillwax, Martin’s methodology features the framing of
Western research practices within Indigenous worldviews and practices. Like these authors, she takes this concept in a different, though related direction. For example, she indicates that research practices such as textual analysis and participant observation should never take precedence over activities which are central aspects to many Indigenous ways of living, such as ceremony, grieving, celebrating, etcetera.

In addition, she emphasizes the importance of dialoguing with all beings in the process of research, emphasizing non-human entities such as water, land, and non-human animals, and integrating what is learned from these beings. In essence, the Indigenous research framework and process defined by Martin is as follows:

Essentially, this describes three main constructs and their processes: first, establishing through law what is known about the Entities (all beings besides people and land); second, establishing relations among entities, and third, enacting ways for maintaining these relations... I identify these as Ways of Knowing, Ways of Being, and Ways of Doing. (Martin & Miraboopa, 208, 2003).

In my research, I incorporated a number of elements from this Indigenous Research Methodology. As described by the quote before, using my spirit name, I connected with, and prayed to Tunkashina, (Great Spirit), on the topic of my research.

In addition, throughout the process of researching, I have done my best to prioritize my health – mental, emotional, spiritual, and physical, as well as making time to attend events, spend time with people close to me, and to allow myself time to work through life events, rather than simply prioritizing my research. This has meant keeping up with meditation to keep a clear mind, making time for artistic expression for the management of emotions, continuing to pray/smudge, and practice yoga for spiritual balance, and maintaining a regular exercise, nutrition, and sleep routine, to keep the physical in balance. As mentioned in the Introduction, I have also framed
Western research methods such as interviewing and text-based analysis, within these practices, as is emphasized by (Miran & Miraboope, 2003).

**Shawn Wilson**

Shawn Wilson, researcher and author, of the Cree Nation, presents several principles which he feels should be at the core of an Indigenous research methodology, defining differences between this and European/Western methodology. For Wilson, at the core of an Indigenous Research Methodology is the concept of ‘relational accountability’. By this he means that research is a relationship between the researcher and everything in the world. Thus, research is about being accountable to everything in the world as this comprises ‘all of your relations’. As follows, morals and accountability must be at the heart of the research process, according to Wilson (2001).

So your methodology has to ask different questions: rather than asking about validity or reliability, you are asking how am I fulfilling my role in this relationship? What are my obligations in this relationship? The axiology or morals need to be an integral part of the relationship, so when I am gaining knowledge, I am not just gaining in some abstract pursuit; I am gaining knowledge in order to fulfill my end of the research relationship. This becomes my methodology, an Indigenous methodology, by looking at relational accountability or being accountable to all my relations, or being accountable to *all my relations* (p. 177)

Being accountable to all my relations has been a main inspiration behind deciding to embark on this journey of research, and has been a guiding light during the research process, particularly at challenging points. Due to my personal experience with ‘psychosis’, being able to withdraw from medication, and, through activism, meeting many people who had been forced on medication after having experiences similar to mine, and who were having difficulty withdrawing from this medication, I felt it was my responsibility to write about my experience and how I was able to remain off medication. As this experience included connections to all my
relations, I felt it was my responsibility to honour these connections in my research, in order to show respect for, and be accountable to, the ways in which these relations supported me through both my experience of ‘psychosis’, and my healing journey.

These avenues of support included the four elements: physical, emotional, spiritual, and mental. My relations consist of what I consider my spirit relations, such as Tunkashina, Krishna, and other religio-spiritual deities, as well as spirit animals, the sun, and energy, such as in colours, and different lights at different times of day. They also consist of my physical relations, my human ancestors, and my clan animals, as was spoken to in the Introduction and narrative sections in Chapter 1.

**Interview Methodology**

In this study, I have conducted interviews with eleven Indigenous and Alternative Health practitioners. Five interviews were selected for transcription and analysis due to their greater relevance to the topic of this study. The individuals I have interviewed were recruited via random sampling of Alternative and Indigenous health practitioners, with connections to the alternative mental health movement, worldwide, in order to attempt to avoid bias as much as possible in such a relatively short study. The criteria concerning who was to be interviewed was intentionally relaxed in order to enable the diversity which exists in terms of healing in the area of mental health, to be reflected in who was interviewed. As stated on the interview invitation, those who I requested respond to the Interview invitation could have included peer counselors, shamans, multi-dimensional and multi-cultural healing practitioners, Medicine Men and Women, Naturopaths, Shiatsu, and Reiki practitioners, as well as other practitioners, thus leaving it open
for people of other disciplines and walks of life to respond as well. Interview participants were recruited via my sending the interview invitation via e-mail, to Alternative mental health organizations and individuals with connections to Alternative and Indigenous health practitioners, based on my knowledge of these organizations and individuals from my research and my activism in Alternative mental health. I initially found these organizations via Google search, as well as by attending conferences and events on the topic of Alternative mental health. Some organizations and individuals contacted had international connections, some did not.

Indigenous Research Methodologies were used to structure this interview, specifically those put forth by Margaret Kovach (2009). Following Kovach’s model, though there are interview questions, these are few, open-ended, and fairly unstructured. Thus, the interviews will follow an ‘open-structured conversational method’ (Kovach, 124, 2009). The rationale for this approach, and the few number of questions, is to allow space for stories which participants might want to share. It also allows for conversations related to the topic of inquiry to have the space to occur, in-line with the flexibility and fluidity characteristic of Indigenous oral traditions (Kovach, 124, 2009). I am a Metis person, and feel strongly about adhering to Indigenous traditions in my research due to the way in which these traditions have the power to begin to reverse the atrocities experienced historically by Indigenous communities worldwide due to the research endeavour.

Analysis of interview data was conducted using the relational worldview and the associated Medicine Wheel Model. Please see Appendix C for Interview Transcripts, and Appendix D for Analysis of interview data. As follows this model, as mentioned previously, interview data will be analyzed according the four quadrants of the Medicine Wheel. As stated by Cross et al (2000), the four quadrants, representing the four dominant life forces which must be balanced for good
health of all elements of the earth, refer to the following:

- **Context**: this quadrant includes culture, community, family, peers, work, school, and social history
- **Mind**: this quadrant include thoughts, memories, knowledge and emotional processes, ie. Feelings
- **Body**: this quadrant includes everything related to the physical body, ie. Nutrition, sleep
- **Spirit**: this quadrant includes spiritual practices and teachings, dreams, gifts, and things of this nature.

Prior to discussing themes which surfaced via the interview process using this model, it is necessary to discuss the rationale behind interviewing these healers for this research, as well as how these interviews fit with the Two-Eyed Seeing Framework, and the Medicine Wheel model. In line with the Two-Eyed Seeing Framework, the interviews of five alternative and Indigenous health practitioners were selected who represented contrasting approaches to ‘psychosis’. Their descriptions are below. This corresponds to the framework in that presenting and discussing this diversity, as is done in the Findings section, illustrates the way in which a multitude of perspectives on ‘psychosis’ exists, all of which must be seen as valid, in order to create an environment most supportive to those experiencing ‘psychosis’. Privileging any one perspective, as put forth by the Two Eyed Seeing Framework, does not honour the diversity which characterizes human experience, and thus the experience of each human being, as each individual is diverse within themselves.
Prior to discussing themes which surfaced via the interview process using this model a brief description of the practices of each of the practitioners interviewed is presented:

**Laini Lascelles:** Laini Lascelles combines the traditions of Shiatsu, and Reiki with traditional First Nations Healing Traditions. As Lascelles states on her website:

> “My Ancestry is Lunaape and Ojibwe, I share the healing energies from the traditional beliefs and practices of my Ancestors. The Healers, Elders recognized the gift of sight and healing hands in my lineage. This encouraged me to enhance this gift of finding balance and harmony in the body.” ([http://laini-lascelles.com/team/](http://laini-lascelles.com/team/))

**Jay Tropianskaia:** Jay Tropianskaia is Director of Training at The Gestalt Institute of Toronto, and is also instructor in the Red Lodge Longhouse at the Institute for Contemporary Shamanic Studies, of which she is also a founding member. As stated on the website of the Institute for Contemporary Shamanic Studies:

> “Jay Tropianskaia, Eagle Sky Rider, has studied the Sweet Medicine Sun Dance Path since 1992. She is a national instructor and A-team roadperson on the Sweet Medicine Sun Dance Path. Jay was one of the founding members of the Institute for Contemporary Shamanic Studies where she currently holds the mantle of instructor in the Red Lodge Longhouse.

> A Gestalt therapist, Senior Faculty and Trainer at the Gestalt Institute of Toronto since 1985, Jay is a respected teacher and trainer of human potential and holistic therapy in Canada and the United States. The driving force in her life has been bridging spirit to substance in people’s everyday lives, and she facilitates people’s ability to make conscious life choices that will support not only their own dreams but the dreams of others.” ([http://icss.org/faculty/jay-eagle-sky-rider/](http://icss.org/faculty/jay-eagle-sky-rider/))
Sangoma Oludoye: Sangoma Oludoye is a traditional Yoruba priestess of Obatala and ancestral custodian of the customs, traditions, codes of conduct for a diversity of cultures. Sangoma is an artist, sacred activist and spiritual midwife. The descendent of 7 generations of root medicine people, the gifts of her ancestors in the Cherokee, Dogon, Bombara and Yoruba tribes continue to manifest healing/wholeness for the wounded, downtrodden survivors of cultural amnesia.

The Kindred of Sangoma network and non-profit organization was born out of her Queenmother's Nonprofit corp. the Willing Workers of Coosawhatchee, SC to fiercely pursue funding sources and capacity building for summer camps, empowerment retreats and personal development intensives.

In her own words:

Sangoma is an elder/instructor/willing vessel to Divinity ....to nurture, tend and be an advocate for the reconnection of humanity with the forces of nature...She teaches us how to keep the ceremony in our everyday lives, find, keep and maintain AT ONE MENT in the seat of the soul through youth summer camps/ On the Forest Floor, Earthskills villages and gatherings, in the celebration of Orisha festivals in Oyotunji, SC or sharing insights and revelations at a solo fire with Coyotes from the Wild Intelligence community in Athens, Ga. Nature is God's other book

More can be read about the workshops and events mentioned and about Kindred of Sangoma at

www.kindredofsangoma.wordpress.com

Bhargavi Davar: Bhargavi Davar is an Arts Based therapist, integrating her personal knowledge with skills in integrated use of Arts in healing and recovery (colour, touch, smell, rhythm, sound, movement, breath). She is also certified in the areas of Buddhist meditative and healing practices, as well as Metaphor therapy and Somatic healing. Since 2009 she has been working with people and families who are in extreme states, using arts based therapies. She is concerned particularly with young adults and adolescents who are first episode psychosis and has been able
to retrieve their personhood before their psychosis becomes established or becomes exacerbated due to anti-psychotic medication. She gives nutrition based consultancy to families and individuals who are interested in building mental resilience and overall fitness. In Bapu Trust, she integrates many of these methods into the program design and acts as mentor to the grassroots team. (Davar, B. personal communication, 2015)

**David Oaks:** David Oaks is former Executive Director of Mind Freedom International, and has been a psychiatric survivor human rights activist since 1976. David is also on the Board of Directors of the United States International Council on Disability. David is knowledgeable on the topic of healing from psychosis via these positions, as well as via his own healing journey from experiencing ‘psychosis’. With support from peers and his family, David used exercise, nutrition, counseling, wilderness trips, protest, and employment to recover mental and emotional well-being. He has been off all psychiatric drugs since 1977. ([http://www.davidwoaks.com/about-david/biography](http://www.davidwoaks.com/about-david/biography))

Interviews were conducted in informal settings, such as farmer’s markets and cafes. Others, in circumstances where participants could not be present in person, were conducted via phone or skype. In general, interviews were about 1 hour in length, in some cases they were closer to two hours.

Interviews conducted in person were considerably longer in length, and of a more personal nature, than those conducted over the phone. It seemed that interviewees felt more comfortable with, and connected to me, when interviewed in person. For myself, personally, the experience was the same. This being said, it was my feeling that the participants interviewed via phone, chose to do so, as they were more comfortable with the added distance. Personally, the
experience of interviewing in person was somehow more relaxed. Rather than being solely focused on getting through the interview questions, when interviews were conducted in person, both myself and the interviewees were able to take in, and enjoy our surroundings (coffee shops, farmer’s markets). All interviews were recorded on a small digital recording device. In addition, I made notes concerning points of interest, during the interviews.

Having introduced and explained research methodologies, the next chapter features a review of literature concerning ‘psychosis’.
Chapter 3 – Literature Review

Introduction

This section will feature a review of the literature concerning the history and nature of the mainstream Western conception of ‘psychosis’, as well as the way in which ‘psychosis’ is taken up in Indigenous and alternative health and healing practices. This chapter will be divided into three sections. The first will focus on explaining and contextualizing the birth and development of the mainstream Western conception of ‘psychosis’. The second will look at how this concept is taken up in traditions of health and healing practices which claim to be alternative to mainstream Western Mental Health. The third will look at how ‘psychosis’ is taken up in Indigenous health and healing traditions. Juxtaposing Western perspectives, with alternative and Indigenous perspectives, and exploring the diversity within each of these categories will illustrate the diversity to which the Two-Eyed Seeing Framework refers. This chapter does not look into how various traditions can be combined, however this aspect of the Framework is discussed in Chapter 5.

Though possible combinations will not be explored, this review will highlight the interaction of ‘psychosis’ with Alternative and Indigenous Healing traditions, from a Two-Eyed Seeing perspective, as previously explained. Such an investigation reveals two trends. The first of these is that a vast number of traditions exist throughout the world, which are completely different from the mainstream Western Mental Healthcare system, in the context of which the mainstream Western mental health concept of ‘psychosis’ is irrelevant. The second is that, in the
context of such traditions, experiences diagnosed as ‘psychosis’ in a mainstream Western mental health context, are, instead, often recognized as the evidence of innate healing capabilities, of a varied diversity.

**Part 1: Socio-Historical Cultural Context**

Psychosis is a concept, born at a certain point in history, with a socio-historical context. This section will feature a brief discussion of the history of this concept, in the European context into which it came into being. It will highlight the historical situation and cultural specificity of the concept of ‘psychosis’. In addition, as is reflective of the Two Eyed Seeing Framework, this section will illustrate the diversity of perspectives, both over time, and within various time periods, which contributed to forming the concept of ‘psychosis’, as it is now known in mainstream Western mental health discourses, where these exist around the world. This will also illustrate the way in which the Two Eyed Seeing Framework indicates approaches to health and healing can be combined to form new perspectives. Simultaneously, this overview illustrates how conflicting perspectives have existed at several points in time during the development of this term, concerning the existence of mental illness in and of itself, including all its subcategories, such as ‘psychosis’. These are explored in light of the Two-Eyed Seeing Framework, illustrating the intellectual climate regarding ‘mental illness’ and its subcategories, such as psychosis, in order to further illustrate the myriad of perspectives concerning health, which were combined, over time, to create today’s mainstream Western mental health concept of ‘psychosis’.

**The Emergence of ‘Psychosis’ as Mental Illness Category: International Perspectives**
The word Psychosis originates in several ancient Greek terms:

“Greek psukhōsis 'animation', from psukhoō 'I give life to', from psukhē 'soul, mind'.”

Despite these ancient roots, and prominence in mainstream Western mental health discourse today, ‘psychosis’ did not become part of this discourse until the late 19th century. Prior to this time there have been a number of terms similar to this, as well as to ‘mental illness’ in general, which have been part of medical discourses in Western contexts. Surrounding these terms, there have been a number of theories and historical processes, which form the varied landscape onto which current concepts of ‘psychosis’ and ‘mental illness’ eventually emerged.

As it is beyond the scope of this research endeavor to discuss all of these perspectives from philosophical and historical literature, a few prominent examples will be discussed, in order to illustrate the variety of the ways in which these concepts came into being and use. Those featured will be perspectives from what is known about early human social organization, Ancient Greek society, as well as philosophical and historical perspectives concerning the emergence of the terms ‘psychosis’ and ‘mental illness’ in Europe, between the 15th and 19th centuries, a time of increasing industrialization, as well as historical perspectives from the United States during the late 19th and early 20th centuries.

**Early Human Organization**
In their article: *How shamanism and group selection may reveal the origins of Schizophrenia* (2002), Polimeni & Reiss discuss how shamans and traditional medicine people worldwide have been experiencing ‘psychosis’ for what has been estimated to be around 20,000 years (Polimeni & Reiss, 2002). In addition, the current 1% prevalence rate of schizophrenia (Polimeni & Reiss, 2002), a mental illness diagnosis in mainstream Western mental health, characterized mainly by the recurring experience of ‘psychosis’ (American Psychiatric Association, DSM V, 2013), has been shown to correlate directly to the prevalence of the emergence of shamans, healers, or magico-religious practitioners, within the population density of tribal groups, both historically, and communities which continue to follow this organization, with such prevalence being one such individual in groups of 150-180 (Polimeni & Reiss, 2002). This suggests that it is important, for the survival of the human species, for a certain number of individuals to have ‘psychotic’ experiences (Polimeni & Reiss, 2002).

