Envisioning Deep Collaboration Between Psychiatry And Traditional Ways Of Knowing In A British Columbia First Nations Setting: A Personal Reflection

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Abstract:
In this paper, I draw on my experiences of providing psychiatric outreach services to indigenous communities near Chilliwack, B.C. over the course of a two and a half year period. The principle aim of the paper is to critically examine and reflect on the concept of collaboration as it pertains to psychiatric services on Canadian First Nation communities. The hope is that doing so will inform the work of others engaged in service development and delivery in similar settings. The analysis proceeds through a combination of personal reflection and critical reading of pertinent literature. Emerging from the analysis is a tripartite conceptualization of collaboration that recognizes the value of structural or organizational collaboration but which, at the same time, acknowledges the possibility of and calls for a deeper level collaborative approach. A multi-level conceptualization of collaboration then is envisioned in this paper; one that encompasses the notions of collaboration at 'deep' and 'ideological' in addition to 'surface' levels. Barriers to the realization of such a multi-level collaboration are examined and discussed.

Key words: collaboration, Western psychiatry and traditional/indigenous healing asymmetrical relationships, Western and traditional medicine

INTRODUCTION

In the fall of 2012 I was fortunate enough to be invited to start up a psychiatric clinic on Seabird Island, a First Nation close to Chilliwack, in British Columbia, Canada. My understanding was that the leadership at Seabird had approached the local health authority to inquire about possible provision of psychiatric services following a recent spate of adolescent suicides. There had also been a longstanding recognition of the existence of an unmet need for mental health services at Seabird and in neighbouring First Nation communities. I responded eagerly to this invitation, knowing from the outset that this would be a great opportunity not only to contribute to the mental health needs of indigenous communities but to further my knowledge and understanding of indigenous culture, something I had been interested in for several years. I went along to meet key personnel at Seabird in December and the psychiatric clinic became fully operational by February 2013. Three years later, the clinic is thriving and its basic structure is as follows: I see patients at the Seabird Island Health Centre on alternate days. All the patients I see are referred to me by one of two family physicians, both based at Seabird, and my clinic accommodates new patients as well as follow ups. The clinic has received much positive feedback from the key stakeholders. This includes the local community, the band chief, the patients, and both of the referring physicians. Drawing on my three years of experience at Seabird, what I aim to do in this paper is to critically reflect on the concept of 'collaboration' – especially the way in which the concept applies to the specific context of a psychiatric clinic in First Nations communities. As I do so, I intend to draw on my personal observations and reflections as well as relevant literature. The guiding questions in this paper are: *What*

is really meant by the concept of collaboration in the context of psychiatric services in indigenous communities such as Seabird Island? What are its terms and limits? And to what extent are we realizing the full potential of collaboration with the present model of service delivery?

WHAT IS THE COLLABORATIVE IDEAL AND HAVE WE ACHIEVED THIS ON SEABIRD?

Ruiz and Langrod[1] published a compelling paper in the *American Journal of Psychiatry* in 1976 called "Psychiatry and folk healing: A dichotomy?" reporting an interesting collaboration in the South Bronx whereby professionals from a mental health center visited *centros* to observe folk healers (*curanderos*) practicing on members of the Hispanic communities, mainly of Puerto-Rican descent. Such a collaboration transcended the dichotomy that was otherwise held to exist between psychiatry and folk healers allowing for a reciprocal exchange in which Western mental health professionals came to be convinced of the value of folk healing and in which the curanderos came to be informed of the sorts of things to watch out for that might indicate the presence of a serious illness requiring Western style medical intervention.

This strikes me as a great example of collaboration. It is one that involves a direct face-to-face encounter between folk healers and professionals from a mental health center in which there is mutual, reciprocal learning. Has this type of collaboration been achieved at Seabird? The answer is a clear "no." I have never met a traditional healer at Seabird. They exist but do not seem to be easily accessible. My impression is that some members of the community are engaged in traditional healing practices but they are not the ones who generally come to see me. This, for me, epitomizes what Ruiz and Langrod describe as a 'dichotomy'. Even if my clients were accessing traditional healers without me knowing (as many do[2]), this would still represent a dichotomy and could not be regarded as 'collaboration'.

Another example, one that feels much more close to home, is Jilek and Todd's (1974)[3] paper, *Witchdoctors succeed where doctors fail*. This paper reported a collaborative endeavour describing the outcomes of twenty-four individuals from a B.C. Coast Salish community who, over a four year period, had gone through a 'winter spirit dance initiation'. The sequence of events in the winter ceremonial was described: symbolic clubbing to death of the initiate in the smokehouse, followed by relative seclusion for at least four days before a symbolic rebirth in the presence of cheering crowd and rhythms of drums. Out of eleven cases of anxiety or depression or somatic illness,seven showed significant improvement. Out of thirteen cases of behavioral disturbance or aggressive tendencies, 13 were rehabilitated and 4 were described as having improved remarkably. The authors claimed then that collaborations between Western psychiatrists and traditional healers were associated with empirically demonstrable favorable outcomes. This quantitative information was complemented by five detailed case reports and ethnographic descriptions of indigenous healing (including the spirit dance initiation) and this made for what was a methodologically eclectic paper. The case reports suggested that indigenous healing led to clinical improvements in many cases where the efforts of Western psychiatrists had failed. I find this to be an elegant demonstration of collaboration possible with Canadian indigenous communities—one that has not yet unfolded at Seabird.

BARRIERS TO COLLABORATION

(i) Dichotomy and Hierarchy

Western biomedicine has traditionally endorsed the position that only it is good and true. Waldron4, writing specifically about

the marginalization of African healing traditions within Western medicine, echoes those sentiments. She writes about the devaluation and de-legitimization of non-Western forms of knowledge and also refers to a dichotomy separating Western medicine and indigenous healing as well as a hierarchical relationship between them. Such factors, for Waldron, serve to "obscure opportunities for alliances" [4](p52)

Yen & Wilbraham[5] contend that initiatives to nurture collaborations between indigenous healers and Western practitioners are often fraught with challenges because the moral space in which psychiatry is located is characterized by a discourse that construes indigenous healing as unprofessional and naive. Moreover, they argue that the professional discourse within which Western medicine and psychiatry are couched marginalizes and stigmatizes indigenous healing as 'the other'. The authors observe that such discourse is characterized by sharp boundaries between professionals and non-professionals and perceived rationality of professional discourse due to their membership in institutions that regulate medical knowledge and practice. The existence of negative and dismissive attitudes among medical professionals has recently been given empirical support in at least two studies (one from Germany[6], the other from the United States[7]) of medical students' attitudes towards complementary and alternative medicine. A South African study[8] reported the results of individual and focus group interviews with service users and providers in order to explore their perceptions of the interaction of the traditional and Western systems of care. Traditional healers expressed a lack of appreciation from Western health care practitioners but were open to training in Western biomedical approaches and establishing a collaborative relationship in the interests of improving patient care. Western bio-medically trained practitioners, in contrast, were less interested in such an arrangement.

(ii) Fear Among Traditional Healers

Several authors [9],[10]write about the history of governmental attempts to suppress traditional healing. The so-called "potlatch ban" or "potlatch law" was an infamous piece of Canadian legislation enacted in 1885 outlawing native ceremonial practices. It led to many of them being eroded altogether and some of them being forced underground. In recent years, I have been privileged to have had numerous informal conversations with elders in the communities where I have the good fortune to work. During those conversations, the nature and extent of that governmental suppression has been conveyed to me by individuals who witnessed it first-hand. Upon hearing such first person accounts and upon learning about the sort of systematic and sustained subjugation that local indigenous culture was subjected to at the hands of colonial agencies over many decades, one cannot but fail to be deeply moved. Additionally, several elders have shared with me that a culture of fear in local indigenous communities□ one that had become entrenched over the course of a century or so□ persisted for decades, even after the repugnant potlatch law was repealed, in 1951. It has often been shared with me that it wasn't until the 1970s that the icy fear within BC Coast Salish communities started to loosen its paralysing grip, emerging from which was a cautious confidence that participation in traditional ceremonial practices could take place without reprisals from the authorities. Given that historical reality, it is hardly surprising that many keepers of traditional knowledge today continue to be guarded about sharing it with Western professionals.