Aside from rates of prevalence, there are striking similarities between ‘psychosis’, and the experiences of shamans and medicine people, in diverse traditions worldwide (Polimeni & Reiss, 2002). Numerous examples from Indigenous Traditions with origins worldwide, throughout time, illustrate these similarities. For example, the experiences of shamans and medicine people are characterized by visions, auditory hallucinations, which are often understood as spirit possession, the receiving of signs from spirits, as well as the decision to, and capability of going on, vision quests (Polimeni & Reiss, 2002, Deloria, 2006, Wesley-Esquimaux, C., personal communication, April, 16, 2007). These similarities will be further demonstrated by the third section of this chapter.

**Ancient Greece**
In addition to perspectives from the ancient history of people entering states of mind akin to ‘psychosis’, Porter draws attention to references to ‘madness’ in ancient texts such as the Old Testament, Homer’s Odyssey, as well as in what is known of the living ways of the Babylonians, Mesopotamians, and Assyrians. Porter also discusses the ancient Greek traditions which contextualize the origins of the term ‘psychosis’. He explains how these were complex medical traditions involving intricate ways of diagnosing various ailments. These included the belief in the system of humours (bodily fluids), which, if out of balance, could cause many illnesses, ‘mental illness’ among these. Within these traditions, it was also recognized that extremes of emotion could drive people to ‘madness’. In his overview of the history of this phenomenon, Porter illustrates how the medical systems of Ancient Greece influenced and continue to influence the systems of health which developed in Europe and which currently dominate in the Western world, particularly concerning mental health. The pervasive use of the term ‘psychosis’ exemplifies this trend.

**Philosophical and Historical Perspectives from Europe**

Though this discussion is by no means comprehensive, it appears, from the research conducted, that the dominant terms which preceded ‘mental illness’, with characteristics similar to what is known as ‘psychosis’, were ‘madness’, ‘insanity’, and ‘mania’. Perspectives which will facilitate an exploration of these terms include those of philosophers Michel Foucault, and Thomas Szasz, well known for their contribution to the philosophy of psychiatry, as well as those of historian Andrew T. Scull, who wrote influentially on the rise of the ‘mad-doctoring trade’. Perspectives from Roy Porter’s *Madness: A Brief History* will also be touched on.
**Perspectives from Foucault**

Well-known French philosopher Michel Foucault wrote on the topic of ‘madness’ in a European context, particularly concerning its rise during the 16th century, and continued development through, and including, the 18th century, in works such as *The Birth of the Clinic*, published in (1963) and *Madness and Civilization*, published in 1965. For instance, in *The Birth of the Clinic*, published in 1963, Foucault describes the way in which the concept of normality became part of medical practice during the 19th century, thus contributing to the rise of mental illness, as this concept began to be used to diagnose how people had deviated from what became to be known as normal. Prior to this time, the concept of illness had referred to qualities of health within the body which were lost during illness, and which it was the function of doctors to attempt to bring back:

“Nineteenth-century medicine, on the other hand, was regulated more in accordance with normality than with health; it formed its concepts and prescribed its interventions in relation to a standard of functioning and organic structure, a physiological knowledge – once marginal and purely theoretical knowledge for the doctor – was to become established… at the very centre of all medical reflexion” (Foucault, 1963, 67).

In *Madness and Civilization*, Foucault does not use the term ‘psychosis’, however, his use of the term ‘mania’ throughout this work is relatable to the concept of ‘psychosis’. In addition, Foucault’s use of this term can be seen as a pre-cursor to the present day categorization of distinct ‘mental illness’ categories within such documents as the DSM IV (2013).

In this work, Foucault draws attention to the origins and rise of ‘madness’ in the 14th and 15th centuries, his observation being that as leprosy became obsolete, ‘madness’ took its place, with the ‘mad’ taking the place of ‘lepers’, and thus being treated as untouchable. He also
describes how during the course of these three centuries, several categories of ‘madness’ came to be recognized within society at large. Those which are relevant to our discussion are ‘mania’ and ‘melancholia’, as it is aspects of these two phenomena which exhibit the closest similarity to the concept generally understood today as ‘psychosis’:

“The mind of the melancholic is entirely occupied by reflection, so that his imagination remains at leisure and in repose; the maniac’s imagination, on the contrary, is occupied by a perpetual flux of impetuous thought. While the melancholic’s mind is fixed on a single object, imposing unreasonable proportions upon it, but upon it alone, mania deforms all concepts and ideas; either they lose their congruence, or their representative value is falsified; in any case, the totality of thought is disturbed in its essential relation to truth. Melancholia, finally, is always accompanied by sadness and fear; on the contrary, in the maniac we find audacity and fury. Whether it is a question of mania or melancholia, the cause of the disease is always in the movement of the animal spirits. But this movement is quite particular in mania: it is continuous, violent, always capable of piercing new pores in the cerebral matter, and creates, as the material basis of incoherent thoughts, explosive gestures, continuous words which betray mania”

(Foucault, 1965, pp. 125-126).

These descriptions of ‘melancholia’ and ‘mania’ demonstrate similarities to the definition of ‘psychosis’, as well as Bi-Polar Disorder provided by the most recent publication of the DSM. For example, the way in which Foucault describes the melancholic to be preoccupied by reflection, fixated disproportionately on a single object, and preoccupied with disproportionate emotions of sadness and fear, is similar to the way in which, according to the DSM IV, those who experience ‘psychosis’ exhibit ‘catatonic behavior’, as well as exaggerated or seemingly unfounded extremes of emotions, in the form of ‘hallucinations’ and ‘delusions’ in those who are diagnosed with ‘psychosis’ in a mainstream Western context.

Similarities between the condition of ‘mania’ and the Western concept of ‘psychosis’ are also evident. For example, Foucault writes about the way in which the maniac experiences continuously fluctuating thought, as well as speech, and gestures, which appear nonsensical. This
is similar to the delusions, hallucinations, and disorganization of speech and behavior referred to in the definition of ‘psychosis’ from the DSM IV (2013).

Thus, in these particular writings of Foucault, we are provided with a perspective on the historical context which surrounded the rise of ‘madness’, which in turn provides valuable context for the emergence what is today referred to as ‘mental illness’, as well as distinct mental illness categories, such as ‘psychosis’.

**Perspectives from Thomas Szasz**

The writings of Thomas Szasz, such as *The Myth of Mental Illness* (1974) provide further context for the rise of the concepts of ‘psychosis’, and ‘mental illness’. These sources detail the processes which surrounded the continued development and use of these terms during the 19th century in Europe.

For example, Thomas Szasz, a complete disbeliever in mental illness, in *The Myth of Mental Illness* (1974), discusses the way in which the category of mental illness came into being during the 19th century in Europe, among the upper class. Indeed, Szasz discusses how, until the mid-19th century, the term ‘illness’ referred to:

> “a bodily disorder whose typical manifestation was an alteration of bodily structure: that is, a visible deformity, disease, or lesion, such as a misshapen extremity, ulcerated skin, or a fracture or wound….physicians distinguished diseases from non-diseases according to whether or not they could detect an abnormal change in the structure of a person’s body.” (Szasz, 1974, p. 11).

Szasz discusses how the creation of psychiatric diseases was evidence of the extension of the definition of ‘illness’, as ‘alteration of bodily structure’ to ‘alteration of bodily function’.
Thus, Szasz put forth the idea that, whereas new illnesses discovered around this time, following the trend of ‘alteration of bodily structure’ continued to be discovered within the bodies of patients, psychiatric illnesses were invented, as the only evidence for their existence could be seen in behavior.

Thus, according to Szasz, mental illness was a social construction, and created endless possibilities for the creation of new ‘psychiatric diseases’, due to how these diseases were created via observing and pathologizing behavior, rather than in observing any change in the structure of the body. He also makes the point that the creation of such an illness category made it possible for people to no longer be responsible for their behaviors, as these could be made attributable to a psychiatric illness, a possibility which could potentially lead to considerable social unrest. His observations highlight how these changing standards in illness perception, made it possible for illness to be discovered in people who, using previous conceptions of mental illness mentioned, would have been seen as being in perfect health (Szasz, 1974). Though the perspectives of Thomas Szasz do not include direct reference to the modern day concept of ‘psychosis’, they do provide valuable context regarding how the conception of ‘mental illness’, which includes ‘psychosis’, came into being.
Building on Szasz’s observations, renowned historian Andrew T. Scull, in collaboration with Hervey, and Mackenzie, in their co-authored publication, *Masters of Bedlam* (1996), discuss the rise of mental illness concepts, in the context of the increasing stratification of society in mid-19th and early 20th Britain, which occurred alongside the Industrial Revolution. This book discusses how psychiatrists emerged during this time as part of ‘the rise of professional society’, in which entirely new categories of social actors came into being. Scull details how these included:

“...not just an industrial and commercial bourgeoisie (and their counterpart, a burgeoning proletariat) but also an ever-greater enlargement of the knowledge-based professional classes” (Scull et al, 1996, p.5).

Thus, psychiatrists, termed at that time “mad-doctors, alienists, and medical psychologists” (Scull et al, 1996, 5), were part of this emerging knowledge-based professional class, and as such, were running businesses, and in effect, attempting to make as much money as possible, through the process of diagnosing and treating people, often of lower classes, based on their supposed superior knowledge in the emerging area of ‘psychiatric illness’, described by Szasz, as discussed previously. Thus, these were people with self-proclaimed expertise in an emerging area, with the primary goal of gaining and maintaining prestige and status. This calls into question the verity of their diagnoses, and also provides further context regarding how mental illness categories such as psychosis, as well as mental illness in general, and the profession and practice of psychiatry, came into being.

**The Emergence of ‘Psychosis’**
Thus, the stage has been set for the appearance of the term ‘psychosis’, as it is currently used within mainstream mental health. Following the historical trends discussed, the term psychosis was first used in Germany, in 1841, by Karl Friedrich Canstatt, German doctor and writer on medicine, in his text “Handbuch der Medizinischen Klinik”, as a short form for the term ‘psychic neurosis’ (Porter, 2002). This was meant to refer to disease of the brain, and how it manifested. The term psychosis was first used as a ‘mental illness’ category in 1845 by Austrian psychiatrist Ernst von Feuchtersleben, as an equivalent to ‘insanity’ and ‘mania’, terms which were being widely used at this time (Beer, 1995). Later, Emil Kraeplin, a German psychiatrist, divided what was generally referred to as psychosis into two categories: manic depressive illness, and dementia praecox (Porter, 2002). Manic depressive illness eventually became what is known today as ‘bipolar disorder’, and dementia praecox became what is now known as ‘schizophrenia’ (Porter 2002). These disease categories are now part of the DSM. Similar to the time of their origins, they continue to perpetuate social hierarchies and inequalities, and, as this historical exploration has revealed, they are not the unquestionable medical truths they are made out to be in the DSM. Definitions of these terms can be found in the Index section in the Introduction.

**Historical Perspectives: Late 19th Century - Early 20th Century United States**

Alongside the gradual emergence of the terms ‘mental illness’, and associated categories such as ‘psychosis’, on the ideological landscape, in the 19th and 20th century, there existed a dramatically different dynamic in other parts of the world, such as what is now the United States of America, where the ideology of ‘mental illness’ was an important tool of colonial conquest.
For example, mental health institutions, labeled asylums, were created by colonial governmental bodies, in the late 1800s, specifically to incarcerate, and thus further dominate oppress, and remove Indigenous peoples from desired land, on the basis of perceived mental instability. The Hiawatha Insane Asylum for Indians of Canton, South Dakota, was created in 1899 by The United States Congress, specifically for the incarceration and pathologization of Indigenous peoples (Yellow Bird, 2001), and will be discussed to illustrate how the concept of ‘mental illness’ was used within such institutions to achieve these goals, and will further highlight its fictitious and constructed nature.

Indigenous peoples were forced to live at this institution, for a number of reasons, a dominant reason being the refusal to stop practicing their traditional ways. In addition, many were locked up in this institution under the guise of mental illness, when their ailments were otherwise such as ‘tuberculosis, epilepsy, senility, congenital, or injury-related illness’ (Yellow Bird, 2001, 5). Children also were sent to this space for acting out at school. Other reasons for being sent to such spaces were the refusal to allow children to be taken to residential schools.

In addition, healthcare was not available at this institution. Furthermore, as Indigenous people were seen as ‘defective’ it was policy that they be sterilized prior to discharge. However, as the superintendent of the institution did not possess the expertise to conduct the sterilization process, those residing at the asylum remained until death, to ensure making procreation of Indigenous peoples an impossibility.

This information, and more, was made available by a series of investigations, beginning in 1929, conducted by Dr. Samuel Silk, who was sent to investigate by the Secretary of the
Interior of Canton, due to a number of complaints from the female staff at the Asylum. Other horrifying realities were unearthed by his investigations:

“In his investigations, Dr. Silk found children, strait-jacketed and chained to beds, lying quietly in their own excrement, he found a young epileptic girl chained at the ankle to a hot-steam radiator with shackles borrowed from the local sheriff, and said it was a miracle she had not been severely burned; he found calm, well behaved and mentally healthy patients who had been locked in their rooms for up to three years, he found every single window locked and barred – not even in the wards, where each bed had an open and full chamber pot beneath it, was fresh air allowed” (Yellow Bird, 2001, 6).

Due to these investigations, the asylum was closed, though not until 1933, meaning that it operated for nearly 40 years. Illustrative of strong connection between such institutions, the concept of ‘mental illness’, and the colonial conquest of the Americas, the closure of the Asylum was protested by the Chamber of Commerce of Canton (Yellow Bird, 2001, 6).

Along similar lines, in the 1850s, conditions for people of African Descent within Asylums such as the Alabama Insane Asylum, in operation during the late 19th and early 20th century, were similarly horrifying. Additionally, mental illness categories were created during these times in the United States in order to further facilitate the control of slaves. For instance, in Louisiana, U.S.A., the disease of Drapetomia was created in 1851 by Samuel Cartwright, a renowned physician, which was described as a form of ‘mental illness’ causing slaves to want to run away from service. Dr. Cartwright was seen as a leader in the health care of people of African Descent (Jackson, 2002).

Thus, these examples have illustrated the racist and highly damaging contexts and dimensions of the conception of ‘mental illness’ and the associated ‘mental illness’ categories. Indeed, these terms were used as part of eugenic processes perpetrated by colonial powers, intended to destroy entire life ways and people, during the colonial conquest of the Americas (Jackson, 2002, Yellow Bird, 2001).
The emergence of the term ‘psychosis’ onto the scene of mainstream mental health care, has a complex and multi-faceted history, deeply interwoven in colonial and capitalist processes. It has also been demonstrated that this term cannot be separated from the emergence of the concept of ‘mental illness’, and related ‘mental illness’ categories.

In present times, an inquiry into psychosis presents a different landscape. This is most definitely beyond the scope of this discussion, however several interesting trends can be observed. One is the way in which Western mental healthcare, once so obviously a form of human torture and domination in some parts of the world (Yellow Bird, 2001, Jackson, 2002), are now seen as things to strive towards being able to afford in various parts of the world, as is discussed in Crazy Like Us (2010), a book by Ethan Waters, which discusses the globalization of mainstream Western mental health. Simultaneously, in contexts where mainstream Western mental health care dominates, such as Canada and the United States, there is a strong movement for ‘alternative’ mental health care, led by organizations such as UN-acclaimed alternative mental health organization Mind Freedom International (http://www.mindfreedom.org/). In addition, the movement to abolish psychiatry remains strong, in organization such as The Coalition Against Psychiatric Assault (http://coalitionagainstpsychiatricassault.wordpress.com/).

Thus, the international landscape surrounding ‘mental illness’ and ‘psychosis’ continues to change in a multitude of complex and varied ways. Due to this complexity, it is difficult to predict what may transpire in coming years, and thus, these conceptions are highly worthy of further exploration beyond this study.

Regarding the way in which ‘psychosis’ exists in present times, the Two Eyed Seeing perspective remains very relevant. Not unlike the ideological landscape, changing through the years, which led to the mainstream conception of ‘psychosis’, the various trends which continue
to define its present existence exemplify numerous perspectives. Some conflicting, some in agreement, these must be valued separately and in possible combination, in order for greater understanding and possible avenues for health, concerning ‘psychosis’.

**Part 2: Alternative Health Perspectives**

As this research reveals, the term ‘alternative mental health’ generally refers to health practices created and promoted by Caucasian people of Western European descent, which incorporate aspects of Indigenous health practices without acknowledging these practices. The specific history and context of the Indigenous traditions which are being drawn from are most generally not acknowledged by ‘alternative mental health’ practitioners, which can be seen as an example of unrecognized White Privilege on behalf of the practitioners.

There is a wide variety within these practices, which is exemplary of the diversity alluded to by the Two-Eyed Seeing Framework. Several on-line databases, such as the Alternative Mental Health website ([http://www.alternativementalhealth.com/](http://www.alternativementalhealth.com/)), and The International Network toward Alternatives in Recovery (INTAR) ([http://intar.org/](http://intar.org/)) list a wide variety of ‘mental health alternatives’, and make it possible to read about and connect with individual alternatives. Though this discussion does not focus on how these alternatives connect with each other, it is interesting to note that there seems to be relatively little collaboration between them, with a few exceptions such as carefarms, which are connected by several national networks, such as that which exist for the UK area ([http://www.carefarminguk.org/care-farming-explained](http://www.carefarminguk.org/care-farming-explained)). It is interesting to imagine how they might be combined, as per the recommendation of the Two-Eyed Seeing Framework, in order to
maximize the effectiveness of each alternative. It is also interesting to imagine possible combination. For example, it is interesting, when reading this section, to imagine various practitioners collaborating, various theories being combined, and various healing centres collaborating with each other, in addition to every other possible collaboration between these different alternatives.

The following discussion of a number of these practices will demonstrate the observations mentioned concerning this field. For example, mental health practitioners who have put forth alternative perspectives, such as Rufus May, Gabrielle Peacock and Tamasin Knight, and, put forth the perspective that, contrary to mainstream Western mental health, experiences diagnosed as ‘psychosis’ are experiences containing much meaning and value, which are constructed in a negative way by society at large (Knight, 2009, May, 2011).

Such practitioners also focus strongly on recovery, with the value of these experiences considered to be of secondary importance. These practitioners also make the point that what are considered delusions and hallucinations in Mainstream Western mental health are not considered such in shamanic traditions, or in traditions such as the Yogic tradition of Kundalini, namely that the meaning of such experiences is in the eye of the beholder. However, other than indicating that they are people who have had personal experiences with ‘psychosis’, as well as the type of practitioner that they are, they do not say anything about the traditions, cultures, regions of which they are a part, originate from, or are influenced by. For instance, Rufus May is a psychologist, Gabrielle Peacock is a general practitioner (http://www.cet.net.au/MHEIT/page2/page2.html) Tamasin Knight is a public health doctor in England (http://www.madinamerica.com/author/tknight/) and Ron Unger is a licensed clinical social worker and therapist. These forms of healing practices are mentioned without reference to the
regions and historical processes from which they originate, and thus remain in the shroud of unrecognized White Privilege.

**Traumagenic Neurodevelopmental Model**

Another ‘alternative’ perspective is the traumagenic neurodevelopmental model, which is rooted in Western science. This model consists of 125 studies, a number which continues to grow, which show that there are strong similarities between the brains of individuals who have experienced trauma in childhood, and the brains of adults who experience ‘psychosis’ (Read & Fosse, et al, 2014).

Specifically, these studies have shown correlations in relation to characteristics of the hippocampus, frontal lobes, as well as over-reactivity to stress of the hypothalamic-pituitary-adrenal axial system. These correlations, with the first study published in 2001, have been significant enough that proponents of this model put forth the opinion that histories of trauma/neglect/abuse should be taken from all users of the mainstream mental health care system (Read & Fosse et al 2014).

Interestingly, there are strong correlations between this model, and what is known regarding medicine people and shamans from a diverse variety of Indigenous traditions worldwide. These correlations exist in that many people who go on to become medicine people and shamans are individuals who experience trauma as children. Their abilities as shamans and medicine people often stem from the way in which, during these traumatic experiences children often have to disassociate and leave their bodies (Deloria, 2006, Harner, 1980). This ability remains after these experiences, and is often a defining ability of those who become shamans and
medicine people. After these initial experiences, this ability surfaces in subsequent similar experiences, which identify individuals as these kinds of alternative health practitioners (Deloria 2006, Harner, 1980).

As mentioned previously in this review, the experience of ‘psychosis’ is often strikingly similar to the experiences which define shamans as such after their initial traumatic experiences. This aspect of the life experiences of those who become shamans and medicine people is discussed by Vine Deloria Junior (2006), in his book The World We Used to Live In: Remembering the Powers of Medicine People, as well as in The Way of the Shaman (1980), by Michael Harner, as well as many of the examples from various parts of the world, discussed previously. Despite these similarities and connections, in writings and studies concerning the traumagenic neurodevelopmental model, the roots in Indigenous medical practices are not acknowledged. Instead, the perspective remains shrouded in the anonymity of White Privilege.

**Open Dialogue**

Open Dialogue is a form of mental health care which was developed in the 1980s, in Finland, by Jaakko Seikkula, Birgitta Alakare, and Markku Sutela. Open Dialogue is an approach to dealing with ‘psychosis’ which emphasizes that experiences which are often diagnosed as such are instead due to problems in the way people relate to each other, and, thus, the solution to such problems is to make dialogue possible.

The way in which the Open Dialogue model works to heal these rifts between people is via setting up Open Dialogue sessions within 24 hours of the initial crisis, which bring
together everyone connected to the crisis. This usually consists of the person experiencing the crisis, their family, social network, any professional helpers they have been seeing, and anyone else closely involved. After the initial meeting, any and all meetings following, involve everyone. This approach has been shown to greatly increase the full recovery from such experiences. For instance, a five-year study showed that 83% of patients had returned to their jobs. In addition, the institution of such an approach has been shown to have a preventative effect, with the incidence of such experiences having decreased considerably (Hall, W., personal communication, June 13, 2014, [http://www.dialogicpractice.net/](http://www.dialogicpractice.net/)).

This approach is partially based on Finnish Indigenous principles, which is recognized by proponents of Open Dialogue, however, the specific Indigenous groups whose teachings are being drawn from do not seem to be known to these individuals and are thus not acknowledged (Hall W., personal communication, 2014, [http://www.dialogicpractice.net/](http://www.dialogicpractice.net/)). It is yet another demonstration of a form of healing in which the concept of ‘psychosis’ as mental illness located in the individual, dissolves.

**Alternative Healing Spaces**

Another so-called alternative health practice is that of creating alternative healing spaces geared towards supporting those experiencing a variety of ‘mental health’ issues. There is a wide range of diversity among these types of centres. However, as will be illustrated via the discussion of a number of these spaces, these also follow the characteristics of the alternative mental health
It seems that most alternative mental health healing spaces exist in Canada, the U.S., Australia, and Europe. In Africa, Asia, and South America, (http://www.alternativementalhealth.com/directory/experts.htm, http://www.mindfreedom.org/mfdb/mfdb-search-form, http://intar.org/resources/) It seems that alternative medical institutes do exist in these parts of the world, but those specifically focused on mental health do not, though it is definitely possible that my research has missed some of these spaces. This trend can be understood in a variety of ways.

For one, many mental illness categories were born in the Western World, have their strongest anchoring here, and have spread elsewhere. Thus, it would make sense that there would be more ‘mental health alternatives’ in those parts of the world which are most westernized, ie. North America and Europe, as it is in these places that these ideas have the longest history and the strongest hold (Waters, 2010), Whitaker (2010), Scull (1996). It follows then, that in these places there would be the strongest and substantial resistance, manifesting in the creation of ‘mental health alternatives’. Therefore, though the lack of mainstream western and alternative mental health care in Africa, Asia, as well as Central and South America, is often attributed to lack of funds (Waters, 2010), it is important to also acknowledge the possible impact of differences in belief and medical systems in different parts of the world. Thus, this apparent lack may simply be a cultural divide, in the sense that ‘mental health alternatives’ are a Western construction. These practices and spaces may in fact exist in the mentioned parts of the world, however there are very few which appear in the principle international databases of mental health alternatives which exist (http://www.alternativementalhealth.com/directory/experts.htm).
These databases, when combined, seem to be the most reliable way to know where ‘mental health alternatives’ exist, due these databases having multi-cultural leadership and membership.

Obviously, this is my perspective from the research I have done, however it is definitely possible that ‘mental health alternatives’ exist in the mentioned parts of the world, which I did not come across in my research.

On this topic, it is interesting to note that in some cases, the therapies offered in western countries, in Western Mental Health Alternatives, are akin to the traditions which dominate in Africa, Asia, and South America. These issues bring into question the actual need for Western mental health care, as well as alternative mental health care, in these parts of the world.

An in-depth survey of Alternative Mental Health Healing Spaces which exist worldwide, from information gathered via internet searching, as well as dialogue with members of the alternative and peer counseling mental health movements, reveals four categories into which these spaces can be grouped. This survey consisted of ~ 500 alternatives which exist in the following three databases: Mind freedom International Directory of Alternatives (http://www.mindfreedom.org/mfdb/mfdb-search-form), The International Network Towards Alternatives And Recovery, Resources section (http://intar.org/resources/), and the Alternative Mental Health website (http://www.alternativementalhealth.com/), Find Help section. In addition, alternatives which I learned of from the other sources mentioned, total ~ 10. The categories which emerge from such a survey are as follows:

1. Spaces which focus on physical detoxification and rehabilitation from extended periods of psychiatric drug consumption: Examples include the Alternatives to Meds Center in
Arizona (https://www.alternativetomeds.com/) Other spaces which follow this model include Novus Medical Detox (http://novusdetox.com/), and Mental Health Center of Greater Manchester, New Hampshire, U.S. (http://www.mhpgm.org/), as well as Orthomolecular Treatment Centres, which are found throughout North and South America, and Europe.

2. Non-medical work/volunteer stay spaces, which aim to be holistic, featuring longer term respite, as well as multiple healing modalities and support strategies: Examples of such spaces are Earth House, Soteria, and Windhorse Associates (http://www.windhorseimh.org/)

3. Care farms (farms which allow people to stay and/or work, who have been diagnosed with mental illnesses): Examples include Clinks Care Farm, as well as a number of farms which follow the care farm model, which can be found throughout the UK, (http://www.carefarmingscotland.org.uk/) the Netherlands, Canada, and the United States.


**Spaces of Physical Detox and Healing**
A large proportion of Alternative Mental Health Healing Spaces focus on assisting individuals in their efforts to withdraw and/or detoxify from psychiatric medication, through a variety of treatment options alternative to psychiatric medication. An example of one of these is the Alternative to Meds Center, which is located in Sedona, Arizona. As stated on the Alternative Mental Health Website (http://www.alternativementalhealth.com/directory/experts.htm), a site which compiles information about global alternative mental health:

The mission statement of this center is as follows:

“We are a residential facility designed help a person taper off of psychiatric medications. We employ the service of an Orthomolecular doctor with forty years experience in this capacity. Through the use of brain chemistry testing, we isolate imbalances. We then seek to create balance through the use of naturally occurring substances specifically aimed at correcting those imbalances, thereby countering the need for medications and off-setting addictive biochemistry.

We work with people who are on antipsychotics, benzodiazepines, antidepressants, and pain medications. The standard program duration ranges from four to twelve weeks. In this time, under the guidance of a board certified psychiatrist, the medication is tapered. The client spends their time on course learning clinical nutrition, participating in inventive physical exercise and stretching, working with a counselor, focus groups, acupuncture, supervised client outings, or working with a needs specialist, and is free to enjoy activities of their own choosing. Each client is viewed as a success story, and we individualize the treatment that best tells that story along the way.”

(http://www.alternativementalhealth.com/directory/experts.htm)
The following is a detailed description of key elements of the Alternative to Meds Centre:

*Type of Practitioner: Program Director, Medical Doctor, Ph.D, MPH*

*Type of Treatments: Medication tapering, orthomolecular supplements based on brain chemistry labs, allergy testing, heavy metal removal, yoga, acupuncture, organic and whole food diet, residential care, sauna detoxification and chelation, IV nutrients*

*Prescribe or recommend Psychiatric drugs? No*

*The drugs are tapered. If it is necessary for us to fill a prescription so that there is enough medication to taper with we can.*

*Help take patients off Psychiatric drugs if they wish to do so? Yes*

*The neurochemistry is evaluated with labs, then a tapering schedule is combined with targeted nutrition to rebuild balanced neurochemistry*

*Other Notes: We Specifically focus on balancing people without medications*

*Types of clients served:*

*Depressed, Anxious, Opiate Users, Anti-psychotic withdrawal*

**Spaces which claim to offer holistic treatment for various ‘major mental disorders’**

There are a number of spaces which attempt to offer holistic treatment and support for ‘major mental disorders’. For example, Earth House, in Princeton, New Jersey, focuses on providing holistic treatment and support for what is referred to on their website as ‘major mental disorders’, including what is commonly referred to as schizophrenia, bi-polar, and depression:

“Located in a rural community near Princeton, New Jersey, Earth House accommodates a maximum of 14 residents. Earth House maintains an age policy where the minimum age is 18, and the maximum age is at the discretion of the administration. The minimum stay is 3 months;
the average length of stay is 8 months; the maximum stay is 2 years. Most residents have had multiple diagnoses and have been previously hospitalized, some for 10 years or more. Many have a history of suicide attempts, and a history of substance abuse is common.” (http://www.earthhouse.org/index.html)

Earth House focuses on what is referred to as the ‘treatment’ of each individual residing in the house, through a variety of means, with the end goal of reducing each individual’s dependence on psychiatric medication, and increasing the possibilities of each resident to become independent and self-sufficient. Earth House does this by a variety of means. For example, Earth House focuses on searching for the cause of the disturbance being experienced by looking for physical imbalances such as the presence of heavy metals, and allergies. Connected to this is a focus on nutrition, and the creation of individual nutritional plans, complete with food preparation instructions.

Also provided are classes and sessions designed to help enhance self-understanding and life skills, such as psychotherapy, drama, and art classes. Residents also have the opportunity to take part in classes such as driving and banking, as well as classes designed to teach skills needed in order to make it possible for residents to volunteer, with the goal of enhancing the independence of each resident. Emphasis is also placed on physical activity, with 12 hours of compulsory physical education each week. Effort is made to recognize and encourage individual talent. Residents at Earth House are seen as students and are expected to learn from the classes and practitioners at Earth House. Class attendance is compulsory.

Carefarms
The care farm model, which was developed in Europe has its roots in the early 20th century, in the Netherlands. There are networks of care farms in the UK and the Netherlands which follow the basic care farm model, with variation which is to be expected from farm to farm. The basic concept of the care farm is a working farm at which people experiencing a variety of health-related difficulties are able to live and engage in farm work activities. This is meant to act as a form of therapy and respite. There are a number of principles which unite care farms which make up the care farm network, exemplified by what is put forth by the UK care farm network website:

“Care Farming Explained:

Care farming is the therapeutic use of farming practices. Care farms:

- **Utilize the whole or part of a farm.** Be they commercial agricultural units, smallholdings or community farms.

- **Provide health, social or educational care services for one or a range of vulnerable groups of people.** Includes people with mental health problems, people suffering from mild to moderate depression, adults and children with learning disabilities, children with autism, those with a drug or alcohol addiction history, disaffected young people, adults and people on probation.
• **Provide a supervised, structured programme of farming-related activities**, including animal husbandry (livestock, small animals, poultry), crop and vegetable production, woodland management etc.

• **Provide services on a regular basis for participants**, where clients/participants attend the farm regularly as part of a structured care, rehabilitation, therapeutic or educational programme.

• **Are commissioned to provide care farming services by referral agencies** such as social services, health care trusts, community mental health teams, education authorities, probation services, Connexions etc. Clients can also be self-referred as part of the direct payments scheme, or be referred by family members.” ([http://www.carefarminguk.org/care-farming-explained](http://www.carefarminguk.org/care-farming-explained))

An example of a care farm is Clinks Care Farm, set up in 2010. Clinks Care Farm, which acts as a care farm four days a week, is located in Norfolk County. The care farm opportunities offered fall into three categories: care of small animals, from poultry to calves, horticultural care which encompasses care of vegetable plants as well as a market garden, and general environmental work. The goal of the farm is to provide residents with applicable life skills.

Clinks Care Farm states that it works to support the following:

1. People with severe and enduring mental health problems
2. People with learning disabilities
3. People with an autistic spectrum disorder
4. People with brain injuries
5. People with physical health problems
6. Young people who are not in school or at risk of being excluded


Regarding recovery at Clinks Care Farm, the website states:

“For people with mental health problems coming to the farm is very much about working on your recovery. Through the work that you do on the farm you start feeling better in yourself and hence your mental health may improve too. For other people it can be an opportunity to develop social skills and work skills. It can also help you to prepare for the world of real work. The farm can also provide day care in the form of a meaningful activity.” (http://www.clinkcarefarm.org.uk/index.php?option=com_content&view=article&id=6&Itemid=8).