(iii) Current Models

The two elegant examples[1, 3] given in the introduction would appear to go against Waldram's[11] contention that true collaboration between Western biomedicine and traditional healing has never occurred. As well, there are a handful of supposed holistically oriented health services around Canada such as the Anishnawbe Mushkiki Aboriginal health centre in Thunder Bay, the Anishnawbe health centre in Toronto, the Eskasoni community health centre in Nova Scotia, the Noojmowin Teg health centre in Mantoulin Island, Ontario, and so forth.[12] These are not, however, systematically described, which means that there is no description of referral pathways, no reference to either the numbers or types of patients seen, no referral criteria, and no mention of whether or not psychiatrists are involved.

A few exceptions to the above demonstrate similar problems to the Seabird Island Health Centre in terms of setting up collaborations with traditional healers. For example, Wieman [10] provides a description of Six Nations Mental Health Services in Southwestern Ontario (running since 1997). The team is comprised of four mental health nurses and two part-time psychiatrists. The most common presenting problems are mood disorders and 'disruptive behaviors'. Of particular interest to us is the fact that the author describes having had difficulties in establishing collaborative working relationships with traditional healers in the community speculating that "due to discrediting of traditional healing in decades past, many traditional healers in the community work 'underground' and are difficult to access."[10(p184)] The author goes on to hint that the development of collaborative relationships with traditional healers is a work in progress.

Maar & Shawande[9] describe some aspects of an integrated mental health clinic on Manatoulin Island in Lake Huron, Ontario—in existence for 10 years. There is a weekly central intake meeting attended by a psychologist, a mental health nurse, a traditional coordinator, two social workers, and a case manager. The authors share some practical tips/suggestions about factors that facilitate integration such as all team members sharing the same office space and having an open door policy. They write that as the service has developed, increasing numbers of clients have been able to access traditional healing resources and moreover are willing to report having done so. One issue that is emphasised is the fact that not all Aboriginal people want to be able to access traditional healers, implying that referrals should be sensitive to individuals' needs. Another suggestion is that forums and educational events should be facilitated where Western clinicians and traditional healers can come together to learn from each other.

Although at the service-delivery level, things are in their infancy, there is much interest in identifying and understanding barriers so that they can be overcome. A great example of this comes from Crowe-Salazar's[13] impressive study from Southern Saskatchewan, eliciting the views of a psychologist, a psychiatrist, and a traditional healer on the subject of working together and of forging partnerships between different systems of healthcare. All the participants identified the need to know each other's perspectives in a more meaningful way and the researcher suggested directed talking circles in which such a dialogue could unfold. One of the striking features of this study is its optimism and hopefulness. Crowe-Salazar identified differences in the respective worldviews, training and so forth of the Traditional healer, the psychiatrist and the traditional healer but also identified the fact that there is much common ground and it is important to bring attention to these as a starting point. These included a sense of humility, a desire to help others, and