This quote is illustrative of the multiple ways in which care farms can support people with diagnoses of ‘mental health issues’. These spaces provide a unique opportunity to contribute to society while making the choice to work through ‘mental health issues’.

**Crisis Spaces**

Another type of alternative healing space which exists, is that which addresses crisis situations. This type of space exists to provide respite during ‘mental health’ crises, and provides varying amounts of time during which people are allowed to stay after crisis. What makes these spaces alternatives to hospital emergency rooms are their non-medical/alternative medical
approaches to ‘mental health’ crises. The Gerstein Centre is one such crisis space, found in Toronto, Ontario, Canada. The philosophy and description of The Gerstein Centre is as follows:

“The environment and support offered are individualized, responsive to the needs and wishes expressed by the service user, and respectful of the autonomy, dignity and ability of the service user.

The Gerstein Centre provides **crisis intervention** to adults, living in the City of Toronto, who experience **mental health problems**. The Centre provides **supportive counselling** for immediate, crisis issues and referrals to other services for on-going, non-crisis issues. Our service is a community mental health service and is **non-medical**. Crisis calls of a medical nature (psychiatric assessment, severe self-harm or suicide attempts) are **referred to a hospital**.

The service has three aspects, **telephone support**, **community visits** and a ten-bed, **short-stay residence**. All three aspects of the service are accessed through the **crisis line**, (416) 929-5200. It is preferred that anyone wishing to use the Centre's service call the crisis line personally. A **referral line**, (416) 929-9897, is available for workers who would like to make a second party referral.

All services are provided **free of charge** to the service user. **Funding support** is provided by the **Toronto Central Local Health Integration Network (LHIN)**.”

(http://www.gersteincentre.org/)

Thus, as these examples demonstrate, these spaces also follow the characteristics of the alternative mental health approaches listed previously, in that the traditions, histories, and localities which inform their design are not acknowledged. Though it could be said that this
might be obvious, the mainstream Western perspective on mental health is privileged to the extent that it is often accepted as unquestionable truth. Mainstream western mental health perspectives are pervasive and dominant, and in a position of power, due to historical colonial dynamics of power which persist. Unfortunately, many aspects of this, particularly concerning unrecognized White Privilege, continue in practices and establishments meant to be Alternatives to the mainstream Mental Health care system, and it is necessary to draw attention to this in order to ensure that a balanced and truthful review can be produced.

Indigenous and Healing Practices from Indigenous Healing Traditions from those parts of Turtle Island known as North and South America, various parts of Africa, various parts of Asia, the Middle East, Europe, and New Zealand, will now be presented. This section will illustrate the diversity which exists within the practices which exist in each of these regions, as well as between them, and the inherent value of each practice presented, as follows the Two-Eyed Seeing Framework. Again, possible combinations are not explored in this section, however it is interesting to imagine these and what their healing potential might be, both within each context, as well as between them.

**Part 3: Indigenous Healing Traditions**

**North American Aboriginal Traditions**

A research gap exists concerning what are considered the major mental disorders, in a North American Aboriginal context (Nelson, 2012). Interestingly, the relatively few resources
which exist on this topic demonstrate clearly, a lack of a concept of ‘psychosis’, at least as previously defined, within multiple North American Aboriginal Traditions. To illustrate this, healing practices of the Ojibwe, Sioux, Navajo, and Inuit Nations, will be discussed.

**Ojibwe Traditions**

Robert Hahn’s comprehensive, though somewhat dated article, published in 1978, entitled *Aboriginal American Psychiatric Theories*, focuses on North American Aboriginal perspectives on mainstream Western psychiatric ideas. One of the ideas discussed is the Western concept of psychosis. As Hahn discusses, this idea does not exist in many North American Aboriginal traditions. Instead, experiences which would be labeled in Western psychiatry as ‘psychosis’ are often considered to be simply part of the continuum of life experiences, as real as waking life, rather than as separate states of being, symptomatic of mental illness, as is thought to be the case within the mainstream Western paradigm.

Indeed, among many North American Aboriginal Traditions, different states of being have fluid boundaries, and people are expected to move between them naturally, gathering equally valued knowledge and experience from each. All is relatable to a person and their life journey (Hahn, 1978). Hahn gives an example of how this has been a characteristic perspective of Ojibwe traditions for many years:

“Note again that states of consciousness are distinguished in ways which differ from our own distinctions. Hallowell (1955) claims that for the Ojibwa, there is no sharp division between waking and dream states, and both are taken as sources of knowledge” (Hahn pp.49, 1978).
Sioux Traditions

In addition to these kinds of experiences being part of the normal life course in traditions such as that of the Ojibwe people, Vine Deloria Jr.’s book: The World We Used to Live In: Remembering the Powers of Medicine Men (2006), contains a vast number of anecdotes of the experiences and abilities of Medicine People in North, Central, and South America. Many of these are strikingly similar to what is diagnosed, in a Western context, as psychosis. As is the case with Hahn’s article, these anecdotes are mostly from the fairly distant past, illustrating that, though these kinds of experiences used to be the norm, and considered an expected part of reality and human ability, the acceptance, and prevalence of such experiences as such, is no longer the norm as much as it was in the past, concerning these traditions (Deloria, 2006, Hahn, 1978).

Indeed, the kinds of experiences recounted in this book illustrate that the experiences of Medicine People are quite similar to those experiences often diagnosed as psychosis in Western mental health contexts, due to similarities regarding the core elements of what is diagnosed as psychosis, such as auditory and visual hallucinations (American Psychiatric Association, DSM IV, 2013). Many Medicine People had powerful auditory and visual hallucinations, which, instead of being diagnosed as illness, were valued and seen as evidence of ability to connect to higher truths, capable of bringing great good to the Medicine Person and community as a whole. The vision of Oglala Sioux Medicine Man, Horn Chips, which was experienced alongside suicidal thoughts, entitled Horn Chips’ Blessing illustrates this:

“On his way to a lonely spot to end his life, he heard a voice who said it was that of the Great Spirit. The voice told Horn Chips not to kill himself, that he was destined to become a great man. Horn Chips was told to go to a high mountain, dig a hole four feet deep, cover it with boughs, and stay there four days with no food or drink. Horn Chips followed these directions. When he was in the pit, he had a vision. A snake came to him from the Great Spirit and gave him his instructions.” (Deloria, 2006, 13)
**Navajo Traditions**

Selinger’s article: *The Navajo, Psychosis, Lacan, and Derrida* (2007), further illustrates differences in interpretation, of experiences labeled in Western contexts as ‘psychosis,’ in mainstream Western mental health, and within many North American Aboriginal Traditions. In this article, Selinger does this by comparing the mainstream Western mental health perspectives of psychoanalysts Lacan and Derrida, with perspectives from Navajo traditions, concerning this idea.

Selinger’s main point of comparison is that within the traditional Navajo belief system, such experiences are viewed as teaching experiences, imbued with meaning, which can only be gleaned through experience, and which can be resolved definitively, and cured. Psychoanalysis, as Selinger discusses, does not traditionally deal with what is labeled as psychosis in mainstream Western mental health, however both Derrida and Lacan focused on psychosis in their work. In opposition to the Navajo belief, both of these psychoanalysts saw this state of being essentially incurable, to be avoided at all costs (Selinger 2007).

Selinger further illustrates these differences in perspective through discussing how ‘psychosis’ is healed in Navajo traditions. This healing is achieved through the Evilway Ceremony, a ceremony lasting five nights, the purpose of which is to heal individuals from experiences of severe anxiety, delusions, repetitive nightmares, and hallucinations, of which the telling of the Coyote Transformation story is a central aspect (Selinger, 2007). It is this story which is most directly relevant to this discussion of differing perspectives on what is diagnosed as psychosis, and thus which will be focused on in this discussion, though there are other elements, such as the ingestion of certain substances, as well as physical cleansing processes.
which are part of the ceremony. This story is about a hunter who becomes possessed by the mythical Coyote figure, who takes on the hunter’s physical form, and causes the hunter to take on Coyote’s physical form and act like Coyote. Coyote is a mythical though earthly character who is thought to be one of the entities responsible for bringing evil, incest, desire, and witchcraft to Earth, and who appears in numerous traditional teaching stories (Selinger, 2007).

Coyote, now looking identical to the hunter, returns to the hunter’s home to eat greedily and copulate with the hunter’s wife. The hunter during this time, in coyote form, remains, lying under a bush. Finally, after four days of this exchanged identity, the hunter’s mother-in-law smells coyote urine on her daughter and realizes that Coyote has been up to no good, and is to blame, yet again. The hunter, in coyote form, is eventually found, and taken to elders of the Bear people, who have the knowledge of the ceremony which can, and does, restore the hunter from coyote to human form. This ceremony, is, in turn, the Evil way Ceremony.

As Selinger discusses, this story, and ceremony which is its context, have been passed down generation after generation in order to facilitate healing from states such as what is exemplified by the behavior which Coyote and the hunter demonstrate, after Coyote has taken on the hunter’s form. Indeed, the hunter’s coyote-like state, as well as the coyote’s hunter-like state, act as metaphors for unusual and disordered behavior, similar to what is diagnosed as ‘psychosis’ in the context of psychoanalysis. Thus the Evil way Ceremony is performed to make sense of and facilitate the curing of such states of being and behaviour. This ceremony achieves this healing through providing an explanation for how such illnesses happen, and how they can be healed.
This example highlights the difference in perspective regarding the cause and treatment of such states of being, between Western and North American Aboriginal Traditions. In Navajo traditions, this state has a definite cause, namely possession by a non-human animal and mythical figure, who has a known reputation of causing trouble. There is also a definite cure for this ailment, known to elders of the Bear people, namely, the Evil way ceremony. In the mainstream Western mental health tradition of psychoanalysis, such behavior as exhibited by the hunter or Coyote, once the hunter has become possessed, metaphorically speaking, might be analyzed however, would ultimately be diagnosed as psychosis and be deemed incurable (Selinger, 2007).

Indeed, in the psychoanalytic traditions of Lacan and Derrida, the cause of what is diagnosed as psychosis is often unknown, or is thought to be buried in an uncertain web of human relationships and human experiences (Selinger, 2007). The world of non-human nature, particularly as an active perpetrator of this perceived illness, is not acknowledged in searching for the cause of this state of being. Additionally, in psychoanalytic traditions, there is no known cure for what is known as psychosis (Selinger, 2007).

Thus, fundamental differences between these two interpretations of such experiences exist, which have dramatically different outcomes for the individual having such experiences. Such differences illustrate the way in which Western perspectives pathologize the individual having such experiences, in a negative way, due to the perceived lack of cure for this state of being, whereas, conversely, Navajo traditions connect the experience to non-human nature and the larger cosmos. Indeed, the Evil way ceremony facilitates the complete healing of the individual. This ceremony also normalizes and contextualizes these experiences, as part of the natural course of all parts of the earth relating to one another (ie. Coyote interacting with the hunter, a human
being), and emphasizes the need for balance between these parts to be continually re-established, in order for proper human conduct to be a constant.

**Sto:lo Perspectives**

The Sto:lo people of the Skwah and Sto:lo First Nations, who live along the Fraser River Valley along the lower Mainland of British Columbia also see health as balance, and any demonstration of ill-health as being due to imbalance (Labun, Emblen, 211, 2007). As a Sto:lo elder states:

“(To be balanced you must) understand that everything inside of you has got to be balanced....Balance is walking mentally, spiritually, physically....You have to have a good understanding of what it means to yourself and everything around you...like the ground, nature, and the family.” (Labun, Emblen, 211, 2007).

Thus, physical illness, which encompasses any imbalance of the mind, is seen as imbalance among all universal elements which must be corrected (Labun, Emben, 2007).

**Inuit Traditions**

Perspectives on psychosis from Inuit traditions are discussed in *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada*, in a chapter entitled: *Locating the Ecocentric Self: Inuit Concepts of Mental Health and Illness* (Kirmayer, Fletcher, and Watt in Kirmayer & Valaskakis, 2009). This book chapter reveals that early studies attempting to discover Inuit perceptions regarding mental health, such as that conducted by Vallee in 1963, on the Hudson Coast, revealed no concept of psychosis or mental illness (Kirmayer, Fletcher, and Watt in Kirmayer & Valaskis, 2009).
Later studies, however, such as that which is the focus of this chapter, completed by the authors of this chapter in the early 1990’s, reveal the influence of incoming concepts of mental illness, that of psychosis being among these. Indeed, the findings of this study, conducted in Northern Quebec, revealed the development of four different categories of ‘mental illness’ within the Inuit community, organized based on supposed causes. Psychosis is included in these categories. They are as follows: 1., Physical or organic causes, with origins in birth, 2., Emotional or psychological causes, existing on a continuum according to levels of severity, 3., Spirit possession, and 4., The impact of rapid social and cultural change, and its effects, particularly on childrearing and mental health. These categories were developed by the researchers after interviews with study participants were completed. No information about how participants were selected for this study is provided in the chapter (Kirmayer, Fletcher, and Watt in Kirmayer & Valaskis, 2009).

Thus, the way in which the idea of psychosis fits into all of these categories, demonstrates that in Inuit traditions, after the infiltration of Western perceptions of mental health, according to this study, what is known as psychosis became one of the experiences on the continuum of what are seen as mental health disturbances.

**Perspectives from Healers of North American Aboriginal Traditions**

The healing practices of two influential healers of North American Aboriginal Traditions, who are based in Toronto, illustrate similar perspectives to these traditions from specific First Nations. Laini Lascelles, from the Lenape Nation of the Thames River, is a Director at the Toronto Council Fire Native Cultural Centre (http://www.councilfire.ca/), as well as a
practitioner of First Nations healing traditions, Reiki and Shiatsu. She works with clients of all cultural backgrounds, from the perspective that experiences labeled ‘psychosis’, are, in contrast to the illness perspective put forth by mainstream mental health, simply a natural part of the human life experience, often indicative of gifts related to healing combined with energy buildup due to trauma early in life (L. Lascelles, personal communication, January 2008).

Similarly, Farley Eaglespeaker, from the Sioux Nation of the East of the Dakotas, Minnesota, and northern Iowa, former mental health crisis worker, head of Culture at Native Child and Family Services, and nationally acclaimed ceremonial leader, takes the perspective that there is nothing in the realm of human experience that is without truth and/or meaning. His work with Aboriginal youth is centred on the historical reality that, worldwide, throughout time, people have been having experiences akin to what is diagnosed as ‘psychosis’, and that these experiences have always carried meaning (F. Eaglespeaker, personal communication, December, 2012).

**South American Indigenous Traditions**

illustrates a perspective on the phenomenon of psychosis from Indigenous South America, specifically that which exists in Quichuatraditions.

**Quichua Traditions**
The Quichua people, Indigenous to the Andes, whose traditions once dominated what is now Bolivia, Ecuador, Peru, and parts of Argentina, Chile, and Colombia, have a healing tradition which also demonstrates the specificity of the concept of ‘psychosis’ to mainstream Western Mental healthcare. Specifically, the Quichua healing tradition includes the concept of *llaqui*, which consists of four illness sub-categories, which include what would be described in Western terms as both psychological and physical illnesses. *Llaquiis* defined not only via symptoms, but also via causal factors:

“*Llaqui* is a complex illness category defining a symptom (sadness), the name of an illness, life events and a causal factor of illness. It is essential to recognize the low importance of symptom configuration as a criterion for defining *llaqui* and its sub-categories among the Quichua. Rather, attributed causal factors, either natural or supernatural, play a primary role in defining illness categories.” (Incayawar, in Incawayar&Wintrob et. al, eds 2009, p.56).

The four subcategories are as follows. The first two are generally merged and are thus referred to as *mancharisha-wairashca*, meaning ‘victim of malign spirits’. This can manifest via a wide variety of psychological and physical symptoms and is believed to be caused by an attack by spirits with origins in nature, or which are under human control. The third sub-category is *shungunanay*, which means heart pain or shattered heart. It manifests as epigastric pain and convulsion-like episodes, as well as in symptoms similar to what is termed anxiety and depressive disorders in mainstream Western mental health care. The fourth sub category is *rurashca*, meaning victim of sorcery, and is caused by aggressive malign spirits, which are being controlled by humans. No information was given concerning the manifestation of this sub category. Thus, this is yet another healing tradition which confirms that the mainstream Western mental health concept of ‘psychosis’ is not a universal reality, but instead a concept irrelevant to multiple healing traditions worldwide (Incayawar, p. 56 in Incawayar et. al eds. 2009).
**African Indigenous Perspectives**

Indigenous healing traditions of Africa are diverse and numerous in nature. Select traditions are discussed here which demonstrate varied approaches to healing and ‘psychosis’

**West African Traditions**

The majority of people along the Guinean Gulf in West Africa access Indigenous West African Health Practitioners as their primary form of healthcare ((Kpanake & Ndoye, in Moodley & Gielen et al, eds. 2013). These traditions are informed by the broader African worldview, philosophical and medical principles, which share a common concept of unity – namely unification “of life and time, (with) no sharp distinction between animate and inanimate, natural and supernatural, the dead and the living, and material and spiritual.” (Kpanake & Ndoye, in Moodley & Gielen et al, eds. 2013, p. 34).