Case Vignette 1

An illustrative case of collaboration is Wendy (pseudonym), a 50 year old female who I am treating for depression. As a child she had witnessed significant violence between her parents and then sudden abandonment by her mother as a 13 year old. In addition she was separated for several years from her siblings when she was sent to a series of residential schools. At her own request I referred her to a residential treatment program near Nanaimo - Tsow-Tunlelum (Healing house) which incorporates Traditional healing into its program. She recently returned after a 4 week period of treatment telling me that she feels that this program helped her to "get to the root" of her trauma. She reports some cathartic healing experiences, telling me that she cried for the first time since she was a girl, and that, as a result of this, she feels "emotionally unblocked" and that her depression has lifted significantly. While in treatment she participated in several sweat ceremonies, a pipe ceremony, and had dialogues with elders.

an impulse to give. In commenting on the values that are important in services that effectively manage to integrate indigenous and Western models, the importance of the concept of an 'ethical space' defined as a space of possibility that emerges when two groups with distinct worldviews engage with one another in mutual collaboration and respect was highlighted by Tait[14]. Pakula and Anderson[12] argue that successful integration depends on validation and co-existence of two different epistemologies of health rather than the one subsuming the other in the name of integration.

Sts'ailes

In February, 2015 I started another psychiatric clinic in the community of Sts'ailes, not far from Seabird Island. Again, I was delighted to be asked to do this. Several meetings took place between key people on Sts'ailes and professionals from the local health authority over a period of almost a year before I started seeing my first clients. My two years at Seabird have not only helped form a vision of what collaboration should look like but also better recognize the obstacles that get in the way of the realization of this vision. I have been reaching out to traditional healers at Sts'ailes and have met with one of them three times, including participating in a Sweat ceremony that he led. We have spoken about referral pathways (both directions) and exchanged general knowledge in which (much like the Bronx study quoted above) I am learning about the forms of traditional healing available to members of the Sts'ailes community and I am advising them about the sorts of circumstances where I think Western medical intervention would be helpful. We are also exploring the feasibility of an innovative model of service delivery in which the traditional healer and I see clients together. On both our parts, there is a strong appreciation of the importance of data collection ('collecting stories') from the outset. This will assist us not only in quantifying the extent to which traditional healing is already utilized by those attending the psychiatric clinic but in determining if our efforts to forge collaborations prove to be effective.

CULTIVATING A DEEPER COLLABORATIVE ATTITUDE

I have come to appreciate that there is another area that falls under the general rubric of 'collaboration,' albeit a qualitatively distinct type of collaboration from that which I've

discussed so far. It entails the assumption of a collaborative attitude towards the perception of mental illness. For me, it's about building bridges between Western bio-medically oriented explanations of mental disorder and those that are more congruent (and not necessarily in conflict) with indigenous conceptualizations. It is beyond my scope here to review the indigenous conceptualizations of mental disorder in great depth but I can at least acknowledge that indigenous concepts stress such notions as 'loss of balance' and 'loss of harmony', themselves thought to result from some sort of disconnectedness from the land, the family, or the culture. Such terms as 'loss of balance' and 'loss of harmony' themselves transcend the mind-body distinction, something that is widely considered to be an artefact of Western enlightenment logic and as such, incongruent with most indigenous conceptualizations of the mind-body relationship. When I conduct psychiatric interviews with clients, I attempt to bridge this divide by asking a question such as "from your own cultural perspective, how do you make sense of/explain the difficulties you are having?" I have invariably found that an openness and receptiveness to clients' own explanatory model (explanatory story) is informative.

Asking clients about their spiritual practices in an interested, non-judgemental manner can positively affirm their spirituality. I learned this when I saw a 40-year old woman recently on Sts'ailes, suffering from depression. During what I recall was our 2nd meeting, I inquired about her previous spiritual practices and by the time she came back to see me for the 3rd meeting she had for the first time in several years gone and had a 'spiritual bath' on 2 separate occasions—telling me that she had found them to be very therapeutic and rejuvenating.