As follows from this perspective, problems which from a western perspective are ‘psychological’ in nature, such as ‘psychosis’, rather than being seen as incurable illnesses, are seen as situations in which the cause of the issue must be found, and the patterns of interaction stemming from this cause must be changed. Causes of illness are often the angering of a spirit, a hex placed on someone, or the offending of an ancestor, rather than a chemical imbalance in the
brain, as is the case with the ‘psychosis’ concept. In addition, rather than medication with pharmaceutical drugs, such issues are treated through such practices as exorcism, chanting, dancing, the use of herbs, the use of talismans, and other practices of a similar nature. Therefore, this is a completely distinct healing tradition from mainstream Western mental health, in which the concept of psychosis is irrelevant (Kpanake & Ndoye, in Moodley & Gielen et al., eds. 2013).

**Indigenous Haitian traditions: Voodou**

Another way in which the experiences of alternate realities is similar in many places worldwide, which also demonstrates the significant value of making use of the Two-Eyed Seeing Framework, due to the vast differences in how these experiences are dealt with in different places and contexts, is the way in which people who experience alternate realities, and end up diagnosed with what is known as psychosis, and, sometimes schizophrenia, sometimes experience a changing of the nature of physical objects during these experiences. Namely, during these experiences, objects with special powers can be found, and physical objects can take on meanings related to healing processes (Wesley-Esquimaux, personal communication, April 16, 2007, Tropianska, J., personal communication, June 10, 2007, Eaglespeaker, F., June 7, 2013, personal communication). Interestingly and of note is the way in which this symbolism of objects can be seen in healing practices worldwide.

In African-Caribbean Voodou Healing Traditions, the use of *wanga* is common, which are charms, or guards, and represent disharmonious relationships. These charms are prepared using symbolic procedures, by Voodou practitioners, in which ingredients take on symbolic meaning
(Brown, 2003). For example, the following describes the process of a Voodou Priestess preparing a charm known as a *mare dijol*, or “tie-the-lips”, to remedy the *sabilye* leaves, to foster forgetting.

“The name of this leaf puns on the kreyol word to forget, *bliye*……… As a sweetener for the whole transaction Lola was about to be involved in, she added molasses. Lola finished by writing the name of an electronics company on nearby Long Island, and the name of a female employee of that company on a small piece of white paper and adding it to the mix. Next she draped the pot with a clean white cloth, noting at the time: “you tie the mouth with a white cloth.” (Brown, 2003, pp. 291-292).

**Middle-Eastern Traditions**

In Indigenous Islamic traditions, objects are used by traditional medical practitioners to ward off evil spirits (Laher, 2013). For example, in the case of a woman who was unable to become pregnant for 18 years, a faith healer of these traditions gave the diagnosis of spiritual illness, in the form of *sihr* (black magic). Elements of the treatment recommended included the placement of amulets in the woman’s house, as well as the creation of amulets for the woman to wear, to remedy the inability to conceive, and the burning of specific substances in order to rid the woman’s house of black magic (Laher, 2013).

**Asian Indigenous Traditions**

The following section explores Indigenous healing traditions of various parts of Asia, in relation to ‘psychosis’. These, similar to traditions which have been presented from other parts of the
world, further illustrate the diversity of perspectives concerning the western phenomenon of ‘psychosis’, which exist worldwide.

**India: General characteristics**

In India, systems of healing throughout the country concerning ‘mental illness’ differ entirely from mainstream Western perspectives. Specifically, Indian healing systems are not geared towards ‘curing people with illnesses’. Rather they are seen as holistic systems of wellbeing, the purpose of which is to guide individuals through life, with the structure of a teacher-student relationship, in which the student learns the social and moral values consistent with the society they live in, while simultaneously being guided to realize their human potential.

Therefore, the focal points of traditional Indian systems of medicine, are the individuality and uniqueness of each person and the importance of the truths of each individual being revealed for themselves, by themselves, though with assistance from their teacher (therapist-equivalent in mainstream Western healthcare terms). Thus, due to these features, it is reasonable to assume that this is an example of a system of health in relation to which the Western concept of ‘psychosis’ would not make sense, as it would be simply part of the truth and uniqueness of the individual, which in these traditions, is to be encouraged. (Varma, in Icawayar, & Wintrob et al., eds, 2009).

**India: Balaji Traditions**
A specific example from Indian traditions is the healing traditions in Balaji, in Rajasthan, in Northern India, where there exists a strong network of Indigenous healers. The healing vocabulary of the people who make up this network does not include the Western concept of ‘psychosis’. Instead, spirit terms are used, and, rather than the term ‘mental illness’, and mental illness sub-categories such as schizophrenia, and bi-polar disorder, the term ‘spirit illness’ is used, the symptoms of which encompass much, if not all of the range of symptoms of ‘psychosis’:

“The patient’s face is not bright. He has lost interest and enjoyment, he is anxious and fearful of normal things... Others are afraid that they have some serious disease, like cancer... When the doctor says you are OK the patient says I am (still) very ill... A patient may scream and panic suddenly, hear voices in his ears, be afraid of the dark, and startle at non-existent shadows. He may become stubborn, indolent and overbearing, he quarrels with his family and repels his wife’. (Pakaslahti, in Icawayar & Wintrob et al., eds p. 157, 2009)

Rather than prescribing medication, healers in Balaji ‘work with spirits’ to cure spirit illness. As an example, a treatment a Balaji healer would recommend for spirit illness, would be the practice of making offerings to specific spirits both at home and at a religious or spiritual place for one month.

Therefore, this example is another demonstration of the way in which the mainstream Western mental health concept of ‘psychosis’ is completely non-existent in healing traditions other than mainstream Western mental health (Pakaslahti, A., in Icawayar & Wintrob et al. eds, 2009)

India: Angami Traditions
Similarly, divinational shamans from the Angami community of Nagaland, India, are often plagued by experiences nearly identical to ‘psychosis’, prior to becoming practicing shamans (Joshi, 2004), similar to how individuals diagnosed with schizophrenia continue to experience ‘psychotic’ episodes unless medicated (American Psychiatric Association, 2013, DSM V). For example, individuals destined to become shamans in the Angami community, are selected by spirits who pursue them in dreams, and waking life, until they submit to following this path of learning (Joshi, 2004). This is similar to the experience of what is called hallucination, characteristic of ‘psychosis’ (Polimeni & Reiss 2002), however this concept is not a reality in these traditions.

**Bali: Indigenous Traditions**

In Balinese medical traditions there are two major illness categories: illnesses which are caused by the physical environment, in terms of food or weather, and those directly and purposefully caused by other beings, of human, demonic, or divine origins. Also central to Balinese concepts of illness are the concept of balance, and the phenomenon of the life force, the disruption of either of these which can cause illness. Additional causes of illness are the inheritance of the flaws of an ancestor, sorcery and poisoning by other human beings, and offending spirits by enacting rituals improperly (Lemelson in Icawayar & Wintrob et al., eds, 2009).

In addition, those destined to become balian (shamans in a Balinese context), also experience phenomena similar to ‘psychosis’. For example, balian experience spirit possession, as well as visions, and the ability to relay messages from spirits regarding healing and other
subjects, to others, prior to being recognized as balians by the surrounding community (Stephen & Suryani 2000).

Nowhere amongst these conceptions would fit the concept of ‘psychosis’ as a separate namable illness. Instead, all human experiences are seen to be in a relational, cause and effect relationship with the world at large, and the variety of forces which exists within it.

**China: Indigenous Traditions**

The basis of Traditional Chinese Medicine does not contain theories similar to psychiatry and medical psychology. Instead, connections between the actions of the mind and the functions of bodily organs is observed. In addition, there are seven emotions, each of which corresponds to a specific organ, each of which can hurt or heal the particular organ. Thus the concept of ‘psychosis’ does not have traceable roots in TCM, nor does this concept make sense in the context of TCM due to the way in which all organs are recognized as relating, particularly in relation to psychological phenomenon (Zhao, in Icawayar & Wintrob et al., eds, 2009).

**Taoist traditions**

Another way of interpreting experiences of alternate realities is through conceptions of balance, exemplified by several traditions from different places in the world. In these traditions, these experiences are interpreted as an imbalance between elements, illustrating yet another interpretation which can facilitate a balanced ‘Two-Eyed Seeing’ perspective on these
experiences. Chinese Taoism, the beliefs of the Maori people, as well as the beliefs of the Sto’lo people, will be discussed to highlight this point.

For example, in the case of experiences of alternate realities, in Chinese families, individuals often seek to be in balance with the Tao, specifically in relation to the principles of self-transcendence and the integration with The Law of Nature, in order to reach a state of peacefulness and calm, rather than seeking external help for coping with these experiences (Yip, 2013). Self-transcendence refers to striving to accept the following:

“\textit{Wealth and attainment are perishable, sensational gratification is not trustworthy, honor and disgrace are alike, pride and egocentrism are not lasting.}” (Condensed from Yip, 27, 2013).

Integration with the Law of Nature or the Tao refers to:

“\textit{Attempted adherence to the following principles: Abiding and attaining by inaction, striving for inaction as the best form of self-preservation, striving to be passively progressive, returning to the natural silence, and tuning into the natural harmony.}” (Condensed from Yip, 29, 2013).

This example is significant as it illustrates yet another way in which alternate reality experience akin to ‘psychosis’ are approached, reflecting the multiple pathways to well-being which the Two Eyed Seeing Framework indicates is of utmost value.

**Russo/Japanese Traditions**

For example, in the case of the Ainu people, who originally lived in the Southern Sakhalin, and now live in Hokkaido, people destined to be shamans (tusuaynu) experience a state
similar to what is conceptualized as psychosis in psychiatric terms (DSM IV), prior to being recognized as shamans, at similar times in life, and due to similar experiences to those who, in other contexts and situations, are diagnosed with psychosis, and/or schizophrenia (Ohnuki-Tierney, 1973 Polimeni & Reiss 2002).

Tusuaynu often enter a shamanic state (experiencing hallucinations, behaving in ways deemed out of the ordinary) for the first time, a few years after the onset of puberty. This often happens at a time of a life crisis, and, at this time, tusuaynu often perform their first shamanic rite unconsciously, only learning how to perform these rites on-command in subsequent years (Ohnuki-Tierney, 1973). This is similar to the onset of what is diagnosed as psychosis, or the initial episode of schizophrenia or bi-polar disorder, however, different, in that the latter experiences are not recognized as unconsciously performed shamanic rites, and the individuals experiencing these phenomena often do not have the opportunity to develop shamanic capabilities. Rather, medication is prescribed to limit future episodes, often due to a lack of supportive cultural contexts, or the spread and influence of mental illness conceptions from the Western world (Waters, 2010, Whitaker, 2010).

In addition to experiences of alternate realities, once a tusuaynu is practicing, it is routine for the individual to become possessed by spirits in order to relay messages needed, for various reasons (Ohnuki-Tierney, 1973, Stephen & Suryani, 2000, Polimeni & Reiss 2002). Similarly, those experiencing what is conceptualized as psychosis, separate from, or as part of what is diagnosed as schizophrenia or bi-polar, experience this phenomenon (Polimeni & Reiss, 2002). However, this common experience is interpreted as ability in the case of the tusuaynu, and illness, in the case of the individual labeled with psychosis.
New Zealand Indigenous Traditions:

Healing traditions of the Maori people are discussed here as an example of an Indigenous healing tradition from this continent, illustrating yet another approach to experiences labeled in mainstream Western mental health as ‘psychosis’.

Maori traditions

The Maori perspective on health also has balance at its foundation (Lyons & Mark, 2010). The elements which must be in balance in order for good health to be present are hinengaro (the mental), tinana (the physical), wairua (spiritual), whanau (the family), and matauranga (education). In regards to mental health, it seems that this concept was entirely foreign to Maori conceptions of health prior to the arrival of this concept through the process of colonization. In fact, it seems that there was no concept of ‘mental’ in the realm of health, as the maintenance of balance between all afore-mentioned elements was the focus, in the pursuit and maintenance of good health (Lyons & Mark, 2010). As stated by an anonymous Maori healer:

“Do you know, in our time, there was never a mental. We never had a mental problem, Maori. We were physical and spiritual all the way. There was no need for mental, until the white men came…. That mental, that never existed.” (Anonymous Healer, Lyons & Mark, 1758, 2010).
Thus, without even a concept of mental, the concept of psychosis dissolves completely, illustrating yet another interpretation of psychosis which must be acknowledged in order to see in a balanced way with both eyes, as recommended by the Two-eyed Seeing Framework.

**Counter - Arguments**

Despite strong similarities between the different traditions concerning ‘psychosis’, differences between the experiences of shamans, and those who experience ‘psychosis’ must also be noted (Stephen & Suryani 2000, Polimeni & Reiss 2002). For example, Stephen & Suryani, in their article *Shamanism, psychosis and autonomous imagination* (2000), discuss how auditory hallucinations are more common with ‘psychosis’, with visual hallucinations being more common for shamans, as is discussed by Polimeni & Reiss, 2002). In addition, for shamans, the trance state is often achieved voluntarily, whereas for those experiencing ‘psychosis’, this state, with strong similarity to the trance state, is often experienced involuntarily (Polimeni & Reiss, 2002).

Both sources make reference to experiences labeled as psychosis on a global scale, wherever mainstream Western mental health has taken hold, and such diagnoses are utilized. Stephen & Suryani (2000) focus on Bali in their discussion of characteristics of shamans in comparison with people who experience ‘psychosis’, worldwide. Polimeni & Reiss (2002), in comparison, refer to both on a global scale.

Concerning contrasts between the experiences of shamans, and those who experience ‘psychosis’, it has been argued, such as in Stephen & Suryani’s article (2000) detailing how people become shamans in Bali (2000), and contrasting the experiences of such individuals with
those who experience psychosis, that experiences of ‘psychosis’ are most often negative, whereas the experiences of those destined to become shamans are most often positive, and inform individuals that they are destined to become shamans. Stephen & Suryani (2000) go on to discuss how shamans are said to have special abilities as children, whereas those who experience ‘psychosis’ do not, and that shamans are aware they are different from others, even upon initially experiencing altered states, whereas those who experience ‘psychosis’, or who are not shamans, never have this awareness (Stephen & Suryani, 2000).

In addition, it is stated that, on occasion, while shamans experience an awareness of divine connection during alternate reality experiences, those experiencing schizophrenia experience a sense of disintegration of self, and that shamans are able to maintain connection to the outside world during these experiences, whereas those experiencing schizophrenia are unable to do so (Stephen & Suryani, 2000). Though there may be elements of truth in these supposed differences, this does not take into account the way in which many who are diagnosed with ‘psychosis’ grow up in contexts in which shamanistic and traditional healing gifts are not accepted, supported, or understood.

Indeed, it could be hypothesized that this lack of understanding in many societal contexts, might contribute to making the experiences of alternate realities more negative and frightening, due to their association with diagnoses of perceived incurable illnesses, such as psychosis, schizophrenia, and bi-polar disorder, rather than with the profession of a shaman or medicine person. Thus, despite sources, such as Stephen & Suryani (2000), which state otherwise, evidence points much more strongly to significant similarities, rather than differences, between what is known as ‘psychosis’, and perceived illnesses characterized by such, and the
experiences of shamans and traditional medical practitioners, as cross-cultural examples in this chapter have illustrated.

**Conclusion**

This literature review has provided an in-depth analysis of the social and historical context of the ‘psychosis’ concept, as well as the way in which the concept of ‘psychosis’ is taken up in Alternative and Indigenous Health and Healing practices. Namely, the vast variety of ways in which this concept contrasts with these practices have been highlighted.

In addition, such a discussion, due to its situation within the Two-Eyed Seeing Framework, facilitates an appreciation of the importance of accepting and valuing these different traditions equally to one another, rather than privileging any one perspective as ultimate truth. This is because such a perspective enables these perspectives to be explored and/or experienced separately, or in various combinations, as is most beneficial for individuals looking for ways to make sense of experiences diagnosed in mainstream Western mental health contexts as ‘psychosis’.