It took 2 years before I began to envision what a truly collaborative project could and should look like. It took the same amount of time to realize that simply providing 'psychiatric outreach' to First Nations communities in itself represents only the most surface level of collaborative endeavours and that there is so much more that can potentially be achieved in the name of collaboration. I would contend that collaboration should be thought of as a broad concept, perhaps as a spectrum, one that has many facets and dimensions. Tentatively, as guides, I have used the categories of surface level (or structural) collaboration, deep collaboration, and deeper (or ideological) collaboration – but I do acknowledge the arbitrariness of these terms. I would suggest that our understanding of the collaborative approach can be sharpened through a kind of dialectal comparison with a non-collaborative approach. In other words, we gain an understanding of that which is collaborative when we bring to mind that which is evidently non-collaborative.

The different levels of collaboration may also be depicted on a pyramid or 'iceberg' diagram (see Figure 1 below). Surface collaboration (or Collaboration I) refers, in settings such as ours, to a Western physician providing clinical services in a First Nations community.

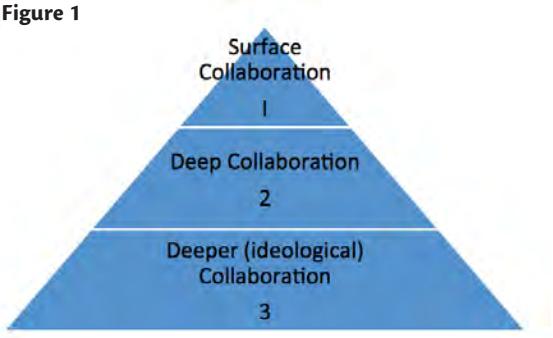
Case Vignette 2

A 52 year old man who I am treating for depression told me that he was 19 when he first came to know of what he calls his 'gifts'. These mostly revolve around a precognitive awareness of the fact that someone close to him is about to die. From the beginning he regarded these gifts as a mixed blessing: It was a gift but it was also a burden and he admits—as a 19 year old—to have been thrown into conflict. This conflict was a significant factor behind his heavy drinking which also began at age 19. He was in his 40s when he embarked on a 20 year period of sobriety and he tells me that this coincided with his full embrace and acceptance of his gifts.

Collaborative approach (Symmetry)	Non-Collaborative approach (Asymmetry)
Psychiatry and traditional healing are equally valued	Psychiatry is superior to traditional healing
Psychiatry complements traditional healing	Psychiatry excludes traditional healing
Biomedical and traditional explanatory models complement one another	Biomedical explanatory models exclude traditional ones
Humility (Western ethno-psychiatry is 'culture bound' and is not universally relevant)	Arrogance (Western psychiatry is universally relevant)

As has been argued in this paper, this level of collaboration merely scratches the surface of collaborative possibilities and so it should prefigure the realization of deep collaboration (Collaboration II) in which the Western clinician and traditional healers interact, mechanisms and pathways for reciprocal referral become established, and mutual knowledge exchange takes place in which the two sides learn from each other about each other's therapeutic approach. Collaboration III goes deeper still for it creates space within the Western clinician's understanding of illness for the client's own – culturally congruent or 'emic' perspective. This is likely to be challenging for Western practitioners whose training, in most instances, has not equipped them with the countenance of non-Western, non-DSM conceptualizations of illness or its causation—some of which, in invoking supernatural causal ideas or concepts such as disconnectedness, imbalance, inter-generational trauma, historical trauma, and so forth, invite Western clinicians to undertake a fundamental re-think of their conceptualizations of the nature and causes of mental illness.

Figure 1



An Asymmetrical Relationship

Asymmetry frames the relationship between Western psychiatry and traditional healing. The former, rooted in and committed to European enlightenment values, has often stood accused of conceptualizing human concerns in overly narrow terms, within a positivistic paradigm whose culturally specific nature often goes unacknowledged. For some commentators, this tendency on the part of psychiatry has been explained as a sort of "science envy"[15 (p114)] in which psychiatry, perhaps because of the inherently ambiguous and contested nature of its subject matter, aims to seek legitimacy through identification with the so-called 'hard' or 'natural' sciences and its methods. Psychiatry's uncritical appropriation of 'evidence based medicine' constitutes, to my mind, a gilt-edged example of this science envy. Yet the evidence based medicine movement is increasingly under scrutiny.[16,17] The prohibitively expensive methods used to legitimize therapeutic interventions in the

West (double blind, placebo controlled randomized controlled trials as a 'gold standard' for instance) are unlikely, realistically speaking because of barriers that are conjointly pragmatic and epistemological to ever legitimize most forms of traditional healing. It is essential then, in my view, that when embarking on the sorts of collaborative ventures that have formed the subject matter of this paper, we adopt a critical relationship towards such concepts as 'hierarchy of evidence', 'outcome', 'efficacy' 'evidence' and so forth. Implicit to these concepts and imbued within them are assumptions about what does and what does not legitimize any given therapeutic or healing practice.

I find support with regards to these concerns in Waldram[11] who says that the sorts of concerns with efficacy that define western medical outcome research should not necessarily be assumed to translate to the sphere of traditional healing. Waldram writes "What science cannot see, is not allowed to see, or is incapable of seeing, is invariably condemned as unscientific. Such is the legacy of positivism." [11(p96)] Waldram admits that when traditional healing has been subject to efficacy research, the results have been "ambiguous"[11(p93)] and I share what I understand as Waldram's lack of confidence about the prospects of traditional healing thriving if it were subject to the prevailing evaluative procedures and technologies of Western biomedicine. This speaks to the asymmetrical relationship between Western medicine and traditional healing—the manifestations of which, though often unacknowledged, remain pervasive.

Describing it as "one of the festering irritants for indigenous peoples" [18(p198)] Ermine [18] decried the Western assumption about the presumed universality of Western thought—what he calls the "God's eye view of humanity" [18(p198)]. Psychiatry is not at immune from such 'God's eye' assumptions of its own universality. I believe that psychiatrists, especially those working in culturally diverse settings, must keep in mind the fact that psychiatry itself is a culturally specific practice, a form of 'ethnomedicine' whose values, premises, and commitments themselves reflect local and contested truths as opposed to universal ones.

Conclusion

What I have come to appreciate over the course of the last 3 years, more than anything else, is that Western psychiatry is forced into a mirror-like confrontation with itself when it comes up against a boundary with another culture whose epistemological and ontological premises, and whose cosmologies are different from its own. I would contend that this boundary also constitutes what we may conceptualize as a 'limit situation' since it is at this interface that Western psychiatry's conceptual limitations become particularly exposed and its assumptions of universality particularly problematized. As a psychiatrist steeped in the Western medical culture for almost 20 years, my recent work with Canadian First Nations communities behooves me to 'question everything' about psychiatry and to be unceasingly self-reflexive and critical about Western psychiatry's conventions and dogmas, its diagnostic categories, its evaluative procedures, its theories of causation of mental illness, its healing modalities, and so forth.

Psychiatry has been guilty of engaging in a systematic negation of the cultural other,[19] often deploying pathologizing language in the service of this invidious undertaking. My hope is that the professional climate is more ripe now for what has historically been an uneasy relationship between Western psychiatry and traditional ways of knowing to move towards

a place of symmetry and of mutual respect. Perhaps I am being naïve and/or idealist, but in the absence of such a vision, the prospects of anything other than the status quo remain slim at best and non-existent at worse. Crowe-Salazar[13] emphasizes that though there are differences, it is more important and more relevant to our task to focus not on them but on commonalities, of which there are many. If we heed Crowe-Salazar's advice, the realization of our collaborative vision is eminently possible.