In addition, such a framework makes it possible to maintain a clear understanding of the ways in which these healing traditions have come into being, in terms of historical time and location, as well as the way in which they have interacted with each other. This affords an important understanding of the colonial dynamics which have enabled mainstream Western mental health traditions to become dominant, which, in turn, allows for an understanding of how
the concept of ‘psychosis’ has been able to become an idea widely accepted as truth, rather than a historically and culturally situated idea, the explanation of which is central to this work. The various contexts surrounding the birth of ‘psychosis’, explored at the beginning of the literature review, illustrate the way in which this ‘mental illness’, as well as others, are socially constructed, as well as historically bound to the time periods and socio-cultural contexts in which they originated.
Chapter 4: Findings – Emerging Themes

This chapter will discuss the major themes which emerged from interviews conducted with five Indigenous and Alternative Health practitioners. Each theme will be discussed in the context of perspectives drawn from my personal lived experience of ‘psychosis’, as well as perspectives from the literature review. Drawing from the themes which emerged during the preliminary analysis of the interview data, several themes of significance will be discussed, again following the model of the Medicine Wheel. Similar to the Two-Eyed Seeing Framework, this model emphasizes the utmost necessity for balance between all elements. The analysis of interview data revealed that this balance between elements is of utmost importance in the healing of psychosis, both on an individual level and a societal level, in order to achieve and maintain health. Themes which were of significance clarify the most important points, in terms of the worth of this study, for making progress, concerning perceptions and healing of ‘psychosis’.

The themes which emerged correlate to the four quadrants of the medicine wheel: Context, Mind, Body, and Spirit, as these are put forth by the Medicine Wheel model of analysis, according to Cross et. Al (2000). The prominence of these themes highlights an overall theme of the importance of balance between all of these elements in the healing of psychosis, which emerged from the interview data. These themes are: 1) Personalized support; 2) The societal reaction on incidence of ‘psychosis’; 3) Diversity of approaches to healing ‘psychosis’; 4) Interpretation of, and attitudes towards ‘psychosis’; 5) The body’s role in the experience/manifestation of ‘psychosis’; 6) The body’s role in healing from ‘psychosis’; 7) Spiritual aspects of ‘psychosis’, The absence of direct reference to spirituality.
Each of these themes will be discussed within the context of mind, body, and spirit, with reference to direct quotes from practitioners interviewed.

**Personalized Support (Context)**

The personal context of an individual experiencing ‘psychosis’, is of utmost importance in ascertaining what kind of support they may need. This theme is clearly articulated by Jay Tropianskaia, Sangoma Oludoye and Bhargavi Davar. Articulating the need for personalized support, Jay Tropianskaia drew attention to the way in which children are taught to fear the other-worldly experiences they have, causing them to reject aspects of themselves. At an older age, these suppressed experiences can manifest as ‘psychosis’, which are recognized or suppressed, depending on whether the immediate personal / cultural context an individual finds themselves in, is cognizant and/or understanding of these experiences. The following quote illustrates how this fear can develop within individuals, and cause these experiences to be permanently rejected:

“… most of our problems, from a shamanic perspective, from early childhood, stem from how we try to fit in basically all the experiences that a child has that are part of their lives, intuitive feelings, visions, nightmares, sense of being magical, imagination, all those things are pushed away and the child has to resolve that, although they feel like a free spirit, suddenly they feel like they are in a prison and that starts the initial problem for everyone in our culture. Some essential part of me is pushed away and considered bad or evil, or not able to emerge, so a lot of people have opened that up through certain kinds of drug experiences – but if the pull to belong via conforming, is so great, if I suddenly take some psychedelic drug/teacher plant and I see myself as God, then if I come home to my family and give them that message, I don’t belong anymore, and I’m not loved. So most people would rather beloved and belong – the price of this is to make any experiences that are not acceptable, non-existent.”

This quote illustrates the Two-Eyed Seeing Framework and Medicine Wheel Model in a microcosm. It illustrates how the diversity of the experiences which characterize the psyches of
children, in mainstream Western society are forcibly amalgamated, rather than being able to be acknowledged and valued, each experience in its own right.

Sangoma Oludoye, on the other hand, shared stories of individuals she has helped recover from psychosis, to illustrate how individual contexts shape the healing and/or support an individual may need regarding psychosis. She emphasizes the importance of examining, in detail, the lineage of each individual experiencing ‘psychosis’, as is articulated in the quote below:

“…the factors that I’m looking at, I’m looking at the day of birth, the day they entered into this world – what were the positions of the planets, what did that mean – what do certain lines through their lineage, and the way they arrived into it – first child, third child, baby child – there are so many things in that area that I look at – and then to look at the numerology around their birth…”

Oludoye’s perspective, detailed in this quote, is exemplary of the core principle put forth by the Two-Eyed Seeing Framework. Specifically, Oludoye’s practice of examining the individual context of each person she works with, in as many dimensions as possible, reflects the importance, as is put forth by this Framework, of valuing different all contexts as equally valid.

Approaching this theme from a different angle, Bhargavi Davar discussed the influence of individual experiences of childhood in the onset of ‘psychosis’. Childhood experience of parental absence, adult responsibilities for house-keeping, and high level of stress were indicated as causal factors for ‘psychosis’ both in childhood and later in life.

Similar to the perspectives shared by these healers, my personal experience both through my own lived experience, as well as that of people close to me, has indicated to me that the personal context of the person experiencing what is labeled as ‘psychosis’, is the most important factor to consider in their healing. This is because it is the most important factor in causing the
experience, and, as was true in my case, it is often a combination of many factors in the context of a person, both past and present, which come together to cause such an experience.

As discussed, in my case, it was experiences which occurred in the past, combined with experimenting with healing practices from various traditions, as well as emotional stresses, which caused me to enter the state I entered, which was labeled as ‘psychosis’. It was also undeniably this context, which shaped the form of support which enabled me to heal from my experience. For example, it was important for me to learn about the way in which memories from childhood can surface at a later time.

The literature review further supports this strong influence in numerous ways, such as via the neuro-developmental model. This model demonstrates how the physiology of a person can be shaped by traumatic experiences. What is experienced and interpreted by people as trauma differs depending on the individual sensitivity of people, and their individual context (Waters, 2010). Thus, combined, perspectives from healers, my personal experience, as well as those explored in my literature review, illustrate the ultimate importance of valuing diverse approaches to healing, as put forth by the Two-Eyed Seeing Theoretical Framework, as well as provide valuable answers to my research question, by illustrating the diversity of perspectives which exist in Indigenous and Alternative health, concerning ‘psychosis’.

**The societal reaction on incidence of ‘psychosis’ (Context)**

Larger societal contexts have considerable influence on the incidence of ‘psychosis’. In addition, the reaction to ‘psychosis’ differs considerably in different societal contexts. These contexts also provide valuable knowledge for techniques of healing and modes of support for
psychosis’. Laini Lascelles discussed the lengthy history and age-old success of traditional Indigenous healing modalities in healing all ailments, mental included, while Jay Tropianskaia discussed the larger context of the many life cycles people are caught in simultaneously, and how this contributes to the incidence of ‘psychosis’. According to Jay Tropianskaia

“Life is cyclical - the cycles of life are huge and we have no connection with them...one is all the planetary changes, second the cultural and political aspects of war and dissent and striving for freedom, all that is the soup that we’re in - the earth that we’re in”

This quote is illustrative of the Two-Eyed Seeing Perspective, in that it describes the diversity of the cycles of life which are behind the diversity of approaches to health and well-being which exist within human society. Just as the Two-Eyed Seeing Framework indicates, regarding different systems of health and healing, the same is true regarding these larger cycles of life. Everything interacts with everything else, all elements are equally valid and important. Without this balance, a healthy whole, whether it be in terms of the earth as a whole, a community, or an individual person, is not possible.

Tropianskaia went on to discuss the concept of ‘psychosis’ as having origins in the traditions of Plato, and the way in which this historical context continues to influence the prevalence of this concept: “...we are still using the ideas of Plato... the old idea of there being an ideal way to be human ... you could shape yourself to be perfect.” Sangoma Oludoye also discussed the historical context of ‘psychosis’, in terms of there having potentially been progress, in a sense, since the time when people thought to have mental health problems were deemed hysterical and/or beheaded, in the context of her opinion that much change is still needed. She stated:

“I think a thousand things have to change in terms of ideology – more education, more sensitivity, a different way to look at it – I guess that the point at which this society, this
same society, beheaded women considered hysterical, or hung them, gave them lobotomies, or did put them in mental institutions, maybe there are people in the mental health communities who would argue with me – oh well ideologies are rolling right along, very involving, look where we were. And probably that would be true, but it doesn’t, to me, say anything less that the ideologies still present today still have a long way to go on the evolution page, as far as I’m concerned.”

In this quote, Oludoye mentions that a vast number of changes on a variety of levels are needed in order to facilitate understanding and healing concerning psychosis. This echoes the importance of valuing diversity, put forth by the Two-Eyed Seeing Framework, as well as the balance required between different elements, emphasized by the Medicine Wheel model.

The evidence presented by Oludoye, for lingering present day issues, despite these changes, include a rise in suicide in the U.S., as well as events such as a shooting of children at a school in Connecticut, and films depicting the consequences of ‘mental health issues’, such as the *Hunger Games*, and *A Beautiful Mind*, in which suicides and homicides are part of the plot, in connection with the ‘mental health’ of the perpetrators of these crimes.

Bhargavi Davar discussed the changing context in India in terms of family structure and work schedule of parents, as well as the infiltration of GMO foods and highly processed foods, both contributing to higher incidences of ‘psychosis’. She also discussed the infiltration of Western disease categories such as schizophrenia and the psychiatric drugs used to treat this, which, she believes, only cause a worsening of the mental condition of the person who consumes these drugs:

“…schizophrenia has acquired a kind of political economy in India – when a person’s behaviour reaches a particular state, you know, whatever the nature of those experiences, they get labeled as schizophrenia, and they start them on all kinds of medications – today I met a boy who had trauma experience, after his father died, and he saw all the death and stuff, when he was about 5,6 years old, who completely isolated, didn’t have any support from his family members – mother was busy working – her husband had just died and he had to take responsibility – and his sister was away at school – 5 year-old boy, left alone
at home, he started hearing his father’s voice and also the voice of an uncle who had died earlier… immediately he got picked up, and psychiatrized – two years he’s been on psychiatric medication.”

In contrast to the way in which the perspectives of Tropianskaia and Oludoye illustrate the Two-Eyed Seeing Framework, Davar draws attention to the importance of taking into account the diversity of the life experiences of an individual, rather than generalizing about this complexity by giving an individual a ‘mental illness’ label.

David Oaks contextualized the incidence of psychosis within the larger environmental crisis which currently grips the world, declaring that these are inseparable: “A silver lining of global warming is that it proves that so-called Normality does not exist. In sum, global warming proves that humanity is psychotic. “In addition, Oaks contextualized the incidence of ‘psychosis’, in relation to the dominant concept of ‘normality’. Also providing historical context, Oaks drew attention to the Greek translation of ‘psychosis’ to ‘spiritual illness’.

As my personal story has illustrated, the larger context of a person, larger than their everyday life, is an extremely important element in their healing. From my own experience, tracing my ancestry, and learning about my larger context in terms of the cultural traditions, and practices of my ancestors, was an essential aspect of my healing. This is because it showed me that my experience was not indicative of ‘mental illness’ but was rather different aspects of my ancestry resurfacing. My own experience is also reflective of the Two-Eyed Seeing Framework in that I had to learn about my multitude of ancestral connections, in order to fully understand and make sense of all elements of my experience – and each of these had to be viewed in its own right. For instance, I had to acknowledge that my ancestry is very diverse with connections to many places in the world, such as Ethiopia, Korea, as well as North America.
Drawing from the literature review, the multiple traditions explored in the literature review, such as examples discussed from Bali, and various parts of India, illustrate this theme further, by demonstrating how different cultural contexts influence the incidence, interpretation, and way in which these experiences are dealt with.

**Diversity of approaches to healing psychosis (Mind)**

The significant diversity of approaches to healing psychosis was clearly articulated by Laini Lascelles, Jay Tropianskaia; Sangoma Oludoye; Bhargavi Davar and David Oaks. This theme is a direct reflection of the Two-Eyed Seeing Framework in that it reflects the core principle of this Framework, namely that diversity is the key to health. Laini Lascelles, who has expertise in Shiatsu, Reiki, and First Nations Healing Traditions, emphasizes working with individuals experiencing ‘psychosis’ to find what ‘feeling better’ means to them, and then making this the goal of their healing:

“...it’s a process… so you want someone to understand more clearly for themselves first of all, what they’re learning about themselves, and then again, sort of, it becomes gathering information, asking a person – what does well-being mean to them. Finding the place that they’re going to have balance. And that can look differently for everyone – it’s never really quite the same for everyone.”

Lascelles draws attention to the process of ‘gathering information’ from a person in the process of healing, rather than imposing a diagnosis. This is illustrative of the Two-Eyed Seeing Framework’s focus on the importance of valuing diversity, as, rather than privileging one diagnostic perspective, this process makes it possible to honour information from various parts of an individual’s life in their journey of healing.
Jay Tropianskaia, who has expertise in both Gestalt therapy and Shamanism, advocates for the healing approaches put forth by these two traditions, while Sangoma Oludoye, who has expertise in the tradition of Sangoma, traditional African healing, works towards wellness with people experiencing ‘psychosis’ by looking at their specific lineage, when they were born, as well as investigating where disease may lurk, between the four bodies - physical, spiritual, mental, and emotional. Once this is ascertained, she works to balance and heal this disease.

She also recommends a change of space to one with as many natural elements as possible. In the following quote, Oludoye describes the ideal healing space:

“I see it as a place of tranquility, of running water, be it a waterfall in the environment, or be it one that is created that you have on a little table in the room. I see it as a wonderful and warm place that’s nearby to the ocean, with the most you can do with plants, with one of those little machines that shoots water up to the ceiling and creates the sound of the ocean. And so I would add what makes not only the person really comfortable – it would also put all those spirits, anxieties, inside their mental bodies, at ease, so that they could be in a safe space for the healing to occur. That is everything to me, I have to say, in my world.”

Bhargavi Davar employs nutritional testing and balancing in supporting individuals experiencing ‘psychosis’. In addition, she emphasizes healing childhood trauma, both through parent-child therapy, as well as body-based therapies, which emphasize releasing the physical remnants of childhood trauma, such as the silent scream:

“…this is when you gather together all the negative energies, bottled up energies – gather it all together, in the pit of the stomach and using body movement, you open your mouth as wide as possible, you make all the gestures of expressing extreme violence, and without making a sound you let it out – let all the negative energies out – it’s amazing.”

This is representative of the diversity of techniques employed in various parts of the world to support individuals experiencing ‘psychosis’, again illustrating the core principle of the Two Eyed Seeing Perspective: the utmost value of diversity.
David Oaks recommends activism for human rights in mental health as a powerful form of healing for those with experiences of ‘psychosis’, as well as a greater connection with healing the global environmental crisis which, according to him, proves directly that all humanity is ‘psychotic’.

My personal opinion, regarding this theme, based on my experience, is that this diversity is so great that it is overwhelming to comprehend, due to its breadth and depth. I strongly believe it is important to marry these approaches in order to maximize the diversity of ways of understanding these experiences, in order to possibly better facilitate the understanding of these experiences by both the people having these experiences, as well as the world at large. The literature review exemplifies this diversity of approaches by exploring a broad diversity of cultural traditions from numerous continents, such as the Americas, Europe, and Africa.

**Interpretations of, and attitudes towards ‘psychosis’ (Mind)**

There are differing uses of, and attitudes, towards ‘psychosis’, as the narratives of the various healers demonstrated during the interviews. For instance, Laini Lascelles indicated that, regarding ‘psychosis’, in her personal healing practice: ‘I don’t approach it at all’. She sees it as a mainstream Western mental health term which ignores the entirety of the experiences labeled as ‘psychosis’.

Jay Tropianskaia indicated that ‘psychosis’ is one of the most complex issues to be faced by a healer. In addition, she sees it as a remnant of the time of Plato, and the ideas which characterized this time. In the shamanic tradition, Jay describes:
“So often we see psychotic breaks as being a taste or foothold of a reality that is much too big for someone who is attached to my body, myself, whether people like me or not, whether I have a job or not and so on. We call that the model of assemblage, in the traditional shamanic model we call it the good red road. There’s no fast road to that. And yet people in our lifetime (what used to be called visions) can get thrown into the highest level.”

Thus, Tropianskaia shares the perspective that multiple realities exist, and that ‘psychosis’ is when a reality is experienced, without warning or support, which is other than what is the normal occurrence for an individual. Similar to Davar’s quote concerning the ‘silent scream’ technique, Tropianskaia’s quote illustrates one of the great diversity of perspectives, concerning what is happening during the experience of ‘psychosis’.

Sangoma Oludoye sees ‘psychosis’ as being along the lines of bi-polar, and thus uses the language and conceptualization of mainstream Western mental healthcare in the context of her own healing techniques. For instance, in speaking about how she treats her clients, she uses terms such as ‘bi-polar’ and ‘schizophrenia’. Bhargavi Davar uses the term ‘psychosis’ to describe the state of someone who is hearing voices and hearing things, though prefers not to use the term, and to approach the issue in a holistic, body-based, and context-based manner. This will be discussed further, in a subsequent section, in which different approaches to the role of the body in ‘psychosis’ are explored. David Oaks emphasizes the original meaning of the term ‘spiritual illness’ and sees it as an entity with reality status, however, which affects everyone, due to the environmental crisis which is affecting everyone.

“Maybe this concept will be a little easier if we just look at the word origin for psychosis, which would be basically be spiritual illness… In other words, to be human is to wrestle with spiritual illness. It is a wonderful gift to have these big brains but humanity has ended up on a collision course with our environment. It is definitely possible to overcome this spiritual illness. However, currently it is becoming clear that the human race is not doing well in this big test. This is why I say that global warming should be one of the top concerns for our Mad Movement. A silver lining of global warming is that it proves that so-called Normality does not exist. In sum, global warming proves that humanity is psychotic.”
The way in which Oaks draws attention to the connections between what is labeled ‘psychosis’, and global warming, is directly related to the Two-Eyed Seeing Framework in that it illustrates the way in which different belief systems can be combined for the greater understanding of human health issues, such as ‘psychosis’. In this case, Oaks, a world leader in alternative mental health, brings together Greek medical perspectives, modern mainstream Western mental health perspectives, and Western scientific perspectives concerning the warming of the earth.

This combination provides valuable insight into the nature of ‘psychosis’, namely, that it can be seen as something which afflicts all human beings, due to what we are causing to happen to the earth. This interpretation would not be possible without the synthesis of multiple perspectives, as is communicated to be essential by the Two-Eyed Seeing Framework.

During my healing journey from what was labeled as ‘acute psychosis’ I connected with Alternative and Indigenous Health Practitioners, as was mentioned previously, from a broad diversity of traditions. Sharing my experience with these practitioners, and hearing their perspectives, taught me that the perspectives held by various practitioners is influenced by their own ancestral connections, as well as personal life experiences, affected by numerous complex factors. This diversity, layer upon layer, demonstrates the verity of the Two Eyed Seeing Framework.

The compilation of different perspectives which is featured in my literature review is exemplary of the different attitudes towards/uses of the term ‘psychosis’. This is due to the myriad of perspectives from different parts of the world and different cultural traditions, as mentioned, particularly the juxtaposition of so-called Alternative healing traditions, and Indigenous Healing Traditions, from various parts of the world. Thus, perhaps most prominently,
this element of the mind quadrant of the Medicine Wheel, illustrates the Two Eyed Seeing Framework by illustrating the importance of valuing the diversity of perspectives and interpretations concerning psychosis.

**The body’s role in healing from ‘psychosis’ (Body)**

Analysis of interview data revealed that the body plays a central role in healing from ‘psychosis’. Laini Lascelles indicated the importance of balancing all elements, physical, emotional, mental, and spiritual, in the healing of psychosis. Jay Tropianskaia discusses the role of energy in the body in causing ‘psychosis’:

“Where psychosis fits in from a shamanic perspective is in what you perceive in the energy field of a human being. Much of shamanism looks at reality as a function of your organ of perception. The organ of perception is as follows (metaphor). Imagine a road of light that comes – demonstrates – from the right upper side of the chest, down across towards the stomach. So, let’s say, enlightenment – a full perception of reality the way it is, which requires non-attachment to your physical form – and basically many of the things that are perceived that create psychotic breaks, are things that we aren’t able to make sense of.

In line with the Two-Eyed Seeing Framework, this quote illustrates one of the diverse ways of understanding the physical manifestation of reality. In turn, this excerpt also illustrates one way of understanding the nature of ‘psychotic’ breaks, namely that these breaks are due to experiences people cannot make sense of. She also discusses how ‘psychosis’ is the result of energy suddenly falling in the body:

“But sometimes an event can push us from somewhere up here, to down there – top of road to middle/bottom of chest – people who have schizophrenia (and experience psychotic breaks), have the painful problem of sometimes being down in this right hand side where I’m only living in my head, then moving suddenly into absolute awareness of the highest level of reality. And they’re absolutely truthful but they can’t do anything with it because they can’t hold it.”
Similar to the quote above, Tropianskaia presents one of a diversity of ways of understanding the physical manifestation of ‘psychosis’.

Sangoma Oludoye discusses the importance of balancing all bodies: physical, spiritual, mental, and emotional, in order to facilitate healing from psychosis, while Bhargavi Davar emphasizes body-based therapies being of utmost importance in healing from psychosis. These include physical release techniques to remove stored childhood trauma, as well as nutritional balancing. About her own approach to helping individuals heal from ‘psychosis’, Bhargavi Davar states:

“...you know, myself, I hate to talk too much, most of the time I’ve used body-based therapies – I include small stuff, like walking, running, swimming, climbing, all those things, nutritional, so when I say body therapy I go a bit beyond that. I’m talking about really – working - we have the chakra theory – in India – in working the healing elements, which are submerged in different parts of the body, particularly the gut, and, the primitive brain, and so on, and to activate them using involuntary methods, involuntary breathing, involuntary movement, exploding the voice box.”

This quote illustrates the Two-Eyed perspective that healing modalities should be valued in their own right with the possibility of combination for greater healing, in that Davar mentions combining basic bodily movement/exercise with a traditional healing system of India, namely the chakra system. Thus the ‘body therapy’ which Davar refers to, is a combination of approaches to healing, and, as such, is a new and powerful healing approach.

Personally, the body has been my most powerful healing tool. Seeing the connections between experiences labeled as ‘mental’ i.e. being in different realities, hearing voices, and experiencing colours in a physical manner, and various balances in my physical body, such as the alkaline/acid balance, was my guiding light in finding balance while in the hospital, and maintaining this balance after being released. The combination of different healing modalities to
maximize healing possibilities, put forward as one of the most important aspects of the Two-Eyed Perspective, was central to my healing journey.

Concerning the physical healing from ‘psychosis’, the neuro-developmental model discussed in the literature review emphasizes the role of the body in both the experience of psychosis, as well as the healing from this. Other perspectives addressing the physical body include the various alternative healing space models discussed, which address the physical needs of residents.

The role of the body in healing from psychosis is significant from a diversity of perspectives, and in a diversity of traditions, as this discussion has illustrated. In addition, as various elements of this discussion have demonstrated, combining various traditions of healing from psychosis, related to the physical body, has proven very effective in a number of different scenarios, thus providing evidence that the Two-Eyed seeing perspective has strength and validity.

**The Body’s Role in the experience/manifestation of ‘psychosis’**

The role of the body in the experience/manifestation of ‘psychosis’ is of great importance, as articulated by a number of healers interviewed. Laini Lascelles emphasized the presence of other physical disturbances concurrent to ‘psychosis’, such as sleep disturbances, and headaches. Jay Tropianskaia describes the energetic manifestation characteristic of ‘psychosis’:

“If someone came to me in ‘psychosis’ the first thing I would look at is this – the energetic road mentioned – this might be unstable, they might be bouncing back and forth – I may do something to stabilize this – stabilize it where they are so that they can experience it – it’s the flipping back and forth that feels like a nightmare”
Sangoma Oludoye describes ‘psychosis’ as energy with roots in disease between the four bodies. Bhargavi Davar emphasizes the manifestation of nutritional deficiency and stored trauma in the body as ‘psychosis’:

“I feel that a lot of extreme state (such as psychosis), has to do with early trauma – trauma for me is settled in the body – I am inspired by people like Peter Levine – waking the tiger, somatic healing methods, a whole range of methods, that says that to de-traumatize you need to mobilize the body in healing – many people who are traumatized do not have an experience of their body – that goes for me too, I had deep trauma as a child, and I’m a hard core body therapist – what’s helped me is mobilizing my body in terms of movement, making sounds, throwing open my vocal chords, shivering and shaking…”

In contrast to Tropianskaia’s perspective that ‘psychosis’ is the instability of an energetic current, and that stabilizing this imbalance is very important in supporting someone experiencing ‘psychosis’, Davar emphasizes the connection of trauma to ‘psychosis’, and the importance of physically moving this out of the body.

Tropianskaia’s technique involves herself, as the practitioner, stabilizing the energy of the person experiencing ‘psychosis’. Davar emphasizes leading an individual who has experienced ‘psychosis’, through physical trauma mobilization and release techniques. These techniques are similar in that ‘psychosis’ is seen as something physical and tangible, which can be brought back into balance via re-balancing the physical body, albeit in different ways.

Without the Two-Eyed Seeing Framework, it would be difficult to set these techniques alongside each other and observe how they interconnect, ie. to imagine how they could be used simultaneously to support someone experiencing psychosis.

Regarding the manifestation of ‘psychosis’ in relation to nutritional deficiency, Davar emphasizes the harm in misdiagnosing nutritional deficiency as ‘psychosis’:
“I believe that it is the failure of the public health system that many malnourished people are showing up with psychosis – nutritional deficiencies, food deficiencies, nutrient deficiencies, and those don’t get picked up by the system, because the health system is in shambles – and when this is the case people are not going to get adequate and appropriate medical care, and they’re going to be subjected to psychiatric treatment. We’re not against medication, but if there needs to be medication, let it be done with the full and appropriate medical tests required for the proper diagnosis and treatment. Healthcare is very important – but comprehensive healthcare. If someone has a health problem and you’re dumping psychiatric medications on them, that’s not ok.”

In this quote, Davar expresses her belief in the connection between malnourishment and ‘psychosis’, namely that the one leads to the other. This quote brings an important element into the discussion of ‘psychosis’, in relation to the Two-Eyed Seeing Framework. This element is the functionality of whichever system of health is being discussed. For instance, Davar brings attention to the mal-functioning of the mainstream Western healthcare system, and how this leads to the misdiagnosis of ‘psychosis’, though she also mentions that she is supportive of the diagnosis of, and medication for ‘psychosis’, when the healthcare system is functioning properly.

Thus, as is drawn attention to by this quote, when observing different systems of healthcare, and laying them side by side to see how and if different modalities can be combined, it is important to take into account the complexity and functionality of each system.

My experience of ‘psychosis’ was very much a physical experience. This, in fact, was one of the most difficult aspects of it. For example, I felt my heart sink so strongly that I felt as though I was dying. I also felt as though my liver was going numb, which made me think I was dying. At one point I almost lost all feeling in my entire physical body and had to be supported by my room-mates.

Interestingly, and in contrast, many perspectives from the literature review do not discuss the physical element of the ‘psychotic’ experience, other than the neuro-developmental model.
Several of the alternative healing centre models address this element via the attention paid to the role of nutrition and chemical body balance in the experience of psychosis. Other perspectives emphasize the spiritual aspect of the experience of ‘psychosis’ as will be discussed in the next section.

**The spiritual aspect of psychosis.**

Laini Lascelles emphasizes balancing the spiritual with other three elements mentioned. While Sangoma Oludoye emphasizes healing disease between bodies – the spirit body being one of these, Bhargavi Davar discussed the strong influence of spiritual healing techniques in the healing of individuals experiencing ‘psychosis’ by discussing the way in which these experiences were dealt with at healing shrines of different traditions, including those of Islamic, Christian, and Hindu traditions. David Oaks emphasizes the importance of healing the ‘spiritual illness’ which is the true identity of ‘psychosis’.

Again, the power of the Two-Eyed Seeing Framework is evident in presenting this diversity. This Framework allows the reader to remember to view all perspectives on equal footing without privileging any particular perspective, at the same time as planting a seed in the mind of the reader to imagine possible combinations of healing modalities mentioned.

From my personal experience, spiritual healing is very much inter-woven with other aspects of healing, such as the physical, mental, etc. I believe, from communicating with people who presently have, and have had, similar experiences, that different aspects stand out for different people, and guide their respective healing processes. Based on my personal experience, the physical and the spiritual, and the inter-connection of the two, has been the most important.
For others, one element, or more than one, have stood out. This being said, spiritual ill-health was a dramatic aspect of my experience of ‘psychosis’. At certain points I felt my spirit growing weak and it felt as though it was leaving me.

While in the hospital, I made jewelry, played a grand piano which was in the psychiatric ward, and practiced yoga. All of these activities brought my spirit back into balance, which was integral to my regaining my balance overall. In general, personally, the spiritual is more difficult to define than other elements, ie., mental, emotional, physical, in relation to ‘psychosis’.

The role of spirit healing in relation to healing from psychosis is something which appeared a number of times in the literature review. Particularly in non-western contexts, healing the spirit, or developing in spiritual ways, is a central aspect concerning experiences labeled as ‘psychosis’. As demonstrated by numerous of these cultural contexts, these experiences are recognized as spiritual experiences, and are recognized as signs of spiritual gifts. This is prominent in Angami traditions. They are also often seen as evidence of the spirit being out of balance with other elements, and thus healing the spirit, and bringing it back into balance with other elements. This is exemplified by Sto:lo traditions.

**The absence of direct reference to spirituality**

Direct reference to, and in depth discussion of spirit was lacking in all interviews. It is possible that this is due to the elusive nature of spirit, in and of itself, which, in turn makes spirit difficult to define and describe (Restoule, personal communication, 2016). For instance, Laini Lascelles did not discuss spirit considerably, except for in reference to the importance of balancing this element with others. Jay Tropianskaia also did not discuss spirit in depth, however
made reference to spiritual problems. Sangoma Oludoye mentioned balancing the spirit body with others. Bhargavi Davar discussed spiritual healing, in reference to practices used to engage with experiences akin to ‘psychosis’, at healing shrines of different traditions, as mentioned.

My own experience speaks to the elusive nature of spirit in general, and to my own lack of natural connection to this element. However, this elusiveness, the way in which I was aware of the role of spirit in my experience, though did not connect with it in a prominent way, could also speak to the way in which spirit is inseparable from other elements (mind, body, context).

The literature also reflects the elusive nature of spirit, or perhaps a gap in the literature on the topic of experiences akin to ‘psychosis’. Unless spirit is referred to in relation to encounters with specific spirits, or as an element which needs to be in balance with others, as mentioned in the discussion of the previous theme, it seems that spirit may either be considered a given, as in the care farm model, or not be a prominent part of the world view at hand, such as in the case of the recovery models prominent in ‘alternative mental health’ circles, as discussed.

Interestingly, when I was in the hospital, there were a number of avenues available for connecting to spirit, such as a piano, as well the freedom to make art, though I brought my own beads to make jewelry with, these were not supplied. There were also group art classes, and yoga mats available. This is a paradox of sorts, as, due to these elements, there was an acknowledgement on the behalf of the psychiatric ward, of the importance of connection to spirit, in working through experiences such as ‘psychosis’, despite the psychiatric ward being a mainstream mental health space. As demonstrated in the Literature Review, the roots of the mainstream mental healthcare system are such that this awareness of the need for spirit connection, is not expected in a psychiatric ward, despite the great healing potential of such awareness.
In sum, the Two-Eyed Seeing Framework is definitely highly applicable to the spiritual elements in the healing practices of the healers interviewed, due to the diversity which exists among these approaches to the connection of spirit.

Thus, this chapter has highlighted the main themes which emerged from the interviews with five Indigenous and Alternative Health practitioners. The recommendations mentioned in these interviews, as well as those which I have formulated as the author of this document, and as someone with lived experience of psychosis will be discussed in the next and final chapter. Alongside these will be the intended future directions and final conclusions stemming from this document.
Chapter 5: Conclusion

This chapter will highlight key findings from this study, as well as the implications of this study for theoretical development and literature. Key findings from both the literature review and interview data will be discussed, as well as the combination thereof. The previous chapter provided further perspectives concerning the many interpretations of experiences labeled as ‘psychosis’. Combined with perspectives from the literature review, this research project has presented a vast plethora of such interpretations. From the literature review, ‘psychosis’ has been shown to be a socio-cultural, historical concept, with roots in Western Europe, however not without contestation in its birthplace. This concept has spread to other parts of the world, where there were, and still are, as the literature review discusses, completely different interpretations of these types of experiences, refuting the ‘psychosis’ concept, which dominates mainstream Western mental health care. In parts of the world where mainstream Western medicine has a stronger hold, such as North America, and the UK, ‘alternative mental health’ practices and healing spaces, have come into being, in reaction to mainstream Western mental health, as was discussed in the literature review.