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References

1. Ruiz, P. & Langrod, J. (1976). Psychiatry and folk healing: A dichotomy? *American Journal of Psychiatry*, 133, 95-97.
2. Cook, S. J. (2005). Use of Traditional Mi'kmaq medicine among patients at a First Nations community health centre. *Canadian Journal of Rural Medicine*, 10(2), 95-99.
3. Jilek, W. & Todd, N. (1974). Witchdoctors succeed where doctors fail: Psychotherapy among Coast Salish Indians. *Canadian Psychiatric Association Journal*, 19, 351-356.
4. Waldron, I. (2010), The marginalization of African Indigenous healing traditions within Western medicine: Reconciling ideological tensions and epistemological tensions along the epistemological terrain. *Women's Health and Urban Life,* 9(1), 50-68.
5. Yen, J. & Wilbraham, L. (2003). Discourses of culture and illness in South African mental health care and indigenous healing, part I: western psychiatric power, *Transcultural Psychiatry*, 40 (4), 542-561.
6. Ditte, D., Schulz, W., Ernst, G., & Schmid-Ott, G. (2010). Attitudes towards complementary and alternative

medicine among medical and psychology students. *Psychological Health & Medicine*, 16(2), 225-237. doi: 10.1080/13548506.2010.532559

7. Abbot, R.B., Hui, K.K., Hays, R.D., Mandel, J., Goldstein, M., Winegarden, B., Glaser, D., & Brunton, L. (2011). Medical student attitudes toward complementary, alternative, and integrative medicine. *Evidence Based Complementary and Alternative Medicine*, doi:10.1093/ecam/nep195
8. Campbell-Hall, V., Peterson, I., Bhana, A. Mjadu, S., Hosegood, V., Fisher, A.J; MHaPP Research Programme Consortium (2010). Collaboration between Traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. *Transcultural Psychiatry*, 47(4), 610-628. doi: 10.1177/1363461510383459
9. Maar, M.A. & Shawande, M. (2010). Traditional Anishinabe healing in a clinical setting: The development of an Aboriginal interdisciplinary approach to community based Aboriginal mental. *Journal of Aboriginal Health*, 6(1), 18-27.
10. Wieman, C. (2000). An Overview of Six Nations Mental Health Services. In The Mental Health of Indigenous Peoples-Proceedings of the Advanced Study Institute McGill Summer Program in Social and Cultural Psychiatry and the Aboriginal Mental Health Research Team. May 29-31.
11. Waldram, J. B. (1997) But Does it Work? Traditional Healing and Issues of Efficacy and Evaluation. In Widening the Circle: Collaborative Research in Mental Health Promotion in Native Communities. Proceedings of the Conference September 26-28. Montreal. Canada.
12. Pakula, B. & Anderson, J.F. (2013). Sts'ailes primary healthcare project: Report.
13. Crowe-Salazar, N. (2007). Exploring the Experiences of an Elder, a Psychologist and a Psychiatrist: How can Traditional Practices and Healers Complement Existing Practices in Mental Health? First Peoples Child and Family Review, 3(4), 83-95.
14. Tait, C.L. (2008). Ethical programming: Towards a community centred approach to mental health and addiction programming in Aboriginal communities. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 6(1), 29-60.
15. Bakker, C.B. & Bakker-Rabdau, M.K. (1985). An Educational Approach to Psychiatric Problems in P. Pichot (Ed.). Psychiatry and the State of the Art Volume 4: *Psychiatry and Psychosomatic Medicine* (pp. 112-118). NY, New York: Plenum Press.
16. Gupta, M. (2014). *Is evidence-based psychiatry ethical?* Oxford: UK. Oxford University Press.
17. Timmermans, S. & Mauck, A. (2005). The promises and pitfalls of evidence-based medicine. Health Affairs (Millwood), 24(1), 18-28.
18. Ermine, W. (2007). The ethical space of engagement. *Indigenous Law Journal*, 6(1), 193-203.
19. Benning, T.B. (2014). Before and after psychopathology: A Foucault-inspired perspective on Western knowledge concerning the shaman. *Fourth World Journal*, 13(1), 59-67.