In these alternative practices, ‘psychosis’ is generally seen as a mental health problem which develops due to imbalances in relationships between people, and/or, due to a combination of early childhood trauma, and so-called chemical imbalances. In therapies and spaces where this approach is taken, use of the arts, and talk therapy, as forms of therapy is common, as is the integration of Yoga, as well as re-balancing the physical body through physical exercise, and nutrition. Examples of spaces which have this approach are Earth House, located in Princeton,
New Jersey, and the Alternative to Meds Centre located, in Sedona, Arizona as discussed in the Literature Review.

Open Dialogue, in Finland, is an example of an alternative which emphasizes the role of relationships in the causation and potential resolution of ‘psychosis’. Other approaches include crisis spaces such as the Gerstein Centre in Toronto, Ontario, Canada, which provides short term non-medical crisis-respite, as well as care farms. The latter exist in several parts of the world, which make it possible for people experiencing ‘psychosis’ and/or other ‘mental illnesses’, to live and work on a farm, and participate in therapies such as those offered at Earth House and the Alternative to Meds Centre. Thus, though these approaches differ, the perspective on the nature of ‘psychosis’ remains generally along the same continuum among Alternative mental health practices and spaces, surveyed for this research project.

Apart from the perspectives on ‘psychosis’ taken in Alternative mental health practices and spaces, there are many other perspectives taken on this type of experience, in Indigenous communities throughout the world, as mentioned. For example, a perspective found in various parts of Asia, and extending into Eastern Europe, is that people who exhibit ‘psychosis-like’ symptoms, are in fact spiritually gifted people. These experiences are interpreted as a call from the spirit world, an indication that it is time for the individual to be spiritual learning. This is the case for the Angami people of Nagaland, India, the Sakhalin Ainu people of the Russo-Japanese border, as well as the Indigenous people of Bali.

In other cases, such as in the traditions of the Ojibwe people of North America, these experiences are considered part of the normal continuum of daily living. This perspective is also common in West African Indigenous traditions. ‘Psychosis’ is also conceptualized as ‘spirit illness’ in some contexts. For example, this is the case in some Middle Eastern, Islamic cultures,
as well as in the Haitian tradition of Voodoo. In addition, there are numerous systems of health, which exist worldwide, in which a conceptualization of ‘psychosis’, or even ‘mental health’, do not exist, and thus, in which, these concepts are not relevant to the systems of medicine which dominate. Examples of these include Traditional Chinese Medicine (TCM), Taoism (also from China), traditions of the Stolo people of the Skwah and Stolo First Nations of the Fraser River Valley along the lower Mainland of British Columbia, and particular medical systems of the Quichua people of the Andes.

Interestingly, from the interviews conducted, perspectives which were shared by the five Alternative and Indigenous health practitioners, concerning ‘psychosis’, for the most part, combined aspects from the Alternative and Indigenous perspectives discussed in the literature review. For example, Sangoma Oludoye, Barghavi Davar, and David Oaks mentioned combining different systems of knowledge in interpreting, understanding, and healing ‘psychosis’. Jay Tropianskaia and Laini Lascelles focused on a primary mode, based in a particular cultural perspective. In combination with the Literature Review, these practitioners were interviewed, in order to provide a deeper look into the healing work and perspectives of individual healers from different traditions and cultural contexts, who practice currently, as perspectives from the Literature Review are more general, and the vast majority are from text sources.

**Trends within Interview Data**

Apart from these insights into possible combinations of healing possibilities, the interviews afforded important insight into the role of mind, body, spirit, and context, in the causes, experience and manifestation of psychosis. Main insights have been, in terms of mind,
that the opinions of Alternative and Indigenous health practitioners have a significant influence on their understanding, and approaches to, ‘psychosis’. In terms of body, major insights were that the body plays an extremely important role in the causation, manifestation, and healing possibilities regarding ‘psychosis’. Context, it became apparent, was an extremely important element, possibly the most important, both in terms of the influence of the context of the health practitioner, on their approach to ‘psychosis, as well as the causation, experience, and manifestation of ‘psychosis’ itself. Though less directly mentioned, for reasons discussed, Spirit was mentioned as an important aspect of ‘psychosis’, by the majority of practitioners, in terms of one of the causes of ‘psychosis’ being imbalance and/or illness of spirit. Thus, important and current insights regarding ‘psychosis’ were shared by interview participants.

**Key Findings: Interview Data**

Apart from trends mentioned above, several key findings emerged from the interview data. Firstly, in all interviews, as well as data from all interviews combined, there was an emphasis on the integration of multiple perspectives and traditions, for the most comprehensive healing, for individuals troubled by experiences labeled as psychosis. Additionally, the location of ‘psychosis’ in the physical body, as well as in the connections and relationships between people, was a notable finding, reflected in data from all interviews.

Also worth special attention, was the importance of the focus on the individual, in attempting to understand, and offer potential healing, concerning experiences labeled as ‘psychosis’. Specifically, it emerged from interview data, that both the individual life
experiences, as well as the opinions and beliefs of the individual concerning their own healing, are of primary importance.

Finally, the importance of acknowledging greater societal and cosmic trends, in relation to the incidence and nature of psychosis, stood out as a notable finding. Amongst those which appeared in the interviews, were astrological, numerological, climactic trends. In addition, there appeared the trend of emerging societal movements, in mainstream Western culture, away from the interconnectedness of all things, towards the isolation of individuals, both from their families, as well as from historical, ancestral, and cultural connections.

**Connections between Interview Data and Research Question**

In terms of the original research question at the centre of this study, namely, how ‘psychosis’ is taken up in Alternative and Indigenous Health and Healing, the interview data reveals much which is relevant. As is apparent in the above sections, concerning trends and findings of note within interview data, the way in which ‘psychosis’ is taken up in these traditions is infinitely complex and multifaceted. Each trend and finding of note, and the combination thereof, is exemplary of this truth. Indeed, it could be said that it would be impossible to completely answer the research question, as this would defy a core principle which it is my hope has communicated by this study, namely that each individual which enters the world is unique, and will thus have unique experiences. This echoes what has been put forth by the Two-Eyed Seeing Framework, namely that each perspective on healing must be honored in its own right, in order for maximum healing potential to be realized for human beings,
collectively. Experiences of ‘psychosis’ are no different from any other human experiences in their uniqueness.

Consequently, ways in which these experiences are taken up in Alternative and Indigenous Health and Healing are extremely numerous, possibly infinite, due to the infinite variety found in experiences labeled as ‘psychosis’, as well as due to how different traditions and healing modalities can be combined, and, simultaneously created. Thus it is more a matter of observing the people and experiences they are having, and the modalities being used in the healing they are embarking on, at any given point in time, in any given place, rather than attempting to ascertain an overview of how experiences labeled as ‘psychosis’ are taken up in these traditions. This will be in constant flux, as the interview data, literature review, and combination thereof, have demonstrated, due to changing cosmic, global, and societal trends, as well as due to the birth of new combinational therapeutic approaches, and, most importantly, new human beings.

**Implications of Interview Data for Theoretical Development and Literature**

The interview data collected, contains much relevant to the further development of theory and literature concerning ‘psychosis’. As far as my knowledge and research has taken me, it appears that there are few studies which present data from as wide a variety of perspectives on this topic, despite the relatively small number of interviews. However, as stated in the previous section, such variety only presents more variety. In terms of theoretical development and literature, the variety presented by the data is an indication that there needs to be less of an attempt to create more theories concerning ‘psychosis’, and more of an attempt to gather
personal accounts of ‘psychosis’ worldwide, in order to form a more comprehensive database than what exists at present, as this is currently sparse. From such a comprehensive database, trends and possible theories could be created, however as it stands, this database does not exist, as far as I have been able to gather, from my research.

Though slim, the contributions made by the data presented by the interviews from this study, towards theoretical development concerning ‘psychosis’, could be said to be as follows:

- Theories concerning ‘psychosis’ must leave room for infinite individuality
- Theories concerning ‘psychosis’ must incorporate awareness concerning the roots of this concept in Western history, culture, and traditions
- Theories concerning ‘psychosis’ must either clearly state which socio-cultural context(s) they are referring to, or incorporate as many contexts as possible, leaving possibilities open for perspectives possibly left out, as well as continuously unfolding variety, as has been described in this study

Concerning literature, as stated, the variety presented by interview data indicates that an ever growing database of personal accounts of ‘psychosis’ is needed, in order for significant new literature on this topic to be created. Needles to say, this study is small in scale, and is my first attempt at such an exploration.

**In Hindsight**

Regarding if this project were to be conducted an additional time, more interviews would have been analyzed and included. In addition, a wider diversity of interview participants would be recruited, via sending interview invitations worldwide, in order to connect with Alternative
and Indigenous healing practitioners from a greater diversity of contexts, and to gather a greater diversity of perspectives on ‘psychosis’.

I feel strongly that this kind of study has great importance in the world today, due to the lasting mysteries surrounding ‘mental illness’, with there being no ‘cure’. In addition, I have learned a great deal from my activism in the area of alternative/mental health, and what I have learned from this, both from written sources, other activists, as well as attending and speaking at conferences such as the Psych out conference (2011), and the De-colonizing the Spirit Conference (2014, 2015), as well as other consumer/survivors (people who either currently take medication and feel they have survived the mental health system, people who have been forced to take medication against their will, and the many variations on these situations). These experiences have taught me that more studies similar to mine are extremely important to resolving the mystery surrounding ‘mental illness’ and ensuring that people who have experiences labeled ‘mental illness’, are respected and have complete autonomy.

In works such as these I feel it is of utmost importance to follow one’s intuition, as the power of individual intuition is much downplayed, leading to many people being on medication, and not living the lives they want to lead. By this, I mean that more survivors of experiences similar to mine, should be writing studies similar to this, focusing on sharing their stories and their healing journeys. To follow a mold of academic research, and to lose the individuality of these experiences, is to go directly against what the Two-Eyed Seeing Framework puts forth, namely that all individual experiences need to be valued in their own right, in order for the organism of the human community to be healthy, and this is no different regarding experiences of ‘psychosis’.
It is my hope that people from many walks of life read this study, though I would expect it would speak most directly to the consumer/survivor community, as well as the communities of Alternative and Indigenous Health Practitioners, those who are activists in the area of mental health, and possibly members of various Indigenous communities worldwide.

I feel it is important for everyone to read my work, and other works of this kind, in order to cultivate a greater, and more in-depth, understanding of experiences labeled as ‘psychosis’, and ‘mental illness’, due to the way in which this type of experience is central to many ‘mental illness’ categories such as ‘schizophrenia’ and ‘bi-polar disorder’ (see Index, Chapter 1).

This being said, in researching and writing, as mentioned in the Introduction, I had envisioned a document which would contribute to the relatively small amount of literature which exists concerning lived experiences of ‘psychosis’, and which would act as a supportive tool to individuals with experiences labeled as such, or related ‘mental illness ‘categories. In my own healing journey, it was extremely helpful to read about experiences similar to my own, and, in my searching during this period of time, I felt there was a lack of such resources, particularly those which consisted of personal narratives of experiences labeled as ‘psychosis’. These were the resources which were the most helpful to me, and which I have also heard from various Alternative and Indigenous healthcare practitioners, are the most helpful to others who have had experiences similar to mine (D. Hill, personal communication, 2014).

In addition, it was my intention to create a piece of research which would become part of the academic body of literature. This was a goal due to the way in which mainstream Western mental health discourse dominates academic literature concerning ‘psychosis’ and ‘mental health’. This domination, in turn, leads to the continued strength of these perspectives in influencing healthcare in the mainstream Western healthcare system.
It was my hope to contribute to the small body of literature concerning the lived experience of, and healing from, experiences labeled as ‘psychosis’, which exists in academia, in order to contribute to the effort to tip this balance, and bring the perspectives of consumer/survivors into mainstream Western mental health. On another front, it means a great deal to be able to provide documents, such as mine, which have become part of the academic body of literature, to alternative mental health organizations such as Mind Freedom International, in order that these documents can become part of the databases of these organizations. Due to the strength of the academy in mainstream Western mental health, bringing this strength to the alternative mental health movement as well, contributes to the overall strength of this movement, and the continued struggle for human rights in mental health.

Essential in this struggle, is taking a Two-Eyed Seeing perspective. It is only by hearing, learning from, and respecting individual stories, that comprehensive non-discriminatory support can be created for individuals with experiences labeled as ‘psychosis’, following the Two-Eyed Seeing perspective that all perspectives on healing and health should be valued and explored in their own right. Apart from the importance of individual narratives, the Two-Eyed Seeing Framework has been the ideal Framework with which to carry out this research project, due to the multiplicity of perspectives on ‘psychosis’ which have been explored, both historically and socio-culturally, as it is a continual reminder to view each perspective as equal.

Indeed, in general, the Indigenous ways of researching selected for this study, were ideal for this study. This has been discussed in terms of the Two-Eyed Seeing Framework, however it is also the case in relation to the open-structure interview method employed, the Medicine Wheel Model, as well, as the principles put forth by some Indigenous research methodologies, which I followed in conducting this research. As discussed in earlier chapters, these have included the
importance of self-location, accountability, dialogue and consultation with spirit and with Elders, and the connection of research to the researcher’s life as a whole.

The open-structure interview method was employed to allow for ultimate open-ness and flexibility in the interview content, in order that any related content, not necessarily related to interview questions, could be shared comfortably. This worked very well as many layers of context were given for much information shared by interview participants. Interestingly, some interview participants answered more closely to the questions posed, while some provided much additional information.

The Medicine Wheel model was uncannily in correlation with interview findings and thus greatly facilitated the analysis of data. Each participant spoke to each quadrant of the Medicine Wheel, as well as to the utmost importance of balance between quadrants, for ultimate health. In terms of the incorporation of the mentioned principles of Indigenous research methodologies, these are directly in-line with my personal beliefs, and thus were enjoyable to use in structuring this research project.

To others embarking on a similar study, I would recommend to make a strong effort to be as aware as possible of how the mainstream Western mental health discourse dominates mental health discourse, often, even in sources which claim to be taking a different vantage point. This was something I came across numerous times in my research.

In a similar vein, a topic I feel is important to explore, in the type of study I have conducted, and which I would have liked to examine in more depth, is the conception of experiences similar to what is labeled, in mainstream Western medicine, as ‘psychosis’, in contexts other than the mainstream Western conception. I feel my survey, though useful and
informative, could have been done with more depth, exploring more perspectives, and going into more detail about each perspective. However, it is possible that this would have been too much—and might be a topic for an additional thesis.

In a future study, I would go into more depth concerning language barriers in this type of study. I am only fluent in English, with some knowledge of French. This means I am limited to resources which are written in English, although this is not as much of an issue as it might be in the context of a different study, as many of the databases which list mental health alternatives, are compiled by international organizations with membership consisting of people who speak different languages, which is reflected in the compilation of organizations which exist on their websites. The websites of many alternative healing spaces also provide translations, either from a language other than English to English, or vice versa. This being said, I still feel I may have missed a number of Alternative and Indigenous practitioners and spaces in my research, due to the mentioned language barrier.

An additional area into which, if writing the same study again, I would have gone into in more depth, would have been so-called ‘alternative mental health’ therapies and spaces. I feel I have missed some diversity here as I did not include a large number of examples, and feel there might be some depth of perspective which I may have missed. However, my feeling, from the research I have done, is that the same lack of awareness concerning the Indigenous roots of many of these therapies, and those which inform these ‘alternative’ spaces, would also be present. To conclude, experiences labeled as ‘psychosis’ are complex in nature, concerning which a vast variety of perspectives exist. It is my hope, that this document has clarified why and how this is the case. As this document has been an attempt to show, this concept was born at a certain point in time, and in a particular cultural context, one which was privileged and thus able to spread. A
vast multitude of other traditions exist throughout the world, to which the mainstream Western concept of ‘psychosis’ is completely irrelevant.

Thus, there is a plethora of ways in which these experiences are approached. There is also a myriad of diverse factors, cross-culturally, which lead to the state described as ‘psychosis’. In light of this diversity, this study demonstrates that there are many alternatives to the forced diagnosis and drugging with psychiatric medications, which occurs frequently when only looking through the one eye of mainstream Western mental health, rather than the two eyes of the multitude of interpretations which exist around the world, and in different socio-cultural contexts. It is my sincere hope that this truth becomes widespread in such a way as to save and protect individuals from the pain of being forcibly medicated and diagnosed, within mainstream Western mental healthcare, in current times and in the future.
Appendix: Interview Questions

Interview Questions

1. Based on your professional healing practice, do you see what is labeled as psychosis in mainstream Western mental healthcare as a culturally, historically, socially situated idea? Why or why not and how? If not, what is psychosis, based on your professional healing practice?

2. How do you approach what is labeled as psychosis in mainstream Western mental healthcare, in your professional healing practice?

3. What are your recommendations concerning how to make positive change in the mental healthcare system, regarding the concept of psychosis?
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